Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
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Public Report

Report Issue Date: January 10, 2025
Inspection Number: 2024-1145-0008
Inspection Type: Complaint Critical Incident
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.
Long Term Care Home and City: Stoneridge Manor, Carleton Place

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 30, 2024, and January 3, 6, 8, 9 and 10, 2025.

The following intake(s) were inspected:

- Intake: #00131886 was a complaint related to concerns about a resident's plan of care.
- Intake: #00132748 / Critical Incident System (CIS) report 3064-000071-24 was related to allegations of staff to resident abuse.
- Intake: #00133270 / CIS report 3064-000072-24 was related to an allegation of staff to resident neglect.
- Intakes: #00133431 and #00134088 were complaints with concerns related to staffing.
- Intake: #00134956 / CIS report 3064-000074-24 was related to an allegation of improper or incompetent care of a resident by staff.
- Intake: #00135242 / CIS report 3064-000075-24 was related to an allegation of improper or incompetent care of a resident by staff.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(b) appropriate action is taken in response to every such incident; and

The licensee has failed to ensure that appropriate action was taken in response to allegations of abuse involving a Personal Support Worker (PSW) and several residents.

Sources: A review of the home's investigation notes and CIS report.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that suspected neglect of a resident was reported to the Director immediately. It was reported the following day when a CIS report was submitted.

Sources: A CIS report and interview with the Director of Nursing and Personal Care.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A) The licensee has failed to ensure that a PSW used safe transferring techniques when they transferred a resident using a mechanical lift by themself. The use of a mechanical lift required the presence of two staff to complete the transfer.

Sources: A review of a resident's health care record, a CIS report and interview with the Director of Nursing and Personal Care.

B) The licensee has failed to ensure that a PSW used safe transferring technique when they transferred a resident using a mechanical lift by themself.

Sources: A review of a resident's health care record, a CIS report and interview with the Associate Director of Care.