

Ministry of Long-Term Care

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

Ottawa District

347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: July 18, 2025

Inspection Number: 2025-1145-0005

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): July 14, 15, 16, 17, 18, 2025

The following intake(s) were inspected:

- Intake: #00146741 - CI: 3064-000023-25 - related to a resident's fall, which resulted in injuries.
- Intake: #00149169 - CI: 3064-000027-25 - related to a resident's fall, which resulted in injuries.
- Intake: #00148049 - complaint about care and services.
- Intake: #00150842 - complaint about resident equipment, care, and services

The following **Inspection Protocols** were used during this inspection:

- Resident Care and Support Services
- Continence Care
- Skin and Wound Prevention and Management
- Safe and Secure Home

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Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that resident was reassessed, and their plan of care was reviewed and revised when an intervention was no longer effective. Specifically, the resident's plan of care indicated that staff were to collect and secure the materials use by the resident for their recreational activity. However, staff reported that this intervention was no longer effective in managing the resident's recreational activity materials.

Sources: resident's health care records, observation, interview with Personal Support Worker (PSW), Registered Nurse (RN) and Interim Director of Care (IDOC)

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WRITTEN NOTIFICATION: Compliance with manufacturer's instructions

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 26

Compliance with manufacturers' instructions

s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee failed to ensure that the resident's fall prevention device was installed as per the manufacturer's instructions, which require that the device be properly placed and to be certain it is functioning properly. On a specific date, the device failed to activate, resulting in the resident's fall and subsequent injury.

Sources: resident's health care records and interview with the Interim Director of Care (IDOC).