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

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Public Report

Report Issue Date: August 14, 2025
Inspection Number: 2025-1145-0006
Inspection Type: 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): August 13 and 14, 2025.

The following Critical Incident (CI) intake(s) were inspected:
-Intake #00153250 (CI 3064-000033-25) - Injury of a resident resulting in transfer to hospital and change in condition; and
-Intake #00154363 (CI 3064-000035-25) and intake #00154541 (CI 3064-000036-25) - Alleged improper/incompetent care of a resident by a staff member related to transfer.

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

Resident Care and Support Services
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an incident of improper treatment or care of a resident that resulted in risk of harm was immediately reported to the Director. Specifically, the licensee failed to ensure that an allegation of an improper transfer of a resident by a Personal Support Worker (PSW) was reported immediately to the Director on the day it occurred.

Sources:
Critical Incident 3064-000035-25;
Interview with ADOC.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 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.

The licensee has failed to ensure that staff use safe transferring techniques when assisting residents. Specifically, the licensee failed to ensure that a PSW transferred a resident as a two-person transfer as specified in the resident's care plan.

Sources:
Interview with Assistant Director of Care;
Investigation interview notes with a PSW conducted by the home;
Critical Incident 3064-000035-25;
Resident's electronic medical records.

The licensee has failed to ensure that a PSW used safe transferring and positioning devices when they transported a resident from their room to the tub room without applying a specific positioning device. As a result, the resident experienced an injury.

Sources: Resident's health care record; Disciplinary notice letter for PSW involved; and interviews with a Registered Practical Nurse (RPN), a Registered Nurse (RN), the Director of Care (DOC), and the resident.

WRITTEN NOTIFICATION: Pain Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically

appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that a Pain Assessment in Point Click Care (PCC) was completed when a resident's pain was not relieved after 72-hour pain monitoring.

Sources: Resident's progress notes; 72-Hour Pain Monitoring Tool; Pain Assessment and Management Procedure, INDEX: CARE8-010.01, reviewed March 31, 2025; and interviews with an RN, an RPN, and the DOC.