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

Original Public Report

Report Issue Date: April 19, 2024	
Inspection Number: 2024-1145-0001	
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	
Lead Inspector Lisa Cummings (756)	**Inspector Digital Signature** Lisa Cummings Digitally signed by Lisa Cummings Date: 2024.04.22 14:23:38 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 8, 9, 10, 15, 16, 17, 19, 2024
The inspection occurred offsite on the following date(s): April 11, 18, 2024

The following intake(s) were inspected:

- Intake #00107485 3064-000001-24/ 3064-000002-24 - An allegation of staff to resident neglect and the complaint response process
- Intake #00111655 - A complaint about the refusal of admission to the home

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

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee consideration and approval

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (7) (b)
Authorization for admission to a home
s. 51 (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 50 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or

The licensee has failed to take into account and approve an applicant's admission to the home based on the assessments and information that were provided to the home by the placement coordinator. The written notice stated they lacked the nursing expertise necessary to meet the applicant's responsive behaviour needs.

However, the Resident Services Coordinator acknowledged they have registered nursing staff with experience caring for persons with responsive behaviours, have access to Psycho-geriatric outreach services, and have a Behaviour Support Ontario (BSO) staff member.

Sources: Applicant refusal letter, behavioural assessment tool, interview with the Resident Services Coordinator.
[756]

WRITTEN NOTIFICATION: Windows

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

1) The licensee has failed to ensure that a window in the hallway of a resident home area had a mechanism in place to prevent the window from opening more than 15 centimeters (cm).

Sources: Observation of the window, interview with Environmental Service Manager.
[756]

2) The licensee has failed to ensure that the windows accessible to residents could not open more than 15cm. The mechanism that prevented the windows from opening more than 15cm was easy to circumvent and not fixed in place.

Sources: Observations of the windows in the common spaces and resident bedrooms on four resident home areas, interviews with the Administrator and the Environmental Services Manager.
[756]