

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: October 26,2023	
Inspection Number: 2023-1347-0005	
Inspection Type: Critical Incident Follow up	
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: Northridge, Oakville	
Lead Inspector Waseema Khan (741104)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 26, 27, 28, 29, 2023 and October 3, 2023

The following intake(s) were inspected:

- Intake: #00089181 - Follow-up #: 1 - O. Reg. 246/22 - s. 102 (2) (b) related to Infection Prevention and Control Inspection #2023_1347_0003 CDD date Aug 15,2023
- Intake: #00094549 - Critical Incident(CI) #2862-000039-23 - related to Falls Prevention and Management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1347-0003 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Waseema Khan (741104)

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

O. Reg. 246/22, s. 54 (1)

The licensee failed to comply with their strategy to monitor a resident, as per home's fall prevention and injury reduction program.

Rationale and Summary

In accordance with O. Reg 246/22, s.11 (1) (b),The policy directed prevention strategies to reduce or mitigate falls are in place to meet the needs of each resident.

Resident had a witnessed fall on August 8, 2023, and was noted to be at risk for falls. The plan of care had interventions: fall risk logo applied to binder, walker and beside name plate in memory box.

On September 28,2023 resident's room was observed. There was no falls risk logo as specified in the plan of care. It is noted that the fall logo was not present for 21 days. Assistant Director of Care (ADOC) confirmed that since resident came back from the hospital, they were in the process of reassessing the resident.

On September 29, 2023, the Registered Practical Nurse (RPN) updated the falls risk logo in resident chart. Inspector observed resident's room and confirmed that the plan of care was in place.

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The resident's risk of fall has been mitigated by the home and this non-compliance has been remedied prior to inspector's exit from the home.

Sources: Resident's clinical records, plan of care, observation, licensee's "Fall Prevention and Injury Reduction Program", Interviews with RPN and ADOC.
[741104]

Date Remedy Implemented: September 29, 2023



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

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