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

Hamilton District
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Public Report

Report Issue Date: August 6, 2025
Inspection Number: 2025-1347-0004
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: Northridge, Oakville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 31, 2025 and August 1, 5- 6, 2025.

The following intake(s) were inspected:

- Intake: #00150716/ Critical Incident (CI) 2862-000024-25 was related to food, nutrition, and hydration.

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

Food, Nutrition and Hydration

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 a resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed related to their activities of daily living.

Sources: Resident's records and interview with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee has failed to ensure that no drug was used by or administered to a resident unless the drug had been prescribed for the resident when a resident was administered a drug without a physician's order for administration and continued to receive it afterwards.

Sources: Resident's records, home's policy, and interview with staff.