

**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

## Public Report

**Report Issue Date:** October 30, 2025

**Inspection Number:** 2025-1334-0003

**Inspection Type:**

Critical Incident

**Licensee:** Axiom Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axiom Extendicare LTC II GP Inc.

**Long Term Care Home and City:** Ridgeview, Stoney Creek

## INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 23, 24, 27, 28 and 29, 2025.

The following intakes were inspected:

- Intake: #00156192 - Critical Incident (CI) 2849-000014-25- related to falls prevention and management.
- Intake: #00157001 - CI 2849-000015-25 - related to prevention of abuse and neglect.
- Intake: #00157657 - CI 2849-000018-25 - related to falls prevention and management.

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

- Prevention of Abuse and Neglect
- Falls Prevention and Management

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## 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 (7)**

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided when they initially demonstrated responsive behaviours towards a co-resident. The initial response of staff did not include interventions, as set out in the plan of care.

Sources: Observations of video footage of incident, review of a resident's plan of care and interview with staff.