

Ministry of Long-Term Care

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

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: August 21, 2025

Inspection Number: 2025-1259-0006

Inspection Type:

Complaint
Critical Incident

Licensee: Maplewood Nursing Home Limited

Long Term Care Home and City: Cedarwood Village, Simcoe

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 29-31, 2025 and August 1, 5, 6, 20, and 21st, 2025

The following intake(s) were inspected:

- Intake: #00150670/Critical Incident (CI) #2768-000023-25 - related to a fall
- Intake: #00151966 - related to a complaint
- Intake: #00153246 - related to a complaint

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

Medication Management
Falls Prevention and Management

INSPECTION RESULTS

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WRITTEN NOTIFICATION: When PASD may be used

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 36 (3)

PASDs that limit or inhibit movement

s. 36 (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

The licensee failed to ensure that a personal assistance services device (PASD) was used to support a resident with a routine activity of living only when it was included in the plan of care.

Clinical records showed the resident began using an assistive device for mobility and positioning after a fall. Although consent had been obtained from the substitute decision-maker (SDM), no assessment was completed, and the device was not added to the plan of care before use.

The plan of care did not include documentation of an assessment or interventions related to the PASD prior to its implementation, as required by the long term care home's (LTCH) policy.

Sources: Resident #001's clinical records, interviews with staff, LTCH PASD policies

WRITTEN NOTIFICATION: Medication Management System

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

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Medication management system

s. 123 (3) The written policies and protocols must be, (a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee failed to implement written medication management policies and protocols related to hypoglycemia in accordance with evidence-based practices.

Ontario Regulation (O. Reg) 246/22 s.11 (1) (b) required licensees to develop and comply with written policies for medication management systems. Staff did not follow the pharmacy's protocol for treating severe and unresponsive hypoglycemia with glucagon, nor the LTCH policy for managing hypoglycemia, which outlined specific actions based on blood glucose levels.

O. Reg 246/22 defines severe hypoglycemia as a blood glucose level below 2.8 mmol/L with the resident remaining conscious. The LTCH policy required staff to administer 15 grams of carbohydrate for blood glucose levels below 4 mmol/L, retest after 15 minutes, and document the assessment, treatment, response, and outcome. For levels below 2.8 mmol/L, documentation was to be completed using a designated event record 2.

A) A review of electronic records showed that a resident experienced severe hypoglycemia with a blood glucose level of 2.5 mmol/L. Staff administered glucose tablets but retested after 30 minutes instead of the required 15. Required documentation on the designated event record was not completed.

Sources: review of complaint intake, pharmacy & LTCH policies, resident #001's electronic records, and staff interviews.

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B) The licensee failed to ensure staff followed hypoglycemia management policies for multiple low blood sugar incidents.

Records showed that on multiple occasions, a resident had blood glucose levels below 4 mmol/L. In each case, staff either delayed retesting beyond the required 15 minutes or failed to document the resident's response and outcome in progress notes. On one occasion, there was no documentation indicating that treatment was provided.

Staff did not consistently follow the LTCH's policy, which required timely retesting and thorough documentation. These omissions posed a risk of health complications and deterioration in the resident's condition.

Sources: Pharmacy & LTCH policies, resident #001's electronic records, and staff interviews.

WRITTEN NOTIFICATION: Medication Management System

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)

Medication incidents and adverse drug reactions

s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is, (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug

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and the pharmacy service provider.

The licensee failed to report an episode of severe hypoglycemia to the Medical Director, as required by the LTCH's policy.

The policy stated that in cases of severe or unresponsive hypoglycemia, notifications were to be made to the SDM, Director of Care, Medical Director, attending physician or nurse practitioner, and the pharmacy service provider. However, the Medical Director and pharmacy were not notified following the event.

Sources: review of complaint intake, LTCH policies, resident #001's electronic records, and staff interviews.

WRITTEN NOTIFICATION: Medication Management System

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 147 (2) (a)

Medication incidents and adverse drug reactions

s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that, (a) all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon are documented, reviewed and analyzed;

The licensee failed to ensure that an episode of severe hypoglycemia was reviewed and analyzed, as required by the LTCH's policy.

The policy mandated documentation of the incident, immediate actions taken, and a review and analysis with corrective actions. No written record was provided to confirm that this process occurred. Staff indicated they were unaware that a review

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and analysis were required.

Sources: review of complaint intake, LTCH policies, resident #001's electronic records, and staff interviews.