

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: October 22, 2025
Inspection Number: 2025-1259-0007
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): October 14, 15, 16, 17, 20, 21, and 22, 2025.

The following intake(s) were inspected:

- Intake #00151466 / Critical Incident (CI) 2768-000024-25 and intake #00158239 / CI 2768-000034-25 were related to infectious disease outbreaks.
- Intake #00158212 and intake #00159042 were complaints related to falls and other aspects of care for a resident.

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

- Resident Care and Support Services
- Infection Prevention and Control
- 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: O. Reg. 246/22, s. 29 (3) 18.

Plan of care

s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

18. Special treatments and interventions.

The licensee did not ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of special treatments and interventions for a resident. A resident was observed to have a falls management intervention in place which was also included their care plan. Staff interviews and a review of the residents records confirmed that an assessment had not been completed prior to the implementation of the device.

Sources: observations of the resident's room; review of assessments, care plan, and progress notes, paper chart; and interviews with the Restorative Care Aide, Physiotherapist and Director of Care.

WRITTEN NOTIFICATION: Reports re critical incidents

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

Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

Reports re critical incidents

s. 115 (3) The licensee shall ensure that the Director is informed of the following

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incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):

4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee did not report to the Director an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition. The resident had complained of pain for which an x-ray was ordered and showed a fracture. The resident was then sent to hospital and received an intervention to assist with healing of the fracture. When the resident returned to the home, their plan of care required adjustments due to the injury. A review of the critical incident reporting system found this incident had not been reported to the Director as required.

Sources: The resident's progress notes, review of the Critical Incident System reports for Cedarwood Village Long-Term Care Home.