

**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

## Amended Public Report Cover Sheet (A1)

<b>Amended Report Issue Date:</b> April 13, 2026
<b>Original Report Issue Date:</b> April 9, 2026
<b>Inspection Number:</b> 2026-1259-0001 (A1)
<b>Inspection Type:</b> Critical Incident
<b>Licensee:</b> Maplewood Nursing Home Limited
<b>Long Term Care Home and City:</b> Cedarwood Village, Simcoe

## AMENDED INSPECTION SUMMARY

This report has been amended to:  
Report was amended for the grounds of CO #2 related to O. Reg 246/22 s. 59 regarding the dates for 1:1 support for a resident.

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## Amended Public Report (A1)

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**Inspection Type:**

Critical Incident

**Licensee:** Maplewood Nursing Home Limited

**Long Term Care Home and City:** Cedarwood Village, Simcoe

## AMENDED INSPECTION SUMMARY

This report has been amended to:

Report was amended for the grounds of CO #2 related to O. Reg 246/22 s. 59 regarding the dates for 1:1 support for a resident.

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 23-26, 2026 and April 2, 9, 2026

The inspection occurred offsite on the following date(s): March 25, 27, 2026 and April 1, 2026

The following intake(s) were inspected:

- Intake: #00163895 - CI #2768-000040-25 -Alleged abuse of a resident.
- Intake: #00164627 - CI #2768-000041-25 -Alleged neglect of a resident.
- Intake: #00166200 - CI# 2768-000043-25 -Fall of a resident with injury.
- Intake: #00170164 - CI #2768-000004-26 -Fall of a resident with injury.

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

Resident Care and Support Services  
Prevention of Abuse and Neglect  
Responsive Behaviours  
Falls Prevention and Management

## AMENDED INSPECTION RESULTS

### WRITTEN NOTIFICATION: Resident Care

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

**Non-compliance with: O. Reg. 246/22, s. 20 (a)**

Communication and response system

s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,  
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

A resident was left without access to a call bell after a procedure for extended period of time, contrary to the care plan, and reported feeling helpless and unable to call for assistance because they relied on staff to position it within reach.

**Sources:** Review of Critical Incident System (CIS), resident's progress notes, complaint email from complainant, investigation notes and interviews with the resident and staff.

### WRITTEN NOTIFICATION: Responsive behaviours

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

**Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)**

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

A resident exhibited ongoing verbal and physical responsive behaviours toward others, but required behavioural monitoring and documentation were not initiated or maintained in accordance with policy following multiple incidents.

**Sources:** Review of Responsive Behaviours Management Policy; review of resident's electronic documentation; and interview with staff members.

**COMPLIANCE ORDER CO #001 Duty to protect**

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: FLTCA, 2021, s. 24 (1)**

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

a) The Administrator or designate shall conduct a comprehensive review and

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analysis of all historical incidents involving a resident, including verbal and physical altercations or alleged abuse involving co residents and/or staff. The review shall be documented and shall include an analysis of patterns, contributing factors, effectiveness of previous interventions, and any identified gaps in risk mitigation.

b) Administrator or designate shall ensure that all future altercations or incidents including but not limited to verbal altercations, physical altercations or abuse involving a resident are documented in the electronic health record of each resident involved. Documentation shall include: 1) Date and time of incident 2) Location within the home 3) Individuals involved 4) Description of the incident 5) Immediate actions taken 6) Follow up actions and outcomes.

c) Document and analyze the home's response to all incidents from part (b) of the order including: 1) Investigation and analysis of each event 2) Implementation of interventions and 3) review of effectiveness of interventions.

**Grounds**

"Physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

There were several incidents involving residents within the Long Term Care, who were subjected to physical abuse, despite having specific interventions in place to help prevent such situations. These incidents posed an ongoing and significant risk to the safety and well being of residents.

**Sources:** Clinical record reviews of multiple residents; review of home's abuse and neglect policy; review of Critical Incident System (CIS); observations; and staff and residents interview.

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**This order must be complied with by** May 15, 2026

**An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001**

## **NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)**

The Licensee has failed to comply with FLTCA, 2021

### **Notice of Administrative Monetary Penalty AMP #001 Related to Compliance Order CO #001**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of \$5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

### **Compliance History:**

In the past 36 months,

A WN under FLTCA, 2021 s. 24 (1) was issued under inspection #2023-1259-0002 on February 8, 2023

A CO under FLTCA, 2021 s. 24 (1) was issued under inspection #2024-1259-0002 on July 17,

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2024

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

## **COMPLIANCE ORDER CO #002 Altercations and other interactions between residents**

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

### **Non-compliance with: O. Reg. 246/22, s. 59**

Altercations and other interactions between residents

s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

- (a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
- (b) identifying and implementing interventions.

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**The inspector is ordering the licensee to comply with a Compliance Order  
[FLTCA, 2021, s. 155 (1) (a)]:**

- a) Review and revise the Responsive Behaviour Management policy to indicate:
- 1) Clear direction and timeline for when the Behavioural Support Ontario (BSO) and Senior Mental Health (SMH) referrals would be initiated, including identification of the person responsible for submitting the referrals.
  - 2) Clear direction and timeline for initiating additional behavioural assessment, including identification of the person responsible for completing those assessments.
  - 3) Outline specific roles and responsibilities of the Resident Behaviour Support Coordinator and Responsive Behaviour Lead.
- b) Educate all registered nursing staff members in the home including agency registered nursing staff members, on the revised Responsive Behaviour Management policy and process from part a.
- c) Complete the following for resident:
- 1) Complete Daily Observation Sheet (DOS) assessment.
  - 2) Complete additional assessments for the resident to identify causative factors, triggers, and interventions to prevent and mitigate risk of altercations with co residents.
  - 3) Complete referrals to external BSO and Senior Mental Health (SMH) services.
  - 4) Complete an interdisciplinary medication review for the resident to support management of their responsive behaviours.
  - 5) Document any identified triggers and interventions from the completed assessments in the resident's plan of care to mitigate the risk of resident to resident altercations.

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d) Educate all staff members working in home area including agency staff members on resident's identified triggers and interventions.

**Grounds**

There were numerous incidents of resident to resident physical and verbal altercations involving a resident over several years, despite a well documented history of responsive behaviours and known triggers. The inconsistent use of 1:1 monitoring, absence of required assessments and referrals, and failure to update care plans and interventions posed an ongoing and significant risk to the safety and well being of a resident and other residents within the Long Term Care Home.

**Sources:** Review of resident's electronic and paper records; Review of Critical Incident System (CIS); Review of home's policy on Responsive Behaviour Management; and Interviews with residents and staff members.

**This order must be complied with by** May 15, 2026

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## REVIEW/APPEAL INFORMATION

**TAKE NOTICE** The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> floor  
Toronto, ON, M7A 1N3

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e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto:MLTC.AppealsCoordinator@ontario.ca)

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:



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

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**Health Services Appeal and Review Board**

Attention Registrar  
151 Bloor Street West, 9<sup>th</sup> Floor  
Toronto, ON, M5S 1S4

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> Floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto:MLTC.AppealsCoordinator@ontario.ca)

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).