

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: February 27, 2026

Inspection Number: 2026-1068-0001

Inspection Type:

Complaint
Critical Incident

Licensee: Better Life LTC Inc.

Long Term Care Home and City: Maple Villa Long Term Care Centre, Burlington

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 19-20, 23, 25-27, 2026.

The following intake(s) were inspected:

Intake #00165827 and Intake#00165862 were related to the prevention of abuse and neglect.

Intake #00167095 was related to resident care and support services.

Intake #00167224 was related to Infection Protection and Control.

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

- Resident Care and Support Services
- Infection Prevention and Control
- Prevention of Abuse and Neglect

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to freedom from abuse and neglect

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 4.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

4. Every resident has the right to freedom from abuse.

A resident's right to freedom from abuse was not fully respected or promoted when staff engaged in physical aggression toward the resident during care.

Sources: Review of resident's clinical record and home's investigation notes and Interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

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

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A resident's plan of care indicated that the resident required a two-person assist for

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transfers. Staff transferred the resident independently, without a second staff member present to assist.

Sources: Review of resident's clinical record, home investigation notes, Zero Lift Policy and interview with staff.

WRITTEN NOTIFICATION: Responsive behaviors

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

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

Responsive behaviours

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

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The resident was agitated and resistive during care. Gentle Persuasive Approaches (GPA) techniques were not implemented, and care was completed, resulting in injuries to the resident.

Sources: Review of resident's clinical record, home's investigation notes; Gentle Persuasive Approaches (GPA) Policy and interviews with staff.

WRITTEN NOTIFICATION: Infection Prevention and Control

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

Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

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(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

A resident presented with symptoms of an illness and required intervention. A review of their clinical records indicated that their symptoms and actions taken to reduce transmission were not recorded on every shift.

Sources: Resident's clinical records, Respiratory Outbreak Line Listing, interviews with staff.