Ontario

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

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: October 7, 2025
Inspection Number: 2025-1497-0006
Inspection Type: Complaint Critical Incident
Licensee: Maxville Manor
Long Term Care Home and City: Maxville Manor, Maxville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 23, 24, 25, 26, 29 and October 1, 2, 3, 6, 7, 2025

The following intake(s) were inspected:

- Intake: #00148322 - Related to resident to resident physical abuse
- Intake: #00149176, Intake: #00153918, Intake: #00154026 and Intake: #00157092 - Related to the fall of a resident which resulted in a significant change in health status
- Intake: #00158114 - Complaint related to care provision of a resident

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Behaviours and altercations

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee has failed to ensure that procedures and interventions were developed and implemented to manage a resident's responsive behaviours and to minimize the harmful interactions with other residents.

On a specific date, the resident was involved in an altercation with a co-resident, which resulted in the co-resident being injured. Upon review of the resident's plan of care no procedures or interventions to manage the resident's responsive behaviours were included despite the resident having a history of responsive behaviours towards other residents.

Sources: Interview with a Personal Support Worker, interview with a Unit Manager, review of resident heath records and review of home's Responsive Behaviours Program policy and procedures.

COMPLIANCE ORDER CO #001 Duty to protect

NC #002 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)]:
The licensee shall:

A) Identify all residents known to exhibit physically responsive behaviours towards other residents and wandering. For each of these residents, behavioural triggers must be identified where possible, and strategies must be developed and implemented to address these behaviours.

B) Develop strategies and interventions to mitigate the identified resident's identified triggers. The home will ensure that the resident plan of care is updated and related to the resident's responsive behaviours, including behavioural triggers are identified, strategies and interventions are developed and implemented to respond to the resident's behaviours and update the plan of care accordingly.

C) Audit the plan of care of three different residents each week for four consecutive weeks to ensure that interventions and strategies implemented reflect the resident identified triggered and responsive behaviours.

D) Maintain a written record of everything required under steps (A) , (B) and (C) of this compliance order until the Ministry of Long-Term Care has deemed that the

licensee has complied with this order.

Grounds

The licensee has failed to protect a resident from physical abuse by a co-resident.

A resident was identified as having responsive behaviours which put the resident at risk of altercations with other residents. The co-resident had a history of aggressive responsive behaviours towards other residents.

On a specific date, the resident had an altercation with the co-resident which resulted in the resident sustaining an injury.

A review of both resident's health records revealed neither resident's plan of care included any documented interventions or strategies to mitigate the risk of harm to themselves or other residents. In addition, there were no clear directions provided to staff on how to respond if the responsive behaviours were elicited, nor any measures in place to prevent potential harm or altercations with other residents.

Sources: Interview with a Unit Manager, interview with four Personal Support Workers, review of two resident heath records, review of the home's Responsive Behaviours Program policy and procedure.

This order must be complied with by November 21, 2025

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, 8th floor
Toronto, ON, M7A 1N3

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:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: 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.