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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: July 7, 2025
Inspection Number: 2025-1058-0003
Inspection Type: Critical Incident
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: Maynard Nursing Home, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 2, 3, 7, 2025

The following Critical Incident (CI) intake(s) were inspected:
· Intake: #00143128 [CI #2211-000003-25], Intake: #00144025 [CI #2211-000006-25] – Staff-to-residents emotional abuse

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

Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that multiple residents were protected from emotional abuse by a Personal Support Worker (PSW).

Section 2 of the Ontario Regulation 246/22 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that were performed by anyone other than a resident.

1) A PSW commented on a characteristic of a resident to the resident themself and to another person who was nearby. The resident was negatively impacted by the comments. The home investigated the incident and determined the resident was emotionally abused by the PSW.

Sources: Resident's clinical records, home's investigation notes, interview with the resident.

2) A resident spoke forcefully to a PSW who was insisting the resident perform an action. The PSW then responded to the resident that resulted in a change to the resident's demeanor. The home investigated and determined the resident was emotionally abused by the PSW.

Sources: Resident's clinical records, home's investigation notes, interview with the resident.

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