

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: September 24, 2025

Inspection Number: 2025-1280-0006

Inspection Type:

Complaint
Critical Incident
Follow up
Director Order Follow Up (DOFU)

Licensee: 2063414 Investment LP, by its general partner, 2063414 Ontario Limited

Long Term Care Home and City: Midland Gardens Community, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 15-19, 22-24, 2025.

The following follow-up intakes were inspected:

- Intake: #00154336 – Follow-up on Director Order (DO) #001 related to reporting certain matters to Director.
- Intake: #00150999 - Follow-up on Compliance Order (CO) #002 related to responsive behaviours.

The following complaint intake was inspected:

- Intake: #00155525 related to alleged resident-to-resident abuse.

The following Critical Incident (CI) intakes were inspected:

- Intake: #00155413/ CI #2789-000037-25 related to alleged resident-to-resident abuse.
- Intake: #00152259/ CI #2789-000031-25 and intake #00155638/ CI #2789-000038-25 related to falls prevention program and management.
- Intake: #00156850/ CI #2789-000041-25 related to an injury of unknown cause.
- Intake: #00156217/ CI #2789-000040-25 related to a disease outbreak.

Previously Issued Compliance Order(s)

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The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2025-1280-0004 related to O. Reg. 246/22, s. 58 (4) (b)
Director Order #001 related to FLTCA, 2021, s. 28 (1) 2.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

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

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that care set out in the plan of care was provided to a resident as specified in their plan.

A resident required a specific level of assistance for certain care tasks. However, staff members provided the assistance independently, without the required support level. Subsequently, the resident was found to have sustained an injury.

Sources: Resident's clinical records, home's investigation records, and interviews with staff.

WRITTEN NOTIFICATION: Duty to protect

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

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

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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 a resident was protected from sexual abuse by another resident.

Section 2 of the Ontario Regulation 246/22 defines sexual abuse "as any non-consensual touching, behavior or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

A resident engaged in a sexually inappropriate behavior toward another resident. The affected resident confirmed that they did not provide consent.

Sources: Video surveillance; review of resident's clinical records, CI, home's investigation records; interviews with the affected resident, and staff.

WRITTEN NOTIFICATION: Reporting and Complaints

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

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,

(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that written complaints concerning the care of a resident were immediately forwarded to the Director.

The home received written complaints from a family member regarding concerns for a resident's safety. The complaints were not forwarded to the Director.

Sources: Review of emails from the complainant to the home, interviews with staff.

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WRITTEN NOTIFICATION: Falls prevention and management

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

Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that an assessment was conducted using a clinically appropriate tool specifically designed for falls after a resident had fallen.

Sources: Review of resident' clinical records, home's Falls Prevention and Management Policy, VII-G-30.10; interviews with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that symptoms indicating the presence of infection in residents were monitored every shift. Specifically, two residents were not monitored for symptoms of infection for several shifts, as required.

Sources: Clinical records of residents; interview with staff.

WRITTEN NOTIFICATION: Police notification

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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Non-compliance with: O. Reg. 246/22, s. 105

Police notification

s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate police service was immediately notified of the alleged incident of resident-to-resident sexual abuse.

The DOC was notified of an alleged sexual abuse from a resident. Police weren't notified until four days after the incident.

Sources: Resident's clinical records, CI; and interviews with the staff.

WRITTEN NOTIFICATION: Dealing with complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that when a written complaint regarding the care of a resident was made to the licensee, a response was provided within 10 business days.

The home received written complaints from a family member concerning the care of a resident. The Resident and Family Experience Coordinator (RFEC) and the DOC, both confirmed that no formal response was provided to the complainant.

Sources: Review of emails from the complainant to the home, interviews with staff.

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WRITTEN NOTIFICATION: Dealing with complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (2)

Dealing with complaints

s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,

- (a) the nature of each verbal or written complaint;
- (b) the date the complaint was received;
- (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- (d) the final resolution, if any;
- (e) every date on which any response was provided to the complainant and a description of the response; and
- (f) any response made in turn by the complainant.

The licensee has failed to ensure that a documented record was kept in the home related to a complaint made by a family member, concerning the care of a resident. There was no record that included the nature of the complaint, the date it was received, the type of action taken to resolve the complaint, the final resolution, if any, every date of which any response was provided to the complainant and a description of the response, and any response made in turn by the complainant.

Sources: Review of email from the complainant to the home; interview with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #009 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 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.

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The licensee failed to ensure that the Director was informed no later than one business day of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

A resident sustained falls and was hospitalized with an injury that resulted in a significant change in their health status. The incident was not reported to the Director until eight days later.

Sources: Review of resident's clinical records, CI; interview with staff.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)

Infection prevention and control program

s. 102 (11) The licensee shall ensure that there are in place,

(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and

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

The licensee shall:

- 1) Provide in-person training on outbreak identification and the process for reporting to all Registered Nurses (RNs) and Registered Practical Nurses (RPNs) who worked in a resident home area on two specific days.
- 2) Maintain a record of all education and training provided, including the content of the training, date, signatures of attendees, and the name(s) of the staff member(s) who delivered the education

Grounds

The licensee has failed to ensure that reporting protocols under the Health Protection and Promotion Act, included in the home's outbreak management system were

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complied with.

In accordance with Ontario Regulation 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the IPAC program are complied with. Specifically, the home's policy required that all suspected outbreaks be reported immediately to the Public Health Unit (PHU). Two residents in a resident home area presented with symptoms meeting the home's definition of a suspected disease outbreak. The next day, additional residents developed similar symptoms. The PHU was not notified of the suspected disease outbreak until two days later, by which time there were several residents who were exhibiting similar symptoms.

The delayed reporting and failure to initiate additional outbreak measures increased residents' risk of infection, led to additional cases, and negatively affected residents' health and overall well-being.

Sources: Review of clinical records of residents, the home's outbreak line list; email communication with the local PHU, Confirming an Outbreak Policy #IX-F-10.00 (revised March 2025); Defining an Outbreak Policy #IX-F-10.00(a) (revised March 2025); Reporting of Communicable Diseases & Outbreaks #IX-B-10.00 (revised May 2025); interviews with staff.

This order must be complied with by November 6, 2025

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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, 8th floor
Toronto, ON, M7A 1N3
e-mail: 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

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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.



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**Inspection Report Under the
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