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: November 27, 2025

Inspection Number: 2025-1280-0007

Inspection Type:
Complaint
Critical Incident
Follow up

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): November 20-21, and 24-27, 2025
The following follow-up intake was inspected:
- Intake: #00158754 - Follow-up on Compliance Order (CO) #001 related to Infection Prevention and Control (IPAC)

The following intake(s) were inspected in this Critical Incident (CI) inspection:
- Intake: #00159277, CI #2789-000044-25 was related to a disease outbreak
- Intake: #00161879 , CI #2789-000045-25 was related to Fall Prevention and Management
- Intake: #00162140, CI #2789-000046-25 was related to Prevention of Abuse and Neglect

The following intake was inspected in this Complaint inspection:
- Intake: #00162017 was related to Environmental Services concerns

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1280-0006 related to O. Reg. 246/22, s. 102 (11) (a)

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC # 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 mobility device was not in a safe position while they were receiving care. As a result, the resident sustained an injury.

A Physiotherapist (PT) and the Director of Care (DOC) both confirmed that the resident should have been positioned safely prior to providing the care.

Sources: The resident's clinical records, Interviews with a Personal Support Worker (PSW), a PT, and the DOC.

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.

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 are performed by anyone other than a resident.”

A resident had an altercation with a non-resident in a home's designated area, which left the resident tearful.

Sources: A CI report, the resident's progress notes, the home's incident form, video surveillance footage and interviews with the Behaviour Support Ontario (BSO) Nurse and the DOC.

COMPLIANCE ORDER CO #001 Home to be safe, secure environment

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 5 [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:

1. The installation of a locking mechanism that prohibits routine entrance from the Midland apartments exit to the Midland Long Term Care Home (LTCH) designated area
2. A plan to monitor the home's designated area to ensure resident safety anytime the space is being used and implementation of the plan.

Please submit the written plan for achieving compliance for inspection #2025-1280-0007 to the LTC Homes Inspector, MLTC, by email by December 12, 2025.
Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

A resident was approached by a non-resident in the home's designated area who had altercation with the resident and left them fearful. The non-resident was able to enter the home's designated area from the apartment side of the building. The non-resident had previous altercations with the resident. The home's designated area was known for being an area that was frequented by residents who engaged in behaviours that often posed risk to other residents.

There was risk to residents' safety as the designated area was unsecured and not monitored.

Sources: A CI report, the resident's progress notes, the home's incident form, video surveillance footage and interviews with the BSO Nurse and the DOC.

This order must be complied with by February 20, 2026

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

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.