

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: March 5, 2026
Inspection Number: 2026-1280-0001
Inspection Type: 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): February 23-27, 2026 and March 2-5, 2026

The following intake(s) was inspected in this Follow-Up inspection: ·

- Intake: #00163759 - compliance order related to Home to be safe, secure environment under inspection #2025-1280-0007

The following intake(s) were inspected in this Critical Incident (CI) inspection: ·

- Intake: #00164374 [CI: 2789-000053-25] - related to allegations of neglect of a resident ·
- Intakes: #00163462 [CI: 2789-000047-25], #00164849 [CI: 2789-000054-25], #00166096 [CI: 2789-000059-25], #00168329 [CI: 2789-000002-26], and #00170520 [CI: 2789-000004-26] - related to a fall of a resident resulting in an injury

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1280-0007 related to FLTCA, 2021, s. 5

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

- Food, Nutrition and Hydration
- Safe and Secure Home
- Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

A resident used a fall prevention intervention that was not part of their plan of care.

The resident's plan of care was updated to include this intervention.

Sources: Observation, a resident's clinical records and interviews with a Personal Support Worker (PSW) and a Registered Practical Nurse (RPN).

Date Remedy Implemented: February 26, 2026

WRITTEN NOTIFICATION: Plan of care

NC #002 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.

A resident was not provided with the care set out in their plan of care specific to their communication and response system.

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Sources: Observation, interviews with a PSW and the Associate Director of Care (ADOC).

WRITTEN NOTIFICATION: Plan of care

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

Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

A resident's plan of care was not reviewed and revised when a falls prevention intervention had not been effective.

Sources: A resident's clinical records, interviews with a resident, a PSW, multiple RPNs, and an ADOC.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #004 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 PSW transferred a resident using a method that was different from the method the resident required, before and after the resident's care provision.

Sources: A resident's clinical records, interviews with A PSW and the ADOC.

WRITTEN NOTIFICATION: Required programs

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

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

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Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Staff did not implement the home's falls prevention and management program after a resident had a fall.

Sources: A resident's clinical records, home's Falls Prevention and Management Policy, and interviews with an RPN and the ADOC.

WRITTEN NOTIFICATION: Required programs

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

Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The registered nursing staff did not implement the home's pain management program when a resident reported pain on three occasions after a fall.

Sources: A resident's clinical records, home's Pain Management Program policy, and interview with the ADOC.

WRITTEN NOTIFICATION: Falls prevention and management

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

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

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A resident required a level of assistance with mobility due to a medical diagnosis. The resident had a fall resulting in injuries when they did not receive the level of assistance required on a specified date.

Sources: The resident's clinical records and interview with the ADOC.