

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: February 9, 2026

Inspection Number: 2026-1613-0001

Inspection Type:
Critical Incident

Licensee: The Regional Municipality of Peel

Long Term Care Home and City: Malton Village Long Term Care Centre,
Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 28 - 30, 2026 and February 3 - 5, 9, 2026

The inspection occurred offsite on the following date(s): February 2, 6, 2026

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

-Intake: #00163813/ CI # M618-000062-25, and Intake: #00165168/ CI #M618-000064-25 related to fall with injury.

-Intake: #00169219/ CI # M618-000002-26 - related to allegation of physical abuse.

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

- 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

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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.

(i) A resident's plan of care indicated specific interventions due to risk of falls. However, on a specified date, the interventions were not implemented, resulting in a fall and negative health outcome.

Sources: Resident's clinical records, interviews with Personal Support Worker (PSW), and Supervisor of Care (SOC).

(ii) A resident's plan of care specified the use of an assistive device. However, during multiple observations on a specified date, the resident was observed walking without their assistive device.

Sources: Resident observations, clinical records, interviews with the PSW, and Registered Practical Nurse (RPN).

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)

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 physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain."

An observation revealed that a PSW used physical force while assisting a resident for which the resident expressed pain and discomfort

Sources: Inspector observation, and interview with the PSW.

WRITTEN NOTIFICATION: Falls prevention and management

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

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

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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).

A resident was at high risk for falls, and their care plan indicated to apply a specific falls prevention intervention. During multiple observations on a specified date, the intervention was not applied.

Sources: Resident's clinical records, observations, interviews with the PSW and SOC.

WRITTEN NOTIFICATION: Responsive behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

A resident had a history of responsive behaviours, and exhibited specific responsive behaviours. Strategies were not developed and implemented to respond to their responsive behaviours.

Sources: Resident's clinical records, observation, and interviews with the PSW, SOC, and Behaviour Support Ontario (BSO) staff.



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

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