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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: August 27, 2025
Original Report Issue Date: August 21, 2025
Inspection Number: 2025-1296-0004 (A1)
Inspection Type: Critical Incident Follow up
Licensee: Mirdem Nursing Homes Ltd.
Long Term Care Home and City: Victoria Gardens Long Term Care, Hamilton

AMENDED INSPECTION SUMMARY

This report has been amended to:
Changed from section 2 in the Ontario Regulation to section 7 in the Ontario Regulation in the grounds of the order.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 7, 8, 11 - 13, 18 - 21, 2025

The following intake(s) were inspected:
-Intake: #00150998/ Follow-up #: 1 - O. Reg. 246/22 - s. 53 (2) (b) CDD - August 5, 2025
-Intake: #00151863/ Critical Incident (CI) #2806-000017-25 - relating to prevention of abuse and neglect,
-Intake: #00153777/ CI #2806-000018-25 - Improper and positioning techniques.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1296-0003 related to O. Reg. 246/22, s. 53 (2) (b) inspected by Brittany Wood (000763)

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

Resident Care and Support Services
Pain Management
Restraints/Personal Assistance Services Devices (PASD) Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Protection from certain restraining

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 34 (1) 3.
Protection from certain restraining
s. 34 (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
3. Restrained by the use of a physical device, other than in accordance with section 35 or under the common law duty referred to in section 39.

The licensee has failed to ensure that a resident was not restrained by the use a physical device. The resident was physically restrained by a PASD on an identified date. A staff tilted the resident's physical device while there was no order for a PASD or a restraint by a physician.

Sources: Resident's clinical records, Video footage and interview with Director of Care (DOC).

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 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.

The licensee has failed to ensure that staff used safe repositioning techniques when assisting a resident. Staff were providing care to a resident and was positioned too close to the side of the bed that resulted in the resident falling off. The resident sustained multiple skin tears.

Sources: Investigation Notes, Critical incident report and interview with staff.

(A1)
The following non-compliance(s) has been amended: NC #003

COMPLIANCE ORDER CO #001 Duty to protect

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall;

1) Have a member of the leadership team randomly complete one random audit of the staff involved in the incident during their shift while interacting with the resident to ensure the restraint and confinement policies and procedures are being followed,

2) The audit may include but is not limited to,
-The name of the auditor,
-Date, time and length of the audit,
-What was observed during the audit,
-Did it meet the LTCH's policy and procedure relating to restraint and confinement,
-Recorrected actions taken, if any,

3) Maintain the audits for an inspector to review upon request.

Grounds

The licensee has failed to ensure a resident was not neglected by staff.

Section 7 of the Ontario Regulation (O. Reg 246/22) defines "neglect" as the failure

to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, and includes inaction or pattern of inaction that jeopardizes the health, safety and wellbeing of one or more residents.

A resident was exhibiting responsive behaviours during the night shift. Staff attempted multiple interventions to manage the behaviours. A staff transferred the resident to a physical device, restrained them and brought them to the TV lounge in front of the television. A staff confined the resident in the TV lounge alone for approximately 5 hours. At a specific hour, the staff opened the door to the TV lounge where the resident was transferred out for care and was brought back to the TV lounge with the door open. Two minutes after the resident attempted to leave the TV lounge however, a staff closed the door to prevent the resident from leaving.

The resident exhibited distress as a result of this incident and indicated that they were still scared to go into the TV lounge.

Sources: Video Footage, Investigation notes, resident's clinical records and interviews with staff.

This order must be complied with by October 1, 2025.

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

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.