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
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Public Report

Report Issue Date: October 2, 2025
Inspection Number: 2025-1338-0004
Inspection Type: Complaint
Licensee: Liuna Local 837 Nursing Home (Hamilton) Corporation
Long Term Care Home and City: Queen's Garden, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 26, 29, 2025 and October 1 and 2, 2025.

The following intake(s) were inspected:

-Intake: #00156409 - was related to Prevention of Abuse and Neglect and Resident Care and Support Services.

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

Resident Care and Support Services
Prevention of Abuse and Neglect

INSPECTION RESULTS

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.

The licensee of a long-term care home failed to protect a resident from abuse by staff.

A staff, who provided care to a resident, acknowledged that they communicated with the resident in a specified manner, while attempted to provide a support with a specified activities to the resident. The resident's specified reaction on this incident was observed by the another staff member.

Sources: a resident's progress notes, copy of electronic communication letter; interviews with staff.

WRITTEN NOTIFICATION: Responsive Behaviors

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee of a long-term care home failed to ensure that the following were developed to meet the needs of a resident with responsive behaviours: written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

Progress notes for a specified period of time indicated that a resident refused specified activities. The Behavioral Support Ontario (BSO) assessment note indicated that the BSO staff lead a specified communication with staff to identified approaches to the resident's care.

Specified approaches and strategies were noted by a staff during their communication with the resident, when they provided a support to the resident's specified activity.

The Director of Care (DOC) acknowledged that there were no written strategies, noted in the resident's plan of care, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours related to a specified activity.

Sources: a resident's progress notes, written care plan; interviews with staff.