Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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

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

Public Report

Report Issue Date: November 13, 2025
Inspection Number: 2025-1338-0005
Inspection Type:
Critical Incident
Follow up

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): October 29 - 31, 2025 and November 4 - 7, 10, 12 - 13, 2025

The following intake(s) were inspected:

- Intake: #00157726 - Order Follow-up related to FLTCA, 2021, s. 24 (1)
- Intake: #00158889 - Falls Prevention and Management Program

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1338-0003 related to FLTCA, 2021, s. 24 (1)

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

Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care, when reassessment or revision is required

NC #001 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 the care set out in the plan had not been effective.

During review of the resident's clinical records, it was documented that the resident had a fall on a day in September, 2025 that caused an injury. Later that month, the resident had another fall during which they sustained another injury. In both instances, the care plan was not reviewed and updated with new interventions to

mitigate any further falls.

In an interview with staff, it was acknowledged that the new interventions were documented in the falls analysis assessment, however confirmed that the new or revised interventions were not updated in the care plan accordingly.

Sources: Review of resident's clinical records, interview with Staff, observation of resident.

WRITTEN NOTIFICATION: Care Plans and Plans of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 9.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
9. Disease diagnosis.

The Resident's plan of care was not developed based on, at a minimum, an interdisciplinary assessment as it related to their disease diagnosis.

It was documented in resident's clinical records that they had a medical condition and on a day in September, 2025 the resident had a fall which resulted in an injury and transfer to hospital. During further review of resident's clinical records there was no information in the care plan with supporting goals and interventions regarding care measures related to the management of resident's medical condition that may or may not have caused the fall.

In an interview with staff it was confirmed that they were unaware of any care

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interventions and an interview with the Management staff confirmed there was no clear direction for staff in the care plan related to the medical condition.

Sources: Review of resident's clinical records, interview with staff and Management, observation of resident.