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

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Public Report

Report Issue Date: May 6, 2026
Inspection Number: 2026-1338-0004
Inspection Type: Critical Incident
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 dates: April 28-30, 2026, and May 4-6, 2026.

The following intakes were inspected:
- Intake: #00169962, Critical Incident (CI) 2853-000004-26 was related to nutrition care; and,
- Intake: #00172169, CI 2853-000005-26 was related to falls prevention and management.

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

Food, Nutrition and Hydration
Palliative Care
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
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's plan of care identified that they were to receive thickened fluids/soup. The plan also specified that the registered staff were to be informed if the resident displayed any signs/symptoms of choking, including coughing.

At lunch, the resident received the wrong fluid/soup consistency which resulted in coughing. The staff feeding the resident did not inform the registered staff who was supervising the dining room.

Sources: resident's clinical records, home's investigation notes; and interviews with staff.

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.

Ontario Regulations (O. Reg. 246/22) section (s.) 7, defines neglect as the failure to

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

After being informed that a resident received the wrong fluid/soup consistency at lunch, which resulting in coughing, the registered staff did not perform an assessment on the resident to determine their condition.

Sources: resident's clinical records, home's investigation notes; and interviews with staff.

WRITTEN NOTIFICATION: Palliative Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 61 (2)
Palliative care
s. 61 (2) The licensee shall ensure that the interdisciplinary assessment of the resident's palliative care needs for their plan of care considers the resident's physical, emotional, psychological, social, cultural, and spiritual needs.

An interdisciplinary assessment of a resident's palliative care needs was not completed considering the resident's emotional, psychological, social, cultural, and spiritual needs.

Sources: resident's clinical records; and interview with registered staff.

WRITTEN NOTIFICATION: Dining and Snack Service

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

Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.

Dining and snack service

s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that written policies developed for the nutrition and hydration programs were complied with. Specifically, the home's meal service and diet list policies specified that residents would be served according to the diet list that specified each resident's diet order, which did not occur for a resident.

Front line staff either did not have access to or did not reference the home area's diet list during lunch meal service.

Sources: resident's clinical records, home's investigation notes, Dining Room Meal Service Protocol, Diet & Snack Lists Policy; and interviews with staff.