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: April 27, 2026

Inspection Number: 2026-1406-0003

Inspection Type:
Critical Incident

Licensee: Liuna Local 837 Nursing Home (Ancaster) Corporation

Long Term Care Home and City: Regina Gardens, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 10-13, 15-17, 20-24, 27, 2026.

The following intake(s) were inspected:

Intake: #00167834 - Fall of resident a resulting in an injury.
Intake: #00169776 - Improper/Incompetent treatment of a resident.
Intake: #00169777 - Neglect of a resident.
Intake: #00169956 - Fall of resident a resulting in an injury.
Intake: #00169995 - Physical abuse to a resident.
Intake: #00172212 - Improper/Incompetent treatment of a resident.
Intake: #00173605 - Fall of a resident resulting in an injury.
Intake: #00174425 - Fall of a resident resulting in an injury.
Intake: #00175074 - Improper/Incompetent treatment of a resident.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care - Integration of Assessments

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Staff did not perform an assessment nor consult a physician when a resident complained of a specific symptom.

Sources: resident's clinical health records, interviews with staff.

WRITTEN NOTIFICATION: Plan of Care - Health Conditions

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 10.
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:
10. Health conditions, including allergies, pain, risk of falls and other special needs.

A resident's plan of care did not included strategies and interventions specific to the resident's health conditions.

Sources: resident's clinical records, interview with the staff.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #003 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.

Staff did not follow the resident's plan of care to use safe transfer techniques, resulting in the resident experiencing pain.

Sources: Home's internal investigation notes, resident's clinical record, interview with resident and staff.

WRITTEN NOTIFICATION: Administration of Drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

A resident did not receive a medication when the resident presented with specific symptoms.

Sources: resident clinical records, review of the LTC Home's investigation notes, interview with staff.