

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

Original Public Report

Report Issue Date: April 30, 2024	
Inspection Number: 2024-1338-0003	
Inspection Type: Critical Incident	
Licensee: Liuna Local 837 Nursing Home (Hamilton) Corporation	
Long Term Care Home and City: Queen's Garden, Hamilton	
Lead Inspector Indiana Dixon (000767)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

<p>The inspection occurred onsite on the following date (s): April 23, 24, 25, 2024</p> <p>The following intake (s) were inspected:</p> <ul style="list-style-type: none"> Intake: #00114215 – [Critical Incident (CI): 2853-000013-24] – related to Resident Care and Support Services.

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

- Resident Care and Support Services
- Infection Prevention and Control

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Additional training - direct care staff

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 82 (7) 5.

Training

s. 82 (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

5. Palliative care.

The licensee has failed to ensure that all direct care staff received additional training in palliative care, at times or intervals provided for in the regulations.

Rationale and Summary

In accordance with O. Reg 246/22 s. 261 (2) (1) The licensee shall ensure that all staff who provide direct care to residents must receive annual training required under subsection 82 (7) (5) of the Act.

The home's training records showed that only 97.3 percent of direct care staff completed their annual training in 2023. This was acknowledged by a member of the leadership team.

Failure to provide the required training could impact the delivery of palliative care to the resident's residing in the home.

Sources: Interviews with staff and training records.

[000767].