

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

Public Report

Report Issue Date: March 27, 2026
Inspection Number: 2026-1568-0002
Inspection Type: Complaint Critical Incident
Licensee: City of Hamilton
Long Term Care Home and City: Macassa Lodge, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 12, 13, 16, 18, 19, 20, 23, 24, 25 and, 27, 2026.

The inspection occurred offsite on the following date: March 26, 2026.

The following intakes were inspected:

-Intake: #00166332 - Critical Incident (CI) M552-000049-25 - related to prevention of abuse and neglect and responsive behaviours.

-Intake: #00166900 - CI M552-000002-26 - related to infection prevention and control program.

-Intake: #00167859 - CI M552-000007-26 - related to medication management.

-Intake: #00169348 - CI M552-000010-26 - related to fall prevention and management.

-Intake: #00172101 - CI M552-000019-26 - related to nutritional care and hydration program.

-Intake: #00172863 - Complaint related to care and services and nutritional care and hydration program.

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

Medication Management

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Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

A resident's plan of care was not revised after an incident related to meal service. The plan was updated on March 19, 2026, to reflect this change in needs.

Sources: Review of clinical health record of a resident and interviews with staff.

Date Remedy Implemented: March 19, 2026

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WRITTEN NOTIFICATION: Involvement of resident, etc

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A resident had a change in condition. Their substitute decision maker (SDM) was not informed of the changes in their condition to support them to fully participate in the development of the resident's plan.

Sources: A review of the clinical health record of a resident and interviews with the resident's SDM and staff.

WRITTEN NOTIFICATION: Duty of the licensee to comply

NC #003 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. A resident's plan of care identified that they used an intervention as a fall prevention strategy. The resident sustained a fall and post fall assessments did not include the intervention.

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Sources: A resident's clinical record and interview with staff.

B. A resident did not receive the correct volume of a nutritional supplement prescribed for a specified period.

Sources: Review of the clinical health record of a resident including Prescribers Orders and electronic Medication Administration Records and interviews with staff.

WRITTEN NOTIFICATION: Nutritional care and hydration program

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

Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)

Nutritional care and hydration programs

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

Procedures in the Nutritional Care and Hydration programs included direction for staff to notify the dietary department when a resident was at risk for specific nutritional issues.

Intake records for a resident had omissions at some meals or nourishment passes, information required to determine if a referral was required.

Staff interviewed were not aware of or, able to communicate a formalized process in place to monitor and evaluate the food and fluid intake of residents for the specific parameters as identified in the procedures, for the submission of a dietary referral.

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Sources: A review of Hydration procedure and Referral for Nutrition Services procedure, review of intake records for a resident and interviews with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (1)

Administration of drugs

s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

A resident was administered medications that were prescribed for another resident in error.

Sources: A resident's clinical record, Medication Incident Report and Analysis Form, Medication Administration record for a resident and interview with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #006 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 was not administered all scheduled medications as specified by the prescriber.

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Sources: A resident's clinical record, Medication Incident Report and Analysis Form, Medication Administration record for a resident, interview with staff.