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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Original Public Report

Report Issue Date: February 8, 2023	
Inspection Number: 2023-1568-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: City of Hamilton	
Long Term Care Home and City: Macassa Lodge, Hamilton	
Lead Inspector Lisa Bos (683)	**Inspector Digital Signature** Lisa Bos Digitally signed by Lisa Bos Date: 2023.02.08 15:33:31 -05'00'
Additional Inspector(s) Daria Trzos (561)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 16-18, 20, 23-25, 2023

The following intake(s) were inspected:

- Intake: #00017359 Proactive Compliance Inspection (PCI)

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

Prevention of Abuse and Neglect
Infection Prevention and Control
Food, Nutrition and Hydration
Residents' and Family Councils
Quality Improvement
Residents' Rights and Choices
Safe and Secure Home
Skin and Wound Prevention and Management

Falls Prevention and Management
Pain Management
Medication Management
Resident Care and Support Services

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)
O. Reg. 246/22, s. 12 (2)

The licensee has failed to ensure that the doors leading to a balcony that was not enclosed, were locked.

Rationale and Summary
In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there was a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

Specifically, the home failed to comply with the policy "Doors in the home."

During a tour of the home, the Inspector observed that a door leading to a balcony that was not enclosed was unlocked. The home's policy identified that all balcony doors should be locked and residents or family who wanted access to balconies or secure outdoor areas could request access through a staff member who could unlock the door.

The Administrator confirmed that the doors to balconies should have been locked.

The home rectified this and locked the doors.

Sources: Observations; home's policy "Doors in the home" (last revised July 5, 2022); interview with

maintenance staff, Nurse Manager, Supervisor/Community Facilities Maintenance and Administrator.
[561]

Date Remedy Implemented: January 17, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 265 (1) 10.

The licensee has failed to ensure that the current version of the visitor policy was posted in the home.

Rationale and Summary
The visitor policy was not posted in the home during the initial tour. The Nurse Manager confirmed that the visitor policy was shared with the residents' families via email; however, was not posted in the home. The home rectified this, and the Inspector observed the visitor policy posted by the screening area.

Sources: Observations; interview with a screener, receptionist and Nurse Manager.
[561]

Date Remedy Implemented: January 23, 2023

WRITTEN NOTIFICATION: Housekeeping

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)

The licensee has failed to ensure that resident equipment, specifically a mechanical lift, was disinfected after resident use.

Rationale and Summary
In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that procedures were developed and implemented for cleaning and disinfection of the resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs.

Specifically, the staff failed to comply with the policy “Safe Resident Handling.”

The Inspector observed two Personal Support Workers (PSWs) enter a resident room to provide a

transfer using a mechanical lift. Several minutes later they exited the room with the lift, and it had not been disinfected. The Inspector interviewed one of the PSWs who stated that they did not sanitize the lift; they only disinfected them when the home was in an outbreak. The home's policy indicated that any contact surfaces on the lifting equipment needed to be wiped with Oxyvir TB wipes after each resident use.

Sources: Observations; home's policy "Safe Resident Handling" (last revised October 21, 2022); interview with a Registered Nurse (RN), PSW and the Administrator.
[561]

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (1)

The licensee has failed to ensure that the drugs, specifically controlled substances, were destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices.

Rationale and Summary
In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that the "Medication Disposal" policy was complied with.

The CareRx pharmacy policy "Medication Disposal," stated that unused and partially used vials/ampoules/cartridges including the box with the prescription label could be placed directly into the container provided by Daniels International Medismart. The medications held or refused medications should be disposed of in a safe and environmentally appropriate manner. The pharmacist and registered personnel document the manner of destruction of the controlled substance on the Resident's individual count sheet.

The Inspector interviewed staff about the process for narcotic destruction in the home. Staff used different processes as to how they discarded narcotics that did not align with the home's policy and were not done in an environmentally safe manner. One staff member indicated that contents of a vial should be poured down the sink and individual pills that were for example refused by a resident, discarded in a sharps container. Another staff member stated that both vials and individual pills were discarded in the sharps containers.

The Pharmacist stated that if staff needed to waste contents of a vial of a narcotic, they would have to get a second nurse to witness, dissolve the contents in liquid and pour it into the white pail provided by Daniels. The empty glass from the ampule would go into the sharps container. If a resident refused to take their narcotic, the staff along with the witness would dissolve the pill and pour it into the white pail as well. It should be rendered unusable.

Sources: "Medication Disposal" policy (last revised March 2020); interviews with registered staff, the Director of Nursing (DON) and Pharmacist.
[561]

WRITTEN NOTIFICATION: Continuous Quality Improvement initiative report

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (6) (b)

The licensee has failed to ensure that the interim continuous quality improvement (CQI) report for the 2022-2023 fiscal year was provided to the Residents' Council and Family Council.

Rationale and Summary
The Residents' and Family Council meeting minutes were reviewed with the Manager of Quality and Privacy and there was no documentation that the interim CQI report for the 2022-2023 fiscal year was shared with the Councils.

The Manager of Quality and Privacy acknowledged that the interim CQI report was posted to the home's website, but was not shared with the Councils as required.

Sources: Residents' and Family Council meeting minutes; interview with the Manager of Quality and Privacy.
[683]