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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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: July 5, 2024	
Inspection Number: 2024-1568-0001	
Inspection Type: Critical Incident	
Licensee: City of Hamilton	
Long Term Care Home and City: Macassa Lodge, Hamilton	
Lead Inspector Erin Denton-O'Neill (740861)	Inspector Digital Signature Erin Denton-O`Neill Digitally signed by Erin Denton-O`Neill Date: 2024.07.16 10:03:43 -04'00'
Additional Inspector(s) Brittany Wood (000763) Betty Jean Hendricken (740884)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 18-21 and 24- 26, 2024.

The following intake(s) were inspected:

- Intake: #00109079 - Critical Incident (CI) M552-000005-24 - related to improper or incompetent treatment of a resident.
- Intake: #00113736 - CI #M552-000019-24 - related to improper or incompetent treatment of a resident.
- Intake: #00114158 - CI #M552-000022-24 - related to improper or incompetent treatment of a resident.

- Intake: #00111721 - CI #M552-000013-24 - related to falls prevention and management.
- Intake: #00111980 - CI #M552-000016-24 - related to Infection Prevention and Control (IPAC).

The following intakes were completed in this inspection:

- Intake: #00109997 - CI #M552-000008-24 - related to falls prevention and management.
- Intake: #00111306 - CI #M552-000010-24 - related to falls prevention and management.
- Intake: #00116495 - CI #M552-000027-24 - related to falls prevention and management.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Dealing with Complaints

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 108 (1) 2.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

The licensee has failed to provide the complainant with a follow-up response within 10 business days of receipt of the complaint, which includes the date by which the complainant can reasonably expect a resolution.

Rationale and Summary
A Nurse Manager received a verbal complaint from a resident and their family member, alleging physical harm during a bath.

The home's policy, Formal Complaints- Residents, Caregivers and Advocates, stated that all complaints shall be investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint.

In an interview with the Nurse Manager, they confirmed that the Long-term care home (LTCH) did not respond to the resident and their family member within 10 business days of receiving the complaint to provide an update on what the LTCH did to resolve the complaint or discuss the outcome of the investigation.

Failure to respond to the complainant with an update regarding the investigation within 10 business days of receiving the complaint may have resulted in a breakdown of communication with the resident.

Sources: Resident interview, Interview with Nurse manager, Policy Formal Complaints- Residents, Caregivers and Advocates (approved 2023/04/27), CI #M552-000019-24, resident's clinical record,
[740884]