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 29, 2025
Inspection Number: 2025-1568-0002
Inspection Type: Critical Incident
Licensee: City of Hamilton
Long Term Care Home and City: Macassa Lodge, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 15, 17, 22 - 25, 28, 29, 2025.

The following intake(s) were inspected:

- Intake: #00137068 - M552-000001-25 related to resident care and services;
- Intake: #00138448 - M552-000003-25 related to falls prevention and management;
- Intake: #00138777 - M552-000004-25 related to resident care and services.

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

Resident Care and Support Services
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

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed. The plan of care was amended during the inspection.

Sources: Review of resident's clinical record; interview with staff.

Date Remedy Implemented: April 24, 2025

WRITTEN NOTIFICATION: Plan of care

NC #002 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.

The licensee has failed to ensure that the care for a resident, who was identified as a

high risk for falls, was provided as specified in their plan of care when specified falls intervention were not in place.

Sources: Observations; review of resident clinical record; and interviews with staff.