Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspection Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: April 3, 2023

Inspection Number: 2023-1568-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: City of Hamilton

Long Term Care Home and City: Macassa Lodge, Hamilton

Lead Inspector	**Inspector Digital Signature**
Parminder Ghuman (706988)	Parminder S Ghuman Digitally signed by Parminder S Ghuman Date: 2023.04.06 11:04:36 -04'00'

Additional Inspector(s)
Betty Jean Hendricken (740884)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 15-16, 20, 22- 24, 27-29, 2023

The following intake(s) were inspected:

- Intake: #00001077 - [AH: IL-02050-AH/CI: M552-000021-22] Neglect of resident by staff.
- Intake: #00001141 - [IL: IL-02092-HA/IL: IL-02587-HA/IL: IL-04492-HA] Complainant with concerns regarding neglect of resident by the home.
- Intake: #00019947 - [CI: M552-000008-23] Fall of resident resulting in fracture to neck.
- Intake: #00002680 - [CI: M552-000036-21] Staff to resident physical/verbal abuse.
- Intake: #00008727 - M552-000057-22 - Sexual Abuse from Resident to Resident Intake: #00007244 and 00008478.

The following intake(s) were completed:

- Intake: #00001805 - [CI: M552-000033-22] Fall of resident resulting in scalp laceration.
- Intake: #00004187 - [CI: M552-000022-22] Fall of resident resulting in left hip fracture.
- Intake: #00006037 - [CI: M552-000010-22] Fall of resident resulting in left hip fracture .
- Intake: #00006069 - [CI: M552-000047-22] Fall of resident resulting in left hip fracture.
- Intake: #00006890 - [CI: M552-000019-22] Fall of resident resulting in traumatic brain injury.
- Intake: #00007274 - [CI: M552-000049-22] Fall of resident resulting in old fracture of left side
- Intake: #00021118 – [CI: M552-000010-23] Fall of resident resulting in cracked right wrist.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident is immediately reported to the director.

Rationale and Summary

On an identified date a staff documented that resident #004 had wandered to another unit and was found sitting on a resident's bed. Staff witnessed alleged abuse by resident #004 to the resident.

The staff documented this incident in resident's electronic chart but failed to report this incident to the Registered Nurse and also failed to report the suspected abuse to the Director. Interviews with Nurse Manager confirmed that staff failed to follow the process for reporting certain matters to the Director.

Not reporting certain matters to the Director puts the residents at risk of harm for abuse .

Sources: Resident #004's progress notes, Zero Tolerance For Resident Abuse and Neglect Policy, and interview with Nurse Manager.

[706988]