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

Public Report

Report Issue Date: December 17, 2024

Inspection Number: 2024-1568-0003

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): December 5 - 6, 9 - 10, 2024.

An Inspection Manager was present for the inspection.

The following intake(s) were inspected:

- Intake: #00128631 - Critical Incident (CI) M552-000054-24 related to falls prevention and management.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 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 failed to ensure that the care set out in a resident's plan of care was provided to the resident, as specified in the plan with regards to their recovery from the fall.

Rationale and Summary
The resident's plan of care specified directions to facilitate healing of a resulting fracture from the fall, which were not fully provided to the resident.

The Director of Care (DOC) acknowledged that the care provided did not follow the resident's plan of care, as specified in the plan.

Sources
Resident's clinical records, observations and staff interviews.