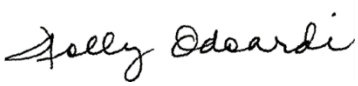
Communication Update

To:	Mayor and Members of City Council
Committee Date:	June 29, 2026
Subject/Report No.:	Ministry of Long-Term Care Inspection - Macassa Lodge (701 Upper Sherman Avenue)
Ward(s) Affected:	Ward 7
Submitted By:	Holly Odoardi Director, Long-Term Care and Seniors Long-Term Care Division Healthy and Safe Communities Department
Signature:	

The purpose of this Communication Update is to advise Council.

Summary

This Communication Update provides Council with an update on a recent inspection of Macassa Lodge completed by the Ontario Ministry of Long-Term Care (MLTC) on May 13, 14, 15, 19, 20, 21, 22, 25, 26 and 27, 2026 which resulted in an Order. As per City policy, this order has been submitted to be posted on the City of Hamilton's website.

Background

The Order was related to ensuring that appropriate actions are taken in response to incidents of improper treatment, suspected abuse and neglect.

In February and April of 2026, registered staff members of Macassa Lodge did not ensure the required post-incident assessments and incident documentation were completed and recorded in the residents' clinical record related to an alleged incident involving neglect of a resident and the alleged abuse/improper treatment of a resident.

During the inspection, the registered staff were interviewed, and it was confirmed the assessments were not completed, and that the registered staff were expected to complete them following such incidents. The absence of the assessments placed the resident at risk for unidentified changes in condition and unmet care needs.

Details

The Order states specifically, the licensee shall:

- Educate all registered staff in the home on the assessment and documentation requirements related to all suspected incidents of abuse, neglect or improper care.
- Ensure that all education provided is documented and records are kept for inspector review, including staff signatures, the dates the education was provided, and copies of the educational materials.
- After the education is complete, conduct an audit to ensure assessments are completed for all abuse, neglect and improper care related to Critical Incidents for three (3) weeks.
- Ensure that all audits are documented, and records are kept for inspector review, including who completed the audit, the dates the audits were completed, and any actions taken.

Next Steps

The Order requires the re-education of 133 registered staff. The action plan to re-educate registered staff includes:

- Sign-off on required policies: Abuse and Neglect Policy (RC-03-06-01) and the Risk Management Policy (RC-05-01-07).
- In-person one (1) hour education sessions for all registered staff are scheduled for June and July 2026.
- An abbreviated workflow has been created and posted to assist staff when documenting Incident Response Assessments and Documentation Requirements.
- The team has this work underway and will satisfy this Order on or before the compliance date of August 21, 2026.

Macassa Lodge staff continue to work closely with MLTC staff to prioritize the safety and well-being of residents and staff. Inspections are an important opportunity for Long-Term Care staff to strengthen and improve procedures and processes and we welcome the Ministry's feedback.

Appendices and Schedules Attached

Appendix A - Ministry of Long-Term Care Public Report Issued May 27, 2026

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: May 27, 2026

Inspection Number: 2026-1568-0003

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 dates: May 13 - 15, 19 - 22, and 25 - 27, 2026.

The following intakes were inspected:
-Intake: #00170927 - Critical Incident (CI) - related to the Prevention of Abuse and Neglect.
-Intake: #00170935 - CI - related to the Prevention of Abuse and Neglect.
-Intake: #00171367 - CI - related to the Prevention of Abuse and Neglect.
-Intake: #00172820 - CI - related to the Prevention of Abuse and Neglect.
-Intake: #00173812 - CI - related to Falls Prevention and Management.
-Intake: #00176005 - CI - related to Falls Prevention and Management.
-Intake: #00177456 - CI - related to the Prevention of Abuse and Neglect.

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

Prevention of Abuse and Neglect
Falls Prevention and Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

A) A resident was not treated with courtesy in a way that recognized their dignity when staff provided care in a common area and exposed the resident.

Sources: Observation, care plan, Critical Incident (CI) investigation notes, interview with staff.

B) A staff member did not respect a resident's rights to be treated with courtesy and respect in a way that recognized their individuality when they forced the resident to sit down.

Sources: Observation, care plan, CI investigation notes, interview with staff.

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WRITTEN NOTIFICATION: Resident's Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 5.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to freedom from neglect by the licensee and staff.

A resident was not provided with the right to freedom from neglect by staff.

According to O. Reg. 246/22 "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A resident was neglected when they were left without care and services for an extended period of time, despite documentation that the resident had requested assistance multiple times.

This resulted in neglect of the resident's care needs and failure to provide necessary care and assistance.

Sources: Resident's clinical records, home's internal report and investigation, resident.

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

A resident was not protected from emotional abuse by staff of the home in accordance with Section 2 of the Ontario Regulation (246/22), which defines emotional abuse as, "any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident".

A staff member did not ensure that a resident's wet hair was dried after their shower, when the resident indicated that they were feeling cold.

The staff member told the resident to stop complaining, as well as prevented them from leaving the dining room when they needed to use the toilet.

Sources: Observation, care plan, Abuse Policy, CI investigation notes, interview with staff.

WRITTEN NOTIFICATION: Reporting and Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1)
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

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1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. 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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

The home did not immediately report an allegation of improper/incompetent care of a resident to the Director, as required.

Sources: The home's investigation notes and interview with Nurse Manager.

WRITTEN NOTIFICATION: Required Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

In accordance with Ontario Regulations O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that their written policy related to falls prevention and management is complied with, as it relates to a specific falls risk intervention.

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A resident did not have a required specific intervention in place at the time of an observation, which was acknowledged by members of the staffing team.

Sources: Observation, care plan, falls prevention policy, interviews with staff.

COMPLIANCE ORDER CO #001 Licensee must investigate, respond and act

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(b) appropriate action is taken in response to every such incident; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure that appropriate actions are taken in response to incidents of improper treatment, suspected abuse and neglect.

Specifically, the licensee shall:

1 Educate all registered staff in the home on the assessment and documentation requirements related to all suspected incidents of abuse, neglect or improper care.

2 Ensure that all education provided is documented and records are kept for inspector review, including staff signatures, the dates the education was provided, and copies of the educational materials.

3 After the education is complete, conduct an audit to ensure assessments are

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completed for all abuse, neglect and improper care related Critical Incidents for three weeks.

4 Ensure that all audits are documented and records are kept for inspector review, including who completed the audit, the dates the audits were completed, and any actions taken.

Grounds

A) On a day in April 2026, the licensee did not ensure required post-incident assessments were completed following an alleged incident involving neglect of a resident.

During the inspection, staff confirmed the assessments were not completed, and that staff were expected to complete them following such incidents.

The absence of the assessments placed the resident at risk for unidentified changes in condition and unmet care needs.

Sources: Resident's clinical records, zero tolerance of resident abuse and neglect policy, home's internal investigation notes, interviews with resident and staff members.

B) In February 2026, a resident was triggered emotionally during care, however there was no assessment completed and no documentation of the incident in the resident's clinical records.

The DOC acknowledged that the expectation would be an an assessment of the resident with written documentation of the incident and the assessment.

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Not completing the required home's assessment following the alleged abuse/improper treatment put the resident's safety, emotional and physical wellbeing at risk.

Sources: Progress note, assessment, CI investigation notes, interview with DOC.

C) In February 2026, a staff held a resident by the hip forcibly and told them to sit down, however there was no assessment completed and no documentation of the incident in the resident's clinical record.

Not completing the required home's assessment following the alleged abuse put the resident's safety and physical wellbeing at risk.

Sources: Progress note, assessment, CI investigation notes, interview with staff.

This order must be complied with by August 21, 2026

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

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Telephone: (800) 461-7137

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.