

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée**

**Long-Term Care Operations Division  
Long-Term Care Inspections Branch**

**Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**

Ottawa Service Area Office  
347 Preston St Suite 420  
OTTAWA ON K1S 3J4  
Telephone: (613) 569-5602  
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa  
347 rue Preston bureau 420  
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**Public Copy/Copie du rapport public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Aug 5, 2021	2021_683126_0011	010158-21, 011022- 21, 011513-21, 012011-21	Critical Incident System

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**Licensee/Titulaire de permis**

DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc.

161 Bay Street, Suite 2100 TD Canada Trust Tower Toronto ON M5J 2S1

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**Long-Term Care Home/Foyer de soins de longue durée**

Lancaster Long Term Care Residence

105 Military Road North P.O. Box 429 Lancaster ON K0C 1N0

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

LINDA HARKINS (126)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): July 15, 16, 22, 23, 26, 27, 28, 29, 30, August 3, 2021**

**During the course of this inspection , the following logs were inspected  
Log #010158-21: Critical Incident (CI) #2680-000006-21, log #011022-21: CI #2680-000007-21, log #011513-21: CI #2680-000008-21 and log #012011-21: CI #2680-000009-21 related to sexual abuse.**

**During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Director of Care (DOC) and the Administrator.**

**During the course of the inspection, the inspector made observations related to resident care, dining and infection control, reviewed resident health care records, reviewed three investigations notes, reviewed the licensee's Abuse and Neglect Policy -P-10, reviewed March 22, 2021 and reviewed the Indoor air temperature and humidex monitoring record.**

**The following Inspection Protocols were used during this inspection:  
Infection Prevention and Control  
Prevention of Abuse, Neglect and Retaliation  
Responsive Behaviours  
Safe and Secure Home**

**During the course of this inspection, Non-Compliances were issued.**

**4 WN(s)  
3 VPC(s)  
1 CO(s)  
0 DR(s)  
0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (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. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

The licensee has failed to protect resident #002, #003, #004, #005 from sexual abuse by resident #001.

Sexual abuse is defined by O. Reg 79/10, s. 2 (1) as any non-consensual touching, behaviour or remarks of a sexual nature directed towards a resident by a person other than a licensee or staff member.

On four occasions in 2021, resident #003 was touched inappropriately by resident #001. Two Registered Practical Nurse (RPNs), documented in the progress note that the Substitute Decision Maker had consented to such touching. It was noted that no interventions were implemented at that time, to protect resident #003 and they had not immediately reported the first three incidents as per the Abuse and neglect policy.

On two occasions in 2021, resident #005 was touched inappropriately by resident #001. On a day in 2021, a Registered Nurse (RN) found resident #001 touching resident #005 inappropriately and had not immediately reported the incident as per the Abuse and neglect policy. The RN indicated that they were not aware of the reporting requirement.

On a day in 2021, resident #002 was touched inappropriately by resident #001.

On two occasions in 2021, resident #004 was touched inappropriately by resident #001. On a day in 2021, the RN documented the incident in the progress notes, but did not immediately report the incident as per the Abuse and neglect policy.

Sources: staff interviews and resident's health care records.

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20.  
Policy to promote zero tolerance**

Specifically failed to comply with the following:

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure their Abuse and Neglect policy was complied with.

On two occasions in 2021, resident #003 was touched inappropriately by resident #001. The incident was not reported to the Director, the Substitute Decision Maker (SDM) and to the Police and on one other occasion in 2021, the incident was not reported to the Director, the SDM and to the police.

On a day in 2021, an RN found resident #001 touching resident #005 inappropriately and had not immediately reported the incident as required by the Abuse and neglect policy. The RN indicated that they were not aware of the reporting requirement.

On a day in 2021, resident # 004 was touched inappropriately by resident #001 and the incident was not reported to the Director, the SDM and to the police as required by the Abuse and neglect policy.

Sources: The licensee's Abuse and Neglect policy and interviews with staff.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1)., to be implemented voluntarily.***

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature  
Specifically failed to comply with the following:**

**s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the temperature was measured on evening and night shift.

The indoor air temperature monitoring record was reviewed for the period of July 8-15, 2021. It was noted that the temperatures were not taken on the night shift of July 8, 9, 12, and 15, and on the evening shift of July 15, 2021.

Sources: Indoor air temperature and humidex monitoring record and interviews with the Administrator and the Director of Care.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24.  
Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (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:**

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 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. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

#### **Findings/Faits saillants :**

The licensee has failed to ensure that the Director was immediately notified of resident to resident abuse.

On four occasions in 2021, the Director was not notified of inappropriate touching by resident #001 to resident #003 and resident #004.

On one occasion in 2021, the Director was not immediately notified of the incident of inappropriate touching by resident #001 to resident # 005. The incident was reported the next day.

Sources: residents health care record and interviews with an RPN and other staff.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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:  
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., to be implemented voluntarily.***

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Issued on this 14th day of September, 2021

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**



**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

Long-Term Care Operations Division  
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée  
Inspection de soins de longue durée

**Public Copy/Copie du rapport public**

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**Name of Inspector (ID #) /**

**Nom de l'inspecteur (No) :** LINDA HARKINS (126)

**Inspection No. /**

**No de l'inspection :** 2021\_683126\_0011

**Log No. /**

**No de registre :** 010158-21, 011022-21, 011513-21, 012011-21

**Type of Inspection /**

**Genre d'inspection:** Critical Incident System

**Report Date(s) /**

**Date(s) du Rapport :** Aug 5, 2021

**Licensee /**

**Titulaire de permis :** DTOC II Long Term Care LP, by its general partner,  
DTOC II Long Term Care MGP (a general partnership)  
by its partners, DTOC Long Term Care GP Inc. and Arch  
Venture Holdings Inc.  
161 Bay Street, Suite 2100, TD Canada Trust Tower,  
Toronto, ON, M5J-2S1

**LTC Home /**

**Foyer de SLD :** Lancaster Long Term Care Residence  
105 Military Road North, P.O. Box 429, Lancaster, ON,  
K0C-1N0

Nicole Gurnsey

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

**Name of Administrator /  
Nom de l'administratrice  
ou de l'administrateur :**

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To DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order(s) of the Inspector****Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

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**Order # /****No d'ordre :** 001**Order Type /****Genre d'ordre :** Compliance Orders, s. 153. (1) (a)**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

**Order / Ordre :**

The licensee must be compliant with s. 19 (1) of the Long-Term Care Homes Act, 2007.

The licensee shall ensure residents #002, #003, #004 and #005 are protected from sexual abuse by completing the following:

-Two RPNs and two RNs shall complete the education on the Abuse and neglect policy and the duty under section 24 to make mandatory reports.

-Keep a record of all training/retraining provided including the dates and the persons who attended.

**Grounds / Motifs :**

**Order(s) of the Inspector****Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

1. The licensee has failed to protect resident #002, #003, #004, #005 from sexual abuse by resident #001.

Sexual abuse is defined by O. Reg 79/10, s. 2 (1) as any non-consensual touching, behaviour or remarks of a sexual nature directed towards a resident by a person other than a licensee or staff member.

On four occasions in 2021, resident #003 was touched inappropriately by resident #001. Two Registered Practical Nurse (RPNs), documented in the progress note that the Substitute Decision Maker had consented to such touching. It was noted that no interventions were implemented at that time, to protect resident #003 and they had not immediately reported the first three incidents as per the Abuse and neglect policy.

On two occasions in 2021, resident #005 was touched inappropriately by resident #001.

On a day in 2021, a Registered Nurse (RN) found resident #001 touching resident #005 inappropriately and had not immediately reported the incident as per the Abuse and neglect policy. The RN indicated that they were not aware of the reporting requirement.

On a day in 2021, resident #002 was touched inappropriately by resident #001.

On two occasions in 2021, resident #004 was touched inappropriately by resident #001. On a day in 2021, the RN documented the incident in the progress notes, but did not immediately report the incident as per the Abuse and neglect policy.

Sources: staff interviews and resident's health care records. (126)

**This order must be complied with by /  
Vous devez vous conformer à cet ordre d'ici le :**

Sep 07, 2021

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

**REVIEW/APPEAL INFORMATION**

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

The written request for review must be served personally, by registered mail, commercial courier or by fax 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  
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar  
Health Services Appeal and Review Board  
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  
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

**RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX  
APPELS**

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le/la titulaire de permis souhaite que le directeur examine;
- c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur  
a/s du coordonnateur/de la coordonnatrice en matière d'appels  
Direction de l'inspection des foyers de soins de longue durée  
Ministère des Soins de longue durée  
438, rue University, 8<sup>e</sup> étage  
Toronto ON M7A 1N3  
Télécopieur : 416-327-7603

**Order(s) of the Inspector****Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)  
Commission d'appel et de révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto ON M5S 1S4

Directeur  
a/s du coordonnateur/de la coordonnatrice en matière  
d'appels  
Direction de l'inspection des foyers de soins de longue durée  
Ministère des Soins de longue durée  
438, rue University, 8e étage  
Toronto ON M7A 1N3  
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Issued on this 5th day of August, 2021**

**Signature of Inspector /**

**Signature de l'inspecteur :**

**Name of Inspector /**

**Nom de l'inspecteur :** LINDA HARKINS

**Service Area Office /**

**Bureau régional de services :** Ottawa Service Area Office