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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: January 22, 2026
Inspection Number: 2026-1182-0001
Inspection Type: Critical Incident
Licensee: DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC II Long Term Care GP Inc. and Arch Venture Holdings Inc.
Long Term Care Home and City: Lancaster Long Term Care Residence, Lancaster

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 16, 20-22, 2026.

The following intake(s) were inspected:

- Intakes: #00156335 and #00163457 were regarding outbreaks declared by the home.
- Intake: #00166941 was regarding a significant change in health condition of a resident after a fall.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Communication and response system

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (g)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

The long-term care home did not ensure that their resident-staff communication and response system (RSCRS) equipped to use sound to alert staff, was properly calibrated so that the level of sound is audible to staff.

Observations revealed that the RSCRS installed in the home was not calibrated at an adequate volume, as alerts were only audible when staff were standing within approximately two bedrooms of a resident's room. A Personal Support Worker (PSW) stated that they would not hear a resident's RSCRS alert unless they were present in the hallway of that resident's home area. Additionally, another staff member reported that the call display screen identifying RSCRS alerts was not configured with an auditory notification to alert all staff when a call was made.

Sources: Observations of RSCRS in resident hallways and main foyer and dining room of the home; interviews with PSW's and LTCH staff and the Administrator.