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
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Hamilton, ON, L8P 4Y7
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Public Report

Report Issue Date: September 2, 2025

Inspection Number: 2025-1127-0005

Inspection Type:
Critical Incident
Follow up

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: Niagara Long Term Care Residence, Niagara On The Lake

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 27-28, 2025 and September 2, 2025.

The following intake(s) were inspected:
-Intake: #00149717 - Critical Incident (CI) 2618-000011-25 - Infection prevention and control program
-Intake: #00153736 -Follow-up #1 - High Priority CO #001/ #2025-1127-0004, FLTCA, 2021 - s. 3 (1) 5. - Resident's Bill of Rights. CDD August 22, 2025.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1127-0004 related to FLTCA, 2021, s. 3 (1) 5.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

In accordance with Additional Requirement 9.1 for Additional Precautions (f) under the IPAC Standard for Long-Term Care Homes, the licensee has failed to ensure that additional precautions were followed on a specified date in August 2025, when a staff member initially failed to donn personal protective equipment (PPE) when conducting an assessment on a resident who was on additional precautions. The staff member donned PPE when they realized the resident was on additional precautions.

Sources: Observations, IPAC Standard for Long-Term Care Homes dated April 2022 (revised September 2023), the resident's progress notes and clinical record.