

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: February 5, 2026

Inspection Number: 2026-1127-0001

Inspection Type:

Proactive Compliance Inspection

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 dates: February 2-5, 2026.

The following intakes were inspected:

-Intake: #00169266 - Proactive Compliance Inspection

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

- Contenance Care
- Infection Prevention and Control
- Prevention of Abuse and Neglect

INSPECTION RESULTS

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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).

In accordance with Additional Requirement 9.1 (f) of The Infection Prevention and Control (IPAC) Standard for Long-term Care Homes (revised September 2023), the licensee shall ensure that at minimum, Additional Precautions include the appropriate selection, application, removal and disposal of Personal Protective Equipment (PPE).

On a specified date, a staff person entered the bedspace of two residents with Enhanced Droplet and Contact Precautions in place to deliver their meal trays. The staff person did not replace their surgical mask with an N95 respirator prior to entering the residents' bed spaces. Further, they doffed their eye protection prior to doffing their gown and performing hand hygiene.

Later the same day, another staff person entered the bedspace of four residents with Enhanced Droplet and Contact Precautions in place to deliver their meal trays. On the first two occasions they did not replace their surgical mask with an N95 respirator, nor don eye protection or gloves where required. Additionally, they did not perform hand hygiene immediately after doffing their PPE and before touching clean equipment. On the other two occasions, the same staff person did not don gloves or eye protection where required. The staff person remained in the last

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resident's bed space for about 15 minutes to assist with feeding.

Sources: The IPAC Standard (September 2023), residents' clinical records, observation of residents, and interviews with staff members.