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

London District
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London, ON, N6A 5R2
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Public Report

Report Issue Date: March 21, 2025
Inspection Number: 2025-1210-0002
Inspection Type: Complaint Critical Incident
Licensee: DTOC Long Term Care LP, by its general partner, DTOC Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc.
Long Term Care Home and City: Chateau Park Long Term Care Home, Windsor

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 19, 20, 21, 2025

The following intake(s) were inspected:

- CI#2712-000003-25 - Fall with injury.
- Concerns regarding improper transfer to resident.
- Concerns regarding fall of resident resulting in injury.
- Concerns regarding alleged neglect to resident.

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

Continence Care
Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that safe transferring techniques were used when assisting a resident. As a result of the transfer being completed without the required two staff, the resident sustained an injury.

Sources: Investigation notes, and interview.