

Ministry of Long-Term Care

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

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: September 3, 2025

Inspection Number: 2025-1210-0004

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): August 25, 26, 27, 28, 2025 and September 2, 3, 2025

The following intake(s) were inspected:

- Critical Incident # 2712-000014-25 - Improper transfer to resident
- 2025-0001215 - From complainant regarding neglect to resident

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Reporting and Complaints
Falls Prevention and Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and Wound Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that an initial skin assessment using a clinically appropriate assessment instrument was completed when a resident exhibited altered skin integrity. A review of the resident's clinical records indicated that an initial assessment was not completed on the area of impairment.

Sources: Resident clinical records and interview with Registered Nurse.

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

Continence care and bowel management

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s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that a resident who required an incontinence device had their plan of care implemented. The resident had a device in place and their plan of care indicated staff were to document every shift. The required documentation was not documented and the resident was sent to the hospital due to pain.

Sources: Resident's clinical records and interview with Registered Nurse (RN).