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

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Public Report

Report Issue Date: October 29, 2025
Inspection Number: 2025-1210-0005
Inspection Type: 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 dates: October 21, 23, 24, 27-29, 2025

The following intakes were inspected:
- Intake: #00158424 - AH-2025-0003116/2712-000020-25 - relating to incident which caused resident injury
- Intake: #00160360 - 2712-000021-25 - relating to unlawful conduct resulting in harm
- Intake: #00160794 - 2712-000022-25 - relating to alleged resident to resident abuse

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours
Admission, Absences and Discharge

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-

compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the plan of care for a resident provided clear direction to staff with regards to transferring the resident. The resident's plan of care indicated a different level of transfer than was being provided to the resident. The resident's plan of care was updated on October 22, 2025.

Sources: Observations of resident room, review of resident's clinical records and interview with staff

Date Remedy Implemented: October 22, 2025

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was protected from sexual abuse by another resident.

Section 2(1) of Ontario Regulation 246/22 defines sexual abuse as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

A review of resident records and interview with a resident and a local police officer indicated a resident had been touched by another resident without consent. Interviews with the staff of the home confirmed that the incident negatively impacted the resident.

Sources: Critical Incident #2712-000022-25, resident progress notes and interviews staff, resident and a local police officer.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee failed to ensure that a resident who demonstrated responsive behaviours, had written strategies and interventions, to prevent, minimize or respond to the responsive behaviours. The resident was identified as having responsive behaviours on several occasions. During an interview, it was confirmed that the home identified strategies to minimize the resident's responsive behaviours and these strategies should be documented in the resident's care plan. A review of the resident care plan indicated that the resident's history of responsive behaviours and strategies to reduce behaviours were not documented.

Sources: review of resident clinical records and interview with staff.