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

Public Report

Report Issue Date: March 11, 2026
Inspection Number: 2026-1210-0003
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 date(s): March 9-11, 2026

The following intake(s) were inspected:

- Intake: #00169027 - CI #2712-000001-26 related to improper care to resident.

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

Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

A critical Incident was sent to the Director when a resident sustained a skin injury possibly attributed to the use of a medical device. No medical directives were found in the resident's clinical records to specify the need for the device and the guidelines of its use, therefore, the medical device remained applied at all times.
It was determined that the lack of collaboration between the nursing staff and the physician resulted in the improper use of the medical device, contributing to the skin injury. A Registered Nurse confirmed that the physician was not contacted to clarify the use of the device. In an interview with the Acting Director of Care it was acknowledged that the medical directives should have been in place for the use of the medical device.

Sources: resident's clinical record and interviews with staff