

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: November 17, 2025

Inspection Number: 2025-1251-0002

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: Regency Park Long Term Care Home, Windsor

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 12-14, and November 17, 2025

The following intake(s) were inspected:

- Intake: #00159695 - CI#2760-000011-25-Fall of resident
- Intake: #00161881 - CI#2760-000012-25-Missing resident <=3hours

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

- Skin and Wound Prevention and Management
- Safe and Secure Home
- Falls 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 (1) (a)

Plan of care

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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,
(a) the planned care for the resident;

A Personal Assistive Support Device (PASD) utilized by a resident was not included in the resident's plan of care. The inspector observed the resident using the PASD on identified dates and it was not part of their plan of care. A Registered Practical Nurse indicated that the PASD applied to the resident should have been assessed and contained in the resident's plan of care.

Sources: observations of resident in their environment, review of their clinical record and interviews with staff