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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: June 4, 2025
Inspection Number: 2025-1182-0002
Inspection Type: Critical Incident
Licensee: DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC II Long Term Care GP Inc. and Arch Venture Holdings Inc.
Long Term Care Home and City: Lancaster Long Term Care Residence, Lancaster

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 30, 2025 and June 2-4, 2025

The following Critical incident (CI) intake(s) were inspected:
·Intake: #00144469/CI #2680-000001-25 related to an Enteric outbreak
·Intake: #00146245/CI # 2680-000002-25 related to a Respiratory outbreak
·Intake: #00146702/CI #2680-000003-25 related to an alleged resident abuse

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) standard, under the Hand Hygiene program Additional Requirement 10.4 (h) which states:
The licensee shall ensure that the hand hygiene program also includes support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting was followed by staff.

During a lunch service observation, it was noted that several residents were not offered hand hygiene prior to their meal. The IPAC Lead stated during an interview that staff are expected to ensure that all residents are either provided with or offered hand hygiene upon both entry to and exit from the dining room during meal times.

Sources: Inspector lunch service observation, staff interviews, Infection Prevention and Control Standard for Long Term Care Homes, April 2022.

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Section 2(1) of the O. Regs 246/22 defines sexual abuse as :
(a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member

The licensee has failed to ensure immediate reporting to the Director for suspicion of a resident abuse. No calls had been made to the Ministry of Long-Term Care after-hours line, management or to the police. The Executive Director had acknowledged and confirmed that the alleged abuse should have been reported immedialty to the Ministry of Long-Term Care and not the following day.

Sources: review of Critical incident #2680-000003-25, staff interviews, staff training records.