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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: July 25, 2025

Inspection Number: 2025-1127-0004

Inspection Type:
Complaint
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: Niagara Long Term Care Residence, Niagara On The Lake

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 17, 18, 22-25, 2025.

The following intakes were inspected:

- Intake: #00147119 [Critical Incident Report (CIR) #2618-000009-25] Prevention of abuse and neglect.
- Intake: #00147271 [CIR #2618-000010-25] Falls prevention and management.
- Intake: #00147277 Complainant with concerns regarding medication administration, dressing, continence care and prevention of abuse and neglect.

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

Continence Care

Housekeeping, Laundry and Maintenance Services
Medication Management
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 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 protect a resident from physical abuse by another resident.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident."

On a specified date, a resident approached another resident. It is unclear if the resident touched or accidentally brushed the other resident's leg but the other resident grabbed the resident's hand and struck them in the face several times. The resident who was struck was injured as a result of this incident.

Sources: Resident's progress notes and assessments, and interviews with staff.

COMPLIANCE ORDER CO #001 Residents' Bill of Rights

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 3 (1) 5.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to freedom from neglect by the licensee and staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee shall:
1) Re-educate a specified staff member on the Residents' Bill of Rights. Specifically, the residents' right to freedom from abuse and neglect by staff.
2) Document the education, including the components of the education, the date the education was provided, the name of the staff receiving education, and the name of the staff member(s) who provided the education.
3) Maintain a record of the education provided for inspector review.

Grounds

The licensee failed to respect and promote a resident's right to freedom from staff neglect.

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

On a specified date, a resident experienced an unwitnessed fall after being left

unattended by a staff member.

A registered staff member assessed the resident post-fall and identified signs of injury and pain and reported the findings to the on-call Nurse Practitioner (NP). The NP directed the registered staff member to transfer the resident to the hospital for further evaluation and treatment, and to inform the resident's Substitute Decision Maker (SDM) about the incident.

The registered staff member did not inform the resident's SDM of the fall and failed to send the resident to the hospital as ordered by the NP. Several hours after the fall incident, the resident was transferred to the hospital for suspected injury by a different registered staff member.

The Home's Director of Care (DOC) acknowledged that staff failed to protect the resident from neglect resulting in a fall and delay in treatment.

The safety and well-being of the resident was compromised when staff failed to address their care needs.

Sources: Resident's Clinical Records, Home's internal investigation report, Home's Pain Management Policy and Procedure, interviews with the DOC and the Nurse Practitioner.

This order must be complied with by August 22, 2025.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar

151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.