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

Central East District
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Public Report

Report Issue Date: January 8, 2025
Inspection Number: 2025-1438-0001
Inspection Type: Critical Incident
Licensee: Southlake Residential Care Village
Long Term Care Home and City: Southlake Residential Care Village, Newmarket

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 6 - 8, 2025

The following intake(s) were inspected:
- An intake related to the Fall of a resident
- An intake related to neglect of resident by staff

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that the method specified in the resident's care plan was utilized during a transfer. The personal support workers assisted the resident with transferring by using equipment which was not indicated in their care plan.

Sources: LTCH investigation notes, Critical Incident Report (CIR), and resident's clinical records.

WRITTEN NOTIFICATION: Skin Assessment

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital, and

The licensee failed to ensure that the resident received a skin assessment upon return from the hospital. No documentation was completed for the skin assessment upon the resident's readmission.

Source: CIR, resident's clinical records, Interview with staff