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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: April 2, 2025
Inspection Number: 2025-1438-0002
Inspection Type: Complaint 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): March 19 – 21, 2025, March 24 – 28, 2025, March 31 – April 2, 2025

The following intake(s) were inspected in this Critical Incident (CI) inspection:
Intake: #00137616 - Fracture of a resident
Intake: #00137837 - Neglect of a resident
Intake: #00137957 - Physical abuse of a resident
Intake: #00139394 - Neglect of multiple residents.

The following intake(s) were inspected in this complaint inspection:
Intake: #00138869 - Improper care of a resident
Intake: #00139179 - Dietary concerns

The following intake was completed in this inspection:
Intake: #00137912 - Fall of a resident

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

Resident Care and Support Services

Continence Care
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that the home is maintained in a safe condition and a good state of repair, specifically insufficient lighting.

Staff moved a resident to a better-lit area to complete an assessment because the room had no light. A work order was initiated and completed to replace all lights the next day.

Source: Interview with staff, and work order.

WRITTEN NOTIFICATION: Duty to Protect

NC #002 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 ensure that residents were protected from neglect by staff.

Ontario Regulation (O. Reg) 246/22, Part 1, Interpretation, Definitions, s. 7 neglect is defined 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.

Residents were found to have not been provided care by staff. The neglect of the residents by staff was confirmed by the LTCH's internal investigation.

Sources: clinical records, LTCH investigation notes, and interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 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 staff used safe transferring and positioning devices or techniques when assisting a resident.

Staff facilitated the transfer of a resident in the washroom, and later, staff moved the resident to complete an assessment. Both transfers did not comply with the resident's care plan and the home's policy for safe transfers.

Source: Home's policy titled "Safe Lifting with Care Program Policy", Resident's Care Plan, Home's Investigation notes, and Interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee failed to identify the behavioural triggers and implement strategies and interventions to address the needs of a resident when they demonstrated responsive behaviours.

An altercation occurred between two residents. The staff member present at the time failed to identify the behavioural triggers and did not apply the strategies specified in the resident's care plan.

Source: Resident's care plan, and Interviews with staff

WRITTEN NOTIFICATION: Nutrition Manager

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 81 (2)
Nutrition manager
s. 81 (2) The licensee shall ensure that every nutrition manager is an active member of the Canadian Society of Nutrition Management or a registered dietitian. O. Reg. 66/23, s. 17 (1).

The licensee failed to ensure that staff was an active member of the Professional Association related to their profession

The staff assumed their roles before completing the membership exam. At the time of inspection, they had not received confirmation of registration.

Sources: interview with staff; email communication of staff.

WRITTEN NOTIFICATION: Dealing with complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee failed to provide a written response to the complaint made by the Substitute Decision Maker (SDM) of a resident.

The resident's SDM expressed concerns to the staff. Thirteen business days after the initial complaint was made, the home provided a written response to the SDM.

Source: Interview with staff, Resident's Progress Note, Email sent by home to SDM.

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702