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:** May 26, 2025

**Inspection Number:** 2025-1438-0004

**Inspection Type:**
Critical Incident
Follow up

**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): May 20-23, and 26, 2025

The following intake(s) were inspected:

- An intake: related to Follow-up #1 - Compliance Order (CO) High Priority (HP) #001, Duty to protect
- An intake related to Falls prevention
- An intake related to Prevention of abuse and neglect

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1438-0003 related to FLTCA, 2021, s. 24 (1)

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

Resident Care and Support Services
Medication Management

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

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (7)**
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure the care set out in the plan of care for a resident was provided to them as specified in the plan.

The resident's plan of care indicated to ensure their mobility device's brakes were on when not in use due to resident's specific responsive behaviour. Personal Support Worker (PSW) #104 confirmed that they had put the mobility device in a different location in the room and not within the reach of the resident. The resident later had a fall in near proximity of their mobility device and sustained a significant injury.

**Sources:** A Critical Incident Report (CIR), the resident's clinical records and the home's investigation notes, interview with PSW #104

## WRITTEN NOTIFICATION: Protecting from certain restraining

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 34 (1) 5.**
Protection from certain restraining
s. 34 (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than under the common law duty referred to in section 39.

The licensee has failed to ensure a resident was protected from being restrained by use of barriers in their room.

Registered Practical Nurse (RPN) #101 and Personal Support Worker (PSW) #104 both confirmed that a physical barrier was being placed in the resident's room to prevent them from entering into another space in their room due to their specific responsive behaviour.

**Sources:** Observation, interviews with staff

## WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 140 (2)**
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a drug was administered to a resident in

accordance with the direction of use specified by the prescriber.

The resident was prescribed a medication to be given prior to a special medical procedure. The resident received the medication in error prior to a different medical procedure.

**Sources:** A CIR, the resident's clinical records and the home's investigation notes, interview with Assistant Director of Care (ADOC) #102.

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