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: July 17, 2025

Inspection Number: 2025-1438-0005

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): July 7 - 11, 14 - 17, 2025

The following intake(s) were inspected:

- One intake was a complaint related to alleged neglect of a resident.
- One intake was related to related to alleged physical abuse of a resident.
- Two intakes were related to alleged neglect of a resident.
- One intake was related to a fall of a resident.
- One intake was related to an outbreak of communicable disease.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee failed to ensure that a resident was free from neglect by a Personal Support Worker (PSW).

A PSW was assigned to care for the resident and did not provide personal care, including hygiene care or monitoring of the resident that shift. The Assistant Director of Care (ADOC) confirmed that the PSW was found to have neglected the resident.

Sources: Resident's clinical record, Critical Incident (CI) Report, home's investigation notes, PSW discipline record, interview with ADOC.

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 11.
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:

11. Every resident has the right to live in a safe and clean environment.

The licensee failed to ensure a resident's right to live in a safe and clean environment. On a specified date, a resident's room was in an unsanitary condition. Staff were aware of the unsanitary condition of the room, but it was not cleaned until a complaint was received. The ADOC acknowledged that housekeeping staff did not provide daily cleaning services on this day, and that staff should have cleaned the resident's room when the mess was discovered.

Sources: CI Report, home's investigation notes, interview with ADOC.

WRITTEN NOTIFICATION: Duty to protect

NC #003 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 was protected from neglect by PSW.

O. Reg. 246/22, s. 7 defines neglect as "a 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."

A report by a PSW was made to the registered staff, indicating that the resident was neglected by the PSW when they didn't provide continence care during their shift.

The ADOC confirmed that PSW did not provide continence care to the resident.

Sources: CI Report, home's investigation notes, PSW's staff record, and interview with the ADOC.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents, was complied with.

During an investigation into an alleged staff to resident abuse incident, the Interim Director of Care (IDOC) became aware of a separate suspected abuse incident involving the resident. The IDOC did not report this suspected case of abuse or the results of the investigation to the Director as required by the home's Zero Tolerance of Abuse and Neglect Program Policy and Investigation of Abuse or Neglect Procedure.

Sources: Resident's progress notes, home's investigation notes, Zero Tolerance of Abuse and Neglect Program Policy, Investigation of Abuse or Neglect Procedure, interview with IDOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 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.

The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred or may occur immediately reported the suspicion and the information upon which it is based to the Director.

A Registered Practical Nurse (RPN) was informed by a PSW about comments of an abusive nature made towards a resident. The RPN did not report the allegation to their supervisor or the Director. The IDOC acknowledged that the staff should have reported the alleged abuse of the resident immediately.

Sources: Resident's progress notes, home's investigation notes, Zero Tolerance of Abuse and Neglect Program Policy, interview with IDOC.

WRITTEN NOTIFICATION: Falls prevention and management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide

for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, and the use of equipment, supplies, devices and assistive aids for the resident.

In accordance with Ontario Regulation (O. Reg.) 246/22 s. 11 (1) (b), the licensee is required to ensure the falls prevention and management program, at a minimum, includes the use of devices and provides strategies to monitor residents, and must be complied with. The home's policy directs nursing staff to identify risks, implement fall prevention strategies, and evaluate the plan of care as needed. Additionally, they are to monitor to ensure PSWs are following the plan of care for fall prevention and management.

The resident was identified as a high risk for fall and were required to have a fall prevention intervention in place when on their bed. However, the intervention was not in place.

Sources: CI Report, Health record, Investigation notes, Falls management program policy, care plan, interview with ADOC

WRITTEN NOTIFICATION: Falls prevention and management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee failed to ensure that when a resident has fallen, specifically the identified resident, that they are assessed and that a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Several clinical records for the resident indicated that they had sustained a fall, but a post fall assessment using a clinically appropriate assessment instrument was not completed. A RPN confirmed that a post fall assessment was required after every fall. The ADOC also confirmed that the post fall assessment was not completed using the designated tool.

Sources: Resident's clinical records and interviews with RPN, and the ADOC.

WRITTEN NOTIFICATION: Dining and snack service

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
3. Monitoring of all residents during meals.

The licensee failed to ensure that a resident was monitored during meal service on a specific date. The plan of care indicated that they are to be monitored while

having meals. The ADOC acknowledged that the staff did not provide monitoring of the resident during their meal as expected.

Sources: Resident's clinical record, CI Report, the home's investigation notes, interview with ADOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #009 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 a standard issued by the Director with respect to infection prevention and control (IPAC), in accordance with section 9.1 under the IPAC Standard for Long-Term Care Homes (Sept 2023), when at minimum, Additional Precautions shall include: f) Additional personal protective equipment (PPE) requirements including appropriate selection, application, removal.

Multiple staff were observed entering the outbreak unit without wearing facial masks, while the residents were sitting in their wheelchair just inside the dining room and hallway. A PPE supply caddy was hanging from the main door entrance, and a mandatory facial mask requirement sign was posted. The IPAC Manager confirmed that PPE was needed to protect the resident from potential exposure to the respiratory outbreak.

Sources: PSW observations, interview with IPAC Manager.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that a resident's symptoms were recorded on each shift when they were diagnosed with a respiratory infection.

The home was experiencing a respiratory outbreak, and the identified resident was symptomatic for a period of time. However, their symptoms were not documented every shift during that period. The IPAC Lead confirmed that the resident's symptoms had not been documented on every shift.

Sources: Resident's progress notes and an interview with the IPAC Lead.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to ensure that respiratory disease outbreaks were reported to the Director immediately.

York Region Public Health confirmed the home was on Respiratory Outbreak. However, the home did not submit the CI report in a timely manner.

Sources: CI Report, and interview with IPAC lead.

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. A Nursing Manager or Education Lead to provide education on the home's policies and procedures related to lifts and transfers, including following the resident's plan of care, to all staff, on all shifts, that participate in resident transfers on the units 3

West and 3 East.
Maintain a record of the education provided including who conducted the education session(s), date and time of session(s), list of attendees including name, designation and signature.
2. Conduct two (2) audits per resident, per week, on transfers for residents #004 and #006 for a period of 4 weeks. At least one audit for each resident must be conducted on a weekend. Audits must include a balance of day shift, evening shift, and night shift (as applicable) and different staff when able.
Maintain a record of the audits in the home, including the dates, who conducted the audits, the staff members being audited, and the results and actions taken in response, if any.

Grounds

1) The licensee failed to ensure that a PSW used safe transferring techniques when assisting a resident.

Rationale and Summary

A resident required a specific transfer on and off the toilet. The IDOC acknowledged that the PSW assigned to the resident on the specified date did not transfer the resident as expected in the plan of care.

The resident was at risk for fall or injury when the PSW failed to transfer the resident as per the plan of care.

Sources: CI Report, resident's clinical record, LTCH investigation notes, interview with IDOC.

2) The licensee has failed to ensure that staff used safe transferring techniques when assisting the resident.

Rationale and Summary

Specifically, an observation was made in which a PSW transferred the identified resident independently, rather than using a mechanical lift with two staff members as outlined in the resident's plan of care.

The ADOC acknowledged that the PSW did not follow the transfer method specified in the plan of care.

Resident was at risk of falling or sustaining an injury due to being transferred by a single staff member.

Sources: Observation, review of resident health records, and interview with PSW, and Associate Director of Care.

This order must be complied with by September 26, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

In the past 36 months, a CO under O. Reg. 246/22 s. 40 was issued (#2023-1438-0002) on 2023-05-16.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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

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.