



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

Health System Accountability and
Performance Division
Performance Improvement and
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Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 5, 2013	2013_102116_0033	T-193-13	Critical Incident System

Licensee/Titulaire de permis

SOUTHLAKE RESIDENTIAL CARE VILLAGE
640 GRACE STREET, NEWMARKET, ON, L3Y-2L1

Long-Term Care Home/Foyer de soins de longue durée

SOUTHLAKE RESIDENTIAL CARE VILLAGE
640 GRACE STREET, NEWMARKET, ON, L3Y-2L1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection



The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 29, 30 & August 19, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Social Worker, a Resident, Registered staff and Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) reviewed the health record of Resident #1, education in service records and the homes zero tolerance for abuse policy.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend

Legendé

WN – Written Notification

WN – Avis écrit

VPC – Voluntary Plan of Correction

VPC – Plan de redressement volontaire

DR – Director Referral

DR – Aiguillage au directeur

CO – Compliance Order

CO – Ordre de conformité

WAO – Work and Activity Order

WAO – Ordres : travaux et activités



Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :



1. The licensee failed to ensure Resident # 1 was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

- On a specified date, Resident #1 reported to the management that a PSW communicated with him/her in an inappropriate manner which did not uphold the residents respect. Resident #1 revealed that he/she remains fearful of the identified PSW due to reporting the incident.

- Resident #1 reported to the inspector that the PSW questioned a request made by the resident to have the scheduled shower provided by another staff member. Resident #1 states that the PSW's tone was harsh and that he/she is fearful of the staff member.

- During an interview the PSW acknowledged that his/her tone at times could be misunderstood.

- An internal investigation was conducted which resulted in discipline of the PSW [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Resident #1 is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

Issued on this 5th day of September, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs