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: December 9, 2025
Inspection Number: 2025-1438-0008
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): December 2 - 5, 8, 9, 2025

The following intake(s) were inspected:
- Three intakes were related to falls prevention and management.
- One intake was related to improper care of a resident.
- One intake was related to alleged neglect of a resident.
- One intake was a complaint related to alleged neglect of a resident.
- One intake was a complaint related to improper care of a resident.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 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.

A complaint alleging abuse towards a resident was reported to the staff. The Registered Nurse (RN) Supervisor who received the information, did not complete an internal incident report or notify management about the allegation as directed by the home's Zero Tolerance of Resident Abuse and Neglect, Response and Reporting Policy.

Sources: Complaint, resident #002's progress notes, Zero Tolerance of Resident Abuse and Neglect Program Policy, and interviews with RN #104, Assistant Director of Care (ADOC) #107, and the Interim Director of Care (IDOC).

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 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 plan of care for a resident indicated they mobilized with an assistive device and was at risk for falls. Personal Support Worker (PSW) #112 was in the process of providing care to the resident and requested the resident mobilize in an unsafe manner.

At the time of the home's investigation, PSW #112 indicated they placed the resident at a higher risk of falling when they had not ensured safe transferring techniques when assisting the resident.

Sources: Critical Incident Report, resident #005's clinical chart, the home's investigation file, interviews with PSW #102, and ADOC #107.

WRITTEN NOTIFICATION: Dealing with complaints

NC #003 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.

A verbal complaint was presented to the registered staff of the home by a family member, alleging mistreatment of a resident.

The ADOC and the IDOC indicated they were not made aware of the reported complaint and an investigation was not completed.

Sources: Complaint lodged to the Director, resident #002's progress notes, the home's Complaint Log Binder, the home's Complaints and Customer Service Policy, and interviews with RN #104, ADOC #107, and the IDOC.

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