

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 6, 2026
Inspection Number: 2026-1438-0004
Inspection Type: Complaint 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): April 30, 2026, and May 1, 4, 5, & 6, 2026.

The following intake(s) were inspected:

- Two Compliance Order (CO) related to Skin and Wound Care
- Intake related to improper care of a resident

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

- Order #001 from Inspection #2026-1438-0001 related to O. Reg. 246/22, s. 55 (2) (b) (iv)
- Order #002 from Inspection #2026-1438-0001 related to O. Reg. 246/22, s. 55 (2) (e)

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

Resident Care and Support Services
Skin and Wound Prevention and Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The resident did not receive an assessment to reflect a change in their care needs.

The resident's care needs were identified in the written plan of care on an identified date. There was no supporting documentation or assessment to support the adjustment in the written plan of care, and the resident was not referred to the Physiotherapist (PT) for an assessment.

Sources: Resident's clinical records, the home's policies, and interview with PT.

WRITTEN NOTIFICATION: Transfer 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 resident was transferred improperly by a Personal Support Worker (PSW).

The resident's written plan of care was not followed related to identified care needs.

Sources: Resident clinical records, home's investigation file, and interview with ADOC.



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**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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