Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Original Public Report

Report Issue Date July 19, 2022
Inspection Number 2022_1079_0002
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
CVH (No. 1) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)

Long-Term Care Home and City
Craiglee Nursing Home, Scarborough

Lead Inspector
Stephanie Luciani (707428)

Additional Inspector(s)
April Chan (704759)

Inspector Digital Signature
Stephanie Luciani
Digitally signed by Stephanie Luciani
Date: 2022.07.19 16:32:32 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 6, 7, 8, 11, 12 and 13, 2022.

The following intake(s) were inspected:

- Intake #009155-22 (CIS #2503-000008-22) related to fall resulting in injury.
- Intake #019080-21 (CIS #2503-000009-21) related to safe and secure home.
- Intake 004462-22 (Complaint) related to alleged emotional abuse and Residents' Bill of Rights.
- Intake #002352-22 (Follow-up) related to staff participation in the implementation of the home's infection prevention and control program.

Previously Issued Compliance Order(s)

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

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 229 (4)	2021_891649_0024	001	Stephanie Luciani (707428)

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Residents' Rights and Choices
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION PLAN OF CARE

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 6 (1) (c)*

The licensee has failed to ensure that the written plan of care for one resident, set out clear directions to staff who provide direct care to the resident.

Rationale and Summary
The resident had cognitive and physical impairments and a recent history of specific behaviours. A plan to maintain the resident's safety was implemented that included removing certain objects from their room.

Direct care staff identified specific objects that were to be removed from the resident's room as per the plan of care. Additionally, registered staff and the Director of Care (DOC) identified different objects to be removed as per the resident's plan of care

Registered staff and DOC acknowledged that the written plan of care for the resident should have clear directions to staff identifying the specific objects that should be removed from the resident's room, to ensure their safety.

There was minimal risk of harm to the resident when the plan of care did not set out clear directions to staff regarding resident safety.

Sources: CIS Report, the resident's care plan, progress notes, the home's investigation notes, interviews with Behavioural Supports Ontario (BSO) Lead, DOC and other staff.

(704759)

WRITTEN NOTIFICATION REPORTING AND COMPLAINTS

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 28 (1) 2.*

The licensee has failed to immediately report an incident of alleged abuse of one resident to the Director.

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Rationale and Summary

On a specified date, the resident reported alleged verbal abuse by a staff member during a visit by a healthcare specialist. A staff member of the home was present during this visit but did not recall the allegation, thus did not report the allegation to the home.

Executive Director (ED) acknowledged that the documented allegation should have been reviewed by registered staff and reported to the Director, however the home had not been aware until a later date. DOC acknowledged that this allegation of verbal abuse was not reported to the Director until four days after the home had become aware of the incident.

There was minimal risk of harm to the resident when reporting requirements were not met.

Sources: CIS Report, the resident's progress notes, interview with the resident, BSO Lead, DOC, ED and other staff.

(704759)