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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: December 7, 2023	
Inspection Number: 2023-1079-0006	
Inspection Type: Critical Incident	
Licensee: CVH (No. 1) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)	
Long Term Care Home and City: Craiglee Nursing Home, Scarborough	
Lead Inspector Arther Chandramohan (000720)	Inspector Digital Signature Arther Chandramohan Digitally signed by Arther Chandramohan Date: 2023.12.11 13:16:02 -05'00'
Additional Inspector(s) Lisa Salonen Mackay (000761) Training Specialist Christine Francis (740880) was also present in this inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 29-30 and December 4-5, 2023.
The inspection occurred offsite on the following date(s): December 1, 2023.

The following intake(s) were inspected:

- Intake #00094387, Critical Incident (CI) #2503-000027-23 related to falls;
- Intake #00095857, Critical Incident (CI) #2503-000030-23 related to care and support services;
- Intake #00101667, Critical Incident (CI) #2503-000035-23 related to IPAC.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Introduction:
The licensee has failed to ensure that resident #002's falls prevention intervention was applied as specified in the plan of care.

Rationale and Summary:
Resident #002 had a fall related to identified risk factors that resulted in injury and hospitalization. Resident #002 had an intervention in their plan of care to help monitor their falls risk.
Two observations of resident #002 were completed and their falls prevention intervention was not in place.
Personal Support Worker (PSW) #105 and Registered Practical Nurse (RPN) #103 both stated resident #002 should have had their intervention applied as per the

plan of care, but did not.
There was an increased risk of falls and a risk of delayed treatment due to resident #002 missing their falls prevention intervention.

Sources:
Observation of resident #002; resident #002's plan of care; interviews with PSW #105 and RPN #103.

[000720]