

**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

**Original Public Report**

<b>Report Issue Date:</b> April 22, 2024	
<b>Inspection Number:</b> 2024-1079-0001	
<b>Inspection Type:</b> Critical Incident	
<b>Licensee:</b> CVH (No. 1) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)	
<b>Long Term Care Home and City:</b> Craiglee Nursing Home, Scarborough	
<b>Lead Inspector</b> Susan Semeredy (501)	<b>Inspector Digital Signature</b>
<b>Additional Inspector(s)</b>	

**INSPECTION SUMMARY**

The inspection occurred onsite on the following dates: April 10, 11, 12, 15, 16, 2024

The following intakes were inspected in this Critical Incident (CI) inspection:  
Intake: #00112043/CI #2503-000014-24 - related to infection prevention and control  
Intake: #00108691/CI #2503-000010-24 - related to fall prevention and management

The following intakes were completed in this CI inspection:  
Intakes: #00104919/CI #2503-000038-23, #00105380/CI #2503-000002-24, #00110243/CI #2503-000012-24, #00111614/CI#2503-000013-24 - related to infection prevention and control  
Intakes: #00105150/2503-000039-23 and #00112813/2503-000016-24 - related to fall prevention and management

**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

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

Infection Prevention and Control  
Falls Prevention and Management

## 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 (7)**

Plan of care

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.

The licensee has failed to ensure that a fall prevention intervention was provided to a resident as specified in the resident's plan of care.

### Rationale and Summary

A resident had a fall and sustained an injury. Upon return from the hospital the resident had responsive behaviours and a fall prevention intervention was implemented. It was noted that the fall prevention intervention had not been provided. An Assistant Director of Care (ADOC) indicated the intervention should have been provided which may have prevented a second fall.

Failing to ensure a resident was provided with an intervention as specified in the

**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

plan of care, put them at risk for further injury.

**Sources:** A resident's progress notes and care plan and an interview with the ADOC.  
[501]

## **COMPLIANCE ORDER CO #001 Directives by Minister**

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: FLTCA, 2021, s. 184 (3)**

Directives by Minister

s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

**The inspector is ordering the licensee to comply with a Compliance Order  
[FLTCA, 2021, s. 155 (1) (a)]:**

The licensee shall:

1. Conduct visual audits daily to ensure visitors and caregivers wear the required personal protective equipment (PPE) in rooms with Enhanced Precautions for a period of two weeks starting the day after this order was issued. Provide on the spot education as necessary.
2. Maintain a record of all audits completed, including the staff completing the audit, dates and times audits were completed, the outcome of the audits, and any education provided.

**Grounds**

The licensee has failed to ensure the home carried out every operational or policy directive that applied to the long-term care home.

**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

**Rationale and Summary**

Section 7 of the Minister's Directive, states that Long-Term Care Homes are required to ensure that the visitor requirements are followed. COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings last revised June 26, 2023, states that all essential visitors/caregivers providing direct care to or interacting within two metres of a resident with suspect or confirmed COVID-19 or in any outbreak area should wear eye protection and a well-fitted medical mask or an N95 respirator.

The home's policy states visitors must don a gown, non-fitted N95 mask, face shield and gloves at the door of the resident's room if the resident is on Enhanced Precautions. This personal protective equipment (PPE) must be worn at all times while in the room and when assisting the resident with feeding, personal hygiene or assisting with ambulation.

A COVID-19 outbreak was declared in the home. Two units were affected and according to the IPAC (Infection Prevention and Control) Lead these units were under "Enhanced Precautions" requiring all staff and visitors to wear N-95 masks and face shields. As well, those entering COVID-19 confirmed and suspect rooms were to don full personal protective equipment (PPE) including gloves, gowns, N95 masks and face shields.

A visitor entered one of the affected units only wearing a surgical mask and was unsure about the required PPE. A caregiver in a room with Enhanced Precautions was only wearing a surgical mask and was later observed to don the required PPE. There were approximately five visitors in another room with Enhanced Precautions. Some of these visitors were not wearing any type of mask or eye protection while in close proximity to the resident who was laying on their bed.

**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

The IPAC Lead confirmed that visitors and caregivers are required to wear full PPE when in rooms with Enhanced Precautions.

Visitors failing to apply the required PPE risked acquiring and transmitting COVID-19.

**Sources:** Observations, the home's policy "Enhanced Precautions" #2.4 last revised May 16, 2023, home's outbreak status from PCC, outbreak notification from Toronto Public Health dated April 5, 2024, and interviews with the IPAC Lead and other staff. [501]

**This order must be complied with by** May 31, 2024

**COMPLIANCE ORDER CO #002 Infection prevention and control program**

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

The licensee shall:

1. Re-educate staff members #101, #102 and #108 on the proper application of

**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

N95 masks.

2. Re-educate staff member #100 on the required PPE when entering a COVID-19 positive unit and staff members #103 and #104 of the required PPE when entering a COVID-19 positive room.
3. Conduct visual audits daily for the correct application of N95 masks and the proper selection of PPE on units in a declared or suspect outbreak for a period of two weeks starting the day after this order was issued. Identify areas of concern and if necessary, develop in person re-education to a broader audience such as visitors, medical professionals, environmental and dietary staff.
4. Maintain a record of all education provided, including the content covered, date, signature of staff members completing the education and the person providing the education.
5. Maintain a record of all audits completed, including the staff completing the audit, dates and times audits were completed, any outcomes of the audit and any corrective action taken, if necessary.

**Grounds**

The licensee has failed to ensure that staff used appropriate personal protective equipment (PPE) in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, staff did not appropriately select and apply the required Personal Protective Equipment (PPE) according to additional precautions 9.1 (f) under the IPAC standard which includes the appropriate selection application, removal, and disposal of PPE.

**Rationale and Summary**

**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

(i) A COVID-19 outbreak was declared in the home. Two units were affected and according to the IPAC Lead these units were under “Enhanced Precautions” requiring all staff and visitors to wear N-95 masks and face shields. As well, those entering COVID-19 confirmed and suspect rooms were to don full personal protective equipment (PPE) including gloves, gowns, N95 masks and face shields.

Staff member #100 entered an affected unit and walked down the hallway to retrieve something from the dining room. They were not wearing an N95 mask or a face shield. The IPAC Lead confirmed all staff needed to wear N95 masks and face shields when on a COVID-19 positive unit.

(ii) Staff member #101 on an affected unit was not wearing their N95 properly as the straps were reversed. When advised of this, they tried several times to correctly apply the mask. It was not until others intervened were they able to be successful. The IPAC Lead acknowledged that not having N95 mask straps applied properly risked having an improper seal.

(iii) Staff member #102 on an affected unit was observed not wearing their N95 mask properly as their straps were over a baseball cap. The IPAC Lead acknowledged this would also affect the seal of the N95 mask.

(iv) Staff member #113 on an affected unit was observed assisting a resident with eating without wearing gloves. The resident was a suspected COVID-19 resident in a room that had Enhanced Precautions. The staff member indicated they had been advised not to wear gloves when feeding residents. The IPAC Lead indicated the staff member was confused about directions and that all PPE should be applied when entering such a room and especially when providing care which included assistance with eating.

(v) Staff member #108 on an affected unit was observed to have an improperly

**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

applied N95 mask on and after the IPAC Lead brought this to their attention, continued to have difficulty with the application.

(vi) Staff member #104 on an affected unit entered a COVID-19 positive room with Enhanced Precautions without wearing gloves to deliver a lunch tray. The IPAC Lead confirmed anyone entering a such a room needed to apply full PPE which included gloves.

Failing to properly select and apply PPE risked acquiring and transmitting COVID-19.

**Sources:** Observations, the home's policy "Enhanced Precautions" #2.4 last revised May 16, 2023, home's outbreak status from PCC, outbreak notification from Toronto Public Health dated April 5, 2024, and interviews with the IPAC Lead and other staff. [501]

**This order must be complied with by** May 31, 2024



**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

## REVIEW/APPEAL INFORMATION

**TAKE NOTICE** The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto:MLTC.AppealsCoordinator@ontario.ca)

**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

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**

Attention Registrar



**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

151 Bloor Street West, 9<sup>th</sup> Floor  
Toronto, ON, M5S 1S4

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> Floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto:MLTC.AppealsCoordinator@ontario.ca)

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).