

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

Public Report

Report Issue Date: February 3, 2025

Inspection Number: 2025-1079-0001

Inspection Type:

Critical Incident
Follow up

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

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 28-31, 2025 and February 3, 2025

The following intakes were inspected:

Intake: #00129399 – related to a follow-up of Compliance Order #001 from inspection #2024-1079-0002 related to plan of care

Intake: #00134155/2503-000050-24 – related to falls prevention and management

Intake: #00130131/2503-000039-24 – related to the prevention of abuse and responsive behaviours

Intakes: #00131962/2503-000043-24, #00134604/2503-000051-24, #00134851/2503-000052-24 – related to Infection Prevention and Control (IPAC)

The following intake was completed in this inspection:

Intake: #00133633/2503-000046-24 – related to falls 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
Telephone: (866) 311-8002

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2024-1079-0002 related to FLTCA, 2021, s. 6 (7)

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

- Resident Care and Support Services
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Responsive Behaviours
- 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 (10) (b)

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed, and the plan of care reviewed and revised when the resident's care needs changed.

A resident had a fall and sustained an injury. Upon return from the hospital, 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
Telephone: (866) 311-8002

resident's needs changed. The resident's plan of care was not reviewed and revised to reflect these changes.

Sources: A resident's care plan and an interview with the Acting Director of Care (DOC) and other staff.

WRITTEN NOTIFICATION: General Requirements of Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (2)

General requirements

s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that when a resident's fall prevention device was discontinued there was documentation that indicated a reassessment was conducted related to the resident's response to the device.

A resident was at high risk for falls and a device was implemented to prevent falls or injuries from falls. Documentation indicated the device was discontinued, but there was no explanation found to explain why. The Acting DOC indicated that it may have been due to the alarm being a trigger for responsive behaviours but could not verify this as there was no documentation.

Sources: A resident's progress notes, care plan and an interview with the Acting DOC.

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

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (3)

Falls prevention and management

s. 54 (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 246/22, s. 54 (3).

The licensee has failed to ensure that bed alarms as part of the falls prevention and management program were readily available in the home.

The home recently received a shipment of new bed alarms. However, these alarms were deemed unusable because they were different from the ones used previously and staff did not know how to apply them. As well, it was deemed that these alarms may not be suitable due to a potential tripping hazard. The home was unable to demonstrate that they had any stock of the previously used bed alarms and as such, did not have any bed alarms readily available for use.

Sources: Observations of the falls prevention supply closet, fall bins on the units and interviews with the PT Assistant and other staff.