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

Public Report

Report Issue Date: July 16, 2025
Inspection Number: 2025-1079-0003
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 7-10, 14-16, 2025
The inspection occurred offsite on the following date(s): July 11, 2025

The following intake(s) were inspected:

- Intake: #00146369, Critical Incident (CI) #2503-000026-25 was related to Falls Prevention and Management Program
- Intake: #00148799, CI #2503-000033-25 was related to the Medication Management System
- Intake: #00149884, CI #2503-000035-25 was related to a disease outbreak

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control

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) (a)
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,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that a Registered Practical Nurse (RPN) collaborated with the Registered Dietitian (RD), the physician, or their manager in the assessment of a resident's medical condition, so that their assessments were integrated and were consistent with and complemented each other.

A resident experienced medical emergencies on multiple occasions. The RPN who initially identified the medical emergencies, did not inform the RD, the physician, or their manager. An Associate Director of Care (ADOC) indicated the incidents should have been logged to ensure that the physician was informed to review and adjust the resident's medications, and that the RD was notified to assess and update the resident's plan of care to help prevent further occurrences of the medical emergencies.

Sources: Review of the resident's clinical notes and home's policy, interviews with a RPN, the RD and an ADOC.

[741672]

WRITTEN NOTIFICATION: Transferring 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 licensee has failed to ensure that staff used safe transferring and positioning techniques when they assisted a resident.

A Personal Support Worker (PSW) transferred a resident using a transferring equipment without the assistance of a second staff member. As a result, the resident fell and sustained injuries.

Sources: The resident's clinical records; home's investigation notes; home's Mechanical Lifts procedure policy, interviews with the resident, a PSW and a RPN.

[000711]

COMPLIANCE ORDER CO #001 Medication management system

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and

disposal of all drugs used in the home.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Provide education to a RPN and a Registered Nurse (RN) on the home's "medication management" Policy.
2. Keep a written record of the education provided including, but not limited to, the person providing the education, date of education provided, and the education content provided.

Grounds

The licensee has failed to ensure that staff complied with the written policies and protocols developed for the medication management system to ensure the accurate administration of a medication for a resident.

In accordance with O. Reg 246/22, s.11.(1)(b), the licensee is required to ensure compliance with the home's medication management system policy.

A resident exhibited symptoms consistent with a medical emergency. Although a specific medication was outlined in the resident’s medical directives, it was not administered as required by the home's policy. Following the resident's transfer to the hospital, their condition deteriorated. Both a RPN and a RN who attended to the resident during the incident did not administer the prescribed medication upon identifying the emergency status. An ADOC confirmed that the medication should have been administered in accordance with the resident’s medical directives and the home's policy.

Failure to administer the medication in accordance with the home's policy put the resident at risk of adverse outcomes to their health status.

Sources: Review of the resident's clinical records, home's medication management policy, interviews with a RPN, a RN and an ADOC.

[741672]

This order must be complied with by August 25, 2025

COMPLIANCE ORDER CO #002 Administration of drugs

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Provide education to a RN and six RPNs on the home's Medication management, administration and documentation Policy and any other relevant policies.
2. Conduct two random audits weekly, on a minimum of two residents, who are diabetic and on insulin to ensure all the required steps are taken for insulin administration. These audits must be conducted for a minimum of four weeks upon service of this order.
3. Maintain a written record of audits conducted, including but not be limited to: date of audit, resident name, staff name(s), and any corrective action taken in response to the audit.
4. Keep a written record of the education provided to staff in step one of this order and ensure the following is included: the person providing the education, date of

education provided, and the education content provided.

Grounds

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

i) A specific medication was not administered in accordance with the physician's order to a resident on multiple occasions over a specific period of time. The physician's order specified that the medication was to be given only when the resident presented with a particular medical condition. However, the medication was administered even when that condition was not present. During this period, the resident experienced medical emergencies on multiple occasions. The Consultant Pharmacist's notes indicated that the inappropriate administration of the medication may have contributed to the recurring medical emergencies.

ii) A resident exhibited symptoms consistent with a medical emergency and was subsequently transferred to the hospital. Initially, the resident's condition was assessed using a medical device, which did not indicate the presence of a medical emergency. However, as per the physician's order, the result was not confirmed with an alternative type of test that may have provided more accurate information. The attending RN was uncertain whether the resident's symptoms were related to a medical emergency, as the initial test result did not support that conclusion. However, the use of a different type of test may have offered more reliable data and confirmed the presence of a medical emergency.

Failure to administer the prescribed medication in accordance with the physician's order, along with the failure to confirm the medical emergency through the appropriate testing, placed the resident at risk of both a medical emergency and delayed treatment.

Sources: Review of the resident's clinical records, Medication Administration and Documentation policy, interviews with a RN, two RPNs, and an ADOC.

[741672]

This order must be complied with by August 25, 2025

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, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: 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.