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**
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# Public Report

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| **Report Issue Date:** September 12, 2025 |
| **Inspection Number:** 2025-1079-0004 |
| **Inspection Type:**<br>Critical Incident<br>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 date(s): September 3-5, 8-9, 11-12, 2025

The following intake(s) were inspected:

- Intake: #00151290/Critical Incident (CI) #2503-000038-25 – related to falls prevention and management
- Intake: #00152860 and intake: #00152861 - follow-up on Compliance Orders related to medication management
- Intake: #00153217/CI #2503-000047-25 and intake: #00156534/CI #2503-000057-25 – related to unknown cause of injuries

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2025-1079-0003 related to O. Reg. 246/22, s. 140 (2)
Order #001 from Inspection #2025-1079-0003 related to O. Reg. 246/22, s. 123 (2)

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

Resident Care and Support Services
Medication Management
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 (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 staff collaborated with each other in the assessment of a resident's injuries, so their assessments were integrated and were consistent with and complemented each other.

The resident was found to have sustained injuries. A Registered Practical Nurse (RPN) failed to complete a head-to-toe skin assessment or document the injuries in Point Click Care (PCC). They also did not communicate the resident's injuries to nursing staff to monitor on the following shift. The resident was later sent to the hospital for further assessment of their injuries.

**Sources:** A resident's clinical records and interviews with staff.

## WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received a skin assessment using a clinically appropriate instrument that is specifically designed for skin and wound assessment when they exhibited altered skin integrity on a specific date.

**Sources:** A resident's clinical records and interviews with staff.