

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:** October 17, 2025

**Inspection Number:** 2025-1079-0005

**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): October 14-17, 2025.

The following intakes were inspected during this Critical Incident (CI) inspection:

- Intake: #00155565 [CI #2503-000053-25], and #00156886 [CI #2503-000058-25] related to falls.
- Intake: #00156916 [CI #2503-000059-25] related to medication administration.

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

Medication Management  
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Integration of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

#### Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

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,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

**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

The licensee has failed to ensure that staff collaborated with each other to implement an intervention for a resident as specified in their plan of care. A resident was observed without an intervention. Staff confirmed that the resident should have had the intervention. Staff confirmed that they failed to implement the intervention and they did not notify registered staff as was the home's procedure.

Sources: Resident's clinical records, observation of resident, and staff interviews.