

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 23, 2026

Inspection Number: 2026-1079-0001

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): February 11, 12, 17, 19, and 23, 2026

The inspection occurred offsite on the following date(s): February 13, 18, and 20, 2026

The following intakes were inspected in this Critical Incident System (CIS) Inspection:

-Intake: #00165825 - [CI: #2503-000082-25] - related to alleged staff to resident abuse

-Intake: #00166825 - [CI: #2503-000001-26] - related to outbreak management

-Intake: #00167163 - [CI: #2503-000002-26] - related to a resident injury of unknown cause which led to injury

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

A resident brought forth concerns regarding the care that was provided to them by a Personal Support Worker (PSW). The Director of Care (DOC) confirmed that the actions of the PSW did not demonstrate respectful and dignifying treatment towards the resident.

Sources: Review of a critical incident (CI) report, home's investigation notes, home's investigation outcome; and interviews with a resident and the DOC.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

A resident previously brought forth care concerns about a PSW to a Registered

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Practical Nurse (RPN). The RPN and the DOC both confirmed that the resident's concerns were not immediately reported to management. Therefore, the Director was not immediately informed.

Sources: Review of a critical incident (CI) report, home's prevention of abuse and neglect policy; and interviews with a RPN and a DOC.

WRITTEN NOTIFICATION: Dining and Snack Service

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

Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.

Dining and snack service

s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

A PSW gave a resident an incorrect meal that was not appropriate for them. The PSW acknowledged that they did not confirm that the resident was the correct resident, that the meal was intended for.

Sources: Care plan, Registered Dietitian assessment, home's investigation notes; and interview with a PSW.



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**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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