

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: August 26, 2025

Inspection Number: 2025-1160-0005

Inspection Type:

Complaint
Critical Incident

Licensee: CVH (NO. 11) 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: Kennedy Lodge, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 19, 20, 21, 22, 26, 2025

The inspection occurred offsite on the following date(s): August 25, 2025

The following complaint intake was inspected:

- Intake: #00154888 was related to food, nutrition and hydration and skin and wound care.

The following Critical Incident (CI) intakes were inspected:

- Intake: #00148688 / CI #2654-000012-25 was related to infection prevention and control.
- Intake: #00149185 / CI #2654-000013-25 was related to falls prevention and management.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
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 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to provide care as set out in the plan of care related to the fluid restriction for a resident.

The care plan indicated that the resident not be given a particular item at afternoon snack. During an observation, a resident was provided the item by Personal Support Worker (PSW) during the afternoon snack. The Registered Dietitian (RD) acknowledged that the resident should not have received the item during snack and confirmed that staff was not following the resident's plan of care.

Sources: Review of resident's clinical records, observation, interviews with the PSW and the RD.

WRITTEN NOTIFICATION: Skin and Wound

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 failed to ensure a skin and wound assessment was completed by a nurse

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for a resident exhibiting altered skin integrity using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

A resident exhibited altered skin integrity and a skin and wound assessment was not completed. The Skin and Wound Lead acknowledged a skin and wound assessment was not completed by a nurse for a resident's altered skin integrity.

Sources: Review of resident's clinical records and interview with the Skin and Wound Lead.

WRITTEN NOTIFICATION: Skin and Wound

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

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

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,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that a resident was reassessed at least weekly after experiencing altered skin integrity.

A review of the skin and wound assessments revealed that no weekly assessments were completed on specific dates, for the resident's altered skin integrity. The Skin and Wound Lead confirmed that assessments had been missed and should have been completed.

Sources: Review of resident's clinical records and interview with the Skin and Wound Lead.

WRITTEN NOTIFICATION: Dining Service

NC #004 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

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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.

The licensee has failed to ensure that the home followed the process to ensure that food service workers and other staff assisting residents were aware of the residents' diets, special needs, and preferences.

A resident's care plan indicated they were on special diet. According to the dietary profile, the resident was to be served specific types of food. During an observation, the resident was not provided the appropriate food as per their special diet.

The RD confirmed meal served did not meet the resident's dietary requirements.

Sources: Review of resident's clinical record, dietary profile list, observation and interview with RD.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented.

Additional Requirement 9.1 of the IPAC Standard for Long-Term Care Homes required Additional Precautions be followed in the IPAC program. Specifically, s. 9.1 (f) around the proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal.

(i) A registered Nurse (RN) was observed to have provided care to a resident who was

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on Enhanced Precautions without donning the required N95 mask.

Sources: Observation, IPAC standard for Long-Term Care Homes, interviews with RN and the IPAC Manager.

(ii) A RN was observed to have completed care for a resident who was on Enhanced Precautions. They doffed the contaminated gloves and retrieved a new pair of gloves without performing hand hygiene.

Sources: Observation, IPAC standard for Long-Term Care Homes, interviews with RN and the IPAC Manager.