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

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Public Report

Report Issue Date: September 25, 2025
Inspection Number: 2025-1160-0006
Inspection Type: 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: September 22, 23, 24, 25, 2025.

The following intakes were inspected:
- Intake: #00157128- related to Critical Incident System (CIS) #2654-000023-25 related to a fall with an injury;
- Intake: #00156434- related to CIS #2654-000020-25 related to a fall with an injury;
- Intake: #00155065- related to CIS #2654-000019-25 related to an alleged incident of resident abuse.

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

Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
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 has failed to ensure that a resident's fall prevention intervention was provided as per their plan of care. A resident's plan of care indicated a specific fall prevention intervention would be applied, however this was not observed by the inspector initially. A Personal Support Worker (PSW) confirmed that this intervention should have been applied as per the resident's plan of care.

The fall prevention intervention was applied shortly afterwards.

Sources: Observation inside the resident's room; A resident's plan of care; Interview with a PSW and other staff.

Date Remedy Implemented: September 22, 2025

WRITTEN NOTIFICATION: Plan of care

NC #002 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.

The licensee has failed to ensure that a physiotherapist (PT) collaborated with the nursing staff in the development of a resident's fall prevention interventions. After a resident sustained a fall, the PT had created an intervention for the resident. A Registered Nurse (RN) stated they were never consulted about this intervention but would have told the PT that the resident would have refuse this intervention. The Director of Care (DOC) confirmed that the PT did not collaborate with the nursing staff when they developed the resident's interventions for fall prevention.

Sources: A resident's progress notes; Interviews with a RN and the DOC.

WRITTEN NOTIFICATION: Nursing and personal support services

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 11 (1) (a)
Nursing and personal support services
s. 11 (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and

The licensee has failed to comply with the home's nursing and personal support services program when a RN did not initiate a head injury routine (HIR) on a resident after a suspected head injury.

In accordance with Ontario Regulation 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the nursing and personal support services program were complied with. Specifically, the home’s assessment and screening tools policy indicates that registered staff are to complete a HIR for all suspected head injuries unrelated to a fall, which was not done for a resident.

Sources: Home's policy titled: Assessments and Supporting Tools Required on Admission and Ongoing; Interview with: a RN and the DOC.

WRITTEN NOTIFICATION: Duty to protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from physical abuse by another resident.

Section 7 of the Ontario Regulation 246/22 defines physical abuse as “the use of

physical force by a resident that causes physical injury to another resident". A resident sustained injuries after being physically hit by another resident.

Sources: Progress notes; Interview with the DOC.