

**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:** March 5, 2025

**Inspection Number:** 2025-1538-0002

**Inspection Type:**

Critical Incident

**Licensee:** City of Toronto

**Long Term Care Home and City:** Cummer Lodge, North York

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 3-5, 2025

The following intake was inspected:

- Intake: #00140264 - Critical Incident (CI) #M512-000003-25 was related to disease outbreak.

The following intake was completed:

- Intake: #00138565 - CI #M512-000002-25 was related to disease outbreak.

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

Infection Prevention and Control

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Infection prevention and control program

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

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**Non-compliance with: O. Reg. 246/22, s. 102 (7) 4.**

Infection prevention and control program

s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:

4. Auditing of infection prevention and control practices in the home.

The licensee has failed to ensure the infection prevention and control (IPAC) manger designated under subsection (5) carried out their responsibilities in the home in regards to IPAC audits.

Specifically, the IPAC manager failed to ensure that audits were conducted, at a minimum quarterly, of specific activities performed by the program and recreation department staff in the selection, donning, and doffing of personal protective equipment (PPE), as required by Additional Requirement 2.1 under the IPAC Standard.

**Sources:** Review of PPE use Audit Summary Reports for November - December 2024, and January - February 2025, IPAC Standard for Long-Term Care Homes, Revised September 2023; and interview with the IPAC manger.

[741672]

**WRITTEN NOTIFICATION: Reports re critical incidents**

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

**Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.**

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under

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subsection (5):

5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed when a confirmed disease outbreak was declared. The IPAC Manager confirmed that the CI report was not submitted on the same day that outbreak was declared by Public Health.

**Sources:** CI #M512-000002-25, interview with the IPAC Manager.

[741672]

## **WRITTEN NOTIFICATION: CMOH and MOH**

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

**Non-compliance with: O. Reg. 246/22, s. 272**

CMOH and MOH

s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives or recommendations issued by the Chief Medical Officer of Health (CMOH) were followed by the home, in relation to cleaning and disinfecting high touch surfaces during a confirmed outbreak.

Specifically, the home did not ensure that high-touch surfaces were cleaned and disinfected at least twice daily in all common areas accessed by residents in one of the resident home areas during a confirmed respiratory disease outbreak. The

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Assistant Administrator (AA) confirmed that there were not enough personnel available on certain days during the outbreak to clean and disinfect high-touch surfaces twice daily.

**Sources:** Review of the housekeeping staff work schedule, interview with a housekeeping staff and the Assistant Administrator (AA).

[741672]