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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: December 10, 2025
Inspection Number: 2025-1538-0006
Inspection Type:
Complaint
Critical Incident
Follow up

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): December 3-5, 8-10, 2025

The following Follow-up intake(s) was inspected:
- Intake: #00159711 – Transferring and positioning techniques

The following Critical Incident System (CIS) intake(s) were inspected:
- Intake: #00159643 – [CIS: M512-000025-25] – Fall with injury
- Intake: #00160094 – [CIS: M512-000027-25] – Communicable disease outbreak
- Intake: #00160440 - [CIS: M512-000030-25] – Injury of unknown cause
- Intake: #00161689 – [CIS: M512-000034-25] – Unexpected death
- Intake: #00163298 – [CIS: M512-000040-25] – Resident to resident physical abuse

The following Complaint intake(s) were inspected:
- Intake: #00160019 – Resident care and support services and restraints
- Intake: #00160855 – Injury of unknown cause

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1538-0005 related to O. Reg. 246/22, s. 40

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 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.

Resident #005 used physical force on resident #006, resulting in resident #006 sustaining injuries.

Sources: Critical Incident (CI) M512-000040-25, resident #005 and #006's clinical records, and interviews with a Registered Nurse and Nurse Manager (NM).

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 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).

A Personal Support Worker (PSW) was observed coming out from a resident's room and discarding soiled linens and items with gloves applied. The PSW then proceeded to

grab clean supplies with the same gloves and had attempted to make the resident's bed. The PSW acknowledged their error of not discarding their soiled gloves when they had started to grab the clean supplies.

Sources: Observations; Interview with a PSW and other staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

i). A PSW was observed doffing their soiled gloves after coming out of the shower room. The PSW did not perform hand hygiene and proceeded to go to a resident's room to retrieve clean linens. The PSW acknowledged they had forgotten to perform hand hygiene after doffing their soiled gloves.

Sources: Observations; Interview with a PSW and other staff.

ii). The home developed a mandatory masking policy as part of the home's Infection Prevention and Control (IPAC) program. Several PSWs were observed to be in close contact with residents and were seen without wearing any surgical mask.

Sources: Observations; Interviews with IPAC Manager and other staff; Home's signage related to mandatory masking in the home.