

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: July 30, 2025

Inspection Number: 2025-1538-0004

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): July 24, 25, 28-30, 2025

The following Critical Incident System (CIS) intake(s) were inspected:

- Intake: #00147578 – [CIS: M512-000009-25], intake #00147784 – [CIS: M512-000011-25] and intake: #00148041 – [CIS: M512-000012-25] – Fall with injury
- Intake: #00149741 – [CIS: M512-000013-25] and intake: #00151114 – [CIS: M512-000014-25] – Communicable disease outbreak

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

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

Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure the written plan of care for a resident set out the planned care for the use of an equipment during bathing.

Sources: Resident's clinical records; interviews with Personal Support Worker (PSWs) and a Registered Nurse (RN).

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 (9) (b)

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that a resident's symptoms were recorded on each shift when they were demonstrating signs of infection.

A resident's symptoms were not documented on one shift when they were on droplet/contact precautions.

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Sources: Resident's respiratory illness assessments; and interview with Infection Prevention and Control (IPAC) Manager.

COMPLIANCE ORDER CO #001 Required programs

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Present this noncompliance and the circumstances leading to it's issuance as a case study to all Personal Support Workers (PSW) in the home. The case study must include instructions on the required actions to be taken post fall as required by the PSW role.
2. Conduct audits of four residents' falls to ensure all the required steps were taken post fall. These audits must be conducted within four weeks upon service of this order.
3. Maintain a written record of audits conducted, including but not be limited to: date of audit, resident name, staff name(s), all the actions taken post fall and any corrective action taken in response to the audit.
4. Maintain a written record of staff attendance and review of the case study and post fall responsibilities. Ensure the following is included: the person providing the presentation, date of the presentation, and the content of the presentation provided.

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Grounds

The licensee has failed to ensure that the falls prevention and management program was implemented when a resident's fall incident was not reported to the registered nursing staff.

In accordance with O. Reg 246/22, s.11 (1) (b), the licensee is required to ensure compliance with the home's "Falls Prevention and Management program" policy. The home's policy indicated that as part of post fall management the registered nursing staff should be informed of any fall incident, so that they could complete the required assessments and notify the physician or nurse practitioner immediately if a significant change is noted after the fall.

A resident sustained a fall. The PSWs who discovered the resident did not report the fall to the registered staff on duty during that shift, nor to the incoming shift. The following day, the resident was in pain and was transferred to the hospital, where they were diagnosed with a significant injury.

The Registered Practical Nurses (RPNs) indicated that they were not aware that the resident had a fall. Registered staff were to assess the resident for evidence of injury prior to being transferred. They also would have monitored the resident more frequently for pain, completed the appropriate assessments and incident report. Furthermore, they indicated they would have contacted the physician and the resident's substitute Decision maker (SDM) soon after the incident. The Director of Care (DOC) confirmed that the PSWs who discovered that the resident had a fall should have reported to the registered nursing staff immediately.

Failure to immediately report the resident's fall, delayed assessment and the provision of appropriate treatment and interventions, placing the resident at

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increased risk of harm.

Sources: CI report #M512-000011-25 and home's investigation notes, review of resident's clinical records, and "Falls Prevention and Management" policy #RC-0518-21, published on August 5, 2024; and interviews with a PSW, RPNs and the DOC.

This order must be complied with by September 11, 2025

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board

Attention Registrar

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Director

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Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.