

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: June 13, 2025

Inspection Number: 2025-1538-0003

Inspection Type:

Complaint

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): May 29 -30, 2025 and June 9 - 13, 2025

The following intakes were inspected:

- Intake: #00142549 - Critical Incident (CI) M512-000004-25 - related to an infectious disease outbreak.
- Intake: #00146052 - Complaint related to allegations of abuse
- Intake: #00146060 - CI M512-000007-25 - related to allegations of abuse
- Intake: #00146065 - CI M512-000006-25 - related to an infectious disease outbreak.
- Intake: #00146361 - CI M512-000008-25 - related to an infectious disease outbreak.

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

Infection Prevention and Control

Prevention of Abuse and Neglect

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Safe and Secure Home

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

Non-compliance with: FLTCA, 2021, s. 5

Home to be safe, secure environment

s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure that the home was a safe and secure environment for its residents by ensuring the doors were closed appropriately on a secure unit.

The Inspector observed a shower room door left open for approximately 10 minutes. The shower room was unoccupied and the floor inside was wet. A Registered Practical Nurse (RPN) acknowledged that the shower room door should have been closed and that there was a risk that a resident could wander in, slip on the wet floor and fall.

Sources: Observation; Interview with the home's staff.

WRITTEN NOTIFICATION: Infection Prevention and Control

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

Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.

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

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home:

11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The licensee has failed to ensure that staff performed their hand hygiene (HH) effectively.

A Personal Support Worker (PSW) exited a resident room and dispensed an alcohol based hand rub (ABHR) on to their hands. They rubbed the solution into their hands for less than 10 seconds and entered another resident room while the foam from the ABHR was still visible on their hands.

The PSW acknowledged that HH should be completed for 15 seconds or greater and that the product should be fully absorbed into their hands.

Sources: Observation; Hand Hygiene Policy, Policy No. IC-0606-01, Published July 24, 2024; interview with the homes staff.