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: October 7, 2025

Inspection Number: 2025-1538-0005

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): September 22-26, 29, 2025 and October 1, 2, 7, 2025.

The inspection occurred offsite on the following date(s): October 3, 6, 2025.

The following intake(s) were inspected:
- Intake: #00151958 - Critical Incident System (CIS) # M512-000017-25 - related to a fall with an injury.
- Intake: #00154157 - CIS # M512-000018-25 - related to medication administration, reporting certain matters to the Director, and physical abuse.
- Intake: #00154150 - follow up to a Compliance Order (CO) relating to falls prevention and management.
- Intake: #00154916 - CIS # M512-000019-25 - related to medication administration.
- Intake: #00155280 - CIS # M512-000020-25 - related to communicable disease outbreak.
- Intake: #00155888 - complaint related to abuse and neglect and improper care.
- Intake: #00157452 - complaint related to improper transfer.
- Intake: #00157618 - complaint related to allegations of abuse and neglect.
- Intake: #00158858 - CIS # M512-000023-25 - related to abuse and neglect.
- Intake: #00158860 - CIS # M512-000022-25 - related to improper transfer.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1538-0004 related to O. Reg. 246/22, s. 53 (1) 1.

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

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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 to mitigate the resident's risk when eating.

Two Personal Support Workers (PSWs) stated that the resident had a behaviour that resulted in an identified risk when eating. A strategy was implemented to minimize the risk. This information was not found in the resident's plan of care. A Registered Practical Nurse (RPN) and a Nurse Manager (NM) acknowledged that this information should have been in their written plan of care.

Sources: The resident's care plan, interviews with two PSWs, the RPN and the NM.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (2) (e)
Policy to promote zero tolerance
s. 25 (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;

The licensee has failed to ensure the policy to promote zero tolerance of abuse and neglect of residents contained procedures for investigating alleged, suspected or witnessed abuse and neglect of residents.

The home's policy included a section "B. Investigation/Action of Alleged Abuse / Neglect" which stated to conduct a full investigation promptly. It does not provide any specific procedures of how to investigate.

The Administrator was unable to demonstrate that the policy contained procedures for investigating alleged, suspected or witnessed abuse and neglect of residents.

Sources: The home's policy and an interview with the Administrator.

WRITTEN NOTIFICATION: Complaints procedure - licensee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that a written complaint received concerning the care of residents was submitted to the Director.

The home received an anonymous complaint letter. The letter described that an identified PSW was neglecting residents and not treating them with dignity and respect. The Administrator admitted this letter had not been submitted to the Director and acknowledged it should have been.

Sources: The home's investigation notes and an interview with the Administrator.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that when there were reasonable grounds to suspect improper care of two residents that resulted in harm or risk of harm, it was immediately reported to the Director.

i) A PSW manually transferred a resident without the assistance and mechanical device required as per their plan of care. The resident sustained injuries. The improper transfer was reported to a Registered Nurse (RN) on the same day.

A NM acknowledged that it should have been immediately reported to the Director.

Sources: The home's investigation notes, interviews with the PSW, the RN and the NM, the resident's care plan.

ii) PSW #105 transferred a resident using a mechanical device without the required assistance as per their plan of care and the home's policy. PSW #116 was aware of the improper transfer that day. PSW #105 and #116 did not report the improper transfer.

Two weeks later, PSW #116 reported the improper transfer to a NM during a home investigation interview. A month after the incident, PSW #105 admitted to not

transferring the resident properly. The home reported the incident to the Director approximately two months after they were made aware of the incident.

Sources: The home's investigation notes, interviews with two PSWs the NM, the resident's care plan.

WRITTEN NOTIFICATION: Report Certain Matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that when there were reasonable grounds to suspect that two residents had been abused, it was immediately reported to the Director.

i) A resident complained of pain related to an injury they had sustained during care. The resident was upset stating they had been physically abused during care and there had been two PSWs involved. The resident further complained of the incident the next day stating that one of the PSWs left their hand with injury and used a lot of force. The home reported the incident around two months later, after it was brought to their attention.

A NM and the Administrator acknowledged the incident should have been immediately to the Director.

Sources: The home's investigation notes, the resident's progress notes, care conference notes and interviews with the NM and the Administrator.

ii) In 2024, a resident reported to a PSW that a staff was being rough with them during care.

The home's zero tolerance abuse and neglect policy indicated that any person who has reasonable grounds to suspect any type of abuse of a resident must immediately report

to a registered staff or immediate supervisor. The policy further indicated that rough handling is an example of physical abuse. The PSW considered the report to be a suspicion of abuse but did not report to any registered staff or supervisor. A NM acknowledged that the PSW should have immediately reported the suspected abuse.

Sources: The home's zero tolerance abuse and neglect policy, interview with the PSW and the NM.

WRITTEN NOTIFICATION: Responsive behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that strategies that had been developed for a resident's responsive behaviours were implemented.

The resident was known to have a history of responsive behaviours. Strategies were in place to manage those responsive behaviours.

The resident exhibited responsive behaviours when strategies were not implemented during care provided by two PSWs. The resident's responsive behaviours escalated when actions taken by the PSWs further triggered the resident. The responsive behaviours resulted in an injury to the resident.

The Administrator acknowledged that care should have been stopped and that the PSWs should have implemented the strategies in place to manage the resident's responsive behaviours.

Sources: The home's investigation notes, the resident's progress notes and plan of care, interviews with the resident, two PSWs, the NM and the Administrator.

WRITTEN NOTIFICATION: Dining and snack service

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
3. Monitoring of all residents during meals.

The licensee has failed to ensure a resident was monitored during a meal when they had tray service.

The home's policy indicated residents are to be monitored when a resident is served a meal tray. A PSW admitted that they served the resident a meal tray in their room and then went on break for 30 minutes. A NM confirmed the PSW should have been available to monitor the resident during their meal.

Sources: The home's policy, the home's investigation notes and an interview with the NM.

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 4.
Licensees who report investigations under s. 27 (2) of Act
s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.

The licensee has failed to ensure that a report to the Director related to an alleged incident of improper care and treatment included information on the home's analysis and follow up. A CIS report was submitted related to an allegation of improper treatment of residents. On the CIS report, it did not provide information on the home's analysis

and follow up related to the incident, after the investigation was completed.

Sources: CIS report; Interview with a NM.

COMPLIANCE ORDER CO #001 Transferring and Positioning Techniques

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Conduct two audits weekly of two identified PSWs when assisting residents with transferring. The audits must be conducted for a period of four weeks, for residents who require a level of assistance with transferring.
2. Maintain a written record of audits conducted, including but not limited to: date of audits, resident names, name of auditor(s), type of transfers completed, any corrective actions taken in response to the audit.

Grounds

The licensee has failed to ensure that safe transferring and positioning devices or techniques were used when assisting two residents.

i) A resident required two staff assistance with transfer using a mechanical device.

A PSW transferred the resident manually alone without the mechanical device. The resident sustained injuries after the transfer.

A NM acknowledged that the PSW did not transfer the resident safely using proper devices and with the required assistance.

Failure to safely transfer the resident resulted in injury to the resident.

Sources: The home's investigation notes, interviews with the PSW and the NM, the resident's care plan.

ii) A resident required two staff assistance with transfer using a mechanical device.

A PSW transferred the resident alone using the mechanical device. The home's mechanical lifting device policy was not followed during this transfer.

A NM acknowledged that the PSW did not transfer the resident safely with the required assistance while operating the mechanical device.

Failure to safely transfer the resident increased the risk of injury to the resident.

Sources: The home's investigation notes, interviews with the PSW and the NM, the home's policy, the resident's care plan.

This order must be complied with by November 19, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

CO was issued on June 26, 2023, under O. Reg. 246/22, s. 40, inspection #2023-1538-0003.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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

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
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

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

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.