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: March 26, 2025

Inspection Number: 2025-1107-0002

Inspection Type:
Complaint
Critical Incident

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: St. George Community, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 18-21 and 24-26, 2025

The following intake(s) were inspected:

- Intake #00136249/Critical Incident (CI) #2594-000001-25 - related to resident to resident physical abuse resulting to injury
- Intake #00141833/CI #2594-000006-25 - related to outbreak management
- Intake #00138695 - complaint related to resident care

The following intake(s) were completed:

- Intakes #00137808/CI #2594-000003-25 and #00140036/CI #2594-000004-25 - related to outbreak management

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours

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 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A resident was observed in bed past the hours indicated in their plan of care.

Sources: Observations in the home, a resident's clinical records, resident and staff interviews.