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
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Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: June 18, 2025

Inspection Number: 2025-1107-0003

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): June 12, 13, 16, 17, 18, 2025

The following intake(s) were completed in this complaint inspection:
Intakes: #00138358 and #00149401 were related to multiple care concerns

The following intakes were completed in this Critical Incident System (CIS) inspection:
Intake: #00148026 (CIS #2594-000014-25) was related to falls prevention and management

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

Resident Care and Support Services
Food, Nutrition and Hydration
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 (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.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident, regarding fall prevention and management.

The resident had a fall with injury, which required a transfer to hospital when their fall interventions were not in place as per their plan of care, and this was acknowledged by a staff.

Sources: Review of Critical Incident (CI) Report, resident's care plan, and investigation notes; and interview with a staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in the plan of care for a resident was documented related to showers.

A resident declined their shower and was provided with alternative method of bed bath but this alternative method of shower was not documented, and this was acknowledged by a staff.

Sources: Review of resident's clinical records; Interview with a staff.

WRITTEN NOTIFICATION: Menu planning

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (7)
Menu planning
s. 77 (7) The licensee shall ensure that meals and snacks are served at times agreed upon by the Residents' Council and the Administrator or the Administrator's designate. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that the meals were served at times agreed upon by the Residents' Council and the Administrator. Residents' Council agreed lunch was to be served at a specified time. During an observation the inspector observed lunch was served to multiple resident past specified time.

Sources: Inspector observations, Residents' Food Committee Meeting minutes; and staff interviews.