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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Public Report

Report Issue Date: August 25, 2025
Inspection Number: 2025-1107-0004
Inspection Type: Complaint Critical Incident
Licensee: 2063414 Investment LP, by its general partner, 2063414 Ontario Limited
Long Term Care Home and City: St. George Community, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 18-22, 25, 2025

The following intake(s) were inspected:
- Intake: #00149388 [CIS# 2594-000016-25] and #00151285 - related to a fall with an injury
- Intake: #00151174 [CIS# 2594-000021-25] - related to concerns with improper care

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

Resident Care and Support Services
Responsive Behaviours
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 that there was a written plan of care for a resident after an unwitnessed fall. After a post fall huddle, a falls intervention was to be implemented. This intervention was not found in the resident's written plan of care, and therefore has not been completed by staff.

Sources: A resident's care plan and post fall assessment, interviews with a Personal Support Worker (PSW), a Registered Practical Nurse (RPN), a Registered Nurse (RN) and Director of Care (DOC).