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
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Public Report

Report Issue Date: December 9, 2025
Inspection Number: 2025-1107-0006
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): November 19-20, 24-28, 2025 and December 3-5, 8-9, 2025

The following intakes were inspected on this complaints inspection:
-Intake: #00161362 - related to concerns regarding fall prevention and management, prevention of abuse and neglect, and medication management
-Intake: #00163719 - related to prevention of abuse and neglect

The following intakes were inspected on this critical incident (CI) inspection:
-Intake: #00160871 - CI: 2594-000031-25 - related to prevention of abuse and neglect
-Intake: #00162061 - CI: 2594-000034-25 - related to concerns regarding fall prevention and management, prevention of abuse and neglect, and medication management

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

Food, Nutrition and Hydration
Medication Management
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 (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 required a certain level of assistance for their activities of daily living (ADLs). The resident sustained an injury after a Personal Support Worker (PSW) provided the incorrect level of assistance to the resident.

Sources: Review of resident's clinical records; CI: 2594-000034-25; Home's investigation notes; interviews with PSW, and the Director of Care (DOC).

WRITTEN NOTIFICATION: Reporting Certain Matters To Director

NC #002 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.

A complainant informed the nursing staff of an alleged incident of suspected abuse of a resident. The LTCH did not immediately call the after-hours line and reported the incident of suspected abuse to the Director the next day.

Sources: CI: 2594-000036-25; Resident's progress notes; Interview with DOC.