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

Central West District
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Public Report

Report Issue Date: May 8, 2025
Inspection Number: 2025-1509-0003
Inspection Type: Critical Incident
Licensee: Saint Luke's Place
Long Term Care Home and City: Saint Luke's Place, Cambridge

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 5-8, 2025

The following intake(s) were inspected:

- Intake: #00140156: Resident to resident altercation

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

Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in

section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that an incident of emotional abuse from a resident towards another resident was immediately reported directly to the manager on call. A staff member did not comply with the home's prevention of abuse and neglect policy when they did not immediately inform a manager by directly speaking to one, causing a delay in the start of the home's investigation.

Sources: Email to managers, interview with staff, home's investigation notes, policy titled "Zero Tolerance of Abuse and Neglect"

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC # 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 immediately report a witnessed incident of emotional abuse from a resident to another resident, preventing the Director from responding to the incident if required.

Sources: home's investigation notes, a resident clinical notes, interview with staff,

LTC after hours action line report

WRITTEN NOTIFICATION: Skin and wound care

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident's altered skin integrity was immediately assessed by a registered staff as per the home's skin and wound policy, when it was first observed by a staff member, but was failed to be reported. This placed the resident at risk for not receiving immediate treatment if required, to manage the altered skin integrity.

Sources: Interview with staff, a resident's clinical notes, home's investigation notes, policy titled "Skin & Wound Care Management Program"