

**Ministry of Long-Term Care**

Long-Term Care Operations Division  
Long-Term Care Inspections Branch

**Central West District**

609 Kumpf Drive, Suite 105  
Waterloo, ON, N2V 1K8  
Telephone: (888) 432-7901

**Public Report**

**Report Issue Date:** July 3, 2025

**Inspection Number:** 2025-1509-0004

**Inspection Type:**

Complaint  
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): June 11-12, 18-20, 23-27, 2025 and July 2-3, 2025.

The following intake(s) were inspected:

- Intake: #00146942: Complaint regarding resident care.
- Intake: #00147333: Alleged financial abuse of residents.
- Intake: #00148190: Complaint regarding resident care.
- Intake: #00148377: Alleged neglect of a resident.
- Intake: #00148402: Alleged resident to resident abuse.

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

Contenance Care  
Skin and Wound Prevention and Management  
Medication Management  
Prevention of Abuse and Neglect  
Falls Prevention and Management

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## INSPECTION RESULTS

### Non-Compliance Remedied

**Non-compliance** was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

**Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.**

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee failed to ensure that the falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented in the home.

A resident required fall prevention interventions, but these were not documented in their care plan. Staff reviewed and revised the resident's care plan to include the fall interventions.

**Sources:** Observations of the resident, resident's clinical records, the home's Fall Prevention and Management Policy and Procedure, and interview with staff.

Date Remedy Implemented: July 2, 2025.

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**WRITTEN NOTIFICATION: Complaints procedure – licensee**

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 6 (10) (c)**

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,  
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident was reassessed, and the plan of care reviewed and revised when fall interventions set out in the plan were not effective.

**Sources:** Inspector's observation, resident's clinical records, and interviews with staff.

**WRITTEN NOTIFICATION: Complaints procedure – licensee**

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 26 (1) (a)**

Complaints procedure – licensee

s. 26 (1) Every licensee of a long-term care home shall,  
(a) ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints;

The licensee has failed to comply with the home's policy and procedures for complaints when a resident's family verbalized a complaint regarding the resident's care. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for dealing with complaints were complied

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with. Specifically, the home's complaints policy outlined a procedure for addressing complaints, as well as a follow-up process. The follow-up process was not completed.

**Sources:** The home's complaints policy, complaint log, and interview with staff.

**WRITTEN NOTIFICATION: Reporting certain matters to Director**

NC #004 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 ensure that staff immediately reported the suspicion of abuse of several residents.

In according to FLTCA s. 154 (3), the licensee is vicariously liable when a staff member failed to comply with subsection 28 (1) 2.

A) The home did not immediately report a suspicion of staff to resident financial abuse to the Director.

**Sources:** the home's investigative notes, interviews with staff.

B) Two incidents related to suspected abuse of residents occurred, and staff did not

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immediately report the incidents.

**Sources:** Interviews with staff, critical incident report, and the homes "Zero Tolerance of Abuse and Neglect" policy.

## **WRITTEN NOTIFICATION: Falls prevention and management**

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 54 (1)**

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to implement a fall prevention and management intervention for a resident who was at high risk for falls.

Over a six month period, a resident had several unwitnessed falls. At the time of their last two falls, a fall intervention was not implemented as per the resident's care plan.

**Sources:** Resident's clinical records, inspector's observations, interviews with staff, the home's Falls Prevention and Management Policy.

## **WRITTEN NOTIFICATION: Exceptions**

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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**Non-compliance with: O. Reg. 246/22, s. 254 (4)**

Exceptions

s. 254 (4) If a staff member is hired or a volunteer is accepted during a pandemic and no police record check that complies with subsections 252 (2) and (3) was provided to the licensee, the licensee shall ensure that a such police record check is provided to the licensee within three months after the staff member was hired or the volunteer was accepted, and the licensee shall keep the results of the record check in accordance with the requirements in section 278 or 279 as applicable.

The licensee has failed to ensure that during a pandemic, a staff member had a police record check submitted to the home within three months after being hired.

**Sources:** Employee file, and communication with staff.

**COMPLIANCE ORDER CO #001 Duty to Protect**

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: FLTCA, 2021, s. 24 (1)**

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

**The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 24 (1) [FLTCA, 2021, s. 155 (1) (b)]:**

The plan must include but is not limited to:

1) A plan to ensure compliance with Ontario Regulation 246/22 specific to resident trust accounts including implementing parameters for accessing resident cash box including:

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- a) who has access to lock/unlock the safe and deposit and withdraw contents in resident cash box
  - b) when the safe can be accessed by individuals specified above (a)
  - c) establish and maintain a separate ledger showing all deposits to and withdrawals, the name of the resident for whom the deposit or withdrawal is made and the date of each deposit or withdrawal
  - d) determine the maximum sum of money to be contained in the resident cash box that ensures the financial needs of the residents are met
  - e) determine a process for how often the cash box contents should be deposited to the trust bank account
- 2) A plan to ensure the accurate accounting of contents of the resident cash box for the reconciliation purposes including clarifying how often the process for reconciling the resident cash box is required, and that the home's policies procedures accurately reflects this requirement.
- 3) A plan to ensure detailed records are maintained of the revisions implemented by the home to any policies and procedures concerning resident trust accounts including when and who implemented the changes.
- 4) A plan to identify which staff require education on any revised policy and procedures concerning resident trust accounts, and maintain a record of the education provided that includes the content, the date of the education, who provided the education and all staff members who attended.

Please submit the written plan for achieving compliance for inspection #2025-1509-0004 by July 17, 2025.

**Grounds**

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The licensee failed to ensure it protected several residents from financial abuse by a staff member.

For the purpose of this Act and Regulation, "financial abuse" means any misappropriation or misuse of a resident's money or property"

A staff member misappropriated a large sum of resident trust account funds for an undetermined length of time.

**Sources:** Inspector's observations, the home's Trust Fund Policy and Procedure, the home's investigative notes, Email communications between the home and police, and interviews with staff.

**This order must be complied with by** August 15, 2025

## **COMPLIANCE ORDER CO #002 Policy to Promote Zero Tolerance**

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

1) Ensure the home's Zero Tolerance of Abuse and Neglect Policy clearly identifies

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what assessments are required to be completed in response to alleged, suspected or witnessed incidents of abuse.

2) Keep detailed records of any revisions implemented by the home to the Zero Tolerance of Neglect and Abuse Policy and Procedures, including when and who implemented the changes.

3) Identify which staff require education on any revised policy and procedures, and maintain a record of the education provided that includes the content, the date of the education, who provided the education and all staff members who attended.

4) Re-educate identified staff on the home's Zero Tolerance of Abuse and Neglect Policy and Procedures. Ensure education includes their roles and responsibilities, what immediate actions to take and what assessments are to be completed in response to an alleged, suspected or witnessed incidents of abuse.

5) Maintain documentation of the education provided to the identified staff members, including the content, the date of the education, who provided the education, and the individuals who attended the education.

**Grounds**

The licensee failed to ensure that their policy to promote zero tolerance of abuse and neglect of residents was complied with for an incident between two residents.

**Sources:** Resident assessments, risk management, interviews with staff.

**This order must be complied with by** August 8, 2025.

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## REVIEW/APPEAL INFORMATION

**TAKE NOTICE** The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> floor  
Toronto, ON, M7A 1N3

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e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto:MLTC.AppealsCoordinator@ontario.ca)

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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**Health Services Appeal and Review Board**

Attention Registrar  
151 Bloor Street West, 9<sup>th</sup> Floor  
Toronto, ON, M5S 1S4

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> Floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto:MLTC.AppealsCoordinator@ontario.ca)

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).