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

Ottawa District
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Public Report

Report Issue Date: July 14, 2025
Inspection Number: 2025-1577-0005
Inspection Type: Complaint Critical Incident
Licensee: United Counties of Prescott and Russell
Long Term Care Home and City: Residence Prescott et Russell, Hawkesbury

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 8-11, 2025

The following complaint intake was inspected:

- Intake: #00144493 - related to resident room door

The following Critical Incident (CI) intakes were inspected:

- Intake: #00144531/CI: #M567-000004-25 - related to a smoking injury
- Intake: #00145307/CI: #M567-000005-25 - related to a fall with injury

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
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 were specific instructions to follow in a resident's written plan of care for a transfer device.
During an interview, a Clinical Manager indicated that the intructions should have been documented in the resident's plan of care.

Sources: Inspectors observations, staff interview, and review of residents' plan of care.

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee has failed to ensure that the outcomes for specific resident care were documented on every shift.

The Director of Care (DOC) acknowledged that the documentation was incomplete and confirmed that this documentation was to be completed on every shift .

Sources: resident Observation/ Flow sheet form, interview with DOC

WRITTEN NOTIFICATION: Infection prevention and control

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement, any standard or protocol issued by the Director with respect to Infection Prevention And Control (IPAC) was followed by a staff member.
Specifically 9. 1 (b) which states: Hand hygiene, including, but not limited to, at the four moments of hand hygiene before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact.

On a specific day, the Inspector observed a Personnal Support Worker (PSW) not performing hand hygiene in the preparation and administration of several resident snacks.

Sources: Inspector observation, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022, revised September 2023.