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

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Public Report

Report Issue Date: February 20, 2026
Inspection Number: 2026-1577-0001
Inspection Type: 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): February 12, 17-20, 2026.

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00166131 / M567-000012-25 related to the fall of a resident with injury.
- Intake: #00168100 / M567-000001-26 related to an infectious disease outbreak.
- Intake: #00169374 / M567-000002-26 related to an incident of alleged abuse between residents.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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.

On a specific date in December 2025, a resident fell while mobilizing, which resulted in an injury. A fall prevention measure was not in place at the time of the fall as per the written plan of care.

Sources: Resident's electronic health record, interview with staff.

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.

When an incident of alleged abuse occurred between two residents on a specific

date in January 2026, this incident was not immediately reported to the Director. The incident was only reported the next day when a nursing supervisor became aware of the incident.

Sources: Critical Incident form M567-000002-26, Interview with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

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).

In accordance with Additional Requirement 9.1 (b) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), staff are to perform hand hygiene including, but not limited to, the four moments of hand hygiene. On a specific date in February 2026, a PSW did not perform hand hygiene between the contact of several residents and/or their environments while performing a fluid pass. Additionally, on the same morning, a different PSW was observed to be providing care to two separate residents without hand hygiene being performed between resident contacts.

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