

Ministry of Long-Term Care

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

Ottawa District

347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: January 23, 2026

Inspection Number: 2026-1508-0001

Inspection Type:

Critical Incident

Licensee: Bruyère Health/Santé Bruyère

Long Term Care Home and City: Saint-Louis Long-Term Care, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 20, 21, 22, 23, 2026.

The following intake(s) were inspected:

- Intake: #00165047 - CI #3013-000052-25 related to an unexpected death of a resident.
- Intake: #00165152 - CI #3013-000053-25 related to an outbreak.

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

- Resident Care and Support Services
- Infection Prevention and Control

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (11) (b)

Plan of care

s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

A resident was moderately impaired and assessed at high risk of fall. In a specified period, the resident had multiple falls, following the same pattern. Post fall huddles and the Fall Squad did not ensure that different approaches were considered in the revision of the plan of care, when the resident was reassessed after each fall.

Sources: Resident Assessment Instrument (RAI), fall risk assessments, post fall huddles, resident's plan of care. Interview with staff members.

WRITTEN NOTIFICATION: Infection prevention and control (IPAC)

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

Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

Three residents had symptoms of infection and was placed in isolation for a

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specified period. The symptoms indicating the presence of infection in these residents were not recorded consistently on every shift during the identified period.

Sources: Line list, residents' progress notes and vital signs record. Interview with staff members.

WRITTEN NOTIFICATION: CMOH and MOH Recommendations

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

Non-compliance with: O. Reg. 246/22, s. 272

CMOH and MOH

s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

Reference to the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings from the Ministry of Health dated February 2025, stated in Section 4: General Recommendations for Confirmed Outbreaks: • Weekly IPAC audits should be conducted for the duration of the outbreak. The results of these audits should be reviewed by the OMT • Ensure dedicated staff conduct IPAC Audits for hand hygiene, PPE usage and cleaning and disinfection and report rates to staff.

An Acute Respiratory Infection (ARI) outbreak was declared by Public Health on in December 2025. Weekly Infection Control and Prevention (IPAC) audits conducted during the outbreak did not assess Personal Protective Equipment (PPE) use or cleaning and disinfection practices. In addition, the results of the completed weekly IPAC audits were not reviewed by the Outbreak Management Team (OMT) and

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therefore did not meet the standards or protocols issued by the Director related to infection prevention and control.

Sources: Review of the Line listing, Critical Incident System (CIS) Report, the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, the licensee's Observation tool for Long-Term Care Homes, and the correspondence with the Administrator. Interview with staff member.