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: March 4, 2025
Inspection Number: 2025-1577-0001
Inspection Type: Complaint Critical Incident Follow up
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 20-21, 24-26, 2025.

The following intake(s) were inspected:
Intake: #00133014 regarding an outbreak in the home.
Intake: #00134828 regarding a complaint for care and services of a resident and an allegation of neglect.
Intake: #00135416 regarding a follow up to Compliance Order (CO) #001 from inspection #2024-1577-0005 related to their Infection Prevention and Control Program (IPAC).

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1577-0005 related to O. Reg. 246/22, s. 102 (2) (b)

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 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).

A - In accordance with the additional requirement under the IPAC standard section 10.1, the licensee has failed to ensure that the hand hygiene program included access to hand hygiene agents that contained 70-90% Alcohol-Based Hand Rub (ABHR).

Purell hand sanitizing wipes were observed on the snack carts in one of the kitchenettes and a specified resident unit. These sanitizing wipes were used for residents during a meal service on this unit. Purell hand sanitizing wipes contained ethyl alcohol level of 62 percent (%). A bottle of ABHR inside the kitchenette used by dietary aids contained ethyl alcohol level of 62 percent (%).

Sources: Observations in a dining room and kitchenette, observations of another resident unit lunch and snack services; interviews with a dietary aide, IPAC lead and the Clinical Nursing Supervisor.

B- In accordance with the Infection Prevention and Control (IPAC) Standard: 9.1 b, the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At a minimum, routine practices shall include hand hygiene, including, but not limited to, the four moments of hand hygiene.

A housekeeping aide was observed after handling garbage, removed soiled gloves and applied clean gloves without performing hand hygiene. On the same day, during a meal service, two Personal Support Workers (PSWs) assisted several residents and their environments and had not performed hand hygiene between contact with each of these residents.

Sources: Inspector's observations; interviews with a housekeeping aide, PSWs and the IPAC Lead.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that residents who had symptoms indicating the

presence of infection were monitored on every shift.

A Resident experienced symptoms of infection from specified dates and a review of the infection documentation, the resident's heath records and communication with the IPAC Lead showed that the resident's symptoms were not monitored consistently.

Another resident experienced symptoms of infection from specified dates and a review of the infection documentation, the resident's heath records and communication with the IPAC Lead showed that the resident's symptoms were not monitored consistently.

Sources: Review the home's line listings and resident's health records; Interview with IPAC Lead.

WRITTEN NOTIFICATION: CMOH and MOH

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.

A - The Licensee has failed to ensure that all alcohol-based hand rubs (ABHR) being used for hand hygiene, should ensure their ABHRs were not expired as recommended by the Chief Medical Officer of Health (CMOH).

Specifically, the Ministry of Health's Recommendations for Outbreak Prevention and

Control in Institutions and Congregate Living Settings, 2024 directive specifies that the ABHR must not be expired. On a specified date, inspector noted two ABHR product bottles were used for the lunch meal that were expired. Another bottle inside a kitchenette for dietary aid use no longer had any expiration date printed on the bottle which the dietary aide reported this was an old bottle.

Sources: Observations; interview with a dietary aide and DOC; review of the Ministry of Health's Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, 2024.

B - The Licensee has failed to ensure that high-touch surfaces throughout all common areas accessed by residents are cleaned and disinfected at minimum twice daily during a confirmed outbreak as recommended by the Chief Medical Officer of Health (CMOH).

Specifically, the Ministry of Health's Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, 2024 directive specifies under section 3.12, enhanced environmental cleaning and disinfection at a minimum twice daily for high-touch surfaces (door handles/knobs, light switches, handrails, phones, elevator buttons, etc.). Provincial Infectious Diseases Advisory Committee (PIDAC) specifies on page 158- for vulnerability of population to environmental infection that high-touch surfaces are those that have frequent contact with hands such as doorknobs, telephone, call bells, bedrails, light switches, wall areas around the toilet and edges of privacy curtains. Furthermore, this section specifies that expiry dates should be reviewed for cleaning and sanitizing products.

Housekeeping Aide (HSK) reported they sanitized high-touch surfaces with the ready to use surface cleaner, which was noted to be expired since over a year ago. These high-touch surfaces were not cleaned or disinfected as required.

Sources: Observations; interview with HSK; review of the Ministry of Health's

Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, 2024. PIDAC and the cleaning product label.