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: June 5, 2025

Inspection Number: 2025-1577-0003

Inspection Type:
Proactive Compliance Inspection

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): May 20, 21, 22, 23, 26, 27, 28, 29, 30, 2025

The following intake(s) were inspected:

- Intake: #00147611 - Proactive Compliance Inspection (PCI)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices

Pain 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 (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.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

In May 2025, during a meal service, a resident did not receive the nutritional supplement outlined in their plan of care as recommended by the Registered Dietitian.

Sources: Inspector observation. RD's assessment and plan of care. Interview with staff members.

WRITTEN NOTIFICATION: Air Temperature

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 1.
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the

home:
1. At least two resident bedrooms in different parts of the home.

The licensee has failed to ensure that the temperature was measured and documented in writing, at a minimum in at least two resident bedrooms in different parts of the home.

The Weekly Temperature Log showed that the temperature in any of the resident's bedrooms was not documented from May 26 to May 29, 2025. The Housing Services Supervisor (HHS) indicated that the temperature in any of the resident's bedrooms has not been measured or documented since April 10, 2025, when they sent the monitors for repair.

Sources: Review of Weekly Temperature Log, HHS' e-mail. Interview with HHS.

WRITTEN NOTIFICATION: Nursing and personal support services

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (3) (e)
Nursing and personal support services
s. 35 (3) The staffing plan must,
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has not updated their staffing plan since October 31, 2022, and as such, has failed to ensure that the staffing plan for nursing and support services was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Sources: Review of LTCH Staffing Plan "Plan de Dotation 2018-2021 Residence

Prescott et Russell Mai 2018 (Revise le 31 octobre 2022)", Interview with operations manager and staff members.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident, exhibiting altered skin integrity on multiple areas, had their wounds reassessed at least weekly.
The resident had multiple identified wounds and some of those wounds did not have a weekly assessment.

Sources: Skin assessments for the resident; interviews with staff members.

WRITTEN NOTIFICATION: Infection prevention and control

NC #005 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).

A- The licensee has failed to ensure that the implementation of any standard or protocol issued by the Director with respect to infection prevention and control.

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.

In May 2025, a staff member was providing a specified care to a resident. After the staff member removed the resident's soiled care products, they changed the soiled gloves without performing hand hygiene.

Sources: Inspector's observation. Interviews with the staff member and IPAC Lead.

B- The licensee has failed to ensure the implementation of any standard or protocol issued by the Director with respect to infection prevention and control.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, revised September 2022, section 9.1(f) states at minimum, Additional Precautions shall include appropriate selection application, removal, and disposal of Personal Protective Equipment (PPE).

In May 2025, two staff members while providing care to a resident that required additional contact precautions. Both staff members did not wear a gown as required during care.

Sources: Inspector's observation. Review of the resident's plan of care. Interviews with the staff members and IPAC lead.

WRITTEN NOTIFICATION: Medication management system

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that the written medication management system policies and procedures to ensure the destruction and disposal of all drugs used in the home was implemented.

Specifically, the licensee did not comply with the component that the medication management system policies and procedures as per O.Reg 246/22 s. 148 (2)(1) in that that drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

On multiple occasions in May 2025, the medication disposal pails from Stericycle were observed to have accessible medications as the Stericycle pails were not sealed closed to prevent access for safety. Policy #340-08 section 5.3 indicated discontinued medications are to be disposed of in the provided container for future destruction in the pharmacy or biohazard containers. The environmental services supervisor indicated all Stericycle pails should be sealed when in use to prevent access when on the nursing units for the safety of storage of these medications.

Sources: review of "Retrait et destruction des medicaments" #340-08 revised 11/2024 by the Administrator; observation of Stericycle pails in nursing home areas storage units; interviews with a staff member, the environmental services supervisor, the Director of Care and the Administrator.

WRITTEN NOTIFICATION: Quarterly evaluation

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)
Quarterly evaluation
s. 124 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 246/22, s. 124 (1).

The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. The Director of Care indicated they had not had a quarterly meeting for medication management system with their interdisciplinary team since Fall 2024.

Source: Interview with Director of Care.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that drugs stored in medication carts in in different care areas in May 2025, were secured and locked.

Sources: Observations of medication carts storage in different care areas; interviews with staff members.

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 3.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
3. That drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure that their drug destruction and disposal policy, provided a safe and environmentally appropriate manner for drugs to be destroyed and disposed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Two registered nursing staff members indicated they disposed of large bottles or containers of prescribed medications in the garbage when these medications were discontinued, as they did not have any other procedure for disposal.

Sources: Interviews with registered nursing staff members; review of the "Retrait et destruction des medicaments #340-08" policy and procedure.

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee has failed to ensure the continuous quality improvement (CQI) committee included at least one employee of the licensee who has been hired as a personal support worker (PSW) or who provided personal support services at the home.

Sources: Review of Quality Improvement, Safety, and Risk Management committee meeting minutes from April 3, June 27, September 11, and December 4, 2024, the Quality Improvement Plan annual report 2025/2026, Interview with clinical manager.

WRITTEN NOTIFICATION: Website

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 271 (1) (e)
Website
s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,
(e) the current report required under subsection 168 (1);

The licensee has failed to ensure that the home's website included the current report related to the homes continuous quality improvement initiative. Review of the home's website revealed a plan for the years of 2022-2023.

Source: Review of Residence Prescott Russell website (May 26, 2025), interview with Clinical Manager.