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

**Central East District**
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# Public Report

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| **Report Issue Date:** March 27, 2025 |
| **Inspection Number:** 2025-1544-0003 |
| **Inspection Type:**<br>Critical Incident |
| **Licensee:** The Corporation of the City of Peterborough and The Corporation of the County of Peterborough |
| **Long Term Care Home and City:** Fairhaven, Peterborough |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 13, 14, 17-21, 25 - 27, 2025
The inspection occurred offsite on the following date(s): March 24, 2025

The following intake(s) were inspected:

- An intake related to ARI Respiratory Syncytial Virus Outbreak.
- An intake related to an unexpected death of a resident.
- An intake related to misappropriation of a resident's money.
- An intake related to fall of resident resulting in a significant change.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Quality Improvement
Falls Prevention and Management

## INSPECTION RESULTS

## Non-Compliance Remedied

**Non-compliance** was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
**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 failed to ensure that any standard or protocol issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented. Specifically, the additional passive screening requirement, in accordance with IPAC Standard, Additional Requirement 11.6 under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), April 2022; last revised September 2023.

The IPAC lead indicated the passive screening of signs and symptoms were posted at the entrances of the Long-Term Care Home. After the Inspector reviewed the IPAC standard for LTC Homes, the IPAC Lead posted additional signage throughout the home immediately on the same day.

**Sources:** Observations, interview with IPAC leads.

Date Remedy Implemented: March 17, 2025

## WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 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 failed to ensure that care set out in a resident's plan of care was provided as specified in the plan.

A Critical Incident Report (CIR) was submitted to the Director regarding a fall of a resident, which resulted in a significant health status change. The resident's plan of care was reviewed and updated to include fall interventions. One intervention indicated that staff are to ensure to have commonly used articles within easy reach. Ten days later, the resident had another fall. The resident indicated that fall incident result from trying to reach to get water from bedside table.

**Sources**: Critical Incident Report, the resident's clinical records, and interview with staff and residents.

## WRITTEN NOTIFICATION: Plan of care

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

**Non-compliance with: FLTCA, 2021, s. 6 (1) (c)**

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,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure the written plan of care, set out clear directions to staff and others who provide direct care to a resident.

A CIR was submitted to the Director regarding a resident's fall incident, which resulted in a significant health status change. After the incident, the resident's written plan of care was updated indicating that an activate alarm was required on both sides of the bed for when resident was in bed.
During the inspection, an observation was made of the alarm beside the bed and it was turned off. A Personal Support Worker (PSW) was unable to determine if and when the alarm was to be active. During the interview with the resident, the inspector was told by the PSW that the alarm was to be removed from resident's room.

**Sources**: Critical Incident Report, resident clinical records, interview with staff and resident.

## WRITTEN NOTIFICATION: Integration of assessments, care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (4) (a)**
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee failed to ensure that the staff and others involved in the different aspects of care of a resident, collaborated with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

A CIR was submitted to the Director regarding an unexpected death of a resident.
A Resident Care Manager indicated that an Registered Nurse role was to respond to acute health status changes or anything the requires consultation. A resident

experienced an acute health status change. A Registered Practical Nurse (RPN), indicated they notified the Registered Nurse. There was no indication of a Registered Nurse completing an assessment during an acute health status change of the resident, until the next shift.

The resident was pronounced dead several hours later.

**Sources**: Critical Incident Report, the resident's clinical records, and interview with staff.

## WRITTEN NOTIFICATION: When reassessment, revision is required

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (10) (b)**
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

The resident's plan of care included a fall intervention that directed the staff to ensure the call bell was within reach when in the recliner chair, which the slept in. A Resident Care Manager (RCM) indicated that the recliner has been removed from the resident's room and no longer sleeps in a recliner. The RCM indicated the plan of care should have been updated.

**Sources:** Critical Incident Report, the resident's clinical records and interviews with staff.

## WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 19 (2) (a)**
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;

The licensee failed to ensure a residents walker was kept clean and sanitary.

A resident had worn white tape wrapped around their assistive device. The tape was not intact and had dark coloured debris or discoloration.

**Sources:** Observations, and interview with staff.

## WRITTEN NOTIFICATION: Personal items and personal aids

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)**
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and

The licensee failed to ensure that residents' personal items, including personal aids

such as dentures, glasses, and hearing aids, were labeled.

A CIR was submitted to the Director regarding a resident missing a change purse. There was no indication that the change purse was labeled.
During the inspection into how personal items were labeled within the long-term care home, a Resident Care Managers indicated that dentures were not being labeled at this time. While the containers for hearing aids were labeled, the actual hearing aids were not.

**Sources**: Critical Incident Report, interview with staff.

## WRITTEN NOTIFICATION: Infection prevention and control program

NC #008 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 failed to ensure that any standard or protocol issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented. Specifically, that Routine Practices and Additional Precautions are followed in the proper use of Personal Protective Equipment (PPE) including appropriate removal and disposal, in accordance with IPAC Standard, Additional Requirement 9.1 (d) under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), April 2022; last revised September 2023.

A Registered Practical Nurse (RPN) was observed doffing their routine surgical mask inappropriately. The RPN doffed their mask and placed it on the hallway railing

prior to donning their additional precaution PPE and entering s resident's bedroom. The resident home area was declared in an outbreak the following day.

**Sources:** Observations, and interview with staff.

## WRITTEN NOTIFICATION: Infection prevention and control program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.**
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The licensee failed to ensure the hand hygiene program was in accordance with any standard or protocol issued by the Director. Specifically, the licensee failed to ensure there was access to hand hygiene agents at point-of-care.

Point-of-care is the place where three elements occur together: the resident, the health care provider and care or treatment involving resident contact. Hand hygiene products available at point-of-care should be easily accessible to staff by being as close as possible, i.e., within arm’s reach, to where resident contact is taking place. Alcohol-Based Hand Rub (ABHR) dispensers were mounted on the external wall immediately adjacent to the entrance and exit to each resident bedroom. There was no ABHR immediately available at the point-of-care location of the observed resident bedrooms.

**Sources**: Observations throughout the long-term care home, interview with IPAC Lead.

## WRITTEN NOTIFICATION: Reports re critical incidents

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.**
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to immediately inform the Director of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Peterborough Public Health defined an outbreak as two or more patient/resident cases of test-confirmed acute respiratory infections (ARI) with symptom onset within 48 hours and an epidemiological link (e.g. same unit/floor/service area) suggestive of transmission within the setting; or three or more patient/resident cases of ARI with symptom onset within 48 hours and an epidemiological link suggestive of transmission within the setting and testing is not available or all negative.

There were four residents on additional precautions related to symptoms of acute respiratory infection, the Director was notified the following day.

**Sources**: Critical Incident Report, and interview with staff.

## WRITTEN NOTIFICATION: Safe storage of drugs

NC #011 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,

1. The licensee failed to ensure drugs are stored in an area or a medication cart that is secure and locked.

First day of the inspection, medicated treatment creams were observed at their bedside of two different resident's room. A Personal Support Worker (PSW) indicated that treatment creams are applied by PSWs and was returned to the nursing station in a plastic container with other co-resident creams. Director of Care and Executive Director were informed the same day of the unsafe storage of the medicated creams.

**Sources:** Observations, and interview with staff.

2. The licensee failed to ensure a resident's treatment cream was stored in an area or a medication cart that was secured and locked.

Observations of a topical treatment cream, was observed on the resident side table.

A resident indicated the treatment cream was used and was stored on bedside table to ensure it was applied by the staff during care. The resident indicated that if

they do not receive the treatment the location gets painful.

**Sources:** Observations, resident clinical records, interview with staff and the resident.

3. The licensee failed to ensure that drugs were stored in an area or a medication cart that is secure and locked.

A resident's medication, which included several different inhalers were observed on the handrail in the hallway unattended. There were no residents in close proximity at the time of the observation. A staff member was observed picking up the medication from the handrail.

**Sources**: Observations.

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