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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: July 2, 2025
Inspection Number: 2025-1544-0005
Inspection Type: Critical Incident Follow up
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): June 23-27, 30, 2025, July 2, 2025

The following intake(s) were inspected in this Critical Incident (CI) inspection:
An intake related to the abuse of a resident.
An intake related to the significant change in the health status of a resident.
An intake related to the improper care of a resident.

The following intake(s) were inspected in this Follow-up (FU) inspection:
Intake related to Compliance Order #005 / 2024_1544_0003 -O.Reg. 246/22 s. 272, CDD March 31, 2025
Intake related to Compliance Order #003 /2024_1544_0003 -O.Reg. 246/22, s. 93 (2) (a) (i), CDD March 31, 2025

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #005 from Inspection #2024-1544-0003 related to O. Reg. 246/22, s. 272
Order #003 from Inspection #2024-1544-0003 related to O. Reg. 246/22, s. 93 (2) (a) (i)

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards

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 (4) (b)
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,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure that staff collaborated with a Registered Nurse (RN) or physician when there is a significant change in the resident's health.

Sources: Resident's clinical records

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 the care outlined in the resident's plan of care was provided to the resident as specified in the plan.

Staff allowed the resident to wait in a high-traffic area for an extended period, resulting in an altercation with a co-resident. The plan of care for the resident aims to limit their time in the high-traffic areas.
Source: Resident's clinical records, interview with staff

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone immediately reported the suspicion and the information upon which it was based to the Director.

Staff did not immediately report witnessing the abuse of a resident during care.

Sources: Critical Incident Report (CIR), home's policy, clinical records of the resident, and interview with staff

WRITTEN NOTIFICATION: Behaviours and altercations

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The Licensee failed to ensure that procedures and interventions were developed and implemented to create a safe environment for residents to minimize the risk of altercations and potentially harmful interactions with other residents.

A resident engaged in aggressive physical contact with a co-resident. There is no procedure or intervention plan in place to ensure a safe environment for residents to wander, to reduce the risk of altercations or potentially harmful interactions with co-residents, or to assign responsibility for creating a safe space for co-residents.

Source: Clinical Records of a resident, interview with staff.

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