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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Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: February 4, 2026

Inspection Number: 2026-1544-0001

Inspection Type:
Complaint
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): January 22 - 23, 27 - 30, 2026 and February 2 - 4, 2026.
The inspection occurred offsite on the following date(s): January 26, 2026.

The following intake(s) were inspected:
An intake related to follow-up #1 - Compliance Order (CO) #004, inspection #2025-1544-0007, with Compliance Due Date (CDD) January 15, 2026.
An intake related to follow-up #1 - CO #001, inspection #2025-1544-0007, with CDD January 15, 2026.
A complaint alleging improper care of a resident.
A complaint alleging no hot water in the home.
Two intakes related to resident to resident altercations.
An intake related to a resident fall resulting in injury.
Two intakes related to outbreaks in the home.
An intake related to an allegation of misappropriation of a resident's funds.
An intake related to an allegation of physical abuse of a resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #004 from Inspection #2025-1544-0007 related to O. Reg. 246/22, s. 57 (2)
Order #001 from Inspection #2025-1544-0007 related to O. Reg. 246/22, s. 53 (1) 1.

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management
Resident Charges and Trust Accounts

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) (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

Staff did not collaborate with/notify the physician when a resident's condition changed.

Sources: Resident clinical records, the LTC home's policy, interviews with staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident’s substitute decision-

maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The substitute decision maker for a resident was not given an opportunity to participate fully in the development and implementation of the resident's plan of care after the resident's condition changed.

Sources: Resident clinical records, and interviews with staff.

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #003 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 care plan for a resident was not revised when the resident's care needs changed.

Sources: Resident clinical records, interview with staff.

WRITTEN NOTIFICATION: Bathing

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Residents were not bathed at a minimum of twice a week when the home was

experiencing water issues.

Sources: Residents' clinical records, interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
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,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

1.A resident's skin was not assessed using a clinically appropriate tool when they exhibited altered skin integrity.

Sources: Resident clinical records, LTC home policy, interview with staff.

2.A resident's skin was not assessed using a clinically appropriate tool when they exhibited altered skin integrity.

Sources: Resident clinical records, LTC home policy, interview with staff.

WRITTEN NOTIFICATION: Behaviours and altercations

NC #006 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

There was an intervention in place on day and evening shift for a resident who had a history of responsive behaviours towards other residents. An altercation occurred on a night shift when the intervention was not in place resulting in injury of a co-resident.

Sources: Residents' clinical health records, licensee records and interviews with staff.

WRITTEN NOTIFICATION: Maintenance services

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (i)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

There was no procedure in place to ensure the water temperature serving the showers in the LTC home was maintained at a temperature of at least 40 degrees Celsius.

Sources: LTC Home’s Water Temperature Logs, LTC home's policy, interviews with staff.

WRITTEN NOTIFICATION: Maintenance services

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (k)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water.

The water temperature was not consistently monitored once per shift in random locations where residents have access to hot water.

Sources: LTC Home’s Water Temperature Logs, LTC home's policy, interviews with

staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 2. iii.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
iii. a loss of essential services, or

There was no critical incident report submitted to the Director when there was a loss of hot water in the home for more than six hours and resident care was impacted.

Sources: Ministry of Long-Term Care Critical Incident Reporting System, interviews with staff.