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 West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: May 30, 2024	
Inspection Number: 2024-1229-0001	
Inspection Type: Critical Incident	
Licensee: Peel Housing Corporation	
Long Term Care Home and City: Vera M. Davis Community Care Centre, Bolton	
Lead Inspector Amanpreet Kaur Malhi (741128)	**Inspector Digital Signature** Amanpreet K Malhi Digitally signed by Amanpreet K Malhi Date: 2024.05.31 15:16:04 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 30, 2024, and May 1-3, 2024.

The following intake(s) were inspected:

- Intake: #00111628, related to resident-to-resident abuse

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reassessment, revision

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (b)
Plan of care
s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

The licensee failed to ensure that different approaches were considered in the revision of resident #002's plan of care when the interventions set out in their plan to manage their risk of altercations or potentially harmful interactions with other residents were not effective.

Rationale and Summary
Upon record review, it was noted that Resident #002 had multiple incidents of altercations with resident #001 and multiple other residents in the home.

The same interventions were implemented following each incident, but were not effective and alternative approaches were not tried.

BSO Nurse #105 stated that further information needed to be collected to understand their triggers as the current aggression incidents did not involve the previous familiar residents.

Failure to reassess the effectiveness of interventions and consider different approaches to manage the resident's risk of altercations, lead to further altercations.

Sources: Critical Incident (CI), Resident #002's clinical records and interviews with the home's staff [741128]