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

Public Report

Report Issue Date: March 5, 2026
Inspection Number: 2026-1229-0002
Inspection Type: Critical Incident
Licensee: Peel Housing Corporation
Long Term Care Home and City: Vera M. Davis Community Care Centre, Bolton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 25-27 and March 2-3, and 5, 2026

The following intake(s) were inspected:
Intake: #00165770 related to Infection Prevention and Control
Intake: #00165987 related to Falls prevention and management
Intake: #00171491 related to Injury with unknown cause

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

Infection Prevention and Control
Prevention of Abuse and Neglect
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: 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.

A resident did not receive the care as specified in their care plan.

Sources: Resident's care plan; MLTC Inspector's observations; Interviews with the resident and PSW.

Date Remedy Implemented: February 26, 2026

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee did not immediately report the alleged abuse of a resident by anyone or staff to the Director.

Sources: Resident's clinical record; Hospital notes and Interview with Supervisor of Care.

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