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: August 08, 2023	
Inspection Number: 2023-1229-0002	
Inspection Type: Critical Incident System	
Licensee: Peel Housing Corporation	
Long Term Care Home and City: Vera M. Davis Community Care Centre, Bolton	
Lead Inspector Gurvarinder Brar (000687)	**Inspector Digital Signature** Gurvarinder K Brar Digitally signed by Gurvarinder K Brar Date: 2023.08.09 11:02:13 -04'00'
Additional Inspector(s) Kaitlyn Puklicz (000685)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 31 and August 1-2, 2023

The following intake(s) were inspected:

- Intake: #00088162 related to prevention of abuse and neglect.
- Intake: #00091259 related to falls prevention and management.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of Licensee to Comply with Plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care was provided to a resident as specified in the resident's care plan.

Rationale & Summary

A Personal Support Worker (PSW) provided care to a resident by themselves.

The resident required two person assistance with care.

The Director of Care (DOC) stated that the resident required two person assistance for care but was provided care by one staff member.

Failing to adhere to the resident's plan of care placed the resident at risk of injury.

Sources

Resident clinical record review and interviews with the DOC and other staff.

[000685]