

**FINAL INSPECTION REPORT**  
**Under the *Retirement Homes Act, 2010***

Inspection Information	
Date of Inspection: June 3, 2025	Name of Inspector: Melanie Leslie
Inspection Type: Responsive Inspection – Mandatory Report	
Licensee: ACC-002637 - V!VA Retirement Communities Inc.	
Retirement Home: V!VA Thornhill Woods Retirement Community	
License Number: T0256	

About Responsive Inspections
<p>A responsive inspection, performed by an RHRA inspector, is a physical inspection of a licensed retirement home. A responsive inspection is conducted when RHRA receives information that the licensee may have failed to meet the standards of the <i>Retirement Homes Act, 2010</i> or its regulations (the “RHA”). An inspection being conducted does not imply that an allegation is substantiated or that a contravention of the RHA has occurred. A licensee is required to report to RHRA if they suspect harm or risk of harm to a resident. During a responsive inspection, an RHRA inspector may observe the operations of the home, interview relevant individuals, review records and other documentation, and determine whether the licensee’s management and staff have followed mandatory policies and practices designed to protect the welfare of residents.</p>

**Concern(s)**

*During a responsive inspection, an inspector will focus primarily on the concern(s) which prompted the inspection and may take various actions to determine whether the licensee is compliant with the RHA in relation to the concern(s). Any findings of non-compliance identified in relation to these concerns are listed below.*

**Concern #1: CON-5363-Improper or Incompetent Treatment or Care****RHRA Inspector Findings**

The Licensee self reported an incident of a resident eloping from the home which resulted in an injury to the resident. In response to the report, the RHRA conducted an inspection in which the inspector interviewed relevant individuals and reviewed the home's files and reports.

The inspection found that the resident's assessment identified behaviours which placed the resident at risk of harm which were not included in the resident's plan of care. Furthermore, the resident's plan of care was not approved by the resident or their substitute decision maker.

The resident's assessment indicated that their care needs included dementia however, the home had not completed an interdisciplinary care conference.

In addition, the inspector found no evidence that the Licensee had implemented techniques and strategies to prevent and address the identified responsive behaviours, nor were they completing any heightened monitoring of the resident.

The Licensee was not able to demonstrate that the resident's plan of care included all relevant information and that they had fully implemented the home's behaviour management policy.

**Outcome**

The Licensee provided information indicating that corrective action was being taken, however, further action must be taken to achieve compliance with all areas outlined in the finding. RHRA to confirm compliance by following up with the Licensee or by inspection.

Following a responsive inspection, the RHRA inspector prepares a draft inspection report which is sent to the licensee. The draft report may include instances where the licensee has failed to meet the standards of the *RHA*. If included, the licensee can respond to these instances and is strongly encouraged to inform RHRA of its plans to meet the standards of the *RHA*.

Following the draft report, the RHRA inspector prepares this final inspection report, incorporating any response from the licensee with their plans to meet the standards of the *RHA*. The most recent final inspection report must be posted in the home in a visible and easily accessible location. All final inspection reports from the previous two years must also be made available in an easily accessible location in the home. The licensee must provide a copy of this report to the home's Residents' Council, if one exists.

In addition to inspection reports, RHRA may provide information to a licensee to encourage improvements of their current practices.

If there is a serious incident or the licensee repeatedly does not meet the required standards, RHRA may take further action.

**Additional Findings**

*During a responsive inspection, an inspector may observe areas of non-compliance that are not related to the concern(s) which prompted the inspection. In these cases, an inspector may cite the home for these contraventions at the time of this inspection. In addition, an inspector may follow-up on findings of non-compliance from previous inspections. Where the licensee is unable to demonstrate they have come into compliance or maintained compliance, an inspector may cite the home for these repeat contraventions at the time of this inspection.*

**Not Applicable**

**Current Inspection – Citations**

*Citations relating to the above Concerns or Additional Findings made during the current inspection are listed below.*

**The Licensee failed to comply with the RHA s. 62. (9); Persons who approve plans of care****s. 62. (9); Persons who approve plans of care**

62. (9) The licensee shall ensure that the following persons have approved the plan of care, including any revisions to it, and that a copy is provided to them:

**Specifically, the Licensee failed to comply with the following subsection(s):**

**s. 62. (9), para. 1**

1. The resident or the resident's substitute decision-maker.

**The Licensee failed to comply with the RHA s. 62. (6); Assessment of resident****s. 62. (6); Assessment of resident**

62. (6) The licensee shall ensure that the plan of care is based on an assessment of the resident and the needs and preferences of the resident.

**The Licensee failed to comply with the O. Reg. 166/11 s. 23. (1); Behaviour management****s. 23. (1); Behaviour management**

23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,

**Specifically, the Licensee failed to comply with the following subsection(s):**

**s. 23. (1), (a)**

(a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;

**s. 23. (1), (b)**

(b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;

**s. 23. (1), (c)**

(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home;

**The Licensee failed to comply with the O. Reg. 166/11 s. 47. (5); Development of plan of care**

**s. 47. (5); Development of plan of care**

47. (5) If an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care and that the resident's plan of care takes into account the results of the care conference.

**Closed Citations**

*During an inspection, an inspector may follow-up with areas of non-compliance cited during a previous inspection, or verify compliance with areas initially cited during the current inspection. The inspector has verified that at the time of this report, the licensee was able to demonstrate that the following areas have come into compliance.*

**Not Applicable**

**NOTICE**

The Final Inspection Report is being provided to the Licensee, the Registrar of the RHRA and the home's Residents' Council, if any.

Section 55 of the *RHA* requires that the Final Inspection Report be posted in the home in a conspicuous and easily accessible location. In addition, the Licensee must ensure that copies of every Final Inspection Report from the previous two (2) years are made available in the Home, in an easily accessible location.

The Registrar's copy of the Final Inspection Report, as it appears here, will be included on the RHRA Retirement Home Database available online at <http://www.rhra.ca/en/retirement-home-database>.

Signature of Inspector: <i>Melanie Leslie</i>	Date: June 27, 2025
--	------------------------