RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: 7/29/2025	**Name of Inspector: Shyla Sittampalam, RN**
Inspection Type: Routine Inspection	
Licensee: ACC-002892 - VCare Retirement Home Inc.	
Retirement Home: V Care Retirement Home Inc	
License Number: T0543	

About Routine Inspections

A routine inspection, performed by an RHRA inspector, is a physical inspection of a licensed retirement home. During a routine inspection, an RHRA inspector will walk through the home, speak to residents and staff, observe care services and conditions in the home, and ensure the licensee's management and staff follow mandatory policies and practices designed to protect the welfare of residents.

Following a routine 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 the licensee repeatedly does not meet the required standards, RHRA may take further action.

Focus Areas

During a routine inspection, an inspector will focus primarily on a set number of areas which have been identified as related to the health, safety and wellbeing of resident, and may take various actions to determine whether the licensee is compliant with the RHA in relating to the areas. The areas listed in this section are ones which an inspector has identified as non-compliant.

Focus Area #1: Maintenance

RHRA Inspector Findings
The inspector attended the home during a declared heat alert and observed elevated indoor temperatures. The Licensee failed to ensure procedures were in place and implemented to address extreme heat conditions as required.

Outcome
The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

Focus Area #2: Medications

RHRA Inspector Findings
The inspector reviewed a sample of medication administration records and found that staff at the home did not complete a written record of medications administered for several residents. In addition, at the time of the inspection, the inspector found medications to be unsecured and unlocked.

Outcome
The Licensee submitted a plan to achieve compliance by Tue Sep 09 2025. RHRA to confirm compliance by following up with the Licensee or by inspection.

Focus Area #3: Resident Record, Assessment, Plan of Care

RHRA Inspector Findings
The inspector reviewed a sample of resident care files and found one resident who was recently admitted to the home did not have an initial assessment or plan of care completed. Furthermore, one resident was not reassessed within the required time period. The Licensee was also unable to demonstrate for any of the plans of care reviewed that the resident or their substitute decision maker had approved the plan of care. In addition, the inspector found that the plans of care did not include the planned care services provided by an external care provider for two residents, including the details of the services and the goals. The Licensee failed to ensure that all the requirements for assessments and plans of care were met.

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.

Focus Area #4: Staff Training

RHRA Inspector Findings
The inspector reviewed a sample of staff training records in the areas of Zero tolerance of abuse, Bill of Rights, Infection control, Whistle Blower protection, Personal Assistive Service Devices (PASDs), Fire prevention and safety, Emergency plans, Complaints, Behaviour management, care services and medication administration. The Licensee has several PSW students providing direct care to residents and a recently hired unregulated care provider who did not have training completed in the areas of Zero tolerance of abuse, Bill of Rights, Infection control, Whistle Blower protection, Fire prevention and safety, Emergency plans, Complaints, care services and medication administration. The Licensee failed to ensure all requirements for training were met.

Outcome
The Licensee submitted a plan to achieve compliance by Tue Sep 09 2025. RHRA to confirm compliance by following up with the Licensee or by inspection.

Additional Findings

During a routine inspection, an inspector may observe areas of non-compliance that are not related to the standard focus areas. 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.

Additional Finding#1: Falls Prevention

RHRA Inspector Findings

As part of the routine inspection, the inspector reviewed the home's documentation related to resident falls in the home. The inspector found that no annual falls analysis had been completed. The Licensee failed to evaluate the risk of falls in the home at least annually and keep a written record of each evaluation as required.

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.

Current Inspection – Citations

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

The Licensee failed to comply with the RHA s. 62. (4); Contents of plan

s. 62. (4); Contents of plan

62. (4) The licensee of a retirement home shall ensure that there is a written plan of care for each resident of the home that sets out,

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

s. 62. (4), (c)

(c) if the resident has consented to the inclusion of the information in the plan of care, the planned care services for the resident that external care providers will provide with the consent of the resident, to the extent that such information is available to the licensee after the licensee has taken all reasonable steps to obtain such information from the resident and the external care provider, including,

s. 62. (4), (c), 1.

(i) the details of the services,

s. 62. (4), (c)

(c) if the resident has consented to the inclusion of the information in the plan of care, the planned care services for the resident that external care providers will provide with the consent of the resident, to the extent that such information is available to the licensee after the licensee has taken all reasonable steps to obtain such information from the resident and the external care provider, including,

s. 62. (4), (c), 2.
(ii) the goals that the services are intended to achieve;

The Licensee failed to comply with the RHA s. 65. (2); Training

s. 65. (2); Training
65. (2) Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in,

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

s. 65. (2), (a)
(a) the Residents' Bill of Rights;

s. 65. (2), (b)
(b) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;

s. 65. (2), (c)
(c) the protection afforded for whistle-blowing described in section 115;

s. 65. (2), (e)
(e) injury prevention;

s. 65. (2), (f)
(f) fire prevention and safety;

s. 65. (2), (g)
(g) the licensee's emergency evacuation plan for the home mentioned in subsection 60 (3);

s. 65. (2), (h)
(h) the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4);

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 O. Reg. 166/11 s. 47. (1); Development of plan of care

s. 47. (1); Development of plan of care
47. (1) Subject to subsection (4), as soon as possible and not later than two days after a resident commences residency in a retirement home, the licensee of a retirement home shall develop an initial plan of care for the resident based on the initial assessment of the resident's immediate care needs conducted under section 43 that includes all of the information listed in subsection 62 (4) of the Act that is relevant to the resident's immediate care needs.

The Licensee failed to comply with the O. Reg. 166/11 s. 16. (1); Temperature control

s. 16. (1); Temperature control

16. (1) Every licensee of a retirement home shall ensure that there are procedures in place for responding to extreme hot and cold weather conditions, including detailed practices for addressing failures of any temperature control systems in the home.

The Licensee failed to comply with the O. Reg. 166/11 s. 14. (3); Staff training

s. 14. (3); Staff training
14. (3) For the purposes of paragraph 5 of subsection 65 (5) of the Act, every licensee of a retirement home shall ensure that every staff member who provides a care service to a resident has received or receives training in,

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

s. 14. (3), (b)
(b) each care service offered in the home so that the staff member is able to understand the general nature of each of those services, the standards applicable under the Act to each of those services and the aspects of each of those services that may be relevant to the staff member's own duties in the home.

The Licensee failed to comply with the O. Reg. 166/11 s. 30.; Storage of drugs or other substances

s. 30.; Storage of drugs or other substances
30. If drugs or other substances are stored in a retirement home on behalf of a resident, the licensee of the home shall ensure that,

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

s. 30. (a)
(a) the drugs or other substances are stored in an area or a medication cart that,

s. 30. (a), 2.
(ii) is locked and secure,

The Licensee failed to comply with the O. Reg. 166/11 s. 29.; Administration of drugs or other substances

s. 29.; Administration of drugs or other substances
29. If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is the administration of a drug or other substance, the licensee shall ensure that,

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

s. 29. (c)
(c) neither the licensee nor a staff member administers a drug to a resident in the home unless the licensee or the staff member has received training in the procedures applicable to the administration of the drug;

s. 29. (e)
(e) if the licensee or a staff member is involved in the administration of the drug or other substance at the home, that the licensee or staff member is trained in,

s. 29. (e), 1.
(i) ways of reducing the incidence of infectious disease, including maintaining proper hand hygiene,

s. 29. (e)
(e) if the licensee or a staff member is involved in the administration of the drug or other substance at the home, that the licensee or staff member is trained in,

s. 29. (e), 2.
(ii) the safe disposal of syringes and other sharps,

s. 29. (e)
(e) if the licensee or a staff member is involved in the administration of the drug or other substance at the home, that the licensee or staff member is trained in,

s. 29. (e), 3.
(iii) recognizing an adverse drug reaction and taking appropriate action;

The Licensee failed to comply with the O. Reg. 166/11 s. 32.; Records

s. 32.; Records
32. If the licensee or a member of the staff of a retirement home administers a drug or other substance to a resident, the licensee shall ensure that,

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

s. 32. (a)
(a) the person who administered the drug or other substance prepares a written record noting the name and amount of the drug or other substance, the route of its administration and the time and date on which it was administered;

The Licensee failed to comply with the O. Reg. 166/11 s. 22. (1); Risk of falls

s. 22. (1); Risk of falls
22. (1) Every licensee of a retirement home shall develop, document and implement strategies to reduce or mitigate the risk of falls in common areas of the home.

The Licensee failed to comply with the O. Reg. 166/11 s. 27. (9); Infection prevention and control program

s. 27. (9); Infection prevention and control program
27. (9) The licensee shall ensure that each staff member who works in the retirement home receives training on how to reduce the incidence of infectious disease transmission, including,

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

s. 27. (9), (a)
(a) the need for and method of maintaining proper hand hygiene and method of preventing cross contamination, including proper handling of soiled linens, the protection of uniforms, and the separation of clean and dirty items;

s. 27. (9), (b)
(b) the need for and process of reporting, providing surveillance of and documenting incidents of infectious illness.

The Licensee failed to comply with the O. Reg. 166/11 s. 14. (1); Staff training

s. 14. (1); Staff training
14. (1) For the purposes of clause 65 (2) (j) of the Act, every licensee of a retirement home shall ensure that all staff who work in the home receive training in the procedure described in subsection 73 (1) of the Act for a person to complain to the licensee.

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 *Shyla Sittampalam*, RN	Date August 18, 2025