RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: 5/24/2024	**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: Behaviour Management

RHRA Inspector Findings
The inspector reviewed a sample of resident care files and was informed by the Licensee of a previous resident who continues to display responsive behaviours. The Licensee was unable to demonstrate implementation of any behaviour management strategies as set forth in their behaviour management strategy.

Outcome
The Licensee must take corrective action to achieve compliance.

Focus Area #2: Emergency Plan

RHRA Inspector Findings
The inspector reviewed the Licensee's records of testing for their emergency plans and found that the testing for situations involving the loss of essential services, situations involving a missing resident, medical emergencies and violent outbursts had not been completed since January 2023. The Licensee failed to ensure that testing was completed as required.

Outcome
The Licensee must take corrective action to achieve compliance.

Focus Area #3: Maintenance

RHRA Inspector Findings
At the time of inspection the basement common area and a bathroom in a common area were found to be unsanitary and unclean.

Outcome
The Licensee must take corrective action to achieve compliance.

Focus Area #4: 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, the Licensee did not have current physician's orders on record for medications being administered to several residents. At the time of the inspection, the inspector found resident medications to be unsecured and unlocked.

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 #5: Resident Record, Assessment, Plan of Care

RHRA Inspector Findings
The inspector reviewed a sample of resident care files and found one resident who did have a plan of care based on an assessment. Furthermore, two residents were not reassessed, and the plans of care were not reviewed and revised within the required time period. In addition, the reviewed care plans did not include all the care services the resident is entitled to receive under the resident's agreement. The care services that are listed in the plan of care did not contain the details of the services, clear

directions, and goals. The Licensee was unable to demonstrate that the resident or their substitute decision maker had approved the care plans. The Licensee informed the inspector that all residents receive care services from an external care provider. The inspector found that the plans of care did not include the planned care services provided by an external care provider, 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 submitted a plan to achieve compliance by Wed Jun 26 2024. RHRA to confirm compliance by following up with the Licensee or by inspection.

Focus Area #6: 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 inspector found that training for behaviour management, care services provided by the Licensee and medication administration training was not completed. The Licensee failed to ensure all requirements for training 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.

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.

Not Applicable

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. 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 RHA s. 14. (5); Staff training

s. 14. (5); Staff training

14. (5) The licensee shall ensure that the persons who are required to receive the training described in subsection 65 (5) of the Act receive that training on an ongoing basis, namely at least annually after receiving the training described in subsection (4).

The Licensee failed to comply with the RHA s. 17. (1); Cleanliness

s. 17. (1); Cleanliness

17. (1) Every licensee of a retirement home shall ensure that the common areas of the home, including the floors and any furnishings, equipment and linens in those areas, are clean and sanitary.

The Licensee failed to comply with the RHA 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 RHA s. 24. (5); Emergency plan, general

s. 24. (5); Emergency plan, general

24. (5) The licensee shall,

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

s. 24. (5), (a)

(a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

s. 24. (5), (a), 1.

(i) the loss of essential services,

s. 24. (5), (a)

(a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

s. 24. (5), (a), 2.

(ii) situations involving a missing resident,

s. 24. (5), (a)

(a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

s. 24. (5), (a), 3.

(iii) medical emergencies,

s. 24. (5), (a)

(a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

s. 24. (5), (a), 4.

(iv) violent outbursts;

The Licensee failed to comply with the RHA 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 RHA 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 RHA 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;

s. 32. (b)
(b) if a drug is administered, there is written evidence that the drug was prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991;

The Licensee failed to comply with the RHA s. 62. (12); Reassessment and revision

s. 62. (12); Reassessment and revision
62. (12) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time if, in the opinion of the licensee or the resident,

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

s. 62. (12), (b)
(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

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), (a)
(a) the care services that are part of a package of care services that the resident is entitled to receive under the resident's agreement with the licensee, whether or not the resident receives the services;

s. 62. (4), (b)
(b) the planned care services for the resident that the licensee will provide, including,

s. 62. (4), (b), 1.
(i) the details of the services,

s. 62. (4), (b)
(b) the planned care services for the resident that the licensee will provide, including,

s. 62. (4), (b), 3.
(iii) clear directions to the licensee's staff who provide direct care to the resident;

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. 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 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. 65. (5); Additional training for direct care staff

s. 65. (5); Additional training for direct care staff
65. (5) The licensee shall ensure that all staff who provide care services to residents receive training in the following matters and at the times required by the regulations, as a condition of continuing to have contact with residents, in addition to the other training that they are required to receive under this section:

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

s. 65. (5), para. 3
3. Behaviour management.

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.

Ontario Regulation 166/11:

s. 11. (1); Posted information

11. (1) For the purposes of paragraph 4 of subsection 55 (2) of the Act, the following information is prescribed as information that must be posted in a retirement home under that subsection:

s. 11. (1), para. 6

6. A copy of the most recent final inspection report prepared by an inspector under section 77 of the Act, subject to section 114 of the Act.

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	Date
Shyla Sittampalam, RN	June 24, 2024