RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 4, 2018	**Name of Inspector:** Corina Gadde
Inspection Type: Mandatory Reporting Inspection	
Licensee: Q & Sons Management Inc. / 560 Canyon Street, Mississauga, ON L5H 4L8 (the "Licensee")	
Retirement Home: Fairfield Manor East / 670 Mclean Court, Kingston, ON K7K 7L8 (the "home")	
Licence Number: N0451	

Purpose of Inspection
The RHRA received a report under section 75(1) of the *Retirement Homes Act, 2010* (the "RHA").

NON-COMPLIANCE
1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Same, neglect. Specifically, the Licensee failed to comply with the following subsection(s): **67. (2)** Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.
Inspection Finding The Licensee's pattern of inaction has resulted in circumstances jeopardizing the health, safety and well-being of residents. Lack of adequate staffing led to a resident providing meals to ensure the continuation of that care service to residents.
Outcome Licensee must take corrective action to achieve compliance.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 118; False information. Specifically, the Licensee failed to comply with the following subsection(s): **118.** No person shall knowingly provide false or misleading information to an inspector, the Registrar or any person employed or retained by the Authority in any statement or document in respect of any matter relating to this Act or the regulations, whether made or given orally, on paper or electronically.
Inspection Finding On August 31, 2018 the Licensee orally provided false and misleading information to the RHRA Manager of Inspections regarding staffing levels in the home, including the availability of trained personnel to provide meals to residents in compliance with regulatory requirements.
Outcome Licensee must take corrective action to achieve compliance.

3. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances. Specifically, the Licensee failed to comply with the following subsection(s): **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, (d) a member of a College, as defined in the Regulated Health Professions Act, 1991, supervises the administration of the drug or other substance to the resident in the home;
Inspection Finding There is no member of a College, as defined in the Regulated Health Professions Act, 1991, supervising the administration of medication to residents of the home.
Outcome Licensee must take corrective action to achieve compliance.

NOTICE

The Final Inspection Report is being provided to the Licensee, the Registrar of the Retirement Homes Regulatory Authority (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 Public Register, available online at http://rhra.ca/en/register/

Signature of Inspector	Date
Caine Gadde	September 24, 2018