Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 12, 2014	2014_333577_0007	S-000203-14	Resident Quality Inspection

Licensee/Titulaire de permis

ATIKOKAN GENERAL HOSPITAL
120 DOROTHY STREET ATIKOKAN ON P0T 1C0

Long-Term Care Home/Foyer de soins de longue durée

ATIKOKAN GENERAL HOSPITAL
120 DOROTHY STREET ATIKOKAN ON P0T 1C0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

DEBBIE WARPULA (577), KARI WEAVER (534)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 20, 21, 22, 23, 26, 27, 28, 29, 30, 2014

During the course of the inspection, the inspector(s) spoke with Chief Nursing Officer (CNO), Patient Care Facilitator, RAI Coordinator, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides (DA), Dietary Staff, Housekeeping Staff, Maintenance Staff, Pharmacy Staff, Pharmacist, Family Members and Residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **15 WN(s)**
- **7 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. Inspector #534 was reviewing the care plan for resident #165 that had been recently

updated. The care plan outlined that the resident was to receive oral care assistance from the staff twice daily. The care plan further outlined "mouth care standard in effect to include cleaning of teeth/dentures after each meal, rinsing mouth and checking for any obvious deterioration of teeth and gums". Staff #S-008 was asked by the inspector to explain the type of assistance that the resident required for oral care. They stated that the resident received assistance with twice daily oral care (morning and bedtime) and was able to brush their teeth once set-up, but needed constant cueing to compete oral care due to the resident’s memory impairment. When asked if the resident was assisted with mouth rinsing after meals, staff #S-008 stated no. The inspector explained that this intervention was in the resident’s care plan. Staff #S-008 was not aware of this intervention for this resident. The inspector had previous conversations with staff in the home about access to latest care plans and had been told by staff #S-001 & #S-014 that due to changes in computer programming, staff did not have access to the latest care plans. Currently, staff can only access the residents’ old care plans. No other methods for accessing current care plans was being implemented within the home at the time of inspection.

The licensee failed to shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident’s plan of care and have convenient and immediate access to it. [s. 6. (8)]

2. Inspector #577 found through staff interview with Staff #S-020, that they do not have computer access to resident care plans. It was reported they do not read any care plans and will ask co-workers questions about resident care information. It was further identified that staff do not have access to current paper and electronic care plans. The Licensee failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident’s plan of care and have convenient and immediate access to it. [s. 6. (8)]

3. Inspector #534 reviewed the care plan for resident #607 and asked staff #S-008 about the oral care assistance that staff provided for the resident. The care plan outlined that the resident was to receive oral care assistance from the staff daily that included mouth care, denture rinsing after each meal, and inspection for “obvious deterioration of teeth and gums”. Staff #S-008 stated that the resident was assisted with oral care twice daily and was in the process of having teeth extracted. They stated they were unaware of any interventions related to denture rinsing after meals and that would only be done immediately after extractions.

The inspector had previous conversations with staff in the home about access to the latest care plans and had been told by staff #S-001 & #S-014 that due to changes in computer programming, staff did not have access to the latest care plans. Currently, staff can only access the residents' old care plans. No other methods for accessing current care plans were being implemented within the home at this time.

The licensee failed to shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. [s. 6. (8)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Inspector #534 observed multiple instances of lack of dignity and privacy while being provided care for residents by staff #S-003. The staff member was noted to be clipping the finger nails of resident #161 while sitting on the resident couches in the home's main corridor in front of main dining room. Other staff and residents were present at the time.

On the same day at a later time, inspector #534 was walking down a hallway and noted the same staff member (# 003) providing nail care to resident #177 while the resident was in their bed. This resident shared a room with 3 other people. The door to the room was open and no privacy curtains were pulled while staff member trimmed resident's fingernails. The resident's roommates were noted to be in the room at the time.

The inspector interviewed the staff member shortly after the observations and asked the staff member about the home's expectations for providing resident care and promoting privacy and dignity. Staff #003 stated they would provide care in an environment that would be the most comfortable for the resident, for example in their room and would pull the privacy curtains closed. The staff member stated they did not think providing nail care was something that required privacy.

Approximately 25 minutes later, inspector observed staff #003 administer an insulin injection to resident #163 at the nursing station in front of the 2 inspectors, 2 residents, and 1 other staff member. Inspector #534 asked staff #S-003 about the home's expectations on injection administration within the home and privacy. The staff member stated that the only place where they had been instructed to not administer resident injections was in the dining room.

The inspector asked staff #S-001 about the home's policy on administering insulin injections to residents and maintaining privacy and dignity. Staff #S-001 stated many staff bring residents into the chapel to provide privacy, and has noted some staff administering injections outside the dining room in the common area, but insulin injections are not administered in the dining room. [s. 3. (1) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. Inspector #534 had observed that at least 3 different types of beds were currently being used within the home. Large gaps existed between the areas where the upper and lower side rails met mid bed and where the top and bottom mattress edge met the head and foot boards. These gaps were confirmed with staff #S-001. The inspector interviewed both staff #S-001 and #S- 003 regarding the homes assessment of residents’ bed systems. It was confirmed by both the staff members that the home could not provide evidence that residents' bed systems are evaluated in accordance with evidence-based practices or prevailing practices to minimize or prevent risk to residents, or that other safety issues related to rails are addressed.

The licensee failed to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. [s. 15. (1) (a)]

2. Inspector #577 made observations of residents #166 room and observed 2 quarter bed rails at head of bed in a raised position. Inspector reviewed residents electronic and paper care plan. Both care plans did not include any information on bed rail use. Inspector reviewed the MDS data for most current period and data did not include bed rail use or an evaluation of their bed system including use of rails.

The licensee has failed to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. Inspector # 534 was examining call bell function within the home and noted that multiple times during the inspection resident #162 did not have their call bell within reach despite staff being notified of the safety risk. The following observations were noted on

the following dates:

The call bell in the shared bathroom was missing its long red pull cord. The pull cord in place was approximately 2 inches long. The resident was unable to reach the call bell in the shared bathroom. In the resident's room, their call bell was noted to be attached to the upper left side rail that was against the wall. The side rail was in the down position and the bed comforter was draped over the lowered side rail covering the call bell. This call bell placement was observed on two particular days.

The inspector spoke with staff #S-010, #S-012, #S-005, and #S-001 regarding the home's expectation for call bell placement. They confirmed that the homes expectations were to ensure that the call bell was in reach for the resident.

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times; is available at each bed, toilet, bath and shower location used by residents; is available in every area accessible by residents. [s. 17. (1) (a)]

2. Inspector #534 was examining call bell function within the home and noted that resident #164's call bell was not available to the resident. The call bell was attached to the upper portion of the call bell cord where the cord came out of the wall, on the other side of the resident's bed. The call bell was not attached to an area where the resident could reach when in the room. Within the resident's shared bathroom, the bathroom call bell was missing its long red pull cord. The pull cord in place was approximately 2 inches long. The resident did not have a cord long enough to reach when in the bathroom.

The inspector spoke with staff #S-010, #S-012, #S-005, and #S-001 regarding the home's expectation for call bell placement. They confirmed that the homes expectations were to ensure that the call bell was in reach for the resident.

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times; is available at each bed, toilet, bath and shower location used by residents; is available in every area accessible by residents. [s. 17. (1) (a)]

3. Inspector #534 was examining call bell function within the home and noted that on two

particular days, the call bell for resident #165 was not placed in an area that the resident would be able to reach when in their room. The call bell was attached to the upper portion of the call bell cord where the cord came out of the wall, on the other side of the resident's bed.

The inspector spoke with staff #S-010, #S-012, #S-005, and #S-001 regarding the home's expectation for call bell placement. They confirmed that the homes expectations were to ensure that the call bell was in reach for the resident.

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times; is available at each bed, toilet, bath and shower location used by residents; is available in every area accessible by residents. [s. 17. (1) (a)]

4. Inspector # 534 noted that resident #172's call bell was attached to the far side rail of the resident's bed. When the resident was in the room sitting in their wheelchair the call bell was not accessible to the resident.

The inspector spoke with staff #S-010, #S-012, #S-005, and #S-001 regarding the home's expectation for call bell placement. They confirmed that the homes expectations were to ensure that the call bell was in reach for the resident.

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times; is available at each bed, toilet, bath and shower location used by residents; is available in every area accessible by residents. [s. 17. (1) (a)]

5. Inspector #577 observed the call light pull cord in a resident bathroom to be inaccessible and not within reach to a resident seated on the toilet. Approximate length of pull cord to be 2 inches long. The Licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, (a) can be easily seen, accessed and used by residents, staff and visitors at all times; [s. 17. (1) (a)]

6. The call bell in the shared bathroom for resident #607 was missing its long red pull cord. The pull cord in place was approximately 2 inches long. The resident was unable to reach the call bell in the shared bathroom. A few days later,the inspector noted that in

resident #607's room, their call bell was missing. A call bell type cord was noted to be lying on the floor at the head of the bed. The inspector asked staff #S-005 about the call bell cord lying on the floor,staff member moved the bed and it was determined that the cord was for the bed alarm system and that the resident did not have a call bell to use in the room.

The inspector spoke with staff #S-010, #S-012, #S-005, and #S-001 regarding the home's expectation for call bell placement. They confirmed that the homes expectations were to ensure that the call bell was in reach for the resident.

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times; is available at each bed, toilet, bath and shower location used by residents; is available in every area accessible by residents. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that, (a) can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. Resident #172 told inspector #534 that they were missing a few teeth and had not seen a dentist in a "couple of years". The inspector asked the resident if the home had offered them to see a dentist and they stated no. Staff #S-001 was asked by the inspector what the home's policy was for offering dental services. The staff member explained that dental services were not offered annually to residents in the home but that during a resident's annual review, the physician would perform a head to toe examination that included an oral exam.

During the remainder of the year if a resident presented with a dental problem then staff would contact the family to arrange for dental care. The staff member went on to say that in some cases if a resident had a dental problem then the resident would be able to see one of the dentists who had an office within the hospital complex.

The licensee failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. [s. 34. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. Inspector #534 noted multiple findings of unlabeled resident items when in the home during the inspection. In a semi-private shared bathroom were 2 wash basins propped up beside each other on the grab bars above the toilet and garbage can. The 1st basin was unlabeled and the 2nd one was labeled with black permanent marker with the name of a resident who lived down the hall and did not share that bathroom. Additionally, in the same bathroom were 2 unlabeled medicine cabinets containing various unlabeled resident care items. One cabinet contained 1 red used toothbrush, 1 yellow used comb, and 1 black used hair brush (sitting on top of the cabinet). The 2nd cabinet was empty with 1 black used hair brush sitting on top of the cabinet. One unlabeled blue denture cup was noted to be on the counter top surface beside the sink tap. Staff #S-004 confirmed the items were unlabeled in the shared bathroom and explained that the incorrectly labeled basin was due to someone using a permanent marker for the name and it was not removed during the basin's cleaning process.

In a 2nd bathroom shared by 4 residents was 1 unlabeled yellow plastic basket on a shelf. The basket contained 1 used disposable razor and 1 used used brown hair brush. On the grab bar above the toilet was 1 blue bedpan and 1 blue wash basin, both propped beside each other and unlabeled. Staff #S-004 confirmed that the items were unlabeled and stated they were not sure why the unlabeled bed pan was in the room since no residents in the room used a bed pan.

In a 2 person shared bathroom on the shelf beside the sink was 1 unlabeled, used electric razor.

In a 4 person shared bathroom medicine cabinet was 1 unlabeled blue toothbrush with visible toothpaste on the bristles. On a shelf beside cabinet was 1 visibly used, unlabeled, burgundy hairbrush.
In a 2nd shared bathroom for 2 residents, propped against the wall on the grab bar was 1 unlabeled, blue wash basin. On the counter top was 1 unlabeled flowered basket that contained 1 unlabeled used blue hair brush and multiple used, unlabeled hair combs. Staff #S-008 confirmed the unlabeled items and explained that the unlabeled basket belonged to the resident whose medicine cabinet the basket was the closest to. Both of the medicine cabinets were unlabeled and it was not clear to the inspector who the items belonged to. Inspector noted that many of the used, unlabeled personal items, required cleaning.

The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labeled within 48 hours of admission and of acquiring, in the case of new items; and (b) cleaned as required. [s. 37. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labeled within 48 hours of admission and of acquiring, in the case of new items; and (b) cleaned as required, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. Inspector #577 examined the medication cart in the medication room. Inspector found medications that were not labeled with residents names.

The Licensee failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. [s. 126.]

2. Inspector #577 inspected the unit medication cart. Inspector discovered 4 bottles of medication not labeled with residents full name. Residents first name only was written with black ink. Various prescribed eye drops had residents first name written in black ink and a bottle of oral medication had a residents first name written in black ink on the cap. Inspector spoke with staff member #S-021 in pharmacy, who reports that medication sprays and drops should be labeled with Atikokan pharmacy labels. Inspector spoke with pharmacist at Atikokan pharmacy, who confirms that medication sprays and eye drops should be affixed with a pharmacy label.

The licensee has failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. [s. 126.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. During the tour of the home, inspector #534 found in a bathroom shared by 4 residents, accessible prescription and non-prescription creams stored in 1 unlabeled plastic yellow bin.

The licensee failed to ensure that, (a) drugs are stored in an area or a medication cart, (i) that is used exclusively for drugs and drug-related supplies, and (ii) that is secure and locked. [s. 129. (1) (a)]

2. Inspector #577 discovered expired medication in the medication cart. Inspector found an inhaler dated November 2013, two prescription creams dated September 2013 and October 2013. Inspector spoke with staff member #S-021 in hospital pharmacy and pharmacist at Atikokan pharmacy. Both confirm that Atikokan pharmacy should be putting expiry dates on prescribed creams labeled from pharmacy. Inspector gave expired medication to staff member #S-022 for disposal.

The licensee has failed to ensure that (a) drugs are stored in an area or a medication cart (iv) that complies with manufacturer's instructions for the storage of the drugs. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that (a) drugs are stored in an area or a medication cart, (i) that is used exclusively for drugs and drug-related supplies, (ii) that is secure and locked, and (iv) that complies with manufacturer's instructions for the storage of the drugs,, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. Resident #176 asked if they could speak to inspector #534 about the toileting program the home had the resident on. The resident stated they were on scheduled toileting times. The resident reported when they rang for toileting assistance to have a bowel movement, some staff told the resident they had to wait for the scheduled toileting time. The resident was unable to toilet themselves due to their visual impairment and was dependent on the staff for toileting. The resident explained they often experienced cramps from "holding it" and was incontinent of feces at times. The resident stated "it's very degrading to poop your pants". They reported some staff did not react well to the resident's incontinence episodes and reported staff stating "you should have held it".

During the inspection it was reported to the inspector that the home had difficulties with resident #176's behavior related to frequent ringing of their call bell for toileting assistance. Documentation supporting this was also noted in the resident's chart. It was reported that when the resident asked for assistance, they did successfully use the toilet and other times not. Staff reported the resident to ring their call bell approximately every 10 minutes. The inspector reviewed the multidisciplinary and physician progress notes, resident's care plan, bowel and bladder incontinence assessment records, assessments completed by Community Counseling Services and Psycho-geriatric Resource Consultant Consultation Summary, Quarterly Continence Assessment tool, and behavior documentation sheet used for the resident. In addition, the inspector did see a note on the resident's bulletin board that stated: "We have implemented a toileting routine for the times are as follows 0800 1030 1230 1430 1630 1830 2100. Please adhere to these times in attempts to retrain their bladder." The same note was also located in the front of PSW bath binder.
Staff were observed to not follow the toileting times outlined by the home for the resident. The inspector interviewed staff #S-001, #S-009, and #S-003 about the bladder retraining program and was told multiple times that the resident's attention seeking behavior had improved since bladder retraining was implemented. Specifically, staff #S-003 told inspector that the purpose for the scheduled toileting times was for behavior management and not for continence care. The inspector could not locate a continence assessment of bowel patterns and noted that "voiding" had been monitored on a behavior documentation form.

The licensee failed to ensure that, (b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented. [s. 51. (2) (b)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. Inspector #577 met with the Patient Care Facilitator, who reports that the Home does not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

The Licensee has failed within 10 days of receiving advice, to respond to the Residents' Council in writing. [s. 57. (2)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. During the entrance conference with staff #S-001, it was reported that the home did not have a Family Council in place. Staff #S-002 confirmed this with the inspector and further clarified that home offers annually, not semi-annually to the family members and persons of importance to the residents of their right to establish a Family Council.

The licensee has failed to ensure that if there is no Family Council, the licensee shall, (b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. [s. 59. (7) (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise. O. Reg. 79/10, s. 73 (1).
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).
7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. During the supper meal, inspector #534 noted that a few residents were receiving their supper meal in their rooms. The inspector made note of the times that the resident #169 was brought their supper tray and made notes on how the resident was monitored while eating in their room.
On a certain evening at 1706 h, inspector observed the supper tray for resident #169 prepared in main dining room and delivered to the residents room. At 1720 h, the resident's supper tray was noted on their bedside table, covered, and untouched. The resident was lying in their bed in fetal position with their eyes closed. At 1722 h, staff #S-010, entered into residents # 169 room and told the resident their supper tray was there. At 1739 h, the inspector spoke with the resident and asked about the quality of the food. The resident stated the food was good. At 1740 h, staff #S-010 and #S-009 were noted to be in hairdressing salon room at the end of the hallway, having their break. The 2 remaining staff on the unit were in the dining room with residents. Staff #S-014 was administering medications and staff #S-004 was monitoring resident's eating supper. No staff were noted to be available to monitor residents eating in their rooms. At 1756 h, residents eating in their rooms still not checked on by any staff. At 1757 h, staff #S-014 entered into residents #169 room to remove the supper tray.

The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the following element: monitoring of all residents during meals. [s. 73. (1)]

2. During a dining observation, Inspector #577 could not find a posting of resident's weekly menu. Inspector spoke with staff members #S-025 and #S-026 and both confirm that only daily menu's are posted for residents. Inspector did not see staff communicating menu items to each resident.

The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 1. Communication of the seven-day and daily menus to residents. [s. 73. (1) 1.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. Through resident interviews, Inspector #577 identified 3 residents were missing clothing items. Specifically, a missing shirt and 4 pairs of pants belonging to resident #169, a few shirts belonging to resident #172 and 2 pairs of pants belonging to resident #173. Inspector reviewed charts on 3 residents and could not find any record of missing laundry belonging to residents. Inspector spoke with staff member #S-024, who reports that laundry is delivered to unit on Tuesday and Thursday. They report that if laundry is missing for a resident, they would search on the active side, but no specific documentation is recorded. It was also reported they are not aware of any specific process or policy to follow for missing laundry, but believes an incident report is filled out. Inspector spoke with staff member #S-022, who reports they would search on the unit for specific missing clothing, call laundry, and search on the active side. Staff #S-022 reported there isn't any specific documentation or process to follow for missing laundry. Inspector spoke with Patient Care Coordinator and they report that the process for staff to follow for missing laundry involves conducting a search on the unit and calling the laundry department.

The licensee failed to ensure that (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure (a) procedures are developed and implemented to ensure that, (iv) there is a process to report and locate residents' lost clothing and personal items; [s. 89. (1) (a) (iv)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. On a certain evening, inspector #534 had gone into residents #351 room. The resident was not in the room at the time. On the bedside table for the resident was a clear medicine cup that contained 1 beige round pill. The inspector immediately found the nurse on duty and confirmed with staff #S-014 that there was medication at the resident's bedside. The staff member stated they thought the pill was the resident's vitamin pill. The inspector asked if the medication was from the day shift and staff #S-014 stated "I do not want to say", took the medication cup containing the pill and walked away.

At 1735 pm, staff #S-014 approached inspector #534 and told them that the medication found at the resident's bedside was their 1600 vitamin pill. Staff #S-014 reported to the inspector that they thought the resident had returned to their room and spit the pill out into the medication cup after the staff member had administered the medication to the resident.

The inspector further clarified with staff #S-001, that resident #351 does not have an order to have oral medications left at the bedside and to self-administer.

The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. [s. 131. (5)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. Inspector #577 observed staff member #S-023 performing medication passes. Inspector observed staff member not wash their hands prior to administering an oral medication to resident #161, and upon exiting residents #163 room after administering insulin. Inspector spoke with staff member about Home's expectation concerning hand washing at point of care. Staff #S-023 reported they washed their hands in medication room and not sure about Home's expectation. They added they don't know how they would wash their hands prior to entering room with items in their hands. Inspector spoke with Patient Care Facilitator about Homes expectation on hand washing and point of care. It was reported the home's expectation on hand hygiene is that staff would be washing their hands prior to entering room, and upon exiting residents room, including performing any care and giving medication. Additionally, it was reported to the inspector that hand wash dispenser's are located outside every resident's room.

The licensee failed to ensure that all staff participate in the implementation of the program. [s. 229. (4)]

2. Inspector #534 reviewed the immunization records for 3 residents within the home and found that resident #176 had a consent form signed within the chart for the pneumococcal vaccine but was unable to determine when the vaccine had been administered to the resident. Upon consultation with staff #S-001 it was determined that no documentation was found indicating that the vaccine had been given and was administered while the inspectors were in the home.

The licensee failed to ensure that the residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 3.]

Issued on this 14th day of November, 2014

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBBIE WARPULA (577), KARI WEAVER (534)
Inspection No. / No de l'inspection :	2014_333577_0007
Log No. / Registre no:	S-000203-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 12, 2014
Licensee / Titulaire de permis :	ATIKOKAN GENERAL HOSPITAL 120 DOROTHY STREET, ATIKOKAN, ON, P0T-1C0
LTC Home / Foyer de SLD :	ATIKOKAN GENERAL HOSPITAL 120 DOROTHY STREET, ATIKOKAN, ON, P0T-1C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Doug Moynihan

To ATIKOKAN GENERAL HOSPITAL, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Order / Ordre :

The licensee shall ensure compliance with LTCHA, 2007 S.O. 2007, c.8, s. 6 (8), whereby staff and others who provide direct care to a resident, specifically residents #607 and resident #165, are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Grounds / Motifs :

1. Inspector #534 reviewed the care plan for resident #607 and asked staff #S-008 about the oral care assistance that staff provided for the resident. The care plan outlined that the resident was to receive oral care assistance from the staff daily that included mouth care, denture rinsing after each meal, and inspection for "obvious deterioration of teeth and gums". Staff #S-008 stated that the resident was assisted with oral care twice daily and was in the process of having teeth extracted. They stated they were unaware of any interventions related to denture rinsing after meals and that would only be done immediately after extractions.

The inspector had previous conversations with staff in the home about access to the latest care plans and had been told by staff #S-001 & #S-014 that due to changes in computer programming, staff did not have access to the latest care plans. Currently, staff can only access the residents' old care plans. No other methods for accessing current care plans were being implemented within the home at the time of the inspection.

The licensee failed to shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

(534)

2. Inspector #577 found through a staff interview with staff member #S-020, that they do not have computer access to resident care plans. It was reported they do not read any care plans and will ask their co-workers questions about resident care information. It was further identified that staff do not have access to current paper and electronic care plans.
The Licensee failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. (577)

3. Inspector #534 was reviewing the care plan for resident #165 that had been recently updated. The care plan outlined that the resident was to receive oral care assistance from the staff twice daily. The care plan further outlined "mouth care standard in effect to include cleaning of teeth/dentures after each meal, rinsing mouth and checking for any obvious deterioration of teeth and gums". Staff #S-008 was asked by the inspector to explain the type of assistance that the resident required for oral care. They stated that the resident received assistance with twice daily oral care (morning and bedtime) and was able to brush their teeth once set-up, but needed constant cueing to complete oral care due to the resident's memory impairment. When asked if the resident was assisted with mouth rinsing after meals, staff #S-008 stated no. The inspector explained that this intervention was in the resident's care plan. Staff #S-008 was not aware of this intervention for this resident. The inspector had previous conversations with staff in the home about access to latest care plans and had been told by staff #S-001 & #S-014 that due to changes in computer programming, staff did not have access to the latest care plans. Currently, staff can only access the residents' old care plans. No other methods for accessing current care plans were being implemented within the home at the time of the inspection.

The licensee failed to shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.
(534)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 05, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 12th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

Service Area Office /
Bureau régional de services : Sudbury Service Area Office