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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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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
Apr 21, 2016	2016_301561_0003-A1	002314-16	Resident Quality Inspection

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

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

LEISUREWORLD CAREGIVING CENTRE - STREETSVILLE
1742 BRISTOL ROAD WEST MISSISSAUGA ON L5M 1X9

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

DARIA TRZOS (561), MICHELLE WARRENER (107), NATASHA JONES (591), SAMANTHA DIPIERO (619)

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): February 4, 5, 8-12, 16-19, 22, 2016

The following inspection were completed concurrently with the Resident Quality Inspection (RQI):

Critical Incident Inspections:
010196-15 - fall with an injury,
013757-15 - resident to resident abuse,
033372-15 - fall with an injury,
017140-15 - injury of an unknown origin
023540-15 - alleged staff to resident abuse

Complaint inspections:
009517-15- failure to notify next of kin of resident transfer to hospital

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Office Manager, Environmental Services Manager (ESM), Director of Dietary Services, Director of Resident Programs and Admissions, RAI Coordinator/Rehab Coordinator, Resident Relations Coordinator (RRC), Registered Dietitian, Physiotherapist, Registered staff including Registered Nurses (RN) and Registered Practical Nurses (RPN), Personal Support Workers, (PSW), Dietary Aides, Housekeeping/Laundry staff , Maintenance staff, Presidents of Resident and Family Councils, residents and families.

During the course of the inspection, the inspectors toured the home, observed the provision of care, observed the meal service, reviewed health care records, reviewed relevant policies, procedures and practices, laundry, maintenance and housekeeping practices, and food production systems, interviewed residents, family members and staff.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Trust Accounts

During the course of this inspection, Non-Compliances were issued.

15 WN(s)
8 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) 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 when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #002 set out clear directions to staff and others who provided direct care to the resident in relation to bed rails.

The plan of care required two half assist rails while in bed; however, also directed staff to put one bed rail up when the resident was in bed. Registered staff #116 and #118 confirmed the plan of care was unclear in relation to the requirement for bed rails and in relation to the terminology being used. Not all staff were using the same terminology to describe the bed rails being used when interviewed by the LTC Inspector. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care for resident #025 set out clear directions to staff and others who provided direct care to the resident in relation to their

nutritional supplement.

The resident had a reduction in their nutritional supplement on an identified date in 2015, from three times daily to once daily. The resident's care plan was updated to include a nutritional supplement once daily; however, the Point of Care (POC) documentation system was not updated to reflect once daily versus three times daily administration of the nutrition supplement. The Director of Dietary Services confirmed that the nutritional supplement was being sent on the snack cart only once daily. It was unclear when reviewing the documentation in the POC system if the resident was receiving a nutritional supplement three times daily or only once daily (as per the plan of care).

The resident's plan of care did not provide clear direction to staff in relation to timing of the resident's nutritional supplement (once daily versus three times daily). [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

A) The written plan of care for resident #015 indicated that resident required one to two staff assist for personal hygiene and oral care twice daily and as needed (PRN). Interview with PSW #124 revealed that resident had a specific routine in the morning for oral care.
The written plan of care did not include the specific routine as indicated by the PSW.
The written plan of care was not based on resident's needs and specific preferences in the morning routine for oral hygiene.(561)

B) Observations of resident #034 throughout the inspection revealed the resident had one quarter bed rail engaged and one disengaged. The resident was observed to get in and out of the bed independently and did not use bed rails for assistance with transfers or bed mobility.

Review of the resident’s most recent Minimum Data Set (MDS) assessment indicated that bed rails were used for mobility or transfer. The most recent written plan of care indicated that two side rails were up while in bed to assist with bed mobility and getting in and out of bed. The "Falls Prevention Program - Falls Prevention/Restraint Reduction Committee Minutes" revealed resident #034 was not listed as one who “used bed rails for

comfort and sense of security” or “not using bed rails”.

An interview with resident #034 revealed that they keep one half bed rail up during the day and the other was kept down. The resident stated they did not use the rails for bed mobility or transfer assistance as they were independent, and they put both rails up at night when sleeping for comfort.

An interview with PSW #125 revealed that resident #034 used only one bed rail. An interview with RPN #114 revealed that resident #034 used two half rails. The staff stated that the last quarterly assessment indicated resident was independent with bed mobility.

An interview with the DOC revealed that the use of bed rails would depend on the resident’s assessed need and their written plan of care should be updated to reflect the resident’s assessed needs. [s. 6. (2)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The plan of care for resident #042 indicated that the resident was at high risk for falls and required assistance with toileting. Resident was placed on a toileting program for a time period in 2014 as most of the falls occurred while resident was attempting to toilet independently. The home had also implemented a falls intervention to alert the staff when resident was getting up.
On an identified date in 2015, the resident sustained a fall in their room. The fall resulted in an injury and transfer to the hospital. Resident's health condition had deteriorated after the fall.

Interview with staff confirmed that the device was not on at the time of the fall. Health care records were reviewed and there was no documentation stating that the device was applied at the time of the fall.

The care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Resident #009 had a specific intervention related to chronic medical condition. On an identified date in 2015, resident was on a specific medical treatment for an acute condition. The progress notes indicated that when the treatment was completed resident continued to display signs and symptoms but did not receive an assessment and there was no documentation related to the identified intervention. On two different days in 2015, after initial treatment, resident received pain medication as they continued to have symptoms of the acute condition; there was no documentation of resident's assessment. Furthermore, an assessment was completed and the resident was seen by the Nurse Practitioner (NP). The NP notes indicated that the resident's symptoms had become worse. The resident received treatment the same day and more tests were ordered. Post NP's assessment resident's condition had deteriorated and was transferred to hospital for treatment.

An interview with RN #126 indicated that the resident should have been reassessed when displaying signs and symptoms of the acute condition.

An interview with the DOC confirmed that reassessment did not take place until the resident's symptoms had increased and confirmed that registered staff should have completed further assessment of the resident when they continued to complain of symptoms.
The resident was not reassessed and the plan of care reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 plan of care sets out clear directions to staff and others who provide direct care to the resident, to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, and to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Falls Prevention policy, protocol, procedure, put in place was complied with.

A) The home's policy titled "Falls Prevention", policy number VII-G-30.00, revised January 2015, indicated that "Registered Staff or designate will:
1. Complete the Falls Risk Assessment in the electronic documentation system at the following times:
-within 24 hours of admission or re-admission
-as triggered by the MDS Resident Assessment Protocol

-a significant change in status, i.e. when there is a physiological, functional, or cognitive change in status”

Resident #042 sustained a number of falls in 2014 and 2015. The health records were reviewed and indicated that the resident had triggered for falls by Minimum Data Set (MDS) Resident Assessment Protocol on a specific date in 2014 and 2015. There were no Fall Risk Assessments completed after the falls had triggered by MDS. The interview with the ADOC indicated that the home did not have a specific tool for assessing the risk for falls before October 2015 and that the Physiotherapist had completed them in progress notes. The interview with the Physiotherapist confirmed that it was their responsibility to assess the risk for falls but only for residents that were on the Physiotherapy program. The last Fall Risk Assessment was done for resident #042 in January 2014 as per progress notes. The home’s fall prevention policy was not complied with.

B) The home’s policy called Head Injury Routine, policy number VII-G-10.40, revised March 2013 and January 2015, indicated that the “Head Injury Routine (HIR) will be initiated on any resident who has sustained or is suspected of sustaining a head injury; and after any un-witnessed resident fall.”

The resident #042’s health records were reviewed and indicated that the resident had two un-witnessed falls. The HIR was not initiated after these falls occurred. RN #127 stated that HIR does not need to be initiated if a resident is cognitive and if resident indicates that they did not hit their head. The interview with the ADOC confirmed that the home’s policy is to initiate HIR after any un-witnessed falls. The staff did not comply with the home’s HIR policy after resident #042 sustained two un-witnessed falls. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's Missing Resident Laundry policy, protocol, procedure, put in place was complied with.

Review of the homes policy titled “Missing Resident Laundry – Laundry”, policy number XII-I-20.40, revised September 2015, stated the PSW should ensure that the Missing laundry form was made readily available to residents/families, assist the resident/family to complete the form when an item was reported missing, conduct a search, and report the lost item by forwarding the form to laundry staff if the item was not found. The Environmental Services Manager (ESM) would return a copy of the completed Missing Laundry Form to the Executive Director (ED).

Interview with Resident #034 revealed several items were reported to staff and to the ESM as missing but not found. The resident stated that they had not been given or assisted to complete a "Missing Laundry" form.

Interview with PSW #108 revealed they were not aware of, nor had they ever completed a "Missing Laundry" form when resident laundry had gone missing.

Interview with registered staff #114 revealed when a resident or family member reported a missing laundry item, the PSW would search for it and if it could not be found, report it to the registered staff who would send an email to all staff about the missing item and document it in the resident's progress notes. During shift change report, the registered staff would pass the message to the next shift staff so that they too would search for the missing clothing. There was a board outside the laundry room for staff and family members to write down the missing item. The PSW and registered staff did not complete the form as it was the Charge Nurse's responsibility.

Interview with the ESM confirmed that resident #034 reported the missing items to them, a search was conducted and the items could not be found. They also stated that they did not complete, assist the resident to complete or receive from the staff or the resident a "Missing Laundry Form". The ESM stated that the PSW staff were expected to search for any reported missing items, and if they were unable to find them, report it to the nurse in charge who would complete the "Missing Laundry" form. The form would then be brought to the ESM as well as the laundry staff who would also assist to find the item. The ESM confirmed that the PSWs did not complete the form but it was the expectation that all staff completed the form as per the above mentioned policy. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Review of Critical Incident report submitted in 2015 indicated that an alleged abuse by PSW #137 to resident #026 had occurred and was witnessed and reported by registered staff #136.

Review of the homes video tape which recorded the incident confirmed the abuse. RPN #136 witnessed the incident and did not intervene.

Review of the home's investigation notes confirmed the alleged staff to resident abuse.

The licensee failed to ensure that the resident was protected from abuse. [s. 19. (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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

Review of policy titled “Prevention of Abuse & Neglect of a Resident”, policy number V11-G-10.00, revised January 2015, indicated “All employees, volunteer, agency staff, private duty caregivers, contracted service providers, residents and families are required to immediately report any suspected or known incident of abuse or neglect to the Director of MOHLTC and the Executive Director/Administrator or designate in charge of the home” and “If any employee or volunteer witnesses an incident, or has any knowledge of an incident, that constitutes resident abuse or neglect; all staff are responsible to immediately take these steps: 1) stop the abusive situation and intervene immediately if safe for them to do so while ensuring the safety of the resident, 2) remove resident from the abuser, or if that is not possible, remove the abuser form the resident if safe for them to do so while ensuring the safety of the resident, 3) immediately inform the Executive Director (ED)/Administrator and/or Charge nurse in the home” and “The Charge Nurse will 2) provide support to the staff member reporting , in immediately reporting any of the following to the (MOHLTC) Director (with ED/Administrator or designate, if available) ….Improper or incompetent care of a resident that resulted in harm or a risk of harm to the resident a) abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident”.

Review of the homes video tape which recorded the incident confirmed staff to resident abuse. RPN #136 witnessed the incident but did not take any immediate action.

An interview with the ED and the RCC revealed that RPN #137 reported the incident to the charge nurse and the ADOC the day of the incident, but the incident was not immediately reported to the Director. Two days after the incident, the RPN reported the incident to the Ministry Director. The ED confirmed that the abuse was not immediately reported to the Director as per the above mentioned policy and RPN #137 did not follow the steps outlined in the policy to ensure the resident's safety. [s. 20. (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 there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that they had written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee dealt with complaints.

Record review of policy titled “Complaints – Response Guidelines”, policy number VI-G-10.00, revised January 2015, revealed that the policy does not include the following requirements:

1) Every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with (as per the act and regulations)
2) The complaint (verbal or written) shall be investigated and resolved where possible and a response provided within 10 business days of the receipt of the complaint and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately
3) Ensure that a documented record is kept in the home that includes the nature of each verbal or written complaint
4) A response shall be made to the person who made the complaint indicating i) what the licensee has done to resolve the complaint OR ii)that the licensee believes the complaint to be unfounded and the reason for the belief
5) For verbal complaints that the licensee is able to resolve within 24 hours of the complaint being received, a documented record of the complaint is not required to be kept in the home
6) Receipt of written complaints with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant
7) Written complaints concerning the care of a resident or the operation of the long term care home shall be immediately forwarded to the Director

Review of an email written by the ED to the Vice President of Operations stated that the above mentioned policy did not comply with the regulations.
Interview with the ED confirmed that the above mentioned policy did not comply with the regulations but was under revision. [s. 21.]

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 they have written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Interviews with resident #034 revealed that they would prefer to have a bath twice weekly but was unable due to staffing and had been instructed by staff that they could have only one bath weekly when they requested two baths per week. The resident stated that they had been permitted to have an extra shower once a week during the evening shift if they wish. The resident confirmed that they have one bath and one shower weekly.

Interview with PSW #125 revealed the residents had one bath and one shower every week. If they wanted a bath on shower day, they could get a bed bath, but could not have two tub baths per week. Residents who do not want a bath could have two showers. Resident #034's care plan indicated that the resident had one bath and one shower weekly.

Interview with RPN #116 revealed the residents had a choice that if they did not wish to have a tub bath, they could have two showers weekly and no bath. Otherwise, the residents all have one bath and one shower every week. A bathing schedule was posted at the station. Resident #034 had a bath and a shower weekly and sometimes received an extra shower during the week at their request.

Interview with the DOC revealed the home had one tub room that required two staff at all times during all tub baths for resident safety. Residents were informed on admission that they could have one bath and one shower. The DOC also stated there were several shower rooms but only one functioning tub room in the home. A former tub room had been converted to an office and another tub room was used as a supply room. The DOC confirmed the residents had one tub bath and one shower weekly, and could not have two tub baths weekly if they preferred due to staffing constraints, safety concerns with transfers in and out of the tub, and building restrictions which included only one functioning tub.

The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice. [s. 33. (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 the resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response in writing within 10 days of receiving Family Council advice related to concerns or recommendations was provided.

Review of the Family Council meeting minutes for several months in 2015 confirmed that the Council had raised concerns, and documentation of responses to the concerns could not be located.

An interview with the Family Council President revealed that concerns, including laundry service which had been raised in several meetings and communicated with the home’s staff representative to the Council were not responded to in writing. Interviews with the Resident Relations Coordinator (RRC) who is the staff representative to the Family Council and the ED confirmed that the home did not respond in writing within 10 days related to Family Council concerns or recommendations. [s. 60. (2)]

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 response in writing within 10 days of receiving Family Council advice related to concerns or recommendations is provided, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of resident and the duty to make mandatory reports under section 24.

Interviews with registered staff #102 and PSW #128 indicated they could not recall having received retraining on the abuse policy or the duty to make mandatory reports. The PSW also indicated that they did not know what "whistle-blowing protection" was.

The LTC Inspector requested printed copies of all of the materials provided to staff for mandatory retraining. The home provided printed copies of the following modules titled: "Abuse and Neglect – its your Business – by SWF", "Resident Rights", and "Customer Service in Senior Care". A review of these documents did not include the home's policy to promote zero tolerance of abuse and neglect of residents, or the duty to make mandatory reports under section 24.

Interview with the Education Lead and former Education Lead confirmed that the home's policy to promote zero tolerance of abuse and neglect of residents, and the duty to make mandatory reports under section 24 were not included in the mandatory annual retraining on-line modules provided in 2015 to staff. [s. 76. (4)]

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 all staff receive retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of resident and the duty to make mandatory reports under section 24, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Review of Critical Incident report indicated that an alleged staff to resident abuse had occurred on an identified date in 2015, and was witnessed. The incident as per the report was not immediately reported to the Director.

Review of the homes investigation notes indicated RPN #136 reported the incident to the charge nurse on the day of the incident, who then notified management. Management did not notify the Director.

An interview with the ED and the RCC revealed that RPN #137 reported the incident to the charge nurse the day of the incident, but the incident was not immediately reported to the Director. It was their understanding that the person who witnessed the abuse was responsible to report it. Two days later, the RPN was instructed to and did report the incident to the Director. The ED confirmed that the alleged abuse was not immediately reported to the Director. [s. 24. (1)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Personal Assistance Service Devices policy was complied with.

The home’s policy titled "Personal Assistance Service Devices (PASD's)”, policy number VII-E- 10.10, indicated “all registered staff will document decision to use PASD in resident’s record and include rationale for use; Update care plan with the interventions and monitoring of PASD, evaluate use of PASD’s quarterly and any other time when a PASD is no longer required based on resident’s condition or circumstance; annual renewal of the consent by the resident/POA approval to the use of the PASD is required”.

Observations of resident #034 throughout the inspection revealed the resident had one quarter bed rail engaged and one disengaged. The resident was observed to get in and out of the bed independently and did not use rails for assistance with transfers or bed mobility. The resident ambulated independently without the use of gait aids.

Review of the resident’s most recent MDS assessment indicated that bed rails were used for mobility or transfer. The most recent written plan of care indicated that two side rails were up while in bed to assist with bed mobility and getting in and out of bed. The "Falls Prevention Program - Falls Prevention/Restraint Reduction Committee Minutes" revealed resident #034 was not listed as one who “used bed rails for comfort and sense of security” or “not using bedrails”.

An interview with resident #034 revealed that they keep one half rail up during the day and the other was kept down. The resident stated they did not use the rails for bed mobility or transfer assistance as they were independent, and they put both rails up at night when sleeping for comfort.

An interview with PSW #125 revealed that resident #034 used only one bed rail. An interview with RPN #114 revealed that resident #034 used two half rails. The staff stated that they conducted a quarterly assessment which indicated resident #034's was independent with bed mobility.

The DOC confirmed a reassessment of rails for every resident is conducted monthly during the Falls prevention and restraint reduction committee meeting and further, if resident #034 was assessed as no longer wanting or needing the rails, they should be disengaged and their written plan of care updated. The DOC confirmed the policy was not complied with. [s. 29. (1) (b)]

WN #11: 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. The licensee has failed to ensure that resident #005 received the required level of assistance with oral care to maintain the integrity of the oral tissue, as per the resident's plan of care.

Resident #005 had a plan of care that directed staff to provide one staff assist with hygiene and oral care twice daily and as needed.

The resident was observed with significant mouth debris around the gum line and mouth odour on two different occasions during the inspection. Staff had signed that oral hygiene was provided just prior observation.

During interview, PSW #136 stated that the resident required only set up help with oral hygiene and would brush their own teeth with intermittent supervision.

The resident was not provided with the level of assistance required on their plan of care in relation to oral hygiene and was observed with poor oral hygiene and mouth odour during this inspection. [s. 34. (1) (b)]

WN #12: 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,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005 who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

The home's policy titled "Continence Program - Guidelines for Care", policy number VII-D-10.00, revised January 2015, directed staff to obtain information about the resident's bowel and bladder routine, identify contributing factors to incontinence, reference the bladder and bowel assessment and implement bowel protocol as per physician's order upon admission, annually, and when there was a significant change in condition that impacted bladder and bowel functioning. The ED and DOC confirmed that staff were to use the home's "Bowel and Bladder Continence Assessment" on Point Click Care to document continence assessments and that they were to be completed on admission, annually, and when there was a change in the resident's condition affecting bowel and bladder continence.

Resident #005 had a decline in bowel continence between October 2015 and January 2016 identified on the RAI-MDS assessment coding. An assessment was not completed using the standardized continence assessment tool in Point Click Care (PCC) after the decline in bowel continence was identified. The RN #129 stated that a continence assessment was completed using the standardized form in the fall of 2015; however, documentation was not available to support that the assessment was completed at that time. The RN confirmed that a continence assessment using the standardized assessment form was not completed with the resident's decline in bowel continence identified in January 2016. [s. 51. (2) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids were served using methods that preserved taste, appearance, and food quality at the observed lunch meal February 4, 2016.

A) Resident #047 required a specific texture menu at meals. PSW #107, who was assisting the resident with eating, was mixing the resident's foods together on the plate. The PSW stated the resident did not like the texture of the bread so they were mixing it together to change the taste of the food. The resident was unable to voice their preference to the LTC Inspector. The resident did not have a plan of care instructing staff to mix the resident's foods together and the resident had not asked staff to mix their foods together. The Director of Dietary Services confirmed that staff were not to mix texture modified foods together unless the resident specifically asked staff to do so or it was identified in the resident's plan of care. The resident's meal was not served using methods that preserved taste, appearance and food quality.

B) Resident #005 required a specific texture menu. Staff #109, who was assisting the resident with eating, was mixing the resident's food together. The resident had not requested the items be mixed together and the resident did not have a plan of care that required their food items to be mixed together during meals. The Director of Dietary Services confirmed that staff were not to mix texture modified foods together unless the resident had specifically asked the staff to do so or unless it was identified in the resident's plan of care. The resident's meal was not served using methods that preserved taste, appearance and food quality.

C) Resident #046 required a specific texture menu. PSW #104, who was assisting the resident with eating, was observed mixing fluid with the resident's dessert. The PSW stated they were making the resident's dessert softer. The resident did not have a plan of care that required staff to mix fluids into the resident's food and the resident was unable to voice their preference to the LTC Inspector. [s. 72. (3) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

An interview with resident #034 revealed that the resident had reported several missing items to the ESM and several staff members on the unit in 2015 and 2016. The resident stated that they were told that the items were searched for but could not be located.

Record review of the homes “Complaint” Binder revealed that a documented record of any of the verbal complaints brought forward in 2015 and 2016 to the ESM and the staff by resident #034 could not be located.

An interview with PSW #125 revealed the PSW staff were to report complaints to the charge nurse.

An interview with registered staff #114 revealed that the PSW staff brought all complaints to the registered staffs' attention who then attempt to resolve the issue as able, document the complaint in the resident’s progress notes and notify the charge nurse. The charge nurse is responsible to document the complaint on the complaint form and escalate to a manager if necessary to complete the process.

An interview with the ESM revealed that the resident brought the above mentioned complaints to their attention verbally, and attempts were made unsuccessfully to locate the missing items.

An interview with the DOC, and the ESM confirmed that they were aware of the above mentioned verbal complaints of resident #034, and confirmed that a documented record of these complaints was not kept. [s. 101. (2)]

WN #15: 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. The licensee failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies.

The licensee failed to ensure that staff using the double locked narcotic box was used exclusively for drugs and drug related supplies. On a specific date during the inspection when the narcotic box located inside the medication cart was unlocked by registered staff #116, personal items that were not narcotic medications were discovered inside. RPN #116 stated that these personal items should not have been stored in the narcotic box. The DOC confirmed that only drugs or drugs related items should be stored in this area. [s. 129. (1) (a)]

Issued on this 9th day of May, 2016

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

Original report signed by the inspector.

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARIA TRZOS (561), MICHELLE WARRENER (107), NATASHA JONES (591), SAMANTHA DIPIERO (619)
Inspection No. / No de l'inspection :	2016_301561_0003
Log No. / Registre no:	002314-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 21, 2016
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	LEISUREWORLD CAREGIVING CENTRE - STREETSVILLE 1742 BRISTOL ROAD WEST, MISSISSAUGA, ON, L5M-1X9
	Susan Bock

Name of Administrator /
Nom de l'administratrice
ou de l'administrateur :

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) 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 when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that the plan of care is reassessed and reviewed and revised when the resident's care needs change or the care set out in the plan is no longer necessary.

1) The plan shall include specific interventions for ongoing monitoring and assessments for all residents with urinary incontinence, history of urinary tract infections, and in dwelling foley catheters.
2) The plan shall include dates and quality management activities used to ensure compliance.

The plan shall be submitted to Long-Term Care Homes Inspector Samantha Di Piero, via email at Samantha.Dipiero@ontario.ca or via mail to the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 119 King St. W, 11th floor, Hamilton, ON L8P 4Y7, by May 6, 2016.

Grounds / Motifs :

1. Judgment Matrix:
Noncompliance Severity: Actual Harm/Risk

Noncompliance Scope: Isolated

Compliance History: Previously issued on April 25, 2014 as VPC, and October

17, 2013 as VPC.

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Resident #009 had a specific intervention related to chronic medical condition. On an identified date in 2015, resident was on a specific medical treatment for an acute condition. The progress notes indicated that when the treatment was completed resident continued to display signs and symptoms but did not receive an assessment and there was no documentation related to the identified intervention. On two different days in 2015, after initial treatment, resident received pain medication as they continued to have symptoms of the acute condition; there was no documentation of resident's assessment. Furthermore, an assessment was completed and the resident was seen by the Nurse Practitioner (NP) that afternoon. The NP notes indicated that the resident's symptoms had become worse. The resident received treatment the same day and more tests were ordered. Post NP's assessment resident's condition had deteriorated and was transferred to hospital for treatment.

An interview with RN #126 indicated that the resident should have been reassessed when displaying signs and symptoms of the acute condition.

An interview with the DOC confirmed that reassessment did not take place until the resident's symptoms had increased and confirmed that registered staff should have completed further assessment of the resident when they continued to complain of symptoms.
The resident was not reassessed and the plan of care reviewed and revised when the resident's care needs changed.

(619)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de sions de longue durée
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
Inspection de sions de longue durée
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 21st day of April, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Daria Trzos

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