Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb 22, 23, 24, Mar 7, 8, 21, 23, 29, Apr 20, 24, 25, 26, 27, 2012	2012_031194_0009	Complaint

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - ELLESMERE
1000 Ellesmere Road, SCARBOROUGH, ON, M1P-5G2

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Directors of Care(ADOC), Environmental Manager, Maintenance Supervisor, RAI Co ordinator, three Registered Practical Nurses(RPN), six Personal Support Workers(PSW),Laundry aide, Volunteer, an identified resident, Substitute Decision Maker (SDM) for identified resident, Pharmacist.

During the course of the inspection, the inspector(s) reviewed identified residents clinical health record,relevant policies,and observed the licensee's response communication system

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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. O. Reg 79/10, s.17 (1)(f) identifies that, the resident-staff communication and response system clearly indicates when activated where the signal is coming from; and

O. Reg 79/10, s.17 (1)(g) indicates that, in the case of a system that uses sound to alert staff, it is calibrated so that the level of sound is audible to staff.

On February 22, 2012 the inspector verified with the managers and direct care staff that the licensee utilizes pagers on unit 1A as a component of the resident-staff communication and response system. The Environmental Manager also verified that the resident-staff communication and response system had the capability of being changed to a system that uses sound to alert the staff. The inspector activated the resident-staff communication and response system in the Activity room on unit 1A, across from the nursing station. The sound audible from the panel at the nursing station could only be heard for 2-3 rings, within close proximity of the nursing station, then became silent. The indicator light outside the activation room remained on. Personal Support Workers on unit 1A verified that only one functional pager was availabe for the three Personal Support Workers working the 700-1500 shift.

On March 5, 2012 the inspector activated the resident-staff communication and response system in room # 126 in the back hall of unit 1A. The indicator light was activated outside the resident room, but no audible sound could be heard in the hall way. None of the three Personal Support Workers working on unit 1A had access to functional pagers. The Director of Care activated the audible component to the resident-staff communication and response system, after the inspector inquired about the lack of functional pagers on unit 1A. The inspector was informed by the Director of Care that the pagers from unit 1A, were broken and replacements had been ordered.

On February 22, 2012 unit 1A had one functional pager and the resident-staff communication response system was not calibrated so that the level of sound was audible to staff.

On March 05, 2012 the resident-staff communication and response system when activated did not clearly indicate where the signal was coming from and was not calibrated so that the level of sound was audible to staff posing a potential high risk to the comfort, safety and well being for residents living in unit 1A at Leisure world Caregiving Center (Ellesmere)

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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 131.(3) by ensuring that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or registered practical nurse

The physician wrote an order for an identified medication and has indicated on the order that the family is to supply.

Registered Practical Nurses interviewed have confirmed that they do not administer the identified medication to the resident as ordered.

The Substitute Decision Maker(SDM) for the resident has confirmed that the SDM administers the identified medication to the resident daily .

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 by ensuring that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or registered practical nurse, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 132. Natural health products

---

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg, s.312(1) by ensuring that where a resident wishes to use a drug that is a natural health product and that has not been prescribed, there are written policies and procedures to govern the use, administration and storage of the natural health product.

The substitute decision maker (SDM)for an identified resident has been providing the resident with natural health products on a daily basis

The Registered Practical Nurse, has confirmed that the SDM for the identified resident, has been giving the natural health products to the resident daily.

The Director of Care has confirmed that the licensee does not have a policy specific to govern the use, administration and storage of the natural health products.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s.53(4) by ensuring that resident #001 and #002 who were demonstrating responsive behaviour, had triggers identified, strategies developed and implemented and actions taken to respond to their needs.

An incident occurred in February 2012 in the activation room, between resident #001 and resident #002. Resident #001 was restless at the beginning of the shift, screaming loudly. The day staff reported that resident #001 had been very loud that day. Resident #002 became agitated by the screaming and a PSW who witnessed the incident states that while she was sitting at the nursing station, she noticed that resident #002 walked into the activation room, picked up the dangling end of resident #001 scarf and pull it across the resident's mouth. The PSW states that resident #002 did not do it aggressively or forcefully. The PSW states that resident #001 did not fight back or become agitated but did stop yelling. The RPN who was sitting at the nursing station with the PSW, separated the residents, notified ADOC and assessed resident #001 noting no signs of injury or distress.

Staff interventions for resident #001 described as;

An RPN states resident #001 will spend time visiting, watching TV in the TV room or in bed. The RPN states that resident #001 is easily re-directed when asked to stop chanting, but only for very short periods of time.

Another RPN states that resident #001 screaming, is constant on the unit, unless the family is present. The RPN states that as soon as the family leaves again the screaming resumes. The RPN stated that you if you approach resident #001 and ask the resident to stop, the resident will stop for a brief time and then the behaviour resumes.

Two PSW's interviewed stated that resident#001 is brought to the nursing station if the resident becomes too loud in the bedroom room, or taken out of the dining room if the resident is disruptive. The resident's response to the interventions are sometimes effective

The Plan of care for resident #001 identifies socially inappropriate or disruptive behaviours with interventions such as;administering medications to calm the resident and staff are to watch and guard against upset resident from approaching. The plan of care does not identify triggers or interventions described by the staff.

The Critical Incident submitted for the February 2012 incident stated that resident #002 "became agitated by the screaming". RPN's and PSW have stated that resident #002 is resistive to care and will wander around the unit.

The Plan of care for resident #002 identifies that the resident is resistive to care and can become physically aggressive towards staff, with interventions listed. The plan of care does not identify noisy situations, as a trigger for resident #002 as demonstrated by the incident in February 2012 and there are no strategies developed and implemented for this behaviour.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10,s.107(4)1.2. by providing the correct date and time and providing the name of the resident involved in the incident

Interview conducted with RPN and PSW indicated that an incident occurred between two residents, in February 2012 at the beginning of the evening shift. The aggressor of the incident was not identified.

The Critical Incident submitted indicates the incident occurred at 2320 hours, staff confirm incident occurred at 1530 hours. The CI does not identify the resident who was the aggressor in the incident.

WN #6: 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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA S.O.2007,c.8,s.6.(1)(c) by ensuring that the written plan of care for resident #001 provides clear direction to staff and others who provide direct care.

The inspector was provided with a written plan of care for resident #001 on February 22, 2012 and a computerized plan of care for resident #001 on February 23, 2012. There were areas of discrepancies noted in the two plans of care for resident #001 as follows;
- The written plan of care for resident #001 states that the resident requires 2 staff pivot transfers for toileting and transferring. The computerized plan of care for resident #001 states that the staff are to use mechanical lift for transferring and toileting. Interviews conducted with staff have confirmed that staff are mechanically transferring the resident for toileting and transfers at this time.

- The written plan of care for resident #001 indicates that the resident has no behaviours, and the computerized plan of care for resident #001 identifies socially inappropriate or disruptive behaviours with interventions such as; administering medications to calm the resident and staff are to watch and guard against upset resident from approaching. Interview with RPN and PSW confirms that resident frequently has episodes of yelling and calling out, where staff will bring the resident out of the dining room when disruptive or bring resident to nursing station to be monitored by staff.

-The written and computerized plan of care have not identified the SDM's request to be notified with all care needs. SDM was not informed of the incident that occurred in February 2012 between resident #001 and resident #002, immediately as per the SDM's direction.

Issued on this 1st day of May, 2012

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

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) :	CHANTAL LAFRENIERE (194)
Inspection No. / No de l'inspection :	2012_031194_0009
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Feb 22, 23, 24, Mar 7, 8, 21, 23, 29, Apr 20, 24, 25, 26, 27, 2012
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	LEISUREWORLD CAREGIVING CENTRE - ELLESMERE 1000 Ellesmere Road, SCARBOROUGH, ON, M1P-5G2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DENISE BROWN

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

Order / Ordre :

The licensee will ensure that the home is equipped with a resident-staff communication and response system that, clearly indicates when activated where the signal is coming from and is properly calibrated so that the level of sound is audible to staff.

Grounds / Motifs :

1. O. Reg 79/10, s.17 (1)(f) identifies that, the resident-staff communication and response system clearly indicates when activated where the signal is coming from; and

O. Reg 79/10, s.17 (1)(g) indicates that, in the case of a system that uses sound to alert staff, it is calibrated so that the level of sound is audible to staff.

On February 22, 2012 the inspector verified with the managers and direct care staff that the licensee utilizes pagers on unit 1A as a component of the resident-staff communication and response system. The Environmental Manager also verified that the resident-staff communication and response system had the capability of being changed to a system that uses sound to alert the staff. The inspector activated the resident-staff communication and response system in the Activity room on unit 1A, across from the nursing station. The sound audible from the panel at the nursing station could only be heard for 2-3 rings, within close proximity of the nursing station, then became silent. The indicator light outside the activation room remained on. Personal Support Workers on unit 1A verified that only one functional pager was available for the three Personal Support Workers working the 700-1500 shift.

On March 5, 2012 the inspector activated the resident-staff communication and response system in room # 126 in the back hall of unit 1A. The indicator light was activated outside the resident room, but no audible sound could be heard in the hall way. None of the three Personal Support Workers working on unit 1A had access to functional pagers. The Director of Care activated the audible component to the resident-staff communication and response system, after the inspector inquired about the lack of functional pagers on unit 1A. The inspector was informed by the Director of Care that the pagers from unit 1A, were broken and replacements had been ordered.

On February 22, 2012 unit 1A had one functional pager and the resident-staff communication response system was not calibrated so that the level of sound was audible to staff.

On March 05, 2012 the resident-staff communication and response system when activated did not clearly indicate where the signal was coming from and was not calibrated so that the level of sound was audible to staff posing a potential high risk to the comfort, safety and well being for residents living in unit 1A at Leisure world Caregiving Center (Ellesmere) (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 04, 2012

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

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

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 27th day of April, 2012

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chantal Lafreniere

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