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

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 19, 2017	2017_518645_0007	004568-17	Resident Quality Inspection

Licensee/Titulaire de permis

341822 ONTARIO INC
28 HALTON STREET TORONTO ON M6J 1R3

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

MAYNARD NURSING HOME
28 HALTON STREET TORONTO ON M6J 1R3

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

DEREGE GEDA (645), JUDITH HART (513), SARAH KENNEDY (605)

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): March 1, 2, 3, 6, 7, 8, 9, 10, 13, 14, 15, 16, 17, 20, 21, 22, 23 and 24, 2017.

The following critical incident inspections were conducted concurrently with the RQI: 026808-16 (related to duty to protect), 004507-17 (related to responsive behaviour), 034629-16 (related to Duty to protect), 021118-15 (duty to protect), 034245-15 (duty to protect), 026394-16 (safe and secure home), and 005831-17 (duty to protect).

The following complaint inspections were conducted concurrently with the RQI; 015498-16 (multiple care concerns), 016490-16 (related to dining and resident bill of rights), 003709-17 (multiple care concerns), and 016673-16 (related to complaints process) and 004321-17 (related to abuse and reporting matters).

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), registered nursing staff , Personal Support Workers (PSWs), Registered Dietitian (RD), Dietary Aide, Social Worker (SW), Environmental Services Manager (ESM), housekeeper, Substitute Decision Makers (SDMs), life enrichment aide, Residents' Council President, Family Council Representative, family members and residents.

During the course of the inspection the inspectors conducted a tour of the home; observed medication administration, dining observation, resident to resident interactions, staff to resident interactions and the provision of care; reviewed resident health care records, staff training records, meeting minutes for Residents' and Family Councils, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting resident #023 and #021.

A review of a Critical Incident Report (CIR) submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, indicated resident#023 sustained an

alteration in skin integrity during care. PSWs #110 and #120 were providing care to a resident using the transferring equipment.

A record review of the home's investigation notes revealed the identified staff members had failed to do a specific routine check prior to using the specified equipment and failed to execute safe care. PSW #110 admitted that he/she forgot to complete the specified routine check of the equipment prior to providing care. He/she stated that the equipment caused an alteration in skin integrity. During the home's interview with PSW #120, he/she revealed that the routine safety check of the equipment was not conducted prior to providing care. Both staff were disciplined and mandatory training was provided.

An interview with PSW #120 confirmed that while care was provided for resident #023, the specified equipment was not properly hooked to the lift. He/she also confirmed that the routine safety check was not completed prior to using the equipment. As a result the resident sustained an alteration in skin integrity. Inspector #645 was unable to interview PSW #110.

An interview with the Director of care (DOC) confirmed that both identified PSWs failed to do the routine safety check of the equipment prior to providing care and as a result, resident #023 sustained an alteration in his/her skin integrity. The DOC stated it is the expectation of the home to do the routine safety check of the equipment and to care for residents safely. [s. 36.]

2. Two complaints were received via the MOHLTC INFOLINE regarding the same incident. Both the first and second complaint received were for an alleged incident of improper care of resident #021 that had caused altered skin condition on identified part of his/her body. The incident involved PSW#115 and PSW#122. The identified staff members were providing care for resident #021 and the resident sustained alteration of his/her skin condition due to improper care.

A record review of the clinical assessment confirmed resident #021 sustained a altered skin condition during the provision of care.

An interview with PSW #115 confirmed the resident was injured during care provision. He/she confirmed that the resident was exhibiting responsive behaviours towards PSW #122. As a result the resident hit the bed side rail sustaining an altered skin condition on an identified part of the body.

An interview with RPN #111 revealed that PSW #115 and PSW #122 notified him/her about the altered skin condition. RPN #111 confirmed resident #121 sustained an altered skin condition on the identified part of the resident's body due to unsafe care. RPN #111 reiterated staff should have taken extra precaution for safety when providing care.

An interview with the interim DOC confirmed that resident #121 was injured as a result of improper or unsafe care.

The severity of the harm was actual. The scope of the non-compliance was isolated. There were no previous non-compliance issued to the home in relation to O.Reg. 79/10. S. 36. As a result of the severity, scope and the licensee's previous compliance history a compliance order is warranted. [s. 36.]

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. 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 any person who had reasonable grounds to

suspect that improper or incompetent treatment or care of a resident that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it is based to the Director.

A review of the CIR submitted to the MOHLTC revealed that the DOC received a complaint (via email) regarding alleged improper care of resident #031. An interview with the DOC revealed she retrieved the email on an identified date when she returned to work.

The DOC confirmed she was aware of the allegation and the CIR was not submitted immediately.

2. Two complaints were received via the MOHLTC INFOLINE regarding the same incident. Both the first and second complaint received were for an alleged incident of improper care of resident #021 that had caused alteration of skin condition on the identified part of the resident's body.

An interview with RPN #111 confirmed that he/she was aware of the alleged incident but did not complete a CIR or call the ACTIONLine. RPN #111 stated that staff reported the alleged incident to him/her. He/she confirmed that the incident was improper care and resident #021 sustained alteration in skin integrity. As a result this incident of improper care/neglect needed to be reported immediately to the Director and confirmed that it was not reported.

An interview with RN #121, assistant/interim DOC at the time of incident, confirmed that he/she was aware of the alleged incident but did not notify the Director. RN #121 confirmed that the incident was improper care and it is reportable to the Director. It is the expectation of the home to notify the Director immediately. [s. 24. (1)]

3. A review of the CIR submitted to MOHLTC revealed resident #034 reported to an identified staff member about an allegation of abuse on identified date. Resident #034 stated a staff member abused him/her because he/she rang his/her call bell multiple times. A review of the Resident Services documentation revealed the DOC was made aware of the incident immediately.

The DOC confirmed she was aware of the alleged incident and the CIR was not submitted immediately. [s. 24. (1)]

4. A review of the CIR submitted to MOHLTC revealed resident #035 reported to the Environmental Services Manager (ESM) an allegation of staff to resident abuse. The ESM reported this allegation to the DOC immediately on identified date. Resident #035 stated a staff member was abusive to him/her. An interview with the ESM confirmed resident #035 told him about an incident of alleged abuse.

The DOC confirmed she was aware of the allegation and the CIR was not submitted immediately. [s. 24. (1)]

5. A review of the CIR submitted for alleged abuse revealed resident #011 reported that an identified individual was loudly telling him/her to go out of his/her room, gesturing with an identified part of the body. Resident #011 was so scared of the identified individual that he/she almost fell down when the daughter was coming near him/her, saying in a loud voice to go away while motioning the identified part of the body.

An interview with RPN #116 indicated the incident occurred on identified date. An interview with the DOC confirmed there was suspicion of abuse, and that the DOC spoke with the identified individual concerning the suspected abuse on the same identified date. DOC confirmed the director was not notified about the suspected abuse. [s. 24. (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 any person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it is based to the Director., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to immediately forward any written complaints that have been received concerning the care of a resident or the operation of a home to the Director.

An anonymous complaint regarding the homes process for handling complaints and concerns was received via the MOHLTC INFOLINE.

A review of the homes process for dealing with concerns and complaints revealed the home was not forwarding written complaints concerning the care of a resident or the operation of a home to the Director.

An interview with the DOC confirmed that written complainants concerning the care of a resident or the operations of the home were not being forwarded on to the Director, as per expectation. [s. 22. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Family Council was sought in carrying out the 2016 satisfaction survey and in acting on its results.

The Family Council meeting minutes were reviewed for an identified date.There were no notations in the minutes regarding the licensee seeking Family Council advice in carrying out the satisfaction survey and acting on the results for an identified time.

An interview with the Family Council President and with the Family Council Assistant indicated that the licensee did not seek advice with carrying out the January 2016 satisfaction survey and in acting on its results.

An interview with the Administrator confirmed the licensee did not seek the advice of Family Council with carrying out and in acting upon the identified time satisfaction survey results. [s. 85. (3)]

2. The licensee has failed to ensure that the satisfaction survey results were documented and made available to the Family Council in order to seek the advice of the Council about the survey.

The Family Council meeting minutes were reviewed for identified time in 2017.There were no notations in the minutes of the licensee seeking Family Council advice regarding the documentation and satisfaction survey results made available to the Family Council in order to seek the advice of the Council about the identified time satisfaction survey.

An interview with the Family Council President and the Family Council Assistant indicated that the licensee did not make available to the Family Council the identified date satisfaction survey results in order to seek the advice of the Council about the survey.

An interview with the Administrator confirmed the identified satisfaction survey results were not specifically made available to the Family Council in order to seek the advice of the Council about the survey. [s. 85. (4) (a)]

Issued on this 25th day of April, 2017

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEREGE GEDA (645), JUDITH HART (513), SARAH KENNEDY (605)
Inspection No. / No de l'inspection :	2017_518645_0007
Log No. / Registre no:	004568-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 19, 2017
Licensee / Titulaire de permis :	341822 ONTARIO INC 28 HALTON STREET, TORONTO, ON, M6J-1R3
LTC Home / Foyer de SLD :	MAYNARD NURSING HOME 28 HALTON STREET, TORONTO, ON, M6J-1R3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Leean Bowman

To 341822 ONTARIO 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 :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The plan shall include but not be limited to the following:

1. Direct care staff receive training/re-training on safe use of mechanical lifts used at the home and safe transferring/positioning of residents while in bed.

2. A schedule to test and monitor staff knowledge and compliance on safe transferring/positioning technique.

This plan is to be submitted via email to inspector Derege.Geda@ontario.ca by June 11, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting resident #023 and #021.

A review of a Critical Incident Report (CIR) submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, indicated resident #023 sustained an alteration in skin integrity during care. PSWs #110 and #120 were providing care to a resident using the transferring equipment.

A record review of the home's investigation notes revealed the identified staff members had failed to do a specific routine check prior to using the specified equipment and failed to execute safe care. PSW #110 admitted that he/she forgot to complete the specified routine check of the equipment prior to providing

care. He/she stated that the equipment caused an alteration in skin integrity. During the home's interview with PSW #120, he/she revealed that the routine safety check of the equipment was not conducted prior to providing care. Both staff were disciplined and mandatory training was provided.

An interview with PSW #120 confirmed that while care was provided for resident #023, the specified equipment was not properly hooked to the lift. He/she also confirmed that the routine safety check was not completed prior to using the equipment. As a result the resident sustained an alteration in skin integrity. Inspector #645 was unable to interview PSW #110.

An interview with the Director of care (DOC) confirmed that both identified PSWs failed to do the routine safety check of the equipment prior to providing care and as a result, resident #023 sustained an alteration in his/her skin integrity. The DOC stated it is the expectation of the home to do the routine safety check of the equipment and to care for residents safely. [s. 36.] (645)

2. Two complaints were received via the MOHLTC INFOLINE regarding the same incident. Both the first and second complaint received were for an alleged incident of improper care of resident #021 that had caused altered skin condition on identified part of his/her body. The incident involved PSW#115 and PSW#122. The identified staff members were providing care for resident #021 and the resident sustained alteration of his/her skin condition due to improper care.

A record review of the clinical assessment confirmed resident #021 sustained an altered skin condition during the provision of care.

An interview with PSW #115 confirmed the resident was injured during care provision. He/she confirmed that the resident was exhibiting responsive behaviours towards resident PSW #122. As a result the resident hit the bed side rail sustaining an altered skin condition on an identified part of the body.

An interview with RPN #111 revealed that PSW #115 and PSW #122 notified him/her about the altered skin condition. RPN #111 confirmed resident #121 sustained an altered skin condition on the identified part of the resident's body due to unsafe care. RPN #111 reiterated staff should have taken extra precaution for safety when providing care.

An interview with the interim DOC confirmed that resident #121 was injured as a result of improper or unsafe care.

The severity of the harm was actual. The scope of the non-compliance was isolated. There were no previous non-compliance issued to the home in relation to O.Reg. 79/10. S. 36. As a result of the severity, scope and the licensee's previous compliance history a compliance order is warranted. [s. 36.]
(645)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 11, 2017

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 soins 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 soins 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 19th day of April, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Derege Geda

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