Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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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
Jun 30, 2015	2015_396103_0040	O-002296-15	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF KINGSTON
216 Ontario Street KINGSTON ON K7L 2Z3

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

RIDEAUCREST HOME
175 RIDEAU STREET KINGSTON ON K7K 3H6

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 15-18, 2015

During the course of the inspection, the inspector(s) spoke with the Office Manager, the Records/Staffing Clerk, the Payroll/Staffing Clerk, the Nurse Practitioner (NP), Personal Support Workers (PSW), Registered Practical Nurses (RPN), a Registered Nurse (RN), the Assistant Directors of Care (ADOC), the Director of Care (DOC), and the Administrator.

During the course of the inspection, this inspector made resident observations, reviewed resident health care records including referral notes from geriatric psychiatry, reviewed staff schedules and viewed video documentation of the altercation.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 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 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 residents were protected from abuse.

Physical abuse is defined as, "the use of physical force by a resident that causes physical injury to another resident."

Resident #2 was admitted to the home on an identified date and had identified diagnoses. According to staff, the resident had an identified language barrier and was physically capable of ambulating independently. The resident was known to wander the halls, entered co-resident rooms and would react in a negative manner if staff tried to redirect.

On an identified date, Resident #2 was involved in an unprovoked physical altercation with Resident #3. The resident was sent out of the home for an assessment and returned the following day. A referral to geriatric psychiatry was ordered to assist in the management of the resident's responsive behaviours and 1:1 monitoring was implemented to ensure resident safety.

On a subsequent identified date, Resident #2 was involved in a second physical altercation with Resident #1. At the time of the altercation with Resident #1, Resident #2 did not have 1:1 monitoring in place.

The home's video surveillance captured the altercation and was reviewed by this inspector. The video showed Resident #2 leaving his/her room at approximately 0612hr and was observed wandering alone in the halls; the resident returned to his/her room at 0613hr. At 0637hr, Resident #2 was once again observed leaving his/her room and wandered unattended down the hall. At 0644hr, Resident #2 entered Resident #1's room. At 0645hr, Resident #1 was observed returning to his/her room, found Resident #2 in his/her room and a physical altercation between the two residents occurred in the doorway of Resident #1's room. Resident #1 fell as a result of the altercation and sustained an identified injury.

While staff were attending to Resident #1, Resident #2 was observed wandering unattended up the hallway at 0626hr. At 0648hr, Resident #2 returned unattended to the site of the altercation, and watched the staff who appeared to be unaware of Resident #2's presence. The resident once again was observed to wander unattended down the hall. At 0704hr, Resident #2 was observed in the hall with a student and at 0721hr, Resident #2 was observed with PSW, S#104 who had been reassigned from another unit to cover the 1:1.

The Administrator and the Director of Care were both interviewed and stated the 1:1

monitoring for Resident #2 had been implemented to ensure the safety of the co-residents after the initial incident on the identified date. The DOC stated the 1:1 was to be in place on the day and evening shifts until such time the resident could be transferred out of the home for further evaluation/management of behaviours. The purpose of 1:1 staffing was to redirect the resident out of co-resident rooms and to monitor the resident's interactions with co-residents to avoid/minimize further physical altercations. Both agreed the altercation could have been avoided if 1:1 monitoring of Resident #2 was in place as staff would have redirected the resident away from Resident #1's room.

Additionally, staff failed to provide 1:1 monitoring to Resident #2 immediately following the physical altercation with Resident #1 which further increased the risk of injury to additional residents and jeopardized their safety and well-being.

In summary, as outlined in WN #2, the licensee failed to protect residents from abuse by failing to comply with LTCHA, 2007, s. 6 (7) whereby care set out in Resident #2's plan of care was not provided in accordance with the plan. [s. 19. (1)]

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. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 6 (7) whereby care set out in the plan of care was not provided to Resident #2 as specified in the plan.

Resident #2 was admitted to the home on an identified date and had identified diagnoses. According to staff, the resident was known to resist care which often resulted in increased anxiety and agitation. Resident #2 had a physician order for an identified medication to be given as needed up to two tablets within a twenty four hour period of

time for anxiety and agitation.

The resident care plan in effect for an identified time frame was reviewed and indicated the following:

Under "Bathing": utilize the prn (as needed) when needed to assist in decreasing anxiety related to bath.
Under "Behaviour": resident has a prn (as needed) order that registered staff may administer when resident is agitated.

The resident progress notes and Medication Administration Record (MAR) were reviewed for an identified period of time in regards to the use of the identified medication to manage Resident #2's anxiety and agitation.
On nine identified dates, Resident #2 did not receive the identified medication in accordance with the resident's plan of care to reduce anxiety and agitation.

The home failed to administer the identified medication, as ordered to reduce the resident's incidents of anxiety and agitation.

On an identified date, Resident #2 initiated an unprovoked physical assault on Resident #3 and was sent out of the home for an assessment. The resident returned to the home the following day with recommendations for a referral to Geriatric Psychiatry to assist in the management of this resident's responsive behaviours.

On an identified date, Dr. Nashed (Geriatric Psychiatry) assessed Resident #2 and made the following recommendations:

-obtain an interpreter,
-do full metabolic work up,
-start an identified medication once daily then increase to twice daily depending on the side effects and benefits,
-alternatively start a trial of another identified medication.

According to S#108, Community Care Access Centre (CCAC) was contacted on an identified date to make inquiries in regards to an interpreter but to date had not had any response from them. No additional efforts were made by the home to locate an interpreter.

Resident #2 was started on the first identified medication recommended by Geriatric Psychiatry once daily. There was no documentation to indicate the resident was experiencing side effects from the new medication, but the recommendations related to increasing this medication to twice daily was not assessed until after the second altercation. Following this incident, the Nurse Practitioner ordered the full metabolic work up, increased the identified medication to twice daily and started the second recommended medication, citing "re: Dr. Nashed suggests."

The home failed to ensure recommendations made by Geriatric Psychiatry to manage Resident #2's responsive behaviours were put into place until a second physical altercation occurred.

The DOC was interviewed and stated at the time of the second altercation, Resident #2 should have been on 1:1 monitoring. According to the DOC, the 1:1 had been in place during the day (0600-1400hr) and evening (1400-2200hr) shifts since the resident returned to the home from a previous physical altercation with Resident #3 to ensure resident safety.

The DOC stated the Mobile Response Team (MRT) provided some of the coverage for the 1:1 shifts and the staff from the home covered the rest. The DOC stated Resident #2 generally slept well overnight (2200-0600hr)and therefore was monitored by one staff member to two residents (2:1).

According to the DOC, the 1:1 was not in place when Resident #2 was involved in a physical altercation with Resident #1. The DOC stated she arrived at the home that day at approximately 0800hr and was advised by staff Resident #2 was being monitored every fifteen minutes following the incident with Resident #1. The DOC stated she clarified with staff that 1:1 should be in place and to restart this immediately.

RN S#109 was interviewed and stated she had been the charge nurse on the identified date of the altercation as well as the two weekend day shifts prior to that date. S#109 stated Resident #2 had a 1:1 in place for the day and evening shifts over the weekend and believed a 1:1 was scheduled to cover the day shift on the identified date. According to S#109, she had missed an entry left in the RN book advising the charge nurse to follow up with the MRT over the weekend to determine their availability to provide some of the 1:1 coverage for Resident #2. S#109 did state the MRT shifts never started before 0800hr and therefore it was her assumption the home's staff were already pre-scheduled to cover the 1:1 at 0600hr on the identified date as this would be the normal practice.

S#109 stated at no time did she receive a call from Resident #2's unit, questioning why the 1:1 was not available at the start of the identified date day shift. S#109 stated it wasn't until after she was notified about the physical altercation that she became aware a 1:1 had not been available for Resident #2. S#109 stated if she had known there was no 1:1 in place, she would have pulled a staff member immediately from another unit.

RPN S#107 was interviewed and confirmed she was the registered staff working on the day shift of the identified date. This staff member stated this was not the usual unit she worked on and that she was unaware a 1:1 should have been in place for Resident #2. The staff member stated she would normally receive that information from either the night staff leaving or from the day RN. S#107 stated she spoke with RN S#109 following the incident between Residents #2 and #1 and at that time stated she felt a 1:1 was required for Resident #2. S#107 stated at times determining if a 1:1 should be in place can be confusing.

RPN S#108 was interviewed and stated she works on the identified unit on a regular basis. She stated she knew the 1:1 for Resident #2 had been discontinued on the night shifts and believed it had been cancelled for all of the shifts. S#108 stated she believed the 1:1 coverage was in limbo at the time of the incident.

PSW S#106 was interviewed and asked if there had been any discussion about 1:1 coverage for Resident #2 during the morning report on the identified date. S#106 stated she recalls someone asking who was doing the 1:1 but stated staff was told it had been discontinued. S#106 was unable to recall the staff member that believed the 1:1 was discontinued.

The home failed to provide 1:1 coverage for Resident #2 in accordance with the plan of care in place on the identified date. [s. 6. (7)]

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 Resident #2's care needs outlined in the plan of care are provided to Resident #2 in accordance with the plan including, medication administration to reduce anxiety and agitation ensuring response/effectiveness of the medications are included, ongoing support of an interpreter to assist in responding to the resident's responsive behaviours and in developing a care plan to meet this resident's needs and 1:1 monitoring of the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure there was monitoring and documentation of Resident #2`s response and effectiveness of an identified medication which was started on an identified date.

Resident #2 was assessed by Geriatric Psychiatry to assist in the management of this resident`s responsive behaviours. Dr. Nashed suggested an identified medication be started once daily then increased to twice daily depending on side effects and benefits. Dr. Cristoveneau ordered the medication once daily following the recommendations.

The resident health care record was reviewed for an identified period of time including the Medication Administration Records and progress notes. There was no documentation found to reflect the resident`s response to or the effectiveness of the new medication.

According to S#108 and S#107, new medications are flagged within the Medication Administration Record (MAR) to remind staff to document the resident response to new medications. Both confirmed the documentation would be found in the progress notes as the MAR is linked to the notes. Both staff members agreed the documentation of response/effectiveness would be important to determine what interventions are effective in the management of a resident`s behaviours.

In an interview with the DOC, she stated it would be her expectation that staff document resident response and effectiveness of medications used in the management of responsive behaviours. [s. 134. (a)]

Issued on this 30th day of June, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2015_396103_0040
Log No. / Registre no:	O-002296-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 30, 2015
Licensee / Titulaire de permis :	THE CORPORATION OF THE CITY OF KINGSTON 216 Ontario Street, KINGSTON, ON, K7L-2Z3
LTC Home / Foyer de SLD :	RIDEAUCREST HOME 175 RIDEAU STREET, KINGSTON, ON, K7K-3H6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Deb Skeaff

To THE CORPORATION OF THE CITY OF KINGSTON, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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).

Order / Ordre :

The licensee is hereby ordered to ensure the 1:1 monitoring of Resident #2 remains in place 24/7 to minimize the risk of harm to co-residents.

The 1:1 monitoring will not be altered or discontinued until such time the resident has a comprehensive, documented clinical assessment that clearly delineates the resident's care needs in relation to responsive behaviours and the strategies required to prevent, minimize or respond to the responsive behaviours have been fully implemented.

Grounds / Motifs :

1. The licensee has failed to ensure residents were protected from abuse.

Physical abuse is defined as, "the use of physical force by a resident that causes physical injury to another resident."

Resident #2 was admitted to the home on an identified date and had identified diagnoses. According to staff, the resident had an identified language barrier and was physically capable of ambulating independently. The resident was known to wander the halls, entered co-resident rooms and would react in a negative manner if staff tried to redirect.

On an identified date, Resident #2 was involved in an unprovoked physical altercation with Resident #3. The resident was sent out of the home for an assessment and returned the following day. A referral to geriatric psychiatry was ordered to assist in the management of the resident's responsive behaviours and 1:1 monitoring was implemented to ensure resident safety.

On a subsequent identified date, Resident #2 was involved in a second physical altercation with Resident #1. At the time of the altercation with Resident #1, Resident #2 did not have 1:1 monitoring in place.

The home's video surveillance captured the altercation and was reviewed by this inspector. The video showed Resident #2 leaving his/her room at approximately 0612hr and was observed wandering alone in the halls; the resident returned to his/her room at 0613hr. At 0637hr, Resident #2 was once again observed leaving his/her room and wandered unattended down the hall. At 0644hr, Resident #2 entered Resident #1's room. At 0645hr, Resident #1 was observed returning to his/her room, found Resident #2 in his/her room and a physical altercation between the two residents occurred in the doorway of Resident #1's room. Resident #1 fell as a result of the altercation and sustained an identified injury.

While staff were attending to Resident #1, Resident #2 was observed wandering unattended up the hallway at 0626hr. At 0648hr, Resident #2 returned unattended to the site of the altercation, and watched the staff who appeared to be unaware of Resident #2's presence. The resident once again was observed to wander unattended down the hall. At 0704hr, Resident #2 was observed in the hall with a student and at 0721hr, Resident #2 was observed with PSW, S#104 who had been reassigned from another unit to cover the 1:1.

The Administrator and the Director of Care were both interviewed and stated the 1:1 monitoring for Resident #2 had been implemented to ensure the safety of the co-residents after the initial incident on the identified date. The DOC stated the 1:1 was to be in place on the day and evening shifts until such time the resident could be transferred out of the home for further evaluation/management of behaviours. The purpose of 1:1 staffing was to redirect the resident out of co-resident rooms and to monitor the resident's interactions with co-residents to avoid/minimize further physical altercations. Both agreed the altercation could have been avoided if 1:1 monitoring of Resident #2 was in place as staff would have redirected the resident away from Resident #1's room.

Additionally, staff failed to provide 1:1 monitoring to Resident #2 immediately following the physical altercation with Resident #1 which further increased the risk of injury to additional residents and jeopardized their safety and well-being.

In summary, as outlined in WN #2, the licensee failed to protect residents from

abuse by failing to comply with LTCHA, 2007, s. 6 (7) whereby care set out in Resident #2's plan of care was not provided in accordance with the plan. [s. 19. (1)]

(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 01, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 30th day of June, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DARLENE MURPHY

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