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

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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
Feb 1, 2016	2015_275536_0022	035287-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE BRAMPTON ON L6T 4B9

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

SHERIDAN VILLA
2460 TRUSCOTT DRIVE MISSISSAUGA ON L5J 3Z8

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

CATHIE ROBITAILLE (536), JESSICA PALADINO (586), THERESA MCMILLAN (526), YVONNE WALTON (169)

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): December 21, 22, 23, 29, 30, 2015, January 4, 5, 6, 7, 8, 12, 2016.

During this Resident Quality Inspection(RQI), Complaint Inspections #022574-15, #002005-15 and Critical Incident System (CIS)Inspections #023670-15, #028100-15, #030395-15, #033958-15, #004048-15, #007332-15, #008537-15, #013762-15, #013940-15, #019551-15 and #020110-15 were conducted concurrently. There were findings of non-compliance in the CIS inspections.

During the course of the inspection, the inspector(s) spoke with residents, family, personal support workers, registered staff, dietary staff, Dietary Services Supervisor, Registered Dietitian (RD), Social Worker, Facility Services Supervisor, Physiotherapist, (PT), Activation and Volunteer Services Supervisor, Resident Assessment Instrument (RAI) Specialist, Behavioural Supports Ontario (BSO) staff, Supervisor's of Care (SOC), Program Support Nurse(PSN), Director of Care (DOC), Administrator and the Acting Administrator.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
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
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

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

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

A) Resident #036 was admitted on an identified date to the home's Special Behaviour Unit. The progress notes indicated that they exhibited specific behaviours during the identified dates. A review of the document the home referred to as the resident's care plan regarding management of these behaviours, indicated what staff were directed to do. Staff persons #107 and #108 were unable to state the specific interventions that were to be implemented from the plan of care. During interview, the Supervisors of Care verified that residents were not protected from resident #036. [526]

B) Resident #055 was admitted to the home on an identified date; and had identified behaviours on their care plan. In the first few weeks following admission, resident #055 had a number altercations with resident #054. Resident #055 had behaviours that were identified as triggers for resident #054. A few days later resident #055 was noted to be exhibiting these behaviours. Resident #055 behaviours continued and they began pushing other residents, one resulting in injury to a resident. After three incidents, the licensee implemented one to one staffing to protect resident #055, and all the other residents on the secured home area. This was confirmed by the clinical documentation and the Supervisors of Care. [169]

C) On an identified date, resident #059 assaulted resident #058. Resident #059 was admitted to the home on an identified date, with a history of these identified behaviours. One day after admission, resident #059 demonstrated these behaviours towards two residents. These behaviours continued for seven days following admission and resulted in one resident being sent to hospital.[169]

The licensee failed to ensure that residents were protected from abuse by anyone.

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 staff and others involved in the different aspects of care of resident #041 collaborated with each other in the assessment of the resident so that their assessments were integrated and consistent with and complement each other.

Resident #041's Resident Assessment Instrument Minimum Data Set (RAI-MDS) Assessment indicated the resident required supervision and set-up help only with eating. The following RAI-MDS Assessment, indicated that the resident's eating status had declined and now required limited assistance and one-person physical assist.

Observation of the resident during mealtime on an identified date, confirmed the resident

was able to eat most of the meal independently, but did require being fed toward the end of the meal. Interview with the personal support worker (PSW) confirmed, the resident's intake varied; however, often they needed assistance finishing up their meal, in which staff would feed the resident. The resident's current documented care plan and kardex, which front line staff use to direct care, still indicated that the resident required supervision and set-up help only, and had not been updated after the change that occurred during an identified date.

Interview with the Registered Dietitian (RD) confirmed that the resident's MDS data and current plan of care did not coincide. The Registered Dietitian (RD) stated that it is the responsibility of nursing staff to complete that section of the coding, and they should have informed the RD of the coding change regarding the resident's eating status. During interview, the Resident Assessment Instrument (RAI) Coordinator confirmed that they did not notify the RD of the change in the resident's eating status, and confirmed the resident's plan of care should have been updated to reflect their current needs. Staff confirmed they did not collaborate in the assessment of resident #041's care. [s. 6. (4) (a)]

2. The licensee failed to ensure that the resident, the Substitute Decision Maker (SDM), if any, and the designate of the resident/SDM was given an opportunity to participate fully in the development and implementation of the plan of care.

During interview, resident #050's SDM expressed concern that the resident had developed an infection and they were not notified until five days later, after the wound became worse and required intervention by a physician. A review of the progress notes indicated that the SDM had not been notified by the registered staff when the infection began. During interview, staff #102 who was involved in resident #050's care at that time, could not confirm that the SDM had been notified. A progress note and interview with the SDM revealed the SDM's dissatisfaction with not being included in the resident's care, regarding their infection. During interview and upon review of progress notes, the Program Support Nurse (PSN) confirmed that resident #050's SDM had not been notified of the resident's infection, and according to the home's expectations. [s. 6. (5)]

3. The licensee has failed to ensure that the care set out in the plan of care for resident #055 was provided as specified in the plan.

On an identified date, the seniors mental health services recommended a wander guard on resident #055's room to prevent co-residents from wandering into their room. The

goal was to reduce the residents anxiety and need for pushing them out of their room. The seniors mental health services recommended a silent bed alarm to be placed on the resident's bed during the night, with toileting by night staff. Both recommendations were not provided to the resident as specified in the plan of care. This was confirmed by clinical documentation, the Supervisors of Care and observation. [s. 6. (7)]

4. The licensee has failed to ensure resident #061 was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

During the evening on an identified date, resident #061 was being transferred from bed to their wheelchair using a sit-to-stand lift when they lost their footing and the two personal support workers (PSW's) lowered the resident to the floor. The resident was assessed by Registered Practical Nurse (RPN) #109, and then sent to the hospital where they were diagnosed with an injury.

A review of the home's internal investigation notes revealed that when RPN #109 indicated, the resident was more sluggish in evening. When asked by the Director of Care (DOC) if this observation of deterioration and need for a total lift was mentioned to anyone, the RPN stated to the DOC, "No". During interview the interim Physiotherapist (PT)confirmed that the PT was not notified of the resident's deterioration in mobility status. The resident was not reassessed when their care needs changed. [s. 6. (10) (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 and ensuring the care is provided as specified in the plan of care as well as, plan of care is reviewed and revised when care needs change (VPC applies to 6 (7) and 6(10)(b)), to be implemented voluntarily.

WN #3: 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 failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A) The home's Residents' Care and Services policy for "Prevention Reporting and Elimination of Abuse/Neglect" policy number LTC1-05.01 directed staff to do the following: "a person who has reasonable grounds to suspect abuse or neglect of a resident shall immediately report the suspicion and the information upon which it is based to the Director".

i) The home submitted a report to the Director through the Critical Incident System(CIS) on an identified date regarding an allegation of abuse against resident #036. The Activation and Volunteer Services Supervisor at the time reported to the Long Term Care (LTC) Inspector during interview, that they were aware of the incident when it occurred and immediately informed the Director of Care (DOC). The Supervisors of Care(SOC) confirmed that the report was not submitted immediately according to the home's policy.

ii) The home submitted a report to the Director through the Critical Incident System (CIS) on an identified date; regarding an allegation of abuse against resident #051, that occurred. The Acting Administrator and SOC confirmed that the report was not submitted immediately according to the home's policy.

iii) A review of progress notes between identified dates, indicated that resident #036 exhibited inappropriate behaviours toward co-residents on an identified number of occasions. These identified number of incidents of abuse against residents, were not reported to the Director as confirmed by the SOC.

iv) The home submitted a report to the Director through the Critical Incident System on an identified date regarding an allegation of abuse against resident #036 that occurred. The Acting Administrator and Supervisors of Care confirmed that the report was not

submitted immediately according to the home's policy.

B) The home's "Residents' Care and Services" policy for "Prevention, Reporting and Elimination of Abuse/Neglect" policy (LTC1-05.01) directed staff to "notify the family/substitute decision-maker or others specified in the resident's/client's health record, immediately upon becoming aware of an alleged, suspected or witnessed incident of abuse or neglect that resulted in a physical injury or pain or causes distress that could be detrimental to the resident's/clients health or well-being."

On an identified date, resident #051 was observed by staff person #105 to be restrained. The Activation and Volunteer Services Supervisor at the time reported to the Long Term Care (LTC) Inspector during interview that they became aware of the incident when it occurred, and immediately informed the DOC. During interview, staff person #104 confirmed that they had inappropriately restrained resident #051. They could not recall if they notified the resident's Substitute Decision Maker (SDM) according to the home's policy and confirmed that progress notes did not include contacting the SDM. During interview, resident #051's SDM stated being made aware of the incident at least one day later and not immediately. [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 and ensuring that the written policy that promoted zero tolerance of abuse and neglect is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (1) The skin and wound care program must, at a minimum, provide for the following:
2. Strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents. O. Reg. 79/10, s. 50 (1).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's skin and wound program provided strategies to promote resident comfort and mobility and promote the prevention of infection, including monitoring of residents.

The home's Skin and Wound Care Program document that directed wound care activities during; last revised on August, 2013, directed registered staff to "observe for clinical signs and symptoms of wound infection. Consult physician immediately if fever, pain, increased redness, swelling, yellow to greenish discharge or unusual odour". The program described a Wound Care Protocol for pressure ulcers, but not for other wounds; this was confirmed by the Program Support Nurse. According to health records, resident #050 was noted to have an identified infection not a pressure ulcer. On that day, the physician ordered a treatment. Despite the treatment, the resident was transferred to hospital for treatment of the infection.

During interview, the Program Support Nurse confirmed that the order should have

included specific instructions for staff regarding the care of resident #050's infection. The staff confirmed that the home's wound care protocol at the time did not include wounds other than pressure ulcers and that directions were unclear for the care of resident #050's altered skin integrity when it was initially noted. [526] [s. 50. (1) 2.]

2. The licensee has failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) A review of resident #050's clinical record indicated that, they were noted to have an identified infection. Over the next few days, the area deteriorated. The resident was hospitalized and received treatment over the next three weeks.

During interview, staff #102, #103 and the Program Support Nurse (PSN) stated that wounds that were not pressure ulcers were not routinely assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. This was verified upon review of resident #050's clinical record, and when the clinically appropriate skin assessment for this wound was unable to be located. The PSN confirmed, that resident #050's alteration in skin integrity had not been assessed using a clinically appropriate assessment tool.

B) A review of resident #050's health record indicated that, between identified dates, they had an identified number of new open areas. A skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment could not be located in the clinical record for these alterations in skin integrity. The PSN confirmed that staff did not routinely use a clinically appropriate instrument to assess new wounds unless they were pressure areas and that these areas has not been assessed according to the legislative requirements. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) A review of the clinical records for resident #050 identified they returned from hospital on an identified date with areas of altered skin integrity. Of these identified areas of altered skin integrity, the majority were not assessed until three weeks later at which time all areas but one had healed over.

During interview, the Program Support Nurse(PSN) confirmed that resident #050's altered skin integrity as noted above were not assessed weekly, and could not confirm why further assessments were not conducted. [s. 50. (2) (b) (iv)]

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 and ensuring that residents who exhibit altered skin integrity receive a skin assessment using a clinically appropriate assessment instrument; and, are reassessed at lest weekly by a member of the registered staff, if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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 has failed to ensure strategies were implemented to respond to residents demonstrating responsive behaviours, where possible.

A) Resident #059 was admitted with a history of identified behaviours. The initial plan of care did identify this history; however, the plan of care dated on another identified date, did not identify these behaviours. There had been an incident resulting in hospitalization and a plan of care was not developed to manage the behaviours. This was confirmed by clinical documentation and interview with the Supervisors of Care (SOC). [169]

B) Resident #045 had identified behaviours, including physical and verbal aggression toward staff. Review of the resident's clinical record included an assessment by the Seniors' Mental Health Services Community Outreach Team, in which the Registered Nurse (RN) made recommendations to mitigate the resident's behaviours including strategies which may decrease the client's sense of isolation and loneliness. Record review, observation, and interview with the Behavioural Supports Ontario (BSO) staff confirmed these two strategies were not implemented. [s. 53. (4) (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 and ensuring that strategies are implemented to respond to residents demonstrating responsive behaviours, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Resident #055 was admitted to the home on an identified date; and had identified behaviours on their care plan. In the first few weeks following admission, resident #055 had a number altercations with resident #054. Resident #055 had behaviours that were identified as triggers for resident #054. A few days later, resident #055 was noted to be exhibiting these behaviours. Resident #055 behaviours continued and they began pushing other residents, one resulting in injury to a resident. After three incidents, the licensee implemented one to one staffing to protect resident #055, and all the other residents on the secured home area. This was confirmed by the clinical documentation and the Supervisors of Care.

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 and ensuring steps are taken to minimize the risk of altercations and harmful interactions between residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assists residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and that minimized the risk of altercations and potentially harmful interactions between and among residents.

Resident #036 was admitted on an identified date to the home's Special Behaviour Unit. The progress notes indicated that they exhibited specific behaviours during the identified dates. A review of the document the home referred to as the resident's care plan regarding management of these behaviours, indicated what staff were directed to do. Staff persons #107 and #108 were unable to state the specific interventions that were to be implemented from the plan of care. During interview, the Supervisors of Care verified that residents were not protected from resident #036.

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 and ensuring that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviour, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee has failed to ensure that, for the purposes of section 35 of the Act, a prohibited device that limited movement, such as sheets, wraps, tensors or other types of strips or bandages (including an electrical cord) used other than for a therapeutic purpose, was not used in the home.

Resident #051's admission RAI MDS completed on an identified date, indicated that they specific behaviours four to six days during the previous seven day observation period. According to progress notes, the resident was exhibiting these behaviours and the Critical Incident System (CIS) report indicated that staff #104 restrained the resident,for a period of 15 to 20 minutes at that time. During interview, staff #105 confirmed that they had observed the resident restrained. During interview, staff #104 confirmed that they had restrained resident #051, stating that they released the restraint when they noted the resident's behaviours. Staff #104 also confirmed, that the resident was not harmed. When interviewed, staff #104 stated that the use of a restraint; was not appropriate, and that the plan of care should have been implemented. They also confirmed that the use of a restraint was not part of the resident's plan of care. Staff #104 also stated that they took this action to quickly settle the resident, in order to address other resident's needs and also to protect the resident; staff, and other residents.

The resident's plan of care directed staff in the management of the resident's behaviours and did not include the use of a restraint. During interview, the Behavioural Supports Ontario Registered Practical Nurse (RPN) and the Acting Administrator confirmed that a restraint should not be used when resident #051 exhibited the behaviours, as described in the progress notes and the use of the identified restraint was not appropriate. [s. 112. 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 and ensuring a prohibited device that limits movement is not used other than for a therapeutic purpose, to be implemented voluntarily.

WN #9: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's policy for "Minimizing Restraint Use and the use of Personal Assistance Services Devices (PASD) Program" last revised April 2013 indicates that "mechanical restraints are any physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts free movement or normal access to one's body e.g. geriatric chairs, wheelchairs with tabletop in place, roll belt/lap belts if they are applied in such a fashion that the opening is placed at the back of the chair and the seat belt cannot be undone by the resident". The home's policy indicated that a Personal Assistive Services Device (PASD) "supports or stabilizes a resident so that his or her participation in activities of daily living and quality of life are improved, and which as a by-product restrict the resident's freedom of movement in some manner".

On an identified date, resident #051 was observed sitting in a chair tilted to approximately 45 degrees. A review of the resident's plan of care revealed that the tilt chair was used as a Personal Assistive Services Device (PASD) "related to agitation, anxiety, poor balance, risk of injury to self, risk of injury to others, falls, unsteady gait, unaware of physical limitations". The goal was that "the resident will not injury self or others". Interventions focused on monitoring and ensuring the resident's safety while the tilt was applied.

During interview staff #106 and #110, and Behavioural Supports Ontario (BSO) staff confirmed the following: the resident was unable to ambulate safely; the resident could ambulate if the chair was in an upright position; the tilt chair prevented them from rising; and they were not able to release themselves from the tilt. During interview, staff person #106 and #110 confirmed that the tilt chair prevented rising; could not be released by the resident, and did not assist with the resident's participation in activities. The Acting Administrator confirmed, that the resident's plan of care should indicate that the tilt chair was a restraint rather than a PASD according to the home's policy. [s. 8. (1) (b)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment was kept clean and sanitary.

On an idenified date, day one of the inspection, coffee mugs were observed to be stained and cracked inside. On another identified date, the coffee mugs were observed again, and once again remained stained. The dishes were on the cart ready to be used. The dietary aide confirmed, they had just received the chemical for de-staining. The Dietary Services Supervisor (DSS) confirmed the visual findings. [s. 15. (2) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #045's responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any identified responsive behaviours.

Resident #045 had identified behaviours. A review of the resident's progress notes, and interview with staff #106 and Behavioural Supports Ontario (BSO)staff, confirmed the resident often refused their medications, which contributed to the behaviours. The resident experienced a fall on an identified date, resulting in transfer to hospital and a fracture.

A review of the resident's clinical record contained a progress note by the physician, which identified resident refusal to take medications. A review of the resident's documented plan of care, which front line staff use to direct care, did not include the resident's frequent refusal of medications. [s. 26. (3) 5.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's substitute decision-maker, was notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health or well-being; and (b) were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A) A review of resident #051's health records indicated, that they were exhibiting identified behaviours since their admission. According to progress notes, the resident was attempting to strike a resident. The progress notes and the Critical Incident System (CIS) report indicated that staff #104 restrained the resident for a period of 15 to 20 minutes. This was confirmed during an interview with staff #105, who observed the resident restrained. During interview, staff #104 also confirmed that they stayed with the resident while they were restrained, and released the restraint when they noted the resident's agitation had increased. They also stated that they could not recall if they immediately notified the substitute decision maker(SDM). The home investigated this incident as an alleged abuse. The progress notes indicated that the resident's SDM was notified of the incident four days later. During interview, the SDM confirmed that they were not notified immediately after the incident had occurred.

B) A review of resident #036's health records indicated that they were admitted on an identified date, and had a cognitive performance scale (CPS) of 3. The progress notes between identified dates, indicated that resident #036 exhibited identified behaviours toward co-residents, on an identified number of occasions. The progress notes did not indicate that the resident's SDM was notified at the time of these incidents or within 12 hours. During interview, the Supervisors of Care (SOC) confirmed the residents involved in resident #036's sexual behaviours, did not have their SDM's notified following each incident of abuse. [s. 97. (1)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the analysis undertaken of every incident of abuse or neglect of a resident at the home were considered in the evaluation.

Review of the home's 2014 evaluation (dated June 2015)of their Prevention of Abuse and Neglect policy revealed, that there had been an identified number of alleged incidents of abuse in the home during 2014 and did not include an identified number of documented incidents of inappropriate behaviour against co-residents by resident #036. The evaluation did not indicate that it was based on the analysis of alleged the incidents of abuse. During interview, the Acting Administrator could not verify that the evaluation was based on an analysis of the incidents involving resident #036. [s. 99. (c)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident that caused injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident.

During the evening on an identified date, resident #061 was being transferred from bed to their wheelchair using a sit-to-stand lift when they lost their footing and the two personal support workers (PSW's) lowered the resident to the floor. The resident was assessed by Registered Practical Nurse (RPN) #109, and then sent to the hospital where they were diagnosed a fracture. The Critical Incident System (CIS) report was not submitted to the Director until an identified date; seven days after the incident occurred. The Supervisors of Care (SOC) confirmed the Director was not notified within one business day of the incident. [s. 107. (3) 4.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Administrator and a Registered Dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home.

A review was completed of the annual evaluation of the medication management system for 2014 and 2015. The Program Support Nurse(PSN) confirmed that the Administrator and the Registered Dietitian (RD) had not taken part in the annual evaluations. [s. 116. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee has failed to ensure that there is no more than a three-month supply of drugs obtained for use in the home.

On an identified date, the government stock supply room was inspected. The following was noted:

i) an identified number of bottles of Alugel 425 millilitre (ml) bottles
ii) an identified number of bottles of calamine lotion 500 ml bottles
iii) an identified number of bottles of iodine solution 450 ml bottles

The Supervisor of Care(SOC) who is responsible for ordering the government stock confirmed that these government stock items would most likely exceed a three-month supply. [s. 124.]

WN #17: 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 has failed to ensure that drugs comply with the manufacturer's instruction for expiration dates.

On January 7, 2016, all medication carts in the home were checked for eye drops and insulin's to ensure they were dated as to when they were opened, and when they were to be discarded as per the manufacturer's instructions.

The inspector noted the following:

i) Garden View/Rosedale home areas-Second Floor-six out of six cartridges of insulin in use were not dated
ii) Ocean View/Sunrise Blvd home areas-Fourth Floor–one cartridges of insulin was outdated; one cartridge of insulin in use was not dated

The discard date for insulin's is 28 days as per manufacturer's instructions, 30 days as per pharmacy directives. This was confirmed by the Registered Practical Nurse (RPN) on second floor, as well as, the RPN on fourth floor. [s. 129. (1) (a)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the quarterly review is undertaken of all medication incidents and adverse reactions in order to reduce and prevent medication incidents and adverse drug reactions.

On an identified date, a review was completed of the Health Services Advisory Committee minutes for 2014 and 2015. The Program Support Nurse (PSW) confirmed that the advisory committee did not review medication incidents and adverse reactions at their quarterly meetings. On an identified date, the long term care (ltc)inspector spoke with both Supervisors of Care(SOC)who confirmed that individualized medication incident reviews occur with the registered staff involved; however, a quarterly review is not completed at this time. [s. 135. (3)]

Issued on this 9th day of February, 2016

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) :	CATHIE ROBITAILLE (536), JESSICA PALADINO (586), THERESA MCMILLAN (526), YVONNE WALTON (169)
Inspection No. / No de l'inspection :	2015_275536_0022
Log No. / Registre no:	035287-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 1, 2016
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF PEEL 10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9
LTC Home / Foyer de SLD :	SHERIDAN VILLA 2460 TRUSCOTT DRIVE, MISSISSAUGA, ON, L5J-3Z8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Griffin

To THE REGIONAL MUNICIPALITY OF PEEL, 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 of a long-term care home shall protect residents from abuse by anyone. The licensee shall also develop and implement procedures and interventions to assist residents and staff who are at risk of harm or who are harmed as a result of the residents' behaviours, including responsive behaviours and to minimize the risk of altercations and potentially harmful interactions between and among residents.

The home shall develop a protocol that identifies potentially harmful behaviours exhibited by newly admitted residents.

The protocol shall include:
1. Identification of the potential abusive behaviours
2. Safety risk assessment of the behaviours toward co-residents
3. Strategies to implement to ensure all residents are protected from abuse
4. Staff will be trained on process and procedures with dealing with such responsive behaviours

The protocol shall ensure there is a collaborative approach by the interdisciplinary team that reviews the behaviours and implements strategies to minimize the risk of abusive inappropriate interactions between residents. The protocol shall include the use of one to one monitoring while the interdisciplinary team develops an individualized plan of care including medication changes and referrals to internal resources and external specialists.

Grounds / Motifs :

1. A) Resident #036 was admitted on an identified date to the home's Special Behaviour Unit. The progress notes indicated that they exhibited specific behaviours during identified dates. A review of the document the home referred to as the resident's care plan regarding management of these behaviours; completed on an identified date, indicated what staff were directed to do. Staff persons #107 and #108 were unable to state the specific interventions that were to be implemented from the plan of care. During interview, the Supervisors of Care verified that residents were not protected from resident #036 between the identified dates. [526]

B) Resident #055 was admitted to the home on an identified date; and had identified behaviours on their care plan. In the first few weeks following admission, resident #055 had a number altercations with resident #054. Resident #055 had responsive behaviours that were identified as triggers for resident #054. A few days later resident #055 was noted to be restless, and began hitting other. Four hours later, the resident continued to be aggressive and pushed identified residents, one resulting in injury to a resident. After three incidents, the licensee implemented one to one staffing to protect resident #055, and all the other residents on the secured home area. This was confirmed by the clinical documentation and the Supervisors of Care. [169]

C) On an identified date, resident #059 assaulted resident #058. Resident #059 was admitted to the home on an identified date, with a history of identified behaviours. One day after admission, resident #059 demonstrated these behaviours towards two residents. These behaviours continued for seven days following admission and resulted in one resident being sent to hospital.

(169)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 21, 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
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 1st day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cathie Robitaille

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