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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5700 Yonge Street 5th Floor
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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
Dec 3, 2015	2015_413500_0014	CSC-024454-15	Resident Quality Inspection

Licensee/Titulaire de permis

ST. DEMETRIUS (UKRAINIAN CATHOLIC) DEVELOPMENT CORPORATION
60 RICHVIEW ROAD ETOBICOKE ON M9A 5E4

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

UKRAINIAN CANADIAN CARE CENTRE
60 RICHVIEW ROAD ETOBICOKE ON M9A 5E4

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

NITAL SHETH (500), CECILIA FULTON (618), JANET GROUX (606)

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): September 10, 11, 14, 15, 16, 17, 18, 21, and 22, 2015.

The following complaint inspection intakes were inspected during this RQI: CSC #022199-15.
The following critical incident (CI) intakes were inspected during this RQI: CSC #019219-15, #017840-15, #001044-15, and #026103-15.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Director of Support Services (DSS), Resident Assessment Instrument (RAI) Coordinator, Food Service Manager (FSM), Registered Dietitian (RD), Administrative Assistant (AA), Human Resource and Finance Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Recreation Assistant, Housekeeping staff, Cook, Residents and Family Members.

During the course of the inspection the inspector(s) conducted observations of medication administration, meal service delivery, residents' and home area, staff to resident interactions, reviewed clinical health records, staffing schedules/assignments, relevant policies and procedures and Residents' Council and Family Council meetings minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Skin and Wound Care

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

- **6 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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 ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A review of resident #007's plan of care revealed that the resident required an identified intervention.

Observations conducted in September 2015 revealed the identified intervention was not implemented as indicated in the plan of care.

Interview with PSW #103, #128, and RN #102 revealed that identified intervention should have been implemented as specified in the plan of care and was not.

Interview with the Administrative Assistant (AA) #124 revealed that staff may be making a judgement decision and modifying the identified intervention. AA #124 confirmed that this is not being reflected in the plan of care or any other documentation.

Interview with DOC #115 confirmed the identified intervention should have been provided as specified in the plan of care. [s. 6. (7)]

2. A review of resident #021's current plan of care indicated that the resident required one person constant supervision and two person extensive physical assistance for toileting.

Review of the resident's progress notes dated July 2015, revealed that the resident was found on the floor when PSW #126 left the resident unattended on the toilet while their attention was drawn to a noise in the hallway.

MDS quarterly review of May 2015 revealed the resident required extensive assistance and one person physical assist needed for - bed mobility, dressing, toileting, locomotion, transfer and bathing.

A quarterly fall assessment conducted in May 2015 put the resident at moderate risk of falls.

A review of the Critical Incident (CI) revealed that PSW #126 left the resident unattended during toileting in July 2015. The PSW stepped out of the bathroom to investigate a noise coming from the hallway. Meanwhile, the resident slid off the toilet and onto the floor and on his/her buttocks. The resident was transferred to the hospital where it was determined that the resident sustained an injury. The resident subsequently passed away in the hospital.

Interview with PSW #126 confirmed that he/she had left the resident unattended on the toilet while his/her attention was drawn to a noise in the hallway.

Interview with DOC #115 confirmed that PSW #126 did not provide care as specified in the plan and left the resident unattended on the toilet, as a result the resident had sustained an injury. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 :

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Review of critical incident (CI) report revealed in July 2015, resident #011 was observed with a swollen identified area and complained of pain. The resident was transferred to the hospital and was diagnosed with an injury. The resident returned to the home four days later. The resident was transferred back to hospital the following day after the staff found the resident with unusual signs and symptoms. Resident #011's condition deteriorated in the hospital and he/she passed away.

The home's investigation records revealed that in July 2015, PSW #127 failed to secure the identified strap of the sit stand lift and completed a one person transfer while transferring resident #011. During the transfer resident #011's foot slipped to the floor from the footrest of the lift while the resident's other foot remained elevated on the foot rest.

Interview with PSW #127 revealed that the home's policy requires two staff at all times when operating a sit stand lift and revealed he/she transferred resident #011 by him/herself because he/she was unable to get assistance from the other staff member. The PSW confirmed he/she did not use safe transferring techniques when transferring resident #011 using a sit stand lift.

Interview with DOC #115 revealed that the home's internal investigation confirmed that staff failed to use safe transferring techniques when resident #011 was transferred with the sit stand lift and as a result the resident sustained an injury.
The severity of the non-compliance and the severity of the harm was actual as the above mentioned incident contributed to resident #011's health condition and subsequently the resident passed away.

The scope of the non-compliance was isolated to resident #011.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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, the home, furnishings and equipment are kept clean and sanitary.

In September 2015, at 11:55 AM, the inspector observed the following concerns in the kitchen:
- floor was unclean and sticky
- black greasy material on the floor under the dishwasher, and on the shelf, side wall and back of the preparation table.

Interview with FSM #110 and the DSS #112 confirmed that the floor and the areas noted above were dirty and required cleaning. [s. 15. (2) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

In September 2015, during the lunch meal on an identified floor, resident #034 was served soup but did not receive assistance to eat the food item. The resident did not eat the soup.

A review of the resident's plan of care and point of care record indicated the resident's eating ability was impaired due to physical weakness, and required total dependence by one person for eating. Six minutes later the RD came and fed the resident a soup.

Interview with RN #109, FSM #111 and RD #110 confirmed that staff should not have served the soup until someone was available to provide feeding assistance to the resident. [s. 73. (2) (b)]

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

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Review of CI revealed that the home reported resident #011 had an incident in July 2015. The resident was transferred to the hospital and sustained an injury. The CI indicated that the home first reported the incident to the Director eight days later.

Review of resident #011's progress notes revealed that the home was informed by the hospital of the resident's injury on the same day.

Interview with DOC #115 confirmed that the home failed to report resident #011's injury to the Director within the time frame required under this legislation. [s. 107. (3.1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the program.

Observation in September 2015, during the initial tour, the inspector observed an unlabelled, dark, pink hairbrush with strands of hair and a dirty black comb in a care cart in an identified clean utility room.

Interview with PSW #132 and RN #133 revealed that the hairbrush and comb were not labelled and should have been. The RN #133 discarded the hairbrush and comb in the garbage disposal.

Interview with DOC #115 confirmed that all resident's personal care items such as hairbrushes and combs are to be labelled and stored in their rooms and not in the care carts. [s. 229. (4)]

Issued on this 4th day of January, 2016

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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) :	NITAL SHETH (500), CECILIA FULTON (618), JANET GROUX (606)
Inspection No. / No de l'inspection :	2015_413500_0014
Log No. / Registre no:	CSC-024454-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 3, 2015
Licensee / Titulaire de permis :	ST. DEMETRIUS (UKRAINIAN CATHOLIC) DEVELOPMENT CORPORATION 60 RICHVIEW ROAD, ETOBICOKE, ON, M9A-5E4
LTC Home / Foyer de SLD :	UKRAINIAN CANADIAN CARE CENTRE 60 RICHVIEW ROAD, ETOBICOKE, ON, M9A-5E4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sandra Lomaszewycz

To ST. DEMETRIUS (UKRAINIAN CATHOLIC) DEVELOPMENT CORPORATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with s. 6 (7) to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The plan shall provide the following:
-outline the home's immediate, short-term and long-term strategies to educate staff on the importance of the plan of care and risks associated with not following a resident's plan of care.
- ensure staff are kept aware of the contents of the residents' plan of care and have convenient and immediate access to it.
- identify how the licensee will ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The plan shall be submitted by December 18, 2015, via email to nital.sheth@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that care is provided to the Resident as set out in the plan of care.

A review of resident #021 current plan of care indicated that the resident required one person constant supervision and two person extensive physical assistance for toileting.

Review of the resident's progress notes dated July 2015, revealed that the resident was found on the floor when PSW #126 left the resident unattended on the toilet while his/her attention was drawn to a noise in the hallway.

MDS quarterly review of May 2015 revealed that resident required extensive assistance and one person physical assist needed for - bed mobility, dressing, toileting, locomotion, transfer and bathing.

A quarterly fall assessment conducted in May 2015, put the resident at a moderate risk of falls with an identified score.

A review of the Critical Incident revealed that PSW #126 left the resident unattended during toileting in July 2015. The PSW stepped out of the bathroom to investigate a noise coming from the hallway. Meanwhile, the resident slid off the toilet and onto the floor on their buttocks. The resident was transferred to the hospital where it was determined that the resident sustained an injury. The resident subsequently passed away in the hospital.

Interview with PSW #126 confirmed that he/she had left the resident unattended on the toilet while his/her attention was drawn to a noise in the hallway.

Interview with DOC #115 confirmed that the PSW #126 did not provide care as specified in the plan of care and left the resident unattended on the toilet. As a result the resident had sustained an injury.

The severity of the non-compliance and the severity of the harm is actual as subsequent to this incident the resident passed away.

The scope of the non-compliance was isolated to resident #021.

A review of the Compliance History revealed the following non-compliances related to the Long-Term Care Homes Act, 2007, s. 6. (7). plan of care:

A Written Notification (WN) and a Voluntary Plan of Correction (VPC) was previously issued for s. 6. (7), during the inspection # 2014_337581_0024 on December 4, 2014. (618)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 15, 2016

Order # / Ordre no : 002

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 for achieving compliance with s. 36 to ensure that staff use safe transferring and positioning devices or techniques when assisting residents particularly in respect to managing residents' safety risks and prevention of harm to residents.

The plan shall provide the following:
-outline the home's immediate, short-term and long-term strategies to ensure residents are transferred safely by staff all the time,
- include who will be responsible for ongoing monitoring of staff using safe transferring techniques and devices to safely transfer residents
- to ensure that a sustainable system is put in place for staff to transfer residents safely at all the time,
- identify how and when re-education will be provided to all staff, including registered staff, as well as who will be responsible for providing the education on the safe transferring,
- education plan shall outline staff roles and responsibilities to identify, communicate and rectify situations in relation to all possible risk for residents for not using safe transferring procedures according to residents' individualized plan of care and the home's policy on safe transferring techniques.

The plan shall be submitted by December 18, 2015, via email to nital.sheth@ontario.ca.

Grounds / Motifs :

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

Review of critical incident (CI) report revealed in July 2015, resident #011 was observed with a swollen identified area and complained of pain. Resident was transferred to the hospital and was diagnosed with an injury. Resident returned to the home four days later. The resident was transferred back to hospital the following day after the staff found the resident with unusual signs and symptoms. Resident #011's condition deteriorated in the hospital and he/she passed away.

The home's investigation records revealed that in July 2015, PSW #127 failed to secure the identified strap of the sit stand lift and completed a one person transfer while transferring resident #011. During the transfer resident #011's foot slipped to the floor from the footrest of the lift while the resident's other foot remained elevated on the foot rest.

Interview with PSW #127 revealed that the home's policy requires two staff at all times when operating a sit stand lift and revealed he/she transferred resident #011 by him/herself because he/she was unable to get assistance from the other staff member. The PSW confirmed he/she did not use safe transferring techniques when transferring resident #011 using a sit stand lift.

Interview with DOC #115 revealed that the home's internal investigation confirmed that staff failed to use safe transferring techniques when resident #011 was transferred with the sit stand lift and as a result the resident sustained an injury.

The severity of the non-compliance and the severity of the harm was actual as the above mentioned incident contributed to resident #011's health condition and subsequently the resident passed away.

The scope of the non-compliance was isolated to resident #011. (606)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 15, 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 3rd day of December, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nital Sheth

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