



**Ministry of Health and  
Long-Term Care**

**Ministère 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**

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**Name of Inspector (ID #) /**

**Nom de l'inspecteur (No) :** DIANA STENLUND (163)

**Inspection No. /**

**No de l'inspection :** 2013\_139163\_0019

**Log No. /**

**Registre no:** 1362-12

**Type of Inspection /**

**Genre d'inspection:** Follow up

**Report Date(s) /**

**Date(s) du Rapport :** Jul 30, 2013

**Licensee /**

**Titulaire de permis :** REVERA LONG TERM CARE INC.  
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA,  
ON, L5R-4B2

**LTC Home /**

**Foyer de SLD :** LAKEHEAD MANOR  
135 SOUTH VICKERS STREET, THUNDER BAY, ON,  
P7E-1J2

**Name of Administrator /**

**Nom de l'administratrice**

**ou de l'administrateur :** Jonathon Riabov

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To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:



**Ministry of Health and  
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Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
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de soins de longue durée*, L.O. 2007, chap. 8

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**Order # /**

**Ordre no :** 001

**Order Type /**

**Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

**Linked to Existing Order /**

**Lien vers ordre existant:** 2012\_053122\_0014, CO #902;

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,

- (a) three meals daily;
- (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
- (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan for achieving compliance with O.Reg.79/10,s.71(3)(b)(c) to ensure that residents, specifically those on the third floor receive, according to their nutritional requirements, a between-meal beverage in the morning, afternoon and in the evening, and a snack in the afternoon and evening.

The plan is to be submitted to Diana Stenlund, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Sudbury Service Area Office, by August 09, 2013. Fax 705-564-3133.

**Grounds / Motifs :**



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

1. A previous compliance order relating to O.Reg, 79/10,s.71(3)(b)(c) was issued on Oct.15/12, during inspection #2012-053122-0014.

The inspector observed the delivery and provision of between-meal beverages and snacks. The inspector noted that approximately half of the unit's residents remained in their rooms on the morning of June 23, 2013 and were not offered a beverage during the morning pass.

On the same day in the afternoon, inspector observed that resident #401 who is at high nutritional risk, was in their room at the time of nourishment rounds and was not offered a beverage and or snack by staff.

Inspector also noted that resident # 301 who is at high nutritional risk, was not offered the full amount of their high calorie supplement drink (approximately only half of the 235ml ordered was provided) on two separate occasions when nourishment rounds were observed. The licensee has not ensured that each resident is offered a minimum of a between-meal beverage in the morning, afternoon and evening and evening a snack in the afternoon and evening. (163)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le : Aug 09, 2013**



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et  
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**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

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**Order # /**  
**Ordre no :** 002

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8,  
s. 11. (1) Every licensee of a long-term care home shall ensure that there is,  
(a) an organized program of nutrition care and dietary services for the home to  
meet the daily nutrition needs of the residents; and  
(b) an organized program of hydration for the home to meet the hydration needs  
of residents. 2007, c. 8, s. 11. (1).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007,S.O.2007.c.8,s.11(1) to ensure that there is (a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents, and (b) an organized program of hydration to meet the needs of residents, specifically relating to the provision of between-meal beverages and snacks to the residents on third floor.  
The plan is to be submitted to Diana Stenlund, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Sudbury Service Area Office, by August 16/13, Fax 705-564-3133.

**Grounds / Motifs :**

1. Inspector observed the provision of between-meal beverages and snacks on a particular unit and noted that it was not organized as evidenced by the following:

- 1) Food that had been pureed was not always labelled, as a result, staff were not aware of what food item they were serving the residents on pureed diets.
- 2) Dietary staff was observed to remove the snack cart before the nourishment rounds were complete.
- 3) There is no organized process in place regarding staff assignment to complete the task of providing between-meal beverages and snacks. Staff reported to the inspector that staff (any staff) finish the task as they "have time", as a result, not all residents were observed to receive a snack (food and/or



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section 154 of the *Long-Term Care  
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beverage) because staff were not clear, or they not did always communicate with each other which residents had been served or still required to be served their nourishment.

4) The resident diet book placed on the cart was not referred to by staff during snack rounds to ensure accuracy, as a result, not all residents received the proper texture of foods and/or consistency of fluids.

5) Staff were observed to not consistently implement hand hygiene practices during nourishment rounds.

6) Residents requiring assistance with eating and/or drinking were not consistently provided the assistance.

7) Staff were observed to mix and prepare thickened beverages during nourishment rounds for all fluid consistencies, while commercially prepared thickened beverages were reported to be available on the unit for nectar and honey consistency.

8) Family members on the unit were observed helping themselves from the nourishment cart and staff were not aware.

9) Beverages such as milk were not stored on the cart to maintain proper, consistent temperatures.

10) Inspector observed over the course of the inspection that the nourishment cart would be left unattended by staff for extended periods of time (placed near the elevator) for time periods up to 51 minutes in duration.

The licensee has not ensured that there is, an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and an organized program of hydration for the home to meet the hydration needs of residents. (163)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le : Sep 13, 2013**



**Ministry of Health and  
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Pursuant to section 153 and/or  
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### **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



**Ministry of Health and  
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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](http://www.hsarb.on.ca).



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## **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.





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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](http://www.hsarb.on.ca).

**Issued on this 30th day of July, 2013**

**Signature of Inspector /  
Signature de l'inspecteur :**

*Diana Stenlund, #163*

**Name of Inspector /**

**Nom de l'inspecteur :** DIANA STENLUND

**Service Area Office /**

**Bureau régional de services :** Sudbury Service Area Office



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Soins de longue durée**

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

**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**

**Sudbury Service Area Office  
159 Cedar Street, Suite 403  
SUDBURY, ON, P3E-6A5  
Telephone: (705) 564-3130  
Facsimile: (705) 564-3133**

**Bureau régional de services de  
Sudbury  
159, rue Cedar, Bureau 403  
SUDBURY, ON, P3E-6A5  
Téléphone: (705) 564-3130  
Télécopieur: (705) 564-3133**

**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Jul 30, 2013	2013_139163_0019	1362-12	Follow up

**Licensee/Titulaire de permis**

**REVERA LONG TERM CARE INC.  
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2**

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

**LAKEHEAD MANOR  
135 SOUTH VICKERS STREET, THUNDER BAY, ON, P7E-1J2**

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

**DIANA STENLUND (163)**

**Inspection Summary/Résumé de l'inspection**



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**The purpose of this inspection was to conduct a Follow up inspection.**

**This inspection was conducted on the following date(s): July 22-23, 2013**

**The following Compliance Orders were followed up:**

**CO #901**

**CO #902**

**During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, registered nursing staff, personal support workers (PSWs), Food Service Manager (FSM), and residents.**

**During the course of the inspection, the inspector(s) walked through resident home areas, observed the provision of snack service on the third floor, observed staff have 24-hour accessibility to appropriate food and beverages according to residents' diets and reviewed resident health care records.**

**The following Inspection Protocols were used during this inspection:**

**Dining Observation**

**Snack Observation**

**Findings of Non-Compliance were found during this inspection.**

<b>NON-COMPLIANCE / NON - RESPECT DES EXIGENCES</b>	
<b>Legend</b>	<b>Legendé</b>
<b>WN – Written Notification</b>	<b>WN – Avis écrit</b>
<b>VPC – Voluntary Plan of Correction</b>	<b>VPC – Plan de redressement volontaire</b>
<b>DR – Director Referral</b>	<b>DR – Aiguillage au directeur</b>
<b>CO – Compliance Order</b>	<b>CO – Ordre de conformité</b>
<b>WAO – Work and Activity Order</b>	<b>WAO – Ordres : travaux et activités</b>



<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>
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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

**s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).**

**s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).**

**Findings/Faits saillants :**



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1. The inspector observed the delivery and provision of between-meal beverages and snacks. The inspector noted that residents who remained in their rooms on the morning of June 23, 2013 on half of one of the units were not offered a beverage during the morning pass.

On the same day in the afternoon, inspector observed that resident #401 who is at high nutritional risk, was in their room at the time of nourishment rounds and was not offered a beverage and or snack by staff.

Inspector also noted that resident # 301 who is at high nutritional risk, was not offered the full amount of their high calorie supplement drink (approximately only half of the 235ml ordered was provided) on two separate occasions when nourishment rounds were observed. The licensee has not ensured that each resident is offered a minimum of a between-meal beverage in the morning, afternoon and evening, and an evening snack in the afternoon and evening. [s. 71. (3) (b)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration**

**Specifically failed to comply with the following:**

- s. 11. (1) Every licensee of a long-term care home shall ensure that there is,**  
**(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and 2007, c. 8, s. 11. (1).**  
**(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).**

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**Findings/Faits saillants :**



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1. Inspector observed the provision of between-meal beverages and snacks on a particular unit and noted that it was not organized by the following evidence:

- 1) Food that had been pureed was not always labelled, as a result, staff were not aware of what food item they were serving the residents on pureed diets.
- 2) Dietary staff was observed to remove the snack cart before the nourishment rounds were complete.
- 3) There is no organized process in place regarding staff assignment to complete the task of providing between-meal beverages and snacks. Staff reported to the inspector that staff (any staff) finish the task as they "have time", as a result, not all residents were observed to receive a snack (food and/or beverage) because staff were not clear, or they not did always communicate with each other which residents had been served or still required to be served their nourishment.
- 4) The resident diet book placed on the cart was not referred to by staff during snack rounds to ensure accuracy, as a result, not all residents received the proper texture of foods and/or consistency of fluids.
- 5) Staff were observed to not consistently implement hand hygiene practices during nourishment rounds.
- 6) Residents requiring assistance with eating and/or drinking were not consistently provided the assistance.
- 7) Staff were observed to mix and prepare thickened beverages during nourishment rounds for all fluid consistencies, while commercially prepared thickened beverages were reported to be available on the unit for nectar and honey consistency.
- 8) Family members on the unit were observed helping themselves from the nourishment cart and staff were not aware.
- 9) Beverages such as milk were not stored on the cart to maintain proper, consistent temperatures.
- 10) Inspector observed over the course of the inspection that the nourishment cart would be left unattended by staff for extended periods of time (placed near the elevator) for time periods up to 51 minutes in duration.

The licensee has not ensured that there is, and organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and an organized program of hydration for the home to meet the hydration needs of residents. [s. 11. (1)]



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

**Additional Required Actions:**

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

**THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/  
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:**

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDRES			
REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 71. (7)	CO #901	2012_053122_0014	163

**Issued on this 30th day of July, 2013**

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

*Diana Jenkund, #163*