Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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# Amended Public Copy/Copie modifiée du rapport public

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 27, 2020 | 2020_848748_0002 (A1) | 003318-20, 004536-20, 009931-20 | Complaint |

## Licensee/Titulaire de permis

St. Peter's Care Centres
125 Redfern Avenue HAMILTON ON L9C 7W9

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

St. Peter's Residence at Chedoke
125 Redfern Avenue HAMILTON ON L9C 7W9

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

Amended by EMMY HARTMANN (748) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

Compliance Orders #001, #002, and #003 now have a compliance due date of February 18, 2021.

Issued on this 27th day of November, 2020 (A1)

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

Original report signed by the inspector.

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

Amended by EMMY HARTMANN (748) - (A1)

## Amended Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): September 18, 21, 22, 23, 24, 25, 28, 29, 30, October 1, 2, 5, 6, 7, 8, 9, 13, 14, 15, 16, 19, 20, 21, 2020.**

**The following intakes were completed in this inspection:**

**Log #003318-20 was a complaint related to care issues.**

**Log #004536-20 was a complaint reinspection related to assessments, medication, and abuse.**

**Log #009931-20 was a complaint related to medication and care issues.**

**This inspection was completed concurrently with Critical Incident Inspection #2020_543561_0011, and non-compliance identified from the CIS inspection was issued in this inspection.**

**During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Care Supervisor (RCS), Recreation Manager, hairdresser, registered nurses (RN), registered practical nurses (RPN), and personal support workers (PSW).**

**During the course of the inspection, the inspector also observed the provision of care and services, and reviewed records, and policies.**

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

**Falls Prevention**
**Hospitalization and Change in Condition**
**Medication**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**

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

- **10 WN(s)**
- **4 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.)<br><br>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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**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 failed to ensure that there was a written plan of care for the resident's medical condition and treatment, that set out the planned care for the resident, the goals the care was intended to achieve, and clear directions to staff and others who provided direct care to the resident.

A. A resident was noted to have a medical condition that lasted for seven months, which affected their activities of daily living and mental health. The staff noted different ways in which they managed the medical condition in the resident's progress notes. The doctor indicated that the medical condition was due to the resident's disease diagnosis. It was identified by the home that the written plan of care would be outlined in the resident's care plan on Point Click Care (PCC);

however, in review of this, the home did not have a written plan that identified how to address the medical issue including outlining the planned care, the goals, and clear directions to staff.

There was a risk of harm to the resident as there was no written plan of care to direct staff on how to manage the resident's medical condition.

Sources: Review of resident's care plan, progress notes; Interviews with RPN #109, RPN #110, RPN #111, Administrator, and Physician.

B. A resident was administered a specific treatment, without a written plan of care for its use, that outlined the planned care, the goals the care was intended to achieve, including but not limited to, when to provide the treatment, the amount to apply, the mode of administration, and when to discontinue the treatment. There was also no clear directions to staff and others who provided direct care to the resident.

The resident was noted to have a change in their health condition, while the resident was receiving the treatment.

Sources: Review of resident's care plan, progress notes; Review of the home's Policy (last revised/reviewed July 31, 2012); Interviews with RPN #110, ADOC, and Administrator.

C. The licensee failed to ensure that there were clear directions related to a resident's treatment administration.

According to the home's policy, the treatment use within the home was to be authorized by the physician by writing an order.

i. The ADOC identified that the resident was administered a specified amount of a certain treatment twice a day as needed. However, there were two areas that Registered Staff were signing off on the administration of the treatment. One area was in the eMAR which indicated that the resident may receive the treatment twice a day as needed, and another area was in the eTAR which indicated that the resident may have an equivalent of two treatments a day. The ADOC identified that the notation in the eTAR was more of a note to alert staff that the

resident may only have a maximum of two treatments a day, but that the resident did not have two orders for the treatment. They acknowledged that this was not clear direction to staff providing care to the resident.

ii. The physician wrote an order for a specified amount of a treatment to be given twice a day, for the resident. However, the eMAR reflected a specified amount twice a day as needed. The ADOC indicated that the order was intended to be on an as needed basis, as the intention of the order was to specify the amount of the treatment from the previous order. The ADOC acknowledged that this was not clear direction to staff providing care to the resident.

Sources: Review of resident's physician's orders, eMARS, eTARS; Review of the home's Policy (last reviewed October 2019); Interview with ADOC. [s. 6. (1)]

2. The licensee failed to ensure that a resident's Power of Attorney (POA) was given an opportunity to participate fully in the development and implementation of a resident's plan of care.

The home identified that they informed the resident's POA of changes to the resident's heath status and treatments; and obtained consent from the resident's POA. They identified that they documented POA notification, or obtained consent in the resident's progress notes or the physician's order's section of the resident's chart.

A review of resident's records identified that there was no notification of the POA or consent obtained for a doctor's order in three different instances.

Sources: Review of resident's progress notes, physician's orders, and September 2019 eMAR; Review of the home's Informed Consent Policy (last revised/reviewed October 19, 2018); Interviews with RPN #111, and DOC. [s. 6. (5)]

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

The home identified that the nurses were able to administer a treatment to residents as a nursing measure if needed, and would then obtain an order from

the doctor if there was an ongoing need for the treatment.

The resident was administered the treatment on a specified date in 2019. Two days later, the resident was again administered the treatment as there was a change and decline in the resident's health status. The nurse filled out a referral for the treatment and indicated that they would leave a message for the nurse practitioner to write an order for the treatment.

However, the nurse practitioner did not write an order for the treatment and the referral was not sent.

The resident had an ongoing need for the treatment and was administered the treatment, without a doctor's order.

Sources: Review of resident's progress notes, assessments, physician's orders; Review of the home's Policy (last revised/reviewed July 31, 2012); Interviews with RPN #110, ADOC, and Administrator. [s. 6. (7)]

4. The licensee failed to ensure that a resident's plan of care was revised when the resident's care needs changed or care set out in the plan was no longer necessary.

The resident was at risk for falls, and their falls were usually as a result of known risk factors. The Falls Committee recommended on two separate instances, that the resident was reminded to call for assistance when they felt weak; and that the resident needed to be reminded to use the call bell.

The home identified that when there were changes to the resident's plan of care, it would be reflected in the resident's care plan on Point Click Care (PCC), but the interventions noted in the Falls Committee meetings were not added to the resident's care plan.

Sources: Review of resident's care plan, progress notes; Review of the home's Falls Prevention and Post Fall Management Program (last revised/reviewed August 2019); Interviews with RPN #110, and Administrator. [s. 6. (10) (b)]

***Additional Required Actions:***

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

**(A1)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001**

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

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

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

The licensee failed to comply with s. 24 (1) in that a person who had reasonable grounds to suspect improper or incompetent care of a resident, failed to report immediately to the Director in accordance with s. 24 (1) of the LTCHA. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

In three instances in 2019, the home was notified of concerns related to improper and incompetent care of the resident.

The home did not report the incidents to the Director.

Sources: Review of the home's Duty to Report Policy (approved Feb 2020); Review of the home's Resolving Complaint's Log 2019; Interviews with Resident Care Supervisor #119, and Administrator.

2. The licensee has failed to comply with s. 24 (1) 2. in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

PSW #115 witnessed PSW #116 emotionally abuse the resident, and failed to report this incident to registered staff. On the following day after the incident, the resident reported the incident to registered staff. The home did not report the alleged abuse until three days after the incident.

Sources: Critical Incident System report 2927-000009-20; LTCH's investigation notes; interview with PSW #115 and ADOC.

This non-compliance was from CIS inspection #2020_543561_0011, which was completed concurrently with this inspection. [s. 24. (1)]

***Additional Required Actions:***

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

**(A1)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002**

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**WN #3: 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 :**

The licensee failed to ensure that residents were not neglected by the licensee or staff.

According to Ontario Regulation 79/10 Neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

A resident's written plan of care identified that the doctor was to be notified of signs and symptoms of complications of the resident's disease diagnosis.

The advanced health care guidelines for the resident, indicated that they were moderate care - level 3, which meant that the home would try to cure their illness and hospitalize them if needed.

The resident demonstrated a deterioration in their health status for a period of 10 days, before they were subsequently sent to the hospital. During this time, the

home was monitoring the resident's condition and documenting their symptoms, but there were incomplete assessments or lack of action.

The resident presented with changes in their condition that called for a referral to the dietitian, reassessment of their condition, and a call to the doctor. The home identified that they would call the physician when there was a need to reassess a treatment, and the physician identified that they expected to be called when there was a change in the resident's condition. However, there was no call to the doctor prior to the day that the resident was sent to the hospital.

There was actual harm or risk of harm to the resident, as the deterioration in their health status jeopardized their safety and well-being.

Sources: Review of resident's progress notes, care plan, physician's orders, Weights and Vitals on PCC; Review of the home's Documentation Policy (last revised/reviewed February 15, 2019); Review of the home's Oxygen-Low Flow Policy (last revised/reviewed July 31, 2012); Interviews with RPN #109, RPN #110, RPN #111, RN#118, and Physician.

2. The licensee has failed to ensure that residents were not neglected by staff.

O. Reg. 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A resident had multiple health diagnoses. Their advanced health care guidelines indicated that the resident was acute care - level 4, which meant that the resident was to be transferred to hospital for treatment and the home was to do everything medically and surgically possible to prolong their life.

Progress notes identified that the resident's health condition had deteriorated and subsequently they were sent to the hospital. For a period of three days, registered staff were monitoring the resident's condition and documenting their symptoms. The doctor was not called until the day that the resident was sent to the hospital.

Progress notes identified that the hospital staff stated the resident's prognosis was poor, they were treated for an infection and returned to the home, with new treatments. The POA stated in an interview with Inspector #561 that the resident

needed life saving interventions at the hospital.

Interview with registered staff #112 indicated that they were monitoring the resident; however, the physician was not called until the day the resident was sent to the hospital. The physician was interviewed and stated that the resident did have a change in their health condition and the on-call physician should have been called. The inaction of not notifying the physician of the change in the resident's condition prior to the day the resident was sent to the hospital, jeopardized the health and well being of the resident.

Sources: Resident's plan of care (care plan, progress notes, assessments, electronic medication administration record); interview with registered staff #104, 105, 108, 112, physician and ADOC.

3. The licensee failed to ensure that residents were protected from emotional abuse by PSW #116.

A resident required assistance with an activity of daily liviing. PSW #115 and PSW #116 assisted the resident. According to the resident's statement, PSW #116 made a comment to the resident that upset the resident. These actions were witnessed and confirmed by PSW #115. The ADOC was interviewed and stated that the home was able to substantiate emotional abuse and corrective action was taken.

Sources: Investigation notes; Interviews with PSW #115, PSW #116, and ADOC.

This non-compliance was from CIS inspection #2020_543561_0011, which was completed concurrently with this inspection. [s. 19. (1)]

***Additional Required Actions:***

**CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

**(A1)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003**

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**WN #4: 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 failed to ensure that where the Act or this Regulation required the licensee to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

A: In accordance with Ontario Regulation 79/10, s. 68 (2), the licensee was to ensure that the nutrition care and hydration program included the implementation of interventions to mitigate and manage risks related to nutrition care, dietary services and hydration.

Specifically, staff did not comply with the home' s Nutritional Care of Residents Policy, which indicated that changes in a resident's medical condition and nutritional intake is to be communicated to the dietitian by completing a Dietitian Referral form.

The home did not complete a referral to the dietitian when a resident had a change in their condition and change in their nutritional intake noted on two separate days.

The resident was not assessed by the dietitian when there were changes in their medical condition and intake, as no referrals were completed.

Sources: Review of resident's progress notes and assessments; Review of the home's Nutritional Care of residents Policy (last reviewed July 30, 2016); Interviews with RPN #109, and DOC.

B: In accordance with Ontario Regulation 79/10, s. 49 (1), the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the home's Head Injury Policy, which indicated to observe resident for symptoms and notify physician if there was an increase or decrease in blood pressure and to check in the chart to ensure that this was not normal for the resident.

A resident had a fall in September 2019, and had a head injury routine initiated. Two days after, the resident had a blood pressure that was lower than their baseline. During an interview with RN #118, they indicated that if the resident's BP was low compared to their baseline, they would check it against their baseline, recheck and call the doctor as needed, however, there was no follow-up to monitor or reassess the resident's BP.

The resident's low BP post-fall, was not reassessed, and communicated to the doctor.

Sources: Review of resident's progress notes, vital signs, and head injury routine form; Review of the home's Head Injury Policy (last revised/reviewed October 18, 2019); Interview with RN #118. [s. 8. (1) (a),s. 8. (1) (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 to ensure that 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, is complied with, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

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

**s. 23. (1) Every licensee of a long-term care home shall ensure that,**
**(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:**
**(i) abuse of a resident by anyone,**
**(ii) neglect of a resident by the licensee or staff, or**
**(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).**
**(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
**(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that every alleged, suspected, or witnessed incident of improper and incompetent care that may cause harm or risk of harm of a resident was immediately investigated.

Resident Care Supervisor #119 identified that a complaint was received related to improper and incompetent care of a resident; however, the incident was not investigated as there were no dates provided to the home by the complainant.

The home identified that this allegation of improper and incompetent care of the resident, was not investigated until four months after the initial report to the home.

Sources: Review of the home's Duty to Report Policy (approved Feb 2020); Review of the home's Resolving Complaint's Log 2019; Interviews with Resident Care Supervisor #119, and Administrator. [s. 23. (1) (a)]

***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 every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated, (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

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

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the skin assessments completed by PSW staff for two residents were documented.

A resident's point of care (POC) documentation for two months in 2019 were reviewed, and identified two days when skin assessments completed by PSW staff, were not documented. Another resident's POC documentation for a month in 2020 was reviewed and identified that PSW staff did not document a skin assessment for a day. PSW #114 stated that it was an expectation to document skin assessments completed on bath days and document the assessment in POC. The DOC confirmed that it was an expectation that PSW staff document the skin assessment in POC.

Sources: Two residents' POC documentation; Interview with PSW #114 and DOC.

2. The licensee failed to ensure that the voiding patterns for two residents were documented.

The POC was reviewed for a resident for two months in 2019, and identified that the PSW staff failed to document whether the resident had voided for:

Two days during the day shift, and two days during the evening shift, on one of the months.
One day during the day shift, on another month.

The POC for another resident was reviewed for a month in 2020 and identified that the PSW staff failed to document voiding:

Three days during the day shift, and two days during the evening shift.

The home's policy titled "Bladder Continence Care Management", policy number

6-2, revised February 26, 2019, stated under Documentation and Monitoring section of the policy that voiding patterns are to be documented in POC with each episode of voiding.

The DOC was interviewed and stated that it was the expectation of the PSW staff to document the resident’s voiding pattern and confirmed that they failed to do that on the dates identified.

Sources: Two residents' POC documentation; Bladder Continence Care Management policy (6-2, revised February 2019); Interview with DOC. [s. 30. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

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

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a medication treatment was administered to a resident in accordance with the directions for use specified by the prescriber.

Medication incident form on a specified date, indicated that on that day a registered staff found two medication treatments applied side by side with one date from the current day and the other from the day before. The direction made by the physician indicated to apply the medication treatment in the morning and remove the medication treatment in the evening. The ADOC was interviewed and they stated that two medication treatments were found on the resident, one dated from the current day and the other dated the day before. The progress notes indicated that the resident was stable, and no harm resulted from the medication error.

Sources: Medication Incident Form; Physician's Orders; May 2020 eMAR; Progress notes; Interview with RPN #103, RPN #108 and ADOC. [s. 131. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the written procedures for how the licensee dealt with complaints complied with the regulations.

In accordance with Ontario Regulation 79/10 s. 101 (2), the home was supposed to ensure that a documented record of every verbal or written complaint was kept in the home, with the exception of verbal complaints that was resolved within 24 hours of being received.

The home's policy identified that documentation of complaints was completed in the home's Resolving Issues log. However, only issues that have not been resolved within 24 hours were documented.

The home identified that written complaints were not documented in the log if they were resolved within 24 hours; which is not consistent with the regulations.

Sources: Review of Responding to Resident Issues Policy (last revised October 2019); Interview with Administrator. [s. 21.]

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**WN #9: 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. (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 failed to ensure that a resident's altered skin integrity received a skin assessment by a member of the registered nursing staff.

The resident had an altered skin integrity of unknown cause that was identified by RPN #111 in 2019. The DOC identified that the altered skin integrity was assessed and documented under a wound assessment on Point Click Care (PCC); however, there was no skin assessment documented for the altered skin integrity.

Sources: Review of resident's Progress Notes, and Assessments; Interview with DOC. [s. 50. (2) (b) (i)]

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

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

**s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,**
**(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).**
**(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).**
**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**
**(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).**
**(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).**
**(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that any response provided to the complainant and a description of the response was documented for the written complaints received in 2019, related to the care of a resident.

The home received a written complaint via an email related to the care of the resident on two dates in 2019. The Resident Care Supervisor identified that they addressed the complaints and provided a response to the complainant. However, the responses to the complainant were not documented.

Sources: Review of the home's Resolving Complaints Log 2019; Interviews with Resident Care Supervisor, and ADOC. [s. 101. (2)]

**Issued on this 27th day of November, 2020 (A1)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

## Ordre(s) de l'inspecteur

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

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

**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

### Amended Public Copy/Copie modifiée du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | Amended by EMMY HARTMANN (748) - (A1) |
| **Inspection No. / No de l'inspection :** | 2020_848748_0002 (A1) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / No de registre :** | 003318-20, 004536-20, 009931-20 (A1) |
| **Type of Inspection / Genre d'inspection :** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Nov 27, 2020(A1) |
| **Licensee / Titulaire de permis :** | St. Peter's Care Centres<br>125 Redfern Avenue, HAMILTON, ON, L9C-7W9 |
| **LTC Home / Foyer de SLD :** | St. Peter's Residence at Chedoke<br>125 Redfern Avenue, HAMILTON, ON, L9C-7W9 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Jennifer Banks |

To St. Peter's Care Centres, you are hereby required to comply with the following order(s) by the date(s) set out below:

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**Order # / No d'ordre:** 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. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

**Order / Ordre :**

The licensee must be compliant with s.6(1) of the Long Term Care Homes Act.

Specifically, the licensee must ensure that there is a written plan of care for residents that specifies,

(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.

**Grounds / Motifs :**

1. The licensee failed to ensure that there was a written plan of care for the resident's medical condition and treatment, that set out the planned care for the resident, the goals the care was intended to achieve, and clear directions to staff and others who provided direct care to the resident.

A. A resident was noted to have a medical condition that lasted for seven months, which affected their activities of daily living and mental health. The staff noted different ways in which they managed the medical condition in the resident's progress notes. The doctor indicated that the medical condition was due to the resident's disease diagnosis. It was identified by the home that the written plan of

care would be outlined in the resident's care plan on Point Click Care (PCC); however, in review of this, the home did not have a written plan that identified how to address the medical issue including outlining the planned care, the goals, and clear directions to staff.

There was a risk of harm to the resident as there was no written plan of care to direct staff on how to manage the resident's medical condition.

Sources: Review of resident's care plan, progress notes; Interviews with RPN #109, RPN #110, RPN #111, Administrator, and Physician.

B. A resident was administered a specific treatment, without a written plan of care for its use, that outlined the planned care, the goals the care was intended to achieve, including but not limited to, when to provide the treatment, the amount to apply, the mode of administration, and when to discontinue the treatment. There was also no clear directions to staff and others who provided direct care to the resident.

The resident was noted to have a change in their health condition, while the resident was receiving the treatment.

Sources: Review of resident's care plan, progress notes; Review of the home's Policy (last revised/reviewed July 31, 2012); Interviews with RPN #110, ADOC, and Administrator.

C. The licensee failed to ensure that there were clear directions related to a resident's treatment administration.

According to the home's policy, the treatment use within the home was to be authorized by the physician by writing an order.

i. The ADOC identified that the resident was administered a specified amount of a certain treatment twice a day as needed. However, there were two areas that Registered Staff were signing off on the administration of the treatment. One area was in the eMAR which indicated that the resident may receive the treatment twice a day as needed, and another area was in the eTAR which indicated that the resident

may have an equivalent of two treatments a day. The ADOC identified that the notation in the eTAR was more of a note to alert staff that the resident may only have a maximum of two treatments a day, but that the resident did not have two orders for the treatment. They acknowledged that this was not clear direction to staff providing care to the resident.

ii. The physician wrote an order for a specified amount of a treatment to be given twice a day, for the resident. However, the eMAR reflected a specified amount twice a day as needed. The ADOC indicated that the order was intended to be on an as needed basis, as the intention of the order was to specify the amount of the treatment from the previous order. The ADOC acknowledged that this was not clear direction to staff providing care to the resident.

Sources: Review of resident's physician's orders, eMARS, eTARS; Review of the home's Policy (last reviewed October 2019); Interview with ADOC. [s. 6. (1)]

An order was made by taking the following factors into account:

Severity: There was minimal harm or risk of harm related to this non-compliance.

Scope: The non-compliance was isolated to one resident, but three areas were identified related to written plan of care.

Compliance History: The licensee was found to be non-compliant with s.6(1) of the Long Term Care Homes Act in the past 36 months, and a Voluntary Plan of Correction was issued to the home. (748)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Feb 18, 2021(A1)

**Order # / No d'ordre:** 002

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

**Order / Ordre :**

The licensee must be compliant with s.24(1) of the Long Term Care Homes Act.

1. Specifically, the licensee must ensure that they immediately report the suspicion and the information upon it is based to the Director, when they have reasonable grounds to suspect that any of the following has occurred or may occur:
a. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
b. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

2. PSW #115, and PSW #116 are re-educated on the home's Duty to Report Policy and Non-Abuse of Residents Policy. The record of the education is to be documented, including who conducted the education, what information was covered, and a knowledge evaluation of the participants.

**Grounds / Motifs :**

1. The licensee failed to comply with s. 24 (1) in that a person who had reasonable grounds to suspect improper or incompetent care of a resident, failed to report immediately to the Director in accordance with s. 24 (1) of the LTCHA. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

In three instances in 2019, the home was notified of concerns related to improper and incompetent care of the resident.

The home did not report the incidents to the Director.

Sources: Review of the home's Duty to Report Policy (approved Feb 2020); Review of the home's Resolving Complaint's Log 2019; Interviews with Resident Care Supervisor #119, and Administrator.

2. The licensee has failed to comply with s. 24 (1) 2. in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

PSW #115 witnessed PSW #116 emotionally abuse the resident, and failed to report this incident to registered staff. On the following day after the incident, the resident reported the incident to registered staff. The home did not report the alleged abuse until three days after the incident.

Sources: Critical Incident System report 2927-000009-20; LTCH's investigation notes; interview with PSW #115 and ADOC.

This non-compliance was from CIS inspection #2020_543561_0011, which was completed concurrently with this inspection. [s. 24. (1)]

An order was made by taking the following factors into account:

Severity: There was minimal harm or risk of harm related to this non-compliance.

Scope: There was a pattern of non-compliance as two residents were involved in the non-compliance.

Compliance History: The licensee was found to be non-compliant with s.24(1) of the Long Term Care Homes Act in the past 36 months, and a Written Notification was issued to the home.
(748)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Feb 18, 2021(A1)

**Order # / No d'ordre:** 003

**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 must be compliant with s.19(1) of the Long Term Care Homes Act.

Specifically, the licensee must ensure that residents are protected from abuse by anyone and ensure that residents are not neglected by the licensee or staff.

**Grounds / Motifs :**

1. The licensee failed to ensure that residents were not neglected by the licensee or staff.

According to Ontario Regulation 79/10 Neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

A resident's written plan of care identified that the doctor was to be notified of signs and symptoms of complications of the resident's disease diagnosis.

The advanced health care guidelines for the resident, indicated that they were moderate care - level 3, which meant that the home would try to cure their illness and hospitalize them if needed.

The resident demonstrated a deterioration in their health status for a period of 10 days, before they were subsequently sent to the hospital. During this time, the

home was monitoring the resident's condition and documenting their symptoms, but there were incomplete assessments or lack of action.

The resident presented with changes in their condition that called for a referral to the dietitian, reassessment of their condition, and a call to the doctor. The home identified that they would call the physician when there was a need to reassess a treatment, and the physician identified that they expected to be called when there was a change in the resident's condition. However, there was no call to the doctor prior to the day that the resident was sent to the hospital.

There was actual harm or risk of harm to the resident, as the deterioration in their health status jeopardized their safety and well-being.

Sources: Review of resident's progress notes, care plan, physician's orders, Weights and Vitals on PCC; Review of the home's Documentation Policy (last revised/reviewed February 15, 2019); Review of the home's Oxygen-Low Flow Policy (last revised/reviewed July 31, 2012); Interviews with RPN #109, RPN #110, RPN #111, RN#118, and Physician.

2. The licensee has failed to ensure that residents were not neglected by staff.

O. Reg. 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A resident had multiple health diagnoses. Their advanced health care guidelines indicated that the resident was acute care - level 4, which meant that the resident was to be transferred to hospital for treatment and the home was to do everything medically and surgically possible to prolong their life.

Progress notes identified that the resident's health condition had deteriorated and subsequently they were sent to the hospital. For a period of three days, registered staff were monitoring the resident's condition and documenting their symptoms. The doctor was not called until the day that the resident was sent to the hospital.

Progress notes identified that the hospital staff stated the resident's prognosis was

poor, they were treated for an infection and returned to the home, with new treatments. The POA stated in an interview with Inspector #561 that the resident needed life saving interventions at the hospital.

Interview with registered staff #112 indicated that they were monitoring the resident; however, the physician was not called until the day the resident was sent to the hospital. The physician was interviewed and stated that the resident did have a change in their health condition and the on-call physician should have been called. The inaction of not notifying the physician of the change in the resident's condition prior to the day the resident was sent to the hospital, jeopardized the health and well being of the resident.

Sources: Resident's plan of care (care plan, progress notes, assessments, electronic medication administration record); interview with registered staff #104, 105, 108, 112, physician and ADOC.

3. The licensee failed to ensure that residents were protected from emotional abuse by PSW #116.

A resident required assistance with an activity of daily liviing. PSW #115 and PSW #116 assisted the resident. According to the resident's statement, PSW #116 made a comment to the resident that upset the resident. These actions were witnessed and confirmed by PSW #115. The ADOC was interviewed and stated that the home was able to substantiate emotional abuse and corrective action was taken.

Sources: Investigation notes; Interviews with PSW #115, PSW #116, and ADOC.

This non-compliance was from CIS inspection #2020_543561_0011, which was completed concurrently with this inspection. [s. 19. (1)]

An order was made by taking the following factors into account:

Severity: There was actual harm or risk of harm related to this non-compliance.

Scope: There was a pattern of non-compliance as three residents were involved in the non-compliance.

Compliance History: The licensee was found to be non-compliant with s. 19 (1) of the Long Term Care Homes Act in the past 36 months, and a Compliance Order was issued to the home. (748)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Feb 18, 2021(A1)

## 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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l’article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this 27th day of November, 2020 (A1)**

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

**Name of Inspector / Nom de l'inspecteur :** Amended by EMMY HARTMANN (748) - (A1)

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