Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 14, 15, 16, 21, 29, 30, 2011; Jan 4, 5, 11, 24, Feb 16, 17, 23, 2012	2011_027192_0046	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7

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

ST JOSEPH'S VILLA, DUNDAS
56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7

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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, family members and residents related to complaints H-002247-11 and H-002137-11.

This inspection report contains findings related to LTCHA 2007 S.O. 2007, c.8, s. 6(10)(b) identified during inspections 2011_027192_0047 and 2011_027192_0054 conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) reviewed medical records, policy and procedure, and observed care provided.

The following Inspection Protocols were used during this inspection:

Nutrition and Hydration

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 subsections:

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Previously issued June 28, 2011 and August 24, 2011.

The licensee failed to 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 the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

a) A specified resident developed a reddened area that was recorded in a specified month in 2011 but was not assessed for approximately one month in 2011. The plan of care was not updated until following the assessment.

b) A specified resident sustained a change in condition in 2011 that resulted in a change in the residents ability to swallow and the amount of assistance required with fluid intake. The plan of care indicates that the resident requires a specified amount of assistance. The plan of care was not updated with a change in the resident's condition.

c) In 2011, a specified resident was started on a treatment. During the administration of the treatment the resident continued to receive all prescribed medications. Interview confirms that the use of a specified medication was not reassessed and that the resident continued the specified medication during the course of treatment in spite of a potential negative impact.

d) In 2011 the physician ordered a urine sample be collected to rule out urinary tract infection for a specified resident who was demonstrating a change in level of activity and decreased intake of food and fluids. A specified treatment was initiated. Attempts to obtain the urine sample were ineffective. The resident's decreased output was not assessed. The Director of Care confirmed that the home has a bladder scan available, but this technology was not used to assess the resident. Obtaining the urine sample was delayed by 4 shifts.

e) In 2011 there is documented improvement in a specified resident's condition. Intake improved, the resident was becoming more responsive during care and vital signs were stabilizing as a result of a treatment initiated. The following day documentation indicates a decline in the resident condition over the course of a shift, with an increase in lethargy, decreased intake of of food and fluids and the pulse rate had increased. In spite of this decline in condition, the physician was not consulted and a prescribed treatment was discontinued. Following this change in condition, at the Power of Attorney's request, the resident was transferred to hospital for assessment and was diagnosed.

f) A specified resident experienced specified changes in condition through two months in 2011. These changes in the resident's condition were not assessed and are not included in the plan of care at the time of this inspection.

g) A specified resident experienced an exacerbation in responsive behaviours that resulted in injury to another resident, an assessment by the Psychogeriatric Resource Consultant completed in 2011 indicates that the resident had pain that may have contributed to an exacerbation in behaviours. The resident was not reassessed by the home for the presence of pain. No pain assessment was completed on return from hospital, even though the resident was readmitted on analgesic. The resident continues to exhibit responsive behaviours. Discussion with the Registered Nurse confirms that no pain assessment was completed.

h) A specified resident sustained a fall with injury in 2011. The resident returned from hospital and was observed during this inspection sitting in a specified wheelchair. Staff interviewed indicated that the resident now requires assistance with all care. The plan of care indicates that the resident requires only limited assistance for activities of daily living, it was not updated to reflect the change in the resident 's status following return from hospital.

i) The plan of care for a specified resident related to risk of injury from falls was created following a fall in 2011. Interventions have not been made specific to the needs of the resident. The plan of care was not updated with subsequent falls, complaints of pain that impaired the resident's mobility or an increasing risk of dehydration.

j) The Nurse Practitioner identified that a specified resident was dehydrated and recommended a treatment - a note on the order indicates the resident refused the treatment - the plan of care does not address alternative approaches for attempting to manage the dehydration and there is no evidence of the dietitian being involved in the resident's re-assessment when intake of food and fluids was declining.

k) A specified resident was noted in 2011 by the Nurse Practitioner to have a lesion on the arm. "Skin is fragile and there is bleeding under the skin". It was noted at the time that the resident was on medication that may contribute to bleeding. The resident has a history of falls. The plan of care does not address the resident's increased risk for bleeding and increased risk in the event of a fall. The resident sustained a fall in 2011 resulting in injury and died in hospital.

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. 8. Policies, etc,, to be followed, and records
Specifically failed to comply with the following subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Previously issued December 6, 2010.

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with. [r.8.(1)b]

The homes policy "Skin and Wound Management" dated March 2011(Draft) in effect at the time of this inspection indicates:
3.2.2 a) All pressure sores will be assessed by the RN/RPN. Treatment should begin when the first sign of redness begins and if skin breakdown is evident initiate the Skin/Wound Care form.

A specified resident was identified in 2011 to be at risk for skin breakdown and was observed to have a reddened area. No assessment of the reddened area was documented as having been completed by a member of the registered staff for a one month period 2011 when it was noted that the reddened area had progressed in severity. Interventions were not documented as being initiated when the reddened area was first identified. Interview with a nurse manager indicates that all wound assessments would be recorded in the progress notes.

3.2.2 m) Stage 1-4 areas will be monitored weekly via the skin/wound care form. Changes in treatment plans or identified need for high intensity products or surfaces must be communicated promptly to the Unit Manager for approval from the MOHLTC prior to initiation.

Weekly assessments of the reddened area on a specified resident were not completed following the identification of the reddened area in 2011. When the next assessment occurred approximately one month later, the area had progressed to a stageable wound.

The homes policy "Fall Prevention and Management" dated May 10, 2011 states under section 4.1.1 bullet 7 to "monitor and evaluate the care plan at least quarterly in collaboration with the interdisciplinary team. If the interventions have not been effective in reducing falls, initiate alternative approaches and update as necessary".

A specified resident's plan of care related to falls was initiated in 2011 and reviewed following two months. The resident sustained falls on specified dates in 2011 and a fall resulting in injury on a specified date in 2011. Alternative approaches were not initiated in spite of the plan of care being ineffective in reducing falls or preventing injury.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care
Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(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;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. Previously issued December 6, 2010.

The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection as required. [r.50(2)(b)(ii)]

a) A specified resident was observed to have a reddened area in 2011. Pressure relieving interventions were not documented as being initiated at the time the redness was observed. The resident's area of altered skin integrity progressed from a reddened area to a stageable pressure ulcer over a one month period in 2011 when it was first assessed by the Registered Nurse.

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 ensuring that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection as required, to be implemented voluntarily.

Issued on this 15th day of March, 2012

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

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) :	DEBORA SAVILLE (192)
Inspection No. / No de l'inspection :	2011_027192_0046
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Nov 14, 15, 16, 21, 29, 30, 2011; Jan 4, 5, 11, 24, Feb 16, 17, 23, 2012
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH SYSTEM 56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7
LTC Home / Foyer de SLD :	ST JOSEPH'S VILLA, DUNDAS 56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SHAWN GADSBY

To ST. JOSEPH'S HEALTH SYSTEM, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)(b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare and submit a plan for ensuring that residents of the home are reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change.
The plan shall be implemented.

The plan shall be submitted electronically to Debora Saville, Nursing Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, Hamilton Service Area Office at debora.saville@ontario.ca by the end of business on February 27, 2012.

Grounds / Motifs :

1. a) A specified resident developed a reddened area that was recorded in a specified month in 2011 but was not assessed for approximately one month in 2011. The plan of care was not updated until following the assessment.

b) A specified resident sustained a change in condition in 2011 that resulted in a change in the residents ability to swallow and the amount of assistance required with fluid intake. The plan of care indicates that the resident requires a specified amount of assistance. The plan of care was not updated with a change in the resident's condition.

c) In 2011, a specified resident was started on a treatment. During the administration of the treatment the resident continued to receive all prescribed medications. Interview confirms that the use of a specified medication was not reassessed and that the resident continued the specified medication during the course of treatment in spite of a potential negative impact.

d) In 2011 the physician ordered a urine sample be collected to rule out urinary tract infection for a specified resident who was demonstrating a change in level of activity and decreased intake of food and fluids. A specified treatment was initiated. Attempts to obtain the urine sample were ineffective. The resident's decreased output was not assessed. The Director of Care confirmed that the home has a bladder scan available, but this technology was not used to assess the resident. Obtaining the urine sample was delayed by 4 shifts.

e) In 2011 there is documented improvement in a specified resident's condition. Intake improved, the resident was becoming more responsive during care and vital signs were stabilizing as a result of a treatment initiated. The following day documentation indicates a decline in the resident condition over the course of a shift, with an increase in lethargy, decreased intake of of food and fluids and the pulse rate had increased. In spite of this decline in condition, the physician was not consulted and a prescribed treatment was discontinued. Following this change in condition, at the Power of Attorney's request, the resident was transferred to hospital for

assessment and was diagnosed.

f) A specified resident experienced specified changes in condition through two months in 2011. These changes in the resident's condition were not assessed and are not included in the plan of care at the time of this inspection.

g) A specified resident experienced an exacerbation in responsive behaviours that resulted in injury to another resident, an assessment by the Psychogeriatric Resource Consultant completed in 2011 indicates that the resident had pain that may have contributed to an exacerbation in behaviours. The resident was not reassessed by the home for the presence of pain. No pain assessment was completed on return from hospital, even though the resident was readmitted on analgesic. The resident continues to exhibit responsive behaviours. Discussion with the Registered Nurse confirms that no pain assessment was completed.

h) A specified resident sustained a fall with injury in 2011. The resident returned from hospital and was observed during this inspection sitting in a specified wheelchair. Staff interviewed indicated that the resident now requires assistance with all care. The plan of care indicates that the resident requires only limited assistance for activities of daily living, it was not updated to reflect the change in the resident 's status following return from hospital.

i) The plan of care for a specified resident related to risk of injury from falls was created following a fall in 2011. Interventions have not been made specific to the needs of the resident. The plan of care was not updated with subsequent falls, complaints of pain that impaired the resident's mobility or an increasing risk of dehydration.

j) The Nurse Practitioner identified that a specified resident was dehydrated and recommended a treatment - a note on the order indicates the resident refused the treatment - the plan of care does not address alternative approaches for attempting to manage the dehydration and there is no evidence of the dietitian being involved in the resident's re-assessment when intake of food and fluids was declining.

k) A specified resident was noted in 2011 by the Nurse Practitioner to have a lesion on the arm. "Skin is fragile and there is bleeding under the skin". It was noted at the time that the resident was on medication that may contribute to bleeding. The resident has a history of falls. The plan of care does not address the resident's increased risk for bleeding and increased risk in the event of a fall. The resident sustained a fall in 2011 resulting in injury and died in hospital. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 09, 2012

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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 Clerk
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.

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 23rd day of February, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : DEBORA SAVILLE

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