



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 prévue
sous *la Loi de 2007 sur les foyers
de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de
longue durée
Inspection de soins de longue durée

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du
Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 28, 2018	2018_787640_0025	029691-17, 012143- 18, 023634-18, 027778-18	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village at University Gates
250 Laurelwood Drive WATERLOO ON N2J 0E2

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

HEATHER PRESTON (640)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 6, 7 and 11, 2018.

During the course of the inspection, the following Critical Incident reports were inspected;

Log #012143-18 related to fall with injury resulting in significant change in condition



Log #023634-18 related to fall with injury resulting in significant change in condition

Log #027778-18 related to fall with injury resulting in significant change in condition.

The following Follow Up inspections were conducted;

Log #029681-17 related to follow up to an order related to plan of care from inspection #2016_262523_0041

The following Critical Incident Report (CIR) inquiries were conducted during the inspection;

Log #029533-18 related to staff to resident neglect

Log #010536-18 related to resident to resident physical altercation

Log #023301-18 related to resident to resident physical altercation

Log #001303-18 related to resident to resident sexual altercation

Log #024545-18 related to resident to resident sexual altercation

Log #025770-18 related to staff to resident verbal abuse

Log #027180-18 related to resident to resident physical altercation

Log #019775-18 related to resident to resident physical altercation

Log #016526-18 related to staff to resident physical abuse

Log #020927-18 related to staff to resident verbal abuse

Log #019880-18 related to fall of a resident

Log #009484-18 related to incident with injury of resident off-site

The following Complaint inquiries was conducted;

Intake log #001672-18 related to concerns regarding Infection Prevention and Control.

Intake log #000959-18 related to concerns regarding care.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), residents, General Manager, Director of Nursing Care (DNC), Assistant Director of Nursing Care (ADNC), Fall Prevention Lead, Resident Assessment Instrument/Minimum Data Set (RAI/MDS) Coordinator, Exercise Therapist and Neighbourhood Coordinator.



The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Minimizing of Restraining

Personal Support Services

Reporting and Complaints

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

3 WN(s)

0 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:

Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / DE L'INSPECTION	NO NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_610633_0017	640



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<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>

WN #1: 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 :

Where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

In accordance with Regulation, s.48, required the licensee to ensure that the interdisciplinary programs including falls prevention and management, were developed and implemented in the home and each program must meet the requirements as set out in section 30. Each program must have a written description of the program that included its goals and objectives and relevant policies, procedures and protocols to meet the requirements as set out in section 30. O. Reg. 79/10.

a) The Long-Term Care Homes (LTCH) Inspector reviewed a Critical Incident Report related to an unwitnessed fall of resident #002 on an identified date in August 2018, resulting in a significant injury.

The home's policy "Fall Prevention & Management Program", tab 04-33 with no date, directed staff to assess the resident using a head to toe assessment initially, document the post fall assessment using the Falls Incident Report in PointClickCare (PCC) and assess each shift for 24 hours in the progress notes. Initiate Head Injury Routine for all unwitnessed falls.

The home's policy "Head Injury Routine", tab 04-37 with no date, directed staff to use the Head Injury Routine form in PCC and follow the time frames as indicated on the form.

The LTCH Inspector and the Fall Prevention Lead reviewed the documented HIR and

found four occasions where the HIR had not been completed as per the home's policy.

b) The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record of resident #004 related to an unwitnessed fall without injury wherein HIR was initiated by the home as per their policy.

On six of 11 occasions, staff failed to complete the required HIR assessments as per their policy.

c) The LTCH Inspector reviewed a CI report related to an unwitnessed fall for resident #002 that resulted in a fracture.

Staff initiated HIR as the fall was unwitnessed. The home's policy directed that HIR be initiated in this case.

On four occasions, the resident did not have a full set of required HIR vital signs completed as per the home's HIR policy.

The Fall Prevention Lead acknowledged that on several occasions, residents #002, #003 and #004 did not have their Head Injury Routine completed as per the home's policy.

The licensee failed to ensure that the home's policy was complied with. [s. 8. (1) (b)]

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. 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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #004 fell in October 2018 that resulted in a significant injury requiring a higher level of care. Upon return to the home, the resident required a higher level of assistance for all activities of daily living.

The Long-Term Care Homes (LTCH) Inspector observed a positioning device sitting on the resident's bed in their room.

The LTCH Inspector reviewed resident #004's clinical record and noted there was no documentation related to the use of the positioning device, no assessment for its use and it had not been included in the resident's plan of care.

During an interview with the home's Fall Prevention Lead, they acknowledged the use of the positioning device had not been documented in the resident's clinical record to include the plan of care.

The home failed to ensure the use of the positioning device as an intervention for resident #004 was documented. [s. 30. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents



Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

- 1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).**
- 2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
 - i. a breakdown or failure of the security system,**
 - ii. a breakdown of major equipment or a system in the home,**
 - iii. a loss of essential services, or**
 - iv. flooding.**O. Reg. 79/10, s. 107 (3).**
- 3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**
- 4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**
- 5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

Findings/Faits saillants :



1. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of an incident: 4. that caused an injury to a resident for which the resident was taken to a hospital and resulted in a significant change in the resident's health condition.

A CI report for resident #002 was submitted on an identified date August, 2018 at a specific time.

Resident #002 fell on an identified date August 2018 at a specific time. The following day they received an x-ray . At a specified time later the same day, the x-ray report identified two fractures. The resident was transferred to a higher level of care via ambulance.

The CI report was submitted to the Director two days following the transfer to higher level of care for treatment.

The General Manager acknowledged the report was submitted to the Director later than within one business day.

The home failed to ensure the Director was informed of the injury that caused a significant change in resident condition within one business day. [s. 107. (3)]

Issued on this 11th day of January, 2019

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

Original report signed by the inspector.



**Ministry of Health and
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**Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée
Inspection de soins de longue durée**

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : HEATHER PRESTON (640)

Inspection No. /

No de l'inspection : 2018_787640_0025

Log No. /

No de registre : 029691-17, 012143-18, 023634-18, 027778-18

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Dec 28, 2018

Licensee /

Titulaire de permis : Schlegel Villages Inc.
325 Max Becker Drive, Suite. 201, KITCHENER, ON,
N2E-4H5

LTC Home /

Foyer de SLD : The Village at University Gates
250 Laurelwood Drive, WATERLOO, ON, N2J-0E2

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Chris-Anne Preston

To Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:



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

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O. 2007, chap. 8

Order # /

Ordre no : 001

Order Type /

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with s. 8 (1) of O. Reg. 79/10.

Specifically, the licensee must:

a) Ensure that staff follow the home's policy regarding the implementation of head injury routine for unwitnessed falls and suspected head injury as directed in the policy.

Grounds / Motifs :

1. Where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

In accordance with Regulation, s.48, required the licensee to ensure that the interdisciplinary programs including falls prevention and management, were developed and implemented in the home and each program must meet the requirements as set out in section 30. Each program must have a written description of the program that included its goals and objectives and relevant policies, procedures and protocols to meet the requirements as set out in section 30. O. Reg. 79/10.

a) The Long-Term Care Homes (LTCH) Inspector reviewed a Critical Incident



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Report related to an unwitnessed fall of resident #002 on an identified date in August 2018, resulting in a significant injury.

The home's policy "Fall Prevention & Management Program", tab 04-33 with no date, directed staff to assess the resident using a head to toe assessment initially, document the post fall assessment using the Falls Incident Report in PointClickCare (PCC) and assess each shift for 24 hours in the progress notes. Initiate Head Injury Routine for all unwitnessed falls.

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Staff initiated HIR as the fall was unwitnessed. The home's policy directed that HIR be initiated in this case.

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The Fall Prevention Lead acknowledged that on several occasions, residents #002, #003 and #004 did not have their Head Injury Routine completed as per the home's policy.



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Soins de longue durée**

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Pursuant to section 153 and/or
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l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.
O. 2007, chap. 8

The licensee failed to ensure that the home's policy was complied with. [s. 8. (1)
(b)]

The severity of this issue was determined to be a level 3, actual harm/risk. The
scope of the issue was a level 3, widespread. The home had a level 3
compliance history in the past three years of previous related non-compliance
that included;

- Compliance Order (CO) issued February 24, 2017 (2016_262523_0041 (640)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le :

Feb 28, 2019



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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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, 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:



**Ministry of Health and
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**Ministère de la Santé et des
Soins de longue durée**

Order(s) of the Inspector

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Pursuant to section 153 and/or
section 154 of the *Long-Term
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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

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 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.



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O. 2007, chap. 8

**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 de la Santé et des Soins de longue durée
1075, rue Bay, 11^e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603



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foyers de soins de longue durée*, L.
O. 2007, chap. 8

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 révision
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 de la Santé et 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 28th day of December, 2018

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Heather Preston

Service Area Office /

Bureau régional de services : Central West Service Area Office