Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 1, 2020	2020_661683_0014	003850-20, 003996-20, 004179-20, 013357-20, 015959-20	Critical Incident System

Licensee/Titulaire de permis

Chippawa Creek Care Centre Ltd.
c/o Bella Senior Care Residences 8720 Willoughby Drive NIAGARA FALLS ON L2G 7X3

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

Bella Senior Care Residences
8720 Willoughby Drive NIAGARA FALLS ON L2G 7X3

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

LISA BOS (683), DARIA TRZOS (561)

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): September 8, 9, 10, 11, 14, 15, 16, 17, 18, 21 and 22, 2020.

This Inspection was completed concurrently with complaint inspection #2020_661683_0013.

The following intakes were completed during this critical incident inspection:
Log #003850-20 was related to medication administration;
Log #003996-20 was related to the prevention of abuse and neglect;
Log #004179-20 was related to continence care and bowel management and the prevention of abuse and neglect;
Log #013357-20 was related to responsive behaviours and the prevention of abuse and neglect;
Log #015959-20 was related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Adminisrator, the Director of Care (DOC), the Admissions and Social Services Coordinator, registered staff, Personal Support Workers (PSWs), residents and families.

During the course of the inspection, the inspector(s) reviewed resident clinical records, reviewed policies and procedures, reviewed investigation notes, reviewed training records, reviewed meeting minutes and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

6 WN(s)
3 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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 O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and recommended any changes necessary to improve the system.

The binder containing the quarterly interdisciplinary team meeting minutes related to the medication management system was reviewed with the Director of Care (DOC) and identified that the home had not held meetings since January 2020 and the medication incidents were not analyzed since then.

Review of the binder containing medication incident/near incident/adverse drug reaction reports identified that multiple medication incidents occurred in the home since January 2020 which involved high risk medications.

Not reviewing and analyzing medication incidents with the interdisciplinary team places the home at greater risk for recurrence of these incidents and places each resident’s health at risk.

Sources: home’s binder containing quarterly interdisciplinary team meetings, medication incident/near incident/adverse drug reaction reports for three residents, interview with the DOC. [s. 115. (1)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for two residents related to responsive behaviours was provided.

A) A resident's plan of care included techniques for staff to respond to their behaviours. On one occasion, the resident demonstrated a behaviour towards a Personal Support Worker (PSW). The PSW did not implement the techniques, resulting in the resident becoming upset.

The PSW did not use the required techniques, despite understanding that they should have been used when the resident exhibited responsive behaviours.

Sources: Critical Incident System (CIS) report, the LTCH's investigative notes, resident's care plan, and interview with PSWs and other staff.

B) A resident's plan of care included techniques for staff to respond to the resident's behaviours. On one occasion, the resident demonstrated a behaviour and in response, a PSW did not implement the techniques. The incident was witnessed by another PSW. The DOC acknowledged that the PSW did not implement the techniques as per their plan of care.

Sources: CIS report, the LTCH's investigative notes, resident's care plan, and interview with PSWs and other staff. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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. A) The licensee has failed to ensure that the “Management of Insulin, Narcotics and Controlled Drugs” policy was complied with for a resident.

O. Reg 79/10, s. 136 (2) 2 requires that any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

Specifically, the home was not compliant with their “Management of Insulin, Narcotics and Controlled Drugs” policy which indicated that the home needed to maintain a separate storage area for discontinued narcotics/controlled drugs.

During an interview with a RPN they identified that controlled substances for a resident that were to be disposed of were kept in the medication cart in the narcotic bin along with other narcotics for administration. The DOC confirmed that the controlled substances

were not disposed of according to the home's policy related to management of controlled drugs.

Sources: the home's Management of Insulin, Narcotics and Controlled Drugs policy, Drug Patch Disposal tool, interview with a RPN and the DOC.

B) The licensee has failed to ensure that the "Medication incident and Reporting" policy was complied with for a resident.

O. Reg 79/10, s. 135 (2) requires that (a) all medication incidents and adverse drug reactions are reviewed and analyzed and (b) corrective action is taken and that (c) a written record is kept of everything required under clauses (a) and (b).

Specifically, the home did not comply with their "Medication incident and Reporting" policy when they did not keep a written record of the investigation related to a medication incident.

The Critical Incident System (CIS) report indicated that there was a medication incident for a resident and the home initiated an investigation. In an interview with the DOC they stated that the home was not able to retrieve records of the investigation from the computer.

Sources: CIS report, the home's Medication Incident and Reporting policy, interview with the DOC. [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 Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.

WN #4: 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 :

1. The licensee has failed to ensure that a resident was protected from abuse by a PSW.

A resident's plan of care included techniques for staff to respond to the resident's behaviours. On one occasion, the resident demonstrated a behaviour towards a PSW. The PSW did not implement the techniques, despite understanding that they should have been used when the resident exhibited responsive behaviours and as a result, the resident was upset.

Sources: CIS report, the LTCH's investigative notes, the resident's care plan, and interview with the PSW and other staff. [s. 19. (1)]

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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #5: 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 :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone occurred immediately reported the suspicion and the information upon which it was based to the Director.

Resident #009's care plan indicated that they required supervision for their safety related to a behaviour and resident #010's care plan indicated that they had a history of behaviours towards co-residents.

A PSW witnessed an incident between resident #009 and resident #010 and it was reported to a RPN. The RPN acknowledged that the PSW reported an incident between resident #009 and #010, but there was a misunderstanding about when the incident occurred and they did not report the incident to the Director. The DOC did not find out about the incident until two days later, at which time it was reported to the Director.

Sources: CIS report, the LTCH's investigative notes, resident care plans, and interview with the DOC and other staff. [s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept of the analysis and corrective action taken of medication incidents and adverse reactions for three residents.

A CIS report was submitted to the Director identifying a medication incident for a resident. The medication incident/near incident/adverse drug reaction report was reviewed and did not contain the documentation of the analysis and corrective action taken. Medication incident/near incident/adverse drug reaction reports were reviewed for two other residents and they did not contain the documentation of the analysis or corrective actions taken. The DOC was interviewed and acknowledged that these reports did not contain the documentation of the analysis or the corrective action taken.

Sources: CIS report, medication incident/near incident/adverse drug reaction reports for three residents, interview with DOC. [s. 135. (2)]

Issued on this 6th day of October, 2020

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	LISA BOS (683), DARIA TRZOS (561)
Inspection No. / No de l’inspection :	2020_661683_0014
Log No. / No de registre :	003850-20, 003996-20, 004179-20, 013357-20, 015959-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 1, 2020
Licensee / Titulaire de permis :	Chippawa Creek Care Centre Ltd. c/o Bella Senior Care Residences, 8720 Willoughby Drive, NIAGARA FALLS, ON, L2G-7X3
LTC Home / Foyer de SLD :	Bella Senior Care Residences 8720 Willoughby Drive, NIAGARA FALLS, ON, L2G-7X3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Veronica Swartz

Ontario

Ministry of Long-Term Care

Ministère 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

To Chippawa Creek Care Centre Ltd., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Order / Ordre :

The licensee must comply with s. 115 (1) of O. Reg 79/10.

Specifically, the licensee shall prepare, submit and implement a plan to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meet at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The plan must include but is not limited to:
1. How the home will evaluate the effectiveness of the medication management system, specifically medication incidents that occurred between January 2020 and present.
2. Who will participate in this evaluation.
3. How the home will ensure that the effectiveness of the medication management system, including medication incidents is being evaluated moving forward.

Please submit the written plan for achieving compliance for inspection #2020_661683_0014 to Lisa Bos, LTC Homes Inspector, MLTC, by email to HamiltonSAO.MOH@ontario.ca by October 15, 2020.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and recommended any changes necessary to improve the system.

The binder containing the quarterly interdisciplinary team meeting minutes related to the medication management system was reviewed with the Director of Care (DOC) and identified that the home had not held meetings since January 2020 and the medication incidents were not analyzed since then.

Review of the binder containing medication incident/near incident/adverse drug reaction reports identified that multiple medication incidents occurred in the home since January 2020 which involved high risk medications.

Not reviewing and analyzing medication incidents with the interdisciplinary team places the home at greater risk for recurrence of these incidents and places each resident's health at risk.

Sources: home's binder containing quarterly interdisciplinary team meetings, medication incident/near incident/adverse drug reaction reports for three residents, interview with the DOC.

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

Severity: Quarterly analysis of the medication management system has not been completed since January 2020. The binder that contained the description of each medication incident identified that multiple medication incidents included high risk medications. One of the medication incidents involving a resident caused increased pain.

Scope: The scope of this non compliance was a pattern because the home has not met on quarterly basis since January 2020, indicating that so far, the home missed two quarterly analysis this year of the medication management system.

Compliance history: No prior history related to this non compliance was issued in

the past 36 months. (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 01, 2021

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 1st day of October, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Bos

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