



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

**Ministère de la Santé et des  
Soins de longue durée**

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

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

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

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

Ottawa Service Area Office  
347 Preston St Suite 420  
OTTAWA ON K1S 3J4  
Telephone: (613) 569-5602  
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa  
347 rue Preston bureau 420  
OTTAWA ON K1S 3J4  
Téléphone: (613) 569-5602  
Télécopieur: (613) 569-9670

## **Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Jul 19, 2016	2016_289550_0018	032324-15, 007200-16	Follow up

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### **Licensee/Titulaire de permis**

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP  
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H  
5L8

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

The Palace  
92 CENTRE STREET ALEXANDRIA ON K0C 1A0

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

JOANNE HENRIE (550)

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



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

**This inspection was conducted on the following date(s): May 18 and 19, 2016.**

**This inspection is a follow-up inspection for a compliance order related to 24hr nursing coverage and a complaint inspection related to responsive behaviours.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of care, several registered practical nurses (RPN), several personal support workers, the administrative assistant and a resident.**

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

**Responsive Behaviours**

**Sufficient Staffing**

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

**1 WN(s)**

**0 VPC(s)**

**1 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<b>Legend</b>  WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	<b>Legendé</b>  WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
<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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services**

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

**s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there was at least one Registered Nurse (RN)



who is an employee of the licensee and a member of the regular nursing staff, on duty and present in the home on February 18, March 10 and 12, 2016

This inspection was a follow-up inspection for compliance order #001 that was issued to the home on August 5, 2015, under inspection #2015\_286547\_0012 with a compliance date of February 3, 2016.

Inspector #550 reviewed the registered nursing staff schedules for the period of February 3 to May 18, 2016 and noted the following:

- February 18, there was not a RN scheduled for the 8 hour night shift; from 2300 to 0700
- March 10, there was not a RN scheduled for the 8 hour night shift; from 2300 to 0700 and,
- March 12, there was not a RN scheduled for the 8 hour day shift; from 0700 to 1500.

Ontario Regulation 79/10 section 31. (3) (d) requires the licensee to have a written staffing plan that includes a back-up plan for nursing and personal care staffing that addresses situation when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work.

Ontario Regulation 79/10 section 45 (1) 2. For homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds,  
ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of the Regulation fails to ensure that that the requirement under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third part may be used if,

A. the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and

B. a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home.

Ontario Regulation 79/10 section.45. (2) indicates that "emergency" means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

The Palace is a 70 bed Long Term Care Home located in a rural community.



During an interview, the Director of Care indicated to the inspector that there was not a registered nurse available to cover the above shifts and that these three shifts were not shifts that would be covered under an "emergency situation". The Director of Care further indicated that the Administrator and herself met with the Union's labor relation members on March 7th 2016, to inform them that the licensee was mandating the RNs onsite to cover a shift when someone would not be able to come for their scheduled shift at the last minute. This change came into effect on March 15, 2016.

On February 18, 2016, the scheduled registered nurse called in sick. The office manager called the roster of RN offering the shift at regular time and overtime with no success. A RPN covered the shift. The DOC and ADOC were out of town on an education course. No other back-up staffing options were planned or available. Therefore, no RN worked on February 18, 2016 from 2300 to 0700 hours.

On March 10, 2016, a registered nurse was given vacation time. The DOC called the roster of RN offering the shift at regular time and overtime with no success. A RPN covered the shift with the DOC on-call. No other back-up staffing options were planned or available. Therefore, no RN worked on March 10, 2016 from 2300 to 0700 hours.

On March 12, 2016, the scheduled registered nurse called in sick. The office manager called the roster of RN offering the shift at regular time and overtime with no success. A RPN covered the shift with the DOC and A-DOC on call. No other back-up staffing options were planned or available. Therefore, no RN worked on March 12, 2016 from 0700 to 1500 hours.

The home's current back-up staffing plan includes strategies such as:

- mandate the registered nurse onsite from the previous shift to stay and attempt to have the registered nurse scheduled for the following shift to come in earlier, both would work 12 hour shifts instead of 8 hour shifts.
- mandate the registered nurse onsite from the previous shift to stay and cover the following shift
- have the assistant DOC/RAI coordinator cover the shift
- the Administrator is working on establishing a contract with two agencies
- the home is recruiting on website

Although the inspector was able to establish that there was compliance from March 13 to May 18, 2016, it was identified that the home still had three shifts from February 3 to



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March 12, 2016 where there was not a registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present in the home. The home's back-up staffing plan was not followed. On March 10 and 12, 2016, when the DOC and/or ADOC, both registered nurses failed to provide coverage for the identified shifts. Furthermore, at the time of the inspection, an agreement with a staffing agency had yet to be reached to ensure RN coverage in response to an emergency.

The scope and severity of this non-compliance was reviewed. Even though there were only 3 shifts where there was not a RN in the home, the fact that there was not a solid back-up staffing plan to deal with emergency situations, plus the licensee's ongoing non-compliance poses a risk to residents' safety and affects every resident living in the home. [s. 8. (3)]

***Additional Required Actions:***

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

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**Issued on this 19th day of July, 2016**

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

**Original report signed by the inspector.**



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**Order(s) of the Inspector**

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

**Ordre(s) de l'inspecteur**

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

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Inspection de soins de longue durée**

**Public Copy/Copie du public**

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

**Nom de l'inspecteur (No) :** JOANNE HENRIE (550)

**Inspection No. /**

**No de l'inspection :** 2016\_289550\_0018

**Log No. /**

**Registre no:** 032324-15, 007200-16

**Type of Inspection /**

**Genre**

Follow up

**d'inspection:**

**Report Date(s) /**

**Date(s) du Rapport :** Jul 19, 2016

**Licensee /**

**Titulaire de permis :** CVH (No.6) GP Inc. as general partner of CVH (No.6)  
LP  
c/o Southbridge Care Homes Inc., 766 Hespeler Road,  
Suite 301, CAMBRIDGE, ON, N3H-5L8

**LTC Home /**

**Foyer de SLD :** The Palace  
92 CENTRE STREET, ALEXANDRIA, ON, K0C-1A0

**Name of Administrator /**

**Nom de l'administratrice**

**ou de l'administrateur :** TERRY DUBE

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To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, 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

**Ministère de la Santé et  
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**Order # /**  
**Ordre no :** 001      **Order Type /**  
**Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Linked to Existing Order /**  
**Lien vers ordre**      2015\_286547\_0012, CO #001;  
**existant:**

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

**Order / Ordre :**

The licensee shall develop a comprehensive back-up staffing plan in line with O. Reg 79/10, s. 45.(1) 2. ii, to ensure proper coverage in case of an emergency where the mandated Registered Nurse is unavailable and a Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is not available to work.

**Grounds / Motifs :**

1. The licensee has failed to ensure that there was at least one Registered Nurse (RN) who is an employee of the licensee and a member of the regular nursing staff, on duty and present in the home on February 18, March 10 and 12, 2016

This inspection was a follow-up inspection for compliance order #001 that was issued to the home on August 5, 2015, under inspection #2015\_286547\_0012 with a compliance date of February 3, 2016.

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Ontario Regulation 79/10 section 45 (1) 2. For homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds,  
ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of the Regulation fails to ensure that that the requirement under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third part may be used if,

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During an interview, the Director of Care indicated to the inspector that there was not a registered nurse available to cover the above shifts and that these three shifts were not shifts that would be covered under an "emergency situation". The Director of Care further indicated that the Administrator and herself met with the Union's labor relation members on March 7th 2016, to inform them that the licensee was mandating the RNs onsite to cover a shift when someone would not be able to come for their scheduled shift at the last minute. This change came into effect on March 15, 2016.

On February 18, 2016, the scheduled registered nurse called in sick. The office

manager called the roster of RN offering the shift at regular time and overtime with no success. A RPN covered the shift. The DOCs were out of town on an education course. No other back-up staffing options were planned or available. Therefore, no RN worked on February 18, 2016 from 2300 to 0700 hours.

On March 10, 2016, a registered nurse was given vacation time. The DOC called the roster of RN offering the shift at regular time and overtime with no success. A RPN covered the shift with the DOC on-call. No other back-up staffing options were planned or available. Therefore, no RN worked on March 10, 2016 from 2300 to 0700 hours.

On March 12, 2016, the scheduled registered nurse called in sick. The office manager called the roster of RN offering the shift at regular time and overtime with no success. A RPN covered the shift with the DOC and A-DOC on call. No other back-up staffing options were planned or available. Therefore, no RN worked on March 12, 2016 from 0700 to 1500 hours.

The home's current back-up staffing plan includes strategies such as:

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- mandate the registered nurse onsite from the previous shift to stay and cover the following shift
- have the assistant DOC/RAI coordinator cover the shift
- the Administrator is working on establishing a contract with two agencies
- the home is recruiting on website

Although the inspector was able to establish that there was compliance from March 13 to May 18, 2016, it was identified that the home still had three shifts from February 3 to March 12, 2016 where there was not a registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present in the home. The home's back-up staffing plan was not followed. On March 10 and 12, 2016, when the DOC and/or ADOC, both registered nurses failed to provide coverage for the identified shifts. Furthermore, at the time of the inspection, an agreement with a staffing agency had yet to be reached to ensure RN coverage in response to an emergency.

The scope and severity of this non-compliance was reviewed. Even though there were only 3 shifts where there was not a RN in the home, the fact that



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**Ministère de la Santé et  
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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*

there was not a solid back-up staffing plan to deal with emergency situations, plus the licensee's ongoing non-compliance poses a risk to residents' safety and affects every resident living in the home. (550)

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

**Vous devez vous conformer à cet ordre d'ici le :** Sep 01, 2016



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### **REVIEW/APPEAL INFORMATION**

#### **TAKE NOTICE:**

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director  
c/o Appeals Coordinator  
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



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When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar  
151 Bloor Street West  
9th Floor  
Toronto, ON M5S 2T5

Director  
c/o Appeals Coordinator  
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](http://www.hsarb.on.ca).





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## **RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL**

### **PRENDRE AVIS**

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur  
a/s Coordinateur des appels  
Inspection de soins de longue durée  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11<sup>e</sup> étage  
Ontario, ON  
M5S-2B1  
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire  
Commission d'appel et de révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto (Ontario) M5S 2T5

Directeur  
a/s Coordinateur des appels  
Inspection de soins de longue durée  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11e étage  
Ontario, ON  
M5S-2B1  
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Issued on this 19th day of July, 2016**

**Signature of Inspector /**

**Signature de l'inspecteur :**

**Name of Inspector /**

**Nom de l'inspecteur :** Joanne Henrie

**Service Area Office /**

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