Ontario

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

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

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

**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 sions 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

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 26, 2016 | 2016_188168_0011 | 10878-16 AND 26629-15 | Critical Incident System |

### Licensee/Titulaire de permis

DELHI NURSING HOME LTD
750 GIBRALTAR STREET DELHI ON N4B 3B3

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

DELHI LONG TERM CARE CENTRE
750 GIBRALTAR STREET DELHI ON N4B 3B3

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

LISA VINK (168)

### 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): April 19 and 20, 2016.**

**An on-site inquiry was also completed and closed for intake number 005646-16, during this visit to the long-term care home.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Quality Outcomes, the Office Manager, registered nursing staff and personal support workers (PSW's).**

**During the course of this inspection and inquiry the inspector: reviewed relevant health care records, observed the provision of care and services, reviewed relevant policies and procedures and training records and employee files.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Personal Support Services**

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **2 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités |
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

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

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

**s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (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; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

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

Resident #100 was dependent on staff to complete most of their activities of daily living, which was an assessed need according to their Minimum Data Set (MDS) assessment conducted on January 18, 2016. The Physiotherapy Quarterly Assessment documented on April 5, 2016, identified that they were able to follow direction and was aware of person and place, required two staff for transfers in and out of bed, two staff for rolling, two staff for bed mobility and two staff to stand.

The resident's current plan of care identified that they required total assistance of two staff for transfers to and from the bed and extensive assistance with personal hygiene, specifically for peri-care, one staff to provide the care after changing when in bed, while a second staff held the resident on their side. Registered staff #205 confirmed that these interventions were current needs for the resident at the time of an incident in 2016 and had been in place for sometime.

According to a written statement and interview, PSW #200 confirmed that she was aware of the resident's care requirements for transfers as set out in the plan of care; however, on an identified date in 2016, transferred the resident independently from the chair to the

bed. Once the resident was transferred to the bed the staff member continued with the provision of care, which included the removal of clothing and continence care. The resident was positioned on their side in bed; however, was not "turned right over" when the staff member let go of the resident, to open a container and the resident made a sudden movement and rolled off of the bed to the floor. The resident was immediately assessed by registered staff, provided comfort care and returned to bed. Shortly after the fall the resident reported pain and was transported to the hospital due to suspected injuries. The resident died the following day.

Staff did not provide care as set out in the plan of care. [s. 6. (7)]

2. The licensee failed to ensure that staff and others who provided direct care to a resident were kept aware of the contents of the plan of care.

Interviews conducted with PSW's #200, #201, #202, #211 and #212 and registered staff #203, #204 and #205 verified knowledge of the plan of care and where to locate individualized information regarding the care needs of residents, including the kardex in Point of Care (POC), the plan of care and communication/report at shift change. Discussion with the Administrator confirmed that the use of the plan of care was routinely discussed at nursing department meetings.

The plan of care for resident #100 identified that they required extensive assistance, due to physical limitations, for personal hygiene, specifically for peri-care they required one staff to provide the care after changing when in bed, while a second staff held the resident on their side. Registered staff #205 confirmed that these interventions were an actual need for the resident at the time of an incident in 2016 and had been in place for sometime.

Interviews conducted with PSW's #200, #202 and #211 verified that they routinely cared for resident #100 and were familiar with their needs; however, prior to an incident in 2016, they were not aware of the need for two staff to provide care after changing in bed as set out in the plan of care.

Not all staff were kept aware of the contents of the plan of care as confirmed during interviews with three identified direct care staff related to the care needs of resident #100. [s. 6. (8)]

3. The licensee failed to ensure that the resident's plan of care was reviewed and revised

at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #100 previously utilized a bed rail while in bed for comfort, to secure the call bell to an accessible location and to assist with positioning, according to the plan of care and interview with registered staff #205.

The current plan of care identified that the resident required extensive assistance of two staff for bed mobility and that the resident used the bed rail to move themselves slightly.

Interview with registered staff #205 verified that the resident previously utilized a bed rail; however, after reassessment it was discontinued and no longer in use.

The Minimum Data Set (MDS) assessment conducted on January 18, 2016, did not include the use of bed rails for resident #100. The Bed Safety Assessment completed February 17, 2016, identified that bed rails were not required for the resident.

The resident's plan of care was not reviewed and revised when care set out in the plan was no longer necessary, as verified during an interview with registered staff #205, related to bed rail use. [s. 6. (10) (b)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 resident's plan of care is 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 and that care is provided to residents as set out in the plan of care, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

## Findings/Faits saillants :

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

For the purpose of the Act and regulations "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Resident #100 was dependent on staff to complete most of their activities of daily living, which was an assessed need according to their Minimum Data Set (MDS) assessment conducted on January 18, 2016. The Physiotherapy Quarterly Assessment documented on April 5, 2016, identified that they were able to follow direction and was aware of person and place, required two staff for transfers in and out of bed, two staff for rolling, two staff for bed mobility and two staff to stand.

The resident's current plan of care identified that they required total assistance of two staff for transfers to and from the bed and extensive assistance with personal hygiene, specifically for peri-care, one staff to provide the care after changing when in bed, while a second staff held the resident on their side. Registered staff #205 confirmed that these interventions were current needs for the resident in 2016 and had been in place for sometime.

According to a written statement and interview, PSW #200 confirmed that she was aware of the resident's care requirements for transfers as set out in the plan of care; however, on an identified date in 2016, she transferred the resident independently from the chair to the bed. Once the resident was transferred to the bed the staff member continued with the provision of care, which included the removal of clothing and continence care. The resident was positioned on their side in bed; however, was not "turned right over" when the staff member let go of the resident, to open a container and the resident made a sudden movement and rolled off of the bed to the floor. The resident was immediately assessed by registered staff, provided comfort care and returned to bed. Shortly after the fall the resident reported pain and was transported to the hospital due to suspected injuries. The resident died the following day.

The licensee did not ensure that assistance was provided, as required, for the resident's health, safety or well-being, which then jeopardized their health, safety and well-being on the identified date in 2016. [s. 19.]

***Additional Required Actions:***

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

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when they assisted residents.

Resident #100 had a Physiotherapy Quarterly Assessment documented on April 5, 2016, which identified that the resident was able to follow direction and was aware of person and place, required two staff for transfers in and out of bed, two staff for rolling, two staff for bed mobility and two staff to stand.

Their current plan of care identified that they required total assistance of two staff for transfers to and from the bed and extensive assistance with personal hygiene, specifically for peri-care, one staff to provide the care after changing when in bed, while a second staff held the resident on their side.

According to a written statement and interview, PSW #200 confirmed that she was aware of the resident's care requirements for transfers; however, on an identified date in 2016, she transferred the resident independently from the chair to the bed. Once the resident was transferred to the bed the staff member continued with the provision of care, which included the removal of clothing and continence care. The resident was positioned on their side in bed; however, was not "turned right over" when the staff member let go of the resident to open a container and the resident made a sudden movement and rolled off of the bed to the floor. The resident was immediately assessed by registered staff, comfort care provided and returned to bed. Shortly after the fall the resident reported pain and was transported to the hospital due to suspected injuries. The resident died the following day.

Staff did not utilize safe transferring or positioning techniques when they provided care to the resident. [s. 36.]

***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 staff use safe transferring and positioning devices or techniques when they assist residents, to be implemented voluntarily.***

**Issued on this 5th day of May, 2016**

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

**Original report signed by the inspector.**

Ontario

**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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | LISA VINK (168) |
| **Inspection No. / No de l'inspection :** | 2016_188168_0011 |
| **Log No. / Registre no:** | 10878-16 AND 26629-15 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Apr 26, 2016 |
| **Licensee / Titulaire de permis :** | DELHI NURSING HOME LTD<br>750 GIBRALTAR STREET, DELHI, ON, N4B-3B3 |
| **LTC Home / Foyer de SLD :** | DELHI LONG TERM CARE CENTRE<br>750 GIBRALTAR STREET, DELHI, ON, N4B-3B3 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Jeremy Zinger |

To DELHI NURSING HOME LTD, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

**Order / Ordre :**

The licensee shall ensure that staff and others who provide direct care residents are kept aware of the contents of the resident's plan of care.

The licensee shall:
a. review and revise, as appropriate, their current system(s) in place to communicate the care needs of residents as identified in their plans of care to all direct care staff to ensure that the system(s) have ease of use, provide the required information in a clear format and are accessible
b. provide education, which is to include expectations for use, to all direct care staff, regarding the licensee's system(s) to communicate the contents of each resident's plan of care.

**Grounds / Motifs :**

1. This Compliance Order is served based upon the application of the factors of severity, scope and compliance history in keeping with LTCHA, 2007 s. 6(8):
in respect to severity the resident sustained actual harm,
in respect to scope the number of staff involved was a pattern, and
in relation to history the licensee had previous related non-compliance in the last three years for plan of care.

The licensee failed to ensure that staff and others who provided direct care to a resident were kept aware of the contents of the plan of care.

Interviews conducted with PSW's #200, #201, #202, #211 and #212 and registered staff #203, #204 and #205 verified knowledge of the plan of care and where to locate individualized information regarding the care needs of residents, including the kardex in Point of Care (POC), the plan of care and communication/report at shift change. Discussion with the Administrator confirmed that the use of the plan of care was routinely discussed at nursing department meetings.

The plan of care for resident #100 identified that they required extensive assistance, due to physical limitations, for personal hygiene, specifically for peri-care they required one staff to provide the care after changing when in bed, while a second staff held the resident on their side. Registered staff #205 confirmed that these interventions were an actual need for the resident at the time of an incident in 2016 and had been in place for sometime.

Interviews conducted with PSW's #200, #202 and #211 verified that they routinely cared for resident #100 and were familiar with their needs; however, prior to an incident in 2016, they were not aware of the need for two staff to provide care after changing in bed as set out in the plan of care.

Not all staff were kept aware of the contents of the plan of care as confirmed during interviews with three identified direct care staff related to the care needs of resident #100. (168)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 30, 2016

**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

**Order / Ordre :**

The licensee shall ensure that residents are not neglected by the licensee or staff, specifically related to a failure to provide treatment, care, services or assistance required for the resident's health, safety or well-being, which includes any inaction that jeopardizes the health, safety or well-being of the residents when providing assistance with transferring, bed mobility or continence care.

The licensee shall conduct audit activities, at a time and frequency as determined by the licensee, to determine direct care staff compliance with providing care to residents, as identified during their assessments and as set out in the plan of care, related to transferring, bed mobility and continence care.

Immediate action shall be taken, which is to include re-education, as deemed appropriate, when care is not provided according to the needs of residents which has the potential to jeopardize their health, safety or well-being when providing assistance with transferring, bed mobility or continence care.

**Grounds / Motifs :**

1. This Compliance Order is served based upon the application of the factors of severity, scope and compliance history in keeping with LTCHA, 2007 s. 19(1):
in respect to severity the resident sustained actual harm,
in respect to scope the incident was isolated to one resident, and
in relation to history the licensee had ongoing non-compliance despite previous action taken by the Ministry, specifically a CO identified during the July 2015, Resident Quality Inspection (RQI).

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

For the purpose of the Act and regulations "neglect" means the failure to provide

a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Resident #100 was dependent on staff to complete most of their activities of daily living, which was an assessed need according to their Minimum Data Set (MDS) assessment conducted on January 18, 2016. The Physiotherapy Quarterly Assessment documented on April 5, 2016, identified that they were able to follow direction and was aware of person and place, required two staff for transfers in and out of bed, two staff for rolling, two staff for bed mobility and two staff to stand.

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According to a written statement and interview, PSW #200 confirmed that she was aware of the resident's care requirements for transfers as set out in the plan of care; however, on an identified date in 2016, she transferred the resident independently from the chair to the bed. Once the resident was transferred to the bed the staff member continued with the provision of care, which included the removal of clothing and continence care. The resident was positioned on their side in bed; however, was not "turned right over" when the staff member let go of the resident, to open a container and the resident made a sudden movement and rolled off of the bed to the floor. The resident was immediately assessed by registered staff, provided comfort care and returned to bed. Shortly after the fall the resident reported pain and was transported to the hospital due to suspected injuries. The resident died the following day.

The licensee did not ensure that assistance was provided, as required, for the resident's health, safety or well-being, which then jeopardized their health, safety and well-being. (168)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Jun 30, 2016

## 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

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.

## 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 sions 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

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
Inspection de sions 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.

**Issued on this 26th day of April, 2016**

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

**Name of Inspector /**
**Nom de l'inspecteur :** LISA VINK

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