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**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

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


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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 1, May 2, 2013 | 2013_205129_0002 | H-000120-13 | Complaint |

**Licensee/Titulaire de permis**

UNGER NURSING HOMES LIMITED
312 Queenston Street, St. Catharines, ON, L2P-2X4

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

HAMPTON TERRACE CARE CENTRE
75 PLAINS ROAD WEST, BURLINGTON, ON, L7T-1E8

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

PHYLLIS HILTZ-BONTJE (129)

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

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

**This inspection was conducted on the following date(s): March 1, 5, 6, 7, 8 and 11, 2013**

**During the course of the inspection, the inspector(s) spoke with family members, residents, registered staff, unregulated nursing staff, the Food Service Supervisor, the Registered Dietitian, the Pharmacist, the Director of Care and the Administrator.**

**During the course of the inspection, the inspector(s) observed residents and equipment used by residents, reviewed clinical records and the home's policies and procedures.**

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

**Nutrition and Hydration**

**Responsive Behaviours**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend | Legendé |
| WN – Written Notification | WN – Avis écrit |
| VPC – Voluntary Plan of Correction | VPC – Plan de redressement volontaire |
| DR – Director Referral | DR – Aiguillage au directeur |
| CO – Compliance Order | CO – Ordre de conformité |
| WAO – Work and Activity Order | 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 O.Reg 79/10, s. 15. Bed rails**
**Specifically failed to comply with the following:**

**s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
**(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**
**(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**
**(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

**Findings/Faits saillants :**

1. a) Documentation in the clinical record on an identified date indicated that resident #001 was found entrapped between the side rail and the bed mattress. Documentation on a subsequent date indicated that the resident continued to be a risk for entrapment while in bed and staff were directed to monitor the resident when in bed. At the time of this inspection it was noted that the mattress on the resident's bed was able to be moved on the bed deck, resulting in a four to five inch gap between the edge of the mattress and the side rail, creating a possible entrapment zone for this resident. [s. 15. (1) (b)]

***Additional Required Actions:***

***CO # - 901 was 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. 30. Protection from certain restraining**

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

**s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:**
**1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).**
**2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).**
**3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).**
**4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).**
**5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).**

**Findings/Faits saillants :**

1. The licensee did not ensure that resident #001 was not restrained by a physical device, other that in accordance with section 31 or under common law duty described in section 36, in relation to the following:[30(1)3]
Resident #001 was not restrained in accordance with section 31 of the Act when on an identified date the resident was noted to be sitting in a wheelchair with a front closing seat belt applied. The resident had returned from hospital following a medical event and because of this event the resident was not physically able to independently remove the seat belt. Staff and clinical documentation confirmed that risks requiring the use of the seat belt were not identified, alternatives to the restraining had not been considered, there was not an order for the restraint and the restraining had not been consented to by the resident's substitute decision maker. [s. 30. (1) 3.]

*Additional Required Actions:*

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

WN #3: 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. (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 did not ensure that all residents were reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective, in relation to the following: [6(10)(c)]
a) Resident #001 was not reassessed or the plan of care reviewed or revised when the care identified to manage the risk of falls was not effective. Clinical documentation indicated that staff identified the resident as a risk for falling, put in place a goal of no falls and identified care interventions. Clinical documentation indicated that the resident subsequently experienced three falls after the care plan was developed, however the resident was not reassessed and the goals of care or care interventions were not changed throughout this period of time. Staff and clinical documentation confirmed that the resident was not reassessed and care identified to prevent falls was not changed despite the resident falling three times.
b) Resident #002 was not reassessed or the plan of care reviewed or revised when the care identified to manage the risk of falls was not effective. Clinical documentation indicated the resident was identified as a risk for falls, a goal of having no falls and interventions were in place. Clinical documentation indicated that the resident fell five times over a four month period of time. The plan of care in place at the time of this inspection was not reviewed or revised despite the resident continuing to experience falls. Staff confirmed that the care identified for the resident had not been reviewed or revised over this above noted period of time.
c) Resident #004 was not reassessed or the plan of care reviewed or revised when the care provided to the resident related to the management of a medical condition was not effective. Staff and the clinical record confirmed that the care plan in place at the time of this inspection indicated the potential to experience side effects and complications from this medical condition and goals and interventions were put in place to manage the condition. The clinical records indicated that over a 96 day period of time the resident was treated for side effects of this condition 89 times. Registered staff confirmed that they had not reviewed clinical documentation available that indicated the number of times the resident required additional treatment and had not communicated the increased requirement to treat side effects of this condition to the resident's physician. Minimum Data Set (MDS) information collected and Resident Assessment Protocols (RAPs) completed over the last two quarterly reviews indicated that the resident was responding to interventions outlined in the care plan, the clinical assessment had not changed since the last assessment and the goals and interventions continued to be effective. The staff person completing these reassessments confirmed that information available indicating an increased need to treat the signs and symptoms of this condition had not been reviewed and the plan of

care for this resident had not been reviewed or revised over the above noted period of time. The resident's physician viewed a laboratory report in November 2012, which indicated the medical management of the this condition was poor/inadequate, but took no action to review and or revise the plan of care. [s. 6. (10) (c)]

***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 and ensuring that all residents are reassessed and the plan of care reviewed and revised when the care set out in the plan of care has not been effective, to be implemented voluntarily.***

**WN #4: 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. The licensee did not ensure that where the Act or the Regulations requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that those plans, policies, protocols, procedures, strategy or systems were complied with, in relation to the following: [8(1)(b)]
a) Staff in the home did not comply with the following policies and procedures related to the use of restraints:
1. The home's Least Restraint/Personal Assistance Services Device policy identified as # RC09-04-06 dated January 24, 2012 directed staff that prior to initiating the use of restraints, the Interdisciplinary Care Team will conduct a thorough assessment of the resident and their environment. Staff and clinical documentation confirmed that these directions where not complied with when Resident #001 did not have an assessment completed prior to the application of a front fastening seat belt that the resident was unable to independently remove.
2. The home's Restraint Reduction Program identified that it was the responsibility of the Registered Nurse to coordinate with the resident's physician and obtain an order for the restraint as well as contacting the resident's Substitute Decision Maker (SDM) to obtain consent for the use of the device. Staff and clinical documentation confirmed that these directions were not complied with when it was noted that there was not a physician's order for the use of a front fastening seat belt that was applied to resident #001 and that there was no documentation indicating the resident's SDM had consented to the use of the restraint.
3. The home's [Use of Safety Device] policy identified as RC09-03-03, dated January 8, 2009 directed that documentation of regular and ongoing use of a safety device will be made on the care plan and the quarterly review. Staff and clinical documentation confirmed that the use of a front fastening seat belt while sitting in a chair was not included in the care plan for Resident #001.
This policy also directed when a restraint is initiated, documentation and completion of the [Record of Alternative Interventions], the [Consultation with the resident/SDM] form must be completed and the [Restraint Monitoring Record] is used and documented on hourly. Staff and clinical documentation confirmed that these directions were not complied with when these documents were not completed when a seat belt restraint was initiated for Resident #001.
b) Staff in the home did not comply with the home's Fall Prevention Program identified as # RC-04-04-11 and dated November 17, 2011
-This program directs that the Registered Nurse (RN) is to notify the physician and POA/SDM of the fall, initiate Head Injury Routine (HIR) for all unwitnessed falls, monitor the resident every hour for the first four hours, then every four hours for 24

hours post fall and document all the above activities in the progress notes. Staff and clinical documentation confirmed that staff did not comply with these directions when the physician and the SDM were not notified, HIR was not initiated and Resident #001 was not monitored in accordance with the above directions following two unwitnessed falls.

c) Staff in the home did not comply with the home's Dietary Referral Policy identified as #NCM-02-05-01 and dated March 3, 2005. This policy directed that referrals to the Registered Dietitian will be made when a resident laboratory values fall outside expected levels and there are nutritional implications. Staff and clinical documentation confirmed that staff did not comply with these directions in the care for Resident #004 when laboratory values taken in 2011 indicated sub-optimal glycemic control and laboratory values taken in 2012 indicated poor/inadequate glycemic control. Dietary staff confirmed that based on the above noted information the residents blood glucose levels were not being adequately controlled, however they did not receive a referral to assess the nutritional status of this resident. [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 and ensuring that where the Act or the Regulations require the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that those plans, policies, protocols, procedures, strategies or systems are complied with, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs**

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the program of nutritional care included the development and implementation, in consultation with the Registered Dietitian, of policies and procedures related to nutritional care and dietary services, with respect to the following: [68(2)(a)]
The nutritional care program does not include specific directions related to:
a) The role of the Food Service Supervisor(FSS) and the Registered Dietitian(RD) with respect to nutritional screening of residents verses nutritional assessment of residents. The nutritional program policies and procedures indicated that the FSS will complete nutritional assessment reviews for residents identified as low and moderate nutritional risk. The FSS confirmed that there are no specific directions with respect to how these assessment reviews should be completed and what factors are to be considered.
b) The RD and the FSS confirmed that the nutrition program in the home does not provide clear directions for communication between staff responsible for the nutritional care of residents. Specifically there are no directions provided to the FSS about what constitutes a change in the resident's nutritional needs and when the RD should complete an assessment of the resident with changing nutritional needs.
c) The policies and procedures included in the program of nutritional care did not provide clear directions to staff responsible for monitoring and managing nutritional care, when it is documented that referrals will be made to the RD or the FSS under a group of 18 identified circumstances. The LTCHA 2007 specifically directs that the RD is to complete an assessment of the resident whenever there is a significant change in the resident's health condition. The RD confirmed that 13 of the 18 circumstances identified would constitute a significant change in the resident's health condition, however referrals are not specifically directed to the RD. The FSS confirmed that the directions provided in the document did not provide information about which conditions she should be reviewing and which conditions the RD should be assessing. [s. 68. (2) (a)]

*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 and ensuring that the organized program of nutritional care includes the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services, to be implemented voluntarily.*

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee did not ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, annual training in the area of minimizing restraints in accordance O. Reg. s. 221(2), in relation to the following: [76(7)4]
The Director of Care and in-service documentation provided by the home confirmed that 82 of the 96 staff identified by the home as providing direct care to residents had not received annual retraining in the area of minimizing retraining of residents and, where restraining was necessary, how to do so in accordance with the Act and the regulations. [s. 76. (7) 4.]

2. The licensee did not ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, annual training in the area of falls prevention and management, in accordance with O.Reg. 79/10 221(1) 1, in relation to the following: [76(7)6]
The Director of Care and in-service documentation provided by the home confirmed that 74 staff who were identified as providing direct care to residents did not receive training in falls prevention and management in the year 2012. [s. 76. (7) 6.]

***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 and ensuring that all staff who provide direct care to the resident receive annual training in the areas of minimizing restraints and falls prevention and management, to be implemented voluntarily.***

**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes**
**Every licensee of a long-term care home shall ensure that,**
**(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;**
**(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and**
**(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.**

**Findings/Faits saillants :**

1. The licensee did not ensure that when residents were taking any drug or combination of drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, in relation to the following: [134(a)]
a)Resident #004's response and the effectiveness of a medication being administered on an as needed basis were not monitored or documented. The resident's physician ordered the resident's blood level to be monitored two times a day and the resident was to receive a specified amount of additional medication based on blood levels obtained. Clinical record information documented on the Medication Administration Records (MAR) indicated that the resident received this additional medication 89 times over a four month period of time. Staff and clinical documentation confirmed that of the 89 times this medication was administered to the resident in order to return blood levels back to ranges identified by the resident's physician, the effectiveness of the medication and the resident's response was not monitored or documented for 87 of those times.
b) Resident #005's was ordered to receive a narcotic analgesic on an as necessary basis to manage pain. Staff and clinical record documentation confirmed that the resident received this medication on and identified date. The resident's response to this medication or the effects of the medication in managing the resident's pain were not documented. Staff confirmed that this resident also received an as needed medication to manage constipation on an identified date, however, the resident's response or the effectiveness of this medication was not documented. [s. 134. (a)]

*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 and ensuring that when residents are taking any drug or combination of drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.*

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident's right to have his or her personal health information kept confidential was fully respected and promoted, in relation to the following: [3(1)11iv]
Personal health information located in clinical record binders for residents living within one home area were left unsecured, unattended and in an area easily accessible to other residents and visitors to the home. The nursing station area where clinical record information was kept is located adjacent to a large lobby and meeting area used by residents and visitors to the home. On March 1, 2013 it was noted that a half door that is designed to prevent residents and visitors from entering the nursing station area was not latched. It was also noted on this day that the clinical binder rack was not locked and there were no staff in the area to prevent visitors or residents from viewing personal health information in the clinical records. Staff confirmed that the lock for the clinical binder rack is to be applied at all times when staff are not in the nursing station area. On March 11, 2013 it was noted that the door latch was again not activated and a resident's clinical binder was left on the counter of the nursing station in close proximity to the area within the nursing station that the key to the public washroom is located. It was also noted on this day that staff were not in attendance in this area for an extended period of time. [s. 3. (1) 11. iv.]

**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**
**Specifically failed to comply with the following:**

**s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,**
**(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).**
**(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).**

**Findings/Faits saillants :**

1. The licensee did not ensure that in accordance with LTCHA O.Reg. 79/10, s 26(3) 13 a registered Dietitian assessed the nutritional status, including height, weight and any risks related to nutritional care for resident #004. [26(4)(b)]
Clinical information for resident #004 indicated that the resident's blood levels were not stable in spite of the resident receiving regularly scheduled medication as well as additional medication in an attempt to manage this condition. Documentation on the Medication Administration Record (MAR) confirmed that over a 96 days period the resident received medication in addition to regularly scheduled doses of medication 89 times. Laboratory reports in the clinical record in November 2012 indicated that the control of this resident's condition was poor/inadequate. The Registered Dietitian confirmed that this information would indicate that the resident's nutritional care was at risk related to this uncontrolled condition and she had not completed an assessment of this resident. [s. 26. (4) (b)]

**THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/**
**LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:**

| COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS: | | | |
|---|---|---|---|
| **REQUIREMENT/ EXIGENCE** | **TYPE OF ACTION/ GENRE DE MESURE** | **INSPECTION # / NO DE L'INSPECTION** | **INSPECTOR ID #/ NO DE L'INSPECTEUR** |
| O.Reg 79/10 s. 15. (1) | CO #901 | 2013_205129_0002 | 129 |

Issued on this 3rd day of May, 2013

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

PHYLLIS HILTZ-BONTJE