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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 21, 2020	2020_746692_0005	021871-19, 021907-19, 022673-19, 022734-19, 022768-19, 023326-19, 023412-19, 024040-19	Critical Incident System

Licensee/Titulaire de permis

2063412 Ontario Limited as General Partner of 2063412 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Muskoka Shores Care Community
200 Kelly Drive GRAVENHURST ON P1P 1P3

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

SHANNON RUSSELL (692), JENNIFER NICHOLLS (691)

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): Febraury 10-14, 2020.

The Following intake(s) were inspected upon during this Critical Incident Inspection:
-One log, which was related to a critical incident that the home submitted to the Director related to an unexpected death of a resident;
-Two logs, which were related to critical incidents that the home submitted to the Director related to incidents resulting in the resident being transferred to the hospital and sustaining a significant change in health status, and;
-Five logs, which were related to critical incidents that the home submitted to the Director related to abuse of a resident by anyone that resulted in harm or a risk of harm to the resident.

A Complaint Inspection #2020_746692_0004 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Associate Director of Care (ADOC), Nurse Managers (NM), Behavioural Support Ontario (BSO) Lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions and resident to resident interactions, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

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

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

- **2 WN(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse was complied with.

A Critical Incident System (CIS) report was submitted to the Director on an identified date, which indicated that resident #007 had reported that they had been experiencing pain in an identified area, and that it had been caused by “a rough Personal Support Worker [PSW].” A further review of the CIS report identified that on an identified date, PSW #106 reported to Registered Practical Nurse (RPN) #103 that they had observed PSW #105 being “forceful” when providing care to resident #007, eight days prior. PSW #106 had indicated that they had not reported it at the time that it had occurred; however, resident #007 was complaining of pain from this incident. When resident #007 was asked what had caused the pain, the resident described the actions of the PSW.

Physical abuse is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "the use of physical force by anyone other than a resident that causes physical injury or pain".

A review of the home’s policy titled, “Prevention of Abuse and Neglect of a Resident, #VII-G-10.00”, last updated April 2019, indicated that abuse and neglect were not tolerated in any circumstance by anyone, and any deviation from this standard would not be tolerated. A further review of the policy identified that all team members, residents, and families, were required to immediately report any suspected or known incident of abuse and neglect to the Executive Director (ED) or designate in charge of the care community.

a)Inspector #692 reviewed the home’s internal investigation notes, which included

interviews that the home's management had conducted with the staff members involved with the incident. The investigation notes identified that on the identified date, PSW #106 had reported to RPN #103 that they had observed PSW #105 being forceful when providing care to resident #007, in which the resident complained of pain in an identified area after what PSW #106 had observed. A further review of the home's internal investigation notes identified a disciplinary letter addressed to PSW #105, which identified that they were in violation of the home's policies and procedures for committing acts of resident abuse.

During a review of resident #007's health care records, Inspector #692 identified a progress note dated on an identified date, in which RPN #103 had documented that a PSW had reported that "someone was really rough" with resident #007, resulting in them complaining of pain in an identified area. There was not any physical markings or areas of concerns when resident #007 was assessed by RPN #103.

b) A further review of the home's internal investigation notes identified that PSW #106 had observed the incident involving resident #007 on an identified date; however, they did not report the incident to RPN #103 until eight days after the incident occurred. The home provided a disciplinary letter to PSW #106 for not complying with the home's policy, as they did not report the incident of resident abuse immediately.

During a further review of resident #007's health care records, Inspector #692 identified a progress note dated two days after the incident was reported to RPN #103, documented by Registered Nurse (RN) #104. RN #104 indicated that they had spoken to resident #007 on this date regarding the reported incident, and that the resident had confirmed that a PSW had been rough.

During separate interviews with PSW #106 and RPN #103, they both identified to Inspector #692 that PSW #106 had observed PSW #105 being more forceful than necessary when providing care to resident #007. PSW #106 indicated that they had not reported the incident they had observed involving resident #007 until eight days after it had occurred; however, they had known they should have reported it immediately. RPN #103 indicted that they had assessed resident #007; they had not noted any physical markings, yet the resident had complained of pain in an identified area.

In separate interviews with Inspector #692, RN #119 and Nurse Manager (NM) #109 both indicated that if staff were to witness an incident of abuse directed towards a resident, they were required to report it to the RN charge nurse or senior management

immediately. They both identified that the incident involving PSW #105 towards resident #007 was not tolerated, had not been reported at the time of the incident, and that PSW #106 should have reported it to them immediately.

Inspector #692 interviewed the ED, who identified that staff were to report all witnessed, suspected or confirmed incidents of resident abuse to the charge nurse and/or senior management immediately at the time that the incident occurred to mitigate risk to residents. The ED indicated that the incident in which PSW #105 was forceful when providing care to resident #007, resulting with them complaining of pain, was not tolerated by the home. The ED further indicated that it was not reported until eight days after it had occurred, and it should have been reported to management immediately. [s. 20. (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. 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 that resulted in harm or risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A CIS report was submitted to the Director on an identified date, related to an allegation of resident to resident physical abuse, from resident #001 towards resident #006.

Inspector #691 reviewed the health care records of resident #006, which identified a progress note, documented from RPN #107, which indicated that the resident had told them that someone had "hit" them. They further indicated that there was an identified injury to a specific area of resident #006.

Inspector #691 interviewed RPN #103, RPN #114, as well as RN #119, who all verified that their understanding of mandatory reporting requirements, was that every form of abuse should be immediately reported to the Ministry.

Inspector #691 interviewed NM #109, who indicated that all staff were trained on mandatory reporting of incidents of alleged abuse. They verified that the RPN had documented the incident in the progress notes, but the incident was not reported to the on-call manager. NM #109 indicated to the Inspector that the manager on call should have been notified in order for the incident to be immediately reported to the Director, and it was not.

Inspector #691 interviewed the ED, who indicated that all staff were trained on mandatory reporting of any alleged abuse, and also identified that all registered staff were to use after-hours reporting line. They further indicated that this incident should have been reported immediately, and was not. [s. 24. (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 the person who has reasonable grounds to suspect that abuse of a resident by anyone, is immediately reported to the Director, to be implemented voluntarily.

Issued on this 24th day of February, 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) :	SHANNON RUSSELL (692), JENNIFER NICHOLLS (691)
Inspection No. / No de l'inspection :	2020_746692_0005
Log No. / No de registre :	021871-19, 021907-19, 022673-19, 022734-19, 022768-19, 023326-19, 023412-19, 024040-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 21, 2020
Licensee / Titulaire de permis :	2063412 Ontario Limited as General Partner of 2063412 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Muskoka Shores Care Community 200 Kelly Drive, GRAVENHURST, ON, P1P-1P3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angela Coutts

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 2063412 Ontario Limited as General Partner of 2063412 Investment LP, 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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee must be compliant with s. 20 (1) of the Long Term Care Homes Act (LTCHA), 2007.
Specifically, the licensee shall:
1. Develop and implement a monitoring system to ensure that abuse is reported as required.
2. Ensure staff members #103, #104 and #106 are trained to identify and report all alleged, suspected and witnessed incidents of abuse immediately to the Director; and,
3. Maintain a record of re-training provided, including dates, times, attendees, trainers and material taught.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse was complied with.

A Critical Incident System (CIS) report was submitted to the Director on an identified date, which indicated that resident #007 had reported that they had been experiencing pain in an identified area, and that it had been caused by "a rough Personal Support Worker [PSW]." A further review of the CIS report identified that on an identified date, PSW #106 reported to Registered Practical Nurse (RPN) #103 that they had observed PSW #105 being "forceful" when providing care to resident #007, eight days prior. PSW #106 had indicated that they had not reported it at the time that it had occurred; however, resident #007 was complaining of pain from this incident. When resident #007 was asked what had caused the pain, the resident described the actions of the PSW.

Physical abuse is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "the use of physical force by anyone other than a resident that causes physical injury or pain".

A review of the home's policy titled, "Prevention of Abuse and Neglect of a Resident, #VII-G-10.00", last updated April 2019, indicated that abuse and neglect were not tolerated in any circumstance by anyone, and any deviation from this standard would not be tolerated. A further review of the policy identified that all team members, residents, and families, were required to immediately report any suspected or known incident of abuse and neglect to the Executive Director (ED) or designate in charge of the care community.

a)Inspector #692 reviewed the home's internal investigation notes, which included interviews that the home's management had conducted with the staff members involved with the incident. The investigation notes identified that on the identified date, PSW #106 had reported to RPN #103 that they had observed PSW #105 being forceful when providing care to resident #007, in which the resident complained of pain in an identified area after what PSW #106 had observed. A further review of the home's internal investigation notes identified a disciplinary letter addressed to PSW #105, which identified that they were in violation of the home's policies and procedures for committing acts of resident abuse.

During a review of resident #007's health care records, Inspector #692 identified a progress note dated on an identified date, in which RPN #103 had documented that a PSW had reported that "someone was really rough" with resident #007, resulting in them complaining of pain in an identified area. There was not any physical markings or areas of concerns when resident #007 was assessed by RPN #103.

b) A further review of the home's internal investigation notes identified that PSW #106 had observed the incident involving resident #007 on an identified date; however, they did not report the incident to RPN #103 until eight days after the incident occurred. The home provided a disciplinary letter to PSW #106 for not complying with the home's policy, as they did not report the incident of resident abuse immediately.

During a further review of resident #007's health care records, Inspector #692 identified a progress note dated two days after the incident was reported to RPN #103, documented by Registered Nurse (RN) #104. RN #104 indicated that they had spoken to resident #007 on this date regarding the reported incident, and that the resident had confirmed that a PSW had been rough.

During separate interviews with PSW #106 and RPN #103, they both identified to Inspector #692 that PSW #106 had observed PSW #105 being more forceful than necessary when providing care to resident #007. PSW #106 indicated that they had not reported the incident they had observed involving resident #007 until eight days after it had occurred; however, they had known they should have reported it immediately. RPN #103 indicted that they had assessed resident #007; they had not noted any physical markings, yet the resident had complained of pain in an identified area.

In separate interviews with Inspector #692, RN #119 and Nurse Manager (NM) #109 both indicated that if staff were to witness an incident of abuse directed towards a resident, they were required to report it to the RN charge nurse or senior management immediately. They both identified that the incident involving PSW #105 towards resident #007 was not tolerated, had not been reported at the time of the incident, and that PSW #106 should have reported it to them immediately.

Inspector #692 interviewed the ED, who identified that staff were to report all witnessed, suspected or confirmed incidents of resident abuse to the charge nurse and/or senior management immediately at the time that the incident occurred to mitigate risk to residents. The ED indicated that the incident in which PSW #105 was forceful when providing care to resident #007, resulting with them complaining of pain, was not tolerated by the home. The ED further indicated that it was not reported until eight days after it had occurred, and it should have been reported to management immediately.

The severity of this issue was determined to be a level three, as there was actual harm/actual risk. The scope of the issue was a level two, as the incident was a pattern. The home has a level three compliance history with related noncompliance in the last 36 months with this section of the LTCHA.

- A Voluntary Plan of Correction (VPC) issued November, 2019, during inspection 2019_782736_0031;
- A Written Notice (WN) issued October, 2018, during inspection #2018_669642_0019.

(692)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 03, 2020

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 21st day of February, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shannon Russell

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