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

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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
Oct 14, 2014	2014_205129_0016	H-000949-13	Critical Incident System

Licensee/Titulaire de permis

1365853 ONTARIO LIMITED
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

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

MAPLE PARK LODGE
6 Hagey Avenue, Fort Erie, ON, L2A-5M5

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

PHYLLIS HILTZ-BONTJE (129)

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): July 21 and 22, 2014

During the course of the inspection, the inspector(s) spoke with registered and unregulated staff, the Resident Assessment Instrument (RAI) Coordinator, the Special Program/Project staff, the Assistant Director of Care (ADOC) and the Director of Care (DOC) in relation to Log # H-000949-13.

During the course of the inspection, the inspector(s) observed residents, reviewed clinical records, made observations of bed alarms in use in the home and reviewed the home's policies and procedures [Restraints and Falls Prevention and Management Program]

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

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were developed and implemented to ensure that all equipment and devices were kept in good repair, in relation to the following: [90(2)(b)]
Staff identified that resident #001 required the use of a bed alarm and a chair alarm in order to manage a risk of falling, however the DOC confirmed that procedures were not developed and implemented to ensure these devices were kept in working order. Clinical documentation and an internal occurrence report confirmed that on an identified date in 2013 the resident fell from bed sustaining a head injury and injuries to an upper extremity. The documentation also indicated that at the time of this fall the bed alarm was not functioning properly when it did not sound to alert staff that the resident was attempting to leave the bed. The clinical record also confirmed that alarms used to manage the risk of falling were not working when in December 2013 staff documented that the wheelchair alarm was not working and was replaced as well as in January 2014 when documentation indicated the resident was found with both legs hanging out of the side of the bed and the bed alarm was not working to alert staff that the resident was attempting to leave the bed.
At the time of this inspection staff in the home confirmed that the alarm sensor pads were to be replaced after a year of use and the manufactures directions printed on the sensor pad also confirmed that the sensor pads were to be taken out of service after a year of use. The alarm sensor pads in use provided a space for staff to document the date the sensor pad was put into use and the date the alarm sensor pad should be removed from service. Three alarm sensor pads in use on one home area were observed and all three of these pads did not have the date the sensor pad was put into use or date the pad was to be removed from service. Staff confirmed that they were unaware of how long these sensor pads had been in use in the home. The DOC confirmed there was not a procedure developed or implemented to ensure that the alarm sensor pads used in conjunction with the alarms were monitored to comply with the safety directions from the manufacture. Ten of the bed alarms being use in this resident home area were battery operated and the DOC confirmed that there was not a procedure implemented in the home to ensure that these battery operated safety devices were in working order. [s. 90. (2) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 the written plan of care provided clear directions for staff and others who provide direct care to the resident, in relation to the following: [6(1)(c)]
Although care directions for resident #001 were included in various parts of the resident's clinical record, the DOC confirmed that the document the home used to provide care directions to staff did not provide clear directions on the use of bed and chair alarms to prevent the resident from falling, the use of bed rails to assist the resident with bed mobility or the use of the device placed over the closing mechanism on the front fastening seat belt to assist in deterring the resident from releasing the seat belt. [s. 6. (1) (c)]

2. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised when the care set out in the plan was not effective, in relation to the following: [6(10)(c)]
Resident #001 was not reassessed and the plan of care was not revised when a care intervention implemented to manage the risk of falling was not effective. The resident fell on an identified date in 2013 while attempting to ambulate from a chair resulting in a head injury as well as injuries to an upper extremity. The resident returned from the hospital the following day at which time the physician ordered the resident to have a front fastening seat belt applied whenever the resident was in the wheelchair in order to minimize the risk of falling. Clinical documentation between October 2013 and December 2014 indicated that on several occasions the resident removed and attempted to remove the seat belt and in response to this staff in the home applied a device over the closing mechanism of the belt. Following this change, clinical documentation continued to indicate that the resident was attempting to remove the seat belt even though the sleeve was in place and on an identified date in January 2014 staff documented that the resident removed the seat belt. At the time of this inspection a Personal Support Worker (PSW) providing care to the resident indicated the resident has good and bad days and has the potential to unlatch the seat belt on the good days. Staff and clinical documentation confirmed that the resident was not reassessed and the plan of care was not revised when staff were aware that an intervention in place to prevent the resident from falling from the chair was not effective. [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 the written plan of care provides clear direction for staff and others who provide direct care to the resident and that residents are reassessed and the plan of care reviewed and revised when the plan has not been effective, to be implemented voluntarily.

WN #3: 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. The licensee did not ensure that when bed rails were used for resident #001 the resident was assessed in accordance with evidence-based practices or prevailing practices in order to minimize the risk to the resident, in relation to the following: [15(1)(a)]
Resident #001 was not assessed in accordance with evidence-based practices when the plan of care indicated that this resident required the use of bed rails to assist with mobility. Clinical documentation confirmed that in October 2013 the resident required bed rails to assist with mobility, two months later the resident required the use of two ¾ bed rails to assist with mobility, four months later clinical documentation indicated that one bed rail was either lowered or raised to accommodate resident's needs and three months later it was again documented that the resident required one bed rail either raised or lowered to accommodate the their needs. At the time of this inspection a Personal Support Worker (PSW) providing care to resident #001 confirmed that bed rails were being used for this resident. The Director of Care (DOC) confirmed that the decision to implement the use of bed rails was not based on an assessment of the resident's condition, functional needs or risk of injury associated with behaviours the resident was demonstrating.
The DOC confirmed that the home has not developed or implemented an individualized resident assessment in accordance with evidence-based practices or prevailing practices when the use bed rails are being considered for resident care. [s. 15. (1) (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 bed rails are used the resident is assessed in accordance with evidence-based practices or prevailing practices, to be implemented voluntarily.

WN #4: 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. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that resident #001's plan of care was based on, at a minimum, an interdisciplinary assessment of safety risks, in relation to the following: [26(3)19]
Resident #001's plan of care was not based on an interdisciplinary assessment of the use of a seat belt restraint. The resident's physician ordered the application of a front fastening seat belt on an identified date in 2013 following a fall while the resident was attempting to ambulate from a wheelchair that resulted in the resident suffering head and arm injuries. Staff and clinical documentation confirmed that staff added the use of a front fastening seat belt to an existing assessment form dated three months earlier that was used to assess the need for the resident to be place on a secured unit of the home. Staff confirmed that this document did not contain assessment data related to the use of the seat belt restraint ordered on October 3, 2013. [s. 26. (3) 19.]

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 resident's plan of care is based on, at a minimum, an interdisciplinary assessment of safety risks, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee did not ensure the written policy to minimize the restraining of resident and to ensure that any restraining that is necessary was complied with, in relation to the following: [29(1)(b)]
Staff did not comply with the home's written policy [Restraints] identified as # CN-R-05 -1and dated July 2010.
1. The policy directed that restraining by a physical device may be included in the resident's plan of care only if, a significant risk to the resident is identified, alternatives to restraining the resident have been considered and tried where appropriate and the method of restraining is reasonable in light of the resident's condition is documented in the plan of care.
- Resident #001 was restrained using a front fastening seat belt. Staff did not complete an assessment of this restraint and as a result the above noted information was not documented in the resident's plan of care.
2. The policy also contained a [Restraint/PASD and Alternative Assessment] form that includes directions that the form must be completed prior to initial restraint/PASD application.
- Staff did not comply with this direction when resident #001's physician ordered the resident to be restrained using a front fastening seat belt whenever the resident was in the wheelchair in order to prevent the resident from falling and staff did not complete form prior to the initial application of this restraining device. [s. 29. (1) (b)]

Issued on this 14th day of October, 2014

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2014_205129_0016
Log No. / Registre no:	H-000949-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 14, 2014
Licensee / Titulaire de permis :	1365853 ONTARIO LIMITED 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	MAPLE PARK LODGE 6 Hagey Avenue, Fort Erie, ON, L2A-5M5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CAROLE JURKOSKY

To 1365853 ONTARIO LIMITED, 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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that procedures are developed and implemented to ensure that devices such as bed and chair alarms used in the home are in a good state of repair and that safety directions from the manufactures directions for these devices are followed.
The plan is to include, but is not limited to the following:
-A review of the manufactures safety requirements for the use of devices, including bed/chair alarms and sensor pads being used in the home.
-The development and implementation of procedures that staff in the home must follow in relation to the safety requirements of devices, including bed/chair alarms and sensor pads being used in the home.
-The development and implementation of a system of monitoring staff's performance in following the safety procedures established when devices such as bed/chair alarms and sensor pads are part of a resident's plan of care.
The plan is to be submitted on or before October 16, 2014 to Phyllis Hiltz-Bontje, by mail at 119 King Street West, Hamilton Ontario L8P 4Y7 or by email at Phyllis.Hiltzbontje@Ontario.ca.

Grounds / Motifs :

1. Resident #001 fell on an identified date in 2013 suffering head and arm injuries when a bed alarm failed to function and alert staff that the resident was attempting to leave the bed.
Staff identified that resident #001 required the use of a bed alarm and a chair alarm in order to manage a risk of falling, however the DOC confirmed that procedures were not developed and implemented to ensure these devices were kept in a good state of repair. Clinical documentation and an internal occurrence report confirmed that on an identified date in 2013 the resident fell from bed sustaining head and arm injuries and that at the time of this fall the bed alarm was not functioning properly and did not sound to alert staff that the resident was attempting to leave the bed. The clinical record also confirmed that alarms used to manage the risk of falling were not working a month later when staff documented that the wheelchair alarm was not working and was replace with a new one and 20 days later when the resident was found with both legs hanging out of the side of the bed and the bed alarm was not working to alert staff that the resident was attempting to leave the bed.
2. Three of three bed alarm sensor pads monitored did not have identified dates when the sensor pad should be removed from service according to the manufactures directions. At the time of this inspection staff in the home confirmed that the alarm sensor pads were to be replaced after a year of use and the manufactures directions printed on the sensor pad also confirmed that

the sensor pads were to be taken out of service after a year of use. The manufacturer of the sensor pads had also provided an opportunity for staff to document on the pad the date the sensor pad was put into use and the date the sensor pad should be removed from use. Three of three sensor pads in use on one home area were observed and did not have the date the sensor pad was initiated and the date the pad was to be removed from service. Staff confirmed that they were unaware of how long these sensor pads had been in use in the home. The DOC confirmed there was not a procedure developed or implemented to ensure that the sensor pads used in conjunction with the alarms were monitored to comply with the manufactures directions that the sensor pads are to be removed from service after a year of use.

3. The home did not have a plan in place to regularly monitor and replace batteries for resident safety equipment that rely on battery power. Ten of the bed alarms in use on one resident home area were battery operated and the DOC confirmed that there was not a procedure implemented in the home to ensure that these battery operated safety devices were in working order. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2014

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
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 14th day of October, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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