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

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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
Apr 25, 2014	2014_109153_0002	T-070-14	Resident Quality Inspection

Licensee/Titulaire de permis

MARKHAVEN, INC.
54 PARKWAY AVENUE, MARKHAM, ON, L3P-2G4

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

MARKHAVEN, INC.
54 PARKWAY AVENUE, MARKHAM, ON, L3P-2G4

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

LYNN PARSONS (153), BARBARA PARISOTTO (558), ERIC TANG (529), JUDITH HART (513)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 2014.

During the course of the inspection, the inspector(s) spoke with executive director(ED), director of human resources and business manager, Director of Care(DOC), clinical nurse manager, director of program services, environmental services manager(ESM), resident services coordinator, food services manager(FSM), registered dietitian(RD), physiotherapist(PT), resident assessment instrument-minimum data set (RAI-MDS)coordinator, registered nurses(RN), registered practical nurses(RPN), scheduling coordinator, physiotherapy aide, personal support workers(PSW), cook, dietary aides(DA), housekeepers, laundry aides, residents and families.

During the course of the inspection, the inspector(s) reviewed clinical health records, staff training records, staff schedules, Resident and Family Council minutes, recipes, menus, food temperature logs and home policies related to fall prevention, continence care, cleaning of resident equipment, medication administration, infection control, missing items, maintenance, laundry, housekeeping, tray service, restraints, side rails, skin and wound, personal hygiene and grooming, abuse, resident bill of rights and criminal reference checks;
completed observations of meal preparation and dining service, food temperatures and taste testing, laundry department, provision of care, infection control practices, medication administration, and staff to resident interactions; conducted a tour of resident care areas.

During this inspection a complaint log was inspected T-707-13.
During this inspection a critical incident log was inspected T-146-14.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care

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 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each

resident that sets out clear directions to staff and others who provide direct care to the resident.

a) The written plan of care for resident #0603 fails to provide clear directions to staff related to toileting. A review of resident #0603's kardex indicates that the resident requires one staff to provide extensive assistance for toileting. Resident #0603's care plan states that the resident requires limited assistance of one staff for toileting. Interviews with staff confirmed that the resident's written plan of care did not provide clear direction related to toileting.

b) The written plan of care for resident #0611 fails to provide clear direction to staff related to oral care.
The written plan of care for resident #0611 under the personal hygiene section does not provide any interventions for the completion of oral hygiene care.
Interviews with staff provided conflicting information as to the oral care provided to the resident.
The DOC confirmed the written plan of care should provide clear direction regarding the process and equipment used to provide oral care.

c) The written plan of care for resident #0602 fails to provide clear direction to staff related to oral care.

The written plan of care for resident #0602 under the dentition/oral section provides conflicting information in the resident kardex and the care plan.

The resident kardex indicates:
- some or all natural teeth lost
- does not have or does not use dentures
- daily cleaning of teeth or dentures by client or staff.

The care plan indicates:
- daily cleaning of teeth or dentures
- or daily mouth care by client or staff.

Interviews with staff provided conflicting information related to oral care. One staff uses swabs dipped in mouth wash to clean mouth while another staff indicated that a family member provides oral care.
The DOC confirmed the plan of care for resident #0602 does not provide clear directions to staff related to mouth care.

d) The written plan of care for resident #0615 fails to provide clear direction to staff related to oral care.
The speech language pathologist made recommendations for resident #0615 which directed staff to provide oral care routine before and after meals.
A review of the kardex directed staff to provide daily cleaning of teeth. An interview with a staff member revealed the resident receives mouth care using a mouth swab before breakfast and after lunch. Another staff member reported that mouth care is provided after supper with a toothbrush and toothpaste, using thickened water, and is rinsed using a swab. The DOC confirmed in an interview that her expectation is that the care plan should reflect what the resident has e.g. teeth or dentures, and what the resident needs e.g. what they are doing and when.

e) The written plan of care for resident #0556 fails to provide clear direction to staff related to oral care.

The written plan of care for resident #0556 under the oral care section indicates:
- place toothbrush with toothpaste in resident hand and guide to resident's mouth
- use sponge dipped in mouthwash twice a day to clean mouth and teeth.
Interviews with staff revealed the resident refuses mouth care with a toothbrush and will only allow oral care to be provided with swabs dipped in mouthwash.
The DOC confirmed the written plan of care does not provide clear direction to staff.

f) The written plan of care for resident #0545 fails to provide clear direction to staff related to the bathing preference.
The written plan of care for resident #0545 provides conflicting information related to type of bath the resident is to receive.
The resident kardex directs staff to provide a tub bath while the care plan indicates staff to provide a shower.
The DOC confirmed the written plan of care did not provide clear direction to staff and others who provide direct care.

g) The written plan of care for resident #0545 fails to provide clear direction to staff related to seat belt use.
The written plan of care for resident #0545 under the safety devices section indicates seat belt to be used on wheelchair.
Through staff/resident interviews and observation it was confirmed the resident does not use a seat belt.

Registered staff confirmed the current wheelchair does not have a seat belt.

h) The written plan of care for resident #0545 fails to provide clear direction to staff related to oral care.

The written plan of care for resident #0545 under the dentition/oral section provides conflicting information related to oral care.
The resident's kardex states:
- daily mouth care by client or staff
- staff to encourage resident to do own mouth care.
The care plan states:
- daily mouth care by staff
- staff to encourage resident to do own mouth care.
Interviews with staff indicated resident refuses to wear the dentures and does not participate in the activity of mouth care which is completed with swabs dipped in mouthwash.
The DOC confirmed the written plan of care does not provide clear directions to staff.

i) The written plan of care for resident #0570 provides conflicting information related to aids for daily living.
The resident's kardex indicates the resident uses both a walker and a cane for ambulation.
The written plan of care indicates the resident is fully independent with devices, remind resident to use cane and in the same section indicates to use a walker for ambulation.
Through interviews and observations it was confirmed the resident uses a walker for ambulation and does not use a cane.
A review of the written plan of care for resident #0570 under the section titled aids to daily living, show handwritten instructions to refer to a new page printed September 20 (which did not indicate a year) for update. A review of the PSW flow sheet binder failed to locate page 20. Interviews with staff confirmed they were unable to locate the updated page 20.
The DOC confirmed the written plan of care does not provide clear directions to staff.
[s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

The care set out in the plan of care for resident #0570 is not based on an assessment of the resident and the needs and preferences of that resident.
A review of the written plan of care for resident #0570 indicated the following strategies to respond to the resident's identified needs:
a) Toileting section states the call bell to be within reach and encourage resident to use to call staff.

b) Falls section states to encourage resident to ask for assistance with use of the call bell.
The RAI-MDS assessment indicated the resident has both short and long term memory deficits and lacks the ability to make good decisions.
Interviews with staff confirmed the resident is unable to remember to use the call bell for assistance.
The strategy to encourage the resident to use the call bell to alert staff that the resident requires assistance for toileting and to reduce the risk for falls, fails to ensure that the care set out in the plan of care is based on an assessment of resident #0570's needs and preferences. [s. 6. (2)]

3. The licensee did not ensure the staff and others involved in the different aspects of care collaborate with each other in the assessments of the resident so that their assessments are integrated, consistent with and complement each other.

a) A physician order was received in May 2013, for resident #0556 to have an intervention applied to one of the resident's hands every two hours.
A review of the quarterly physician order review form indicated this intervention was discontinued in February 2014.
Resident #0556 was observed to have the intervention applied inconsistently throughout the inspection.
During the inspection a handwritten notice was observed posted on the wall in the resident's room directing staff to apply the intervention to one of the resident's hands.
An interview with the registered staff member confirmed a lack of collaboration had occurred between the different staff and proceeded to remove the posted sign from the resident's room. The registered staff indicated a call would be placed to the physician to clarify the intervention.

b) Resident #0556 experiences frequent discharge from eyes requiring specific eye care interventions.
A review of various documents revealed several different interventions for the

resident's eye care needs.
The Treatment Administration Record (TAR) instructs registered staff to apply warm compresses to cleanse eyelids four times a day.
The Medication Administration Record (MAR) instructs registered staff to wash eyelids with baby shampoo twice weekly on bath days.
The written care plan directs PSWs to wash eyes gently morning and bedtime with warm water.
The registered staff confirmed a lack of collaboration between staff in the different aspects of care for resident #0556.
The registered staff indicated additional follow-up with the physician will be completed to determine the required interventions related to eye care. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and compliment each other.

A record review indicates that resident #0026 was assessed by a PT upon returning from a hospital. The PT recommended the use of a mechanical lift for transfer. A record review of the resident's kardex and written plan of care following the assessment by the PT does not indicate the use of a mechanical lift for transfer. An interview with the PT confirmed that resident #0026's kardex and plan of care were not updated to include the change in the resident's transfer status. [s. 6. (4) (b)]

5. The licensee failed to ensure the care set out in the plan of care is provided to the resident as specified in the plan.

a) A review of the plan of care and the diet list for resident #0617 directed staff to provide regular texture, cut up food into small pieces. During lunch observation on March 13 and 17, 2014, the resident was served beef pie and sole fingers, respectively, and on neither occasion were the food items cut up into small pieces. Interviews with two dietary aides and the food service manager confirmed that PSWs are responsible for cutting food for residents. When interviewed, a staff member stated the resident does not require staff assistance for the food to be cut up.

b) A review of the plan of care for resident #0545 indicates the resident likes to take a nap after lunch.
On March 7, 2014, at 2:19p.m. the resident was observed to be sitting in the lounge

and had not been transferred to bed for a nap after lunch.
On March 11, 13 and 18, 2014, the resident was observed to be sitting in the lounge after lunch and had not been transferred to bed for a nap as per the identified resident's care plan.

Interviews with the resident and a family member confirmed the resident preferred to return to bed after lunch for a nap.
The resident's primary caregiver works a short shift and leaves at 12:00p.m.
Other staff interviewed were unsure if the resident needed to be transferred to bed after lunch.
Interviews with registered staff and the DOC confirmed the resident should be transferred back to bed after lunch as per the resident's plan of care.

c) Resident #0026 experienced a fall in November 2013, in the resident's own room.
As per the home's Head Injury Routine (HIR) policy and procedure - RCSM-E-045 reviewed June 2011:
- vital signs to be checked and recorded for forty-eight hours on the HIR form
- first four hours every hour, next four hours every two hours, next sixteen hours every four hours and next twenty-four hours every eight hours
- vital assessments for this procedure to include: blood pressure, pulse, respiration, pupil reaction and size and level of consciousness.
Resident #0026's vital signs were to be checked and recorded for forty-eight hours on the HIR form. A record review of resident #0026's HIR form indicated that the resident was sleeping on three occasions. An interview with the DOC confirmed that the HIR was not completed as per home policy.

d) In November 2013 resident #0570 was found on the floor beside the resident's bed.

The home's Head Injury Routine (HIR) policy and procedure - RCSM-E-045 reviewed June 2011:
- vital signs to be checked and recorded for forty-eight hours on the HIR form
- first four hours every hour, next four hours every two hours, next sixteen hours every four hours and next twenty-four hours every eight hours
- vital assessments for this procedure to include: blood pressure, pulse, respiration, pupil reaction and size and level of consciousness.

An initial assessment was completed for resident #0570. A review of the HIR and progress notes failed to reveal any further head injury assessments completed until

twelve hours after the initial fall.
Documentation on the HIR for the assessments due to be completed every hour for four hours followed by assessments every two hours for four hours indicated the assessments were not completed because the resident was sleeping.

In January 2014, resident #0570 was found on the floor near the washroom. An initial assessment was completed. A review of the HIR and progress notes failed to reveal any further head injury assessments completed until six hours after the initial fall. Documentation on the HIR for the assessments due to be completed every hour for four hours indicated the assessments were not completed because the resident was sleeping.
When interviewed the DOC confirmed the HIR was not completed as per the established guidelines and residents need to be assessed whether sleeping or not to determine their health status.

e) A review of the kardex and the care plan indicated resident #0585 requires a two-person physical assist with toileting. A review of the RAI-MDS assessment indicated the resident requires two persons assist for toileting. On March 17, 2014, at 3:46p.m. resident #0585 was observed being assisted with toileting by only one staff member.
Interviews with staff confirmed the resident requires a two-person assist when toileted. [s. 6. (7)]

6. The licensee has failed to ensure the provision of the care set out in the plan of care is documented.

a) A record review of resident #0546's PSW flow sheet for March 10, 2014, indicated that the oral care provided on the evening shift was not documented. Interviews with front line staff and the clinical nurse manager confirmed that evening care/oral care was not documented on the PSW flow sheet for resident #0546.

b) A review of the physician's orders for resident #0026 revealed a request for a pain assessment to be completed for 7 days during the evening shift. On review of the resident's MAR, the order was recorded as completed for the seven day period. However, a review of the pain flow sheet documented the resident's pain just two of the seven days. Interview with the DOC confirmed that the pain assessments were not documented for the time period requested.

c) Resident #0556 had a physician order for a specific eye care intervention. A review of the TARs for January, February and March 2014, revealed the intervention was not documented on the following dates:
January 2014
- only 5 of 31 days were recorded just twice a day
February 2014
- once a day on 3, 7, 11, 12, 13, 14, 17, 18, 23, 27
- twice a day on 25, 26, 28
March 2014
- twice a day on 4, 5, 6, 7, 8, 9.

d) Resident #0570 was found on the floor beside the bed in December 2013, which resulted in a HIR being initiated.
A review of the HIR form revealed the required documentation was not completed on three occasions as per the home's policy.

e) Resident #0585 fell on the floor while transferring self out of bed in February 2014, which resulted in a HIR being initiated.
The HIR was not documented for resident #0585 on four occasions.
An interview with the DOC confirmed that the documentation on the HIR was incomplete.

f) A review of the February 2014, MAR for resident #0570 revealed an order for a nutritional supplement orally three times a day. The administration of the supplement was not documented by the registered staff on two occasions.

A record review of the March 2014, MAR for resident #0617 revealed a RD order to offer additional fluid with medication at each medication pass. The administration of additional fluid was not documented by the registered staff on six occasions.
The policy Missing E-Mar Initials RCSM-F-070 reviewed April 2013 confirmed each registered staff person is responsible for administering medications and initialing on the MAR prior to the end of their shift. The DOC confirmed in an interview that the expectation is that registered staff will document on the MAR. [s. 6. (9) 1.]

7. The licensee failed to ensure that resident #0570 was reassessed and the plan of care reviewed and revised because the care set out in the plan of care has not been effective and different approaches were not considered in the revision of the plan of care.

A review of resident #0570's clinical health record identified 21 fall incidents over a six month period.
Post fall assessments completed after two falls in September 2013 identified the strategy to toilet resident every two hours as needed, however this strategy was never incorporated into the plan of care.
In February 2014, resident #0570 was found on the floor beside the bed. A referral to the occupational therapist(OT) and the PT was completed.
The OT recommended the following fall prevention strategies:
- hip protectors
- walker with slow down brakes
- trial for a dynamic wheelchair.

The PT recommended the following strategies:
- rollator walker
- 1 person assist during ambulation.

The only interventions implemented involved the rollator walker.
However the plan of care was not revised to include the following strategies which were implemented by nursing:
- floor mats at bedside
- hi/lo bed in low position
- establishment of an individualized toileting routine.

In March 2014, resident #0570 was found on the floor in the bathroom near the toilet. The PT assessed the resident and provided the following recommendations for fall prevention:
- use wheelchair when resident is tired or gait is unsteady.
This recommendation was not incorporated into the plan of care.
Interview with registered staff confirmed the above strategies had not been incorporated into the plan of care for resident #0570. [s. 6. (11) (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 to ensure that:
- there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident
- the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident
- the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other
- the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other
- the care set out in the plan of care is provided to the resident as specified in the plan
- the provision of the care set out in the plan is documented
- when a resident is reassessed and the plan of care reviewed and revised, because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: 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 has failed to comply with the following home policies and procedures:

a) Preventative Maintenance Systems and Schedule C-40 reviewed May 2012
Procedure 9: A monthly preventative maintenance report shall be completed by the environmental services manager or maintenance person and copies forwarded to the director of human resources and business services.
A record review indicates that the above mentioned report was completed quarterly in 2013 (March, May, October, and December).
An interview with the ESM confirmed that the reports were not completed on a monthly basis as required by the preventative maintenance systems and schedule policy and procedure.

b) Missing Items policy RCSM-P-040 dated December 2004 and reviewed June 2012
Procedure 6: Follow-up shall be recorded on the missing items form.
During interviews with resident #0599 and his/her family it was identified that the resident reported a piece of jewelry to be missing approximately 2 weeks after the admission in February 2011. A staff interview with the resident services coordinator indicated that follow-up actions were completed for resident #0599 but they were not documented on the missing item form. A staff interview with the ED confirmed that procedure six of the home's policy and procedure on missing items was not followed.

c) Head Injury Routine policy and procedure RCSM-E-045 reviewed June 2011 indicates:
Procedure 1:
- vital signs to be checked and recorded for forty-eight hours on HIR form
- first four hours every hour, next four hours every two hours, next sixteen hours every four hours and next twenty-four hours every eight hours
- vital assessments for this procedure to include: blood pressure, pulse, respiration, pupil reaction and size and level of consciousness.

Resident #0026 experienced a fall in November 2013.
A record review of resident #0026's HIR form identified documentation that the resident was sleeping on the following occasions and the HIR was not completed on three occasions.
An interview with the DOC confirmed that head injury routine was not followed as per the home's policy and procedure on head injury routine.

d) Clothing Identification, Receipts, Labeling, Inventory, Policy and Procedure LDY-C-

20-05 reviewed April 2012.
Procedure 1.0: When a resident/family member brings in clothing items, the unit supervisor/in charge/designate shall place the clothing into a clear plastic bag.The clothing will be recorded on the inventory form which includes the resident's name, room number and date. This inventory form should be placed in a clear plastic bag along with the clothing and brought to the laundry.The bag will be placed in the cart provided in the laundry room until such a time as the clothing can be labeled.

Procedure 1.2: It is the responsibility of the charge nurse or designates to list the clothing on the clothing inventory form

Procedure 2.4: The clothing inventory must be kept in a binder located in the laundry room. Nursing may also want a copy for the resident's chart.
When interviewed the following residents #0587, #0603 and #0621 indicated they were missing clothing items.
A record review was completed for the above residents which revealed there were no clothing inventory forms completed and filed as per the home's policy.
The ED and RN confirmed during interviews that the clothing inventory form cited by the policy is not in use by the home.

e) Medication Storage #06-02-60 – Expired Drugs reviewed January 31, 2007 indicates:
There are to be no expired medications in the medication cart (except narcotics awaiting disposal).
There are to be no expired medications in medication room (except narcotics awaiting disposal in a separate location).

The following medications were observed on March 18, 2014, at 2:30p.m. in an identified medication cart to have expired:
- Anuzinc Suppositories expired November 2011
- Novasen 325mg expired January 2013
- Potassium Chloride solution 500mls expired January 2013
- Lansoprazole liquid for resident #0041 - expired February 20, 2014.

The following medications were observed in the emergency drug box to have expired:
- two ampoules of Epinephrine injectable expiry date- July 2013
- one vial of Diphenhydramine 50mg/ml expired January 2014

All expired drugs were given to the RPN who indicated she would ensure the expired drugs were discarded according to procedure. [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 to ensure that any policy and procedure that the Act or this Regulation requires a long term care home to have is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home and equipment is kept clean and sanitary.

a) Resident #0558's walker was observed on numerous occasions to have a white stain on the seat of the walker along with several particles of white debris in the seams
.
Through interviews with staff it was identified that resident equipment is cleaned on the night shift by the PSWs according to an established schedule.
A review of the cleaning schedule for cleaning resident equipment failed to identify resident #0558's walker for cleaning.
The clinical nurse manager confirmed that resident #0558's name and walker should have been added to the schedule when the assistive device was provided to the resident.

b) Flooring in the following areas of the home were noted to have dirt and debris build-up:
2 South
- resident bathroom #2086 - black marks and dirt on floor behind the toilet beside the baseboard.
- resident bathroom #2087 - black marks and dirt on floor behind the toilet beside the baseboard.
- resident bedroom #2088A- collection of dirt in corners outside outside the entrance to the bathroom.

2 Centre Area
- outside elevator - collection of dirt along baseboard.
- entrance to 2 North behind entrance doors near the baseboard - collection of dirt.

c) Wall surfaces were noted to be soiled with dried food, debris and unidentified substances in the following areas of the home:
2 North
- resident room #2003
- hallway outside resident room #2005

d) Fold down grab bars soiled with feces was noted in the resident bathroom #2003 on 2 North.

The observations were acknowledged by the ESM and staff. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

a) The following damages were observed during a tour conducted on March 7, 2014 between 11:18a.m. and 11:24a.m.:
- water leakage and rusting around the drainage piece noted from the washing sink in the 2 North jacuzzi tub room
- toilet water was observed to be running continuously in room #1073A
- scuff marks noted on the bathroom sliding door, five small holes noted around the clothes hanger, and wall damage noted in the area next to the bathroom sliding door in room #1088A.

b) The following damages were observed during a tour conducted on March 10, 2014 between 1:04p.m. and 1:20p.m.:
- extensive damage noted on drywall near the clothes hanger in the washroom for room #2084
- scuff marks along the television wall and the wall near the window, and a big white patch noted by the head of bed near the electrical outlet in room #2085
- cracked paint noted near the clothes hanger, three white patches noted on the wall near the floor light, and one big patch noted on the wall by the head of bed near the phone jack and electrical outlet in room #2086
- scuff marks noted on the wall opposite to the bed and drywall damaged at a corner near the floor light in room #2088. [s. 15. (2) (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 to ensure that;
- the home and equipment is kept clean and sanitary
- the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee did not ensure there is a resident-staff communication response system that can be easily accessed and used by the resident at all times.
On March 7, 2014, at 2:19p.m. resident #0545 asked the inspector for the call bell so the resident could request assistance from the staff.
The resident was unable to access the call bell due to its location.
The written plan of care directs staff to encourage the resident to use the call bell for staff assistance and place the call bell within reach.
The DOC confirmed call bells should be accessible to residents in order to access staff assistance. [s. 17. (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 to ensure that the resident-staff communication response system can be easily accessed and used by residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraint plan of care includes an order by the physician or the registered nurse in the extended class.
A review of the care plan directs staff to use partial bed rails when resident #0585 is in bed to decrease the risk of falling.
A review of the resident's personal health records did not include a physician's order for the use of bed rails.
An interview with the resident identified the bed rails are used to prevent the resident from falling on the floor.
Staff interviews confirmed the bed rails are used to keep the resident from falling out of bed.
The home's Side Rails policy RCSM-E-005 reviewed June 2011 identifies a partial rail is considered a restraint if used for the purpose of keeping the resident in the bed.
The home's Restraint policy RCSM-E-040 reviewed in March 2013 confirms a physician's order is required for all restraints. [s. 31. (2) 4.]

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 when a resident is restrained by a physical device that the restraint is included in the resident's plan of care, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee did not ensure the resident is bathed by the method of his or her choice.
Interview with resident #0545 indicated a bathing preference for a tub bath and stated staff provide resident #0545 a shower rather than a tub bath.
When asked, on several occasions, the resident confirmed a bathing preference for a tub bath.
An interview with a family member confirmed the resident's bathing preference was a tub bath.
A review of the resident kardex indicated a tub bath was to be provided twice a week.
Interviews with staff indicated a shower is given because the resident prefers a shower.
The clinical nurse manager when interviewed indicated the resident would be offered a tub bath on the next scheduled bath day. [s. 33. (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 each resident is bathed by the method of his or her choice, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee failed to ensure there is an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

An interdisciplinary falls committee held their first meeting on January 30, 2014, to develop terms of reference and identify committee members including DOC, clinical nurse manager, PT, registered staff and director of program services.
The DOC confirmed the Falls Prevention Program was not a formal program in the home. [s. 48. (1) 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 a falls prevention and management program is developed and implemented to reduce the incidence of falls and the risk of injury, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a criminal reference check, including a vulnerable sector screen was conducted within six months before the staff member was hired. A review of a staff member's personnel file revealed that the vulnerable sector screening report was not in the file. An interview and a follow-up email from the director of human resources and business services on March 20, 2014, confirmed that the vulnerable sector screening report was not available. [s. 75. (2)]

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 screening measures shall include criminal reference checks that consist of a vulnerable sector screen conducted within six months before the staff member is hired, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure measures to prevent the transmission of infections are implemented.
The following expired wall mounted alcohol based hand sanitizers were observed on March 12, 2014, between 8:15a.m. and 8:56a.m.:
- 1 North dining room - expiration date December 2011
- resident room #1004 - expiration date December 2011
- resident room #1013 - expiration date December 2011
- resident room #1022 - expiration date December 2011
- resident room #1026 - expiration date December 2011
- resident room #1073 - expiration date December 2011
- resident room #1095 - expiration date December 2011
- resident room #2003 - expiration date December 2011
- resident room #2014 - expiration date December 2011
- resident room #2016 - expiration date December 2011
- resident room #2023 - expiration date December 2011
- resident room #2028 - expiration date December 2011
- resident room #2069 - expiration date December 2011
- resident room #2079 - expiration date December 2011
- resident room #2086 - expiration date December 2011
- resident room #2091 - expiration date December 2011
- outside of DOC's office - expiration date February 2014
- 1 North nursing station - expiration date February 2014

An interview with the ED indicated that it is the responsibility of the housekeepers to check wall mounted hand sanitizers in the resident's room on a weekly basis. Wall mounted hand sanitizers in common areas such as lobby, hallways, dining room are to be checked on a weekly basis by the project worker. The ED confirmed that the wall mounted alcohol based hand sanitizers in residents' rooms and common areas had not been checked for expiration dates.
On March 16, 2014, a respiratory outbreak was declared for 1 South and later identified as an Influenza A outbreak. [s. 86. (2) (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 to ensure that all alcohol based hand sanitizer products used in the home are regularly monitored and replaced when expired to prevent the transmission of infections, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are schedules in place for remedial maintenance.

a) The following damages were observed during a tour conducted on March 7, 2014 between 11:18a.m. and 11:24a.m.:
- water leakage and rusting around the drainage piece noted from the washing sink in the 2 North jacuzzi tub room
- toilet water was observed to be running continuously in room #1073A
- scuff marks noted on the bathroom sliding door, five small holes noted around the clothes hanger, and wall damage noted in the area next to the bathroom sliding door in room #1088A.

b) The following damages were observed during a tour conducted on March 10, 2014 between 1:04p.m. and 1:20p.m.:
- extensive damage noted on drywall near the clothes hanger in the washroom for room #2084
- scuff marks along the television wall and the wall near the window, and a big white patch noted by the head of bed near the electrical outlet in room #2085
- cracked paint noted near the clothes hanger, three white patches noted on the wall near the floor light, and one big patch noted on the wall by the head of bed near the phone jack and electrical outlet in room #2086.

A record review and an interview with the ESM confirmed that the home did not have schedules in place for remedial maintenance. [s. 90. (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 to ensure that there are schedules in place for remedial maintenance, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee did not ensure a drug is administered to a resident in the home unless the drug has been prescribed for the resident.
Resident #0041 was administered an identified medication on March 18, 2014.
A physician order for the identified medication was received on January 21, 2014.
A review of the quarterly physician order review completed by the physician on January 28, 2014 failed to reveal an order for the identified medication for resident #0041.
A review of the MARs for January, February and March indicated the identified medication had been administered to the resident as per the physician order of January 21, 2014.
The home's policy titled Medication Reviews #03-01-30 reviewed January 31, 2007 indicates at the time of the physician's order review, all previously ordered medications, which are not listed on the review or added by the physician, are automatically discontinued.
An interview with the DOC confirmed the drug had been administered without a physician order since the completion of the physician review and as such constitutes a medication error. [s. 131. (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 no drug is administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program.

a) On March 4, 2014, during a dining observation conducted over the lunch service on an identified home area, it was observed that a staff member cleared dirty dishes and proceeded to serve dessert without washing or sanitizing her hands. Signs posted in or at the serveries direct staff to wash and/or sanitize hands between clearing dirty dishes and handling clean dishes. An interview with the staff member confirmed the home's expectation is to wash hands after clearing dirty dishes and before serving clean dishes.

b) On March 4, 2014, an unlabeled, uncovered, expired (2007) 400g used jar of petroleum jelly was observed in the cabinet in the identified tub room. Staff interviews confirmed this product was not supplied by the home and that the item should be labeled. The clinical nurse manager confirmed that the expectation is that family supplied personal care items should be labeled and stored in the resident's room. The clinical nurse manager discarded the product as it was unlabeled.

c) On March 18, 2014,on an identified home area, adjacent to the nurses' station, a staff member was observed to crush medications for resident #0040, proceed to dining room to obtain yogurt, attempted to administer crushed medications to resident and then administered insulin without performing hand hygiene.
The Staff member then proceeded to another resident, completed a glucometer reading, administered insulin and oral medications without completing hand hygiene. Interviews with staff confirmed hand hygiene should have been performed between residents, procedures and between the administration of medications via different routes. [s. 229. (4)]

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 all staff participate in the infection prevention and control program as it relates to hand hygiene and the storage of personal care products, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident' s condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written description of the program that includes its goals and objectives is complied with, in respect of each of the interdisciplinary programs required under section 48 of this Regulation.

A record review of the Falls Prevention Program document - RCSM-E-160 reviewed February 2013, does not contain the program's goals and objectives. A telephone interview with the DOC confirmed there is no written description of the home's falls prevention program goals and objectives. [s. 30. (1) 1.]

2. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions, are documented.

A record review of resident #0603's continence care flow sheet was not documented on March 2, 6 and 7, 2014. A record review of resident #0603's seven day observation and monitoring form identified a lack of documentation for the elimination section for March 5 night, day, and evening shift, March 6 day shift, March 7 night and day shift and March 8 day and evening shift. An interview with a registered nursing staff and the clinical nurse manager confirmed the documentation was incomplete. [s. 30. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that foods are stored and served using methods which preserve taste and food quality.
On March 14, 2014, the inspector observed the tray service on an identified home area. At 12:50p.m. the dining room meal service was complete and all but one steam basin was turned off. There was a plated hot entree, covered, and sitting on top of the lid of the steam basin that remained on. The dietary aide reported the single basin was on to keep the plated entree warm.
Upon delivery of the tray at 1:00p.m., the inspector took the temperature and the sloppy joe was 43.1 degrees Celsius and the soup was 45.2 degrees Celsius.
An interview with the FSM confirmed temperatures must reach 60 degrees Celsius or higher.
An interview with the dietary aide confirmed that the temperature of hot foods is taken at the start of meal service and not taken again prior to tray delivery.
A review of the Tray Service policy DS C-15-25 reviewed January 7, 2010, states hot meals must not be pre-plated before the PSW is ready to take the tray to the resident's room.
An interview with the FSM confirmed that if a PSW is unable to deliver a tray within two minutes or so, the entree should be stored in the fridge until ready to serve. The FSM also confirmed the temperature should be taken before the tray is delivered. [s. 72. (3) (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the daily menus are communicated to the residents.
On March 4, 2014, the daily menu identified an egg cheese sandwich as an entree choice at lunch.
A dining lunch meal observation revealed an omelet was served.
A review of the production recipe sheet indicated the omelet was an alternate to the egg cheese sandwich. The home failed to communicate the change in menu to the residents.
On March 7, 2014, the daily menu identified an egg salad plate as an entree choice at lunch and turkey salad sandwich was served.
An interview with the FSM confirmed that the daily menu posted on March 7, 2014 was an old menu substitution. [s. 73. (1) 1.]

2. The licensee failed to ensure that the home is serving food at a temperature that is both safe and palatable to the residents.
An interview with resident #0611 identified that meals are usually cold and happens on a daily basis.
On March 13, 2014, the tray service was observed for resident #0611. The dietary aide removed the beef pie from its original aluminum container and plated it without taking the temperature or re-heating the item.
The temperature taken by the inspector at 1:07p.m. was 59C.
An interview with the resident confirmed the pie was cold on the periphery and hot in the middle.
Interviews with dietary aide and the FSM confirmed the expectation is to take the temperature before tray service and must reach 60C or higher, otherwise, interventions such as microwaving the food before serving should be implemented.
Front line staff confirmed the temperature of the pie was not taken and the pie was not heated in the microwave before serving. [s. 73. (1) 6.]

Issued on this 28th day of April, 2014

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

L. Parsons E. TANG

B. Parisotto J. Hart