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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
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Public Copy/Copie du 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 11, 2019	2019_723606_0002	027813-18, 032363-18	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Tullamore Care Community
133 Kennedy Road South BRAMPTON ON L6W 3G3

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

JANET GROUX (606), FARAH_ KHAN (695)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 3, 4, 8, 9, 10, and 11, 2019.

The following complaint intakes were inspected:
Log # 027813-18 regarding personal support services, and resident neglect.
Log # 032363-18 regarding falls prevention and management, responsive behaviours, and care planning.

PLEASE NOTE: Written Notification and Compliance Order related to O. Reg. 79/10, s. 8. (1)(b) and Long Term Homes Act, 2007 s 6. (10)(c) and 6. (11)(b) were identified in a concurrent Critical Incident Systems inspection #2019_723606_0001(Log #009808-18, and #033430-18).

During the course of the inspection, the inspector(s) spoke with the Administrator, Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Occupational Therapist (OT), Home Medical Equipment (HME) Accounts Manager, Personal Support Workers (PSW), Resident Relations Coordinator (RRC), Substitute Decision Makers (SDM), and residents.

During the course of the inspection, the inspector(s) observed the provision of care and services, reviewed relevant documents, including but not limited to, clinical records, policies and procedures, internal investigation notes, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with O. Reg. 79/10, s. 30, the licensee was required to provide a written description of each of the interdisciplinary programs, including falls management, required under Regulation, section 49 (1) the licensee was required to ensure the falls prevention management program must, at a minimum provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipments, supplies, devices and assistive aids.

Two Critical Incidents (CI) reported resident #004 fell and sustained serious injuries.

An identified home's policy directed staff to initiate a Head Injury Routine (HIR) if a head injury is suspected and directed staff to complete the HIR as per the schedule outlined. The schedule provided on the Head Injury Monitoring Record was to conduct the HIR at specified times.

Resident #004's clinical record revealed the resident fell on an identified date and sustained injuries and an HIR was initiated. Review of the Head Injury Monitoring Record showed required assessments on identified dates were incomplete.

Registered Nurse (RN) #104 acknowledged that it was required that the HIR was completed at the specified times. The RN reviewed the Head Injury Monitoring Record for resident #004 that was initiated on an identified date and confirmed that there were required assessments missing.

2. A CI reported resident #003 fell and a sustained a serious injury.

An identified home's policy stated to complete HIR as per the scheduled outline or as ordered by the Physician. The registered staff were directed to assess the resident at specified times or until directed by the physician to cease monitoring.

Resident #003's has a number of falls and their HIR records for identified dates were missing the required assessments for specified times.

Registered Nurse (RN) #104 acknowledged that it was required that the HIR was completed at the specified times.

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with. [s. 8. (1) (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. (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).

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 failed to ensure that the resident was reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective.

A complaint submitted to the Ministry of Health And Long-Term Care (MOHLTC) reported concerns regarding the home's fall prevention and management for resident #001.

Resident #001's clinical records stated they had had a number of falls during an identified time. The resident's written care plan and progress notes were reviewed and did not show evidence that changes were made to the falls prevention and management interventions during a period of time. On an identified date, the resident fell and sustained a serious injury.

Personal Support Worker (PSW) #124 explained that the written care plan was the document they would access to know about a resident's falls prevention and management strategies.

An identified home's policy directed staff to have access to the falls prevention kit which included various falls prevention items. The staff were required to inform the registered nurse when they introduced a new item to a resident and the registered nurse was expected to add the intervention to the resident's plan of care.

PSWs #119 and #120, and Registered Nurse (RN) #104 stated they were not familiar with the falls prevention kit or where it was located. RN #104 acknowledged that during the a number of months prior to the resident's injury, the resident had a number of falls and there were no new interventions tried.

The licensee failed to ensure that the resident #001's falls prevention and management strategies were reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective. [s. 6. (10) (c)]

2. The licensee has failed to ensure that the care plan was reviewed and revised when care needs changed.

Resident #004's room was observed on an identified date with an identified falls prevention item near their bed.

The current written plan of care was reviewed and under the falls prevention strategies it did not state that resident had an identified falls prevention item.

Personal Support Worker (PSW) #119 stated to the Long Term Care Homes (LTCH) Inspector that resident #004 had an identified falls prevention item. PSW #120 could not recall whether the resident had an identified falls prevention item but explained that the written plan of care was where all of the falls prevention strategies were documented.

RN #104 acknowledged that the resident had an identified falls prevention item and that it was expected to be in the written plan of care. The RN confirmed that it was not in the current written plan of care for resident #004.

The licensee failed to ensure that the current falls prevention strategies were in the written plan of care for all direct care staff to be aware of. [s. 6. (10) (c)]

3. The licensee has failed to ensure that when a resident is reassessed and 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 were considered in the revision of the plan of care.

A CI reported resident #003 fell and sustained a serious injury.

The progress notes stated resident #003 was found in the floor in their room with injuries to identified areas of their body. On assessment, the resident was observed with a change in condition and was transferred to the hospital.

Resident #003's clinical records stated the resident had fallen a number of times prior to this fall and identified the cause of the falls were due to an identified resident action.

Resident #003's written care plans during a time period identified the resident as high risk for falls related to their medical condition and directed staff to closely monitor the resident. The care plan included a number of physiotherapy interventions but there were no other interventions tried to manage the resident's risk of falling during the time period reviewed.

The physiotherapist (PT), the Occupational Therapist (OT), Personal Support Workers (PSW) #116, and Registered Nurse (RN) #111 stated resident #003 fell due to a repeated action of the resident. The PT, OT and the RN indicated a an identified mobility aide for the resident was recommended as an intervention to prevent the resident from falling but it was never implemented and that there were no other interventions tried.

The licensee has failed to ensure that when a resident is reassessed and 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 were considered in the revision of the plan of care. [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 the resident is reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective;
- to ensure that the care plan is reviewed and revised when care needs changed;
- to ensure that when a resident is reassessed and 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 were considered in the revision of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A complaint submitted to the MOHLTC reported concerns regarding the home's fall prevention and management for resident #001.

A clinical record review revealed that resident #001 had a number of falls during an identified period of time.

During identified dates, the Long Term Care Homes (LTCH) Inspector observed resident #001 in bed with an identified falls prevention device in an identified location but was turned off. On an identified date, the resident was seen in their mobility aide without an identified falls prevention device. On an identified date, the identified falls prevention device was observed on while the resident was in bed.

The written plan of care identified falls prevention strategies for resident #001 but did not include the resident had an identified falls prevention device.

PSW #140 stated resident #001 had an identified falls prevention device while PSW #100 believed the resident had another type of falls prevention device. PSW #124 explained that the falls prevention and management interventions would be documented in the resident's written plan of care.

RN #104 acknowledged that one of the falls prevention strategies was to ensure the identified falls prevention device was on when the resident was in bed. The RN confirmed that it was required to be documented in the written plan of care and was not.

The licensee has failed to ensure that an action taken with respect to resident #001 under the falls prevention and management program, specifically an intervention was documented. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 13th day of February, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JANET GROUX (606), FARAH_ KHAN (695)
Inspection No. / No de l'inspection :	2019_723606_0002
Log No. / No de registre :	027813-18, 032363-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 11, 2019
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Tullamore Care Community 133 Kennedy Road South, BRAMPTON, ON, L6W-3G3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Astrida Kalnins

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Ministère 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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The Licensee must be compliant with O. Reg 79/10, s. 8 (1) (b) of the Long Term Care Homes Act (LTCHA).

Specifically, the licensee must comply with the home's policy "Head Injury Routine" and the procedures identified within the policy related to the initiation of head injury routine.

Grounds / Motifs :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with O. Reg. 79/10, s. 30, the licensee was required to provide a written description of each of the interdisciplinary programs, including falls management, required under Regulation, section 49 (1) the licensee was required to ensure the falls prevention management program must, at a minimum provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipments, supplies, devices and assistive aids.

A) Two Critical Incidents (CI) reported resident #004 fell and sustained serious injuries.

An identified home's policy directed staff to initiate a Head Injury Routine (HIR) if a head injury is suspected and directed staff to complete the HIR as per the schedule outlined. The schedule provided on the Head Injury Monitoring Record was to conduct the HIR at specified times.

Resident #004's clinical record revealed the resident fell on an identified date and sustained injuries and an HIR was initiated. Review of the Head Injury Monitoring Record showed required assessments on identified dates were incomplete.

Registered Nurse (RN) #104 acknowledged that it was required that the HIR was completed at the specified times. The RN reviewed the Head Injury Monitoring Record for resident #004 that was initiated on an identified date and confirmed that there were required assessments missing.

B) A CI reported resident #003 fell and a sustained a serious injury.

An identified home's policy stated to complete HIR as per the scheduled outline or as ordered by the Physician. The registered staff were directed to assess the resident at specified times or until directed by the physician to cease monitoring.

Resident #003's has a number of falls and their HIR records for identified dates were missing the required assessments for specified times.

Registered Nurse (RN) #104 acknowledged that it was required that the HIR was completed at the specified times.

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with. [s. 8. (1) (b)]

The severity of Non-Compliance (NC) was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a 2 pattern as it related to two out of three residents reviewed. The home had a level 4 history as despite Ministry of Health (MOH) action (Voluntary Plan of Correction (VPC), order), NC continued with original area of NC with this section of the LTCHA that included: a Voluntary Plan of Correction (VPC) issued:

August 31, 2018, 2018_723606_0014 (A1) and September 14,2018, (2018_723606_0017).
(606)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 08, 2019

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 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, 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 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 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 de la Santé et 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 de la Santé et 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 11th day of February, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Janet Groux

Service Area Office /
Bureau régional de services : Central West Service Area Office