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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 8, 2017	2017_570528_0001	000156-17	Resident Quality Inspection

Licensee/Titulaire de permis

PEEL HOUSING CORPORATION
10 Peel Centre Drive, Suite A BRAMPTON ON L6T 4B9

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

VERA M. DAVIS NURSING HOME
80 Allan Drive Bolton ON L7E 1P7

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

CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581)

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): January 5, 6, 9, 10, 2017

This inspection was concurrently completed with complaint inspection log #030376 -16, related to skin and wound care and transferring and positioning techniques.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Supervisors of Care (SOC), the Registered Dietitian (RD), the Physiotherapist (PT), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), dietary staff, residents and families.

The inspectors also toured the home, observed the provision of care and services, reviewed documents, including but not limited to: staffing schedules, policies and procedures, meeting minutes, clinical health records, and log reports.

The following Inspection Protocols were used during this inspection:
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **2 VPC(s)**
- **3 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	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were free from neglect by the licensee or staff in the home.

For purposes of The Act and its Regulations, the definition of neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or pattern of inaction that jeapordizes the health safety or wellbeing as one or more residents.

A. Resident #040 was not free from neglect by the licensee or staff in the home related to skin and wound care.

i. Resident #040 was admitted to the home in 2015, with multiple comorbidities. The resident began displaying an area of altered skin integrity in June 2016.
ii. Weekly wound assessments were not completed in June 2016, as confirmed by SOC #114.
iii. In July and August 2016, staff documented altered skin integrity eleven times but no treatment identified or documented to the area of altered skin integrity, nor were wound assessments completed initially or weekly.
iv. Interview with SOC #114 confirmed that the resident had a recurring area of altered skin integrity but weekly wound assessment had not been completed from June to August 2016.
v. In September 2016, registered staff noted the wound as open and then six days later and increase in size was documented, however; the wound was not assessed using a clinically appropriate assessment tool, as confirmed by SOC #114.
vi. In September 2016, the resident was diagnosed with an injury, requiring transfer to hospital for treatment. Upon return from the hospital, a head to toe assessment was not completed for the resident with altered skin integrity. Interview with SOC #114 confirmed that the resident's hospital visit had contributed to a worsening area of altered skin integrity, however, a head to toe assessment had not been completed upon the resident's return from the hospital to assess the wound.
vii. The resident required a full mechanical lift and total assistance with care and the resident was not placed on a turning and repositioning schedule. Interview with registered staff #107 confirmed that as a part of the skin and wound program, residents who require assistance with turning and repositioning, will be placed on a turning and repositioning schedule.
viii. A wound assessment using a clinically appropriate assessment tool was not completed until the wound measuremen was larger with necrotic tissue. The resident was then placed on a turning and repositioning schedule, referred to physician, enterostomal (ET) nurse, and RD.
ix. Interview with the home's Interim RD who confirmed that the RD did not assess the resident related to altered skin integrity until September 2016, at which time, a nutritional

supplement and change in diet texture was ordered.
x. For the next two weeks, while the wound continued to be treated, weekly wound assessment had not completed and in October 2016, the resident was transferred to the hospital for wound treatment, as confirmed by SOC #114.
xi. When the resident returned to the home weekly wound assessment were not completed for one week in October 2016.
xii. Interview with registered staff #114 confirmed that from June to September 2016, weekly wound assessment were not completed for resident #040, who had an ongoing area of altered skin integrity, and in September and October 2016, weekly wound assessment were not consistently completed by registered staff, as required in the home's policy.

The home failed to provide resident #040 who had documented ongoing worsening altered skin integrity, with skin and wound care as outlined in Ontario Regulation section 50, subsection (2) including inaction as follows, registered staff did not complete wound assessments using a clinically appropriate assessment tool, registered staff did not complete weekly wound assessments, RD did not assess the resident related to skin and wound, registered staff did not complete a head to toe assessment on a resident with altered skin integrity upon return from hospital, and did not initiate a turning and repositioning for the resident who is dependent on staff for repositioning, that jeapordized the health and well being of the resident. Interview with the Administrator confirmed that the care to resident #040 was not consistent related to skin and wound.

B. Resident was not free from neglect by the licensee or staff in the home, related to safe transferring and positioning techniques.

i. On an identified date in June 2016, resident #040 was assessed by physiotherapy related to their transfer status. At that time, the resident used two person for transferring and a sit to stand lift, as needed. The physiotherapist determined that the resident was not able to follow directions and therefore, was no longer safe to use the sit to stand lift, requiring a full mechanical lift, as needed.
ii. Five days later, registered staff updated the care plan to direct staff to use the sit to stand lift as needed, however, there was no assessment documented related to the change in transfer status, as required in the home's Minimal Lift Program. Interview with registered staff #100 confirmed that the plan of care did not include an assessment related to the use of the sit to stand lift.
iii. On August 20, 2016, registered staff documented that the resident was not weight bearing well and required the use of the sit to stand lift. Interview with registered staff

#114 revealed that the information was reported by PSW staff and the registered staff did not assess the resident using the sit to stand lift, as required in the home's Minimal Lift Program.
iv. Review of point of care (POC) documentation revealed that PSW staff continued to use the sit to stand lift thirteen times in June 2016, twelve times in July 2016, and thirty eight times in August 2016.
v. Interview with PSW #111 confirmed that as of August 2016, the sit to stand lift was used most of the time, and PSW #112 confirmed that the resident had limited mobility in one arm and was not able to hold the lift with that arm.
vi. In September 2016, the resident began complaining of pain during transfer, and two days later registered staff documented that the resident had bilateral underarm pain from the sit to stand lift. Signs and symptoms of injury were documented and the MD was informed.
vii. Review of POC documentation revealed PSW staff continued to use the sit to stand lift for an additional three days, until the resident was transferred to hospital and diagnosed with an injury. Interview with PSW # 111 confirmed that after the resident began complaining of pain, staff continued to use the sit to stand lift until physiotherapy assessed the resident.
viii. Interview with the physiotherapist confirmed that the resident was not cognitively able to to use the sit to stand lift when assessed in June 2016. Interview with SOC #107 confirmed that PSW staff should not have used the sit to stand lift after it was identified as a cause of resident's pain.

The home's staff failed to provide resident with safe transfers when PSW staff did not transfer resident #040 according to their transfer assessment in June 2016, and registered staff changed the transfer status in June and August 2016 without completing an assessment of the resident. Furthermore, in September 2016, when the resident began displaying symptoms of an injury from the sit to stand lift, PSW staff continued to use the sit to stand lift for an additional three days. The resident was diagnosed with an injury, as a result of the use of the sit to stand lift, as confirmed by the home's investigation notes and interview with the DOC. (528) [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

In June 2016, resident #040 was assessed by physiotherapy related to their transfer status. At that time, the resident used two person for transferring and a sit to stand lift, as needed. The physiotherapist determined that the resident was not able to follow directions and therefore, was no longer safe to use the sit to stand lift, requiring a full mechanical lift, as needed.
Five days later, registered staff updated the care plan to direct staff to use the sit to stand lift as needed, however, there was no assessment documented related to the change in transfer status, as required in the Minimal Lift Program. Interview with registered staff #100 confirmed that the plan of care did not include an assessment related to the use of the sit to stand lift.
In August 2016, registered staff documented that the resident was not weight bearing well and required the use of the sit to stand lift. Interview with registered staff #114 revealed that the information was reported by PSW staff and the registered staff did not assess the resident using the sit to stand lift, as required in the homes Minimal Lift Program.
Review of point of care (POC) documentation revealed that PSW staff continued to use the sit to stand lift thirteen times in June 2016, twelve times in July 2016, and thirty eight times in August 2016.
Interview with PSW #111 confirmed that as of August 2016, the sit to stand lift was used most of the time, and PSW #112 confirmed that the resident had limited mobility in one arm and was not able to hold the lift with that arm.
In September 2016, the resident began complaining of discomfort during transfer, and two days later registered staff documented that the resident had pain as a result of the sit to stand lift. Swelling and pain were documented and the MD was informed.
Review of POC documentation revealed PSW staff continued to use the sit to stand lift for an additional three days,until the resident was transferred to hospital and diagnosed with an injury. Interview with PSW # 111 confirmed that after the resident began

complaining of pain, staff continued to use the sit to stand lift until physiotherapy assessed the resident.
Interview with the physiotherapist confirmed that the resident was not cognitively able to to use the sit to stand lift when assessed in June 2016. Interview with SOC #107 confirmed that PSW staff should not have used the sit to stand lift after it was identified as a cause of resident's pain.

The PSW staff did not transfer resident #040 according to their transfer assessment in June 2016 and registered staff changed the transfer status in June and August 2016 without completing an assessment of the resident. Furthermore, in September 2016, when the resident began displaying symptoms of an injury related to the sit to stand lift, staff continued to use the sit to stand lift for an additional three days. The resident was diagnosed with an injury, as a result of the sit to stand lift, as confirmed by the home's investigation notes and interview with the DOC. [s. 36.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

In August 2016, the plan of care for resident #040 identified that they were wheelchair bound, requiring a mechanical lift for transfers. In September 2016, registered staff

documented an open area. Four days later the resident was transferred to the hospital for assessment and treatment of an injury. When the resident returned to the home, the next morning, a skin assessment was not completed until five days later when the wound measured significantly larger than the pre-hospital assessment. Interview with SOC #107 identified that the transfer and care at the hospital had contributed to a worsening of the wound; however, a skin and wound assessment was not completed when the resident returned from the hospital to confirm that statement. (528) [s. 50. (2) (a) (ii)]

2. The licensee failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Resident #040 was admitted to the home in 2015, with multiple comorbidities. Review of the plan of care identified a number of occasions where staff documented altered areas of skin integrity but did not assess the wound using a clinically appropriate assessment tool:
i. Registered staff documented an open area requiring treatment six times from June to September 2016.
ii. PSW staff documented in Point of Care (POC), an altered area of skin integrity eleven times in July and August 2016.
iii. A skin assessment using a clinically approrpriate assessment tool was not completed by registered staff until late September 2016, at which time, the wound had significantly worsened.

Interview with registered staff #100 and SOC #107 confirmed that the resident had a recurring area of altered skin integrity, and assessment of the wound was not completed using a clinically appropriate assessment tool until late September 2016. [s. 50. (2) (b) (i)]

3. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented.

In June 2016, registered staff documented resident #040 had an open area of altered skin inteigrty. Six days later the RD assessed the resident related to weight loss, and did not address the altered skin integrity.
Later that month, registered staff measured the open area to be larger than the last

assessment. Three days, later the RD completed the resident's quarterly assessment and did not address the altered skin integrity.
Furthermore, areas of altered skin integrity were documented by staff in July, August and September 2016. The resident was not assessed by the RD related to altered skin integrity until late September 2016, at which time, a change in food texture and supplements were added to the resident's plan of care. Interview with the Interim RD confirmed that the previous RD did not assess the resident related to altered skin integrity until three months after altered skin integrity was documented. (528) [s. 50. (2) (b) (iii)]

4. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #040 was admitted to the home in 2015, with multiple comorbidities. In June 2016, registered staff documented a open area of altered skin integrity requiring treatment. Ten days later, registered staff measured the wound to be larger than the previous assessment and treatment continued.
In July 2016, registered staff documented the area as open. POC documentation identified that PSW staff observed altered skin integrity ten times in July and August 2016. In September 2016, registered staff measured the wound and six days later a larger measurement was documented.
A wound assessment using a clinically appropriate assessment tool was not completed until late September 2016, at which time, the wound was significantly larger.
For the next two weeks, weekly wound assessment were not completed and in October 2016, the resident was transferred to the hospital requiring treatment for the wound.

The resident returned to the home in October 2016, and weekly wound assessment was not completed for one week in October 2016.
Interview with registered staff #100 and #114 confirmed that from June to September 2016, weekly wound assessment were not completed for resident #040, who had an ongoing area of altered skin integrity, and in September and October 2016, weekly wound assessment were not consistently completed by registered staff. (528) [s. 50. (2) (b) (iv)]

5. The licensee failed to ensure that the resident who was dependent on staff for repositioning had been repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if

clinically indicated.

Since June 2016, the plan of care for resident #040 identified a recurring open area of altered skin integrity. In July 2016, due to a deterioration in cognition and mobility the resident was provided a wheelchair for safety, and by September 2016, registered staff documented the resident was wheelchair bound requiring a mechanical lift for transfers. In September 2016, registered staff noted an open area and four days later, the resident was diagnosed with an injury requiring hospital treatment and affecting mobility. In the days following the resident's return from the hospital, registered staff measured the wound larger than the previous measurement and staff documented the resident as requiring extensive assistance of three persons for all transfers and care. Two days after staff identified that the resident required extensive assistance for mobiltiy, registered staff documented the wound had significantly worsened. Review of the plan of care, identified that the home did not place the resident on a turning and positioning schedule until late September 2016, almost 12 days after altered skin integrity was identified. Interview with registered staff #107 confirmed that in September 2016, the resident displayed altered skin integrity and a change in condition that required a turning and repositioning schedule, however, was not implemented in the written plan of care until September 2016. (528) [s. 50. (2) (d)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that where a resident was being restrained by a physical device under section 31 of the Act: that the resident was released from the physical device and repositioned at least once every two hours.

Resident #012's plan of care identified they required two restraining devices to prevent injury related to high risk for falls, impaired mobility, positioning problems and fidgeting related to cognitive impairment. On multiple days during the course of the inspection, they were observed positioned in a tilted wheelchair with two physical restraints and the resident was unable to remove or release the devices..

On an identified day in January 2017, for approximately four and a half hours, the resident was observed sitting in their tilt wheelchair, physical devices were not not released and reapplied and they were not repositioned during that period. Interview with PSW #103 stated that devices were applied that morning and they tilted the resident approximately thirty degrees and left the resident in the lounge. Interview with PSW #105 and PSW #106 stated that the resident was restrained and was monitored every hour; however, confirmed that the physical devices were not released and the resident was not repositioned for approximately six hours and twenty minutes. Interview with registered staff #101 stated that the resident was restrained and was to be monitored every hour and both restraints were to be released every two hours. [s. 110. (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 where a resident is being restrained by a physical device under section 31 of the Act: that the resident is released from the physical device and repositioned at least once every two hours, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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. (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 failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

In June 2016, resident #040 was assessed by the physiotherapy to be unsafe for use of the sit to stand lift. Interview with PT confirmed that the resident was unable to follow directions at the time and was unable to hold onto the lift, as a result, the staff were to use a full mechanical lift, as needed, when unable to complete a two person side by side transfer. Approximately five days later, registered staff #100 identified that the resident was to be transferred using a sit to stand lift. Interview with registered staff #100 confirmed that the PT and registered staff did not collaborate with each other related to the resident's transfer status. [s. 6. (4) (a)]

2. The licensee filed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs changed.

In June 2016, resident #040 was referred to physiotherapy related to safe transfers. An assessment was completed by the physiotherapist at that time and determined that the resident was unsafe to use the sit to stand lift due to inability to follow directions; therefore a full mechanical lift was recommended when the resident was unable to complete a two person transfer. Review of the care plan did not include the specific directions from the physiotherapist and instead stated the resident was to use a mechanical aid, sit to stand lift or transfer belt for transferring. Interview with the physiotherapist confirmed that in June 2016, the resident was not safe to use a sit to stand lift. The home's Minimal Lift Program, directed registered staff to update the resident's care plan and transfer logo following any transfer assessment. Interview with registered staff #100 confirmed that the plan of care was not updated to include the Physiotherapist's recommendation. (528) [s. 6. (10) (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 the following:
i. that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other,
ii. that the resident iss reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

WN #6: 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 failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

During the initial tour of the home, it was identified that the large enclosed outdoor patio and the small Budha Garden patio did not have a resident-staff communication and response system and that they were used by residents. Interview with the Administrator stated the two patios were used by residents and confirmed there was no communication and response system. [s. 17. (1) (e)] (581)

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The home's Pain Program, dated March 2011, directed registered staff to complete weekly pain assessments using the Pain Monitoring Flow Sheet when a resident is on regular pain medications, and the Pain Assessment Tool when family, staff or volunteer indicate pain is present.

Resident #040 was admitted to the home with multiple co-morbitities. In April 2016, the resident was started on a regularly scheduled anti-inflammatory. Review of the plan of care did not include weekly pain assessment using the Pain Monitoring Flow Sheet until August 2016. Interview with the DOC confirmed that the home does not utilize the Pain Monitoring Flow Sheet, as required in the home's policy.
In September 2016, registered staff documented that the resident had increased pain on transfers. Review of the plan of care did not include a completed pain assessment using a Pain Assessment Tool. Interview with registered staff #100 confirmed that a Pain Assessment Tool was not completed when staff observed the resident display increased pain with transfers, as required in the home's policy. (528) [s. 52. (2)]

Issued on this 22nd day of February, 2017

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581)
Inspection No. / No de l'inspection :	2017_570528_0001
Log No. / Registre no:	000156-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 8, 2017
Licensee / Titulaire de permis :	PEEL HOUSING CORPORATION 10 Peel Centre Drive, Suite A, BRAMPTON, ON, L6T-4B9
LTC Home / Foyer de SLD :	VERA M. DAVIS NURSING HOME 80 Allan Drive, Bolton, ON, L7E-1P7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Liezle Trinidad

To PEEL HOUSING CORPORATION, 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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that:
i. All residents, including resident #040, are provided with skin and wound care and transferred safely according to their assessed needs.
ii. All residents who have altered skin integrity are provided with skin and wound care according to the home's Skin and Wound Care Program.
iii. All resident who have a change in condition or transfer status are assessed for safe transfers by registered staff according to the home's Minimal Lift Policy.

Grounds / Motifs :

1. For purposes of The Act and its Regulations, the definition of neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or pattern of inaction that jeapordizes the health safety or wellbeing as one or more residents.

A. Resident #040 was not free from neglect by the licensee or staff in the home related to skin and wound care.

i. Resident #040 was admitted to the home in 2015, with multiple comorbidities. The resident began displaying an area of altered skin integrity in June 2016.
ii. Weekly wound assessments were not completed in June 2016, as confirmed by SOC #114.
iii. In July and August 2016, staff documented altered skin integrity eleven times but no treatment identified or documented to the area of altered skin integrity, nor were wound assessments completed initially or weekly.
iv. Interview with SOC #114 confirmed that the resident had a recurring area of altered skin integrity but weekly wound assessment had not been completed

from June to August 2016.
v. In September 2016, registered staff noted the wound as open and then six days later and increase in size was documented, however; the wound was not assessed using a clinically appropriate assessment tool, as confirmed by SOC #114.
vi. In September 2016, the resident was diagnosed with an injury, requiring transfer to hospital for treatment. Upon return from the hospital, a head to toe assessment was not completed for the resident with altered skin integrity. Interview with SOC #114 confirmed that the resident's hospital visit had contributed to a worsening area of altered skin integrity, however, a head to toe assessment had not been completed upon the resident's return from the hospital to assess the wound.
vii. The resident required a full mechanical lift and total assistance with care and the resident was not placed on a turning and repositioning schedule. Interview with registered staff #107 confirmed that as a part of the skin and wound program, residents who require assistance with turning and repositioning, will be placed on a turning and repositioning schedule.
viii. A wound assessment using a clinically appropriate assessment tool was not completed until the wound measuremen was larger with necrotic tissue. The resident was then placed on a turning and repositioning schedule, referred to physician, enterostomal (ET) nurse, and RD.
ix. Interview with the home's Interim RD who confirmed that the RD did not assess the resident related to altered skin integrity until September 2016, at which time, a nutritional supplement and change in diet texture was ordered.
x. For the next two weeks, while the wound continued to be treated, weekly wound assessment had not completed and in October 2016, the resident was transferred to the hospital for wound treatment, as confirmed by SOC #114.
xi. When the resident returned to the home weekly wound assessment were not completed for one week in October 2016.
xii. Interview with registered staff #114 confirmed that from June to September 2016, weekly wound assessment were not completed for resident #040, who had an ongoing area of altered skin integrity, and in September and October 2016, weekly wound assessment were not consistently completed by registered staff, as required in the home's policy.

The home failed to provide resident #040 who had documented ongoing worsening altered skin integrity, with skin and wound care as outlined in Ontario Regulation section 50, subsection (2) including inaction as follows, registered staff did not complete wound assessments using a clinically appropriate

assessment tool, registered staff did not complete weekly wound assessments, RD did not assess the resident related to skin and wound, registered staff did not complete a head to toe assessment on a resident with altered skin integrity upon return from hospital, and did not initiate a turning and repositioning for the resident who is dependent on staff for repositioning, that jeapordized the health and well being of the resident. Interview with the Administrator confirmed that the care to resident #040 was not consistent related to skin and wound.

B. Resident was not free from neglect by the licensee or staff in the home, related to safe transferring and positioning techniques.

i. On an identified date in June 2016, resident #040 was assessed by physiotherapy related to their transfer status. At that time, the resident used two person for transferring and a sit to stand lift, as needed. The physiotherapist determined that the resident was not able to follow directions and therefore, was no longer safe to use the sit to stand lift, requiring a full mechanical lift, as needed.
ii. Five days later, registered staff updated the care plan to direct staff to use the sit to stand lift as needed, however, there was no assessment documented related to the change in transfer status, as required in the home's Minimal Lift Program. Interview with registered staff #100 confirmed that the plan of care did not include an assessment related to the use of the sit to stand lift.
iii. On August 20, 2016, registered staff documented that the resident was not weight bearing well and required the use of the sit to stand lift. Interview with registered staff #114 revealed that the information was reported by PSW staff and the registered staff did not assess the resident using the sit to stand lift, as required in the home's Minimal Lift Program.
iv. Review of point of care (POC) documentation revealed that PSW staff continued to use the sit to stand lift thirteen times in June 2016, twelve times in July 2016, and thirty eight times in August 2016.
v. Interview with PSW #111 confirmed that as of August 2016, the sit to stand lift was used most of the time, and PSW #112 confirmed that the resident had limited mobility in one arm and was not able to hold the lift with that arm.
vi. In September 2016, the resident began complaining of pain during transfer, and two days later registered staff documented that the resident had bilateral underarm pain from the sit to stand lift. Signs and symptoms of injury were documented and the MD was informed.
vii. Review of POC documentation revealed PSW staff continued to use the sit to stand lift for an additional three days, until the resident was transferred to

hospital and diagnosed with an injury. Interview with PSW # 111 confirmed that after the resident began complaining of pain, staff continued to use the sit to stand lift until physiotherapy assessed the resident.
viii. Interview with the physiotherapist confirmed that the resident was not cognitively able to to use the sit to stand lift when assessed in June 2016. Interview with SOC #107 confirmed that PSW staff should not have used the sit to stand lift after it was identified as a cause of resident's pain.

The home's staff failed to provide resident with safe transfers when PSW staff did not transfer resident #040 according to their transfer assessment in June 2016, and registered staff changed the transfer status in June and August 2016 without completing an assessment of the resident. Furthermore, in September 2016, when the resident began displaying symptoms of an injury from the sit to stand lift, PSW staff continued to use the sit to stand lift for an additional three days. The resident was diagnosed with an injury, as a result of the use of the sit to stand lift, as confirmed by the home's investigation notes and interview with the DOC.
(528) (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that:
i. All resident who are at risk of altered skin integrity, including resident #040, receive a skin assessment by a member of the registered staff upon any return from hospital
ii. All residents who have altered skin integrity are assessed by registered staff using a clinically appropriate assessment tool.
iii. All residents who have altered skin integrity are assessed by the RD related to skin and wound
iv. All residents who have altered skin integrity are reassessed at least weekly
v. All residents who are dependent on staff for repositioning is repositioned every two hours or more frequently as required
vi. All staff collaborate with each other to ensure that all residents receive skin and wound care according to the home's Skin and Wound Care Program.

Grounds / Motifs :

1. This non-compliance had a severity of "actual harm/risk", with a scope "isolated" and an ongoing history of noncompliance with a VPC issued in June 2015.

A. In August 2016, the plan of care for resident #040 identified that they were wheelchair bound, requiring a mechanical lift for transfers. In September 2016, registered staff documented an open area. Four days later the resident was transferred to the hospital for assessment and treatment of an injury. When the resident returned to the home, the next morning, a skin assessment was not completed until five days later when the wound measured significantly larger than the pre-hospital assessment. Interview with SOC #107 identified that the transfer and care at the hospital had contributed to a worsening of the wound; however, a skin and wound assessment was not completed when the resident returned from the hospital to confirm that statement. (528) [s. 50. (2) (a) (ii)]

B. Resident #040 was admitted to the home in 2015, with multiple comorbidities. Review of the plan of care identified a number of occasions where staff documented altered areas of skin integrity but did not assess the wound using a clinically appropriate assessment tool:
i. Registered staff documented an open area requiring treatment six times from June to September 2016.
ii. PSW staff documented in Point of Care (POC), an altered area of skin integrity eleven times in July and August 2016.
iii. A skin assessment using a clinically approrpriate assessment tool was not

completed by registered staff until late September 2016, at which time, the wound had significantly worsened.

Interview with registered staff #100 and SOC #107 confirmed that the resident had a recurring area of altered skin integrity, and assessment of the wound was not completed using a clinically appropriate assessment tool until late September 2016. [s. 50. (2) (b) (i)]

C. In June 2016, registered staff documented resident #040 had an open area of altered skin inteigrty. Six days later the RD assessed the resident related to weight loss, and did not address the altered skin integrity.
Later that month, registered staff measured the open area to be larger than the last assessment. Three days, later the RD completed the resident's quarterly assessment and did not address the altered skin integrity.
Furthermore, areas of altered skin integrity were documented by staff in July, August and September 2016. The resident was not assessed by the RD related to altered skin integrity until late September 2016, at which time, a change in food texture and supplements were added to the resident's plan of care.
Interview with the Interim RD confirmed that the previous RD did not assess the resident related to altered skin integrity until three months after altered skin integrity was documented. (528) [s. 50. (2) (b) (iii)]

D. Resident #040 was admitted to the home in 2015, with multiple comorbidities. In June 2016, registered staff documented a open area of altered skin integrity requiring treatment. Ten days later, registered staff measured the wound to be larger than the previous assessment and treatment continued.
In July 2016, registered staff documented the area as open. POC documentation identified that PSW staff observed altered skin integrity ten times in July and August 2016. In September 2016, registered staff measured the wound and six days later a larger measurement was documented.
A wound assessment using a clinically appropriate assessment tool was not completed until late September 2016, at which time, the wound was significantly larger.
For the next two weeks, weekly wound assessment were not completed and in October 2016, the resident was transferred to the hospital requiring treatment for the wound.

The resident returned to the home in October 2016, and weekly wound assessment was not completed for one week in October 2016.

Interview with registered staff #100 and #114 confirmed that from June to September 2016, weekly wound assessment were not completed for resident #040, who had an ongoing area of altered skin integrity, and in September and October 2016, weekly wound assessment were not consistently completed by registered staff. (528) [s. 50. (2) (b) (iv)]

E. Since June 2016, the plan of care for resident #040 identified a recurring open area of altered skin integrity. In July 2016, due to a deterioration in cognition and mobility the resident was provided a wheelchair for safety, and by September 2016, registered staff documented the resident was wheelchair bound requiring a mechanical lift for transfers. In September 2016, registered staff noted an open area and four days later, the resident was diagnosed with an injury requiring hospital treatment and affecting mobility. In the days following the resident's return from the hospital, registered staff measured the wound larger than the previous measurement and staff documented the resident as requiring extensive assistance of three persons for all transfers and care. Two days after staff identified that the resident required extensive assistance for mobiltiy, registered staff documented the wound had significantly worsened. Review of the plan of care, identified that the home did not place the resident on a turning and positioning schedule until late September 2016, almost 12 days after altered skin integrity was identified. Interview with registered staff #107 confirmed that in September 2016, the resident displayed altered skin integrity and a change in condition that required a turning and repositioning schedule, however, was not implemented in the written plan of care until September 2016. (528)
(528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall ensure that staff use safe transferring and positioning techniques with all residents as outlined in the home's Minimal Lift Policy and ensure that all nursing, physiotherapy staff, and any other staff members as appropriate, are collaborating when completing safe and lift transfer assessments.

Grounds / Motifs :

1. This non-compliance had a severity of "actual harm/risk", with a scope "isolated" and an ongoing history of unrelated noncompliance issued.

In June 2016, resident #040 was assessed by physiotherapy related to their transfer status. At that time, the resident used two person for transferring and a sit to stand lift, as needed. The physiotherapist determined that the resident was not able to follow directions and therefore, was no longer safe to use the sit to stand lift, requiring a full mechanical lift, as needed.
Five days later, registered staff updated the care plan to direct staff to use the sit to stand lift as needed, however, there was no assessment documented related to the change in transfer status, as required in the Minimal Lift Program.
Interview with registered staff #100 confirmed that the plan of care did not include an assessment related to the use of the sit to stand lift.
In August 2016, registered staff documented that the resident was not weight bearing well and required the use of the sit to stand lift. Interview with registered staff #114 revealed that the information was reported by PSW staff and the registered staff did not assess the resident using the sit to stand lift, as required in the homes Minimal Lift Program.
Review of point of care (POC) documentation revealed that PSW staff continued to use the sit to stand lift thirteen times in June 2016, twelve times in July 2016,

and thirty eight times in August 2016.
Interview with PSW #111 confirmed that as of August 2016, the sit to stand lift was used most of the time, and PSW #112 confirmed that the resident had limited mobility in one arm and was not able to hold the lift with that arm.
In September 2016, the resident began complaining of discomfort during transfer, and two days later registered staff documented that the resident had pain as a result of the sit to stand lift. Swelling and pain were documented and the MD was informed.
Review of POC documentation revealed PSW staff continued to use the sit to stand lift for an additional three days,until the resident was transferred to hospital and diagnosed with an injury. Interview with PSW # 111 confirmed that after the resident began complaining of pain, staff continued to use the sit to stand lift until physiotherapy assessed the resident.
Interview with the physiotherapist confirmed that the resident was not cognitively able to to use the sit to stand lift when assessed in June 2016. Interview with SOC #107 confirmed that PSW staff should not have used the sit to stand lift after it was identified as a cause of resident's pain.

The PSW staff did not transfer resident #040 according to their transfer assessment in June 2016 and registered staff changed the transfer status in June and August 2016 without completing an assessment of the resident. Furthermore, in September 2016, when the resident began displaying symptoms of an injury related to the sit to stand lift, staff continued to use the sit to stand lift for an additional three days. The resident was diagnosed with an injury, as a result of the sit to stand lift, as confirmed by the home's investigation notes and interview with the DOC. (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2017

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
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 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
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 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, 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 8th day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cynthia DiTomasso

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