Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 27, 2020	2020_657681_0005	012081-20	Complaint

Licensee/Titulaire de permis

Algonquin Nursing Home of Mattawa
231 Tenth Street P.O. Box 270 MATTAWA ON P0H 1V0

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

Algonquin Nursing Home
231 Tenth Street P.O. Box 270 MATTAWA ON P0H 1V0

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

STEPHANIE DONI (681)

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): June 19, 22-26, and 29-30, 2020, as an off-site inspection.

One complaint submitted to the Director, related to a resident's admission to the home, was inspected during this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Office Manager, Registered Practical Nurses (RPNs), Placement Admissions Coordinator with the North East Local Health Integration Network (NE LHIN), Care Coordinators with the NE LHIN, a Social Worker with the North Bay Regional Health Centre, and family members.

The Inspector also reviewed relevant resident care records and home policies.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, at a minimum, the policy to promote zero tolerance of abuse and neglect of residents clearly set out what constituted abuse and neglect; set out the consequences for those who abuse or neglect residents; and dealt with any additional matters as provided for in the regulations.

Section 96 (a) of the Ontario Regulation 79/10 identifies that the licensee's written policy under section 20 of the Act shall contain procedures and interventions to assist and support residents who have been abused or neglected. Section 98 of the Ontario Regulation 79/10 identifies that every licensee shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The Inspector reviewed the home's Abuse & Neglect Policy (Policy #: NM-L-03), last revised January 2016, and identified the following:

- The policy was missing key information about what constitutes abuse.

- The policy did not identify the consequences of abuse or neglect, with the exception of indicating that the DOC would report to the staff member's professional college, as applicable.

- The policy did not identify procedures and interventions to assist and support residents who have been abused or neglected, with the exception of indicating that the physically abused resident would be examined by a Physician and a Registered Staff member.

- The policy indicated that the police would only be notified in the case of injury or if it was requested by the resident or the resident's substitute decision maker.

During an interview with the DOC, they stated that the home's policy related to abuse and neglect was the document that was titled Abuse & Neglect Policy (Policy #: NM-L-03). [s. 20. (2)]

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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged or suspected incident of abuse of a resident that was reported to the licensee, was immediately investigated and that appropriate action was taken in response to every such incident.

The Ontario Regulation 79/10 defines financial abuse as any misappropriation or misuse of a resident's money or property. Section 98 of the Ontario Regulation also indicates that the appropriate police force must be immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

A complaint was submitted to the Director related to resident #001's admission to the home.

a) Inspector #681 reviewed resident #001's electronic medical record and identified progress notes entered by RPNs #108 and #109, which indicated that resident #001 voiced concerns about their money being used inappropriately.

During an interview with the Inspector, RPN #108 stated that resident #001 voiced concerns to them about the resident's money being used inappropriately. RPN #108 stated that they were unsure if they had reported these concerns to anyone.

b) During an interview with the Inspector, the Office Manager stated that resident #001's family member told them that there were concerns with resident #001's money being used inappropriately. The Office Manager stated that they advised the DOC and the Administrator that there were concerns with resident #001's money being used inappropriately.

During an interview with the Administrator, they stated that they were aware of some concerns related to resident #001's funds. The Administrator stated that they did not suspect financial abuse in this instance because they were not aware that resident #001 had expressed concern about the inappropriate use of their money. The Administrator stated that if they were aware that the resident had expressed concern about the inappropriate use of their money, they would have contacted the Ontario Provincial Police and submitted a Critical Incident Report to the Ministry of Long-Term Care. [s. 23. (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 every alleged, suspected or witnessed incident of resident abuse or neglect that the licensee knows of, or that is reported to the licensee, is immediately investigated and appropriate action is taken, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (1) Every licensee of a long-term care home shall ensure that,
(a) a package of information that complies with this section is given to every resident and to the substitute decision-maker of the resident, if any, at the time that the resident is admitted; 2007, c. 8, s. 78. (1).
(b) the package of information is made available to family members of residents and persons of importance to residents; 2007, c. 8, s. 78. (1).
(c) the package of information is revised as necessary; 2007, c. 8, s. 78. (1).
(d) any material revisions to the package of information are provided to any person who has received the original package and who is still a resident or substitute decision-maker of a resident; 2007, c. 8, s. 78. (1).
(e) the contents of the package and of the revisions are explained to the person receiving them. 2007, c. 8, s. 78. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a package of information was given to resident #001, or resident #001's substitute decision maker at the time that the resident was admitted, and that the contents of the package were explained to the person receiving them.

Section 78 (2) (k) of the Long-Term Care Homes Act identifies that the information package must contain information about what is paid for by funding under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019 or the payments that residents make for accommodation and for which residents do not have to pay additional charges.

A complaint was submitted to the Director related to resident #001's admission to the home.

Inspector #681 reviewed resident #001's admission information and identified that a form, acknowledging that the resident information package was provided to resident #001, had been signed by the resident approximately two weeks after they were admitted to the home.

The Inspector also identified that resident #001's family member completed specified documents from the admission information package approximately one month after the resident was admitted to the home.

During an interview with the Office Manager, they indicated that the documents in the admission package were not reviewed with resident #001 until more than two weeks after their admission to the home. The Office Manager stated that resident #001 signed most of the documents in the admission package, but requested that certain documents be sent to their family member.

During an interview with the Administrator, they indicated that the admission package was usually reviewed and completed on admission to the home. However, there was a delay in completing resident #001's admission documents. [s. 78. (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 a package of information that complies with section 78 of the LTCHA is given to every resident and to the substitute decision-maker of the resident, if any, at the time that the resident is admitted, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any person who had reasonable grounds to suspect misuse or misappropriation of a resident’s money immediately reported the suspicion and the information upon which it was based to the Director.

Section 152 (2) of the Long-Term Care Homes Act states that where an inspector finds that a staff member has not complied with subsection 24 (1) or 26 (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in Section 152 (1). Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A complaint was submitted to the Director related to resident #001’s admission to the home.

The Inspector reviewed progress notes in resident #001’s electronic medical record, as well as, email communications sent to the home by resident #001’s family member. These documents each identified concerns related to inappropriate use of resident #001's funds.

The Inspector reviewed the Ministry of Long-Term Care Critical Incident Reporting portal and was unable to locate a critical incident report submitted by the home related to the misappropriation of resident #001’s funds.

During an interview with Administrator, they indicated that a critical incident report was not submitted because they were not aware that resident #001 expressed concern about the inappropriate use of their money. The Administrator stated that the RPNs who the resident reported this concern to should have reported it to the RN, DOC, or Administrator so that a critical incident report could have been submitted. [s. 24. (1)]

Issued on this 29th day of July, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STEPHANIE DONI (681)
Inspection No. / No de l'inspection :	2020_657681_0005
Log No. / No de registre :	012081-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 27, 2020
Licensee / Titulaire de permis :	Algonquin Nursing Home of Mattawa 231 Tenth Street, P.O. Box 270, MATTAWA, ON, P0H-1V0
LTC Home / Foyer de SLD :	Algonquin Nursing Home 231 Tenth Street, P.O. Box 270, MATTAWA, ON, P0H-1V0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Amy Morrison

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Algonquin Nursing Home of Mattawa, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Order / Ordre :

The licensee must be compliant with s. 20 (2) of the Long-Term Care Homes Act.

Specifically, the licensee must:

a) Revise the home's Abuse and Neglect Policy to ensure that the policy complies with s. 20 (2) of the Long-Term Care Homes Act and s. 96 - s. 99 of the Ontario Regulation 79/10.

b) Ensure that all staff are trained on the contents of the revised Abuse and Neglect Policy. Documentation of this training and who completed the training must be maintained.

Grounds / Motifs :

1. The licensee has failed to ensure that, at a minimum, the policy to promote

zero tolerance of abuse and neglect of residents clearly set out what constituted abuse and neglect; set out the consequences for those who abuse or neglect residents; and dealt with any additional matters as provided for in the regulations.

Section 96 (a) of the Ontario Regulation 79/10 identifies that the licensee's written policy under section 20 of the Act shall contain procedures and interventions to assist and support residents who have been abused or neglected. Section 98 of the Ontario Regulation 79/10 identifies that every licensee shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The Inspector reviewed the home's Abuse & Neglect Policy (Policy #: NM-L-03), last revised January 2016, and identified the following:

- The policy was missing key information about what constitutes abuse.

- The policy did not identify the consequences of abuse or neglect, with the exception of indicating that the DOC would report to the staff member's professional college, as applicable.

- The policy did not identify procedures and interventions to assist and support residents who have been abused or neglected, with the exception of indicating that the physically abused resident would be examined by a Physician and a Registered Staff member.

- The policy indicated that the police would only be notified in the case of injury or if it was requested by the resident or the resident's substitute decision maker.

During an interview with the DOC, they stated that the home's policy related to abuse and neglect was the document that was titled Abuse & Neglect Policy (Policy #: NM-L-03).

The severity of this issue was determined to be a level three, as there was actual risk to the residents of the home. The scope of the issue was a level one, as it only related to the home's Abuse and Neglect Policy. The home had a level

two compliance history, as there was no previous non-compliance issued with this subsection of the Long-Term Care Homes Act. (681)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 11, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of July, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Stephanie Doni

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