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

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130 Dufferin Avenue 4th floor
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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
Mar 18, 2021	2021_563670_0003	003223-21, 003627-21, 003887-21, 003888-21	Complaint

Licensee/Titulaire de permis

Meadow Park (Chatham) Inc.
c/o Jarlette Health Services 711 Yonge Street Midland ON L4R 2E1

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

Meadow Park Nursing Home (Chatham)
110 Sandys Street Chatham ON N7L 4X3

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

DEBRA CHURCHER (670), CASSANDRA TAYLOR (725)

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): March 9, 10, 11 and 15, 2021.

The purpose of this inspection was to inspect the following;
-Log# 003627-21 IL-88319-LO related to alleged abuse and visiting restrictions.
-Log# 003223-21 IL-87925-LO related to alleged abuse and visiting restrictions.
-Log# 003887-21 CIS# 2685-000006-21 related to alleged staff to resident abuse and visitor to resident abuse.
-Log# 003888-21 CIS# 2685-000005-21 related to alleged staff to resident abuse and visitor to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Educator, one Physician, two Registered Nurses, three Personal Support Workers, one Housekeeper and multiple residents.

During the course of this inspection the Inspectors observed the overall cleanliness and maintenance of the home, observed IPAC practices, observed PPE availability, observed staff to resident interactions, observed the provision of care, reviewed relevant internal documentation, reviewed relevant policies and procedures and reviewed relevant resident records.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. 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 :

The licensee has failed to ensure that resident #002 and #003 were protected from abuse.

O. Reg. 79/10 defines emotional abuse as a)"any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

A)Registered Nurse (RN) #105 identified resident #002 and #003 as residents that had been adversely affected by the actions of identified visitors in the home.

An interview was conducted with resident #002. Resident #002 stated that they had concerns with identified visitors in the home related to yelling at staff and threatening staff while they were in the building. Resident #002 shared that they felt vulnerable when the identified visitors were in the building and used a specific strategy to not be exposed to the yelling.

B)An interview was conducted with resident #003. Resident #003 shared that the identified visitors would yell and scream at staff. Resident #003 stated that it was constant and that they had experienced adverse effects requiring specific interventions.

Interview with PSW #109 stated that the identified visitors were normally verbally aggressive towards staff when they were in the home. PSW #109 acknowledged that resident #002 would often make comments about how this behavior was affecting them and resident #003 has had a significant change in a specific condition since the identified visitors started visiting the home.

Interview with PSW #107 stated that two specific visitors will yell and swear when they are in the home visiting. Stated that this is normally directed at staff however all the residents in that hallway can hear this and it has resulted in multiple residents being upset. PSW #107 gave examples of a specific resident often crying related to this issue and residents with cognitive impairments coming out into to hallway to try and find out what is wrong and experiencing increased anxiety related to hearing yelling and threats.

Interview with Administrator #100 and Director of Care #101 stated that they had not had any concerns related to residents reported to them.

Resident #002 and #003 experienced emotional abuse related to the actions of the identified visitors. This resulted in actual harm to resident #002 and #003.

Sources: Resident #002 and #003 interviews, interviews with Administrator #100, DOC #101, RN #105, PSW #107 and #109, and resident #001 record review.

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, suspected or witnessed incident of abuse of resident #005 by anyone that the licensee knows of, or that is reported to the licensee, was immediately investigated.

An email was received by the DOC #101 from PSW #108, that stated resident #005 had reported to them that they were unable to use a specific item in the room or an identified visitor would behave in a specific manner towards them.

During a telephone Interview with PSW #108 they confirmed that they had sent the email to the DOC #101 on a specific date. PSW #108 stated that they could not recall the exact date however they recalled resident #005 requesting water and PSW #108 moved a specific item in the room closer to the beside and resident #005 immediately became very fearful and said that they could not use the item or the "mean" person would behave in a certain manner towards them. PSW #108 stated that they clarified with resident #005 and they stated it was "the one that visits".

During an interview with the Administrator #100 and the DOC #101, the DOC #101 they acknowledged that they had received the email from PSW #108 on a specific date. Both the Administrator #100 and the DOC #101 stated that there had been no investigation as there had been no concerns and there was no danger.

The home failed to investigate the reported alleged abuse resulting in risk to resident #005 related to potential abuse.

Sources: Internal email from PSW #108 to the Director of Care, interview with PSW #108 and interview with the Administrator #100 and DOC #101. [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 to 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; (b) appropriate action is taken in response to every such incident; and (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with, to be implemented voluntarily.

WN #3: 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 a person who had reasonable grounds to suspect that abuse of resident #005 had occurred immediately reported the suspicion and the information upon which it was based to the Director:

An email was received by the DOC #101 from PSW #108, that during an approximate time frame resident #005 had stated to them that they were unable to use a specific item in the room or an identified visitor would behave in a specific manner towards them.

During a telephone Interview with PSW #108 they confirmed that they had sent the email to the DOC #101 on a specific date. PSW #108 stated that they could not recall the exact date however they recalled resident #005 requesting water and PSW #108 moved a specific item in the room closer to the beside and resident #005 immediately became very fearful and said that they could not use the item or the "mean" person would behave in a certain manner towards them. PSW #108 stated that they clarified with resident #005 and they stated it was "the one that visits".

During an interview with the Administrator #100 and the DOC #101, the DOC #101 acknowledged that they had received the email from PSW #108 on a specific date and a Critical Incident System report had not been submitted.

The home failed to immediately report the alleged abuse to the Director that was documented in the email sent by PSW #108, resulted in risk to resident #005.

Sources: Internal email from PSW #108 to the Director of Care, interview with PSW #108 and interview with the Administrator #100 and DOC #101. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who had 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, to be implemented voluntarily.

WN #4: 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,
(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).

Findings/Faits saillants :

1. The licensee had failed to ensure that resident #001's skin integrity issues were assessed weekly by a member of the registered staff.

O. Reg. 79/10, s. 50 (3) states in part that altered skin integrity is defined as, potential or actual disruption of the epidermal or dermal tissue.

On review of the home's online charting system Point Click Care (PCC) it was documented on five dates that resident #001 had specific conditions.

There were no further assessments documented.

During an interview with the Wound Care Lead #103 it was acknowledged that a weekly assessment was not completed and should have been.

There was a potential risk of harm to the resident due to the fact that weekly assessments were missed.

Sources: Progress notes, head to toe assessments, and staff interviews with the Wound Care Lead #103. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

Issued on this 23rd day of March, 2021

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) :	DEBRA CHURCHER (670), CASSANDRA TAYLOR (725)
Inspection No. / No de l’inspection :	2021_563670_0003
Log No. / No de registre :	003223-21, 003627-21, 003887-21, 003888-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 18, 2021
Licensee / Titulaire de permis :	Meadow Park (Chatham) Inc. c/o Jarlette Health Services, 711 Yonge Street, Midland, ON, L4R-2E1
LTC Home / Foyer de SLD :	Meadow Park Nursing Home (Chatham) 110 Sandys Street, Chatham, ON, N7L-4X3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Anne Marie Rumble

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 Meadow Park (Chatham) Inc., 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. 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 must be compliant with s. 19 (1) LTCHA, 2007.

Specifically the licensee must;
1) Ensure resident #002, #003 and all residents are protected from abuse.
2) Re-educate all Registered Nurses in the home, related to the definition of emotional abuse and their role and responsibility if any abuse is alleged or suspected.
3) Retain documentation that includes the content of the education, the date the education was completed and the name of the staff member that was educated.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #002 and #003 were protected from abuse.

O. Reg. 79/10 defines emotional abuse as a)"any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

A)Registered Nurse (RN) #105 identified resident #002 and #003 as residents that had been adversely affected by the actions of identified visitors in the home.

An interview was conducted with resident #002. Resident #002 stated that they had concerns with identified visitors in the home related to yelling at staff and threatening staff while they were in the building. Resident #002 shared that they felt vulnerable when the identified visitors were in the building and used a specific strategy to not be exposed to the yelling.

B)An interview was conducted with resident #003. Resident #003 shared that the identified visitors would yell and scream at staff. Resident #003 stated that it was constant and that they had experienced adverse effects requiring specific interventions.

Interview with PSW #109 stated that the identified visitors were normally verbally aggressive towards staff when they were in the home. PSW #109 acknowledged that resident #002 would often make comments about how this behavior was affecting them and resident #003 has had a significant change in a specific condition since the identified visitors started visiting the home.

Interview with PSW #107 stated that two specific visitors will yell and swear when they are in the home visiting. Stated that this is normally directed at staff however all the residents in that hallway can hear this and it has resulted in multiple residents being upset. PSW #107 gave examples of a specific resident often crying related to this issue and residents with cognitive impairments coming out into to hallway to try and find out what is wrong and experiencing increased anxiety related to hearing yelling and threats.

Interview with Administrator #100 and Director of Care #101 stated that they had not had any concerns related to residents reported to them.

Sources: Resident #002 and #003 interviews, interviews with Administrator #100, DOC #101, RN #105, PSW #107 and #109, and resident #001 record review.

An order was made taking the following into account;
Severity: Resident #002 and #003 experienced emotional abuse related to the actions of identified visitors. This resulted in actual harm to resident #002 and #003.

Scope: This issue was a pattern as two out of four residents inspected upon experienced emotional abuse.

Compliance History: 9 Written Notifications, 8 Voluntary Plans of Correction and one compliance order which is outstanding, were issued to the home related to

different sub-sections of the legislation in the last 36 months.
(670)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 26, 2021

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 18th day of March, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debra Churcher

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