Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 6, 2019	2019_641665_0023	014743-19, 016679-19	Critical Incident System

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Pine Grove Long Term Care Residence
8403 Islington Avenue North Woodbridge ON L4L 1X3

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

JOY IERACI (665)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 28, 29, December 3 and 4, 2019.

The following critical incident system (CIS) intakes related to falls prevention were inspected:
-Log #014743-19/CIS #2808-000006-19,
-Log #016679-19/CIS #2808-000009-19.

During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Resident Care and Services Consultant (RCSC), Director of Care (DOC), registered practical nurses (RPNs) and personal support workers (PSWs).

During the course of the inspection, the inspector conducted resident observations, observed staff and resident interactions, reviewed clinical health records, investigation documents, relevant home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care was provided to residents #001 and #002 as specified in the plan.

The home submitted a critical incident system (CIS) report for a fall resident #001 had on an identified date and time in 2019, which resulted in a significant change in the resident's health status. The CIS report documented that a staff member heard the resident calling out in a co-resident's room, and found the resident sitting on the floor in a specified area of the room, with one hand on their mobility device. The resident was transferred to hospital and returned to the home, with an identified injury.

A review of the progress notes in point click care (PCC) documented resident #001's significant change in status after the fall and at the time of the inspection.

A) A review of the plan of care at the time of the fall indicated that the resident was at an identified risk of falls, used an identified mobility device, required assistance with an identified activity of daily living (ADL) and the fall interventions directed staff to ensure four identified safety devices were in use.

In separate interviews, RPN #101 and PSW #103 indicated that the resident was at risk for falls. Both staff stated that prior to the fall, the resident ambulated with an identified mobility device on their own. The resident would attempt to perform a specified ADL without calling for assistance, and had an identified safety device in place prior to the fall. After the fall, the resident did not ambulate with their identified mobility device on their own.

The interview with PSW #103 indicated that on the day of the critical incident, PSW #110 called for assistance as they found resident #001 in a co-resident's room at an identified time. PSW #103 told the inspector that they did not hear the identified safety device activated, so together with PSW #110, they checked the safety device and discovered that it was not turned on. The safety device was turned on immediately and PSW #103 indicated that the staff on the previous shift may have assisted the resident with an identified ADL, and the safety device was not turned on afterwards. PSW #103 acknowledged that the plan of care was not followed for the resident.

In an interview, DOC #100 indicated that there was a significant change in status for the resident as the injury the resident sustained from the fall decreased their functional abilities. The DOC stated it was the home's expectation for the staff to follow the plan of care for all residents. The plan of care provided instructions and was a guideline as to the care needs of the residents. The evidence was reviewed with the DOC and they acknowledged that the plan of care for resident #001 was not followed to ensure the

resident's safety.

B) A further review of the plan of care at the time of the inspection indicated that the resident required assistance from an identified number of staff with all aspects of personal hygiene and bed mobility. The plan of care directed staff to ensure another identified safety device was on at all times when the resident was in bed.

During observations conducted on an identified date and time, the other identified safety device was not observed while the resident was in bed. RPN #101 and PSW #102 went into the resident's room with the inspector at separate times and confirmed that the safety device was not present while the resident was in bed.

In an interview, RPN #101 indicated that resident #001's plan of care directed staff to ensure that the identified safety device was present while the resident was in bed. The RPN stated after the inspector's observation, the safety device was put in place. RPN #101 acknowledged that the resident was at risk for falls and not following the plan of care was a safety risk for the resident.

In an interview, PSW #102 told the inspector that they were not aware that the resident was to have the safety device and that the safety device was not present at the start of their shift. The PSW reviewed the plan of care and confirmed that the resident's plan of care was not followed during their shift.

C) In another observation on an identified date and time, PSW #102 was observed at the bedside of the resident providing personal hygiene. No other staff was observed in the room with the PSW.

In an interview, PSW #102 indicated that they did not have access to the resident's care plan and kardex at the start of the shift as they had issues signing into PCC. The PSW stated they provided care to the resident at the start of their shift on their own and was not aware that the resident's plan of care indicated an identified number of staff was to provide care, until it was brought to their attention by another PSW after care was rendered. In the interview, the PSW stated that their co-worker had left the resident's room to check on another resident, and they proceeded with care, prior to the inspector entering the room at an identified time. PSW #102 acknowledged that they did not follow the resident's plan of care.

In an interview, the evidence was reviewed with DOC #100. The DOC acknowledged

that the resident’s plan of care was not followed as the safety device during the above observation was not in place and PSW #102 provided care on their own, affecting the safety of resident #001.

This non compliance was issued as staff failed to ensure that resident #001’s plan of care was provided as specified in the plan.

2. The home submitted a CIS report for a fall resident #002 had on an identified date and time. The CIS report documented that the resident was found on the floor in an identified area of the resident home area. The resident was transferred to hospital and returned the same day with an identified injury.

A review of the hospital's documentation for the resident on an identified date, indicated that they were diagnosed with three identified injuries as a result of the fall.

A review of an identified assessment in PCC, completed four days prior to the fall, indicated that the resident was at an identified risk of falls. A further review of the resident's clinical records documented that the resident had a history of falls in the past six months prior to the fall which included three falls within a 14 day period over two consecutive months. The resident sustained injury on two of the falls.

A review of the resident's plan of care at the time of the fall indicated that the resident was at the identified risk for falls related to an identified ADL. The plan of care directed staff to provide supervision with an identified number of staff while the resident performed the ADL.

In an interview, RPN #104 indicated that the resident was at the idenified risk for falls. Prior to the fall, staff supervised the resident when they performed the identified ADL and, re-directed them to a common area of the unit or to their bedroom. In another interview, PSW #109, also indicated that they supervised the resident when they performed the identified ADL and re-directed them to a common area of the unit, since the resident was at risk for falls.

DOC #100 informed the inspector that agency PSW #105 was assigned to the resident on the identified date of the critical incident. In an interview, PSW #105 confirmed they were the assigned PSW on the day of the fall, and was aware that the resident was at risk for falls. The PSW stated that they provided care at the start of their shift to the

resident and once care was completed, the PSW guided the resident with their mobility device to the bedroom door, where the resident performed the identified ADL on their own. PSW #105 indicated after guiding the resident out of the bedroom, they went back into the resident's room to finish making the resident's bed and clean up. A few minutes after the resident left the room, they heard the nurse calling from an identified common area that the resident had fallen. The PSW went to the common area and observed the resident on the floor with with an identified injury. During the interview, the PSW indicated that they were not aware that the plan of care directed staff to supervise the resident when they performed the identified ADL.

In an interview, DOC #100 indicated it was the home's expectation for the resident's plan of care to be followed. The DOC reviewed the plan of care of the resident and stated that PSW #105 should have supervised the resident while they performed the identified ADL. The DOC acknowledged that the PSW did not follow the plan of care for resident #002.

This non compliance was issued as staff failed to ensure that resident #002’s plan of care was provided as specified in the plan.

Additional Required Actions:

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

Issued on this 17th day of December, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JOY IERACI (665)

Inspection No. / No de l'inspection : 2019_641665_0023

Log No. / No de registre : 014743-19, 016679-19

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Dec 6, 2019

Licensee / Titulaire de permis : Chartwell Master Care LP
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

LTC Home / Foyer de SLD : Chartwell Pine Grove Long Term Care Residence
8403 Islington Avenue North, Woodbridge, ON, L4L-1X3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Christina Matta

To Chartwell Master Care LP, 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.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s.6 (7) of the Long Term Care Home Act (LTCHA), 2007.

Specifically the licensee must:

1. Ensure resident #001 and all other residents with two identified types of safety devices have them in place and turned on, when required as per the plan of care.

2. Ensure resident #001 and any other resident are provided care by the identified number of staff, when required as per the plan of care.

3. Conduct audits to ensure resident #001's identified types of safety devices are in place and turned on.

4. Ensure resident #002 and all other residents who require supervision with an identified activity of daily living (ADL), receive the required assistance, as per the plan of care.

5. Conduct audits to ensure resident #002 is supervised while performing the identified ADL.

6. Maintain a written record of the audits conducted in the home. The written record must include the date of the audit, the resident's name, the name of the person completing the audit, the outcome of the audits, actions taken to address any concerns, and an evaluation of the results.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #001 and #002 as specified in the plan.

The home submitted a critical incident system (CIS) report for a fall resident #001 had on an identified date and time in 2019, which resulted in a significant change in the resident's health status. The CIS report documented that a staff member heard the resident calling out in a co-resident's room, and found the resident sitting on the floor in a specified area of the room, with one hand on their mobility device. The resident was transferred to hospital and returned to the home, with an identified injury.

A review of the progress notes in point click care (PCC) documented resident #001's significant change in status after the fall and at the time of the inspection.

A) A review of the plan of care at the time of the fall indicated that the resident was at an identified risk of falls, used an identified mobility device, required assistance with an identified activity of daily living (ADL) and the fall interventions directed staff to ensure four identified safety devices were in use.

In separate interviews, RPN #101 and PSW #103 indicated that the resident was at risk for falls. Both staff stated that prior to the fall, the resident ambulated with an identified mobility device on their own. The resident would attempt to perform a specified ADL without calling for assistance, and had an identified safety device in place prior to the fall. After the fall, the resident did not ambulate with their identified mobility device on their own.

The interview with PSW #103 indicated that on the day of the critical incident, PSW #110 called for assistance as they found resident #001 in a co-resident's room at an identified time. PSW #103 told the inspector that they did not hear the identified safety device activated, so together with PSW #110, they checked the safety device and discovered that it was not turned on. The safety device was turned on immediately and PSW #103 indicated that the staff on the previous shift may have assisted the resident with an identified ADL, and the safety device was not turned on afterwards. PSW #103 acknowledged that the plan of care was not followed for the resident.

In an interview, DOC #100 indicated that there was a significant change in status for the resident as the injury the resident sustained from the fall decreased their functional abilities. The DOC stated it was the home's expectation for the staff to follow the plan of care for all residents. The plan of care provided instructions and was a guideline as to the care needs of the residents. The evidence was reviewed with the DOC and they acknowledged that the plan of care for resident #001 was not followed to ensure the resident's safety.

B) A further review of the plan of care at the time of the inspection indicated that the resident required assistance from an identified number of staff with all aspects of personal hygiene and bed mobility. The plan of care directed staff to ensure another identified safety device was on at all times when the resident was in bed.

During observations conducted on an identified date and time, the other identified safety device was not observed while the resident was in bed. RPN #101 and PSW #102 went into the resident's room with the inspector at separate times and confirmed that the safety device was not present while the resident was in bed.

In an interview, RPN #101 indicated that resident #001's plan of care directed staff to ensure that the identified safety device was present while the resident was in bed. The RPN stated after the inspector's observation, the safety device was put in place. RPN #101 acknowledged that the resident was at risk for falls and not following the plan of care was a safety risk for the resident.

In an interview, PSW #102 told the inspector that they were not aware that the resident was to have the safety device and that the safety device was not present at the start of their shift. The PSW reviewed the plan of care and confirmed that the resident's plan of care was not followed during their shift.

C) In another observation on an identified date and time, PSW #102 was observed at the bedside of the resident providing personal hygiene. No other staff was observed in the room with the PSW.

In an interview, PSW #102 indicated that they did not have access to the

resident's care plan and kardex at the start of the shift as they had issues signing into PCC. The PSW stated they provided care to the resident at the start of their shift on their own and was not aware that the resident's plan of care indicated an identified number of staff was to provide care, until it was brought to their attention by another PSW after care was rendered. In the interview, the PSW stated that their co-worker had left the resident's room to check on another resident, and they proceeded with care, prior to the inspector entering the room at an identified time. PSW #102 acknowledged that they did not follow the resident's plan of care.

In an interview, the evidence was reviewed with DOC #100. The DOC acknowledged that the resident's plan of care was not followed as the safety device during the above observation was not in place and PSW #102 provided care on their own, affecting the safety of resident #001.

This non compliance was issued as staff failed to ensure that resident #001's plan of care was provided as specified in the plan. (665)

2. The home submitted a CIS report for a fall resident #002 had on an identified date and time. The CIS report documented that the resident was found on the floor in an identified area of the resident home area. The resident was transferred to hospital and returned the same day with an identified injury.

A review of the hospital's documentation for the resident on an identified date, indicated that they were diagnosed with three identified injuries as a result of the fall.

A review of an identified assessment in PCC, completed four days prior to the fall, indicated that the resident was at an identified risk of falls. A further review of the resident's clinical records documented that the resident had a history of falls in the past six months prior to the fall which included three falls within a 14 day period over two consecutive months. The resident sustained injury on two of the falls.

A review of the resident's plan of care at the time of the fall indicated that the resident was at the identified risk for falls related to an identified ADL. The plan of care directed staff to provide supervision with an identified number of staff

while the resident performed the ADL.

In an interview, RPN #104 indicated that the resident was at the idenified risk for falls. Prior to the fall, staff supervised the resident when they performed the identified ADL and, re-directed them to a common area of the unit or to their bedroom. In another interview, PSW #109, also indicated that they supervised the resident when they performed the identified ADL and re-directed them to a common area of the unit, since the resident was at risk for falls.

DOC #100 informed the inspector that agency PSW #105 was assigned to the resident on the identified date of the critical incident. In an interview, PSW #105 confirmed they were the assigned PSW on the day of the fall, and was aware that the resident was at risk for falls. The PSW stated that they provided care at the start of their shift to the resident and once care was completed, the PSW guided the resident with their mobility device to the bedroom door, where the resident performed the identified ADL on their own. PSW #105 indicated after guiding the resident out of the bedroom, they went back into the resident's room to finish making the resident's bed and clean up. A few minutes after the resident left the room, they heard the nurse calling from an identified common area that the resident had fallen. The PSW went to the common area and observed the resident on the floor with with an identified injury. During the interview, the PSW indicated that they were not aware that the plan of care directed staff to supervise the resident when they performed the identified ADL.

In an interview, DOC #100 indicated it was the home's expectation for the resident's plan of care to be followed. The DOC reviewed the plan of care of the resident and stated that PSW #105 should have supervised the resident while they performed the identified ADL. The DOC acknowledged that the PSW did not follow the plan of care for resident #002.

This non compliance was issued as staff failed to ensure that resident #002’s plan of care was provided as specified in the plan.

The severity of this issue was determined to be a level 3 as there was actual harm to residents #001 and #002. The scope of the issue was a level 2 as it is related to two out of the three residents reviewed. The home had a level 3 compliance history as they had a previous non compliance to the same

subsection of the LTCHA that included:
- Voluntary plan of correction (VPC) issued June 18, 2018, (2018_632502_0008). (665)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Mar 02, 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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 6th day of December, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Joy Ieraci

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