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
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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
May 21, 2021	2021_768693_0010	023113-20, 023114-20	Follow up

Licensee/Titulaire de permis

Board of Management of the District of Kenora
1220 Valley Drive Kenora ON P9N 2W7

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

Pinecrest (Kenora)
1220 Valley Drive Kenora ON P9N 2W7

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

MELISSA HAMILTON (693), JULIE KUORIKOSKI (621)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): May 10 to 13, 2021.

The following intakes were inspected on during this Follow Up Inspection:
-one intake, related to CO#001 from inspection #2020_740621_0020, issued pursuant to O.Reg 79/10, s. 8. (1); and
-one intake, related to CO#002 from inspection #2020_740621_0020, issued pursuant to O. Reg 79/10, s. 30. (1).

Critical Incident System (CIS) inspection #2021_768693_0009, was conducted concurrently with this Follow Up inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Dietary Supervisor, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and a Scheduler.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, Infection Prevention and Control (IPAC) practices, observed staff to resident interactions, reviewed relevant health care records, as well as relevant policies and procedures.

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

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)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 30. (1)	CO #002	2020_740621_0020	621

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute, or otherwise put in place a nutrition care/dietary program, and a falls prevention and management program, they were complied with.

Compliance order (CO) #001 related to Ontario Regulation (O. Reg.) 79/10, s. 8 (1) from inspection #2020_740621_0020, with an amended compliance due date (CDD) of May 7, 2021, is being re-issued as follows:

a)The licensee was ordered to be compliant with s. 8. (1) of O. Reg. 79/10, to ensure that the home’s policy “Hydration – DTY 250”, as part of the home’s hydration program, was complied with. This included the provision of training to all PSWs and Registered Nursing staff on daily fluid intake monitoring and documentation procedures, consistent with the home’s policy; the performance and documentation of monthly audits of fluid intake monitoring on two residents, and a random selection of high nutrition risk residents, to ensure completeness and accuracy of the record, and timeliness of referral to the RN and/or RD when intakes were less than goal.

In accordance with the Long-Term Care Homes Act (LTCHA), 2007, s. 11 (1) (a), the licensee was required to ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents. Specifically, pursuant to O. Reg. 79/10, s. 68 (2) (d), the program was required to ensure a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

On review of a unit's daily food and fluid intake records for both meals and between-meal nourishments, incomplete fluid documentation was found for 34 out of 34 (100 per cent) of residents after the CDD. A review of the home’s Hydration DTY 205 policy, identified that designated staff were to record fluid intake at meals, and morning, afternoon and evening nourishment. On review of the home’s three “Surge Learning” education reports, it identified that 22 out of 93 (24 per cent) of PSWs and Registered Nursing staff did not complete training on the “Hydration – DTY 250” policy, and 19 out of 93 (20 per cent) did not complete the required training on each of the fluid legends, (ie. one of each for meals and between-meal nourishments). The ADOC confirmed that not all PSW and Registered Nursing staff completed the required education for the order, by the CDD. During an interview with the RD, they reported that a record of monthly fluid intake audits was not kept as required. On review of a unit's food and fluid intake records for both meals and between-meal nourishments, the RD confirmed that all records had gaps in fluid intake documentation by both PSWs and Registered Nursing staff, before and after the CDD, which was inconsistent with the home’s policy. They also confirmed that resident's food and fluid intake records after May 7, 2021, were incomplete, and that the RD referrals generated on May 9, 2021 for the residents, would have not been based on accurate fluid intake information from the previous three days, as indicated in the home’s hydration policy. On further review of the home’s Hydration DTY 205 policy, it identified that registered staff were to total daily fluid intakes for each resident and compare to the residents’ fluid goal and refer to the RD if intakes did not meet goals for three consecutive days.

Sources: "Hydration – DTY 250" policy, last revised February 2021; Resident’s “Food & Nourishment Daily Record” and “Nourishment Daily Record” for May 2021 from a unit; a unit's Daily Roster; resident RD referrals; Surge Learning course completion reports for “dty_250_hydration.pdf”; “Hydration DTY 250 fluid_level_legend_nourishment.pdf” and “Nutrition DTY 250 fluid_level_legend_c.pdf”; and interviews with the RD, ADOC and other relevant staff. [s. 8. (1)]

2. b) The licensee was ordered to be compliant s. 8. (1) of O. Reg. 79/10, to ensure that Registered Nursing staff were compliant with the home’s policy “Falls Prevention Program, NUR 145”, with respect to completion of falls risk assessments; and to have completed audits of two residents, and a random selection of residents at high falls risk, to ensure falls risk assessments were conducted, with risk level identification documented in the resident's falls care plan, along with interventions appropriate to the resident's most current care needs. The home was to keep a record of all audits

performed, along with any discrepancies found and actions taken.

In accordance with O. Reg. 79/10, s. 48 (1) 1., the licensee was required to ensure that a falls prevention and management program to reduce the incidents of falls and risk of injury was developed and implemented. Specifically, pursuant to O. Reg. 79/10, s. 48 (2) (b), the program was required to ensure that in addition to meeting the requirements set out in section 30, the falls prevention and management program provided for assessment and reassessment instruments.

A review of the home's policy, titled, "Falls Prevention and Management Program, NUR 145", last revised March 2021, indicated that Registered Nursing Staff were to conduct the fall risk assessment using the Morse Falls Risk Assessment Tool, within 24 hours of a resident's admission, and initiate a written plan of care within 24 hours of admission, readmission, post fall, change in condition and quarterly based on resident's assessed condition, fall history, needs, behaviours, medications and preferences using the Morse Falls Risk Assessment Tool and safety measures as a guide. In addition, when a resident had fallen, the policy indicated that Registered staff would review and update the fall risk care plan with any newly identified preventative measures, assessed fall risk level and date of fall.

i) The ADOC provided Inspector #693 with a list of residents who had sustained falls over a three day period in May 2021, and their current care plans that related to a falls focus. The ADOC indicated that a resident sustained a fall, and that the resident did not have a falls care plan in place.

Together with an RN, Inspector #693 reviewed a resident's medical chart. There was post fall documentation for falls that the resident sustained. An RN indicated that the post fall documentation for both falls identified that the resident was considered at a level of risk for falls, and should have had a falls care plan in place, but they did not. Inspector #693 and the RN reviewed the resident's chart further, and the RN indicated that when the resident was admitted to the home a falls risk assessment should have been completed for the resident, and a corresponding falls care plan, that would have identified appropriate falls prevention interventions.

During an interview with the DOC, they confirmed that the resident, did not have a falls care plan in place, and that a falls risk assessment wasn't completed for the resident when they moved in, and that the home's falls program indicated these measures were to be completed.

ii)Inspector #693 requested from the DOC the audits that were required to be completed for two residents, and a random selection of residents at high falls risk, to ensure falls risk assessments were conducted, with risk level identification documented in the resident's falls care plan, along with interventions appropriate to the resident's most current care needs. The DOC provided the Inspector with audits related to falls that were completed in January and February 2021, for three residents, who were not mentioned in the compliance order.

During an interview with the ADOC, they indicated they were not aware of any audits completed for CO #001, related to falls.

During an interview with the DOC, they indicated that they did not know there was any part of CO #001 still due relating to falls.

During an interview with the Administrator, they indicated that they along with their team were not aware that there was a portion of CO #001, that related to the home’s Falls program, and that no work was completed for this portion of the order.

Sources: “Falls Prevention and Management Program, NUR 145” policy, last revised March, 2021; a resident's progress notes; a resident's fall risk assessments; interviews with an RN, the ADOC, DOC, Administrator, and other relevant staff. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

Issued on this 25th day of May, 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

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 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) :	MELISSA HAMILTON (693), JULIE KUORIKOSKI (621)
Inspection No. / No de l’inspection :	2021_768693_0010
Log No. / No de registre :	023113-20, 023114-20
Type of Inspection / Genre d’inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 21, 2021
Licensee / Titulaire de permis :	Board of Management of the District of Kenora 1220 Valley Drive, Kenora, ON, P9N-2W7
LTC Home / Foyer de SLD :	Pinecrest (Kenora) 1220 Valley Drive, Kenora, ON, P9N-2W7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Kevin Queen

To Board of Management of the District of Kenora, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2020_740621_0020, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8. (1) of O. Reg. 79/10.

Specifically, the licensee must:

Part A

1) Ensure PSWs and Registered Nursing staff are compliant with the home's policy "Hydration – DTY 250", as part of the home's hydration program;

2) Ensure all direct care PSW and Registered Nursing staff are trained on daily fluid intake monitoring and documentation procedures for all residents, consistent with the home's policy. The home is to keep a record of who completed the training, the date of the training, who provided the training and what the training entailed.

3) Complete randomized daily audits of at least 10 residents food and fluid intake records, to ensure completeness of the record, accuracy of resident intake tabulations and appropriateness of referral to the Registered Dietitian; when calculated fluid intakes are less than goal. The home's management is to ensure that a record is kept of all audits performed, along with details of who completed the audit, the date of the audit, what discrepancies were found, and the follow up action taken; and

4) Continue the randomized daily audits of at least 10 residents until 100% compliance has been achieved.

Part B

1) Ensure Registered Nursing staff are compliant with the home's policy "Falls Prevention Program - NUR 145" with respect to completion of falls risk assessments, and care plans; and

2) Ensure there is an updated falls risk assessment, and a written plan of care for a specific resident with their fall risk score and appropriate falls prevention interventions included, based on the resident's most recent fall.

Grounds / Motifs :

1. The licensee has failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute, or otherwise put in place a nutrition care/dietary program, and a falls prevention and management program, they were complied with.

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In accordance with the Long-Term Care Homes Act (LTCHA), 2007, s. 11 (1) (a), the licensee was required to ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents. Specifically, pursuant to O. Reg. 79/10, s. 68 (2) (d), the program was required to ensure a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

On review of a unit's daily food and fluid intake records for both meals and between-meal nourishments, incomplete fluid documentation was found for 34 out of 34 (100 per cent) of residents after the CDD. A review of the home's Hydration DTY 205 policy, identified that designated staff were to record fluid intake at meals, and morning, afternoon and evening nourishment. On review of the home's three "Surge Learning" education reports, it identified that 22 out of 93 (24 per cent) of PSWs and Registered Nursing staff did not complete training on the "Hydration – DTY 250" policy, and 19 out of 93 (20 per cent) did not complete the required training on each of the fluid legends, (ie. one of each for meals and between-meal nourishments). The ADOC confirmed that not all PSW

and Registered Nursing staff completed the required education for the order, by the CDD. During an interview with the RD, they reported that a record of monthly fluid intake audits was not kept as required. On review of a unit's food and fluid intake records for both meals and between-meal nourishments, the RD confirmed that all records had gaps in fluid intake documentation by both PSWs and Registered Nursing staff, before and after the CDD, which was inconsistent with the home's policy. They also confirmed that resident's food and fluid intake records after May 7, 2021, were incomplete, and that the RD referrals generated on May 9, 2021 for the residents, would have not been based on accurate fluid intake information from the previous three days, as indicated in the home's hydration policy. On further review of the home's Hydration DTY 205 policy, it identified that registered staff were to total daily fluid intakes for each resident and compare to the residents' fluid goal and refer to the RD if intakes did not meet goals for three consecutive days.

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(621)

2. b) The licensee was ordered to be compliant s. 8. (1) of O. Reg. 79/10, to ensure that Registered Nursing staff were compliant with the home's policy "Falls Prevention Program, NUR 145", with respect to completion of falls risk assessments; and to have completed audits of two residents, and a random selection of residents at high falls risk, to ensure falls risk assessments were conducted, with risk level identification documented in the resident's falls care plan, along with interventions appropriate to the resident's most current care needs. The home was to keep a record of all audits performed, along with any discrepancies found and actions taken.

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to O. Reg. 79/10, s. 48 (2) (b), the program was required to ensure that in addition to meeting the requirements set out in section 30, the falls prevention and management program provided for assessment and reassessment instruments.

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ii)Inspector #693 requested from the DOC the audits that were required to be completed for two residents, and a random selection of residents at high falls risk, to ensure falls risk assessments were conducted, with risk level identification documented in the resident's falls care plan, along with interventions appropriate to the resident's most current care needs. The DOC provided the Inspector with audits related to falls that were completed in January and February 2021, for three residents, who were not mentioned in the compliance order.

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Sources: “Falls Prevention and Management Program, NUR 145” policy, last revised March, 2021; a resident's progress notes; a resident's fall risk assessments; interviews with an RN, the ADOC, DOC, Administrator, and other relevant staff. [s. 8. (1) (a),s. 8. (1) (b)]

An order was made by taking the following factors into account:

Severity: There was actual risk related to residents with respect to incomplete fluid intake records to support hydration monitoring and assessment. In addition, there was actual risk to a resident, with respect to lack of a falls risk assessment on admission, and lack of a falls care plan for the resident who was assessed as being at a level of risk for falls.

Scope: The scope of this non-compliance was a pattern. Two out of three policies inspected upon, were not followed.

Compliance History: A compliance order is being re-issued for the licensee

failing to comply with s. 8. (1) of O. Reg. 79/10. This section was issued as a compliance order on November 12, 2020, from inspection #2020_740621_0020 with an amended compliance due date of May 7, 2021.
(693)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 22, 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 21st day of May, 2021

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Melissa Hamilton

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