Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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
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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
Feb 11, 2019	2019_767643_0003	033079-18, 033155-18, 000462-19	Complaint

Licensee/Titulaire de permis

The Wexford Residence Inc.
1860 Lawrence Avenue East TORONTO ON M1R 5B1

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

The Wexford
1860 Lawrence Avenue East SCARBOROUGH ON M1R 5B1

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

ADAM DICKEY (643)

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): January 10, 11, 14-17, 21-25, 2019.

The following complaint intakes were inspected concurrently during this inspection:
Log #033155-18 and Log #000462-19 - related to falls prevention and pain management.

The following Critical Incident System (CIS) intake was inspected concurrently during this inspection:
Log #033079-18; CIS #C579-000026-18 - related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Nurse Manager (NM), Nurse Practitioner (NP), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), personal support workers (PSW), diagnostic imaging provider representative, residents and family members.

During the course of the inspection the inspector conducted observations of provision of care, review of resident health records and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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 :

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

Neglect as outlined in section 2. (1) of the Regulation (O. Reg. 79/10) means the failure to provide a resident with the treatment, care services or assistance required for health, safety, or well-being, and includes inaction or pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Complaints were submitted to the Ministry of Health and Long-Term Care (MOHLTC) from the family of resident #001 concerning the falls prevention measures and pain management in place after a fall incident on an identified date. The complainants indicated that the resident did not have an x-ray of the suspected injury for eight days after the fall incident and was in pain as a result.

A Critical Incident System report (CIS) was submitted by the home, reporting the fall incident which resulted in a significant change in condition for resident #001. The CIS report indicated that on an identified date, resident #001 had a fall incident. No injury was noted at that time, though an x-ray conducted seven days later revealed an identified injury.

Resident #001's care plan indicated they were at risk for falls and had specified falls prevention and management interventions in place.

Review of resident #001's progress notes indicated that they had been found by PSW #107 to be climbing out of bed at an identified time. Resident #001 was attended by RN #112 who did not observe any obvious injury at the time. A referral was made to NP #109 who assessed resident #001 on the date of the fall incident, and observed pain, and a change in condition or altered skin integrity to an identified area and ordered an x-ray. A physician order for x-ray written by NP #109 was also completed on the date of the fall, and was checked by RN #110 and RN #112. A subsequent progress note four days later, authored by RN #102 indicated that x-ray requisition was faxed. Progress notes further indicated that the x-ray results were provided to the home seven days following the fall incident, showing findings consistent with an identified injury.

In an interview, NP #109 indicated that when the x-ray result was received confirming the injury, they knew it was a more painful condition. NP #109 indicated that registered staff advised them that resident #001 was still exhibiting pain and were worried the resident was still in pain. NP #109 ordered a specified medication for pain management.

In an interview, RN #110 indicated that the process in the home when the NP or physician ordered an x-ray was for the nurse who first checks the order to complete and fax the requisition to the imaging vendor. RN #110 indicated that they had likely sent the requisition as they checked the NP order first and that was their process. RN #110 acknowledged that they could not be completely certain if the requisition had been faxed as they may have become busy and forgot.

In an interview, RN #102 indicated that physician orders for an x-ray would be handled by the nurse on the unit who would complete and fax the form. RN #102 further indicated that the requisition was faxed four days after the order was written, and should have been faxed when the order was written.

In a telephone interview, imaging vendor representative #115 indicated that their process when receiving faxed requisitions from facilities was to stamp the requisition with the date and time received. The representative further indicated that the requisition was stamped at an identified time four days following the date the physician order was written.

In an interview, Nurse Manager (NM) #104 indicated that the process in the home for handling x-ray orders was for the physician or NP to write the order in the physician orders in the resident chart. NM #104 further indicated that the order would then be checked by the registered staff on the unit who would complete and fax the requisition to the imaging vendor. NM #104 indicated that the expectation of the home was for the registered staff who checked the order to fax the requisition the same day as the order was received. NM #104 further indicated that the technician from the imaging vendor would typically arrive in 1-2 business days to perform the service. NM #104 acknowledged that as NP #109 ordered an x-ray for resident #001 on the above mentioned identified date, and a requisition had not been faxed until four days later, that this constituted neglect of resident #001. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Complaints and a CIS were submitted to the MOHLTC following a fall incident involving resident #001 on an identified date.

Review of resident #001's physician orders showed that on the above mentioned date, the resident had an as needed (PRN) order for an identified analgesic medication. Resident #001's administration records showed that the identified PRN analgesic had been administered twice on the above mentioned identified date and documented as effective. Two days later, the analgesic order was changed from a PRN to a scheduled dose. Six days following the change to the analgesic order change, identified analgesic medication was discontinued and a second identified analgesic medication was ordered and started.

Review of progress note for post-fall monitoring authored by RN #102 the day after the above mentioned identified date, indicated resident #001 complained of pain and the above mentioned PRN analgesic was administered. Progress note for post fall monitoring authored by RN #102 two days following the identified date, indicated that resident #001 complained of pain and PRN analgesic was administered. The progress note further indicated an order for scheduled analgesic had been obtained from the NP. The PRN analgesic administrations by RN #102 above were not shown on resident #001's administration records.

In an interview, RN #102 indicated that resident #001 was expressing pain and the PRN analgesic was administered for pain relief. RN #102 indicated they had asked for the PRN analgesic order to be changed to a scheduled order as the PRN order was not effective in providing continuous pain relief for resident #001. RN #102 further indicated

that an assessment was not conducted at that time to assess the effectiveness of resident #001's pain management interventions.

In an interview, NP #109 indicated that when an x-ray result was received seven days following the above mentioned identified date, confirming injury, they knew it was a more painful condition. NP #109 indicated that registered staff advised them that resident #001 was still exhibiting signs of pain and were worried the resident was still in pain. At that point NP #109 ordered the second identified analgesic medication as a new pain management intervention.

Review of resident #001's assessments in the electronic documentation system showed that a quarterly pain assessment had been carried out on an identified date 10 days prior to the above mentioned identified date which indicated the resident had pain less than weekly. Pain management was identified in the assessment as satisfactory based on the assessment. A subsequent Abbey pain assessment for the cognitively impaired resident was carried out 10 days following the fall incident. No assessment had been carried out during the nine day period following the fall incident, during which time resident #001 showed indicators of pain and had two changes in their pain management medications.

In an interview, NM #104 indicated that the tool used to assess resident pain in the home was the pain assessment in the electronic documentation system for cognitively well residents and the Abbey pain assessment for cognitively impaired residents. NM #104 further indicated that registered staff would complete a pain assessment when a resident's pain is not controlled by the interventions in place, and refer to the NP or physician. NM #104 acknowledged that resident #001's pain was not assessed using a clinically appropriate tool when their pain was not managed by the initial interventions [s. 52. (2)]

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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #3: 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 Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

As required by Regulation O. Reg. 79/10, s. 114. (2) the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

A review was conducted of the home's Medication Administration policy under the subject titled General Policy, policy number G-05, reviewed on April 30, 2018. The policy instructed that any PRN medications administered are to be documented on the electronic medication administration record (e-MAR) including the time, reason for administration and effect.

Review of resident #001's physician orders showed that the resident had a PRN order for an identified analgesic medication. Review of progress note authored by RN #102 on an identified date, indicated resident #001 complained of pain and the identified analgesic was administered. Progress note authored by RN #102 on the following day, indicated that resident #001 complained of pain and and the identified analgesic was administered at a specified time.

Review of resident #001's e-MAR did not show documentation of the administration of the identified analgesic medication by RN #102 on the two above mentioned dates. RN #102 was not available for interview regarding the medication administration practices in the home.

In an interview, NM #104 indicated that the expectation for documentation of PRN medication under the Medical Directive was for registered staff to document at the time of administration in the e-MAR. NM #104 acknowledged that RN #102 had not documented the Tylenol administration on the above identified dates in the e-MAR and had not complied with the home's medication administration policy. [s. 8. (1) (a),s. 8. (1) (b)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 12th day of February, 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

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ADAM DICKEY (643)
Inspection No. / No de l'inspection :	2019_767643_0003
Log No. / No de registre :	033079-18, 033155-18, 000462-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 11, 2019
Licensee / Titulaire de permis :	The Wexford Residence Inc. 1860 Lawrence Avenue East, TORONTO, ON, M1R-5B1
LTC Home / Foyer de SLD :	The Wexford 1860 Lawrence Avenue East, SCARBOROUGH, ON, M1R-5B1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sandy Bassett

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

To The Wexford Residence Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

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 LTCHA 2007, c. 8, s. 19. (1).

The licensee shall prepare, submit and implement a plan to ensure that residents are free from neglect by the licensee or staff in the home.

The plan must include, but is not limited to the following:
1) Develop an internal auditing system to ensure when a Physician or Nurse Practitioner writes an order for diagnostic imaging to be carried out, a member of the registered staff completes and faxes a requisition form to the imaging company when cosigning the physician order form.
2) Develop an internal tracking system to monitor the status of diagnostic imaging service requisitions from the time of requisition to the time of receipt of imaging results.
3) Create a detailed description of all required steps to execute this action plan including the timelines, the person responsible to complete the action, and a completion date.

Please submit the written plan, quoting log number 2019_767643_0003 and Inspector Adam Dickey by email to TorontoSAO.moh@ontario.ca no later than February 28, 2019.

Grounds / Motifs :

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

Neglect as outlined in section 2. (1) of the Regulation (O. Reg. 79/10) means the failure to provide a resident with the treatment, care services or assistance

required for health, safety, or well-being, and includes inaction or pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Complaints were submitted to the Ministry of Health and Long-Term Care (MOHLTC) from the family of resident #001 concerning the falls prevention measures and pain management in place after a fall incident on an identified date. The complainants indicated that the resident did not have an x-ray of the suspected injury for eight days after the fall incident and was in pain as a result.

A Critical Incident System report (CIS) was submitted by the home, reporting the fall incident which resulted in a significant change in condition for resident #001. The CIS report indicated that on an identified date, resident #001 had a fall incident. No injury was noted at that time, though an x-ray conducted seven days later revealed an identified injury.

Resident #001's care plan indicated they were at risk for falls and had specified falls prevention and management interventions in place.

Review of resident #001's progress notes indicated that they had been found by PSW #107 to be climbing out of bed at an identified time. Resident #001 was attended by RN #112 who did not observe any obvious injury at the time. A referral was made to NP #109 who assessed resident #001 on the date of the fall incident, and observed pain, and a change in condition or altered skin integrity to an identified area and ordered an x-ray. A physician order for x-ray written by NP #109 was also completed on the date of the fall, and was checked by RN #110 and RN #112. A subsequent progress note four days later, authored by RN #102 indicated that x-ray requisition was faxed. Progress notes further indicated that the x-ray results were provided to the home seven days following the fall incident, showing findings consistent with an identified injury.

In an interview, NP #109 indicated that when the x-ray result was received confirming the injury, they knew it was a more painful condition. NP #109 indicated that registered staff advised them that resident #001 was still exhibiting pain and were worried the resident was still in pain. NP #109 ordered a specified medication for pain management.

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The severity of this issue was determined to be a level 3 as there was actual harm to resident #001. The scope of the issue was a level 1 as it related to one of the three residents reviewed. The home had a level 3 history of one or more related noncompliance in last 36 months for LTCHA 2007, c. 8. s. 19. (1) which included:

- Compliance Order (CO) issued September 7, 2016 (2016_321501_0009);
- Voluntary plan of correction (VPC) issued March 14, 2017 (2017_630589_0004); and
- Director's Order issued August 2, 2018. As a result a Compliance Order is warranted.
(643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 2019

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 11th day of February, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Adam Dickey

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