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

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 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
Nov 3, 2021	2021_659189_0002	005898-21	Complaint

Licensee/Titulaire de permis

Yee Hong Centre for Geriatric Care
2311 McNicoll Avenue Scarborough ON M1V 5L3

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

Yee Hong Centre - Mississauga
5510 Mavis Road Mississauga ON L5V 2X5

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

NICOLE RANGER (189), DEREGE GEDA (645)

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): September 9, 10, 14, 15, 16, 22, 23, October 4, 2021 (off- site), and September 17, 2021 on-site.

The following intake was completed in this complaint inspection:
Log #005898-21 related to Resident Charges.

During the course of the inspection, the inspector(s) spoke with the Director of Resident Care (DRC), Associate Director of Resident Care (ADRC), Foot Care Nurse, Registered nurse, Registered practical nurses, personal support workers, and family members.

During the course of the inspection, the inspectors conducted observations of the home, including staff to resident interactions, and reviewed clinical health records, policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Resident Charges

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **2 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 O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident of the home received preventive

and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

The Ministry of Long-Term Care (MLTC) received a complaint related to foot care service charges for resident #001. The complainant indicated that the home did not provide foot care services, including the cutting of toenails, for residents.

RN #103 identified that the admission process included written information on the home's foot care program. During the admission process, families were required to choose and consent to the available options which included paying for Chiropody services or performing the care themselves.

Upon admission to the home, resident #001's Substitute Decision-Maker (SDM) declined chiropody services and chose to provide the resident foot care services, including cutting of toenails themselves for resident #001.

PSWs #106 and #107 indicated they do not provide basic foot care services including cutting of the toenails to residents, as they were told by management that PSWs were not required to provide foot care. When showering or bathing residents, the PSWs would clean and observe the residents feet, but they did not cut the residents' toenails.

A review of the Chiropody Treatment list , reported that 30 out of 43 residents on an identified floor received chiropody services. In a interview with RPN #109, who the home identified as the foot care nurse, revealed that they did not provide foot care services to any residents in the home, as all of the current residents met the criteria of having high risk conditions. RPN #109 confirmed that foot care is provided either by a chiropodist or by the family of residents.

Due to the COVID-19 pandemic, there was a period when family members (essential caregivers) were not permitted to visit the residents indoors. During this time, families who provided foot care services to residents were contacted to obtain verbal consent for the resident to receive chiropody services for a cost. The home also did not provide basic foot care services to residents during this time. Interview with PSW #106 who worked in the home for 17 years, indicated that they never provided foot care services to the residents.

Inspector #645 conducted observations on an identified date and observed resident #002 in their room. The resident required foot care services. The inspector observed resident

#003 in their room, with family members present. The family members indicated that the home does not provide basic foot care for residents and they provide the care. They stated that resident #003 did not require chiropody services as the resident was not high risk. The family member stated that during the COVID-19 outbreak, they were unable to provide foot care as they were not allowed in the home and had to pay a fee for the chiropodist to provide foot care to the resident.

The Director of Resident Care (DRC) and the Assistant Director of Resident Care (ARDC) stated that as part of the admission process, the foot care options are reviewed with families to decide. If residents met the criteria of having high risk conditions, foot care services are provided either by a chiropodist or the family will have to make their own arrangements . The DRC and ARDC acknowledged that there are currently no residents in the home they provide basic foot care services to, and that foot care services are provided by the chiropodist or family members.

Sources: Review of resident #001, #002, #003's clinical health records, progress notes, chiropody list, inspector observations, interview with family members on- site, and interviews with RPN #109, RN #103, DRC #100, ARDC #108, PSW#106 and #107. [s. 35. (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 LTCHA, 2007 S.O. 2007, c.8, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (2) The agreement referred to in paragraphs 2 and 3 of subsection (1) must be a written agreement with the resident or a person authorized to enter into such an agreement on the resident's behalf. 2007, c. 8, s. 91 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written agreement was in place with residents (or their authorized representative) for charges for advanced (specialized) foot care services

According to LTCHA s. 91(1)3. A licensee shall not charge a resident for anything, except in accordance with the following: For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount.

According to LTCHA s. 91(2), the agreement referred to in paragraphs 2 and 3 of subsection (1) must be a written agreement with the resident or a person authorized to enter into such an agreement on the resident's behalf.

The MLTC received a complaint related to foot care service charges for resident #001. The complainant indicated that the home did not obtain written consent for Chiropody services, which is beyond basic foot care services.

Resident #001's SDM was the primary/designated caregiver for the resident and participated in many care related activities. Resident #001 was high risk and required specialized/advanced foot care services.

Due to the COVID-19 pandemic, there was a period when resident #001’s SDM was not permitted to visit the resident indoors. This resulted in the SDM being unable to provide foot care to the resident and on an identified date, resident #001’s SDM provided a one-time verbal consent for foot care to be provided by a Chiropodist.

Staff interviews confirmed that the consent for Chiropody was obtained verbally and not in writing. There was no written agreement at any time with the resident or SDM for the chiropody (advanced foot care) charges.

The sample of residents was expanded and staff identified that the consent for Chiropody was obtained verbally and not by written agreement for residents #002, #003, #004, and #006. There was no written agreement at any time with the resident or their authorized representative for these advanced foot care charges.

Sources: Review of resident #001, #002, #003, #004, #006's clinical health record, progress notes, chiropody billing, and interviews with RPN #101, #105, DRC #100 and ARDC #108. [s. 91. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 19th day of November, 2021

[redacted]

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) :	NICOLE RANGER (189), DEREGE GEDA (645)
Inspection No. / No de l'inspection :	2021_659189_0002
Log No. / No de registre :	005898-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 3, 2021
Licensee / Titulaire de permis :	Yee Hong Centre for Geriatric Care 2311 McNicoll Avenue, Scarborough, ON, M1V-5L3
LTC Home / Foyer de SLD :	Yee Hong Centre - Mississauga 5510 Mavis Road, Mississauga, ON, L5V-2X5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chau Nhieu-Vi

To Yee Hong Centre for Geriatric Care, 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

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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Order / Ordre :

The licensee must be compliant with s. 35 (1) of O. Reg. 79/10.

Specifically, the licensee shall ensure the following:
1. Immediately provide residents preventative and basic foot care services, including cutting of toenails.
2. Include details on admission and in the admission package (in writing) related to basic foot care services provided by the home and outlining the procedure and any related costs for specialized or advanced foot care services, subject to a written agreement with the resident or person authorized to enter in an agreement on the resident's behalf for any charges for specialized or advanced foot care services.
3. Revise the home's policy on foot care services to clearly identify the staff members responsible for providing preventative and basic foot care services, including cutting of toenails to residents. Outline the procedure, including written agreement (with resident or authorized representative), required assessments, referrals, and consent when specialized or advanced foot care services are necessary.
4. Educate all PSWs and registered staff on the home's revised policy on preventative and basic foot care services. Maintain a record of the education provided including the content, facilitator, attendees, dates, and times.

The above mentioned documentation shall be made available to the inspector upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that every resident of the home received

preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

The Ministry of Long-Term Care (MLTC) received a complaint related to foot care service charges for resident #001. The complainant indicated that the home did not provide foot care services, including the cutting of toenails, for residents.

RN #103 identified that the admission process included written information on the home's foot care program. During the admission process, families were required to choose and consent to the available options which included paying for Chiropody services or performing the care themselves.

Upon admission to the home, resident #001's Substitute Decision-Maker (SDM) declined chiropody services and chose to provide the resident foot care services, including cutting of toenails themselves for resident #001.

PSWs #106 and #107 indicated they do not provide basic foot care services including cutting of the toenails to residents, as they were told by management that PSWs were not required to provide foot care. When showering or bathing residents, the PSWs would clean and observe the residents feet, but they did not cut the residents' toenails.

A review of the Chiropody Treatment list , reported that 30 out of 43 residents on an identified floor received chiropody services. In a interview with RPN #109, who the home identified as the foot care nurse, revealed that they did not provide foot care services to any residents in the home, as all of the current residents met the criteria of having high risk conditions. RPN #109 confirmed that foot care is provided either by a chiropodist or by the family of residents.

Due to the COVID-19 pandemic, there was a period when family members (essential caregivers) were not permitted to visit the residents indoors. During this time, families who provided foot care services to residents were contacted to obtain verbal consent for the resident to receive chiropody services for a cost. The home also did not provide basic foot care services to residents during this time. Interview with PSW #106 who worked in the home for 17 years, indicated that they never provided foot care services to the residents.

Inspector #645 conducted observations on an identified date and observed resident #002 in their room. The resident required foot care services. The inspector observed resident #003 in their room, with family members present. The family members indicated that the home does not provide basic foot care for residents and they provide the care. They stated that resident #003 did not require chiropody services as the resident was not high risk. The family member stated that during the COVID-19 outbreak, they were unable to provide foot care as they were not allowed in the home and had to pay a fee for the chiropodist to provide foot care to the resident.

The Director of Resident Care (DRC) and the Assistant Director of Resident Care (ARDC) stated that as part of the admission process, the foot care options are reviewed with families to decide. If residents met the criteria of having high risk conditions, foot care services are provided either by a chiropodist or the family will have to make their own arrangements . The DRC and ARDC acknowledged that there are currently no residents in the home they provide basic foot care services to, and that foot care services are provided by the chiropodist or family members.

Sources: Review of resident #001, #002, #003's clinical health records, progress notes, chiropody list, inspector observations, interview with family members on-site, and interviews with RPN #109, RN #103, DRC #100, ARDC #108, PSW#106 and #107.

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

Severity: This issue was determined to be minimal harm or minimal risk of harm, as residents not being provided foot care could lead to discomfort and infection.

Scope: This is a widespread issue in the home, as no residents were provided preventative or basic foot care services.

Compliance History: In the past 36 months, the licensee was found to be non-compliant with one or more unrelated requirements of the Act.
(189)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Dec 10, 2021

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 : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 91. (2) The agreement referred to in paragraphs 2 and 3 of subsection (1) must be a written agreement with the resident or a person authorized to enter into such an agreement on the resident's behalf. 2007, c. 8, s. 91 (2).

Order / Ordre :

The licensee must be compliant with s. 91 (2) of the Long-Term Care Homes Act (LTCHA).

1. Specifically, for residents #001, #002, #003, #004, #006 and any other residents who do not have written agreements for charges for advanced (or specialized) foot care services , the licensee must enter into a written agreement with the resident or a person authorized to enter into such an agreement on the resident's behalf for the advanced (specialized) foot care charges.

2. For any resident seeking advanced (or specialized) foot care services (or for anything other than accommodation), in accordance s. 91(1)3. of the LTCHA, the licensee must ensure that a resident is charged only if it was provided under a written agreement with the resident or a person authorized to enter into such an agreement on the resident's behalf.

Grounds / Motifs :

1. The licensee has failed to ensure that a written agreement was in place with residents (or their authorized representative) for charges for advanced (specialized) foot care services

According to LTCHA s. 91(1)3. A licensee shall not charge a resident for anything, except in accordance with the following: For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount.

According to LTCHA s. 91(2), the agreement referred to in paragraphs 2 and 3 of subsection (1) must be a written agreement with the resident or a person authorized to enter into such an agreement on the resident's behalf.

The MLTC received a complaint related to foot care service charges for resident #001. The complainant indicated that the home did not obtain written consent for Chiropody services, which is beyond basic foot care services.

Resident #001's SDM was the primary/designated caregiver for the resident and participated in many care related activities. Resident #001 was high risk and required specialized/advanced foot care services.

Due to the COVID-19 pandemic, there was a period when resident #001's SDM was not permitted to visit the resident indoors. This resulted in the SDM being unable to provide foot care to the resident and on an identified date, resident #001's SDM provided a one-time verbal consent for foot care to be provided by a Chiropodist.

Staff interviews confirmed that the consent for Chiropody was obtained verbally and not in writing. There was no written agreement at any time with the resident or SDM for the chiropody (advanced foot care) charges.

The sample of residents was expanded and staff identified that the consent for Chiropody was obtained verbally and not by written agreement for residents #002, #003, #004, and #006. There was no written agreement at any time with the resident or their authorized representative for these advanced foot care charges.

Sources: Review of resident #001, #002, #003, #004, #006's clinical health record, progress notes, chiropody billing, and interviews with RPN #101, #105, DRC #100 and ARDC #108

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

Severity: This issue was determined to be minimal harm or minimal risk of harm, as the home did not obtain prior written agreements for Chiropody services as per s. 91(2) of the LTCHA.

Scope: This is a widespread issue in the home, as 3 out of 3 residents reviewed did not have written agreements in place.

Compliance History: In the past 36 months, the licensee was found to be non-compliant with one or more unrelated requirements of the Act. (189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 10, 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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 3rd day of November, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : NICOLE RANGER

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