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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
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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 27, 2021	2021_595110_0006	022478-19, 003374-21, 003416-21	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

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

Extendicare Guildwood
60 Guildwood Parkway Scarborough ON M1E 1N9

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

DIANE BROWN (110)

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): April 22, 23, 26-29, 2021.

Log #022478-19 a follow up to a previous compliance order #002 related to failing to provide at least one registered nurse who is an employee of the licensee on duty and present at all times.
Log #003416-21 a follow up to a previous compliance order #001 related to staffs lack of adherence to the home's fall prevention policy and procedures.
Log #003374-21 a critical incident related to a resident injury of unknown cause.

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Director of Care, Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Activity Aide, Personal Support Workers (PSW).

During the course of the inspection the Inspector toured resident home areas, conducted resident observations and interviews; reviewed clinical records and relevant policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 8. (1)	CO #001	2021_838760_0005	110
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #002	2019_702197_0025	110

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 failed to ensure residents are protected from abuse by anyone and free

from neglect by the licensee or staff in the home.

For the purposes of the Act and Regulations, O.Reg. 79/10, s. 5 "neglect" 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 a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A critical incident was forwarded to the Ministry of Long-Term Care reporting resident #001's injury of unknown cause.

Personal Support Worker #119 identified an area of altered skin integrity on resident #001. The PSW stated the resident was crying and holding this area, but could not question the resident because of a communication barrier. A pain assessment was completed and pain medication was administered by a registered staff.

PSW #119 worked the following 5 consecutive shifts and stated the resident would scream a long time and was resistant to care and not wanting to be touched. The PSW revealed they noticed that the resident cried and screamed more than usual and the screaming hurt their ears. The PSW shared they reported it to the RN.

A record review of the medication administration record failed to identify any pain medication being administered during any shift over the 5 day period.

Over the same five day period, days and evening shifts, PSW confirmed awareness that the resident had pain in an area and they could not touch the area during care. All staff interviews identified that due to the communication barrier they could not communicate with the resident. Staff identified the resident was cognitively aware and in the past would cry out but the communication barrier prevented them from understanding the cause of the resident's distress. Over the 5 day period no pain assessments were conducted.

A physician note on day two, identified the presence of pain to an area of the resident's body, suspecting trauma and for staff to monitor. No follow up or monitoring was evident. Registered staff were unaware of the physician's note and communications.

On day three the resident was transferred to a mobility aid to attend a program in the lounge. The activity aide present identified that the resident at the program and that they appeared to be in pain demonstrating uncommon shouting outbursts so they returned the resident to their room and reported it to either a PSW or registered staff. The activity aide

revealed no prior awareness of the resident's injury or pain. No pain assessment was completed or pain medication administered on day three.

On day five a PSW reported the presence of pain while attempting care. The PSW stated the resident was shouting and crying and revealed an area of altered skin integrity. A pain assessment and pain medication was administered and an X-ray was ordered. The X-ray reported a significant change in the resident's health status. An interview with the physiotherapist identified that the pain level with this type of injury would be very high.

A review of the home's critical incident investigation and an interview with the DOC revealed a failure to identify the lack of pain management and collaboration and the need for communication strategies for resident #001 with a known communication barrier.

The licensee demonstrated a pattern of inaction by failing to provide care related to pain management, failing to collaborate in the resident's altered skin integrity and failing to provide the resident an opportunity to communicate their injury and pain, all jeopardizing the health, safety and well-being of resident #001.

Sources: X- ray report, medication administration record, progress notes, pain assessments, staff interviews with PT #103, PSWs #105, #106, #107, #119, #114, RPN #118, #111, RN #112, activity aide #116. [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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Personal Support Worker (PSW) #119 identified an area of altered skin integrity on resident #001. The PSW stated the resident was crying and holding this area, but could not question the resident because of a communication barrier. A pain assessment was completed and pain medication was administered by a registered staff

The next shift PSW, #114, reported that when they started care the resident was screaming and did not want them to touch an area on their body. The resident was pointing to an area of their body. The PSW stated they reported the concern to the days RPN who stated they were aware of it and to keep the resident in bed. No pain assessment was completed or no pain medication administered for the remainder of day. An interview with days RPN recalled the prior shift reporting the area of altered skin integrity but could not recall resident concerns related to pain.

The following two days PSW #114 stated it was same schedule because of the resident's pain, they tried not to touch the resident, they stayed in bed with no attempts made to move them. The PSW restated that when they touched an area of the resident's body they would cry and scream and that it was not normal for them to cry and scream during care. During the two days an evening RPN documented that the resident was awake and started crying and screaming. The writer documented that they talked to them, consoled them by spending time. An interview with the RPN revealed they were unaware of the resident's concerns or potential pain related to the resident's communication barrier and that the resident could cry out at times. No pain assessment was completed

or no pain medication administered.

A physician note on day two, identified the presence of pain to an area of the resident's body, suspecting trauma and for staff to monitor. No follow up or monitoring was evident. Registered staff interviewed revealed an unawareness of the physician's note and communications until the Inspector questioned it. No pain assessment was completed or pain medication administered despite the physician's documentation and PSW statements of the presence of resident #001's pain.

On day three the resident was transferred to a mobility aid to attend a program in the lounge. The activity aide confirmed the resident attended the program and stated they appeared to be in pain demonstrating uncommon shouting outbursts so they returned the resident to their room and reported it to either a PSW or registered staff. The activity aide revealed no prior awareness of the resident's injury or pain. An interview with the day RPN, working day three shared that they had no knowledge of the resident's pain and that nothing had been reported. No pain assessment was completed or no pain medication administered on day three.

On day five a PSW reported the presence of pain while attempting care. The PSW stated the resident was shouting and crying and revealed an area of altered skin integrity. A pain assessment and pain medication was administered and an x-ray was ordered. The x-ray reported a significant change in the residents health status. An interview with the physiotherapist identified that the pain level with this type of injury would be very high.

The licensee failed to ensure staff and others collaborate in the management of resident #001's pain.

Sources: Staff interviews including registered staff, activity aides and personal support workers; medication administration record, multi-month participation report and progress notes.

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies are developed and implemented to meet the needs of those residents with compromised communication and verbalization skills, residents with cognitive impairment and residents who cannot communicate in the languages used in the home.

Resident #001 had a specified communication barrier. Most staff interviewed were unsure of what language the resident spoke. The resident's written plan of care directed staff to ask the resident to communicate in a manner that they were unable to do.

During the inspection the Inspector and a PSW entered the resident's room. The resident began communicating with Inspector. The Inspector followed the care plan directions for communicating with the resident, which asked the resident to communicate in a manner that they were unable to do.

Staff interviews confirmed that they were often unaware of what the resident was saying, asking or talking about and that the resident was social and often verbal but there was a communication barrier.

Resident #001 had an injury resulting in pain for several days that was later was discovered as a significant change in the resident's health status. During this time the resident was not provided an opportunity to communicate, to express their pain or asked what may have happened to their unwitnessed injury resulting in a significant change.

The licensee failed to provide strategies to meet the communication needs of resident #001.

Sources: Resident Observations and Interview, record review of plan of care and X-ray report, medication administration records, specifically related to pain management. Interviews with PSWs #105, #106, #107, #108, #109, #114, #119, Activity Aide #116, RPN #111, #117 and #118. [s. 43.]

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 strategies are developed and implemented to meet the needs of those residents with compromised communication and verbalization skills, residents with cognitive impairment and residents who cannot communicate in the languages used in the home, to be implemented voluntarily.

Issued on this 21st day of June, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	DIANE BROWN (110)
Inspection No. / No de l’inspection :	2021_595110_0006
Log No. / No de registre :	022478-19, 003374-21, 003416-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 27, 2021
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, Markham, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Guildwood 60 Guildwood Parkway, Scarborough, ON, M1E-1N9
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Deslyn Willock

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19.(1) of the LTCH Act.

Specifically, the licensee must:

1. Develop a plan to ensure communication is established for resident #001.
2. Develop a plan to ensure timely response to those resident's experiencing pain.
3. Set up a system/process to follow through on physician communications, to determine appropriate next actions.
4. Keep a record of plans, systems/processes identified in steps 1-3 for review by an Inspector.

Grounds / Motifs :

1. The licensee failed to ensure residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

For the purposes of the Act and Regulations, O.Reg. 79/10, s. 5 "neglect" 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 a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A critical incident was forwarded to the Ministry of Long-Term Care reporting resident #001's injury of unknown cause.

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but could not question the resident because of a communication barrier. A pain assessment was completed and pain medication was administered by a registered staff.

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A record review of the medication administration record failed to identify any pain medication being administered during any shift over the 5 day period.

Over the same five day period, days and evening shifts, PSW confirmed awareness that the resident had pain in an area and they could not touch the area during care. All staff interviews identified that due to the communication barrier they could not communicate with the resident. Staff identified the resident was cognitively aware and in the past would cry out but the communication barrier prevented them from understanding the cause of the resident's distress. Over the 5 day period no pain assessments were conducted.

A physician note on day two, identified the presence of pain to an area of the resident's body, suspecting trauma and for staff to monitor. No follow up or monitoring was evident. Registered staff were unaware of the physician's note and communications.

On day three the resident was transferred to a mobility aid to attend a program in the lounge. The activity aide present identified that the resident at the program and that they appeared to be in pain demonstrating uncommon shouting outbursts so they returned the resident to their room and reported it to either a PSW or registered staff. The activity aide revealed no prior awareness of the resident's injury or pain. No pain assessment was completed or pain medication administered on day three.

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and an X-ray was ordered. The X-ray reported a significant change in the resident's health status. An interview with the physiotherapist identified that the pain level with this type of injury would be very high.

A review of the home's critical incident investigation and an interview with the DOC revealed a failure to identify the lack of pain management and collaboration and the need for communication strategies for resident #001 with a known communication barrier.

The licensee demonstrated a pattern of inaction by failing to provide care related to pain management; failing to collaborate in the resident's altered skin integrity and failing to provide the resident an opportunity to communicate their injury and pain, all jeopardizing the health, safety and well-being of resident #001.

Sources: X- ray report, medication administration record, progress notes, pain assessments, staff interviews with PT #103, PSWs #105, #106, #107, #119, #114, RPN #118, #111, RN #112, activity aide #116. [s. 19. (1)]

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

Severity: There was actual harm to resident #001, when the resident experienced prolonged periods of pain caused by an unknown fracture with no pain assessments or medication and no opportunity to communicate pain and cause of injury.

Scope: The scope of this non-compliance was isolated as only one resident was inspected related to neglect.

Compliance History: The licensee has a past non-compliance with a compliance order to the same section on March 8, 2019, under inspection #2019_414100_0003.

(110)

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 : Jun 30, 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

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

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 27th day of May, 2021

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : DIANE BROWN

Service Area Office /
Bureau régional de services : Central East Service Area Office