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
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Bureau régional de services de Toronto
5700 rue Yonge 5e étage
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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
Mar 18, 2019	2019_641665_0005	001181-19	Critical Incident System

Licensee/Titulaire de permis

Kristus Darzs Latvian Home
11290 Pine Valley Drive Woodbridge ON L4L 1A6

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

Kristus Darzs Latvian Home
11290 Pine Valley Drive Woodbridge ON L4L 1A6

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

JOY IERACI (665)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 22, 25, 28, March 1, 5, 6, 7, 8 and 11, 2019. Off site on March 12 and 13, 2019.

The following intake Log #001181-19/CIS #C533-000002-19 related to staff to resident abuse was inspected.

PLEASE NOTE: A Compliance Order #001 related to LTCHA, 2007, c.8, s. 6 (7),was identified in this inspection and has been issued in a Complaints Inspection Report #2019_641665_0004, dated March 18, 2019, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Quality Lead (QL), Resident Support Manager (RSM), Nurse Practitioner (NP), Facilities Manager (FM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Substitute Decision Maker (SDM) and residents.

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

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 :

The licensee has failed to ensure that residents were protected from abuse by anyone.

The Ministry of Health and Long Term Care (MOHLTC) received a critical incident system (CIS) report for staff to resident abuse for an incident that occurred on an identified date. A review of the CIS report indicated that on an identified date, resident #002 informed NP #122 that they were injured on a specified day of the week and shift by a person who provided care, which caused altered skin integrity and pain to two specified areas of the body.

In an interview, NP #122 indicated that on their visit to the home on an identified date, they received a request from the unit staff to assess resident #002 for their complaint of pain to the specified area of the body. The NP stated that during their assessment, the resident reported that they were injured when a staff member provided care. In the interview, the NP indicated that the resident made an allegation of abuse and informed the charge nurse and left a voicemail with the DOC the same day.

A record review of the home's investigation notes indicated that the ED interviewed resident #002 four days after the resident reported the incident. The resident indicated that during an identified time period, a staff member came to assist them off the toilet and into bed. The resident indicated that the staff grabbed them roughly, which caused marks to an identified area of the body, and the resident screamed out loud. The interview notes indicated that the ED documented that marks were visible. Resident #002 further indicated that the identified staff was very rough and felt like they were thrown on the bed and the way the staff grabbed a specified extremity caused an area of altered skin integrity. The resident stated that a registered staff came in and saw the area of altered skin integrity and provided treatment.

The following day, the investigation notes further indicated that the resident visually identified the staff member as being PSW #123. The DOC spoke to the resident regarding the incident, and the resident again recounted that they were treated roughly when they were transferred to bed by PSW #123. The resident informed the DOC that they screamed and was in pain. The resident indicated that they did not report the incident to the nurse when they provided treatment to the altered skin integrity. In addition, the police came to the home, and resident #002 had informed them that PSW #123 was rough when they were transferred from the toilet, was scared and afraid, and had pain to three identified areas of the body.

During an interview, resident #002 was not able to recall the incident. In interviews, RPNs #117 and #121, PSW #120 and the DOC indicated that there had been a recent

change in the resident's cognitive status. The DOC indicated that the resident was cognitively aware at the time of the incident.

In an interview, RPN #117 indicated that on an identified shift and date, PSW #123 informed them that the resident had an area of altered skin integrity. The RPN stated that they went into the resident's room and found the resident in the washroom sitting on the toilet crying and observed the altered skin integrity.

Attempts to contact PSW #123 during this inspection were unsuccessful.

A review of the progress note made by RPN #117 and the skin and wound assessment on an identified date indicated the presence of the altered skin integrity and its specified measurements.

Another progress note made by NP #122 after their assessment of the resident, indicated that the resident complained of pain to identified areas of the body with an identified limitation and characteristic, and was prescribed medications to manage the pain.

In interviews, the DOC and ED indicated that the home conducted an investigation and disciplined PSW #123 for treating resident #002 roughly during care. The ED stated that the resident was consistent with their story and had told the home and the police they were scared of PSW #123. Both the DOC and ED indicated that PSW #123 had a history of providing care fast to residents and was previously disciplined related to care provision to another resident. The ED stated PSW #123 denied resident #002's allegations and had resigned. Both the DOC and ED considered the incident to be abuse towards resident #002 by PSW #123.

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The home submitted a CIS report on an identified date, regarding staff to resident abuse related to resident #002. A review of the CIS report indicated that five days prior to the CIS submission, resident #002 informed NP #122 that they were injured on a specified day of the week and shift by a person who provided care, which caused altered skin integrity and pain to two specified areas of the body. The CIS was submitted by FM #105.

A review of the progress note made by NP #122, indicated that they reported resident #002's allegation to the charge nurse and DOC after their assessment of the resident.

In an interview, NP #122 indicated resident #002 made an allegation of abuse and that they had informed the charge nurse and left a voicemail with the DOC.

In an interview, FM #105 indicated that they were informed by the NP of resident #002's allegation the day the NP assessed the resident. The FM stated that any allegation of abuse was to be reported to the Director immediately, however, resident #002's allegation of staff to resident abuse was not reported to the Director immediately, as they submitted the CIS report five days after the home was made aware of the allegation.

In an interview, the DOC indicated that any allegation of abuse was to be reported to the Director immediately. The DOC acknowledged that the allegation of abuse by resident #002 was not reported immediately to the Director. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The home has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Resident #003 was randomly selected to expand the sample for non-compliance identified for resident #002.

A review of the progress note made by RPN #103 on an identified date, indicated that PSW #119 reported resident #003's altered skin integrity.

A review of the assessment tab in point click care (PCC) did not locate a skin and wound assessment for the altered skin integrity of resident #003.

In an interview, RPN #103 indicated it is the home's process for a skin and wound assessment to be completed upon discovery of altered skin integrity. The RPN reviewed the assessment tab in PCC and acknowledged that they did not complete a skin and wound assessment for resident #003's altered skin integrity as per the home's process.

In interviews, FM #105 and the DOC indicated that it is the home's process for skin and

wound assessments to be completed upon discovery of altered skin integrity. They acknowledged that RPN #103 failed to ensure that resident #003 received a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered staff.

The home submitted a CIS report on an identified date, regarding staff to resident abuse related to resident #002 where the resident sustained an area of altered skin integrity when care was provided by staff.

A review of the clinical records indicated a progress note by RPN #117 dated on an identified date, documenting resident #002's altered skin integrity.

A review of the resident's electronic treatment administration record (ETAR) for an identified month indicated that the altered skin integrity healed on a specified date, 19 days after it had occurred. A review of the skin and wound assessments in the assessment tab in PCC indicated that weekly skin and wound assessments were completed weekly for two specified weeks. Weekly skin and wound assessment was not completed weekly for a period of 14 days.

In interviews, RPN #121 and FM #105 indicated it is the home's process for weekly skin and wound assessments to be completed. The FM indicated that staff failed to ensure that resident #002 received weekly skin assessment for their altered skin integrity for two identified weeks.

In an interview, the DOC indicated it is important to complete weekly skin and wound assessments for altered skin integrity to monitor for infection and healing. The DOC acknowledged that resident #002 did not have their altered skin integrity reassessed at least weekly for two identified weeks, as per the home's process. [s. 50. (2) (b) (iv)]

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 26th day of March, 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) :	JOY IERACI (665)
Inspection No. / No de l'inspection :	2019_641665_0005
Log No. / No de registre :	001181-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 18, 2019
Licensee / Titulaire de permis :	Kristus Darzs Latvian Home 11290 Pine Valley Drive, Woodbridge, ON, L4L-1A6
LTC Home / Foyer de SLD :	Kristus Darzs Latvian Home 11290 Pine Valley Drive, Woodbridge, ON, L4L-1A6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lauma Stikuts

To Kristus Darzs Latvian Home, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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.6 (7) of the LTCHA, 2007.

Specifically the licensee must:

a) Ensure that resident #002 is protected from abuse by staff.

b) Audit the provision of care provided by staff who have been identified with documented care concerns and complaints related to the provision of care to ensure that appropriate actions have been taken to prevent abuse. Include the name of the auditor, the care concern and or complaint, name of complainants, name of staff being audited and action(s) taken.

c) Ensure any allegation of abuse by resident #002 and any other residents is reported immediately to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

The Ministry of Health and Long Term Care (MOHLTC) received a critical incident system (CIS) report for staff to resident abuse for an incident that occurred on an identified date. A review of the CIS report indicated that on an identified date, resident #002 informed NP #122 that they were injured on a specified day of the week and shift by a person who provided care, which caused altered skin integrity and pain to two specified areas of the body.

In an interview, NP #122 indicated that on their visit to the home on an identified

date, they received a request from the unit staff to assess resident #002 for their complaint of pain to the specified area of the body. The NP stated that during their assessment, the resident reported that they were injured when a staff member provided care. In the interview, the NP indicated that the resident made an allegation of abuse and informed the charge nurse and left a voicemail with the DOC the same day.

A record review of the home's investigation notes indicated that the ED interviewed resident #002 four days after the resident reported the incident. The resident indicated that during an identified time period, a staff member came to assist them off the toilet and into bed. The resident indicated that the staff grabbed them roughly, which caused marks to an identified area of the body, and the resident screamed out loud. The interview notes indicated that the ED documented that marks were visible. Resident #002 further indicated that the identified staff was very rough and felt like they were thrown on the bed and the way the staff grabbed a specified extremity caused an area of altered skin integrity. The resident stated that a registered staff came in and saw the area of altered skin integrity and provided treatment.

The following day, the investigation notes further indicated that the resident visually identified the staff member as being PSW #123. The DOC spoke to the resident regarding the incident, and the resident again recounted that they were treated roughly when they were transferred to bed by PSW #123. The resident informed the DOC that they screamed and was in pain. The resident indicated that they did not report the incident to the nurse when they provided treatment to the altered skin integrity. In addition, the police came to the home, and resident #002 had informed them that PSW #123 was rough when they were transferred from the toilet, was scared and afraid, and had pain to three identified areas of the body.

During an interview, resident #002 was not able to recall the incident. In interviews, RPNs #117 and #121, PSW #120 and the DOC indicated that there had been a recent change in the resident's cognitive status. The DOC indicated that the resident was cognitively aware at the time of the incident.

In an interview, RPN #117 indicated that on an identified shift and date, PSW #123 informed them that the resident had an area of altered skin integrity. The

RPN stated that they went into the resident's room and found the resident in the washroom sitting on the toilet crying and observed the altered skin integrity.

Attempts to contact PSW #123 during this inspection were unsuccessful.

A review of the progress note made by RPN #117 and the skin and wound assessment on an identified date indicated the presence of the altered skin integrity and its specified measurements.

Another progress note made by NP #122 after their assessment of the resident, indicated that the resident complained of pain to identified areas of the body with an identified limitation and characteristic, and was prescribed medications to manage the pain.

In interviews, the DOC and ED indicated that the home conducted an investigation and disciplined PSW #123 for treating resident #002 roughly during care. The ED stated that the resident was consistent with their story and had told the home and the police they were scared of PSW #123. Both the DOC and ED indicated that PSW #123 had a history of providing care fast to residents and was previously disciplined related to care provision to another resident. The ED stated PSW #123 denied resident #002's allegations and had resigned. Both the DOC and ED considered the incident to be abuse towards resident #002 by PSW #123.

The severity of this issue was determined to be a level three, as there was actual harm to resident #002. The scope of this issue was a level one, as it was isolated to resident #002. The home had a level four compliance history with the same area of non compliance that included:
- A compliance order was issued April 16, 2018, under inspection #2018_712665_0004. (665)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 19, 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 18th day of March, 2019

Signature of Inspector /
Signature de l'inspecteur :

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

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