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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém 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
May 7, 2019	2019_778563_0012	003165-18, 008891-18, 010816-18, 015099-18	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way THOROLD ON L2V 4T7

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

Northland Pointe
2 Fielden Avenue PORT COLBORNE ON L3K 6G4

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

MELANIE NORTHEY (563), CHERYL MCFADDEN (745)

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 23, 24, 25 and 26, 2019

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care, the Long Term Care Program Manager, Registered Practical Nurses, Registered Nurses, Personal Support Workers and residents

The inspector(s) also made observations of residents, care provided and medication administration. The home's investigation notes, relevant policies and procedures, as well as clinical records, medication records and plans of care for identified residents were reviewed.

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

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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance

with the directions for use specified by the prescriber.

A) The Critical Incident (CI) Report documented that a resident was administered a higher dose of a medication than what was prescribed.

The Medical Pharmacies Combined Monitored Medication Record with Shift Count documented that the Registered Practical Nurse (RPN) administered the incorrect dose of a controlled substance twice during their shift.

The Director of Resident Care (DRC) verified the RPN did not administer the medication to the resident as ordered by the physician.

The College of Nurses of Ontario Report Form for Facility Operators and Employers documented that the RPN administered the incorrect dose and scratched out documentation on the count sheet to appear correct.

"Documentation of Narcotics and Controlled Meds" power point was presented by the Clinical Consultant Pharmacist and there was an in-service for the registered staff that included a visual assistance tool for injectable controlled substance. There was also a review of independent double checks, multiple doses from the same vial, and a method of counting injectable controlled substances.

The licensee failed to ensure that the controlled substance was administered to the resident in accordance with the directions for use specified by the prescriber.

B) The Critical Incident (CI) Report documented that a resident had a physician's order for the administration of a controlled substance. A Registered Nurse (RN) had insisted on administering the doses of medication to the resident and normally the Registered Practical Nurse (RPN) would administer this medication to the resident.

The electronic Medication Administration Record (eMAR) for the resident documented that the RN signed for the administration of the routine controlled substance that was due at a specific time. The Medical Pharmacies Combined Monitored Medication Record with Shift Count documented the RN signed the record as administering the medication at that specific time.

The handwritten statement by the RPN documented that the RN administered the resident's scheduled controlled substance at a specific time and informed the RPN

afterwards. The statement also documented that the resident had unusual behaviours that day and this would have only occurred if the resident did not get their scheduled medication.

For other dates in early 2018, the RN signed the eMAR for the resident's administration of the controlled substance. In an interview with the RN with the Director of Resident Care and the Administrator, the RN admitted to "diverting some of the medications" for personal use.

The Director of Resident Care (DRC) stated the RN admitted to taking the controlled substance dose for themselves. The DRC read the physician's order for the resident and stated that the dose was signed by the RN as part of the eMAR and documented on the Combined Monitored Medication Record with Shift Count, but was never administered to the resident.

The College of Nurses of Ontario Report Form for Facility Operators and Employers documented the theft of both regularly administered and PRN controlled substances which the RN self administered while on duty on multiple occasions. The RN confessed and the Niagara Regional Police were notified and an incident was filed. The home provided education to the registered staff related to "Improved narcotic/controlled substance practice" and completed audits.

The licensee failed to ensure that the controlled substance was administered to the resident in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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. 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 failed to ensure that medication management policies instituted or otherwise put in place were complied with.

Ontario Regulation 79/10 s. 114 (2) states, "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."

Ontario Regulation 79/10 r. 136 (1) states, “Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of” drugs.

A) The Critical Incident (CI) Report documented that a resident had a physician’s order for the administration of a controlled substance. A Registered Nurse (RN) had insisted on administering the doses of medication to the resident and normally the Registered Practical Nurse (RPN) would administer this medication to the resident.

The home's investigation notes included an interview with the RN with the Director of Resident Care (DRC) and the Administrator. The following was documented during that interview:

i) The RN stated they were “suffering from substance abuse issues. Recently I have diverted some of the medications. First just the waste (wasted narcotics) but recently it has got worse.” The RN admitted to pre-drawing a dose of medication for a resident and the RN consumed the wasted dose and replaced the medication for waste with water for

the witnessed destruction of the controlled substance.

ii) The RN's interview documented, "Sometimes I would take a bit (of narcotics) from here and a bit from there, so it would not show. Took it from multiple vials". The RN admitted to taking a dose of a controlled substance prescribed to a second resident. The dose was signed for on the Medical Pharmacies Combined Monitored Medication Record with Shift Count, but was not documented on the electronic Medication Administration Record (eMAR).

iii) The RN called the RPN to the resident's room and the RN stated to the RPN that they inadvertently spilled the entire ampule of controlled substance on the resident's soaker pad and had to get another ampule for administration. The RN admitted to taking the contents of the ampule and documenting that it was wasted. The Medical Pharmacies Combined Monitored Medication Record with Shift Count had two entries documented and signed by the RN and witnessed by the RPN.

iv) The RN documented the administration of a controlled substance on the Medical Pharmacies Combined Monitored Medication Record with Shift Count with no documentation on the eMAR. The RN admitted to taking part of the dose. The DRC then asked the question, "When you are saying you "took it" you mean you injected the medication into yourself?" The RN replied, "Yes".

v) The Resident also had an order for a controlled substance as needed (PRN), the dose was documented as administered and the RN admitted to taking this dose for personal use. The RN's interview documented, "Usually I took part or all of the medication".

Medical Pharmacies Monitored Medications Policy 6-7 last revised July 2017 stated registered staff were to document the administration of the monitored medication on the residents' Medication Administration Record (MAR). The policy directed the registered staff to "Sign each time a dose is administered. Include the date, time, amount given, amount of wasted drug/removed patch, and new quantity/balance remaining."

The DRC stated the RN was falsifying documentation on the eMAR for the PRN dose administration of a controlled substance on multiple occasions. The DRC reviewed the progress notes for the dates identified above and verified that the residents were assessed as resting comfortably with no complaints of pain. The DRC explained that the RN was preparing PRN doses of a controlled substance that were not required for administration to the residents. The DRC acknowledged that the RN did not follow the

home's policy related to the drug documentation, destruction and disposal.

The RN did not document the administration of the monitored medication on the Medication Administration Record (MAR) for the resident on multiple occasions. The RN did not sign each time a dose was administered that included the date, time, amount given, amount of wasted drug, and the new quantity/balance remaining.

The Medical Pharmacies Combined Monitored Medication Record with Shift Count did not have the required documentation as stated in the Medical Pharmacies Monitored Medications Policy 6-7 on multiple occasions. Registered staff did not document the date the dose was administered and the times were missing at shift counts for multiple records reviewed.

Senior Services Policies and Procedures Narcotics and Controlled Substances Policy Index Number PTH02-001 last revised October 17, 2018, stated registered staff are responsible to ensure that all narcotics and controlled substances were properly stored, accurately counted, and administered to residents on a consistent basis. Each registered staff member was to ensure documentation was complete, including the date, time, quantity of medication and signature on the Combined Monitored Medication record with shift count. Also, the wastage of narcotics stated only one prescribed dose of medication can be withdrawn from a vial. This would apply to single and multi-dose vials. The remainder of the medication must be wasted with two registered staff witnessing the wasting of the narcotic.

The RN was responsible to ensure that the controlled substance for was wasted with two registered staff witnessing the wasting of the narcotic. The RN was also responsible to ensure that on multiple dates the controlled substance was documented and wasted according to the Senior Services Policies and Procedures Narcotics and Controlled Substances Policy Index Number PTH02-001.

B) The Critical Incident (CI) Report documented that a resident was administered a higher dose of a medication than what was prescribed.

The electronic Medication Administration Record (eMAR) for the resident documented an order for the administration of a controlled substance.

The Medical Pharmacies Combined Monitored Medication Record with Shift Count for the resident's controlled substance was not documented according to the Senior

Services Policies and Procedures Narcotics and Controlled Substances Policy Index Number PTH02-001.The Director of Resident Care (DRC) acknowledged that the registered staff were not documenting the correct milliliter "ml" or milligram "mg" accurately; confusing the two measurements and using them interchangeably. The DRC also verified that the registered staff opened one vial and drew both doses from the same vial and the documentation was inaccurate. The DRC stated that the RN falsified the Medical Pharmacies Combined Monitored Medication Record with Shift Count for the resident's controlled substance on a specific date.

The DRC called Clinical Pharmacist (CP) with the Inspector present and the CP stated that there was no policy in place with Medical Pharmacies related to single dose vials, but there was with Classic Care at the time of this incident. The DRC stated that the home implemented this process in response to the audit conducted and the documentation concerns discovered at the time of this incident investigation.

The licensee failed to ensure that Medical Pharmacies Monitored Medications Policy 6-7 and the Senior Services Policies and Procedures Narcotics and Controlled Substances Policy Index Number PTH02-001 put in place were complied with. [s. 8. (1) (b)]

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 medication management policies instituted or otherwise put in place are complied with., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to make a report in writing to the Director setting out the following with respect to the incident, a description of the individuals involved in the incident including the names of any residents involved in the incident.

Th Critical Incident (CI) Report documented the name of one resident only. The CI reported that a Registered Nurse (RN) had insisted on administering the doses of medication to the resident and normally the Registered Practical Nurse (RPN) would administer this medication to the resident.

The home's investigation notes and interviews with the RN and other registered staff identified other residents residing in the home as a part of the missing controlled substance investigation.

The DRC verified there were other residents discussed during an interview with the RN. The DRC acknowledged that the RN admitted to consuming the wasted dose of controlled substance for more than one resident.

The licensee failed to make a report in writing to the Director setting out a description of the individuals involved in the incident, including the names of the two other residents involved in the incident. [s. 107. (4) 2. i.]

Issued on this 8th day of May, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Long-Term Care 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) :	MELANIE NORTHEY (563), CHERYL MCFADDEN (745)
Inspection No. / No de l'inspection :	2019_778563_0012
Log No. / No de registre :	003165-18, 008891-18, 010816-18, 015099-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 7, 2019
Licensee / Titulaire de permis :	The Regional Municipality of Niagara 1815 Sir Isaac Brock Way, THOROLD, ON, L2V-4T7
LTC Home / Foyer de SLD :	Northland Pointe 2 Fielden Avenue, PORT COLBORNE, ON, L3K-6G4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Leslie Hancock

To The Regional Municipality of Niagara, 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 131 (2) .

Specifically the licensee must:
a) Ensure both residents and any other resident are administered their injectable controlled substance in accordance with the directions for use specified by the prescriber.
b) Ensure there is complete and accurate documentation of each administration as part of the electronic Medication Administration Record and documented as part of the Medical Pharmacies Combined Monitored Medication Record with Shift Count.

Grounds / Motifs :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) The Critical Incident (CI) Report documented that a resident was administered a higher dose of a medication than what was prescribed.

The Medical Pharmacies Combined Monitored Medication Record with Shift Count documented that the Registered Practical Nurse (RPN) administered the incorrect dose of a controlled substance twice during their shift.

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scratched out documentation on the count sheet to appear correct.

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The licensee failed to ensure that the controlled substance was administered to the resident in accordance with the directions for use specified by the prescriber.

B) The Critical Incident (CI) Report documented that a resident had a physician's order for the administration of a controlled substance. A Registered Nurse (RN) had insisted on administering the doses of medication to the resident and normally the Registered Practical Nurse (RPN) would administer this medication to the resident.

The electronic Medication Administration Record (eMAR) for the resident documented that the RN signed for the administration of the routine controlled substance that was due at a specific time. The Medical Pharmacies Combined Monitored Medication Record with Shift Count documented the RN signed the record as administering the medication at that specific time.

The handwritten statement by the RPN documented that the RN administered the resident's scheduled controlled substance at a specific time and informed the RPN afterwards. The statement also documented that the resident had unusual behaviours that day and this would have only occurred if the resident did not get their scheduled medication.

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for the resident and stated that the dose was signed by the RN as part of the eMAR and documented on the Combined Monitored Medication Record with Shift Count, but was never administered to the resident.

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The licensee failed to ensure that the controlled substance was administered to the resident in accordance with the directions for use specified by the prescriber.

The severity of this issue was determined to be a level 3 as there was actual risk. The scope of the issue was a level 2 as it was related to 2 out of 3 residents reviewed. The compliance history (last 36 months from first date of on-site inspection) was a level 1 as they had been no history of non- compliance with this section of the LTCHA. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 17, 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 7th day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Northey

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