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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
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Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
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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
Aug 24, 2020	2020_569508_0013	022664-19, 014501-20, 015505-20, 015740-20	Critical Incident System

Licensee/Titulaire de permis

The Governing Council of the Salvation Army in Canada
2 Overlea Blvd TORONTO ON M4H 1P4

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

R. H. Lawson Eventide Home
5050 Jepson Street NIAGARA FALLS ON L2E 1K5

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

ROSEANNE WESTERN (508)

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): July 31, August 4, 5, 7, 10 and 11, 2020.

PLEASE NOTE: A Follow Up inspection # 022664-20, was conducted concurrently with this Critical Incident System inspection;

- Critical Incidents # 015740-20, # 014501-20, # 015505-20 related to falls with significant injuries were inspected;

During the course of the inspection, the inspector toured the facility, observed the provision of care, reviewed resident clinical records, relevant policies and procedures and staff training records.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Acting Directors of Care, the Associate Director of Care, registered staff, Personal Support Workers and residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Pain

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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. 48. (2)	CO #001	2019_569508_0032	508

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. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of a Critical Incident (CI) report submitted in 2020, indicated that resident #002 sustained an injury. The resident was transferred to hospital for further assessment where it was identified that the resident had significant injuries.

Prior to this incident, the resident had an order for a routine pain medication to manage their pain for a pre-existing condition. Upon return from the hospital, there were no new orders for additional pain medication to manage the resident's pain.

A review of the resident's clinical records indicated that the resident was complaining of pain and PRN (when necessary) Tylenol was being administered according to the home's medical directive.

A week after the incident, the documentation indicated that the resident wanted more Tylenol for their pain at the start of the night shift and that the resident was restless. RN #103 documented that Tylenol had already been administered by the evening staff and no additional pain medication was administered.

Two days later, the documentation indicated that the resident continued to be in pain and Tylenol was administered but with minimal effect. The resident had a restless night.

Four days later, the documentation indicated that the resident was complaining of pain. Tylenol was administered; however, the resident's pain was not relieved. The resident indicated that their pain level was 10/10 (ten out of ten) even after the Tylenol had been administered.

The next day, the Physician ordered an additional PRN analgesic for the resident's pain. A pain assessment had not been conducted when the resident was experiencing worsening pain due to their injuries.

During interview with Acting DOC #102 it was confirmed that the resident's pain was not relieved and had not been assessed using a clinically appropriate assessment instrument. The Acting DOC #102 implemented pain assessments to be conducted after the LTCH Inspector identified the resident had on-going complaints of pain that was not being relieved by their interventions.

It was confirmed during review of the resident's clinical records and during interview with Acting DOC #102 that the resident was not reassessed using a clinically appropriate assessment instrument specifically designed for this purpose when their pain was not relieved by initial interventions. [s. 52. (2)]

2. A CI report indicated that resident #003 had a fall and sustained an injury. The resident was transferred to hospital for further assessment and returned to the home. The resident had routine analgesics ordered and in addition a PRN analgesic to manage their pain.

During review of the resident's clinical record over an identified period, the resident required the PRN medication for intermittent complaints of pain. On an identified date, the resident was deemed palliative and medication changes were implemented for end of life care.

There were no pain assessments conducted using a clinically appropriate assessment instrument during this time.

During interview with the ADOC, they indicated that staff had education on their pain management policy in January, 2020, which included when and how to conduct pain assessments using the clinically appropriate assessment instrument. The ADOC confirmed that these residents should have had a full pain assessment conducted due to their intermittent complaints of pain requiring additional doses of PRN pain medication. [s. 52. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the resident's pain is not relieved by initial interventions, the resident is reassessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

On an identified date in July, 2020, resident #002 sustained an injury. A review of the resident's plan of care indicated that the resident had a hi/low bed to be kept in the lowest position while resident was in bed. During an observation of resident #002, the resident was observed in their bed; however, the resident's bed was up at a high level and not in the lowest position. The LTCH Inspector asked PSW #105 about why the resident's bed was up so high and the PSW indicated it had been in that position since the start of their shift and confirmed it should have been in the lowest position.

It was confirmed during interview with PSW #105, review of the resident's plan of care and during observation that the care set out in the plan of care was not provided to the resident when their bed was not in the lowest position while resident #002 was in bed. [s. 6. (7)]

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 the care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Where the Act or this Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with, specifically, 52(2) every licensee of a long-term care home shall ensure that when a resident's pain was not relieved by initial interventions, the resident was reassessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The LTC Home's Pain Management Policy #N-166 with a review date of January 29, 2020, indicated that each resident must have a formal pain assessment on admission and be reassessed quarterly and with significant changes in condition. A pain assessment would be conducted when a resident exhibited a change in health status or pain was not relieved by initial interventions.

During this inspection, the LTCH Inspector reviewed 3 (three) Critical Incidents involving resident's #001, #002 and #003. All CI's involved resident's who had fallen at the LTC

Home and sustained injuries resulting in changes in their condition.

During review of the resident's clinical records, it was identified that resident's #002 and #003 experienced pain that was not relieved by initial interventions.

Resident #002 sustained significant injuries due to an incident. The resident was transferred to hospital and returned to the LTC Home. A pain assessment was conducted prior to the resident going out to hospital which indicated the resident's pain was a 9/10.

During review of the resident's clinical records, it was identified that the resident's pain was not being managed after the resident returned back from hospital. Over an identified period, the resident had verbalized that their pain medication at times was not effective.

There were no pain assessments using a clinically appropriate assessment instrument designed for this purpose conducted over this period.

Resident #003 had a fall in their room on July 18, 2020 and sustained an injury. The resident was transferred to hospital and returned to the home later that night.

The resident had routine analgesics ordered and in addition a PRN analgesic to manage their pain. During review of the resident's clinical record between over an identified period, the resident required the PRN medication for intermittent complaints of pain.

On an identified date, the resident was deemed palliative and medication changes were implemented for end of life care. There were no pain assessments conducted using a clinically appropriate assessment instrument during this period of time.

During interview with the ADOC, they indicated that staff had education on their pain management policy in January, 2020, which included when and how to conduct pain assessments using the clinically appropriate assessment instrument.

The ADOC confirmed that these residents should have had a full pain assessment conducted due to their injuries and changes in condition.

It was confirmed during interview with the ADOC and during clinical record reviews that the Pain Management policy was not complied with for resident's #002 and #003. [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 where the Act or this Regulation require the licensee of a long-term care home to have, instituted or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with, specifically, 52(2) every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is reassessed using a clinically appropriate assessment instrument specifically designed for this purpos, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe positioning techniques when assisting resident #002.

According to a Critical Incident (CI) report, it was reported to registered staff by PSW #105 that while they were providing care to the resident, the resident sustained an injury due to an incident.

Registered staff #106 assessed the resident and at that time did not identify any abnormalities or injuries. The resident was transferred back to bed. A follow up assessment was conducted shortly after by RN #108 when it was reported that the resident appeared to have an injury. The resident was transferred to hospital for further assessment and was diagnosed with an injury.

During interview with PSW staff #105, the staff confirmed that while they were providing care, an incident occurred which caused an injury to the resident. Resident #002 also confirmed this information.

It was confirmed during interviews and during review of the resident's clinical records that staff #105 did not use safe positioning techniques when assisting resident #002. [s. 36.]

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 staff use safe positioning techniques when assisting residents, to be implemented voluntarily.

Issued on this 21st day of September, 2020

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) :	ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2020_569508_0013
Log No. / No de registre :	022664-19, 014501-20, 015505-20, 015740-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 24, 2020
Licensee / Titulaire de permis :	The Governing Council of the Salvation Army in Canada 2 Overlea Blvd, TORONTO, ON, M4H-1P4
LTC Home / Foyer de SLD :	R. H. Lawson Eventide Home 5050 Jepson Street, NIAGARA FALLS, ON, L2E-1K5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lynne Blake

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

Order / Ordre :

The licensee must be compliant with r. 52(2) of the O. Reg. 79/10.

Specifically the licensee must:

1. Re-educate all registered staff on the home's pain policy, specifically the use of the pain assessment and maintain records of this training;

2. Implement an auditing tool to ensure that residents who are experiencing pain and/or have a change in their condition are being assessed/re-assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Grounds / Motifs :

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

A review of a Critical Incident (CI) report submitted in 2020, indicated that resident #002 sustained an injury. The resident was transferred to hospital for further assessment where it was identified that the resident had significant injuries.

Prior to this incident, the resident had an order for a routine pain medication to manage their pain for a pre-existing condition. Upon return from the hospital, there were no new orders for additional pain medication to manage the resident's pain.

A review of the resident's clinical records indicated that the resident was complaining of pain and PRN (when necessary) Tylenol was being administered according to the home's medical directive.

A week after the incident, the documentation indicated that the resident wanted more Tylenol for their pain at the start of the night shift and that the resident was restless. RN #103 documented that Tylenol had already been administered by the evening staff and no additional pain medication was administered.

Two days later, the documentation indicated that the resident continued to be in pain and Tylenol was administered but with minimal effect. The resident had a restless night.

Four days later, the documentation indicated that the resident was complaining of pain. Tylenol was administered; however, the resident's pain was not relieved. The resident indicated that their pain level was 10/10 (ten out of ten) even after the Tylenol had been administered.

The next day, the Physician ordered an additional PRN analgesic for the resident's pain. A pain assessment had not been conducted when the resident was experiencing worsening pain due to their injuries.

During interview with Acting DOC #102 it was confirmed that the resident's pain was not relieved and had not been assessed using a clinically appropriate assessment instrument. The Acting DOC #102 implemented pain assessments to be conducted after the LTCH Inspector identified the resident had on-going complaints of pain that was not being relieved by their interventions.

It was confirmed during review of the resident's clinical records and during interview with Acting DOC #102 that the resident was not reassessed using a clinically appropriate assessment instrument specifically designed for this purpose when their pain was not relieved by initial interventions. [s. 52. (2)]

(508)

2. A CI report indicated that resident #003 had a fall and sustained an injury. The resident was transferred to hospital for further assessment and returned to the home. The resident had routine analgesics ordered and in addition a PRN analgesic to manage their pain.

During review of the resident's clinical record over an identified period, the resident required the PRN medication for intermittent complaints of pain. On an identified date, the resident was deemed palliative and medication changes were implemented for end of life care.

There were no pain assessments conducted using a clinically appropriate assessment instrument during this time.

During interview with the ADOC, they indicated that staff had education on their pain management policy in January, 2020, which included when and how to conduct pain assessments using the clinically appropriate assessment instrument. The ADOC confirmed that these residents should have had a full pain assessment conducted due to their intermittent complaints of pain requiring additional doses of PRN pain medication. [s. 52. (2)]

The severity of this issue was determined to be a level 2 as there was minimum harm to the resident. The scope of the issue was a level 2 as it was related to two residents. The home had a level 3 compliance history of a previous Voluntary Plan of Correction (VPC) on February 28, 2018. (508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 09, 2020

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

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 24th day of August, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Roseanne Western

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