

**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**

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de
Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
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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
Sep 9, 2021	2021_907692_0003	008605-21, 010474-21	Critical Incident System

Licensee/Titulaire de permis

Lakeland Long Term Care Services Corporation
6 Albert Street Parry Sound ON P2A 3A4

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

Lakeland Long Term Care Services
6 Albert Street Parry Sound ON P2A 3A4

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

SHANNON RUSSELL (692), AMANDA BELANGER (736)

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): August 23-27, 2021.

The following intake(s) were inspected upon during this Critical Incident System inspection:

-Two logs, which were related to critical incidents that the home submitted to the Director related to abuse of a resident.

A Complaint inspection #2021_907692_0002 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Housekeepers, Activation staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

**The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation**

During the course of this inspection, Non-Compliances were issued.

5 WN(s)

2 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: 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 anyone who had reasonable grounds to suspect abuse or unlawful conduct by a staff member that resulted in risk of harm to four residents, immediately reported the suspicion to the Director. Pursuant to s. 152 (2) the licensee was vicariously liable for staff members failing to comply with subsection 24 (1).

a) There had been an allegation of staff to resident physical abuse, in which a Personal Support Worker (PSW) observed another PSW complete a specific task for a resident in a way that was not respectful of the resident. The PSW had not reported the allegation to a Registered Nurse (RN) until later in the shift, at which time the RN sent an email to the Director of Care (DOC); however, they did not contact the after hours line and the Critical Incident System (CIS) report was not submitted to the Director until the following day.

b) A PSW reported to an RN that they had observed another PSW being inappropriate towards two residents. The PSW had not reported the incidents to the RN until over an hour after the last incident occurred. The after-hours pager was not contacted to report the incident to the Director until 10 hours after both incidents had been reported to management.

c) During an internal investigation into other allegations of resident abuse exhibited by a PSW, the reporting PSW indicated that they had also witnessed the PSW be verbally abusive towards another resident. The PSW had not immediately reported the allegation of staff to resident abuse on the date it had occurred, when they had reported the other allegations of resident abuse.

The DOC indicated that the allegations of staff to resident abuse should have been reported immediately to the Director of Long-Term Care, and had not been. There was minimal risk of harm to the residents by not reporting the allegation of resident abuse.

Sources: Residents' progress notes; CIS reports; licensee policy titled "ADMRF-Abuse Investigation"; interview with the DOC and other staff. [s. 24. (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. 20.
Policy to promote zero tolerance**

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the abuse policy was complied with in relation to the allegations of staff to resident abuse involving four residents.

The licensee's policy titled, "Abuse-Investigation", indicated that the individual accused of the abuse was to be interviewed, and that the Nurse Manager who was notified of the suspected abuse, was required to complete the "Alleged Abuse Investigation Form".

In the internal investigation packages for the four allegations of abuse, there were no notes from an interview with the residents involved and the accused PSWs, nor was there a completed "Alleged Abuse Investigation Form".

The DOC indicated that the abuse policy had not been complied with in all of the aforementioned incidents of staff to resident abuse, as the staff had not completed the required forms, and the staff members involved in the allegations had not been interviewed.

Sources: CIS reports; internal investigation notes; licensee policy titled "ADM-RF Abuse-Investigation"; interview with the DOC, and other staff. [s. 20. (1)]

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 ensuring that the home's abuse policy is complied with by all staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that five residents' substitute decision makers (SDM) were notified immediately of an allegation of abuse.

There had been allegations of abuse reported that had occurred towards five different residents by staff. When each of the residents' progress notes were reviewed, they indicated that two of the residents' SDMs were not notified of the allegations until the following day, one resident's SDM was not notified until 19 days after the incident occurred, and two of the other residents' SDMs were not notified at all of the allegations of resident abuse.

The DOC identified that the residents' SDM was to have been notified within 12 hours of the allegation of abuse, and that they had not been in all of the aforementioned incidents.

Sources: Residents' progress notes; CIS reports; internal investigation notes; licensee policy titled "ADM-RF Abuse-Investigation"; interviews with an ADOC, the DOC and other staff. [s. 97. (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 ensuring that the substitute decision maker (SDM) is notified within 12 hours of an allegation of abuse, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident had their rights respected, related to being treated with dignity and respect.

There was an allegation of staff to resident physical abuse, in which a PSW observed another PSW complete specific care on a resident that was not done in a respectful manner; the resident indicated at the time of the incident that it was not okay for that to occur.

Care was not provided to the resident in a way that respected the resident's dignity.

Sources: CIS report; internal investigation notes; licensee policy titled "Personal Hygiene, Grooming, Dressing and Bathing"; interviews with the DOC, and other staff [s. 3. (1) 1.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

- s. 23. (1) Every licensee of a long-term care home shall ensure that,**
- (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:**
 - (i) abuse of a resident by anyone,**
 - (ii) neglect of a resident by the licensee or staff, or**
 - (iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).**
 - (b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
 - (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that an allegation of physical abuse towards a resident was immediately investigated.

In a written statement by a PSW, they reported an allegation of physical abuse from another PSW towards a resident, which caused the resident to become upset.

The DOC stated that the allegation had not been investigated.

Sources: internal investigation notes; CIS report; interview with the DOC, and other staff.
[s. 23. (1) (a)]

Issued on this 15th day of September, 2021

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

Original report signed by the inspector.

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 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) : SHANNON RUSSELL (692), AMANDA BELANGER
(736)

Inspection No. /

No de l'inspection : 2021_907692_0003

Log No. /

No de registre : 008605-21, 010474-21

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Sep 9, 2021

Licensee /

Titulaire de permis : Lakeland Long Term Care Services Corporation
6 Albert Street, Parry Sound, ON, P2A-3A4

LTC Home /

Foyer de SLD : Lakeland Long Term Care Services
6 Albert Street, Parry Sound, ON, P2A-3A4

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Steve White

To Lakeland Long Term Care Services Corporation, you are hereby required to
comply with the following order(s) by the date(s) set out below:

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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee must be compliant with s. 24 (1) of the Long-Term Care Home's Act (LTCHA), 2007.

Specifically, the licensee shall:

Re-train the DOC and ADOC #102 on the home's abuse and prevention policy, specifically on the reporting requirements, and maintain a record of the re-training provided.

Grounds / Motifs :

1. The licensee has failed to ensure that anyone who had reasonable grounds to suspect abuse or unlawful conduct by a staff member that resulted in risk of harm to four residents, immediately reported the suspicion to the Director. Pursuant to s. 152 (2) the licensee was vicariously liable for staff members failing to comply with subsection 24 (1).

a) There had been an allegation of staff to resident physical abuse, in which a Personal Support Worker (PSW) observed another PSW complete a specific task for a resident in a way that was not respectful of the resident. The PSW had not reported the allegation to a Registered Nurse (RN) until later in the shift, at

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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

which time the RN sent an email to the Director of Care (DOC); however, they did not contact the after hours line and the Critical Incident System (CIS) report was not submitted to the Director until the following day.

b) A PSW reported to an RN that they had observed another PSW being inappropriate towards two residents. The PSW had not reported the incidents to the RN until over an hour after the last incident occurred. The after-hours pager was not contacted to report the incident to the Director until 10 hours after both incidents had been reported to management.

c) During an internal investigation into other allegations of resident abuse exhibited by a PSW, the reporting PSW indicated that they had also witnessed the PSW be verbally abusive towards another resident. The PSW had not immediately reported the allegation of staff to resident abuse on the date it had occurred, when they had reported the other allegations of resident abuse.

The DOC indicated that the allegations of staff to resident abuse should have been reported immediately to the Director of Long-Term Care, and had not been. There was minimal risk of harm to the residents by not reporting the allegation of resident abuse.

Sources: Residents' progress notes; CIS reports; licensee policy titled "ADMRF-Abuse Investigation"; interview with the DOC and other staff.

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

Severity: There was minimal risk of harm by staff not reporting the incidents to the Director immediately.

Scope: The scope of this non-compliance was widespread as it included five of the five allegations of resident abuse reviewed during this inspection.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with s. 24 (1) of the LTCHA, and a Voluntary Plan of Correction (VPC) was issued to the home. (736)

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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

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

Oct 08, 2021

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

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

**RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX
APPELS**

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le/la titulaire de permis souhaite que le directeur examine;
- c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8^e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

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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 révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière
d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 9th day of September, 2021

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Shannon Russell

Service Area Office /

Bureau régional de services : Sudbury Service Area Office