Ontario

Ministry of Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère des Soins de longue durée

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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
Feb 11, 2020	2020_530726_0002	023350-19, 000273-20	Critical Incident System

Licensee/Titulaire de permis

Broadview Foundation
3555 Danforth Avenue TORONTO ON M1L 1E3

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

Chester Village
3555 Danforth Avenue TORONTO ON M1L 1E3

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

REBECCA LEUNG (726)

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): Jan 22, 23, 24 and 27, 2020

The following Critical Incident System intakes were inspected during this inspection:
Log #023350-19 and Log #000273-20 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), family member and residents.

During the course of the inspection, the inspector made observations related to the home's care processes, staff to resident interactions; conducted record reviews and reviewed relevant policy.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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

- **2 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. 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 has failed to ensure that PSW #101 used safe positioning techniques when assisting resident #002.

A critical incident system (CIS) report was submitted to the Ministry of Long-Term Care

(MLTC) related to a fall incident involving resident #002. Review of the CIS report and the related incident report indicated that on the date of the incident, when PSW #101 was providing care to resident #002, the resident was lying in an identified position in bed. Resident #002 moved their identified body part and fell off the bed. PSW #101 tried to pull resident #002 back, but the resident just went down to the floor. PSW #101 reported the incident to RN #102. RN #102 assessed resident #002 and noted the resident had an identified injury on their identified body part. The PSWs on the following shift noted that resident #002 presented with symptoms on another identified body part. The registered staff was called to assess resident #002 and the physician was notified. Resident #002 was then sent to the hospital for assessment.

Review of the progress notes written by the registered staff, indicated that resident #002 was diagnosed with a specified injury and returned to the home with a therapeutic device applied on their identified body part.

Review of the care plan indicated that resident #002 required specified assistance by two persons for bed mobility and the identified care to ensure safety.

Review of the home's investigation notes, indicated that before the incident occurred, PSW #101 provided the identified care for resident #002 at the left side of the resident, then walked over to the other side to continue providing the identified care while resident #002 was lying in an identified position in bed. PSW #101 then wanted to go back to the other side of the resident again to pull them up. While PSW #101 was walking around the foot end of the bed, resident #002 moved their identified body part and slid down from the bed to the floor. PSW #101 was unable to reach resident #002 and the resident landed on the floor with their identified body part.

In an interview, PSW #101 confirmed the sequence of events of the incident as described in the investigation notes. PSW #101 acknowledged that they had not read resident #002's care plan before the incident occurred. PSW #101 stated that they had always assisted resident #002 with one person for bed mobility and the identified care since resident #002 came to the unit. PSW #101 also stated that they had always put resident #002 lying in the identified position in bed during care, and nothing had ever happened before. PSW #101 acknowledged that resident #002 was unable to support themselves when the staff assisted them with bed mobility. PSW #101 acknowledged that they had put resident #002 at increased risk for falls as they did not provide the care to resident #002 with two persons as specified in their care plan, and they had placed resident #002 lying in an unsafe position in bed with no support for safety when they walked away from

the resident to the other side of the bed. PSW #101 stated that the home's management staff had advised them how to position the resident in bed at all times in the future.

During the interview, the DOC confirmed that PSW #101 did not follow resident #002’s care plan as they did not provide resident #002 with the specified assistance by two persons for bed mobility. When PSW #101 left resident #002 lying in the identified position in bed and walked over to the other side of the bed, there was no second staff present to support resident #002 at the bedside to prevent the resident from falling off the bed. The DOC acknowledged that PSW #101 had put resident #002 at increased risk for falls by not following their care plan. In addition, PSW #101 also placed resident #002 lying in an unsafe position in bed with no support for safety when PSW #101 walked over to the other side of the bed.

Please refer to the grounds provided for Written Notification #2 issued pursuant to LTCHA, s. 6 (7).

The home has failed to ensure that PSW #101 used safe positioning techniques when assisting resident #002 with bed mobility during the provision of the identified care. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 has failed to ensure that there was a written plan of care for resident #002 that set out clear directions to staff and others who provided direct care to the resident.

Review of resident #002’s care plan indicated that under the focus of toileting, one of the written interventions identified that the resident needed specified assistance by two persons to provide the identified care.

In an interview, the DOC stated that they reviewed resident #002’s care plan during their investigation and decided that the focus on "toileting" and the above-mentioned intervention was outdated and no longer applicable to resident #002, as the resident had not been toileted for some time before the incident occurred. The DOC said that they thought the specified assistance by two persons for the identified care was required only when resident #002 was being toileted in the washroom. The DOC stated that during the investigation, they had no concerns when the staff reported that resident #002 was provided with one-person assistance for the identified care in bed.

In an interview, the RAI coordinator (#106) stated that resident #002’s care plan was reviewed at an identified time interval by the team involving the PSWs and registered staff that took care of the resident. The RAI coordinator confirmed that the focus on "toileting" and the above-mentioned intervention was up-to-date and reflecting resident #002’s needs for specified assistance by two persons before and after the fall incident. The RAI Coordinator stated that the identified care was always written under the focus on "toileting" with reference to the RAI-MDS data collection process, regardless the

residents were getting toileted or not. The RAI coordinator stated that they had offered training to all PSWs to ensure that they were able to understand the information written in the care plan correctly. The RAI coordinator acknowledged the issue identified by the DOC as mentioned above and agreed to discuss with team to resolve the issue. The RAI coordinator encouraged the inspector to interview the PSWs in the unit to verify the issue.

In an interview, PSW #100 reviewed the focus on "toileting" and the above-mentioned intervention in resident #002’s care plan and stated that they interpreted the information as outdated and no longer applicable to resident #002, as the resident had not been toileted by the staff for some time. However, PSW #100 clarified that as they were familiar with resident #002’s care needs, they always provided resident #002 with the specified assistance by two persons for bed mobility during the identified care. PSW #100 acknowledged that the focus on "toileting" and above-mentioned intervention written in resident #002’s care plan did not provide clear directions to the staff.

During the exit debriefing, the DOC stated that they had discussed the issue with the RAI Coordinator and confirmed that the focus on "toileting" and the above-mentioned intervention written in resident #002’s care plan did not provide clear directions to the staff. [s. 6. (1) (c)]

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

Review of resident #002's care plan indicated that the resident required specified assistance by two persons for bed mobility and the identified care to ensure safety.

In an interview, PSW #108 stated that before the fall incident occurred, they had always assisted resident #002 with bed mobility and the identified care in bed with one-person assistance as specified in resident #002’s care plan. The inspector requested PSW #108 to review resident #002’s care plan on the computer. PSW #108 then admitted that they were wrong and acknowledged that resident #002’s care plan indicated the resident required the specified assistance by two persons for bed mobility and the identified care before and after the fall incident occurred.

In an interview, RPN #103 stated that one person could provide the identified care to resident #002 lying in the specified location of the bed because the resident did not move

much. The inspector then requested RPN #103 to review resident #002's care plan on the computer. RPN #103 apologized for providing the wrong information and confirmed that resident #002 required specified assistance by two persons for bed mobility and the identified care.

In the interviews, PSW #101 acknowledged that they had not read resident #002’s care plan before the incident occurred. PSW #101 stated that they had always assisted resident #002 with one person for bed mobility during provision of the identified care since resident #002 came to the unit. After reviewing resident #002's care plan, PSW #101 acknowledged that they did not provide resident #002 with two-person assistance for bed mobility and the identified care as specified in their care plan.

During the phone interview with the RN-charge nurse (RN #102) who worked with PSW #101 on the day of incident, RN #102 stated that resident #002 required one-person assistance for bed mobility during provision of the identified care prior to the fall incident as indicated in the care plan. When the inspector informed RN #102 that the record review of resident #002's care plan and MDS assessments, indicated that the resident required two-person assistance for the identified care prior to fall incident, RN #102 stated that with them, if resident #002 did not exhibit an identified behaviour, they needed one-person assistance. However, RN #102 acknowledged that as resident #002 had a specified condition and they could not support themselves when being assisted with bed mobility, the resident could not be assisted with one-person safely for the identified care.

During the interview, the DOC confirmed that PSW #101 did not follow resident #002’s care plan as they assisted resident #002 with bed mobility by one person. When PSW #101 left resident #002 lying in the identified position in bed, there was no second staff present to support resident #002 at the bedside to prevent the resident from falling off the bed. The DOC acknowledged that the staff did not provide resident #002 with two-person assistance for bed mobility as specified in their care plan. [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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 12th day of February, 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

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) :	REBECCA LEUNG (726)
Inspection No. / No de l’inspection :	2020_530726_0002
Log No. / No de registre :	023350-19, 000273-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 11, 2020
Licensee / Titulaire de permis :	Broadview Foundation 3555 Danforth Avenue, TORONTO, ON, M1L-1E3
LTC Home / Foyer de SLD :	Chester Village 3555 Danforth Avenue, TORONTO, ON, M1L-1E3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Cynthia Marinelli

To Broadview Foundation, 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) (a)

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 36.

Specifically, the licensee shall ensure that PSW #101 and all staff use safe positioning techniques when assisting resident #002 and all other residents in the home.

Upon receipt of this report the licensee shall:

1. Provide additional training to all registered nursing staff and personal support workers who are working or covering the specified unit on:

a. Use of safe and proper positioning techniques when assisting residents with bed mobility during the provision of care procedures in bed.

b. The importance for staff to follow the relevant guidance and instructions specified in individual resident's care plan, including the number of staff required for assisting individual resident with bed mobility to ensure resident safety.

Maintain the related training records including names of those attended, dates, who provided the education and training materials.

2. Develop and implement an on-going auditing process to ensure that all staff working on the specified shift and all other shifts on the specified unit are using safe positioning techniques, and following the care plans when assisting residents with bed mobility during provision of care. Maintain a written record of the auditing process including the frequency of the audits, who will be responsible for doing the audits and evaluating the results. The written record must include the date and location of the audit, the resident's name, staff members audited, the name of the person completing the audit, the outcome and follow-up of the audit results.

Grounds / Motifs :

1. The licensee has failed to ensure that PSW #101 used safe positioning techniques when assisting resident #002.

A critical incident system (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to a fall incident involving resident#002. Review of

the CIS report and the related incident report indicated that on the date of the incident, when PSW #101 was providing care to resident #002, the resident was lying in an identified position in bed. Resident #002 moved their identified body part and fell off the bed. PSW #101 tried to pull resident #002 back, but the resident just went down to the floor. PSW #101 reported the incident to RN #102. RN #102 assessed resident #002 and noted the resident had an identified injury on their identified body part. The PSWs on the following shift noted that resident #002 presented with symptoms on another identified body part. The registered staff was called to assess resident #002 and the physician was notified. Resident #002 was then sent to the hospital for assessment.

Review of the progress notes written by the registered staff, indicated that resident #002 was diagnosed with a specified injury and returned to the home with a therapeutic device applied on their identified body part.

Review of the care plan indicated that resident #002 required specified assistance by two persons for bed mobility and the identified care to ensure safety.

Review of the home's investigation notes, indicated that before the incident occurred, PSW #101 provided the identified care for resident #002 at the left side of the resident, then walked over to the other side to continue providing the identified care while resident #002 was lying in an identified position in bed. PSW #101 then wanted to go back to the other side of the resident again to pull them up. While PSW #101 was walking around the foot end of the bed, resident #002 moved their identified body part and slid down from the bed to the floor. PSW #101 was unable to reach resident #002 and the resident landed on the floor with their identified body part.

In an interview, PSW #101 confirmed the sequence of events of the incident as described in the investigation notes. PSW #101 acknowledged that they had not read resident #002's care plan before the incident occurred. PSW #101 stated that they had always assisted resident #002 with one person for bed mobility and the identified care since resident #002 came to the unit. PSW #101 also stated that they had always put resident #002 lying in the identified position in bed during care, and nothing had ever happened before. PSW #101 acknowledged that resident #002 was unable to support themselves when the

staff assisted them with bed mobility. PSW #101 acknowledged that they had put resident #002 at increased risk for falls as they did not provide the care to resident #002 with two persons as specified in their care plan, and they had placed resident #002 lying in an unsafe position in bed with no support for safety when they walked away from the resident to the other side of the bed. PSW #101 stated that the home's management staff had advised them how to position the resident in bed at all times in the future.

During the interview, the DOC confirmed that PSW #101 did not follow resident #002’s care plan as they did not provide resident #002 with the specified assistance by two persons for bed mobility. When PSW #101 left resident #002 lying in the identified position in bed and walked over to the other side of the bed, there was no second staff present to support resident #002 at the bedside to prevent the resident from falling off the bed. The DOC acknowledged that PSW #101 had put resident #002 at increased risk for falls by not following their care plan. In addition, PSW #101 also placed resident #002 lying in an unsafe position in bed with no support for safety when PSW #101 walked over to the other side of the bed.

Please refer to the grounds provided for Written Notification #2 issued pursuant to LTCHA, s. 6 (7).

The home has failed to ensure that PSW #101 used safe positioning techniques when assisting resident #002 with bed mobility during the provision of the identified care. [s. 36.]

The severity of this issue was determined to be a level 3 as there was actual harm to resident #002. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 3 compliance history as they had previous non-compliance to the same subsection of the LTCHA that included:
- Written notification (WN) issued Feb 28, 2019 (2019_630589_0004).

(726)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 27, 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 11th day of February, 2020

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Rebecca Leung

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