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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
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Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
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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
Feb 14, 2019	2019_625133_0002	027161-18	Complaint

Licensee/Titulaire de permis

City of Ottawa
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

Garry J. Armstrong Home
200 Island Lodge Road OTTAWA ON K1N 5M2

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 6, 7, 8, 2019

This inspection was related to a complaint regarding water leaking from the ceiling and from under the window in a specified resident bedroom, and water leaking from the ceiling in resident bedrooms in general.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, the Facility Supervisor, maintenance staff, registered and non-registered nursing staff, housekeeping staff and residents.

During the course of the inspection, the inspector observed resident bedrooms and common areas throughout specified care units. The Inspector reviewed corrective work orders related to reported leaks in specified bedrooms. The Inspector reviewed documentation related to corrective actions taken in response to leaks in specified bedrooms.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance

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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is maintained in a safe condition and in a good state of repair.

On February 8, 2019, at approximately 1030 hours on the 7th floor, the Inspector observed accumulated water and a saturated sheet and towel in the area in front of the balcony doors, within the lounge. Water could be seen coming in from underneath the doors and window area to the left of the doors. The home's Facility Supervisor (FS) met with the Inspector in the lounge. The FS directed a maintenance worker to bring up rope barriers, which were subsequently put into place in attempts to prevent residents from accessing the area. The FS contacted maintenance worker #109 who indicated that leaking also occurred on the floor in the balcony area on the 6th and 2nd floors. Housekeeper #103 indicated to the Inspector that this leaking had been occurring for the past day or two. Housekeeper #103 indicated that when they had started their shift that morning, there was standing water around water saturated sheets and towels. Housekeeper #103 indicated that they had bagged up the sheets and towels, cleaned up the water, and then put down another sheet and towel. The FS directed housekeeper #103 to clean up the water that was currently accumulated, which they did. The FS and the Inspector noted that approximately 10-15 minutes later, there was more water accumulating around the saturated sheet and towel on the floor. It was noted that there was a large amount of snow on the balcony, which was melting, as outdoor temperatures were above zero degrees Celsius and it was a clear and sunny day. It was later noted by the Inspector that on February 5th, 2019, outdoor temperatures had been above zero degrees Celsius and there had been rain, on February 6th, 2019 there had been both rain and freezing rain, and on February 7th, 2019 the outdoor temperature had been close to zero degrees Celsius and it had been a clear and sunny day.

Registered Nurse (RN) #102 indicated to the Inspector and the FS that water leaking in from the balcony door area was a recurring issue over the last two years that they had been working on the 7th floor unit. RN #102 indicated that this occurred when accumulated snow on the balcony melted, and also when there was rain with a strong wind.

The Inspector and the FS proceeded to the balcony areas on all units, and the following was observed:

On the 6th floor, the carpeted area in front of the right side balcony door was saturated. When the carpet was lifted, standing water was observed. The carpet was buckled and there was duct tape along a cut or torn seam. Under the lower window to the right of the balcony doors, there was black discoloration along the window molding. In the corner under the curtain bracket there was accumulated gelatinous matter, which the FS understood to be algae given the presence of standing water and the green hue of the matter. On the lower wall, in the right corner above the gelatinous matter, paint had peeled away and there was some black discoloration on an area of exposed drywall. On the ceiling above this area, there were water stains. Above the left balcony door, next to the door operator, the paint was blistered and there was an area of exposed drywall on which there was black discoloration. In the left corner above the window area to the left of the balcony doors, there was water stains and the paint was blistered and cracked. The wall under the affected ceiling was blistered.

On the 5th floor, the ceiling above the windows to the right of the balcony doors was cracked and peeling.

On the 3rd floor, the sliding balcony door was not properly sealed. The Inspector's pen could easily fit in between the door jamb and the right side of the door. The FS noted that the door could not be properly closed as there was some gasket material where there should have been a seal, along the side of the door. Wind could be felt blowing in all around the door. The FS noted that the floor in the right corner, at the door threshold, was damp.

RPN #104 indicated to the Inspector and the FS that the rain does come in around the balcony door and that it had been like this for years.

On the 2nd floor, the sliding balcony door was not properly sealed. The Inspector's pen fit easily in between the door jamb and the side of the door, as well as under the bottom of

the door. Wind could be felt blowing in all around the door.

Following this observation period with the FS, the FS indicated that they had not been aware of these issues and that consequently there was no plan in place for corrective action.

Further related to the 6th floor, on February 8, 2019, Registered Nurse #105 indicated to the Inspector that when there is a lot of rain with wind, or when the snow melts, water comes in from around the balcony doors.

Further related to the 3rd floor, on February 8, 2019, Personal Support Workers (PSW) #106, #107 and #108 indicated to the Inspector that when there is a heavy rain, water comes in from around the balcony doors and that the last time this had occurred was the summer of 2018. PSW #107 indicated that they had noticed this for the first time about a year ago. PSW #108 indicated that they had been aware of the problem for about two to three years. PSW #108 indicated that they recalled that the last time this had occurred, maintenance worker #109 had come to clean up the water and to dry the area.

Further related to the 2nd floor, on February 8, 2019, housekeeper #110 indicated that sometimes when they start their shift in the morning, they will notice accumulated water on the floor in the area of the balcony doors. The housekeeper indicated that sometimes there will be saturated towels in front of the door and sometimes there are no towels to contain the water. The housekeeper indicated that this usually coincided with rain, and that they had noticed this problem for about a year, with the last event occurring in the Summer of 2018.

Related to the sliding balcony doors on the 2nd and 3rd floors, on February 8, 2019, maintenance worker #109 indicated that in the past, the former FS had made a type of seal for the doors. The maintenance worker explained that the seals were held in place with Velcro, along the length of the side of the door. The maintenance worker indicated this had been done in an effort to block out the cold air in the winter. The maintenance worker indicated that they could not find the seals, and could not recall when they had last been in place. The maintenance worker indicated that the seals did not prevent water from leaking in around the doors.

The licensee has failed to ensure that the home is maintained in a safe condition and in a good state of repair.

In conclusion, the severity of the issues identified was determined to be a level 2, in that there was the potential for actual harm to residents in light of the described water infiltration in the area of the balcony doors on the 7th and 6th floors and the potential for water infiltration in the area of the balcony doors on the 3rd and 2nd floors. The scope of the issues identified was widespread, at level 3. The home had a compliance history of 3, in that there was one or more related findings of non-compliance in the last 36 months. Consequently, a compliance order will be served to the licensee [s. 15. (2) (c)]

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 has failed to ensure that the maintenance reporting procedure is complied with.

As per O. Reg. 79/10, s. 30 (1) 1., in respect of the organized program of maintenance services required under section 15 of the Act, there is a procedure in place for staff to report maintenance issues.

In an identified month in 2018, the Ministry of Health and Long Term Care received a complaint related to a specified bedroom. Specifically, the complainant referenced numerous ceiling leaks, with the most recent leak having occurred in the identified month in 2018. As well, the complainant referenced leaks through the wall under the window in

the specified bedroom, which had occurred at least twice, once two years ago and once more recently.

On February 6th, 2019, the Inspector met with the home's Facility Supervisor (FS), who was informed of the complaint. The FS later indicated to the Inspector that they had searched through the maintenance program (SAP program), and had found no reports of water leaking through the wall under the window in the specified bedroom. The FS indicated that the only ceiling leak in the specified bedroom that was noted in the maintenance program had occurred the month prior to the identified month in which the most current leak had occurred. The FS detailed the follow up actions that had been taken as a result of that leak.

Related to the maintenance reporting procedure, the FS explained to the Inspector that to report maintenance issues, on weekdays between 0730 hours and 1600 hours, staff are to contact the Facility Service Desk at (613) 580-2424 ext. 29999. A different phone number is to be used for after hours and public holidays. The FS indicated that by using the specified numbers, maintenance issues are formally logged into the maintenance program, and a corrective work order is generated. This allows for documented follow up and tracking of the issues. The specified phone numbers are posted in every nursing station in the home.

On February 6th, 2019, Registered Nurse (RN) #102 indicated to the Inspector that they recalled having observed water leaking in onto the floor, from the window area in the specified bedroom. The RN indicated that they could not recall exactly when this had last occurred, estimating that it had perhaps been a specified number of months ago. The RN indicated that they had called a maintenance worker in the home directly about the issue. The RN indicated that they had not followed up with a call to report the issue as per the established reporting procedure.

On February 8th, 2019, in the nurses station on a specified unit, the FS and the Inspector found a clipboard on the wall titled “Need to know”. On one of the sheets, a ceiling leak for the specified bedroom, on an identified date in 2018, was documented. The date coincided with the complainant's report of the most recent leak. RN #102 indicated to the Inspector and the FS that the “need to know” sheets were not supposed to be used for maintenance issues. RN #102 indicated that they recalled having observed the ceiling in the specified bedroom, a day or two after the identified date in 2018, and they did not see any water leaking at that time. RN #102 indicated that they had not followed up with a call to report the issue as per the established reporting procedure.

The licensee has failed to ensure that the maintenance reporting procedure is 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 with the requirement that the procedure in place to report maintenance issues is complied with, to be implemented voluntarily.

Issued on this 15th day of February, 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) : JESSICA LAPENSEE (133)

Inspection No. / No de l'inspection : 2019_625133_0002

Log No. / No de registre : 027161-18

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Feb 14, 2019

Licensee / Titulaire de permis : City of Ottawa
Community and Social Services, Long Term Care Branch, 200 Island Lodge Road, OTTAWA, ON, K1N-5M2

LTC Home / Foyer de SLD : Garry J. Armstrong Home
200 Island Lodge Road, OTTAWA, ON, K1N-5M2

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Mary Zion

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To City of Ottawa, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee shall:

1) Immediately develop and implement procedures to ensure residents' safety with regards to water infiltration into the home, due to snow melt and/or rain events. Staff's responsibilities are to be formally designated and monitored. Actions taken are to be documented to allow for follow up.

2) Remediate the areas around the 6th floor balcony doors where signs of potential microbial growth have been observed.

3) Immediately assess all balcony doors and surrounding areas. Implement any temporary or permanent solutions that are available, based on the assessments.

4) Permanently rectify the issue of water and air infiltration into the home in the area of the balcony doors on the 7th, 6th, 3rd, and 2nd floors.

Grounds / Motifs :

1. The licensee has failed to ensure that the home is maintained in a safe condition and in a good state of repair.

On February 8, 2019, at approximately 1030 hours on the 7th floor, the Inspector observed accumulated water and a saturated sheet and towel in the

of the balcony doors, within the lounge. Water could be seen coming in from underneath the doors and window area to the left of the doors. The home’s Facility Supervisor (FS) met with the Inspector in the lounge. The FS directed a maintenance worker to bring up rope barriers, which were subsequently put into place in attempts to prevent residents from accessing the area. The FS contacted maintenance worker #109 who indicated that leaking also occurred on the floor in the balcony area on the 6th and 2nd floors. Housekeeper #103 indicated to the Inspector that this leaking had been occurring for the past day or two. Housekeeper #103 indicated that when they had started their shift that morning, there was standing water around water saturated sheets and towels. Housekeeper #103 indicated that they had bagged up the sheets and towels, cleaned up the water, and then put down another sheet and towel. The FS directed housekeeper #103 to clean up the water that was currently accumulated, which they did. The FS and the Inspector noted that approximately 10-15 minutes later, there was more water accumulating around the saturated sheet and towel on the floor. It was noted that there was a large amount of snow on the balcony, which was melting, as outdoor temperatures were above zero degrees Celsius and it was a clear and sunny day. It was later noted by the Inspector that on February 5th, 2019, outdoor temperatures had been above zero degrees Celsius and there had been rain, on February 6th, 2019 there had been both rain and freezing rain, and on February 7th, 2019 the outdoor temperature had been close to zero degrees Celsius and it had been a clear and sunny day.

Registered Nurse (RN) #102 indicated to the Inspector and the FS that water leaking in from the balcony door area was a recurring issue over the last two years that they had been working on the 7th floor unit. RN #102 indicated that this occurred when accumulated snow on the balcony melted, and also when there was rain with a strong wind.

The Inspector and the FS proceeded to the balcony areas on all units, and the following was observed:

On the 6th floor, the carpeted area in front of the right side balcony door was saturated. When the carpet was lifted, standing water was observed. The carpet was buckled and there was duct tape along a cut or torn seam. Under the lower window to the right of the balcony doors, there was black discoloration along the

window molding. In the corner under the curtain bracket there was accumulated gelatinous matter, which the FS understood to be algae given the presence of standing water and the green hue of the matter. On the lower wall, in the right corner above the gelatinous matter, paint had peeled away and there was some black discoloration on an area of exposed drywall. On the ceiling above this area, there were water stains. Above the left balcony door, next to the door operator, the paint was blistered and there was an area of exposed drywall on which there was black discoloration. In the left corner above the window area to the left of the balcony doors, there was water stains and the paint was blistered and cracked. The wall under the affected ceiling was blistered.

On the 5th floor, the ceiling above the windows to the right of the balcony doors was cracked and peeling.

On the 3rd floor, the sliding balcony door was not properly sealed. The Inspector's pen could easily fit in between the door jamb and the right side of the door. The FS noted that the door could not be properly closed as there was some gasket material where there should have been a seal, along the side of the door. Wind could be felt blowing in all around the door. The FS noted that the floor in the right corner, at the door threshold, was damp.

RPN #104 indicated to the Inspector and the FS that the rain does come in around the balcony door and that it had been like this for years.

On the 2nd floor, the sliding balcony door was not properly sealed. The Inspector's pen fit easily in between the door jamb and the side of the door, as well as under the bottom of the door. Wind could be felt blowing in all around the door.

Following this observation period with the FS, the FS indicated that they had not been aware of these issues and that consequently there was no plan in place for corrective action.

Further related to the 6th floor, on February 8, 2019, Registered Nurse #105 indicated to the Inspector that when there is a lot of rain with wind, or when the snow melts, water comes in from around the balcony doors.

Further related to the 3rd floor, on February 8, 2019, Personal Support Workers

(PSW) #106, #107 and #108 indicated to the Inspector that when there is a heavy rain, water comes in from around the balcony doors and that the last time this had occurred was the summer of 2018. PSW #107 indicated that they had noticed this for the first time about a year ago. PSW #108 indicated that they had been aware of the problem for about two to three years. PSW #108 indicated that they recalled that the last time this had occurred, maintenance worker #109 had come to clean up the water and to dry the area.

Further related to the 2nd floor, on February 8, 2019, housekeeper #110 indicated that sometimes when they start their shift in the morning, they will notice accumulated water on the floor in the area of the balcony doors. The housekeeper indicated that sometimes there will be saturated towels in front of the door and sometimes there are no towels to contain the water. The housekeeper indicated that this usually coincided with rain, and that they had noticed this problem for about a year, with the last event occurring in the Summer of 2018.

Related to the sliding balcony doors on the 2nd and 3rd floors, on February 8, 2019, maintenance worker #109 indicated that in the past, the former FS had made a type of seal for the doors. The maintenance worker explained that the seals were held in place with Velcro, along the length of the side of the door. The maintenance worker indicated this had been done in an effort to block out the cold air in the winter. The maintenance worker indicated that they could not find the seals, and could not recall when they had last been in place. The maintenance worker indicated that the seals did not prevent water from leaking in around the doors.

The licensee has failed to ensure that the home is maintained in a safe condition and in a good state of repair.

In conclusion, the severity of the issues identified was determined to be a level 2, in that there was the potential for actual harm to residents in light of the described water infiltration in the area of the balcony doors on the 7th and 6th floors and the potential for water infiltration in the area of the balcony doors on the 3rd and 2nd floors. The scope of the issues identified was widespread, at level 3. The home had a compliance history of 3, in that there was one or more related findings of non-compliance in the last 36 months. Consequently, a

compliance order will be served to the licensee
(133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 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 14th day of February, 2019

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : JESSICA LAPENSEE

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