Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée 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
Nov 19, 2019	2019_625133_0017 (A1)	003811-19	Follow up

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

Amended by JESSICA LAPENSEE (133) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Upon request from the licensee, the Compliance Order due date (CDD) has been extended. The CDD was November 29, 2019. The CDD is now December 20, 2019. No other changes have been made.

Issued on this 19th day of November, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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200 Island Lodge Road OTTAWA ON K1N 5M2

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

Amended by JESSICA LAPENSEE (133) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 12, 13, 2019

The following intake was completed in the Follow Up inspection: Log #003811-19, which was related to water and air infiltration into the home

During the course of the inspection, the inspector(s) spoke with the Administrator, the Facility Supervisor, nursing staff and a housekeeper.

During the course of the inspection the inspector reviewed documents related to water infiltration tracking and balcony door replacement projects. The inspector observed the balcony doors and surrounding areas within the 7th, 6th, 3rd and 2nd floor lounges, with a focus on the 7th and 6th floor during a rain event on August 12, 2109.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

During the course of the original inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 comply with Compliance Order (CO) #001 issued as a result of Complaint Inspection #2019_625133_0002. The CO report date was

February 14, 2019. The CO had a compliance due date of July 31, 2019. The CO was issued pursuant to O. Reg. 79/10, s. 15 (2).

The licensee was ordered to specifically comply with the following items:

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 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.

The licensee completed step 1 in that there is a process in place whereby the Manager of Hospitality Services (MHS, #103) has documented dates on which they have done rounds and there has been a rain event, specifying the floor checked (balcony area) and action taken. It is noted that the MHS and Inspector worked together to ensure that an effective checking process was in place going forward, specifically related to the 6th floor balcony area.

The licensee completed step 2 in that the areas of black discoloration were remediated and the accumulation of green gelatinous matter was removed, in the area of the 6th floor balcony doors. The licensee did not complete step 2 in that additional green matter was found on the carpet in the same area.

The licensee completed step 3.

The licensee failed to complete step 4.

On the morning of August 12, 2019, the Inspector met with the Administrator (#100) and the Facility Supervisor (FS, #101). The Inspector was informed that the work required to permanently rectify the issue of water and air infiltration into the home in the area of the balcony doors on the 2nd, 3rd, 6th and 7th floors had

not been completed. The FS informed that new balcony doors for 2nd and 3rd had been ordered and were with the contractor, who was waiting for delivery of the glazing. The FS anticipated that work would begin to replace the doors at the end of August 2019 or beginning of September 2019. Related to the 6th and 7th floors, the FS indicated that possible alternative solutions were considered, and some trialed, before the conclusion was made that the doors had to be replaced. The FS informed the Inspector that the new 7th floor balcony door had been recently ordered and was expected to be received by the contractor in approximately 6 weeks. Related to the 6th floor balcony, the contractor was directed by the FS to order the new door that day, August 12, 2019.

On August 12, 2019, the Inspector spoke with Registered Practical Nurse (RPN, #102), who had worked some evening shifts on the 7th floor during the week of August 5th, 2019. The RPN indicated that they recalled a shift when it had rained and they had found some water on the floor in front of the 7th floor balcony doors. The RPN indicated that they used towels to dry the water, and no additional actions were required. The RPN could not recall the day on which this had occurred. It is noted that it had rained in the Ottawa area on August 6th and 8th, 2019. It was later determined that RPN #103 had worked a 7th floor evening shift on August 8th, 2019.

A document was provided to the Inspector by the Administrator, titled "Hospitality department water infiltration tracking 2019". The document was created and maintained by the Manager of Hospitality Services (MHS, #103). It was documented that on August 6th, on the 7th floor balcony area "thunder storms, water by balcony door, wet vac brought up, staff cleaned up water, no slip hazard. action: check daily". The MHS indicated that during their daily rounds, if it was raining, they went to balcony areas to visually inspect and verify if there has been any water infiltration into the home. The MHS indicated that they may have conducted such inspections the day following a rain event if the rain had occurred after they had left. The MHS indicated that on August 6th, water infiltration in the area of the 7th floor balcony doors was reported to them by staff. They went to the area and observed a small amount of water and saturated towels on the floor. The saturated towels were removed and a housekeeper used the wet vac to dry the area.

On August 12, 2019, between approximately 1630 hours and 1800 hours, it rained intermittently. On the 7th floor, the Inspector first observed a small amount of water on the floor in front of the right side balcony door at 1649 hours. The

MHS was contacted and they met the inspector in the area. The MHS placed a flannel sheet down to absorb the water and instructed staff to monitor. At 1715 hours, the inspector returned to the area and moved the sheet away from the door. The inspector observed that the area of accumulated water after a few moments was approximately 12 inches in length, and approximately ¼ of an inch in width out from the door sill. On the 6th floor, at 1735 hours, the Inspector observed that the carpet in front of the right balcony door, the door sidelight, the window, and around the corner from the window was wet. Prior to the rain that afternoon, the Inspector had observed this area to be dry. The carpet under the window was split along the seam, raised and buckled and had duct tape along split, as was previously observed by the Inspector in February 2019 during complaint inspection #2019_625133_0002. The caulking under the window sill was not adhered to the sill in the area of the split. The Inspector lifted the right side of the carpet and there was some accumulated water on the concrete slab, towards the sill. The slab was wet along the length of the window sill, with the largest wet area in the corner and along the side wall. The Administrator was notified and accompanied the Inspector to observe the 6th and 7th floor balcony door areas.

On August 13, 2019, at 0946 hours, the Inspector returned to the 6th floor balcony door area. With the sunlight at the time, the Inspector observed two discolored areas on the wet carpet with a green hue to them. These areas were under the window sill to the right of the split carpet area, and in the corner. The inspector scraped their pen along these areas and then wiped their pen on a piece of white paper. The matter scraped from the carpet was green. It is noted that the Inspector had observed accumulated green gelatinous matter in this corner, which the Facility Supervisor (#101) had understood to be algae, in February 2019 during complaint inspection #2019_625133_0002. The ceiling above this area was water stained and in the left corner above the window area to the left of the balcony doors, the ceiling was water stained, blistered and cracking, as was observed in February 2019 during complaint inspection #2019_625133_0002.

On August 13, 2019, the Inspector met with the Manager of Hospitality Services (MHS, #103) to inform them of the water infiltration in the 6th floor balcony area the previous evening. The MHS indicated that they had checked the area that morning, and it was dry. The Inspector and the MHS proceed to the 6th floor balcony area, and the MHS indicated that they had felt the carpet in the area of the split, to the left, where the carpet was raised and buckled. The Inspector noted that this area of the carpet was dry, as the carpet was raised. The MHS then felt

the carpet to the right of the split and along the window sill, noting that it was wet. The Inspector lifted the carpet and the MHS observed the slab was wet. The discolored areas on the carpet were also noted.

In summary, the licensee has failed to ensure that the home is maintained in a safe condition and in a good state of repair, specifically related to the 2nd, 3rd, 6th and 7th floor balcony door areas. [s. 15. (2) (c)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

Issued on this 19th day of November, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JESSICA LAPENSEE (133) - (A1)
Inspection No. / No de l'inspection :	2019_625133_0017 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	003811-19 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 19, 2019(A1)
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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

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

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2019_625133_0002, CO #001;

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 be compliant with LTCHA 2007, s. 15 (2).

Specifically, the licensee shall:

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

2. In the area of the 6th floor balcony doors, remediate the damaged and discolored carpet, the water stained and damaged ceiling areas, and the wall to the right of the doors.

3. Until such time that a permanent solution is found to rectify the issue of water and air infiltration, ensure resident safety by routinely monitoring the areas around the 2nd, 3rd, 6th and 7th floor balcony doors during rain events and/or snow melt. Ensure the 6th floor carpet is cleaned and dried following a water infiltration event. Document the monitoring, as well as all corrective actions and safety measures taken.

Grounds / Motifs :

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

1. The licensee has failed to comply with Compliance Order (CO) #001 issued as a result of Complaint Inspection #2019_625133_0002. The CO report date was February 14, 2019. The CO had a compliance due date of July 31, 2019. The CO was issued pursuant to O. Reg. 79/10, s. 15 (2).

The licensee was ordered to specifically comply with the following items:

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 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.

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The licensee completed step 2 in that the areas of black discoloration were remediated and the accumulation of green gelatinous matter was removed, in the area of the 6th floor balcony doors. The licensee did not complete step 2 in that additional green matter was found on the carpet in the same area.

The licensee completed step 3.

The licensee failed to complete step 4.

On the morning of August 12, 2019, the Inspector met with the Administrator (#100) and the Facility Supervisor (FS, #101). The Inspector was informed that the work required to permanently rectify the issue of water and air infiltration into the home in the area of the balcony doors on the 2nd, 3rd, 6th and 7th floors had not been completed. The FS informed that new balcony doors for 2nd and 3rd had been ordered and were with the contractor, who was waiting for delivery of the glazing. The FS anticipated that work would begin to replace the doors at the end of August 2019 or beginning of September 2019. Related to the 6th and 7th floors, the FS indicated that possible alternative solutions were considered, and some trialed, before the conclusion was made that the doors had to be replaced. The FS informed the Inspector that the new 7th floor balcony door had been recently ordered and was expected to be received by the contractor in approximately 6 weeks. Related to the 6th floor balcony, the contractor was directed by the FS to order the new door that day, August 12, 2019.

On August 12, 2019, the Inspector spoke with Registered Practical Nurse (RPN, #102), who had worked some evening shifts on the 7th floor during the week of August 5th, 2019. The RPN indicated that they recalled a shift when it had rained and they had found some water on the floor in front of the 7th floor balcony doors. The RPN indicated that they used towels to dry the water, and no additional actions were required. The RPN could not recall the day on which this had occurred. It is noted that it had rained in the Ottawa area on August 6th and 8th, 2019. It was later determined that RPN #103 had worked a 7th floor evening shift on August 8th, 2019.

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removed and a housekeeper used the wet vac to dry the area.

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On August 13, 2019, at 0946 hours, the Inspector returned to the 6th floor balcony door area. With the sunlight at the time, the Inspector observed two discolored areas on the wet carpet with a green hue to them. These areas were under the window sill to the right of the split carpet area, and in the corner. The inspector scraped their pen along these areas and then wiped their pen on a piece of white paper. The matter scraped from the carpet was green. It is noted that the Inspector had observed accumulated green gelatinous matter in this corner, which the Facility Supervisor (#101) had understood to be algae, in February 2019 during complaint inspection #2019_625133_0002. The ceiling above this area was water stained and in the left corner above the window area to the left of the balcony doors, the ceiling was water stained, blistered and cracking, as was observed in February 2019 during complaint inspection #2019_625133_0002.

On August 13, 2019, the Inspector met with the Manager of Hospitality Services

(MHS, #103) to inform them of the water infiltration in the 6th floor balcony area the previous evening. The MHS indicated that they had checked the area that morning, and it was dry. The Inspector and the MHS proceed to the 6th floor balcony area, and the MHS indicated that they had felt the carpet in the area of the split, to the left, where the carpet was raised and buckled. The Inspector noted that this area of the carpet was dry, as the carpet was raised. The MHS then felt the carpet to the right of the split and along the window sill, noting that it was wet. The Inspector lifted the carpet and the MHS observed the slab was wet. The discolored areas on the carpet were also noted.

In summary, the licensee has failed to ensure that the home is maintained in a safe condition and in a good state of repair, specifically related to the 2nd, 3rd, 6th and 7th floor balcony door areas.

In conclusion, the decision to reissue this compliance order was based on the following:

The severity of the non-compliance identified was such that there was minimal risk to residents.

The scope of the non-compliance identified was pattern in that four of six balcony areas are in issue.

The licensee had a compliance history, in that the Compliance Order (CO) is being reissued to the same section and subsection, LTCHA 2007, s. 15 (2). The CO was initially served to the licensee in February 2019 as a result of Complaint Inspection #2019_625133_0002. As well, the licensee has been issued an additional 5 COs within the last 36 months, all of which have since been complied. As a result of complaint inspection #2017_625133_0013, two COs were issued, pursuant to O. Reg. 79/10, s. 90 (2) (a) and LTCHA 2007, s. 6 (1) (c) respectively. As a result of Critical Incident Inspection #2017_620126_0004, two COs were issued, pursuant to LTCHA 2007, s. 19 (1) and s. 6 (7) respectively. As a result of Complaint Inspection #2017_584161_0007, one CO was issued, pursuant to LTCHA 2007, s. 6 (7). (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 20, 2019(A1)

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:

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

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 19th day of November, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by JESSICA LAPENSEE (133) - (A1)

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

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