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*

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
Dec 06, 2019	2019_625133_0016 (A1)	032859-18	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Carlingview Manor
2330 Carling Avenue OTTAWA ON K2B 7H1

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 originally December 17, 2019. The CDD has been extended to January 24, 2020. There has been no other changes made.

Issued on this 6 th day of December, 2019 (A1)

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

Original report signed by the inspector.

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

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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 Complaint inspection.

This inspection was conducted on the following date(s): July 16, September 5, 6, 10, 13, 2019

The following intake was completed in the Follow Up inspection: Log #032859-18, which was related to pest control

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Environmental Services Manager, nursing staff, housekeeping staff and residents.

During the course of the inspection, the inspector reviewed documentation related to pest control and made observations in resident and non-resident areas related to pest control.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance

During the course of the original 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, furnishings and equipment are kept clean and sanitary.

In December 2018, the Ministry of Health and Long Term Care received a complaint related to cockroaches throughout the home. Specific concerns raised included cockroach sightings in a resident's dresser drawers.

On July 16, 2019, the Inspector observed a glueboard insect monitor next to resident #001's bedside table. There were approximately seven cockroaches on the monitor, four of which were alive. The monitor was dated July 10, 2019. The Inspector then observed inside of resident #001's bedside tables drawers. The back of the second drawer was dirty with a dead cockroach, three cockroach egg sacks, and an accumulation of small dark organic matter that appeared to be cockroach feces.

On September 5, 2019, it was determined through an initial interview with the Director of Care (#106) and the Administrator (#105), and a subsequent interview with the Environmental Services Manager (ESM, #107), that there was no procedure in place to ensure that inside of residents' drawers are kept clean and sanitary while they live in the home.

On September 5, 2019, the Inspector observed the outside and inside of resident #002's bedside table drawers. The inside of the second drawer, along the front ridge, was dirty with accumulation of small dark organic matter that appeared to be cockroach feces. Two live cockroaches were observed along this front ridge and they scattered to the outside of the drawer. The right side outer drawer was similarly dirty. The accumulation was most notable within an indentation on the side of the drawer, where there was a live cockroach and where the drawer slide met the drawer face, where there was another live cockroach. The inside of the bottom drawer was dirty with two dead cockroaches.

On September 5, 2019, the Inspector observed the inside of resident #003's bedside table drawer. Inside the drawer was dirty with a dead cockroach and an accumulation of cockroach egg sacks and small dark organic matter that appeared to be cockroach feces. There was a glueboard insect monitor within the drawer, dated July 16, 2019, with at least 50 dead cockroaches on it. There were two live cockroaches within the drawer, not on the monitor. During the observation period, the Inspector observed three cockroaches on the resident's pillow and one on their blanket.

On September 6, 2019, the Inspector observed around the area of resident

#004's bedside table. The top drawer was filled with multiple personal items and open food items, such as a bag of marshmallows. The inspector moved the items around and observed that the outer front edge of the drawer and the base of the drawer was dirty with brown sticky matter and accumulated small dark organic matter that appeared to be cockroach feces. Cockroaches scattered when the inspector moved the items around. On top of the bedside table there was three open cups of brown liquid, and four closed bottle of liquid. Behind one of the bottle, next to a watch, there was a dead cockroach and an accumulation of small dark organic matter that appeared to be cockroach feces. The privacy curtain next to the bedside table was dirty with a dead cockroach. The base of the hand sanitizer dispenser, to the right of the privacy curtain, was dirty with a cockroach egg sac, two dead cockroaches, an accumulation of small dark organic matter that appeared to be cockroach feces, and an accumulation of cockroach limbs.

On September 6, 2019, the Inspector spoke with resident #005 in their bed area. The resident indicated that there were cockroaches in their drawers and on top of their bedside table and in the table across from the foot of their bed. The resident had a fly swatter and indicated that they used it to move the bugs along. The Inspector observed inside of the resident's bedside table drawers. The inside of the second drawer was dirty with brown sticky matter and a dead cockroach. The outside of the drawer was dirty with a dead cockroach, within an indentation on the side of the drawer along the drawer slide. Inside of the third drawer was also dirty with sticky matter and a dead cockroach. In the table across from the foot of the resident's bed, the top drawer was dirty with a dead cockroach and some accumulated small dark organic matter that appeared to be cockroach feces.

On September 6, 2019, the Inspector observed inside of resident #006's bedside table. Inside of the top drawer, in the center, there were spots of organic dark matter that appeared to be mold. The drawer was also dirty with cockroach egg sacks and small dark organic matter that appeared to be cockroach feces. The second drawer was dirty with cockroach egg sacks and accumulated small dark organic matter that appeared to be cockroach feces. The bottom drawer was dirty with three dead cockroaches and accumulated small dark organic matter that appeared to be cockroach feces.

On September 10, 2019, the Inspector observed inside of the dresser across the room from resident #008's bed. The second drawer was dirty with an accumulation of cockroach egg sacks and one dead cockroach. The third drawer was dirty with an accumulation of cockroach egg sacks, dead cockroaches,

cockroach limbs, and small dark organic matter that appeared to be cockroach feces. There were two live cockroaches in the third drawer at the time of observation.

The licensee has failed to ensure that the home and furnishings are kept clean and sanitary. This is related to residents' drawers, which as a result appear to have served as areas of pest harbourage. [s. 15. (2) (a)]

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

In December 2018, the Ministry of Health and Long Term Care received a complaint related to cockroaches throughout the home. Specific concerns raised included ongoing cockroach sightings in the fourth floor shower room.

On September 5, 2019, the Inspector entered the fourth floor shower room with Personal Support Worker #102. Approximately fourteen cockroaches were observed within the room. Some cockroaches scattered outside of the shower room, around the lower door frames. The Inspector observed that the outer lower vinyl door frame protection and lower wall to the left side was in poor repair, serving as harbourage for cockroaches. On the right and left side, the door protection was cracked, torn and loose. The Inspector observed live and dead cockroaches in between the door protection and the door frames. The baseboard to the left of the door was loose and the wall above it was crumbling. The Inspector observed several live cockroaches within the top area of the loose baseboard and damaged wall area. Across from the shower room, to the left of the elevator, the lower wall was in poor repair, serving as harbourage for cockroaches. The metal corner bead was exposed and the wall was crumbled. The baseboard was loose. There was an accumulation of pieces of plaster on the floor, between the baseboard and the metal corner bead. The Inspector observed a live cockroach within the debris.

On September 10, 2019, the Inspector reviewed the service report provided to the home by the home's contracted pest control company, for September 5, 2019. Recommendations related to maintenance were noted for the second floor servery and the second floor staff washroom. Related to the second floor servery, the technician noted that caulking around the sink must be sealed to eliminate harbourage for pests, and, that pipes extending through the wall under the sink must be sealed to eliminate harbourage and entry points for pests. Related to the

second floor staff washroom, the technician noted that there were two gaps around pipeways that need to be sealed to eliminate entry points for pests. On September 13, 2019, the Inspector was provided with the subsequent service report, for September 12, 2019. The three maintenance items for the 2nd floor servery and staff washroom remained as open recommendations. The Inspector and the Environmental Services Manager went to the second floor servery and staff washroom and it was observed that the maintenance recommendations had not been addressed.

The licensee has failed to ensure that the home is maintained in a good state of repair, resulting in areas of harbourage and entry points for pests. [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

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 home be maintained in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for cleaning inside of residents' drawers while the residents live in the home.

On July 16, 2019, the Inspector observed inside resident #001's bedside tables drawers. The back of the second drawer was dirty with a dead cockroach, three cockroach egg sacks, and an accumulation of small dark organic matter that appeared to be cockroach feces.

On September 5, 2019, it was determined through an initial interview with the Director of Care (#106) and the Administrator (#105), and a subsequent interview with the Environmental Services Manager (ESM, #107), that there was no procedure in place for cleaning the inside of residents' drawers while the residents live in the home. The ESM qualified that when residents leave the home, the inside of drawers are cleaned out by housekeeping staff before a new resident moves in to the bedroom.

Over the subsequent course of the inspection, dead cockroaches and accumulated cockroach matter such as egg sacks and small dark organic matter was also observed in drawers belonging to resident #002, #003, #004, #005, #006 and #008. These observations are further described within Written Notification #1. [s. 87. (2) (a)]

Issued on this 6 th day of December, 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

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

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_0016 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 032859-18 (A1)

Type of Inspection / Genre d'inspection : Complaint

Report Date(s) / Date(s) du Rapport : Dec 06, 2019(A1)

Licensee / Titulaire de permis : Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4

LTC Home / Foyer de SLD : Carlingview Manor
2330 Carling Avenue, OTTAWA, ON, K2B-7H1

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Matt Carroll

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

To Revera Long Term Care Inc., 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 must be compliant with s.15 (2) of the LTCHA.

Specifically, the licensee must:

a) Clean resident #001, #002, #003, #004, #005, #006, and #008's furniture drawers.

b) Develop and implement a written multidisciplinary procedure that will ensure that the following residents' furniture drawers are kept clean, sanitary and do not serve as pest harbourage sites: resident #001, #002, #003, #004, #005, #006, #008, and any other resident. The procedure must also include all other bedroom furnishings. The procedure must be reflective of individual residents' needs and of pest sightings. Audit, review and revise the procedure as required.

Grounds / Motifs :

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

In December 2018, the Ministry of Health and Long Term Care received a complaint related to cockroaches throughout the home. Specific concerns raised included

cockroach sightings in a resident's dresser drawers.

On July 16, 2019, the Inspector observed a glueboard insect monitor next to resident #001's bedside table. There were approximately seven cockroaches on the monitor, four of which were alive. The monitor was dated July 10, 2019. The Inspector then observed inside of resident #001's bedside tables drawers. The back of the second drawer was dirty with a dead cockroach, three cockroach egg sacks, and an accumulation of small dark organic matter that appeared to be cockroach feces.

On September 5, 2019, it was determined through an initial interview with the Director of Care (#106) and the Administrator (#105), and a subsequent interview with the Environmental Services Manager (ESM, #107), that there was no procedure in place to ensure that inside of residents' drawers are kept clean and sanitary while they live in the home.

On September 5, 2019, the Inspector observed the outside and inside of resident #002's bedside table drawers. The inside of the second drawer, along the front ridge, was dirty with accumulation of small dark organic matter that appeared to be cockroach feces. Two live cockroaches were observed along this front ridge and they scattered to the outside of the drawer. The right side outer drawer was similarly dirty. The accumulation was most notable within an indentation on the side of the drawer, where there was a live cockroach and where the drawer slide met the drawer face, where there was another live cockroach. The inside of the bottom drawer was dirty with two dead cockroaches.

On September 5, 2019, the Inspector observed the inside of resident #003's bedside table drawer. Inside the drawer was dirty with a dead cockroach and an accumulation of cockroach egg sacks and small dark organic matter that appeared to be cockroach feces. There was a glueboard insect monitor within the drawer, dated July 16, 2019, with at least 50 dead cockroaches on it. There were two live cockroaches within the drawer, not on the monitor. During the observation period, the Inspector observed three cockroaches on the resident's pillow and one on their blanket.

On September 6, 2019, the Inspector observed around the area of resident #004's bedside table. The top drawer was filled with multiple personal items and open food items, such as a bag of marshmallows. The inspector moved the items around and observed that the outer front edge of the drawer and the base of the drawer was dirty

with brown sticky matter and accumulated small dark organic matter that appeared to be cockroach feces. Cockroaches scattered when the inspector moved the items around. On top of the bedside table there was three open cups of brown liquid, and four closed bottle of liquid. Behind one of the bottle, next to a watch, there was a dead cockroach and an accumulation of small dark organic matter that appeared to be cockroach feces. The privacy curtain next to the bedside table was dirty with a dead cockroach. The base of the hand sanitizer dispenser, to the right of the privacy curtain, was dirty with a cockroach egg sac, two dead cockroaches, an accumulation of small dark organic matter that appeared to be cockroach feces, and an accumulation of cockroach limbs.

On September 6, 2019, the Inspector spoke with resident #005 in their bed area. The resident indicated that there were cockroaches in their drawers and on top of their bedside table and in the table across from the foot of their bed. The resident had a fly swatter and indicated that they used it to move the bugs along. The Inspector observed inside of the resident's bedside table drawers. The inside of the second drawer was dirty with brown sticky matter and a dead cockroach. The outside of the drawer was dirty with a dead cockroach, within an indentation on the side of the drawer along the drawer slide. Inside of the third drawer was also dirty with sticky matter and a dead cockroach. In the table across from the foot of the resident's bed, the top drawer was dirty with a dead cockroach and some accumulated small dark organic matter that appeared to be cockroach feces.

On September 6, 2019, the Inspector observed inside of resident #006's bedside table. Inside of the top drawer, in the center, there were spots of organic dark matter that appeared to be mold. The drawer was also dirty with cockroach egg sacks and small dark organic matter that appeared to be cockroach feces. The second drawer was dirty with cockroach egg sacks and accumulated small dark organic matter that appeared to be cockroach feces. The bottom drawer was dirty with three dead cockroaches and accumulated small dark organic matter that appeared to be cockroach feces.

On September 10, 2019, the Inspector observed inside of the dresser across the room from resident #008's bed. The second drawer was dirty with an accumulation of cockroach egg sacks and one dead cockroach. The third drawer was dirty with an accumulation of cockroach egg sacks, dead cockroaches, cockroach limbs, and small dark organic matter that appeared to be cockroach feces. There were two live

cockroaches in the third drawer at the time of observation.

The licensee has failed to ensure that the home and furnishings are kept clean and sanitary. This is related to residents' drawers, which as a result appear to have served as areas of pest harbourage.

In conclusion, the decision to issue a compliance order was based on the following:

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

The scope of the non-compliance identified was widespread as seven residents' drawers were observed not to be clean and sanitary, and there was no procedure in place for cleaning residents' drawers.

The licensee had a compliance history, in that there has been previous non-compliance issued to different subsections.
(133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 24, 2020(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:

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 6 th day of December, 2019 (A1)

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Amended by JESSICA LAPENSEE (133) - (A1)

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