Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
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Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 31, 2021	2021_838760_0010	021466-20, 021695-20, 025633-20, 025753-20, 000480-21, 000739-21, 001255-21, 002867-21	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
Seniors Services and Long-Term Care (Union Station) c/o 55 John Street Toronto ON M5V 3C6

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

Bendale Acres
2920 Lawrence Avenue East Scarborough ON M1P 2T8

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

JACK SHI (760), SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 17, 18, 19, 22, 23, 24, 25, 26, 29, 2021.

The following intakes were completed in this critical incident inspection:

A log was related to safe transferring and positioning;
Three logs were related to an allegation of resident abuse;
Four logs were related to a fall.

During the course of the inspection, the inspector(s) spoke with the Physiotherapist, the Social Worker, a Recreational Service Assistant (RSA), Registered Nurses (RN), a Behavioural Supports Ontario Registered Practical Nurse (BSO RPN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nurse Managers (NM), the Assistant Administrator, the Administrator and the Director of Care (DOC).

During the course of the inspection, the inspector conducted observations, interviews and record reviews.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that two PSWs followed the home's infection prevention and control (IPAC) practices related to a resident's care.

Video footage indicated one PSW was using a washcloth to clean themselves and the same washcloth was used by another PSW to provide care for a resident. A nurse manager confirmed the PSWs did not follow the home’s IPAC practices. There was potential risk to spread infectious diseases to the resident from the PSWs.

Sources: Video footage and interviews with a nurse manager and other staff. [s. 229. (4)]

2. The licensee has failed to ensure that the staff and a person in the facility followed the home's IPAC practices.

The home had a suspected outbreak on a resident unit. According to public health directions, the affected unit had been put on precautions. Prior to and during the home’s suspected outbreak, a number of other floor units also had rooms with precautions.

Observations and interviews had noted the following:
- A PPE caddie did not have any gowns or gloves stocked in it. Furthermore, a person on the unit was observed to have walked into an affected room without wearing any additional personal protective equipment (PPE). An RPN stated that PPE was supposed to stocked by the staff member who had used the last PPE item. The nurse manager stated the person should have followed the signage posted outside the room related to the proper PPE protocols, prior to entering the room.
- An RPN was seen inside an affected room without wearing a gown. The RPN apologized for their actions and indicated they should have worn a gown while inside the room.
- A PSW was observed to not have performed hand hygiene prior to putting their gown on. The nurse manager stated that the PSW should have performed hand hygiene as they may have contaminated the clean gown without doing so.

The observations demonstrated that that there were inconsistent IPAC practices from the staff and visitors of the home and a lack of PPE equipment inside a PPE caddie. There was actual risk of harm to residents associated with these observations because by not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Interviews with two RPNs, a nurse manager and other staff; Observations made in the home during the inspection. [s. 229. (4)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident had a written plan of care that sets out the planned care.

The resident had a fall and sustained an injury. The resident continued to be at risk for falls. Observations and interviews indicated that a fall prevention intervention was used. Review of the current written plan of care indicated this intervention was not included. Interviews with an RN and nurse manager acknowledged the fall prevention intervention should have been part of the resident's written plan of care.

Failing to include the fall prevention intervention in the resident's plan of care can put the resident at risk for further falls.

Sources: A resident's medical record, observation and interviews with an RN and other staff. [s. 6. (1) (a)]

2. The licensee failed to ensure that the directions on a resident's plan of care was clear related a communication intervention.

An allegation was made related to a staff to resident physical abuse. An interview with three RPNs indicated that after this incident, they had understood the resident did not want a method of communication. A review of the resident's most recent care plan indicated that this method was used as a form of communication with the resident. The care plan did not provide clear directions to the staff related to how this resident prefers to be communicated towards, therefore, it would potentially impact the resident's well being if it was followed.

Sources: A resident's care plan; Home's investigation notes; Interviews with three RPNs and other staff. [s. 6. (1) (c)]

3. The licensee has failed to ensure a resident had constant monitoring as specified in their plan of care.

A review of this resident's care plan indicated that they required constant monitoring so that they did not engage in responsive behaviours towards co-residents. The PSW assigned to this resident's behavioural monitoring was seen assisting with the care in another resident. The PSW added that the resident's responsive behaviours were unpredictable. The nurse manager stated that the PSW did not follow the resident's care plan and should not have assisted with the other resident's care. There was potential risk to this resident and others around them as constant monitoring was required to ensure safety of this resident and others around them.

Sources: Video footage from another resident's room; the resident's care plan; Interviews with a PSW, a nurse manager and other staff. [s. 6. (7)]

4. The licensee has failed to ensure that a resident had a preferred staff member assigned for their care as specified in their plan of care.

An allegation was made related to a physical abuse incident from the staff to the resident. A review of the resident's care plan at the time of the incident indicated a preferred type of staff member for personal care. The RN stated they were unaware of the resident's need to receive the preferred staff member for personal care. The RN said it was the responsibility of the PSWs to read the resident's care plan prior to giving care to them. The PSW misunderstood the resident's care needs at the time of the incident. The PSW stated they believed that it was the responsibility of the RN to have informed them about the resident's preferred staff member.

Sources: Video footage of a resident; a resident's care plan; Interviews with an RN, a PSW and other staff. [s. 6. (7)]

5. The licensee has failed to ensure that a resident had their fall prevention intervention in place as specified in their plan of care.

The resident had a fall and sustained injuries. The care plan was updated afterwards and a fall prevention intervention was implemented. An interview with a PSW indicated the resident continued to be at risk for falls. The PSW was not aware that the resident was to have this fall prevention intervention. The RN confirmed the resident did not have their fall prevention intervention in place, as specified in their care plan and that a refusal was not noted.

Failing to apply the fall prevention intervention for the resident put them at risk for injury if a fall should occur.

Sources: A Critical Incident System (CIS) report, the resident's medical record and interviews with an RN and other staff. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident and (c) clear directions to staff and others who provide direct care to the resident; to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that five PSWs used safe transferring techniques with a resident.

A review of the resident's care plan indicated they used a transfer device. Two PSWs were observed to have been performing personal care on the resident while the resident was on the transfer device. They were also observed to have left the resident alone on the transfer device for a period of time. The PT confirmed that the transfer device is not used for the provision of care. Furthermore, the PT and a nurse manager stated the PSWs had put the resident at risk of injury when they left the resident alone on the transfer device. One of the PSWs stated the resident was supposed to be monitored at all times while on the transfer device. The other PSW apologized for their actions for leaving the resident alone while they were on the transfer device.

On a number of days, three PSWs were seen providing a transfer to the resident. The nurse manager confirmed that the staff did not follow the resident's transfer status on their care plan. The nurse manager added that this had put the resident at further risk of injury during the transfer.

The PSWs did not utilize safe transferring techniques with the resident and there was actual risk of harm to the resident. The resident may have sustained an injury during the care they received by the PSWs.

Sources:The home's transfer policy (dated January 2019); a resident's care plan; Video footage of the resident; Interviews with two PSWs, the PT, the nurse manager and other staff. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that an abuse allegation by a staff member of the home to a resident was investigated.

A Critical Incident Systems (CIS) report was submitted by the home related to an allegation of abuse from a staff member to a resident. A review of the home's investigation notes indicated that the Resident Services Manager (RSM) did not complete their investigation and had delegated it to other staff. The administrator stated the RSM did not bring the investigation to the home's attention. The administrator stated the investigation could have been completed earlier.

Sources: Home's investigation report; Interview with an administrator and other staff. [s. 23. (1) (a)]

Issued on this 1st day of April, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JACK SHI (760), SUSAN SEMEREDY (501)
Inspection No. / No de l’inspection :	2021_838760_0010
Log No. / No de registre :	021466-20, 021695-20, 025633-20, 025753-20, 000480-21, 000739-21, 001255-21, 002867-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 31, 2021
Licensee / Titulaire de permis :	City of Toronto Seniors Services and Long-Term Care (Union Station), c/o 55 John Street, Toronto, ON, M5V-3C6
LTC Home / Foyer de SLD :	Bendale Acres 2920 Lawrence Avenue East, Scarborough, ON, M1P-2T8
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Gina Filice

Ontario

Ministry of Long-Term Care

Ministère 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 Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Conduct monitoring in all home areas to ensure staff and visitors are adherent to the appropriate Infection Prevention and Control (IPAC) practices.
2. Provide on the spot education and training to staff and/or visitors not adhering with appropriate IPAC measures.
3. Ensure care caddies with PPE are fully stocked at all times.

Grounds / Motifs :

1. The licensee failed to ensure that two PSWs followed the home's infection prevention and control (IPAC) practices related to a resident's care.

Video footage indicated one PSW was using a washcloth to clean themselves and the same washcloth was used by another PSW to provide care for a resident. A nurse manager confirmed the PSWs did not follow the home's IPAC practices. There was potential risk to spread infectious diseases to the resident from the PSWs.

Sources: Video footage and interviews with a nurse manager and other staff. [s. 229. (4)] (760)

2. The licensee has failed to ensure that the staff and a person in the facility followed the home's IPAC practices.

The home had a suspected outbreak on a resident unit. According to public health directions, the affected unit had been put on precautions. Prior to and

during the home's suspected outbreak, a number of other floor units also had rooms with precautions.

Observations and interviews had noted the following:
- A PPE caddie did not have any gowns or gloves stocked in it. Furthermore, a person on the unit was observed to have walked into an affected room without wearing any additional personal protective equipment (PPE). An RPN stated that PPE was supposed to stocked by the staff member who had used the last PPE item. The nurse manager stated the person should have followed the signage posted outside the room related to the proper PPE protocols, prior to entering the room.
- An RPN was seen inside an affected room without wearing a gown. The RPN apologized for their actions and indicated they should have worn a gown while inside the room.
- A PSW was observed to not have performed hand hygiene prior to putting their gown on. The nurse manager stated that the PSW should have performed hand hygiene as they may have contaminated the clean gown without doing so.

The observations demonstrated that that there were inconsistent IPAC practices from the staff and visitors of the home and a lack of PPE equipment inside a PPE caddie. There was actual risk of harm to residents associated with these observations because by not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Interviews with two RPNs, a nurse manager and other staff; Observations made in the home during the inspection.

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

Severity: There was actual risk of harm to the residents because public health had put the home in a suspected outbreak and there was potential for possible transmission of infectious agents due to the staff and visitor not participating in the implementation of the IPAC program and PPE not being fully stocked outside of resident rooms.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during the inspection and from observations

throughout the home, and the non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: Multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation in the past 36 months. (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 19, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 31st day of March, 2021

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Jack Shi

Service Area Office /
Bureau régional de services : Central East Service Area Office