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

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 rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 13, 2020	2020_785732_0004 (A1)	018511-19, 023040-19	Critical Incident System

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 EMILY BROOKS (732) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The CDD has been changed to April 6, 2020.

Issued on this 13th day of February, 2020 (A1)

[redacted]

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

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

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Carlingview Manor
2330 Carling Avenue OTTAWA ON K2B 7H1

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

Amended by EMILY BROOKS (732) - (A1)

Amended 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): February 3 - 6, 2020

Log #023040-19 (CIR #2420-000078-19) related to alleged resident to resident abuse was completed during this Critical Incident System inspection.

Log #018511-19, follow-up to CO #001 from inspection #2019_625133_0016/032859-18 regarding s.15. (2) was also completed during this Critical Incident System inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Environmental Manager (EM), an Assistant Director of Care (ADOC), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a housekeeper, and residents.

The inspector(s) reviewed resident health care records, relevant policies and procedures related to pest control; as well as observed residents in home care environments, resident to resident interactions, and resident bedrooms and their furnishings related to pest control.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
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 ensure that resident #010's furnishings are kept clean and sanitary.

On February 4, 2020, Inspector #732 observed the outside and inside of resident #010's bedside table dresser. In the top drawer of resident #010's bedside table dresser, Inspector #732 observed two dead and flattened cockroaches, pieces of cockroach shell, small dark organic matter that appeared to be cockroach feces, two areas of dried brown matter; one in the top left corner of the drawer and another to the right of that, with small, dried brown matter around it. A small area of dried purple matter was also observed. In the middle drawer of resident #010's bedside table dresser, Inspector #732 observed the inner front corners (including ledge) dirty with accumulated dried yellow matter. On the right side of the drawer, small dark organic matter that appeared to be cockroach feces as well as the limbs of cockroaches were observed on resident 010's magazine.

On February 5, 2020, Inspector #732 returned to observe resident #010's bedside table dresser. Inspector #732 moved around the contents of resident #010's middle drawer. In addition to what was observed on February 4, 2020, the Inspector also observed a dead cockroach, cockroach limbs, and an accumulation of white granular matter and an area of dried brown matter under a chess board. Inspector #732 observed the bottom drawer of resident #010's bedside table dresser and observed dead bugs and small dark organic matter that appeared to be cockroach feces.

Later that day, Environmental Manager (EM) #105 accompanied Inspector #732 to observe resident #010's bedside table dresser. EM #105 told Inspector #732 that it appeared the drawers had not been cleaned for some time.

EM #105 explained that every residents' bedroom is to be deep cleaned once every three weeks, including inside of all furnishings. EM #105 provided Inspector #732 with the housekeeper weekly routine, in support of the licensee's deep cleaning program for resident bedrooms. The schedule indicated that resident #010's bedroom had been deep cleaned on January 18, 2020.

In addition to the deep cleaning program in place for resident bedrooms, Executive Director (ED) #106 informed Inspector #732 that Personal Support Workers (PSW) are assigned a task on Point of Care (POC) whereby, on the resident's assigned bath days, PSW's are required to open residents' drawers and check that they are clean and maintained, and remove all food. On February 5, 2020, Director of Care (DOC) #107 provided Inspector #732 with a print out of the above-mentioned task for every resident of the home. Specifically, the task read, "Bedside table, closest and other personal storage cleaned. Any food items that were not stored in sealed container removed and discarded?". Inspector #732 noted that for resident #010, the referenced task on POC had been documented as completed by PSW's on January 29, 2020, and February 5, 2020.

On February 6, 2020, the Inspector returned to observe resident #010's bedside table dresser and noted that it had not yet been cleaned.

In summary, the licensee failed to ensure that resident #010's dresser drawers were kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee has failed to ensure that furnishings are maintained in a good state of repair.

On February 4, 2020, resident #010's bedside table drawers were observed. It was noted that the laminated surface of the base of the top drawer was degraded throughout. The underlying particle board was exposed, rendering the surface porous and absorbent. Such a surface can not be kept clean and sanitary.

On February 4, 2020, resident #012's dresser, on the wall opposite their bed, was observed. The front cover of the bottom drawer was not fully connected to the remainder of the drawer. The front left corner of the drawer cover was touching the floor. Inspector #732 was unable to pull open the bottom drawer. In order to observe inside resident #012's bottom drawer, Inspector #732 was required to pry

the front left drawer cover forward.

The licensee has failed to ensure that resident #010 and resident #012's furnishings were maintained in a good state of repair. [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 / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

Issued on this 13th day of February, 2020 (A1)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by EMILY BROOKS (732) - (A1)
Inspection No. / No de l'inspection :	2020_785732_0004 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	018511-19, 023040-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 13, 2020(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

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 Revera Long Term Care Inc., 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

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 # / No d'ordre: 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_625133_0016, 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 must comply with s. 15 (2) of the LTCHA. Specifically, the licensee shall:

a) Clean resident #010's bedside dresser drawers.

b) Implement a written multidisciplinary procedure that will ensure that resident #010's furniture drawers are kept clean, sanitary and do not serve as pest harbourage sites. The procedure must also include all other bedroom furnishings. The procedure must be reflective of the individual resident needs and of pest sightings. Audit, review and revise the procedure as required.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #001 from Complaint Inspection #2019_625133_0016. CO #001 was served on September 19, 2019 with a compliance date of December 17, 2019. The compliance date was subsequently amended, upon request from the licensee, to January 24, 2020.

The licensee was ordered to comply with s. 15 (2) of the LTCHA.

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

Specifically, the licensee was ordered to:

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.

The licensee completed the first step. The licensee failed to complete the second step; in that the multidisciplinary procedure did not ensure that resident #006’s furniture drawers were kept clean, sanitary and did not serve as a site for pest harbourage.

For the purposes of this inspection report, the resident referenced as #006 in relation to complaint inspection #2019_625133_0016 is referenced as resident #010.

On February 4, 2020, the Inspector observed the outside and inside of resident #010’s bedside table dresser. In the top drawer of resident #010’s bedside table dresser, Inspector #732 observed two dead and flattened cockroaches, pieces of cockroach shell, small dark organic matter that appeared to be cockroach feces, two areas of dried brown matter; one in the top left corner and another to the right of that one with small, dried brown matter around it. A small area of dried purple matter was also observed. In the middle drawer of resident #010’s bedside table dresser, Inspector #732 observed the inner front corners (including ledge) dirty with accumulated dried yellow matter. On the right side of the drawer, small dark organic matter that appeared to be cockroach feces as well as the limbs of cockroaches were observed on resident 010’s magazine.

On February 5, 2020, the Inspector returned to observe resident #010’s bedside table dresser. Inspector #732 moved around the contents of resident #010’s middle drawer. In addition to what was observed on February 4, 2020, the Inspector also observed a dead cockroach, cockroach limbs, and an accumulation of white granular matter and an area of dried brown matter under a chess board. Inspector #732

observed the bottom drawer of resident #010's bedside table dresser and observed dead bugs and small dark organic matter that appeared to be cockroach feces.

Later that day, Environmental Manager (EM) #105 accompanied Inspector #732 to observe resident #010's bedside table dresser. EM #105 told Inspector #732 that it appeared the drawers had not been cleaned for some time.

EM #105 explained that every residents' bedroom is to be deep cleaned once every three weeks, including inside of all furnishings. EM #105 provided Inspector #732 with the housekeeper weekly routine, in support of the licensee's deep cleaning program for resident bedrooms. The schedule indicated that resident #010's bedroom had been deep cleaned on January 18, 2020.

In addition to the deep cleaning program in place for resident bedrooms, Executive Director (ED) #106 informed Inspector #732 that Personal Support Workers (PSW) are assigned a task on Point of Care (POC) whereby, on the resident's assigned bath days, PSW's are required to open residents' drawers and check that they are clean and maintained and remove all food. On February 5, 2020, Director of Care (DOC) #107 provided Inspector #732 a print out of the above-mentioned task for every resident of the home. Specifically, the task read, "Bedside table, closest and other personal storage cleaned. Any food items that were not stored in sealed container removed and discarded?". Inspector #732 noted that for resident #010, the referenced task on POC had been documented as completed by PSW's on January 29, 2020, and February 5, 2020.

On February 6, 2020, the Inspector returned to observe resident #010's bedside table dresser and noted that it had not yet been cleaned.

In summary, the licensee failed to develop and implement a written multidisciplinary procedure that ensured that resident #010's furniture drawers were kept clean, sanitary and did not serve as pest harbourage sites.

The severity of non-compliance was such that there was minimal risk to the resident. The scope of the non-compliance identified was isolated in that it applied to resident #010.

Related to the licensee's compliance history, the Compliance Order (CO) is reissued

to the same section and subsection, LTCHA, 2007, s. 15 (2) (a), related to keeping furnishings clean and sanitary. CO #001 was initially served to the licensee on September 19, 2019, as a result of Compliant inspection #2019_625133_0016. The licensee has been issued an additional four CO's and a Director's Order within the last 36 months:

Resulting from Critical Incident Inspection #2018_730593_0004, CO #001 was related to LTCHA, 2007, s. 5. The CO was issued in October 2018 and was associated to a Director's Referral (DR), which resulted in a Director's Order. The Director's Order was complied in December 2018.

Resulting from Follow Up Inspection #2018_597655_0009, CO #001 was related to O. Reg. 79/10, s. 9 (1). The CO was issued in July 2018 and complied in September 2018.

Resulting from Critical Incident Inspection #2017_708548_0029, CO #001 was related to O. Reg. 79/10, s. 9 (1). The CO was issued in January 2018 and complied in July 2018.

Resulting from Complaint Inspection #2017_682549_0011, CO #001 was related to O. Reg. 79/10, s. 114 (1) and CO#002 was related to O. Reg 79/10, s. 131 (2). The CO's were issued in November 2017. The CO's were complied in February 2018. (732)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 06, 2020(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

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:

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 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 13th day of February, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by EMILY BROOKS (732) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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