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 le Loi de 2007 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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Aug 09, 2018;	2018_610633_0005 (A7)	005175-18	Complaint

Licensee/Titulaire de permis

Golden Years Nursing Homes (Cambridge) Inc.
704 Eagle Street North P.O. Box 3277 CAMBRIDGE ON N3H 4T3

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

Golden Years Nursing Home
704 Eagle Street North P.O. Box 3277 CAMBRIDGE ON N3H 4T3

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

Amended by SHERRI COOK (633) - (A7)

Amended Inspection Summary/Résumé de l'inspection modifié

Final Public Report

Issued on this 9 day of August 2018 (A7)

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

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Ministère de la Santé et des Soins de longue durée

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

Amended by SHERRI COOK (633) - (A7)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): March 26-30, 2018.

The following intake was completed during this inspection:

Log #005175-18/HLTC2966MC-2018-2524- Complaint related to medication and falls prevention.

Inspector Zinnia Sharma #696 was present at this inspection.

During the course of the inspection, the inspector(s) spoke with the Vice President of Clinical Services, the Administrator, a Physician, the Director of Care, the Assistant Director of Care, the previous Director of Resident Care, the previous Assistant Director of Resident Care, the Vice President of the home's Pharmacy, a Pharmacist, Registered Nurses, a Physiotherapist, Registered Practical Nurses, Personal Support Workers, a Substitute Decision Maker and residents.

The inspector(s) reviewed the clinical records of the identified residents and the home's relevant documentation and policies. In addition, the medication administration practices were observed at the home.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Medication

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

During the course of the original inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **2 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	Legendé 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 #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

(A5)
1. The licensee has failed to ensure that an identified resident's plan of care was revised at any other time when the care set out in the plan had not been effective.

The complaint and documents submitted to the MOHLTC by the SDM stated that the resident had multiple falls with increased injuries while at the nursing home. The resident sustained a significant injury from a fall.

The SDM stated that the home did not try to prevent the resident from falling and the interventions that were in place were not effective. The SDM also said that the resident used a device at home.

The home's policy "005190.00 Fall Prevention & Management program-Falls Risk Factors & Related Interventions", last revised on June 27, 2017, stated in part:

-"That the DOC will ensure that action plans to address trends were in place.
-The Registered staff will ensure:
-That preventative interventions were included in the resident's plan of care.
-That the resident's care plan must be re-evaluated and updated with preventative measures following the falls conference or "huddle".
-That the physician will review the medication regime.
-That interventions related to history of falls included the investigation of medication regime and use of restraints.
-That interventions related to medications included alteration of drug therapy and collaboration with the physician and pharmacist.

-That interventions related to environmental hazards included the use of raised toilet seats and the post falls and skin and wound assessments in PCC documented that.
-That interventions related to equipment use included padded clothing such as house coats, hip protectors, falls mats and the use of one side rail.
-That intervention related to disease process included the monitoring of pharmacological interventions".

The home's policy 005530.00 stated in part:
-That all residents being admitted to the home after April 1, 2015 will not utilize a specific device upon admission to the home.
-That a specific device will only be considered for resident mobility if the physiotherapist and other members of the interdisciplinary team find the device to be a consideration for mobility or transfer they will institute an assessment process.
-That the resident will be assessed for alternative devices for mobility or transfer.
-That if there are no other alternatives an assessment will be completed.
-That if the resident passes the assessment, a specific device can be implemented into the plan of care.
-That the specific device will remain if the resident meets the criteria, if the resident does not meet the criteria for a specific device the plan of care will be updated and the resident/SDM will be notified.

The plan of care stated that the identified resident was independent with their mobility by use of a devise however staff supervision was required. The resident was assessed upon admission as having a high falls risk and a specific intervention was in place. Assessments documented that the resident had multiple falls during a specific period of time and a specific percentage of their falls were related to the resident's repositioning. The post fall assessments also documented that the plan of care for the resident was ineffective. The resident's care plan was not revised to include the alternate interventions that were implemented by the home that were identified in their completed assessments. The assessments also showed that the resident's injuries related to their falls increased.

Two Registered Practical Nurses (RPN's), a Registered Nurse (RN), a Physiotherapist (PT) and the Assistant Director of Care (ADOC) all said that a specific intervention was not effective. All staff also identified fall and injury prevention interventions for the resident that had not been implemented into their plan of care. The ADRC also identified interventions that were not implemented for the resident.

Two registered staff said that when a resident was frequently falling and interventions were ineffective they talked about it at the team huddle. The DOC stated that a specific device or alternatives and the resident's medications were not considered or implemented as fall prevention strategies and they agreed that the resident was documented frequently as having falls. There was no action plan developed from the post fall team huddles. The DOC also stated that the home had specific policy and unless the family requested a specific device an assessment was not completed.

A RN they said that the resident fell often. They also said that when a resident falls a post fall assessment was completed and the care plan would be updated to include interventions to prevent further falls and the tasks would be updated for the Personal Support Workers (PSW's). The RN was unable to identify injury prevention strategies and they stated that specific interventions were not implemented for the resident into their plan of care related to their falls.

The Monthly Fall Reporting for two months under the heading of Care Plan was blank.

A Physiotherapist said that a specific device was not considered by them related to the home's policy and specific alternatives were not implemented for the resident. They also said that medications could contribute to falls and this was discussed related to the resident at a falls meeting. A Pharmacist confirmed that a medication review was not completed for this resident.

The ADOC said that they were the falls lead at the home. The ADOC agreed that a specific device was not considered for the resident related to the home's policy and specific interventions were also not implemented as falls prevention strategies. The ADOC was unable to identify injury prevention strategies and they could not confirm how and when two interventions were implemented however they agreed that these were not included in the resident's care plan until a later specific date.

The licensee has failed to ensure that an identified resident plan of care related to falls prevention was revised at any other time when their care set out in their plan had not been effective. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A5)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed protect resident #001 from neglect by the licensee or staff.

The following is further evidence to support Compliance Order (CO) #001 issued from a Resident Quality Inspection (RQI) related to LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) with a compliance due date of March 30, 2018.

O. Reg. 79/10, s. 5. states that "neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

An identified resident was admitted to the home on a specific date, with complex needs related to their diagnoses that were not addressed by the home. The medication management system related to specific medications and the plan of care related to falls prevention failed to provide the resident with the treatment,

care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

1. The complaint intake and documents submitted by the SDM for the identified resident stated that the home did not adhere to the resident's basic need of receiving their medications on time.

The SDM said that the resident's medications were not given appropriately and the staff were unaware of the resident's needs related to their medication administration. The SDM stated that a medication schedule was required to manage the resident's symptoms and this was ignored by the home.

The plan of care for the resident during a specific time period and a record review of additional relevant documentation that included the best possible medication history completed on admission, the best practices related to medication reconciliation and administration, the home's medication policies and a medication case review showed that the home's interdisciplinary medication management system failed to provide safe medication management that optimized effective drug therapy outcomes for two resident's that had a specific diagnoses. Staff interviews confirmed that the two resident's did not receive the treatment required related to their diagnoses specifically related to medication management and there was a pattern of inaction by the home identified. Evidence to support this non-compliance related to LTCHA, 2007 O. Reg 79/10 r. 114(1) is contained in this report.

2. The complaint intake and documents submitted by the SDM stated that the home did not put interventions in place related to the resident's falls prevention.

The SDM said that the resident fell often at the home sustaining injuries and the strategies in place to prevent their falls were ineffective.

The assessments for the resident documented they had numerous falls during a specific time period. The plan of care for the resident related to their falls prevention and the home's policies and fall program documentation showed that the resident's care plan was not revised and did not include alternate interventions to prevent their falls or protect them from injury. Staff interviews confirmed that the resident did not receive the treatment or care required for their health, safety or well-being and there was a pattern of inaction by the home related to falls prevention identified. Evidence to support this non-compliance related to LTCHA,

2007, c. 8, s 6.(10)(c) in contained in this report.

The licensee has failed protect an identified resident from neglect by the licensee or staff. [s. 19. (1)]

(A4)(Appeal/Dir#DR #087)
The following Non-Compliance has been Revoked: WN #2

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

Issued on this 9 day of August 2018 (A7)

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
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by SHERRI COOK (633) - (A7)

Inspection No. / No de l'inspection : 2018_610633_0005 (A7)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 005175-18 (A7)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Aug 09, 2018;(A7)

Licensee / Titulaire de permis : Golden Years Nursing Homes (Cambridge) Inc.
704 Eagle Street North, P.O. Box 3277,
CAMBRIDGE, ON, N3H-4T3

LTC Home / Foyer de SLD : Golden Years Nursing Home
704 Eagle Street North, P.O. Box 3277,
CAMBRIDGE, ON, N3H-4T3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Danny Pereira

To Golden Years Nursing Homes (Cambridge) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

(A3)(Appeal/Dir# DR# 087)
The following Order has been rescinded:

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must be complaint with s. 6 (10)(c) of the LTCHA.
Specifically the licensee must ensure:
1. That the care plan is revised when a resident is assessed post fall and the care set out in the plan has not been effective related to their falls. This revision must be documented.
-That when the care plan is being revised because the care set out in the plan has not been effective related to their falls, the licensee must ensure that different approaches are considered and implemented in the revision of the plan of care related to falls prevention. These different approaches and their effectiveness must be documented.
2. That as part of the falls prevention program, the licensee must ensure that for all residents that are assessed as a high risk for falls and have had multiple falls, and medications have been identified as a contributing factor, the resident has a medication review completed and documented.
-That action plans are developed and implemented for a resident with frequent falls. These action plans must be documented.
-That all staff are re-educated on falls prevention. This training must be documented.

Grounds / Motifs :

The licensee has failed to ensure that an identified resident's plan of care was revised at any other time when the care set out in the plan had not be effective.

The complaint and documents submitted to the MOHLTC by the SDM stated that the resident had multiple falls with increased injuries while at the nursing home. The resident sustained a significant injury from a fall.

The SDM stated that the home did not try to prevent the resident from falling and the interventions that were in place were not effective. The SDM also said that the resident used a device at home.

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-That the resident's care plan must be re-evaluated and updated with preventative measures following the falls conference or "huddle".
-That the physician will review the medication regime.
-That interventions related to history of falls included the investigation of medication regime and use of restraints.
-That interventions related to medications included alteration of drug therapy and collaboration with the physician and pharmacist.
-That interventions related to environmental hazards included the use of raised toilet seats.
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-That a specific device will only be considered for resident mobility if the physiotherapist and other members of the interdisciplinary team find the device to be a consideration for mobility or transfer they will institute an assessment process.
-That the resident will be assessed for alternative devices for mobility or transfer.
-That if there are no other alternatives an assessment will be completed.
-That if the resident passes the assessment, a specific device can be implemented into the plan of care.
-That the specific device will remain if the resident meets the criteria, if the resident does not meet the criteria for a specific device the plan of care will be updated and the resident/SDM will be notified.

The plan of care stated that the identified resident was independent with their mobility by use of a devise however staff supervision was required. The resident was assessed upon admission as having a high falls risk and a specific intervention was in place. Assessments documented that the resident had multiple falls during a specific period of time and a specific percentage of their falls were related to the resident's repositioning. The post fall assessments also documented that the plan of care for the resident was ineffective. The resident's care plan was not revised to include the alternate interventions that were

implemented by the home that were identified in their completed assessments. The assessments also showed that the resident's injuries related to their falls increased.

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and specific interventions were also not implemented as falls prevention strategies. The ADOC was unable to identify injury prevention strategies and they could not confirm how and when two interventions were implemented however they agreed that these were not included in the resident's care plan until a later specific date.

The licensee has failed to ensure that an identified resident plan of care related to falls prevention was revised at any other time when their care set out in their plan had not been effective. [s. 6. (10) (c)]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one of the three residents reviewed. The home had a level 3 compliance history as there was related non-compliance that included:

• Voluntary plan of correction (VPC) related to 6.(10)(b) from complaint inspection 2015_260521_0048 issued November 10, 2015.
• VPC related to 6.(10)(b) from RQI inspection 2016_226192_0002 issued February 5, 2016.
• WN related to 6.(10)(b) from Follow up inspection 2016_226192_0023 issued August 8, 2016.

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

Jul 20, 2018

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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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.

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

Issued on this 9 day of August 2018 (A7)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by SHERRI COOK - (A7)

Service Area Office /
Bureau regional de services: Central West