

**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**

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de
Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
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Public Copy/Copie 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 |
|--|---|-----------------------------------|--|
| Dec 3, 2021 | 2021_895609_0004 | 013038-21 | Critical Incident System |

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Owen Hill Care Community
130 Owen Street Barrie ON L4M 3H7

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

KAREN HILL (704609)

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): November 16 - 19, 2021.

The following intake was inspected upon during this Critical Incident System inspection:

- one log, related to resident to resident abuse.

Inspector #155 attended this inspection as an observer.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Services Manager, Infection Prevention and Control (IPAC) Lead, Resident and Family Experience Coordinator/Internal Behavioural Supports Ontario (BSO) Lead, Public Health Unit Liaison, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Client Service Associates (CSAs), Housekeeping staff and residents.

The Inspector also conducted a daily tour of resident home areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, observed staff IPAC practices, reviewed relevant resident health care records, relevant staffing schedules, and the home's policies and protocols.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control

Medication

Personal Support Services

Responsive Behaviours

Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

4 WN(s)

3 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that the home was a safe and secure environment for its residents, specifically related to staff use of Personal Protective Equipment (PPE) and wearing protective eye wear.

COVID-19 Directive #3 indicates that homes must follow any guidance provided by the local public health unit (PHU) related to any additional measures that must be implemented to reduce the risk of COVID-19 transmission in the Long-Term Care home.

The home was directed by the PHU to implement additional measures, including the use of eye protection in resident home areas (RHAs), for a designated period.

During the inspection, the following observations were made related to staff implementation of the PHU's direction:

- Four staff members entered resident rooms on additional precautions and did not wear the appropriate PPE.
- One staff member had their protective eye wear on top of their head while preparing medications and another staff member was not wearing any eye protection while preparing and administering medications nor when in the RHAs.
- An additional staff member was not wearing the correct eye wear when assisting with meal delivery in the RHAs. Five other staff members did not wear protective eye wear while in the RHAs or when entering resident rooms.

In interviews with staff, they indicated they should have worn the appropriate PPE when entering resident rooms with additional measures in place, and protective eye wear in the RHAs. The improper use of PPE, including not wearing eye protection as directed, put other residents in the home at risk of disease transmission.

Sources: Observations, COVID-19 Directive #3 for Long-Term Care Homes under the Long Term Care Homes Act (LTCHA), 2007 and issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c.H.7, in effect as of July 16, 2021, review of the home's relevant policies, and interviews with the local Public Health Unit liaison, Administrator, and other staff.

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 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 :

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

A PSW transferred a resident alone using a transfer device. The resident's plan of care indicated that they required two staff members for transfers when using a transfer device.

In an interview with the Director of Care, they verified that the resident had not been transferred as indicated; therefore, posing a safety risk to the resident.

Sources: Observations, review of "Zero Lift and Protocol", Policy #IVM-10.10, last revised, March 2021, "Safe Resident Handling", Policy # VII-G-20.30(I), "Mechanical Lifting and Sling Safety Protocols", last revised April 2019, and interviews with the DOC and other staff.

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 and techniques when assisting the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

- 1. All areas where drugs are stored shall be kept locked at all times, when not in use.**
- 2. Access to these areas shall be restricted to,**
 - i. persons who may dispense, prescribe or administer drugs in the home, and**
 - ii. the Administrator.**
- 3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.**

Findings/Faits saillants :

1. The licensee has failed to ensure the security of the drug supply, specifically that the medication room was always kept locked when not in use.

During the inspection, two registered staff members acknowledged that they left the doors to the medication rooms open. Both staff members verified that they should have kept the doors closed and locked.

Failure to keep the doors to the medication rooms locked may have resulted in unauthorized access.

Sources: Medication room, observations, and interviews with staff.

2. The licensee has failed to ensure the security of the drug supply, specifically that access was restricted to authorized persons.

During the inspection, two registered staff members allowed unsupervised access to the medication rooms by a delivery person. Both staff members verified that unauthorized persons must not be in the medication rooms unsupervised.

Failure to restrict access to the medication rooms to authorized persons only may have resulted in access to and possible diversion of drugs stored, including narcotics.

Sources: Medication room, observations, and interviews with staff.

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 steps are taken to ensure the security of the drug supply, to be implemented voluntarily.

WN #4: 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 has failed to ensure that staff participated in the implementation of the Infection Prevention and Control (IPAC) program, specifically related to hand hygiene.

During the inspection, the Inspector noted the following:

- Several staff members did not perform hand hygiene when entering and leaving resident rooms.
- A registered staff member administered medications without performing hand hygiene.
- Two other staff members performed hand hygiene for two to 12 seconds while donning and doffing PPE.

In interviews with staff members, they verified that hand hygiene was to be performed before and after entering resident rooms, before administering medications, when putting on and taking off personal protective equipment; and for 15 seconds. Staff not performing hand hygiene as required may have put the residents at risk for contracting a health care associated infection in the home.

Sources: Observations, review of the home's policy titled "Hand Hygiene", IX-G-10.10, Revised April, 2019, and interviews with the IPAC lead, Director of Care, Administrator, and other staff.

2. The licensee has failed to ensure that staff participated in the implementation of the Infection Prevention and Control (IPAC) program, specifically related to the donning and doffing of Personal Protective Equipment (PPE).

Public Health Ontario's (PHO) document , "Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition" dated November 2012, indicated that in non-acute settings there were specific PPE to be worn dependent upon the additional precautions required.

During the inspection, the Inspector observed signage for additional precautions on the doors of all resident rooms in the home.

The Inspector observed two staff members enter and exit several resident rooms and did not change their mask or gown and two staff members did not sanitize their protective eye wear.

In interviews with the staff members, they indicated that they should have changed their mask and gowns and sanitized their protective eye wear upon exiting the resident rooms. The improper use of PPE placed residents at risk of disease transmission.

Sources: Observations; review of PHO's, "Routine Practices and Additional Precautions in All Health Care Settings, 3rd edition", November 2012, the home's policy titled "Additional Precautions", IX-G-10.70, Revised April, 2019, and interviews with the Administrator, and other staff.

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 participate in the implementation of the Infection Prevention and Control program, specifically related to hand hygiene and the donning and doffing of Personal Protective Equipment, to be implemented voluntarily.

Issued on this 9th day of December, 2021

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

Original report signed by the inspector.

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 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) : KAREN HILL (704609)

Inspection No. /

No de l'inspection : 2021_895609_0004

Log No. /

No de registre : 013038-21

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Dec 3, 2021

Licensee /

Titulaire de permis : 2063414 Ontario Limited as General Partner of 2063414
Investment LP
302 Town Centre Blvd., Suite 300, Markham, ON,
L3R-0E8

LTC Home /

Foyer de SLD : Owen Hill Care Community
130 Owen Street, Barrie, ON, L4M-3H7

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Lenka Fousek

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

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l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with s. 5 of the LTCHA, 2007.

The licensee shall ensure that the home is a safe and secure environment for its residents, specifically, that the appropriate Personal Protective Equipment (PPE) is utilized when additional precautions are in place or as directed by Public Health, including the correct donning and doffing of PPE by completing the following:

1. Establish a process to ensure that all direction from public health is implemented in the home as required.
2. Ensure that all staff in the home are retrained on additional precautions, as well as hand hygiene, the use of protective eye wear, and the appropriate utilization and correct donning and doffing of PPE. Documentation of this training, including who provided the training, the names of the staff trained, dates of the training, and the content of the training, must be maintained.
3. Conduct audits at least four times weekly, on different shifts, for three (3) consecutive weeks, to assess compliance by staff to established processes and procedures related to hand hygiene, donning and doffing and the use of PPE. Documentation of the completed audits must be maintained and provided to an Inspector upon request.
4. Implement and evaluate any corrective actions required to address any identified deficiencies during the audits while ensuring that lessons learned are incorporated into the quality improvement processes and that these be documented.

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

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents, specifically related to staff use of Personal Protective Equipment (PPE) and protective eye wear.

COVID-19 Directive #3 indicates that homes must follow any guidance provided by the local public health unit (PHU) related to any additional measures that must be implemented to reduce the risk of COVID-19 transmission in the Long-Term Care home.

The home was directed by the PHU to implement additional measures, including the use of eye protection in resident home areas (RHAs), for a designated period.

During the inspection, the following observations were made related to staff implementation of the PHU's direction:

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- An additional staff member was not wearing the correct eye wear when assisting with meal delivery in the RHAs. Five other staff members did not wear protective eye wear while in the RHAs or when entering resident rooms.

In interviews with staff, they indicated they should have worn the appropriate PPE when entering resident rooms on additional precautions, and protective eye wear in the RHAs. The improper use of PPE, including not wearing eye protection as directed, put other residents in the home at risk of disease transmission.

Sources: Observations, COVID-19 Directive #3 for Long-Term Care Homes under the Long Term Care Homes Act (LTCHA), 2007 and issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c.H.7, in

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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

effect as of July 16, 2021, review of the home's relevant policies, and interviews with the local Public Health Unit liaison, Administrator, and other staff.

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

Severity: There was potential risk to residents of the home when staff did not utilize PPE, including protective eye wear, as required.

Scope: The scope of this non-compliance was identified as a pattern because several of the staff observed did not utilize the appropriate PPE nor the required protective eye wear.

Compliance History: In the last 36 months, the licensee was found to be non-compliant under s. 5 of the legislation and a Written Notification (WN) was issued to the home.
(704609)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le :

Jan 17, 2022

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

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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

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

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
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2007, c. 8

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2007, chap. 8

**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
438, rue University, 8^e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

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 révision
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 3rd day of December, 2021

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Karen Hill

Service Area Office /

Bureau régional de services : Sudbury Service Area Office