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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

London Service Area Office
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 8, 2016	2016_419658_0011	029164-16	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

ILER LODGE
111 ILER AVENUE ESSEX ON N8M 1T6

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

NEIL KIKUTA (658), AMIE GIBBS-WARD (630)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 17, 18, 19, 20, and 21, 2016.

The following intakes were completed within this Resident Quality Inspection:
Critical Incident log #008952-16, CIS #2129-000003-16 & CIS #2129-000004-16, related to responsive behaviours;
Critical Incident log #020552-16, CIS #2129-000019-16, related to responsive behaviours;
Critical Incident log #027298-16, CIS #2129-000023-16, related to falls and significant change;
Critical Incident log #024568-16, CIS #2129-000024-16, related to falls and significant change;
Critical Incident log #029153-16, CIS #2129-000031-16, related to falls and significant change;
Complaint log #026325-16, IL-46274-LO, related to falls, and skin and wound.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Associate Director of Care, the Program Manager, the Resident Assessment Instrument Coordinator, three Registered Nurses, two Registered Practical Nurses, two Housekeeping staff, 13 Personal Support Workers, three family members, the Family Council and Residents' Council Representative, and over 20 residents.

The inspector(s) conducted a tour of the home, and reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, Residents' and Family Council minutes, and the staff schedule. Observations were also made of general maintenance, cleanliness, and condition of the home, infection prevention and control practices, provision of care, staff to resident interactions, medication administration and storage areas, and required Ministry of Health and Long-Term Care postings.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 to ensure that residents were not neglected by the licensee or staff.

Under the Long-Term Care Homes Act, 2007, and Regulation 79/10, neglect was defined as “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.”

A. Review of the medical health records of resident #005 indicated that they had fallen on a specified date and sustained an injury. Prior to the fall, resident #005 was assessed as high risk for falls, and interventions in the care plan were updated to reflect the assessment.

Resident #005 had two more falls on two specified dates. Review of both post fall assessments indicated that no new interventions were initiated to prevent recurrence and minimize harm.

On another specified date, resident #005 had another fall with injury. The post fall assessment was completed and showed that the Registered Nurse (RN) had checked off specific interventions to prevent recurrence of a fall and to minimize harm to the resident.

On two more specified dates, resident #005 had two more falls. Review of the post fall assessment completed on one of the falls indicated that a new intervention would be implemented. The post fall assessment completed on the other fall had no indication of new interventions to prevent recurrence and minimize harm.

Observations conducted on two specified dates showed that resident #005 was not using the specified interventions. On one day, resident #005 was observed in their room with the call bell located in the top drawer of the resident’s bedside table.

On a specified date, Personal Support Workers (PSW) #110 and #111 stated that resident #005 did not use the specified falls interventions. PSWs #110 and #111 informed the Inspector that the resident was capable of utilizing the call bell sometimes, but has transferred and ambulated independently in the past which has led to some of their falls.

On a specified date, Registered Nurse (RN) #108 stated that resident #005 was identified as an individual at high risk for falls. When asked about the use of the specified interventions as indicated in the post fall assessments, RN #108 stated that they had delegated the initiation of the interventions to a PSW, but did not follow up with the

implementation of the device. RN #108 acknowledged that as part of the Registered Nurses assessment of a resident following a fall, they were to implement the interventions that had been assessed for, and ensure that it was reflected in the resident's plan of care.

Upon review of the resident's most recent plan of care, resident #005's goals and interventions related to risk for falls had not been reviewed or revised after the significant change following their first fall, or any of the falls thereafter.

On a specified date, the Director of Care (DOC) #119 stated that the RN was responsible for completing the post fall assessment, and ensuring that appropriate interventions were implemented. It was the DOC's expectation that interventions were in place to prevent further incidents, and that the resident's plan of care reflected the assessment.

A review of the data gathered during the inspection indicated that resident #005 had an initial fall that led to a significant change in their status. Over a period of two months, resident #005 had six falls in the home, where five of the six falls occurred when the resident was unsupervised. Interventions that were assessed for by the RN to prevent recurrence and minimize harm were not implemented, and the licensee demonstrated a pattern of inaction and failure to protect the health, safety, and well-being of resident #005.

B. Upon their admission, resident #006 was assessed for as a resident at medium risk for falls. The resident's Resident Assessment Protocol (RAP) note related to falls indicated that resident #006 had fallen since admission and had a history of falls. The resident's plan of care was updated to reflect the assessment, and interventions were implemented.

On three separate dates, resident #006 had three unwitnessed falls. Post fall assessments were completed by registered staff, and in all three incidents, no new interventions were initiated to prevent recurrence and minimize harm. Review of the resident's plan of care following each fall reflected the post fall assessments, as no new interventions were evident, and the plan of care had not been reviewed or revised following the resident's multiple falls.

On another specified date, resident #006 had an unwitnessed fall with injury.

On a specified date, the Director of Care (DOC) #119, and Associate Director of Care (ADOC) #117, explained that the Registered Nurses (RN) were responsible in ensuring

that assessments were completed appropriately, which included implementing interventions to prevent recurrence and minimize harm. They acknowledged that since their admission, resident #006's plan of care related to falls had not been reviewed or revised following the first three falls.

A review of the data gathered during the inspection indicated that resident #006 had four falls in 22 days. Upon the first three post fall assessments, the resident's plan of care had not been reviewed or revised for new interventions to prevent recurrence and minimize harm. The licensee had demonstrated a pattern of inaction that jeopardized the health, safety, and well-being of resident #006.

The scope of this area of non-compliance was determined to be a level two, where a pattern was demonstrated throughout the home. The severity was determined to be a level four, related to immediate jeopardy and risk. There was a history of unrelated non-compliance in the last three years. [s. 19. (1)]

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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident’s plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On a specified date, RN #100 stated that resident #007 had altered skin integrity with interventions in place.

RN #100 stated that they had previously completed assessments using a tool called the Treatment Observation Record (TOR) for the initial and ongoing weekly skin assessments. RN #100 explained that at some point the home had ceased the use of the TOR for altered skin integrity other than pressure ulcers, and completed the initial and weekly assessments using a skin care progress note. Review of the skin care progress note completed online through Point Click Care (PCC) showed that registered staff completed a Subjective, Objective, Assessment, Plan (SOAP) note for their altered skin integrity assessments.

On a specified date, the Director of Care (DOC) #119 explained that the TOR had been discontinued near the end of May, 2016, and that the direction was to transition to complete all assessments online using the PCC SOAP notes for wounds. The DOC acknowledged that their current practice of using SOAP notes as a clinically appropriate assessment instrument specific for skin and wound assessment was determined by the documentation of the registered staff, and that it was not always the case that documentation reflected a complete assessment of resident #007's altered skin integrity. [s. 50. (2) (b) (i)]

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 a resident exhibiting altered skin integrity, including skin breakdown or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee had failed to ensure that the written plan of care provided clear direction to staff and others who provided direct care to the resident regarding a Personal Assistance Services Device (PASD).

Multiple observations on three specified dates found resident #001 positioned using a PASD.

On a specified date, PSW #101 reported that staff used the PASD for resident #001 to support comfort and positioning when this resident was tired.

Review of Kardex, Point of Care (POC), and electronic plan of care for resident #001 identified that there was no direction provided for staff regarding the PASD.

On a specified date, the Assistant Director of Care (ADOC) #117 reported that they were the main person responsible for assessing residents and updating the plan of care regarding PASDs. ADOC # 117 reported that all staff had been educated on when to use the specified PASD unless it was in the resident's Kardex and electronic plan of care. ADOC #117 reported they had not been notified by staff that they were using the PASD for resident #001. ADOC #117 acknowledged that this PASD for resident #001 had not been assessed, and this intervention was not included in the plan of care. ADOC #117 said it was the expectation in the home that all PASDs were to be included in the plan of care to provide clear direction for staff. [s. 6. (1) (c)]

Issued on this 20th day of December, 2016

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

Original report signed by the inspector.

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NEIL KIKUTA (658), AMIE GIBBS-WARD (630)
Inspection No. / No de l'inspection :	2016_419658_0011
Log No. / Registre no:	029164-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 8, 2016
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	ILER LODGE 111 ILER AVENUE, ESSEX, ON, N8M-1T6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Elizabeth Desjarlais-Tefft

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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).

Order / Ordre :

The licensee will ensure compliance with LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) by ensuring that all residents are not neglected by the licensee or staff.

The licensee must immediately initiate steps towards protecting the health, safety, and wellbeing of resident #005, and all other residents who fall or have fallen while in the care of the long term care-home. This includes, but is not limited to:

- Reassessing resident #005's risk for falls, and current falls intervention and prevention strategies;
- Ensuring that interventions are implemented to prevent recurrence and minimize harm of residents;
- Reviewing and revising resident #005's plan of care to ensure that assessments are integrated and are consistent and complement each other;
- Ensuring that implemented interventions are monitored and evaluated.

The licensee will also ensure that all registered staff are re-educated on the home's falls prevention and management program.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

Under the Long-Term Care Homes Act, 2007, and Regulation 79/10, neglect was defined as "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."

A. Review of the medical health records of resident #005 indicated that they had fallen on a specified date and sustained an injury. Prior to the fall, resident #005 was assessed as high risk for falls, and interventions in the care plan were updated to reflect the assessment.

Resident #005 had two more falls on two specified dates. Review of both post fall assessments indicated that no new interventions were initiated to prevent recurrence and minimize harm.

On another specified date, resident #005 had another fall with injury. The post fall assessment was completed and showed that the Registered Nurse (RN) had checked off specific interventions to prevent recurrence of a fall and to minimize harm to the resident.

On two more specified dates, resident #005 had two more falls. Review of the post fall assessment completed on one of the falls indicated that a new intervention would be implemented. The post fall assessment completed on the other fall had no indication of new interventions to prevent recurrence and minimize harm.

Observations conducted on two specified dates showed that resident #005 was not using the specified interventions. On one day, resident #005 was observed in their room with the call bell located in the top drawer of the resident's bedside table.

On a specified date, Personal Support Workers (PSW) #110 and #111 stated that resident #005 did not use the specified falls interventions. PSWs #110 and #111 informed the Inspector that the resident was capable of utilizing the call bell sometimes, but has transferred and ambulated independently in the past which has led to some of their falls.

On a specified date, Registered Nurse (RN) #108 stated that resident #005 was identified as an individual at high risk for falls. When asked about the use of the specified interventions as indicated in the post fall assessments, RN #108 stated that they had delegated the initiation of the interventions to a PSW, but did not follow up with the implementation of the device. RN #108 acknowledged that as part of the Registered Nurses assessment of a resident following a fall, they

were to implement the interventions that had been assessed for, and ensure that it was reflected in the resident's plan of care.

Upon review of the resident's most recent plan of care, resident #005's goals and interventions related to risk for falls had not been reviewed or revised after the significant change following their first fall, or any of the falls thereafter.

On a specified date, the Director of Care (DOC) #119 stated that the RN was responsible for completing the post fall assessment, and ensuring that appropriate interventions were implemented. It was the DOC's expectation that interventions were in place to prevent further incidents, and that the resident's plan of care reflected the assessment.

A review of the data gathered during the inspection indicated that resident #005 had an initial fall that led to a significant change in their status. Over a period of two months, resident #005 had six falls in the home, where five of the six falls occurred when the resident was unsupervised. Interventions that were assessed for by the RN to prevent recurrence and minimize harm were not implemented, and the licensee demonstrated a pattern of inaction and failure to protect the health, safety, and well-being of resident #005.

B. Upon their admission, resident #006 was assessed for as a resident at medium risk for falls. The resident's Resident Assessment Protocol (RAP) note related to falls indicated that resident #006 had fallen since admission and had a history of falls. The resident's plan of care was updated to reflect the assessment, and interventions were implemented.

On three separate dates, resident #006 had three unwitnessed falls. Post fall assessments were completed by registered staff, and in all three incidents, no new interventions were initiated to prevent recurrence and minimize harm. Review of the resident's plan of care following each fall reflected the post fall assessments, as no new interventions were evident, and the plan of care had not been reviewed or revised following the resident's multiple falls.

On another specified date, resident #006 had an unwitnessed fall with injury.

On a specified date, the Director of Care (DOC) #119, and Associate Director of Care (ADOC) #117, explained that the Registered Nurses (RN) were responsible in ensuring that assessments were completed appropriately, which

included implementing interventions to prevent recurrence and minimize harm. They acknowledged that since their admission, resident #006's plan of care related to falls had not been reviewed or revised following the first three falls.

A review of the data gathered during the inspection indicated that resident #006 had four falls in 22 days. Upon the first three post fall assessments, the resident's plan of care had not been reviewed or revised for new interventions to prevent recurrence and minimize harm. The licensee had demonstrated a pattern of inaction that jeopardized the health, safety, and well-being of resident #006.

The scope of this area of non-compliance was determined to be a level two, where a pattern was demonstrated throughout the home. The severity was determined to be a level four, related to immediate jeopardy and risk. There was a history of unrelated non-compliance in the last three years. [s. 19. (1)] (658)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2017

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 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 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 8th day of December, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Neil Kikuta

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