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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 25, 2019	2019_751649_0019	014078-19, 015680-19, 016710-19	Complaint

Licensee/Titulaire de permis

Villa Colombo Homes for the Aged Inc.
40 Playfair Avenue TORONTO ON M6B 2P9

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

Villa Colombo Homes for the Aged
40 Playfair Avenue TORONTO ON M6B 2P9

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

JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 2, 3, 4, 8, 9, 21, 22, 23, 24, 25, 26 (off-site), and 28, and November 22 (off-site), 2019.

Log #014078-19 related to altered skin integrity and continence care and bowel management.
Logs #015680-19 and #016710-19 related to duty to protect and reporting certain matters to the Director.

During the course of the inspection, the inspector(s) spoke with the director, resident services (DRS), directors, nursing unit (DNU), physiotherapist (PT), occupational therapist (OT), registered dietitian (RD), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), residents and family members.

A Voluntary Plan of Correction related to LTCHA, 2007, c.8, s .6. (1) (c) and s. 6. (9) 1 and a Compliance Order s. 6. (7) were identified in this inspection and have been issued in Inspection Report #2019_804600_0022, dated November 25, 2019, which was conducted concurrently with this inspection.

During the course of the inspection the inspectors reviewed residents' health records, staffing schedules, investigation notes, conducted observations related to the home's care processes, staff to resident interactions, and reviewed any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **5 WN(s)**
- **2 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	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. 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 resident #003 was not neglected by the licensee or staff.

In accordance with the definition identified in section 2(1) of the Regulation 79/10 “neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) alleging that resident #003’s area of skin integrity had worsened.

A review of resident #003’s progress notes indicated they were discovered on an identified date with an area of altered skin integrity.

On an identified date, the resident was first assessed by the home’s skin and wound consultant who recommended three interventions for the resident to have related to their altered skin integrity. None of these interventions were implemented by the home after the home’s skin and wound consultant visit.

The resident had a second assessment by the home’s skin and wound consultant on another date, they made the same recommendations as per their first visit. Additionally, they identified an issue that contradicted with one of the three recommended interventions, made preliminary adjustments then informed the staff. None of the recommended interventions by the home’s skin and wound consultant were implemented by the home after their second visit.

The resident had a third visit by the home’s skin and wound consultant on a later date

and during their visit they made the same recommendations as mentioned above. No action was taken by the home or any of the recommended interventions implemented after the home's skin and wound consultant's third visit.

On another date, resident #003 had a fourth visit by the home's skin and wound consultant for altered skin integrity on an identified body area, they identified an issue that contradicted with one of the three recommended interventions, and made preliminary adjustments (second occurrence). The same recommendations as before were made. Again, no action with regards to any of the above mentioned, recommendations and interventions were implemented by the home.

A fifth visit was made by the skin and wound consultant on an identified date, they made two of the same previously mentioned recommendations. The skin and wound consultant identified that three of the recommended interventions were not implemented.

Further record review of the resident's assessment tab indicated that a referral was initiated from the nursing department on an identified date, for the second recommended intervention and the assessment was completed by the OT the following day. This recommended intervention was completed four and a half months after it was initially recommended by the home's skin and wound consultant.

In an interview with RN #101, they acknowledged that the skin and wound consultant notes were e-mailed to them after every consult, and confirmed receipt of all of the above mentioned consultation notes. According to the RN upon receipt of a consultation note they would review it to determine if any referrals were recommended and process them. When the inspector inquired why a referral for the second recommended intervention was not sent to the OT since their first visit, and was only completed several months later, they responded that it was missed.

According to a weekly huddle progress note on an identified date indicated that RN #101 informed RPNs and PSWs staff that the resident's area of altered skin integrity was deteriorating, and they were to remain in bed during scheduled times. The note further indicated that the resident will be on a turning and repositioning schedule while in bed. The skin and wound consultant's first, second, third and fourth visits recommended interventions, was not what RN #101 communicated to the staff in the huddle. The inspector requested information from the home to verify the practice of the third intervention, but the home was unable to provide any documentation in support of this. In an interview with DNU #119, they told the inspector that they were unable to provide any

documentation to support this practice. According to the DNU the resident was returned to bed to have incontinent brief changes and would stay in bed after.

The resident had a sixth visit by the home's skin and wound consultant where they indicated that the resident did not have the first recommended intervention and the resident's area of altered skin integrity had deteriorated.

On October 4, 2019, at approximately 0900 hours the resident was observed by the inspector lying in bed without the first recommended intervention.

During an interview with DNU #119 they told the inspector that on an identified date, they requested for the first recommended intervention to be implemented, and this was completed 20 days later. The inspector requested information from the DNU on the features of the first implemented intervention as this intervention did not appear to be the same type that the home's skin and wound consultant recommended since their first visit.

During an interview with RN #101, they told the inspector that they only became aware that the skin and wound consultant requested for the resident to have the first recommended intervention when they saw that the resident's altered skin integrity was worsening. RN #101 confirmed that the resident did not have the first recommended intervention. According to the RN they were told by their manager that the home does not have the first recommended intervention, and only has an alternative option. The inspector inquired with the RN if they ever had a conversation with the home's skin and wound consultant to explore any other alternative therapeutic interventions and they explained that the skin and wound consultant comes to the home very early, and they do not see them and therefore had not had a conversation with them about this.

During the inspection, the inspector spoke to the DRS #128 explaining that they did not observe the first recommended intervention on resident #003's bed. According to the DRS the resident had an alternative option on their bed. Later that day the DRS advised that they discovered that the alternative option was mistakenly placed on the resident's roommate's bed instead of theirs. An observation on October 25, 2019, at approximately 1000 hours, indicated that resident #003 was still without the alternative option on their bed.

Record review indicated that the resident started to receive as needed (PRN) pain medication prior to treatment of altered skin integrity, six months after the area was initially identified.

During an observation of the resident's altered skin integrity on October 8, 2019, the resident had a jerking movement. RPN #100 who was completing the dressing told the inspector that maybe the resident was in pain even though they were given their scheduled pain medication prior to the treatment. A review of the resident's electronic medication administration record (e-MAR) and physician orders during an identified period did not indicate that any changes were made to the resident's pain medication.

During an interview with RN #101, they acknowledged that the resident continued to have jerking movements during their treatments after administration of their scheduled pain medication, and explained that the jerking movements were less frequent. The inspector shared the above mentioned observation with the RN who explained that the resident only has the jerking movements when an identified treatment was performed.

During an interview with PSW #129, who was the second staff assisting with resident #003's care told the inspector they observed the resident in pain demonstrated through facial expression, and making sounds of pain during care, and when they were being turned and repositioned. They explained they observed the resident in pain as recently as of an identified date, and stated everyone knows that the resident has pain.

The above observation and staff interviews demonstrated that resident #003 continued to experience pain during treatments and care provision even after the administration of their scheduled pain medication.

Resident #003 was not interviewable due to cognitive decline.

In an interview with DRS #128, they explained that the home has a responsibility to identify, assess, and manage the resident's pain and stated that the home has a medical directive in place if the scheduled analgesic was not effective, and to follow-up with the physician.

In an interview with DNU #119, they acknowledged that neglect had occurred with resident #003 based on the lack of altered skin integrity interventions as indicated in the plan of care and evidence above.

In conclusion, based on the above evidence the home has failed to provide resident #003 with the treatment, care, services required for health, safety or well-being, including a pattern of inaction in aspects of resident's care that jeopardized the health and safety of

the resident resulting in a deterioration of altered skin integrity and pain experience. [s. 19. (1)]

2. The licensee has failed to ensure that residents were protected from verbal abuse.

In accordance with the definition identified in section 2(1) of the Regulation 79/10 “verbal abuse” means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A complaint was submitted to the MLTC, alleging abuse by staff towards two residents. According to the complainant a PSW employed by the home privately disclosed to them incidents of abuse by themselves towards two residents. The complainant further indicated that they had audio recordings to support the allegation of residents' abuse and identified the PSW by name. The complainant told PSW #123 that they had audio recordings and would report the incidents to the home's management and the MLTC.

On an identified date, another inspector from the MLTC contacted DRS #128 at the long-term care home related to the complainant's allegation of staff to resident abuse. The name of the PSW involved in the allegation was provided to the DRS who acknowledged that a PSW by that name is an active employee in the home. The inspector requested for the complainant to forward the audio recordings and any additional information they have related to the allegation to the DRS. The audio recordings were sent by the complainant to the home's DRS the next day. The DRS told the inspector that the home will immediately initiate an investigation

The home submitted a critical incident system (CIS) report to the MLTC on an identified date, related to the above allegation of staff to resident verbal abuse. According to the home’s CIS report PSW #123 was placed on administrative leave. Two audio recordings were received by the home prior to their investigation. Six days later, PSW #123 was terminated by the long-term care home. In a letter from the home to PSW #123 indicated during their meeting they admitted to making abusive remarks and using vulgar language towards two identified residents they were speaking about in the audio recordings.

According to the complainant the two audio recordings were made during a phone conversation they had with PSW #123. The two audio recordings received from the complainant were reviewed by Inspector #649 as follows:

The PSW was heard admitting to the complainant, to using inappropriate words to two identified residents.

The audio recordings did not indicate the date when the incidents occurred between PSW #123 and the two residents. The identification of the two residents involved in the allegation of verbal abuse were not disclosed in the audio recordings. PSW #123 could not recall the residents' names and alleged that they were no longer in the home and that the incidents happened more than a year ago.

A review of the home’s investigation notes indicated that PSW #123 grieved their termination and based on the union’s agreement with the home was granted a “last-chance” and they returned to work on an identified date. The inspector was unable to locate any training that was provided to PSW #123 prior to their return to work after they admitted to verbal abuse.

In an interview with PSW #123 they acknowledged that they were verbally abusive towards the resident in the second recording and had used an inappropriate word towards the resident. According to the PSW the resident was having a responsive behaviour towards them while they were providing care and they responded to the resident with the use of an inappropriate word. The PSW denied any allegation of verbal abuse towards the resident in the first audio recording even though the use of inappropriate words was clearly heard on the audio recording. PSW #123 consistently denied recalling any of the residents' names, they indicated the residents’ home area and which floor they resided on and that they were no longer in the home. Additionally, the letter from the home to PSW #123, indicated they admitted to making abusive remarks and using vulgar language towards the two residents they were speaking about in the audio recordings. PSW #123 acknowledged that they had not completed any type of training prior to their return to work.

In an interview with DRS #128, they acknowledged that PSW #123 had admitted to being verbally abusive to the resident in the second audio recording. The DRS denied hearing PSW #123 use inappropriate words in the first audio recording. The DRS acknowledged that the home had not provided any retraining to PSW #123 prior to their return to work, as they had already completed the home's abuse and neglect training modules prior to the home becoming aware of the allegation.

In conclusion, PSW #123 and DRS #128 acknowledged that verbal abuse had occurred towards the resident in the second recording, both denied that verbal abuse had

occurred towards the resident in the first audio recording even though it was clearly heard in the audio recording by the inspector and complainant. Additionally, PSW #123 had returned to work in the home on a "last chance" basis but did not receive any retraining on abuse and neglect from the home prior to their return to work with the elderly population. [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 residents #003, #010, and #011 who were exhibiting altered skin integrity were reassessed at least weekly by a member of the registered nursing staff.

A complaint was submitted to the MLTC alleging that resident #003's altered skin integrity had worsened.

Record review indicated that resident #003 was first identified with an area of altered skin integrity on an identified date, and the next weekly skin and wound assessment was completed nine days later. Another weekly skin and wound assessment was completed on an identified date and the next one three weeks later. Another assessment was completed on an identified date, and the next assessment thereafter was completed nine days later. The resident was further assessment on an identified date and the next weekly skin and wound assessment was completed six and a half weeks after, and the next assessment thereafter was completed four weeks later. Another weekly skin and wound assessment were completed on an identified date and the next assessment was completed two weeks after, the next assessment was completed on an identified date then the next assessment thereafter was completed two weeks later.

Further review of the physician orders indicated that the resident was treated with antibiotics four times. According to a progress note, the resident's area of altered skin integrity had deteriorated, and the resident had developed another area of altered skin integrity, even though they were on a turning and repositioning schedule every two hours while in bed.

In an interview with RN #101, they acknowledged that there were gaps in resident #003's weekly skin and wound assessments for the area of altered skin integrity during identified periods.

In an interview with DNU #119, they acknowledged if the resident has altered skin integrity the expectation is that weekly skin and wound assessments are completed by the registered nursing staff. [s. 50. (2) (b) (iv)]

2. Resident #010 was selected for sample expansion related to non-compliance with resident #003.

Record review indicated that resident #010 has altered skin integrity and had it for some time. On an identified date, they sustained an injury to the existing area of altered skin integrity.

Record review of the weekly skin and wound assessments indicated an assessment was completed on an identified date and the next weekly skin and wound assessment was 12 days later, and the next assessment was completed three weeks after. Another weekly skin and wound assessment was completed on an identified date and the next assessment thereafter was completed five weeks after.

In an interview with RN #122, they acknowledged that there were gaps in resident #010's weekly skin and wound assessments for altered skin integrity during identified periods. They explained that the weekly skin and wound assessments should be completed on a weekly basis by whichever registered nurse was assigned to the resident. [s. 50. (2) (b) (iv)]

3. Resident #011 was selected for sample expansion related to non-compliance with resident #003.

Record review indicated that resident #011 was admitted with an area of altered skin integrity.

According to the assessment tab a weekly skin and wound assessment was completed on an identified date, when the resident was admitted. Further record review indicated that no other weekly skin assessments were completed thereafter. A review of the electronic – treatment administration record (e-TAR) indicated that the site healed on an identified date.

In an interview with RN #101, they acknowledged that a weekly skin and wound assessment was completed on an identified date and no other assessments were completed thereafter.

In an interview with DRS #128, they acknowledged that residents #010 and #011 with pressure ulcers should have been reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

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 license has failed to ensure all areas where drugs were stored shall be kept locked at all times, when not in use.

On Thursday October 3, 2019, at 1235 hours the inspector observed the medication cart unlocked on Fusco resident home area on the fourth floor – south wing. The medication cart was parked across from an identified resident's room. A resident was observed standing beside the medication cart but walked away as the inspector approached. The inspector was able to open the medication drawers consisting of the residents' medications and other related medication supplies. The nurse saw the inspector opening the drawers of the medication cart and came over to the inspector.

In an interview with RPN #130, they acknowledged they had left the medication cart unlocked and should have locked it before they went to administer medication to a resident in the dining room.

In an interview with DNU #119, they acknowledged that the medication cart should be locked at all times when not in use. [s. 130. 1.]

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 all areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person administers a drug to resident #003 in the home unless that person is a physician, dentist, registered nurse or registered practical nurse.

On October 3, 2019, between 1240 and 1245 hours approximately, the inspector observed a cup of an identified supplement on resident #003's bedside table. The resident's spouse was at their bedside feeding the resident.

The inspector inquired with the resident's spouse if anyone had given them the supplement and they advised that the nurse brought it.

During an initial interview with RPN #111, they denied giving resident #003's spouse the identified supplement to give to the resident. They acknowledged that the supplement is prescribed by the physician or registered dietitian and should be administered by the nurse. In a subsequent interview the RPN acknowledged that they gave the supplement to the resident's spouse for them to administer to the resident.

In an interview with DNU #119, they explained that if the identified supplement was given to the resident's spouse to give to the resident, the nurse must be present to monitor and ensure that the resident consumes the supplement. Since RPN #111 acknowledged giving the supplement to the resident's spouse for them to administer to the resident, this confirms non-compliance with this legislation. [s. 131. (3)]

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 no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or registered practical nurse, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with for resident #003.

In accordance with O. Reg. 79/10, s.114 (2) the licensee shall ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the licensee's Medication Administration/ Electronic – MAR policy (document #09-01-02, dated February 2005, reviewed: August 2015), which was part of the licensee's medication policy that required registered staff to sign the electronic MAR in PCC when medications are administered.

A complaint was submitted to the MLTC alleging that resident #003's altered skin integrity had worsened.

A review of resident #003's progress notes indicated they were identified on an identified date with an area of altered skin integrity. The resident was not started on scheduled pain medication until approximately seven months later, and according to staff they were giving as needed (PRN) pain medication prior to a treatment.

A review of the home's policy document #09-01-02 titled Medication Administration/ Electronic – MAR dated February 2005 reviewed August 2015 indicated under documentation that:
-The electronic MAR in PCC will be signed when medications are administered.

-The effect of the medication will be recorded when giving PRN medications. This will be documented in the e-MAR and resident progress notes in PCC.

A review of resident #003's progress notes indicated that the resident was given PRN pain medication on two identified dates prior to a treatment. A review of the e-MAR did not indicate that the PRN medication given on the above mentioned, dates were documented as given.

In an interview with RPN #111, they acknowledged that they had documented under the home's Pain Assessment in Advanced Dementia (PAINAD) assessments that the resident had pain on the above mentioned, dates and had administered pain medication to the resident according to the progress notes documentation. They confirmed they had not documented on the resident's e-MAR the administration of pain medication as was indicated in the home's Medication Administration/ Electronic – MAR policy.

In an interview with DNU #119, they told the inspector PRN medication given to a resident must be documented on the e-MAR and acknowledged that the home's medication policy was not followed. [s. 8. (1) (b)]

Issued on this 24th day of December, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIEANN HING (649)
Inspection No. / No de l'inspection :	2019_751649_0019
Log No. / No de registre :	014078-19, 015680-19, 016710-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 25, 2019
Licensee / Titulaire de permis :	Villa Colombo Homes for the Aged Inc. 40 Playfair Avenue, TORONTO, ON, M6B-2P9
LTC Home / Foyer de SLD :	Villa Colombo Homes for the Aged 40 Playfair Avenue, TORONTO, ON, M6B-2P9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tracey Comeau

To Villa Colombo Homes for the Aged Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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)

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 must be compliant with s. 19. (1) of the LTCHA, 2007.

Specifically, the licensee must:

1. Ensure that resident #003 and all residents are protected from neglect and verbal abuse by the licensee or staff.
2. Implement a process to ensure all skin and wound care consultant recommendations are immediately implemented for resident #003 and any other residents.
3. Provide registered practical nurses (RPNs) and registered nurses (RNs) assigned to resident #003 with education on pain management for residents with altered skin integrity, including how to assess and identify pain for residents who are non-verbal, monitoring and reassessing the effectiveness of pain medication during dressing changes and provision of care. A record of the education provided must be maintained that includes the topic covered, staff attendance records, date of the education and who provided the education.
4. Provide re-training to PSW #123 on the home's prevention of abuse and neglect policy. A record of the education provided must be maintained including the topics covered, date of the education and who provided the education.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #003 was not neglected by the licensee or staff.

In accordance with the definition identified in section 2(1) of the Regulation 79/10 "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction

or a pattern of inaction that jeopardizes the health or safety of one or more residents.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) alleging that resident #003's area of skin integrity had worsened.

A review of resident #003's progress notes indicated they were discovered on an identified date with an area of altered skin integrity.

On an identified date, the resident was first assessed by the home's skin and wound consultant who recommended three interventions for the resident to have related to their altered skin integrity. None of these interventions were implemented by the home after the home's skin and wound consultant visit.

The resident had a second assessment by the home's skin and wound consultant on another date, they made the same recommendations as per their first visit. Additionally, they identified an issue that contradicted with one of the three recommended interventions, made preliminary adjustments then informed the staff. None of the recommended interventions by the home's skin and wound consultant were implemented by the home after their second visit.

The resident had a third visit by the home's skin and wound consultant on a later date and during their visit they made the same recommendations as mentioned above. No action was taken by the home or any of the recommended interventions implemented after the home's skin and wound consultant's third visit.

On another date, resident #003 had a fourth visit by the home's skin and wound consultant for altered skin integrity on an identified body area, they identified an issue that contradicted with one of the three recommended interventions, and made preliminary adjustments (second occurrence). The same recommendations as before were made. Again, no action with regards to any of the above mentioned, recommendations and interventions were implemented by the home.

A fifth visit was made by the skin and wound consultant on an identified date, they made two of the same previously mentioned recommendations. The skin

and wound consultant identified that three of the recommended interventions were not implemented.

Further record review of the resident's assessment tab indicated that a referral was initiated from the nursing department on an identified date, for the second recommended intervention and the assessment was completed by the OT the following day. This recommended intervention was completed four and a half months after it was initially recommended by the home's skin and wound consultant.

In an interview with RN #101, they acknowledged that the skin and wound consultant notes were e-mailed to them after every consult, and confirmed receipt of all of the above mentioned consultation notes. According to the RN upon receipt of a consultation note they would review it to determine if any referrals were recommended and process them. When the inspector inquired why a referral for the second recommended intervention was not sent to the OT since their first visit, and was only completed several months later, they responded that it was missed.

According to a weekly huddle progress note on an identified date indicated that RN #101 informed RPNs and PSWs staff that the resident's area of altered skin integrity was deteriorating, and they were to remain in bed during scheduled times. The note further indicated that the resident will be on a turning and repositioning schedule while in bed. The skin and wound consultant's first, second, third and fourth visits recommended interventions, was not what RN #101 communicated to the staff in the huddle. The inspector requested information from the home to verify the practice of the third intervention, but the home was unable to provide any documentation in support of this. In an interview with DNU #119, they told the inspector that they were unable to provide any documentation to support this practice. According to the DNU the resident was returned to bed to have incontinent brief changes and would stay in bed after.

The resident had a sixth visit by the home's skin and wound consultant where they indicated that the resident did not have the first recommended intervention and the resident's area of altered skin integrity had deteriorated.

On October 4, 2019, at approximately 0900 hours the resident was observed by the inspector lying in bed without the first recommended intervention.

During an interview with DNU #119 they told the inspector that on an identified date, they requested for the first recommended intervention to be implemented, and this was completed 20 days later. The inspector requested information from the DNU on the features of the first implemented intervention as this intervention did not appear to be the same type that the home's skin and wound consultant recommended since their first visit.

During an interview with RN #101, they told the inspector that they only became aware that the skin and wound consultant requested for the resident to have the first recommended intervention when they saw that the resident's altered skin integrity was worsening. RN #101 confirmed that the resident did not have the first recommended intervention. According to the RN they were told by their manager that the home does not have the first recommended intervention, and only has an alternative option. The inspector inquired with the RN if they ever had a conversation with the home's skin and wound consultant to explore any other alternative therapeutic interventions and they explained that the skin and wound consultant comes to the home very early, and they do not see them and therefore had not had a conversation with them about this.

During the inspection, the inspector spoke to the DRS #128 explaining that they did not observe the first recommended intervention on resident #003's bed. According to the DRS the resident had an alternative option on their bed. Later that day the DRS advised that they discovered that the alternative option was mistakenly placed on the resident's roommate's bed instead of theirs. An observation on October 25, 2019, at approximately 1000 hours, indicated that resident #003 was still without the alternative option on their bed.

Record review indicated that the resident started to receive as needed (PRN) pain medication prior to treatment of altered skin integrity, six months after the area was initially identified.

During an observation of the resident's altered skin integrity on October 8, 2019, the resident had a jerking movement. RPN #100 who was completing the dressing told the inspector that maybe the resident was in pain even though they

were given their scheduled pain medication prior to the treatment. A review of the resident's electronic medication administration record (e-MAR) and physician orders during an identified period did not indicate that any changes were made to the resident's pain medication.

During an interview with RN #101, they acknowledged that the resident continued to have jerking movements during their treatments after administration of their scheduled pain medication, and explained that the jerking movements were less frequent. The inspector shared the above mentioned observation with the RN who explained that the resident only has the jerking movements when an identified treatment was performed.

During an interview with PSW #129, who was the second staff assisting with resident #003's care told the inspector they observed the resident in pain demonstrated through facial expression, and making sounds of pain during care, and when they were being turned and repositioned. They explained they observed the resident in pain as recently as of an identified date, and stated everyone knows that the resident has pain.

The above observation and staff interviews demonstrated that resident #003 continued to experience pain during treatments and care provision even after the administration of their scheduled pain medication.

Resident #003 was not interviewable due to cognitive decline.

In an interview with DRS #128, they explained that the home has a responsibility to identify, assess, and manage the resident's pain and stated that the home has a medical directive in place if the scheduled analgesic was not effective, and to follow-up with the physician.

In an interview with DNU #119, they acknowledged that neglect had occurred with resident #003 based on the lack of altered skin integrity interventions as indicated in the plan of care and evidence above.

In conclusion, based on the above evidence the home has failed to provide resident #003 with the treatment, care, services required for health, safety or well-being, including a pattern of inaction in aspects of resident's care that

jeopardized the health and safety of the resident resulting in a deterioration of altered skin integrity and pain experience. (649)

2. The licensee has failed to ensure that residents were protected from verbal abuse.

In accordance with the definition identified in section 2(1) of the Regulation 79/10 "verbal abuse" means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A complaint was submitted to the MLTC, alleging abuse by staff towards two residents. According to the complainant a PSW employed by the home privately disclosed to them incidents of abuse by themselves towards two residents. The complainant further indicated that they had audio recordings to support the allegation of residents' abuse and identified the PSW by name. The complainant told PSW #123 that they had audio recordings and would report the incidents to the home's management and the MLTC.

On an identified date, another inspector from the MLTC contacted DRS #128 at the long-term care home related to the complainant's allegation of staff to resident abuse. The name of the PSW involved in the allegation was provided to the DRS who acknowledged that a PSW by that name is an active employee in the home. The inspector requested for the complainant to forward the audio recordings and any additional information they have related to the allegation to the DRS. The audio recordings were sent by the complainant to the home's DRS the next day. The DRS told the inspector that the home will immediately initiate an investigation

The home submitted a critical incident system (CIS) report to the MLTC on an identified date, related to the above allegation of staff to resident verbal abuse. According to the home's CIS report PSW #123 was placed on administrative leave. Two audio recordings were received by the home prior to their investigation. Six days later, PSW #123 was terminated by the long-term care home. In a letter from the home to PSW #123 indicated during their meeting they admitted to making abusive remarks and using vulgar language towards

two identified residents they were speaking about in the audio recordings.

According to the complainant the two audio recordings were made during a phone conversation they had with PSW #123. The two audio recordings received from the complainant were reviewed by Inspector #649 as follows: The PSW was heard admitting to the complainant, to using inappropriate words to two identified residents.

The audio recordings did not indicate the date when the incidents occurred between PSW #123 and the two residents. The identification of the two residents involved in the allegation of verbal abuse were not disclosed in the audio recordings. PSW #123 could not recall the residents' names and alleged that they were no longer in the home and that the incidents happened more than a year ago.

A review of the home's investigation notes indicated that PSW #123 grieved their termination and based on the union's agreement with the home was granted a "last-chance" and they returned to work on an identified date. The inspector was unable to locate any training that was provided to PSW #123 prior to their return to work after they admitted to verbal abuse.

In an interview with PSW #123 they acknowledged that they were verbally abusive towards the resident in the second recording and had used an inappropriate word towards the resident. According to the PSW the resident was having a responsive behaviour towards them while they were providing care and they responded to the resident with the use of an inappropriate word. The PSW denied any allegation of verbal abuse towards the resident in the first audio recording even though the use of inappropriate words was clearly heard on the audio recording. PSW #123 consistently denied recalling any of the residents' names, they indicated the residents' home area and which floor they resided on and that they were no longer in the home. Additionally, the letter from the home to PSW #123, indicated they admitted to making abusive remarks and using vulgar language towards the two residents they were speaking about in the audio recordings. PSW #123 acknowledged that they had not completed any type of training prior to their return to work.

In an interview with DRS #128, they acknowledged that PSW #123 had admitted

to being verbally abusive to the resident in the second audio recording. The DRS denied hearing PSW #123 use inappropriate words in the first audio recording. The DRS acknowledged that the home had not provided any retraining to PSW #123 prior to their return to work, as they had already completed the home's abuse and neglect training modules prior to the home becoming aware of the allegation.

In conclusion, PSW #123 and DRS #128 acknowledged that verbal abuse had occurred towards the resident in the second recording, both denied that verbal abuse had occurred towards the resident in the first audio recording even though it was clearly heard in the audio recording by the inspector and complainant. Additionally, PSW #123 had returned to work in the home on a "last chance" basis but did not receive any retraining on abuse and neglect from the home prior to their return to work with the elderly population.

The severity of this non-compliance was identified as actual harm, the scope was identified as pattern. Review of the home's compliance history revealed a compliance order (CO) was issued on June 23, 2017, under inspection report #2017_642606_0005 and a CO was issued on July 17, 2018, under inspection report #2018_654618_0015 for the non-compliance with the LTCHA, 2007, s. 19. Due to the severity of actual harm and previous non-compliance, a CO is warranted. (649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 16, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, r.50. (2).

Specifically, the licensee shall ensure that residents #003, #010, and #011 who were exhibiting altered skin integrity were reassessed at least weekly by a member of the registered nursing staff.

Upon receipt of this compliance order the licensee must:

1. Conduct audits for residents #003, #010, and #011 and all other residents who require weekly skin and wound assessments by a member of the registered nursing staff. A record of the audits completed must be maintained that include residents' name and room number, date of the audit including the shift, names of staff who were audited and the name of staff who completed the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that residents #003, #010, and #011 who were exhibiting altered skin integrity were reassessed at least weekly by a member of the registered nursing staff.

A complaint was submitted to the MLTC alleging that resident #003's altered skin integrity had worsened.

Record review indicated that resident #003 was first identified with an area of altered skin integrity on an identified date, and the next weekly skin and wound assessment was completed nine days later. Another weekly skin and wound assessment was completed on an identified date and the next one three weeks later. Another assessment was completed on an identified date, and the next assessment thereafter was completed nine days later. The resident was further assessment on an identified date and the next weekly skin and wound assessment was completed six and a half weeks after, and the next assessment thereafter was completed four weeks later. Another weekly skin and wound assessment were completed on an identified date and the next assessment was completed two weeks after, the next assessment was completed on an identified date then the next assessment thereafter was completed two weeks later.

Further review of the physician orders indicated that the resident was treated with antibiotics four times. According to a progress note, the resident's area of

altered skin integrity had deteriorated, and the resident had developed another area of altered skin integrity, even though they were on a turning and repositioning schedule every two hours while in bed.

In an interview with RN #101, they acknowledged that there were gaps in resident #003's weekly skin and wound assessments for the area of altered skin integrity during identified periods.

In an interview with DNU #119, they acknowledged if the resident has altered skin integrity the expectation is that weekly skin and wound assessments are completed by the registered nursing staff. (649)

2. Resident #010 was selected for sample expansion related to non-compliance with resident #003.

Record review indicated that resident #010 has altered skin integrity and had it for some time. On an identified date, they sustained an injury to the existing area of altered skin integrity.

Record review of the weekly skin and wound assessments indicated an assessment was completed on an identified date and the next weekly skin and wound assessment was 12 days later, and the next assessment was completed three weeks after. Another weekly skin and wound assessment was completed on an identified date and the next assessment thereafter was completed five weeks after.

In an interview with RN #122, they acknowledged that there were gaps in resident #010's weekly skin and wound assessments for altered skin integrity during identified periods. They explained that the weekly skin and wound assessments should be completed on a weekly basis by whichever registered nurse was assigned to the resident.
(649)

3. Resident #011 was selected for sample expansion related to non-compliance with resident #003.

Record review indicated that resident #011 was admitted with an area of altered

skin integrity.

According to the assessment tab a weekly skin and wound assessment was completed on an identified date, when the resident was admitted. Further record review indicated that no other weekly skin assessments were completed thereafter. A review of the electronic– treatment administration record (e-TAR) indicated that the site healed on an identified date.

In an interview with RN #101, they acknowledged that a weekly skin and wound assessment was completed on an identified date and no other assessments were completed thereafter.

In an interview with DRS #128, they acknowledged that residents #010 and #011 with pressure ulcers should have been reassessed at least weekly by a member of the registered nursing staff.

The severity of this non-compliance was identified as minimal harm, the scope was identified as widespread. There is no compliance history related to this legislation. Due to the severity of minimal harm and the scope being widespread, a compliance order is warranted. (649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 16, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

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 25th day of November, 2019

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : JulieAnn Hing

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