Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jan 28, 2015;	2014_396103_0006 (A1) (Appeal\Dir#: DR# 033)	O-001064-14	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE PORT HOPE
360 Croft Street PORT HOPE ON L1A 4K8

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

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Mary Nestor (Director) - (A1)(Appeal\Dir#: DR# 033)

Amended Inspection Summary/Résumé de l’inspection modifié

Director Review DR# 033 of Inspector's Order(s) has been rescinded.

Issued on this 28 day of January 2015 (A1)(Appeal\Dir#: DR# 033)

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

Original report signed by the inspector.

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Mary Nestor (Director) - (A1)(Appeal/Dir# DR# 033)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): October 20-24, 27-30, 2014

The following logs were completed during this inspection:

O-000633-14,O-000625-14, O-000406-14,O-000385-14, O-000378-14, O-000326-14, O-000909-13.

During the course of the inspection, the inspector(s) spoke with Residents, the President of Resident Council, the President of Family Council, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the RAI Coordinator, the Office Manager, the Physiotherapist, the Dietitian, the Nutritional Manager, Dietary aides, the lead for Infection Prevention and Control, Activity aides , the Assistant Director of Care, the Director of Care, and the Program Manager/Acting Administrator.

During the course of the inspection, the inspector(s) the inspectors conducted a full walking tour of all resident areas, observed resident dining and resident care including resident activities, observed medication administration and drug storage areas, reviewed infection control practices, reviewed relevant home policies, reviewed staffing schedules including Registered Nurse coverage, and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Admission and Discharge

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Safe and Secure Home

Sufficient Staffing

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

- **11 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	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. 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 comply with the LTCHA, 2007, s. 19 (1) whereby residents were not protected from abuse.

The legislation defines verbal abuse as 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.

During the stage one resident interviews, Resident #14 reported staff have tried to force them into getting ready for bed before they want to and speak in an intimidating manner. Resident #14 further described that when these staff assist them in getting ready for bed, they are rough and always in a hurry. Resident #14 stated the incidents were reported to staff.

S#110 was interviewed and stated Resident #14 had reported an allegation of verbal abuse a couple of weeks ago and the staff member believed the allegations were reported to S#102. S#110 indicated the resident was encouraged to go to management with this concern and that the home has a zero tolerance of abuse policy.

S#102 was interviewed and denied having been made aware of Resident #14's allegations. S#108 was interviewed and stated they could recall an incident involving Resident #14 that occurred several months ago. S#108 recalled the resident alleged a staff member had been rude and told the resident they had to go to bed "now". S#108 indicated the resident had been upset by the incident. S#108 reviewed Resident #14's notes and was able to show the inspector a progress note which had been the basis of the allegations. S#108 was asked if the incident had been reported and initially believed it had been reported to the DOC. S#108 later stated they had not been in charge at the time but recalled hearing about the incident from the charge nurse. This charge nurse no longer works in the home and could not be interviewed, but S#108 was confident it had been reported to the DOC. S#108 recalls having spoken with Resident #14 about this incident and that the resident was upset and unhappy with being forced to go to bed and the manner in which they were spoken to. S#108 was told by the resident the staff member had raised their voice and appeared to be angry. S#108 believed this would be considered resident abuse.

S#112 made the written entry on Resident #14's chart on the identified date. S#112 was interviewed and stated they had a clear recall of the event, remembers the resident was demanding and rang for "trivial things" that night. Stated that despite being frequently reapproached, the resident had refused to get ready for bed because they were watching something on television. S#112 stated there is a routine in the home and residents need to be settled.

The DOC was interviewed and recalled having to counsel S#112 previously in regards to an incident with Resident #55. The DOC stated the resident had complained they were spoken to in an abrupt manner and that they felt rushed in their care. There was no written documentation to support an investigation into these allegations was ever completed. The DOC stated Resident #55 told her the following day that they had spoken with the staff member and everything was settled. The DOC stated she did speak with the staff member about the behaviour, but did not view the incident as abusive. The DOC stated there was nothing "official" left on S#112's personnel file and she believed the resident had been upset because they were newly admitted to the home. According to the DOC, there have not been any further incidents involving S#112.

On October 24, 2014 during the discussion with the inspectors regarding the two allegations made by Resident #14, the DOC stated this resident has many behaviours, and produced a report from PASE dated on an identified date. The DOC believed the resident was possibly confusing the facts due to a cognitive impairment. The DOC was advised that the resident described two separate incidents, and despite the descriptions provided, the DOC appeared to dismiss this allegation. The DOC was reminded all allegations of abuse must be investigated.

On an identified date, S#120 was being interviewed and stated on several occasions they had reported incidents of verbal abuse by staff members toward residents. S#120 stated these incidents had been reported to the Program Manager and that most recently, they witnessed an incident on an identified date which the staff member believed to be resident abuse. S#120 stated it was not reported until four days later when the Program Manager/Acting Administrator was advised.

S#120 stated they are aware of their legal requirement to report all suspected abuse, but stated past concerns have never resulted in any action against the responsible staff members. S#120 also stated the home has a "nasty environment when people know you have reported." S#120 recalled another incident whereby S#112 had told Resident #29 it was much later than the actual time to entice the resident into getting ready for bed early. S#120 stated this incident was reported to the Program Manager.

The Program Manager/Acting Administrator was interviewed on October 29, 2014 and stated she had been advised of an allegation of abuse involving Resident #52 and that S#112 had been placed on leave pending the investigation. The Program Manager was asked if S#120 had ever previously reported other allegations of staff to resident verbal abuse. She stated yes but could not recall any specifics. Additionally she was

able to recall being advised of the incident involving S#112 and Resident #29. The Program Manager/Acting Administrator stated all of these allegations would have been reported to the DOC.

The DOC was interviewed in regards to these allegations of abuse. The DOC stated they may have been reported during a morning meeting, but had no documentation to support any investigation was done. The DOC did advise this inspector the home was actively investigating the allegations of verbal abuse against Resident #14.

The home failed to follow the staff to resident abuse policy, #OPER-02-02-04. Under Policy Statement it states, "Every person in the home, including staff, has a mandatory and legal obligation to immediately report suspected or witnessed abuse". The home's education records were reviewed and annual abuse training is provided to all employees and includes mandatory reporting obligations. Despite this education, allegations of abuse were not immediately reported.

The DOC was advised by the inspectors of the two allegations of staff to resident abuse involving Resident #14 on October 24, 2014. The home verbally reported and subsequently submitted a critical incident which referred only to one of the incidents. The second allegation was not immediately reported to the Director despite being made aware of the two separate allegations on October 24/14 and to date of this inspection has still not been reported.

Under "Actions to be taken against the Perpetrator", the policy states to advise the employee there has been a report of suspected or witnessed abuse toward a resident and to immediately remove the employee from the work schedule. The DOC was made aware of the allegations involving S#112 and Resident #14 on an identified date, however, the staff member was not immediately removed from the work schedule. S#112 continued to work in the home for two more days and was allegedly involved in another incident of resident abuse involving Resident #52 on one of those identified dates. Additionally the family of Resident #52 was not notified of the allegation of abuse.

Past allegations of resident abuse were reported to the management in the home but the home failed to immediately investigate the allegations of abuse. [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. 212. Administrator

Specifically failed to comply with the following:

s. 212. (4) Subject to subsection (5), the licensee shall ensure that everyone hired as an Administrator after the coming into force of this section,
(a) has a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration; O. Reg. 79/10, s. 212 (4).
(b) has at least three years working experience,
(i) in a managerial or supervisory capacity in the health or social services sector, or
(ii) in another managerial or supervisory capacity, if he or she has already successfully completed the course mentioned in clause (d); O. Reg. 79/10, s. 212 (4).
(c) has demonstrated leadership and communications skills; and O. Reg. 79/10, s. 212 (4).
(d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time. O. Reg. 79/10, s. 212 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure the home's Administrator has successfully completed or is enrolled in a program in long term care home administration.

On October 3, 2014, the home's previous Administrator ceased to work at the home. The Program Manager was put into the position as Acting Administrator at that time. In an interview with the Program Manager/Acting Administrator, she indicated she completed a three year degree in Gerontology, has been a Program Manager in this home since 2011, but does not have an Administrator's certificate and is not currently enrolled in a program in long term care administration.

The Program Manager stated she had been advised by Extendicare that she would be the go-to person until a permanent Administrator could be hired. During this time, the Program Manager/Acting Administrator continues to fulfill her duties as a Program Manager.

On November 6, 2014, the Regional Director advised this inspector that a new Administrator has been hired and will start effective December 1, 2014. She stated the Program Manager will continue to be the Acting Administrator as there is not a qualified Administrator to fill the role in the interim. The Regional Director stated she and the Nurse Consultant will be monitoring the home until such time the new Administrator begins. [s. 212. (4)]

Additional Required Actions:

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

(A1)(Appeal/Dir# DR# 033)
The following order(s) have been rescinded:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 3 (1) 8. whereby resident rights to be afforded privacy in treatment and in caring for his or her personal needs were not protected.

On October 22, 2014, S#104 was observed administering injectable insulin at the breakfast table while several residents and staff were present in the dining room. This staff member was interviewed and indicated treatments are not permitted in the dining

room. In an interview with the Director of Care, she stated this is not considered an acceptable practice in the home and does not support the resident's right to privacy in treatment. [s. 3. (1) 8.]

2. During the course of this inspection, a notice was observed posted above Resident #37's bed and in the shared bathroom of Resident #54. Both notices contained personal health information.

These notices do not support the resident's right to privacy in treatment and in caring for his/her personal needs. [s. 3. (1) 8.]

3. The licensee has failed to ensure that the home fully respected Resident #41's right to keep personal possessions in their room.

Regarding log #O-000406-14

A complaint was lodged regarding the removal of personal belongings from Resident #41's room.

The Programs Manager/Acting Administrator was interviewed in regards to the items removed from Resident #41's room. She indicated some of the items did pose a tripping hazard and made it difficult for staff to utilize the needed equipment in the resident room. The Program Manager did state that some of the articles removed could have been discreetly stored within the resident room and did not pose a safety risk. The Program Manager was unaware of any event that had precipitated the removal of these specific items. (103) [s. 3. (1) 10.]

4. The licensee has failed to comply with LTCHA, 2007, s. 3 (1) 11. iv, whereby resident's personal health information was not kept confidential.

On October 21,2014 at approximately 1000 hours on the Mowat unit, the electronic medication administration record terminal on the medication cart was left open and unattended outside of the dining room. Health information pertaining to several residents' residing on the unit was visible on the screen. At this time, several residents and visitors were observed in the area of the cart.

On October 22, 2014 at approximately 0930 hours on the Augusta unit, the electronic medication administration record terminal on the medication cart was left open and unattended outside of the unit's dining room. Health information pertaining to several

residents' residing on the unit was visible and several residents were observed in the area of the cart.

#S104 was interviewed and indicated it should not be left open when staff are not in attendance at the cart. [s. 3. (1) 11. iv.]

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 resident treatments are completed in a private area, notices that include resident treatment and personal needs are not posted in public view, residents are permitted to keep personal possessions in their rooms subject to safety requirements and personal health information is kept confidential, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).
3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).
4. Customary routines and comfort requirements. O. Reg. 79/10, s. 24 (2).
5. Drugs and treatments required. O. Reg. 79/10, s. 24 (2).
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs 79/10, s. 24 (2) whereby the twenty four hour admission care plan did not include the minimum requirements legislated.

Regarding log # O-000633-14

Resident #47 was admitted to the home on a specified date. The resident health care record was reviewed and on the day of admission the home completed the resident fall assessment (Morse Fall Scale). Resident #47 was assessed as high risk for falls due to an impaired gait and a history of past falls. Two days after admission, the Physiotherapist assessed the resident as requiring assistance for all transfers.

Nine days after admission, the resident sustained a fall at the bedside while attempting to self transfer from the wheelchair into bed. At the time of this fall, the twenty four hour admission care plan was in effect. The legislation requires this care plan to identify specific resident information including the following:

- the resident risk of falling and interventions to mitigate the risks,
- the type and level of assistance required related to activities of daily living (ADL's), and
- customary routines and comfort requirements.

S#100 was interviewed and provided this inspector with the twenty four hour admission care plan that PSW staff would have had access to in order to provide care to Resident #47. The twenty four hour admission care plan was reviewed. The section under "Falls" identified the resident as having no potential problems related to falls and there were no interventions listed to mitigate any fall risk. This was contrary to the fall risk assessment completed on admission and the Physiotherapist's assessment. The section under "Activities of Daily Living" which includes the resident's transfer and mobility requirements was not completed. Additionally, the care plan did not include any resident customary routines. S#100 confirmed the required documentation on the twenty four hour admission care plan was incomplete.

Resident #47 passed away in hospital several days later. [s. 24. (2)]

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 the twenty four hour admission care plan includes all resident information as required by the legislation, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan related to administration of pain medication.

On October 21,2014 at 1520 hours during a review of the home's medication management system, S#103 was observed preparing a narcotic drug for the administration to Resident #48. #S103 indicated to the inspector that she begins all of her afternoon medication administration early in order to complete all of her workload.

S#103 recorded on the form titled, "Monitored Medication Record for 7 Day Card" the date and time of the administration of this narcotic as 1700 hours when the actual time was 1525 hours. S#103 then advised the inspector that she would not administer the medication as the inspector was there and it was too early to administer it. S#103 confirmed that the resident had not requested the narcotic early for pain nor had she received any communication from the previous shift report indicating the resident required the pain medication early.

During a review of the resident health care record, the order indicated the narcotic drug was to be administered twice daily and the Medication Administration Record (MAR) indicated the administration times were 0600 hours and 1700 hours.

S#102 and S#103 were interviewed on October 22, 2014 and both confirmed the resident receives the narcotic at those specified times as they meet the needs of the resident. The Director of Care was also interviewed and indicated it is not acceptable practice of staff to administer medications in the home that far in advance of the scheduled times. [s. 6. (7)]

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff is on duty and present at all times unless there is an allowable exception to this requirement.

Regarding log #O-000326-14

Extendicare Port Hope is a 128 bed home.

The home's staffing schedule for Registered Nurses was reviewed for the months of March, June, August, September and October 1st to October 24th, 2014. There was no Registered Nurse (RN) noted to be working in the home on the following days:

March 2/14 between 3am and 7am ,
March 17/14 between 7am and 8am,
March 23/14 between 11pm and 7am,
August 2/14 between 7am and 11am,
August 3/14 between 7am and 11am,
August 13/14 between 7am and 3pm,
August 19/14 between 11pm and 7am,
August 27/14 between 11pm and 7am,
August 28/14 between 7am and 11am,
August 28/14 between 11pm and 7am,
August 29/14 between 7am and 3pm, and
September 12/14 between 11pm and 7am.

The Director of Care (DOC) was interviewed on October 28/14 and confirmed that the home did not have a Registered Nurse on duty on the above dates. The home has had an RN on site from September 13, 2014 to the date of this inspection and the currently posted schedule to November 16,2014 does not indicate any deficiencies at this time.

The DOC has been actively recruiting Registered Nurses and in July, 2014 hired four registered nurses, two full-time and two part-time. Registered Nurse Agency staff are utilized when available in accordance with the allowable exceptions. [s. 8. (3)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall.

During the tour of the resident care areas, it was noted that two easily accessible grab bars are not provided in the shower area located in the Augusta and Mowat home areas.

In the Augusta home area, it was observed that a grab bar is located on the faucet wall. A grab bar is not provided as required on an adjacent wall in the shower area.

In the Mowat home area, it was observed that a grab bar is not located on the same wall as the faucet. A grab bar is noted to be provided on an adjacent wall in the shower area. [s. 14.]

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and a good state of repair.

During the inspection period, the following was noted:

- Floor coverings are damaged in the shower area of the Augusta house. The shower floor is ripped and lifting and there is a gap in the floor at the doorway leading from the shower area to tub room #1216. Non intact floor coverings are a potential safety risk and cannot be properly cleaned, (570)

- Black marks were observed on the lower doors of Spa rooms #1218 and #1216. Brown/rusty marks were observed on the shower floor in August house. There is unfinished repair to the drywall next to the small tub; black and brown marks on the floor next to the small tub in Spa room #1218. (570)

-Spa room #1216 had black marks observed inside the tub and there were unfinished repair to drywall patches/not painted, (570)

- Two 12X4 inch holes were observed in the ceiling above the shower area with exposed pipes evident in the Mowat house, (570)

- Spa room #1116 had black marks evident inside tub and there were unfinished repairs to dry wall patches/not painted, (570)

- Room #2238, the ceiling tile above the toilet has a yellow ring of staining; there is scarred paint on the door frames and lower walls with minor damage to dry wall in this shared bathroom,

- Room #1210 was observed to have scraped paint with damage to dry wall behind the door in the room; a gap was noted between the baseboard and floor at the wall with window; damage to floor under bed with scraped floor tiles and black marks evident,

- Room #1234, had scraped paint with black marks on wall next to window, (570)

- Room #1240, had scraped lower walls in room and drywall damage behind door at door handle level and above baseboard, (570)

- Room #2241, there was wall disrepair on the wall at the end of the bed and at the window corner, gouges/paint missing was observed; there was scarring on the bottom of the door frame into bathroom, (103)

- Room #2242, there was disrepair of the wall at the end of the bed which has been repaired but not painted, (103)

- Room #1134, the lower frame of the bathroom door was scraped and there was a cracked ceiling tile in the shared bathroom, (548)

- Room #1138, the lower wall surface was scraped and there was drywall damage behind the door at door handle level, (570)

- Room #1222, had observed damage to the drywall behind the door at the handle level and was missing the door stopper; black marks were observed on the lower walls in shared bathroom and there was a 1X3 inch hole in the drywall next to toilet paper holder, (570)

- Room #2237, had stained ceiling tiles in bathroom, (103) and

- there were numerous stains on the carpet in the hallways throughout the home. [s. 15. (2) (c)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs 79/10, s. 37 (1) (a) whereby personal items are not labelled within fourty eight hours of admission and of acquiring, in the case of new items.

Throughout the inspection period, the following unlabelled items were observed:

Resident #15's shared bathroom- Unlabelled black comb observed beside sink, (570)

Resident #5's shared bathroom- numerous personal care products were unlabelled including a toothbrush and razor, (553)

Resident #12's shared bathroom- one black comb and blue urine collection container are unlabelled and placed on top of toilet tank, (570)

Resident #1's shared bathroom- two unlabelled hair brushes, one unlabelled pink comb, three unlabelled toothbrushes and one unlabelled gum massager; all of these items were found sitting on the counter by sink, (103)

Resident #10's bathroom- a hairbrush and personal bath wash was unlabelled, (548)

Resident #26's shared bathroom- unlabeled toothbrush and used soap bar in unlabeled container left by sink, (570)

Resident #14's shared bathroom- unlabelled dentures and unlabelled denture cup, (548)

Resident #19's shared bathroom- unlabelled hair trimmer and electric toothbrush, (553) and

Resident #17's shared bathroom- unlabelled dentures sitting in open unlabelled denture cup, numerous unlabelled items sitting in white basket by sink including deodorant, hair pik, and toothbrush. (103) [s. 37. (1) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On October 24, 2014 at 1145 hours on the Augusta Unit, an unattended medication cart was observed to have a bottle of Lactulose and a bottle of Soflax left on top of the cart. The medication cart was located to the right of the nurses' station, adjacent to the television viewing areas where multiple residents were sitting.

S#104 was the staff member responsible for administering medications at that time. The staff member was interviewed and indicated the Lactulose and Soflax should not be left on the medication cart when it is unattended. [s. 129. (1) (a) (ii)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure all staff participate in the implementation of the infection prevention and control program.

Throughout the inspection, the following observations were made:

-Resident #24's shared bathroom was observed to have a used catheter bag hanging on the towel rack next to clean white towels; additionally two unlabelled blue wash basins were stored under the sink, (570)

Resident #29's shared bathroom was observed to contain a visibly soiled blue wash basin labelled 1111; this is not the room number for this resident, (570)

Resident #4's bathroom had no toilet paper holder and open rolls of toilet paper were observed on several occasions stored on the back of the toilet, (103)

Resident #17's shared bathroom had no toilet paper holder and two open rolls of toilet paper were observed on several occasions to be placed on the grab bar beside the toilet, (103)

Resident #39's shared bathroom was observed to have two unlabelled wash basins under the sink in the bathroom, (570)

A staff member was observed exiting a resident room which indicated the resident was on contact precautions without performing hand hygiene and entered another resident room, (553)

S#104 failed to wash or disinfect hands prior to the preparation and administration of an injectable medication to Resident #4, (548)

S#102 was observed providing wound care to Resident #14's feet; the staff member failed to wash hands prior to the treatment and did not adhere to good infection control practices while completing the treatment, (548)

S#108 is the lead for the Infection Prevention and Control program in the home. She indicated resident catheter bags when not in use should be stored in the dirty utility rooms and also indicated it would be the home's expectation that all resident wash basins are clearly labelled to prevent cross contamination. Additionally she reported the staff have received education in proper hand hygiene. (103) [s. 229. (4)]

Issued on this 28 day of January 2015 (A1)(Appeal/Dir# DR# 033)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, L1K-0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Mary Nestor (Director) - (A1)(Appeal/Dir# DR# 033)

Inspection No. / No de l'inspection : 2014_396103_0006 (A1)(Appeal/Dir# DR# 033)

Appeal/Dir# / Appel/Dir#: DR# 033 (A1)

Log No. / Registre no. : O-001064-14 (A1)(Appeal/Dir# DR# 033)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jan 28, 2015;(A1)(Appeal/Dir# DR# 033)

Licensee / Titulaire de permis :

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700,
MARKHAM, ON, L3R-9W2

LTC Home / Foyer de SLD :

EXTENDICARE PORT HOPE
360 Croft Street, PORT HOPE, ON, L1A-4K8

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : LAURA YONTZ

To EXTENDICARE (CANADA) 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, 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 shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007 s. 19 (1) to ensure all residents are protected from abuse.

This plan shall include :

- a mandatory, comprehensive and interactive education session for all direct care staff offered in various formats to meet the learning needs of adult learners on all forms of abuse and mandatory reporting,

-additional mandatory education for all direct care staff which includes some form of sensitivity training and promotes a supportive and respectful work environment and reduces staff fear of reporting co-workers,

-defined interventions to support staff in the integration of the mandatory education into their day to day practice,

-a system to monitor and evaluate staff adherance to the Zero Tolerance of Abuse policy and Resident Rights,

-an outline of what the home's actions will be if non compliance is found,

-the plan should also identify who is responsible for ensuring the completion of each item above.

This plan shall be submitted in writing to Inspector, Darlene Murphy, 347 Preston St., 4th floor, Ottawa, Ontario K1S 3J4 or by fax at 613-569-9670 on or
before December 1, 2014.

Grounds / Motifs :

1. The licensee has failed to comply with the LTCHA, 2007, s. 19 (1) whereby residents were not protected from abuse.

The legislation defines verbal abuse as 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.

During the stage one resident interviews, Resident #14 reported staff have tried to force them into getting ready for bed before they want to and speak in an intimidating manner. Resident #14 further described that when these staff assist them in getting ready for bed, they are rough and always in a hurry. Resident #14 stated the incidents were reported to staff.

S#110 was interviewed and stated Resident #14 had reported an allegation of verbal abuse a couple of weeks ago and the staff member believed the allegations were reported to S#102. S#110 indicated the resident was encouraged to go to management with this concern and that the home has a zero tolerance of abuse policy.

S#102 was interviewed and denied having been made aware of Resident #14's allegations. S#108 was interviewed and stated they could recall an incident involving Resident #14 that occurred several months ago. S#108 recalled the resident alleged a staff member had been rude and told the resident they had to go to bed "now". S#108 indicated the resident had been upset by the incident. S#108 reviewed Resident #14's notes and was able to show the inspector a progress note which had been the basis of the allegations. S#108 was asked if the incident had been reported and initially believed it had been reported to the DOC. S#108 later stated they had not been in charge at the time but recalled hearing about the incident from the charge nurse. This charge nurse no longer works in the home and could not be interviewed, but S#108 was confident it had been reported to the DOC. S#108 recalls having spoken with Resident #14 about this incident and that the resident was upset and unhappy with being forced to go to bed and the manner in which they were spoken to. S#108 was told by the resident the staff member had raised their voice and appeared to be angry. S#108 believed this would be considered resident abuse.

S#112 made the written entry on Resident #14's chart on the identified date. S#112 was interviewed and stated they had a clear recall of the event, remembers the resident was demanding and rang for "trivial things" that night. Stated that despite being frequently reapproached, the resident had refused to get ready for bed because they were watching something on television. S#112 stated there is a routine in the home and residents need to be settled.

The DOC was interviewed and recalled having to counsel S#112 previously in

regards to an incident with Resident #55. The DOC stated the resident had complained they were spoken to in an abrupt manner and that they felt rushed in their care. There was no written documentation to support an investigation into these allegations was ever completed. The DOC stated Resident #55 told her the following day that they had spoken with the staff member and everything was settled. The DOC stated she did speak with the staff member about the behaviour, but did not view the incident as abusive. The DOC stated there was nothing "official" left on S#112's personnel file and she believed the resident had been upset because they were newly admitted to the home. According to the DOC, there have not been any further incidents involving S#112.

On October 24, 2014 during the discussion with the inspectors regarding the two allegations made by Resident #14, the DOC stated this resident has many behaviours, and produced a report from PASE dated on an identified date. The DOC believed the resident was possibly confusing the facts due to a cognitive impairment. The DOC was advised that the resident described two separate incidents, and despite the descriptions provided, the DOC appeared to dismiss this allegation. The DOC was reminded all allegations of abuse must be investigated.

On an identified date, S#120 was being interviewed and stated on several occasions they had reported incidents of verbal abuse by staff members toward residents. S#120 stated these incidents had been reported to the Program Manager and that most recently, they witnessed an incident on an identified date which the staff member believed to be resident abuse. S#120 stated it was not reported until four days later when the Program Manager/Acting Administrator was advised.

S#120 stated they are aware of their legal requirement to report all suspected abuse, but stated past concerns have never resulted in any action against the responsible staff members. S#120 also stated the home has a "nasty environment when people know you have reported." S#120 recalled another incident whereby S#112 had told Resident #29 it was much later than the actual time to entice the resident into getting ready for bed early. S#120 stated this incident was reported to the Program Manager.

The Program Manager/Acting Administrator was interviewed on October 29, 2014 and stated she had been advised of an allegation of abuse involving Resident #52 and that S#112 had been placed on leave pending the investigation. The Program Manager was asked if S#120 had ever previously reported other allegations of staff

to resident verbal abuse. She stated yes but could not recall any specifics. Additionally she was able to recall being advised of the incident involving S#112 and Resident #29. The Program Manager/Acting Administrator stated all of these allegations would have been reported to the DOC.

The DOC was interviewed in regards to these allegations of abuse. The DOC stated they may have been reported during a morning meeting, but had no documentation to support any investigation was done. The DOC did advise this inspector the home was actively investigating the allegations of verbal abuse against Resident #14.

The home failed to follow the staff to resident abuse policy, #OPER-02-02-04. Under Policy Statement it states, "Every person in the home, including staff, has a mandatory and legal obligation to immediately report suspected or witnessed abuse". The home's education records were reviewed and annual abuse training is provided to all employees and includes mandatory reporting obligations. Despite this education, allegations of abuse were not immediately reported.

The DOC was advised by the inspectors of the two allegations of staff to resident abuse involving Resident #14 on October 24, 2014. The home verbally reported and subsequently submitted a critical incident which referred only to one of the incidents. The second allegation was not immediately reported to the Director despite being made aware of the two separate allegations on October 24/14 and to date of this inspection has still not been reported.

Under "Actions to be taken against the Perpetrator", the policy states to advise the employee there has been a report of suspected or witnessed abuse toward a resident and to immediately remove the employee from the work schedule. The DOC was made aware of the allegations involving S#112 and Resident #14 on an identified date, however, the staff member was not immediately removed from the work schedule. S#112 continued to work in the home for two more days and was allegedly involved in another incident of resident abuse involving Resident #52 on one of those identified dates. Additionally the family of Resident #52 was not notified of the allegation of abuse.

Past allegations of resident abuse were reported to the management in the home but the home failed to immediately investigate the allegations of abuse. [s. 19. (1)]

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

(103)

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

Dec 31, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

(A1)(Appeal/Dir# DR# 033)
The following Order has been rescinded:

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 212. (4) Subject to subsection (5), the licensee shall ensure that everyone hired as an Administrator after the coming into force of this section,
(a) has a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration;
(b) has at least three years working experience,
(i) in a managerial or supervisory capacity in the health or social services sector, or
(ii) in another managerial or supervisory capacity, if he or she has already successfully completed the course mentioned in clause (d);
(c) has demonstrated leadership and communications skills; and
(d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time. O. Reg. 79/10, s. 212 (4).

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
Performance Improvement and Compliance 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

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 28 day of January 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Mary Nestor (Director) - (A1)(Appeal/Dir# DR# 033)

Service Area Office /
Bureau régional de services : Ottawa