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 sous la Loi de 2007 sur 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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347 Preston St, 4th Floor
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 7, 2013	2012_199161_0004	O-000532-12	Critical Incident System

Licensee/Titulaire de permis

COUNTY OF RENFREW
9 INTERNATIONAL DRIVE, PEMBROKE, ON, K8A-6W5

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

BONNECHERE MANOR
470 ALBERT STREET, RENFREW, ON, K7V-4L5

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

KATHLEEN SMID (161)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): on-site December 12, 13, 14, 2012.

During the course of the inspection, the inspector(s) conducted six Critical Incident Inspections Log #O-000532-12, Log #O-000686-12, Log #O-000969-12, Log #O-001471-12, Log #O-001495-12, Log #O-001796-12.

During the course of the inspection, the inspector(s) spoke with identified Residents, the Administrator, Director of Care, Environmental Services Manager, Resident Care Coordinator, Registered nursing staff and Personal Support Workers.

During the course of the inspection, the inspector(s) interviewed identified Residents and reviewed their health records, the home's Policy # G-007 Prevention of Abuse or Neglect dated July 1, 2010 and the revised policy dated November 14, 2012, Policy # N-19-008 Restraint Use and Minimizing the Use of Restraints and Personal Assistive Devices dated March 19, 2012, Employer Investigation Reports and Discipline Letters to identified staff members.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 :

The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (7) to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

On June 22, 2012 the home submitted a report via the Critical Incident System regarding an incident that occurred on June 17, 2012 @ 03:45. Resident #01 rang her/his call bell for assistance to the bathroom. Resident #01 was taken to the bathroom and afterwards transferred via wheelchair to her/his bed. When staff attempted to assist the resident back into bed, the resident became resistive, trying to push herself/himself back into her/his wheelchair. Together, Registered staff member #S100 and student nurse #S110 transferred Resident #01 back to bed. On June 17, 2012 at 04:48 Registered staff member #S100 documented in Resident #01's progress notes that during the transfer of the resident back to bed, the Resident resisted with + + force, biting, kicking and scratching herself/himself and the Registered staff member. On December 28, 2012 in discussion with staff member # S111 who was witness to this incident, the staff member indicated to the inspector that once Resident #01 was back in bed, the Registered staff member #S100 held the resident's ankles down against the mattress for 5 – 10 minutes in an attempt to prevent Resident #01 from getting out of bed.

Resident #01's care plan dated June 10, 2012 was reviewed. It indicates in part, that when Resident #01 demonstrates responsive behaviours as evidenced by self-mutilation, biting and striking out at staff, the staff are to be cognizant of Resident #01's unpredictable responsive behaviours during care and to stop their provision of care.

On December 13, 2012 the Director of Care in discussion with the inspector indicated that Registered staff member #S100 was reported to the College of Nurses of Ontario and also received a five day unpaid suspension for the incident that occurred on June 17, 2012. [Log #O-001495-12]

On June 18, 2012 the home submitted a report via the Critical Incident System regarding an incident that occurred on June 15, 2012. At 08:30 on the morning of June 15, 2012 Registered staff member #S112 went to change a surgical dressing on Resident #02. The Resident's nightgown, continence brief, mattress cover and sheet were saturated with urine. This incident was immediately reported to the Director of Care who initiated an investigation. On June 15, 2012 Resident #02 indicated to the

Director of Care that his/her continence brief had not been changed during the night of June 15, 2012 and that he/she was distressed by this situation.

Resident #02's care plan dated June 5, 2012 was reviewed. It indicates that Resident #02 is to be checked for wetness on rounds during the night shift between 0030 - 0200 and 0330 – 0430 and to change the Resident's continence brief as required.

On December 13, 2012 the Director of Care in discussion with the inspector indicated that Personal support worker #S102's probationary employment was terminated. Personal support worker # S103 received a one day unpaid suspension for the incident that occurred on June 15, 2012. [Log #O-001471-12]

On February 29, 2012 the home submitted a report via the Critical Incident System regarding an incident that occurred during the night of February 14, 2012. At 05:10 on February 14, 2012, Resident #05 was found on the floor of her/his room by Personal support worker #S108 near the bathroom door. The Resident indicated to Registered nursing staff member #S114 that she/he was walking to the bathroom when she/he fell to the floor. The Resident indicated that her/his backbone was sore from lying on the floor since approximately 02:00. She/he also indicated that she/he was upset about lying on the floor for 3 hours and unable to obtain assistance. On February 14, 2012 @ 07:21 Registered staff member #S113 documented in Resident #05's progress notes that the Resident stated she/he tried to make it to the bathroom by herself/himself during the night which resulted in a fall. She/he could not reach her/his call bell. When asked why she/he did not ring for assistance the Resident stated she/he had been told she/he is "ringing too much".

Resident #05's PointClickCare Point of Care Resident Detail record of February 14, 2012 indicates that the Resident is to be checked hourly.

On December 14, 2012 Resident #05 indicated to the inspector that she/he recalled the incident that had occurred on February 14, 2012 stating that the Personal support worker #S108 had not checked on her/him for three hours.

On December 13, 2012 the Director of Care in discussion with the inspector indicated that Personal support worker #S108 received a written warning for this incident of resident neglect that occurred on February 14, 2012. On February 27, 2012, Personal

support worker #S108 wrote a letter addressed to the members of Bonnechere Manor in which she apologized for the incident. [Log #O-000532-12]

Previous non-compliance was identified February 16, 2012, February 18, 2012 and November 16, 2010. [s. 6. (7)]

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. 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 comply with O.Reg. 79/10, s. 8. (1)(b) in that the home has not complied with their Prevention of Resident Abuse or Neglect Policy as required by O. Reg 79/10, s. 96.

O. Reg 79/10, s. 96 provides that every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents. A component of the home's Prevention of Resident Abuse or Neglect Program is the home's Prevention of Resident Abuse or Neglect Policy (#G-007) dated July 1, 2010 that directs anyone who witnesses any form of abuse/inappropriate care or is aware of alleged or suspected abuse/inappropriate care is responsible for reporting it to their supervisor or designate immediately.

On June 17, 2012 Registered Practical Nurse #S100 was emotionally abusive towards Resident #01 which was witnessed by Personal support worker #S111. On June 20, 2012 Personal support worker #S111 reported the incident of June 17, 2012 to a Resident Care Coordinator.[Log # 001495-12] [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.24(2) in that a person who has reasonable grounds to suspect that any abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur, did not immediately report the suspicion and the information upon which it is based to the Director.

On February 14, 2012 an incident of staff neglect related to Resident #05 occurred. The home notified the Director via the Critical Incident Reporting System CIS #M506-000012-12 on February 29, 2012. [Log # O-000532-12]

On June 15, 2012 an incident of staff neglect related to Resident #02 occurred. The home notified the Director via the Critical Incident Reporting System CIS # M506-000035-12 on June 18, 2012. [Log # O-001471-12]

On April 8, 2012 an incident of staff emotional abuse to Resident #06 occurred. The home notified the Director via the Critical Incident Reporting System CIS # M506-000025-12 on April 13, 2012. [Log # O-000969-12] [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.107(3)(4) in that the licensee did not ensure that the Director is informed of an injury in respect of which a person is taken to hospital no later than one business day after the occurrence of the incident.

On March 8, 2012 Resident #07 fell and was sent to hospital. The home notified the Director via the Critical Incident Reporting System CIS # M506-000020-12 on March 19, 2012. [Log #O--000686-12] [s. 107. (3)]

Issued on this 7th day of January, 2013

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

Kathleen Smith

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

Ministére 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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHLEEN SMID (161)
Inspection No. / No de l'inspection :	2012_199161_0004
Log No. / Registre no:	O-000532-12
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 7, 2013
Licensee / Titulaire de permis :	COUNTY OF RENFREW 9 INTERNATIONAL DRIVE, PEMBROKE, ON, K8A-6W5
LTC Home / Foyer de SLD :	BONNECHERE MANOR 470 ALBERT STREET, RENFREW, ON, K7V-4L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SHAYNE HOELKE

To COUNTY OF RENFREW, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

the licensee shall develop and implement a process to monitor that the care set out in the plan of care for all residents is provided to the residents as specified in the plan.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (7) to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

On June 22, 2012 the home submitted a report via the Critical Incident System regarding an incident that occurred on June 17, 2012 @ 03:45. Resident #01 rang her/his call bell for assistance to the bathroom. Resident #01 was taken to the bathroom and afterwards transferred via wheelchair to her/his bed. When staff attempted to assist the resident back into bed, the resident became resistive, trying to push herself/himself back into her/his wheelchair. Together, Registered staff member #S100 and student nurse #S110 transferred Resident #01 back to bed. On June 17, 2012 at 04:48 Registered staff member #S100 documented in Resident #01's progress notes that during the transfer of the resident back to bed, the Resident resisted with + + force, biting, kicking and scratching herself/himself and the Registered staff member. On December 28, 2012 in discussion with staff member # S111 who was witness to this incident, the staff member indicated to the inspector that once Resident #01 was back in bed, the Registered staff member #S100 held the resident's ankles down against the mattress for 5 – 10 minutes in an attempt to prevent Resident #01 from getting out of bed.

Resident #01's care plan dated June 10, 2012 was reviewed. It indicates in part, that when Resident #01 demonstrates responsive behaviours as evidenced by self-mutilation, biting and striking out at staff, the staff are to be cognizant of Resident #01's unpredictable responsive behaviours during care and to stop their provision of care.

On December 13, 2012 the Director of Care in discussion with the inspector indicated that Registered staff member #S100 was reported to the College of Nurses of Ontario and also received a five day unpaid suspension for the incident that occurred on June 17, 2012. [Log #O-001495-12]

On June 18, 2012 the home submitted a report via the Critical Incident System regarding an incident that occurred on June 15, 2012. At 08:30 on the morning of June 15, 2012 Registered staff member #S112 went to change a surgical dressing on Resident #02. The Resident's nightgown, continence brief, mattress cover and sheet were saturated with urine. This incident was immediately reported to the Director of Care who initiated an investigation. On June 15, 2012 Resident #02 indicated to the Director of Care that his/her continence brief had not been changed during the night of June 15, 2012 and that he/she was distressed by this situation.

Resident #02's care plan dated June 5, 2012 was reviewed. It indicates that Resident #02 is to be checked for wetness on rounds during the night shift between 0030 - 0200 and 0330 – 0430 and to change the Resident's continence brief as required.

On December 13, 2012 the Director of Care in discussion with the inspector indicated that Personal support worker #S102's probationary employment was terminated. Personal support worker # S103 received a one day unpaid suspension for the incident that occurred on June 15, 2012. [Log #O-001471-12]

On February 29, 2012 the home submitted a report via the Critical Incident System regarding an incident that occurred during the night of February 14, 2012. At 05:10 on February 14, 2012, Resident #05 was found on the floor of her/his room by Personal support worker #S108 near the bathroom door. The Resident indicated to Registered nursing staff member #S114 that she/he was

walking to the bathroom when she/he fell to the floor. The Resident indicated that her/his backbone was sore from lying on the floor since approximately 02:00. She/he also indicated that she/he was upset about lying on the floor for 3 hours and unable to obtain assistance. On February 14, 2012 @ 07:21 Registered staff member #S113 documented in Resident #05's progress notes that the Resident stated she/he tried to make it to the bathroom by herself/himself during the night which resulted in a fall. She/he could not reach her/his call bell. When asked why she/he did not ring for assistance the Resident stated she/he had been told she/he is "ringing too much".

Resident #05's PointClickCare Point of Care Resident Detail record of February 14, 2012 indicates that the Resident is to be checked hourly.

On December 14, 2012 Resident #05 indicated to the inspector that she/he recalled the incident that had occurred on February 14, 2012 stating that the Personal support worker #S108 had not checked on her/him for three hours.

On December 13, 2012 the Director of Care in discussion with the inspector indicated that Personal support worker #S108 received a written warning for this incident of resident neglect that occurred on February 14, 2012. On February 27, 2012, Personal support worker #S108 wrote a letter addressed to the members of Bonnechere Manor in which she apologized for the incident. [Log #O-000532-12]

Previous non-compliance was identified February 16, 2012, February 18, 2012 and November 16, 2010. [s. 6. (7)] (161)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2013

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

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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 7th day of January, 2013

Signature of Inspector / Signature de l'inspecteur : Kathleen Smid

Name of Inspector / Nom de l'inspecteur : KATHLEEN SMID

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