Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 1, 2019	2019_684604_0023	000322-19, 015341-19	Critical Incident System

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Cedarvale Lodge Retirement and Care Community
121 Morton Avenue Keswick ON L4P 2M5

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

SHIHANA RUMZI (604)

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): October 7 and 8, 2019.

During this inspection the following intakes where inspected:

-Intake log #015341-19, related to abuse
-Intake log #000322-19, related to a fall with injury

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Registered Nurses (RN), and Personal Support Worker (PSW).

During the course of the inspection, the inspector conducted observations of staff and resident interactions, provision of care, conducted reviews of health records, critical incident log, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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

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

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

The licensee has failed to ensure the resident was protected from abuse by anyone.

The definition of "abuse" in subsection 2 (1) of the Regulation “abuse” means, subject to section (2), (c) the use of physical force by a resident that causes physical injury to another resident. O. Reg 79/10 s. 2 (c).

On an identified date, the home contacted the Ministry of Long-Term Care (MLTC) After Hours Pager, reporting staff to resident abuse involving resident #002 and #003 had occurred. On an identified date the home submitted a Critical Incident System (CIS) report to the MLTC Director which indicated agency Personal Support Worker (PSW) abused resident #002 and #003 which was witnessed by the home's PSW. The CIS report further stated resident #003 sustained injuries.

An interview was conducted with PSW #104 who indicated they worked an identified shift and location of the home. The PSW stated they were with resident #002 and with the assistance of PSW #105 provided specified care to the resident. PSW #104 stated during the care resident#002 struck agency PSW #105 and the agency PSW abused the resident. PSW #104 asked the agency PSW to leave the identified location of the home and provided support to the resident.

In further interviews, PSW#104 stated right after the above incident had occurred with resident #002, PSW#104 went to resident #003 with the same agency PSW #105. The PSW stated resident #003 was to be provided with an identified care and stated they witnessed the agency PSW #105 abuse resident #003. When PSW #104 asked the agency staff why they abused the resident the agency staff indicated the resident had scratched them. PSW #104 stated they did not report the incidents until after they went home. PSW #104 stated they called the home and spoke to Charge Registered Nurse (CRN) #103 and reported two above incidents. In closing PSW #104 stated they could have prevented the second incident of abuse towards resident #003 if they had reported the initial incident of abuse towards resident #002 by the agency PSW. The PSW identified the two incidents above to be abuse by the agency PSW towards resident #002 and #003 and acknowledged they did not report the two incidents of abuse immediately to the home.

An interview was conducted with CRN #103 who indicated they worked on an identified date and shift in the home. The CRN stated they spoke to PSW #104 and was informed of the above incidents. The CRN had directed the PSW staff to document the events which occurred and would be investigated. The CRN identified the incident above to be abuse towards resident #002 and #003.

The home's policy titled "Prevention of Abuse & Neglect of a Resident"-policy #VII-G-10.00, with a revision date of April 2019, indicates all team members (employees, volunteers, agency staff, private duty caregivers, contracted service providers) residents, and families are required to immediately report any suspected or known incidents of abuse or neglect to the provincial health authorities and the ED or designate in charge of the care community.

In an interview with the home's Executive Director (ED) #101, stated PSW #104 could have prevented the second incident of abuse occurring involving resident #003. The ED further indicated resident #002 was injured related to the above incident. The ED identified the above incidents as abuse towards resident #002 and #003 by the agency PSW #105 as both residents sustained identified injuries and the residents where not protected from abuse.

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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee has failed to ensure that there was a written policy that promotes zero tolerance of abuse of residents and that it was complied with.

On an identified date, the home contacted the Ministry of Long-Term Care (MLTC) After Hours Pager, reporting staff to resident abuse involving resident #002 and #003 had occurred. On an identified date the home submitted a Critical Incident System (CIS) report to the MLTC Director which indicated agency Personal Support Worker (PSW) abused resident #002 and #003 which was witnessed by the home's PSW. The CIS report further stated resident #003 sustained identified injuries.

The home's policy titled "Prevention of Abuse & Neglect of a Resident", policy #VII-G-10.00, with a revision date of April 2019, in the policy section indicates all team members (employees, volunteers, agency staff, private duty caregivers, contracted service providers) residents, and families are required to immediately report any suspected or known incidents of abuse or neglect to the provincial health authorities and the ED or designate in charge of the care community.

In separate interviews CRN #103 and PSW #104 stated it was the home's expectation that staff in the home report abuse of any type to the home immediately. The PSW indicated on an identified date, time, and location of the home they witnessed two incidents of abuse. The PSW stated they witnessed agency PSW #105, abuse resident #002 and #003 and the PSW did not report the abuse immediately to the charge nurse. The CRN indicated on an identified date and time they received a call from PSW #105 who reported witnessing two incidents of abuse and the CRN did not report the abuse to the Associate Director of Care (ADOC) #106 until an identified time. The PSW and CRN acknowledged the home's abuse policy was not followed.

In an interview the ED indicated staff in the home are educated on the home's abuse and neglect policy annually and reviewed when needed. The ED stated the PSW staff are to report immediately to their CRN of abuse and neglect, and the CRN is to call the manager on-call immediately who will provide further direction. The ED acknowledged the home's policy related to prevention of abuse and neglect of residents was not followed by the home's staff related to abuse which had occurred on an identified date and shift.

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 there was a written policy that promotes zero tolerance of abuse of residents and that it was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

The licensee has failed to ensure that staff received training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

On an identified date, the home contacted the Ministry of Long-Term Care (MLTC) After Hours Pager, reporting staff to resident abuse involving resident #002 and #003 had occurred. On an identified date the home submitted a Critical Incident System (CIS) report to the MLTC Director which indicated agency Personal Support Worker (PSW) abused resident #002 and #003 which was witnessed by the home's PSW. The CIS report further stated resident #003 sustained injuries.

The home's policy titled "Onboarding", #III-C-10.10 with a revision date of March 2015, indicates to ensure safety and successful onboarding of all newly hired employees, independent operators, contractors (including agency staff), sub-contractors, and students, the organization will provide effective onboarding experience within a timely manner, in compliance with all applicable legislation and our vision, mission, and values. As a part of the on boarding a "Policy Declaration" is to be signed by all staff as indicated above which also included agency staff acknowledge they have read, understood, and agree to abide by the home's "Reporting Improper Activities and Prevention of Abuse and Neglect" of a resident policy.

Inspector #604 had no evidence to show Agency PSW #105 had completed and signed off the "Policy Declaration" as per the home's "Onboarding" policy.

An interview was carried out with ED #101 who indicated all agency staff arrive early prior to their shift and an RPN or RN designate would review the "Onboarding", policy which included the "Policy Declaration" with the agency staff and once completed the "Policy Declaration" is provided to the ED. The ED indicated during the home's investigation process it was noted agency PSW #105 had not signed off the "Policy Declaration" as per the home's "Onboarding" policy and did not sign in on August 4, 2019, for there evening shift. The ED acknowledged the agency PSW did not receive training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to working at the home.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff received training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities, to be implemented voluntarily.

Issued on this 5th day of November, 2019

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHIHANA RUMZI (604)
Inspection No. / No de l'inspection :	2019_684604_0023
Log No. / No de registre :	000322-19, 015341-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 1, 2019
Licensee / Titulaire de permis :	The Royale Development GP Corporation as general partner of The Royale Development LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Cedarvale Lodge Retirement and Care Community 121 Morton Avenue, Keswick, ON, L4P-2M5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Anna Urbanowicz

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

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19. (1) of the LTCHA.

Specifically, the licensee shall ensure that:
1) All staff know their responsibilities when they witness abuse.
2) All staff know the reporting requirement when they witness or become aware of any abuse.

Grounds / Motifs :

1. The licensee has failed to ensure the resident was protected from abuse by anyone.

The definition of "abuse" in subsection 2 (1) of the Regulation "abuse" means, subject to section (2), (c) the use of physical force by a resident that causes physical injury to another resident. O. Reg 79/10 s. 2 (c).

On an identified date, the home contacted the Ministry of Long-Term Care (MLTC) After Hours Pager, reporting staff to resident abuse involving resident #002 and #003 had occurred. On an identified date the home submitted a Critical Incident System (CIS) report to the MLTC Director which indicated agency Personal Support Worker (PSW) abused resident #002 and #003 which was witnessed by the home's PSW. The CIS report further stated resident #003 sustained injuries.

An interview was conducted with PSW #104 who indicated they worked an identified shift and location of the home. The PSW stated they were with resident #002 and with the assistance of PSW #105 provided specified care to the resident. PSW #104 stated during the care resident#002 struck agency PSW

#105 and the agency PSW abused the resident. PSW #104 asked the agency PSW to leave the identified location of the home and provided support to the resident.

In further interviews, PSW#104 stated right after the above incident had occurred with resident #002, PSW#104 went to resident #003 with the same agency PSW #105. The PSW stated resident #003 was to be provided with an identified care and stated they witnessed the agency PSW #105 abuse resident #003. When PSW #104 asked the agency staff why they abused the resident the agency staff indicated the resident had scratched them. PSW #104 stated they did not report the incidents until after they went home. PSW #104 stated they called the home and spoke to Charge Registered Nurse (CRN) #103 and reported two above incidents. In closing PSW #104 stated they could have prevented the second incident of abuse towards resident #003 if they had reported the initial incident of abuse towards resident #002 by the agency PSW. The PSW identified the two incidents above to be abuse by the agency PSW towards resident #002 and #003 and acknowledged they did not report the two incidents of abuse immediately to the home.

An interview was conducted with CRN #103 who indicated they worked on an identified date and shift in the home. The CRN stated they spoke to PSW #104 and was informed of the above incidents. The CRN had directed the PSW staff to document the events which occurred and would be investigated. The CRN identified the incident above to be abuse towards resident #002 and #003.

The home's policy titled "Prevention of Abuse & Neglect of a Resident"-policy #VII-G-10.00, with a revision date of April 2019, indicates all team members (employees, volunteers, agency staff, private duty caregivers, contracted service providers) residents, and families are required to immediately report any suspected or known incidents of abuse or neglect to the provincial health authorities and the ED or designate in charge of the care community.

In an interview with the home's Executive Director (ED) #101, stated PSW #104 could have prevented the second incident of abuse occurring involving resident #003. The ED further indicated resident #002 was injured related to the above incident. The ED identified the above incidents as abuse towards resident #002 and #003 by the agency PSW #105 as both residents sustained identified

injuries and the residents where not protected from abuse.

The severity of this issue was determined to be a level three as there was actual harm to resident #002 and #003. The scope of the issue is a level two as it affected two out of three residents inspected. The home had a level two as the home had previous on-going non-compliance with different subsection of the Act. (604)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 31, 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 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, 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 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 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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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 de la Santé et 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 1st day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shihana Rumzi

Service Area Office /
Bureau régional de services : Central East Service Area Office