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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 18, 2014	2014_328571_0026	O-000954-14	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE CENTRAL ONTARIO INC
82 Park Road North OSHAWA ON L1J 4L1

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

EXTENDICARE OSHAWA
82 PARK ROAD NORTH OSHAWA ON L1J 4L1

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

PATRICIA BELL (571), GWEN COLES (555), HUMPHREY JACQUES (599), MATTHEW STICCA (553), SUSAN DONNAN (531), WENDY BERRY (102)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 29, 30, 2014 and October 1,2,3,6,7,and 8, 2014.

Log# O-000158-14, O-000594-14 (CIATT log # O-000931-14) and O-000377-14 were inspected concurrently with this Resident Quality Inspection and any non-compliance can be found in this report.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), RAI/MDS Co-ordinator, Maintenance Staff, Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW)

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

15 WN(s)
1 VPC(s)
3 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 O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. On a specified date, 2014 illumination levels in resident areas were checked by Inspector 102. A hand held GE light meter was used. The meter was held at varying heights above the floor surface. All available electric light fixtures were turned on and warmed up.

Levels of illumination throughout the 2nd and 3rd floor open concept central program/ lounge areas were less than 50% to 75% of the required lighting level of 215.28 lux throughout the majority of the rooms. Lighting levels were compliant directly underneath and in close proximity to the surface mounted ceiling light fixtures.

Levels of illumination in all residents' bedrooms on the 1st, 2nd and 3rd floors of the home, were less than 50% to 75% of the required lighting level of 215.28 throughout the majority of the floor area of each bedroom. Window curtains were closed and privacy curtains, where provided, were fully opened when light meter readings were taken. Note: The lighting level provided at the bed reading position was compliant. Ensuite toilet room/washroom lighting was also identified to be compliant.

The levels of illumination provided in the corridors throughout the 1st, 2nd and 3rd floors, was identified to range from less than 50 % to 75% of the required illumination level between the surface mounted, round, covered ceiling light fixtures, to greater than 215.28 lux directly under and in close proximity to the light fixtures. Shadowing was evident though out the corridors. A minimum level of 215.28 lux of continuous, consistent lighting is not provided throughout corridors.

Low levels of lighting are a potential risk to the health, comfort, safety and well being of residents. Insufficient lighting levels may negatively impact the ability of staff to clean effectively and to deliver safe and effective care to residents including: the distribution or application of prescribed drugs and treatments; to conduct assessments; to provide treatments. Low levels of illumination and shadows may negatively impact residents' perception of the surrounding environment affecting mobility, nutritional intake, and overall quality of life. [s. 18.]

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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident accessible doors leading to non secure areas outside of the home are kept closed and locked:
-the 1st floor main entrance/exit door in the vicinity of the reception desk remains unlocked for approximately 51 seconds every time the door access code is entered, regardless of whether the handicap door opener is engaged, allowing sufficient time for a resident to exit the home after the door has closed and not relocked;
-the 1st floor door in the vicinity of the reception desk that leads to the fenced out door area that is not a secure outside area, remains unlocked for approximately 42 seconds every time the access code is entered, regardless of whether the handicap door opener is engaged, allowing sufficient time for a resident to exit the home after the door has closed and not relocked;
-on October 01, 2014, Inspectors #571 and #531 observed a main floor receiving door to be closed but not locked. The door leads to an outside elevated loading dock. The door is accessible to residents through a non lockable door across from bedroom #130 and from the rear door of one elevator which is a risk to the safety of residents.

Unlocked doors to non secure areas outside of the home are a risk to the safety and well being of residents. [s. 9. (1)]

2. Resident accessible doors leading from 1st, 2nd and 3rd floor corridors into the centrally located stairway, were observed to be closed and not locked for approximately 25 to 30 seconds after each manual deactivation of the locking system to allow access into or out of the stairway. The identified stairway doors on each floor were observed to be frequently used by staff. Typically, the stairway doors were observed to remain closed and not locked for approximately 20 seconds following each use of the door. Unlocked resident accessible stairway doors present a potential safety risk to residents. [s. 9. (1)]

3. On October 07, 2014 at approximately 3:40 pm, Inspectors # 555 and #102 observed the receiving door at the loading dock to be unlocked and accessible to residents through a non lockable corridor door to the service area as well as from one elevator. The janitors' closet located inside and adjacent to the open door to the kitchen was also open and accessible to residents within the same service area. Undiluted cleaning agents are located within the janitors closet. It was confirmed through observation by both Inspectors that the area was not under supervision by staff. [s. 9. (1)]

4. Noted that on October 08, 2014, a member of the maintenance staff identified to Inspector #571 that the bypass time for door locks had been decreased so that the doors

locked more quickly upon closing. [s. 9. (1)]

5. The licensee has not ensured that all doors leading to non residential areas are equipped with locks to restrict unsupervised access to those areas by residents when the doors are not under supervision by staff.
A resident accessible door leading from the main floor corridor in the vicinity of room 130 into a service corridor to the kitchen and the loading dock is not equipped with a lock. The corridor is not maintained or equipped for safe resident use:
- there are no corridor handrails to assist with resident mobility
-the resident-staff communication and response system is not available in this resident accessible area
- the corridor is partially obstructed at various times of the day, with deliveries of products. The door security system provided for the receiving door was observed to be shut off and the doors open while deliveries were occurring.
-kitchen equipment, including carts and milk crates, and staff garments hanging from a wall mounted rack, are stored in the corridor.

The lower level staff room is a non residential area that is accessible to residents through a door that is not equipped with a lock. The resident-staff communication and response system is not available in this room.

Unsupervised resident access into non-residential areas is a potential risk to the health, comfort, safety and well being of residents. [s. 9. (1) 2.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 10. Elevators

Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the elevators are equipped to restrict access to areas that are not to be accessed by residents. The home has 2 elevators that both allow for access to the basement (lower) level of the home by residents. The basement level does not contain any resident areas and is not equipped with a resident-staff communication and response system. The staff room located on the lower level does not have a lockable door to prevent unsupervised resident access. Miscellaneous items are stored in the east end of the corridor, obstructing the handrails that are provided. Note: during the inspection, one of the two elevators was out of service as it was undergoing planned maintenance work. [s. 10. (1)]

2. One of the two elevators is equipped with front and rear opening doors. The rear door of the elevator opens into the service area in the vicinity of the main floor kitchen. The service area is a non residential area which has receiving doors to a loading dock, food storage refrigeration equipment, kitchen supplies and garments on a wall mounted rack in a corridor without handrails that leads into the kitchen, and a narrow corridor section that leads to the centre core stairway. The resident-staff communication and response system is not available in this area.

The elevators are not equipped to restrict access to areas that are not to be accessed by residents, which places residents at potential risk of harm by being able to access areas that are non residential. [s. 10. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system is available at the roll in shower location used by residents in the east wing bathing area on the 2nd and 3rd floor. A system activator is available at the toilet in each of the shower rooms. [s. 17. (1) (d)]

2. The licensee has failed to ensure that the resident staff communication and response system is available in every area that is currently accessible by residents:
-residents have access to the main floor service area in the vicinity of the kitchen and receiving doors;
-residents have access to the basement (lower) level of the home, including the staff lounge.
-the resident-staff communication and response system is not available in the main floor celebration dining room, which is a resident area.

The lack of availability of the resident-staff communication and response system in all resident accessible areas is a potential risk to the health, comfort, safety and well being of residents, staff and visitors who may not be able to alert staff that assistance is needed. [s. 17. (1) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident-staff communication and response system and system activator are available in all resident accessible areas, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

On a specified date, Staff #101 was observed assisting Resident #12 with both breakfast and lunch meals without engaging Resident #12 in conversation, providing direction or encouragement throughout the meal time.

On October 1, 2014, Staff #101 was observed using Resident #45's knife to scrape up soup that had spilled onto the tablecloth wiped it back into Resident #45's soup bowel and continued assisting the resident with the soup.

During an interview with Staff #101 he/she confirmed that there "was nothing wrong with the action as it was not cross contamination" [s. 3. (1) 1.]

WN #6: 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA 2007, c. 8, s. 6 (7) whereby the licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Review of clinical records indicated that Resident #16 was a high risk for falls and on two specified dates, a post fall assessment was completed and documented.
Review of the current plan of care indicated a focus of falls due to limitations. The plan of care did include interventions on how to reduce risk of falling or strategies to achieve stated goal of "resident will remain free of falls and/or injury related to falls through review date".
The plan of care specified the interventions as :
-check q30 minutes for safety during periods where risk of falls is high
-bed sensor pad
-tabs monitor when in bed or up in wheelchair
-resident identified as a frequent faller and has been placed on falling star program
On four specified dates, Resident #16 was observed up in wheelchair in both the dining room and his/her room without the tabs monitor applied.
On a specified date, Resident #16 was observed in bed napping and the bed sensor pad was not applied.
On a specified date, in an interview with Staff #11, they confirmed that the tab monitor

has not been applied "in a very long time."
During an interview, the Director of Care, Staff #109, Staff #105, and the physiotherapist confirm that the specified interventions are current. [s. 6. (7)]

2. The licensee has failed to ensure that the plan of care is reviewed and revised when the resident's care needs changed.

Related to Log #O-000594-14:

A review of the clinical record indicated that Resident #48 fell on the following occasions: eight specified dates.

The only intervention specific to preventing falls in the plan of care during a specified time period, was for staff to check resident hourly during the night.

During a specified time period, Resident #48 fell six times. Although Resident #48's falls risk increased from moderate to high on a MDS assessment and the resident continued to have falls, new interventions to prevent falls were not added to the plan of care until a specified date, when the resident was placed on the "falling star" program.

The plan of care was again revised to include more interventions , after the resident had fallen 2 additional times. A hi-low bed, mats at the bedside and a bed alarm were introduced.

Although the home assessed Resident #48 on a specified date, and determined that the resident's risk for falls had increased from moderate to high, the residents plan of care was not revised until a later specified date. [s. 6. (10) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.
Under O. Reg 79/10 s. 131 (6) Where a resident is permitted to administer a drug to himself or herself under subsection (5), the licensee shall ensure that there are written policies to ensure that the residents who do so understand:
(a) The use of the drug
(b) The need for the drug
(c) The need for monitoring and documentation of the use of the drug, and
(d) The necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on his or her person or in his or her room. (7). O. Reg. 79/10, s. 131 (6).

Review of Policy entitled "Self Administration" dated September 2010 indicated:
-residents may self-administer medication with a Physician or Nurse Practitioner's written order
-Residents who self -administer medication must store the medication in a locked safe location away from other residents
-Registered staff will assess and document the assessment of the resident's cognitive and functional ability to self-administer medications
-Registered staff will update the resident's plan of care to reflect self-administration of medication
-The resident is responsible for providing a locked box for storage of medication
-Thereafter Registered staff should review, audit and document on a weekly basis a residents' ongoing ability to self- administer their medications
-the MAR/TAR/eMAR sheet should clearly indicate that the resident is self-administering their own medications."

-Progress Notes should be used to document the assessment and decision making process that was undertaken to determine if the resident is able to self -administer medications. Any observations regarding a resident's ability or lack of ability should be documented as well
-the Medication or Treatment Administration Record should contain the appropriate code for all medications self -administered
-Care Plan – the residents plan of care should clearly indicate if a resident is self-administering medication

Observation made on the following days:

On a specified date:
- medicated cream on the bedside table of Resident #42
-inhaler at the bedside of Resident #24
-medicated drops and cream at the bedside of Resident # 27
-medicated inhalers at the bedside of Resident #4

On a specified date:

-Resident #4 indicated that the inhaler is kept on himself/herself during the day and on the bed table at night as he/she does not have a secure area to keep the medication
-Resident # 27 indicated that he/she kept their medication in basket on bedside table as he/she does not have a secure area to keep the medication
-Resident #24 indicated that he/she kept their inhaler on the bedside table for self-administration and reported that he/she does not have locked drawer or secure area to store medication.

No evidence of medication stored in a locked safe location for Residents # 4, 24, 27, 42, and 43 could be found. This is not compliant with the homes policy which states that medication should be kept locked safe location.

In an interview conducted on a specified date, the DOC indicated that the licensee had a number of residents that self- administer medications and reported these residents are required to have a MD order to self-administer and an order to keep at bedside. The DOC also indicated that residents usually keep their medication in purses or nightstands which do not lock.

The DOC indicated in an interview on October 2, 2014 that they could not find evidence

in the clinical records for Residents #4, 24, 27, 42 and 43 of registered staff documenting resident's initial assessment or ongoing ability to self- administer medications.

After a review of the clinical record, no evidence of an order for self-administration could be found for Residents # 42, 24, 27, and 4.
A review of Care Plans for Residents' #4, 24, 27, 42, and 43, found no evidence related to the self-administration of medication.
In addition, an assessment of capability to self-administer is required and this could not be found in the resident's progress notes. [s. 8. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #24's plan of care was based on the resident's risk for falls.

On a specified date, Resident #24 had a fall where they were assisted to the floor due to sliding out of bed. The resident complained of pain.

In Review of Resident #24's plan of care accessible to staff (electronically and printed) there is no indication that the plan of care was based on the resident's risk for falls.

Interview with RAI Coordinator:
In review of Resident #24's current plan of care, the RAI coordinator indicated that there is no current Falls Risk focus in the resident's care plan, and that there should be one. Also, the RAI coordinator indicated that Resident #24's care plan should have been updated, after the resident fell. [s. 26. (3) 10.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #24 was assessed with a clinically appropriate assessment instrument that is specifically designed for falls, after sustaining a fall on a specified date.

Review of Resident #24's progress notes indicated:

On a specified date, Resident #24 was heard calling out from their room. Registered staff responded and found Resident #24 hanging off of the side of their bed. The Registered Staff member attempted to help Resident #24 lift their legs back into bed, they were unable to do so. Resident #24 began to slip off the side of the bed and was lowered to the floor with assistance by the Registered staff member. Resident #24 was assessed by the Registered Staff and it was indicated that Resident #24 has pain in their knee and shoulder.

Review of the clinical record indicated:
-Resident #24 had a Risk Management Report filled out for a fall
-A progress note providing detail of the incident was completed
-There is no indication of a post fall assessment being completed for Resident #24 post fall.

Interview with Staff #100:

Staff #100 indicated that when a resident has fallen a "post falls" assessment should be completed.

Staff #100 indicated that a post fall assessment should have been completed for Resident #24 after their fall.

Interview with the DOC:

The DOC stated that the expectation in the home is that a Post Fall Assessment, a Risk Management Report, a Progress note and 72 hour charting of the resident is to occur after a fall. [s. 49. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #26 received an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

A review of the clinical record indicated that Resident #26 needed increased staff assistance with toileting due to pain related to a diagnosis for a specified period of time, Resident #26's incontinence of worsened from frequently incontinent to incontinent during this time period.

In an interview, Staff # 109 indicated that Continence assessments are done on the computer.

No evidence of an incontinence assessment can be found.

A review of the homes Policy RESI-10-04-01 Continence Management Program, dated November 2013 indicates that Staff will complete a continence assessment using a clinically appropriate assessment tool that is specifically designed for assessing continence when there is any deterioration in continence level. [s. 51. (2) (a)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 56. Residents' Council

Specifically failed to comply with the following:

s. 56. (2) Only residents of the long-term care home may be a member of the Residents' Council. 2007, c. 8, s. 56 (2)

Findings/Faits saillants :

1. The licensee has failed to ensure that only residents living in the Home may be members of the Residents' Council.

During a specified time period , Inspector # 599 observed posted on the information board on third floor east, information about Residents' Council and membership. The fact sheet posted indicates that all residents in the facility or their representatives or next-of-kin may become members of the Residents' Council.

During an interview with the President of the Residents' Council he stated that some family representatives do attend the meetings of the residents' council.

In an interview the program manager stated that next of kin of residents or their Power of Attorney may attend the meeting on their behalf for cognitive or medical reasons.

Article 3 (1) of the constitution of the Residents' Council of the Home states membership is open to all residents of Extendicare Oshawa (Note: If a resident is not able to attend due to cognitive or medical reasons they may have a next of kin or power of Attorney represent for them at the meeting) All members shall be voting members.

The Licensee has failed to ensure that only residents of a long-term care home may be members of the Residents' Council. {c. 8,s. 56 (2)} [s. 56. (2)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are measures in place to prevent the transmission of infections.

The following observations were made in shared bathrooms:
-two unlabeled urinals were on the bathroom floor of specified room
-the following unlabeled items were found in a specified tub room: three used nail files, a scrub brush, a wash basin and body lotion
-in a specified room the following unlabeled items where observed: denture cup and lotion at the sink and a urinal in washroom
-in a specified room, an unlabeled denture cup was observed by the sink
-in a specified room, an unlabeled bed pan and a small child size "Dora toilet seat" was observed stored on the floor in the bathroom
-in a specified room an unlabeled urinal was observed in the bathroom
-in a specified room three unlabeled denture cups were observed in the bathroom
-in a specified room a urine collector and specimen container where observed on the back of the toilet [s. 86. (2) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times when not in use.

On a specified date, a medication cart was observed, unsecured with keys hanging in lock and residents in close proximity. Inspector #555 remained with the unsecured cart until Staff #113 returned to cart from a nearby residence room and secured cart. Staff #113 reported that the expectation is for medication carts to be secured when staff are not in close proximity. On a specified date, another medication cart was observed to be unlocked with residents in proximity but not close. Inspector #555 remained with the unsecured cart until Staff #102 returned to cart and secured cart. Staff #102 reported the expectation is for the cart to be secured when staff not in attendance.

Interview conducted with DOC who was made aware of 2 separate incidents of unlocked medication carts on 2nd floor on a specified date and reported that the expectation is for medication carts to be kept secured when staff are not in attendance. [s. 130. 1.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Related to Log #O-000594-14:

On a specified date, Resident #48's Substitute Decision Maker (SDM) found a topical medication on the resident's person which was dated from a specified date and reported this to staff on a specified date. Review of the Physician order on a specified date indicated the topical medication was to be removed at night. Review of medication administration records from June 1 to 9, 2014 indicated registered staff had removed the medication routinely each evening.

The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

2. The licensee has failed to ensure that no resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except (a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident.

Observations made on a specified date: The spouse of Resident #42 showed inspector hemorrhoid cream and topical antibiotic cream stored in the resident's bedside.

Review of the clinical records for a specified date found no evidence of an order for either medication.

In an interview conducted on a specified date, with Staff #102, they indicated that Resident #42 no longer has antibiotic cream as it has been discontinued and not aware of any other resident's on her wing having self-administration of medications. [s. 131. (7)]

WN #15: 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 that staff participate in the implementation of the infection prevention and control program.

Observed a medication pass and found no evidence of hand hygiene done during medication administration between residents. Staff #102 reports expectation for hand hygiene is to be done between each residents' care.

Interview with DOC, the DOC reported the expectation is for hand hygiene to be done between contact with each resident and their environment. [s. 229. (4)]

Issued on this 21st day of November, 2014

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

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) :	PATRICIA BELL (571), GWEN COLES (555), HUMPHREY JACQUES (599), MATTHEW STICCA (553), SUSAN DONNAN (531), WENDY BERRY (102)
Inspection No. / No de l'inspection :	2014_328571_0026
Log No. / Registre no:	O-000954-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 18, 2014
Licensee / Titulaire de permis :	EXTENDICARE CENTRAL ONTARIO INC 82 Park Road North, OSHAWA, ON, L1J-4L1
LTC Home / Foyer de SLD :	EXTENDICARE OSHAWA 82 PARK ROAD NORTH, OSHAWA, ON, L1J-4L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DEBORAH WOODS

To EXTENDICARE CENTRAL ONTARIO INC, 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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Order / Ordre :

The licensee will ensure that required levels of lighting are provided in all areas of the long term care home including:
• A minimum of 215.28 lux of continuous consistent lighting throughout corridors;
• A minimum level of 215.28 lux in residents' bedrooms and common areas including program/lounge and dining areas;

The licensee will provide a written progress report indicating the status of the lighting levels by May 01, 2015. This progress report must be submitted in writing to the MOHLTC, Attention: Wendy Berry, Fax (613)569-9670.

Grounds / Motifs :

1. On a specified date, illumination levels in resident areas were checked by Inspector 102. A hand held GE light meter was used. The meter was held at varying heights above the floor surface. All available electric light fixtures were turned on and warmed up.

Levels of illumination throughout the 2nd and 3rd floor open concept central program/ lounge areas were less than 50% to 75% of the required lighting level of 215.28 lux throughout the majority of the rooms. Lighting levels were compliant directly underneath and in close proximity to the surface mounted ceiling light fixtures.

Levels of illumination in all residents' bedrooms on the 1st, 2nd and 3rd floors of the home, were less than 50% to 75% of the required lighting level of 215.28 throughout the majority of the floor area of each bedroom. Window curtains were closed and privacy curtains, where provided, were fully opened when light meter readings were taken. Note: The lighting level provided at the bed reading position was compliant. Ensuite toilet room/washroom lighting was also identified to be compliant.

The levels of illumination provided in the corridors throughout the 1st, 2nd and 3rd floors, was identified to range from less than 50 % to 75% of the required illumination level between the surface mounted, round, covered ceiling light fixtures, to greater than 215.28 lux directly under and in close proximity to the light fixtures. Shadowing was evident though out the corridors. A minimum level of 215.28 lux of continuous, consistent lighting is not provided throughout corridors.

Low levels of lighting are a potential risk to the health, comfort, safety and well being of residents. Insufficient lighting levels may negatively impact the ability of staff to clean effectively and to deliver safe and effective care to residents including: the distribution or application of prescribed drugs and treatments; to conduct assessments; to provide treatments. Low levels of illumination and shadows may negatively impact residents' perception of the surrounding environment affecting mobility, nutritional intake, and overall quality of life. (102)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 16, 2015

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee will ensure that all resident accessible doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents including:
- the door leading from the main floor corridor to the kitchen and receiving area;
- the door leading into the lower level staff lounge that is accessible to residents by elevator.

Grounds / Motifs :

1. The licensee has not ensured that all doors leading to non- residential areas are equipped with locks to restrict unsupervised access to those areas by residents when the doors are not under supervision by staff.
A resident accessible door leading from the main floor corridor in the vicinity of room 130 into a service corridor to the kitchen and the receiving area is not equipped with a lock. The corridor is not maintained or equipped for safe resident use:
- corridor walls are not equipped with handrails which may be required for resident mobility;
-the resident-staff communication and response system is not available in this resident accessible area which may be required to summon for assistance;
- the corridor is partially obstructed at various times of the day, with deliveries of products which is a potential tripping hazard;
-the door security system provided for the receiving door which opens to an elevated loading dock was observed to be shut off several times during the inspection while not under staff supervision. The doors were also kept open while deliveries were occurring. Residents are at increased risk for elopement and for injury by being able to access the elevated loading dock;
-kitchen equipment, including carts and milk crates, and staff garments hanging from a wall mounted rack, are stored in the corridor which is a potential tripping hazard.

The lower level staff room is a non- residential area that is accessible to residents through a door that is not equipped with a lock. The resident-staff communication and response system is not available in this room or elsewhere in the lower level that is resident accessible.

Unsupervised resident access into the non-residential areas identified is a potential risk to the health, comfort, safety and well-being of residents.
(102)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Order / Ordre :

The licensee will ensure that elevators are equipped to restrict resident access to areas that are not to be accessed by residents, including but not limited to:
- non-residential areas that are not under supervision by staff; and
- areas that are not equipped and maintained for safe use by residents.

Grounds / Motifs :

1. Grounds:
The home has 2 elevators that both allow for access to the basement (lower) level of the home by residents. The basement level does not contain any resident areas and is not equipped with a resident-staff communication and response system. The staff room located on the lower level does not have a lockable door to prevent unsupervised resident access. Miscellaneous items are stored in the east end of the corridor, obstructing the handrails that are provided.

Note: during the inspection, one of the two elevators was out of service as it was undergoing planned maintenance work.
One of the two elevators which was operational at the time of the inspection, is equipped with front and rear opening doors. The rear door of the elevator opens into a service area in the vicinity of the main floor kitchen. The service area is a non-residential area which has receiving doors to a loading dock, food storage refrigeration equipment; kitchen supplies and garments hung on a wall mounted rack are stored in the corridor area which is not equipped for resident use. The resident-staff communication and response system is not available in this area that is resident accessible.

The elevators are not equipped to restrict access to areas that are not to be accessed by residents, which places residents at increased risk of harm by being able to enter unsupervised, non-residential areas which are not set up or maintained for safe use by residents.
(102)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2015

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 18th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Patricia Bell

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