Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 29, 2021	2021_882760_0025 (A1)	009364-21, 009645-21	Complaint

Licensee/Titulaire de permis

Trilogy LTC Inc.
7070 Derrycrest Drive Mississauga ON L5W 0G5

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

Chartwell Trilogy Long Term Care Residence
340 McCowan Road Scarborough ON M1J 3P4

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

Amended by SARAH GILLIS (623) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The finding of non-compliance related to s.229 (4) of O.Reg. 79/10 is the third consecutive compliance order. As such, a referral to the Director is warranted.

The licensee requested an extension to the compliance due date to August 16, 2021.

Issued on this 29th day of July, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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340 McCowan Road Scarborough ON M1J 3P4

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

Amended by SARAH GILLIS (623) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 30, July 2, 5, 6, 7, 2021.

The following intakes were completed in this complaints inspection:

A log was related to allegations of abuse;

A follow-up log was related to Compliance Order (CO) #002, O. Reg 79/10 s. 229 (4), related to infection prevention and control, issued under inspection #2021_598570_0011, on May 17, 2021, with a compliance date of May 24, 2021, was inspected.

During the course of the inspection, the inspector(s) spoke with Housekeepers, the Infection Prevention and Control lead (IPAC Lead), a Registered Practical Nurse Student (RPNS), Registered Practical Nurses (RPN), Agency Personal Support Workers (APSW), Personal Support Workers (PSW), the Director of Care (DOC), the Administrator, and an Environmental Services Consultant (ESC).

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, reviewed home's air temperature monitoring logs, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of the original inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 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 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 :

(A1)
1. Compliance Order (CO) #002 related to O. Reg. 79/10, s. 229 (4) from Inspection #2021_598570_0011 issued on May 17, 2021, with a compliance due date of May 24, 2021, is being re-issued as follows:

The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

A follow-up inspection was conducted, and the staff along with a visitor and students continued to be noncompliant with the implementation of the home's IPAC program.

Observations were carried throughout the home during this inspection:
- A visitor was seen going into a resident's room without wearing a face shield. An RPN said that this resident was on precautions. The DOC stated that because the resident was on precautions, the visitor should have worn a face shield.
- Three PSWs were seen providing care to residents without wearing a face shield. The DOC states that staff should be wearing their face shield if they are in close contact with the resident.
- An RPN student was observed coming out of a resident’s room after providing them with medications and stated they did not perform hand hygiene after they had finished. The DOC states the expectation was to perform hand hygiene after medication was provided to the resident.
- An agency PSW was observed inside a resident's room without a gown on. The signage outside of the resident’s room indicated they were on precautions. The DOC stated that the agency PSW should have worn the proper personal protective equipment (PPE), in accordance to the signage outside of the resident’s room.
- A PSW student was observed wearing soiled gloves on one of their hands, while their other hand did not have any gloves on. The PSW student was then seen using their gloved hand to touch their glasses. The DOC stated that the PSW student should have removed both of their gloves after they had completed care, cleaned their hands afterwards and then fix their glasses.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff, students and a visitor of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

This finding of non-compliance related to s.229 (4) of O.Reg. 79/10 is the third consecutive compliance order. As such, a referral to the Director is warranted.

Sources: Interviews with the DOC and other staff; Observations made throughout the home during the inspection. [s. 229. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the air temperatures were measured and documented in writing within the required areas in the home.

The administrator and the Environmental Services Consultant (ESC) were unable to produce any documentation of the air temperature logs from the home. The ESC stated that they could not find the air temperature logs that may have been recorded by the home's previous Environmental Services Manager (ESM) and upon speaking with the home's maintenance staff, the ESC stated that they were not recording the home's air temperatures within the required locations of the home. Failure to document and monitor the home's air temperatures may result in an uncomfortable environment for residents.

Sources: Interviews with Administrator, the ESC and other staff. [s. 21. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home: 1. At least two resident bedrooms in different parts of the home. 2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. 3. Every designated cooling area, if there are any in the home, to be implemented voluntarily.

WN #3: 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 :

1. The licensee has failed to ensure that a PSW student and a PSW provided the care set out in a resident's plan of care, as it relates to their transfer status.

An observation was made and the PSW student and the PSW were observed to have transferred a resident. A review of the resident's care plan indicated that they required a specific type of transfers, however, this transfer was not observed with the PSW student and the PSW. The PSW stated they were unaware of the resident's transfer status. The DOC stated that the PSW should have reviewed the resident's care plan prior to transferring the resident. The DOC mentioned that by not following the resident's assessed transfer status, there was a risk with the resident injuring themselves from the staff's transfer.

Sources: A resident's care plan; Observation with a resident; Interviews with the DOC and a PSW. [s. 6. (7)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that a PSW used safe transferring techniques with a resident.

An observation noted that the PSW was transferring a resident in a specific manner. The PSW confirmed that they did not have a second person present to assist in the transfer. The DOC stated that as per the home's policy, there should be two staff present when this transfer technique was used for the resident. Failure to have a second staff member present while performing this transfer may cause injury to a resident during the transfer process.

Sources: Observation with a resident; Interviews with a PSW and the DOC. [s. 36.]

Issued on this 29th day of July, 2021 (A1)

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

Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by SARAH GILLIS (623) - (A1)
Inspection No. / No de l'inspection :	2021_882760_0025 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	009364-21, 009645-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 29, 2021(A1)
Licensee / Titulaire de permis :	Trilogy LTC Inc. 7070 Derrycrest Drive, Mississauga, ON, L5W-0G5
LTC Home / Foyer de SLD :	Chartwell Trilogy Long Term Care Residence 340 McCowan Road, Scarborough, ON, M1J-3P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shoma Maraj

To Trilogy LTC Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Linked to Existing Order / Lien vers ordre existant: 2021_598570_0011, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must prepare, submit, and implement a plan to ensure that all staff, visitors and students in the home participate in the home's infection prevention and control (IPAC) program. The plan must include but is not limited to:

1. Steps to be taken by the licensee to ensure that all staff, visitors and students within the home adhere to the appropriate IPAC practices.

2. Measures to evaluate the effectiveness of the steps undertaken to ensure the adherence of the home's IPAC program.

3. A process to manage staff, visitors and students who continue to not be adherent with the home's IPAC program.

Please submit the written plan for achieving compliance for inspection #2021_882760_0025 to Jack Shi, LTC Homes Inspector, MLTC, by email to CentralEastSAO.MOH@ontario.ca by July 20, 2021.

Grounds / Motifs :

(A1)
1. Compliance Order (CO) #002 related to O. Reg. 79/10, s. 229 (4) from Inspection #2021_598570_0011 issued on May 17, 2021, with a compliance due date of May

24, 2021, is being re-issued as follows:

The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

A follow-up inspection was conducted, and the staff along with a visitor and students continued to be noncompliant with the implementation of the home's IPAC program.

Observations were carried throughout the home during this inspection:
- A visitor was seen going into a resident's room without wearing a face shield. An RPN said that this resident was on precautions. The DOC stated that because the resident was on precautions, the visitor should have worn a face shield.
- Three PSWs were seen providing care to residents without wearing a face shield. The DOC states that staff should be wearing their face shield if they are in close contact with the resident.
- An RPN student was observed coming out of a resident's room after providing them with medications and stated they did not perform hand hygiene after they had finished. The DOC states the expectation was to perform hand hygiene after medication was provided to the resident.
- An agency PSW was observed inside a resident's room without a gown on. The signage outside of the resident's room indicated they were on precautions. The DOC stated that the agency PSW should have worn the proper personal protective equipment (PPE), in accordance to the signage outside of the resident's room.
- A PSW student was observed wearing soiled gloves on one of their hands, while their other hand did not have any gloves on. The PSW student was then seen using their gloved hand to touch their glasses. The DOC stated that the PSW student should have removed both of their gloves after they had completed care, cleaned their hands afterwards and then fix their glasses.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff, students and a visitor of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Interviews with the DOC and other staff; Observations made throughout the home during the inspection.

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

Severity: There was actual risk of harm to the residents because staff, a visitor and students of the home continued to be non-compliant with the proper IPAC measures, which may possibly lead to the spread of infectious diseases.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during observations throughout the home, and the non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: The licensee continues to be in non-compliance with s. 229 (4) of the O. Reg. 79/10, resulting in a compliance order (CO) being re-issued.
CO #001 was issued on December 31, 2020, (Inspection # 2020_715672_0023) with a compliance due date of January 7, 2021.
CO #002 was issued on May 17, 2021, (Inspection # 2021_598570_0011) with a compliance due date of May 24, 2021.

This finding of non-compliance related to s.229 (4) of O.Reg. 79/10 is the third consecutive compliance order. As such, a referral to the Director is warranted. (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 16, 2021(A1)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 29th day of July, 2021 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by SARAH GILLIS (623) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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