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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 23, 2021	2021_823653_0013	006405-21, 007497-21	Critical Incident System

Licensee/Titulaire de permis

Southlake Residential Care Village
690 Grace Street Newmarket ON L3Y 8V7

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

Southlake Residential Care Village
640 Grace Street Newmarket ON L3Y 8V7

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

ROMELA VILLASPIR (653)

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): June 8, 9, 10, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:
-Follow-up Log #006405-21, Compliance Order (CO) #001 issued on April 14, 2021, within report #2021_838760_0011, related to the Ontario Regulation (O. Reg.) 79/10, s. 229 (4).
-CIS Log #007497-21 related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Resident Assistants (RAs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Physiotherapist Assistants (PTAs), Housekeeper, Maintenance, Environmental Services Manager (ESM), IPAC Lead, Assistant Directors of Care (ADOCs), interim Director of Care (iDOC), and the interim Executive Director (iED).

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, provision of care, staff to resident interaction, reviewed clinical health records, staffing schedule, IPAC audits, air temperature records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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 :

1. The licensee has failed to ensure that the staff participated in the implementation of

the home’s Infection Prevention and Control (IPAC) program.

The home was issued a compliance order on April 14, 2021, within report #2021_838760_0011, related to O. Reg. 79/10, s. 229 (4). A follow-up inspection was conducted, and the staff continued to be non-compliant with the implementation of the home's IPAC program.

The following observations were conducted by Inspector #653:

-A resident’s room was on droplet/ contact precautions. Following care provision, Personal Support Worker (PSW) #108 stepped outside the room wearing full Personal Protective Equipment (PPE), and doffed their gown over their gloves. The PSW did not perform hand hygiene after doffing their gloves, and did not change their mask after leaving the room.

-A resident’s room was on droplet/ contact precautions. There was no PPE caddy outside the room, and no PPE disposal bin inside the room. The IPAC Lead confirmed the resident in the room was supposed to be on contact precautions.

-Physiotherapy Assistant (PTA) #113 wore gloves and transported a resident in their wheelchair from the common area to their room. PTA #113 assisted with exercises inside the room. Afterwards, the PTA did not doff their gloves before leaving the room, and did not perform hand hygiene.

-A resident’s room was on droplet/ contact precautions, and the PPE caddy outside did not have disinfectant wipes.

-A resident’s room was on droplet/ contact precautions, and the PPE caddy outside did not have disinfectant wipes. Housekeeper (HK) #114 was inside cleaning the washroom, not wearing a gown. Subsequently, the HK did not clean and disinfect their face shield, nor change their mask after leaving the room.

-A droplet/ contact signage was placed on top of the PPE caddy, underneath the box of gloves, and Alcohol Based Hand Rub (ABHR) pump. The PPE caddy also did not have disinfectant wipes.

-A resident’s room was on droplet/ contact precautions. As per Registered Practical Nurse (RPN) #115, the signage was supposed to be contact precautions.

-PSW #116 exited from a resident’s room, wearing gloves while pushing the lift machine in the hallway, and returned to the room wearing the same gloves.

-Three staff members were observed wearing their eye protection on their heads,

-PTA #117 disinfected a supportive device, doffed their gloves, and donned a new pair of gloves without performing hand hygiene in between.

-PSW #118 doffed gloves outside of a resident’s room, and proceeded to the next room without performing hand hygiene, until inspector prompted them.

-Resident Assistant (RA) #119 was observed donning gloves while walking in the hallway. After checking the residents' rooms, the RA doffed their gloves on the other side of the unit, and donned new gloves without performing hand hygiene in between.

During an interview, the IPAC Lead acknowledged the inspector's observations, and indicated that the risk associated to the staff not participating in the implementation of the home's IPAC program was the potential for transmission of infection.

Sources: Inspector #653's observations; Review of clinical health records; Interviews with the staff, and the IPAC Lead. [s. 229. (4)]

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment related to IPAC measures specified in Directive #3, regarding wearing the required eye protection and appropriate use of PPE.

The Chief Medical Officer of Health (CMOH) implemented Directive #3, which has been issued to Long-Term Care Homes (LTCHs), and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in LTCHs. As part of this directive, issued on May 21, 2021, all staff and essential visitors are required to wear appropriate eye protection when they are within 2 Metres (M) of a resident as part of provision of direct care and/ or when they interact with a resident in an indoor area. LTCHs must also ensure that essential visitors adhere to the IPAC recommendations for use of PPE for care of individuals with suspect of confirmed COVID-19.

The following observations were conducted by Inspector #653:

-A resident’s room was on droplet/ contact precautions. An Essential Care Giver (ECG) was inside the room within 2M of the resident, not wearing gown and gloves.

- A resident’s room was on droplet/contact precautions. An ECG was inside the room within 2M of the resident, not wearing gloves.

-Two PSWs were inside a resident’s room performing care activities, and both staff were not wearing eye protection.

-RPN #120 was inside a resident’s room not wearing eye protection, and was within 2M of the resident.

During an interview, the IPAC Lead acknowledged the inspector's observations, and indicated that the risk associated to the ECGs not wearing the appropriate PPE, and the staff not wearing eye protection, was the potential for transmission of infection.

Sources: Inspector #653's observations; Interviews with the staff and the IPAC Lead. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: 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 has failed to ensure that the air temperature was 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.

On June 9, 2021, the inspector requested for the Environmental Services Manager (ESM) to provide the home's air temperature records. The ESM was unable to produce documentation and confirmed that they had not been measuring and documenting air temperatures in the home. Maintenance staff #107 further indicated they would only measure the air temperature if they received a complaint. An interview with the Executive Director (ED) indicated that the risks or potential negative outcome that could result from not measuring and documenting air temperatures throughout the home would be increase in residents' body temperatures, dehydration, as well as for staff and visitors.

Sources: Interviews with the ESM, maintenance staff member, and the ED. [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, to be implemented voluntarily.

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 has failed to ensure that PSW #108 used safe transferring techniques when assisting resident #002.

During an observation, PSW #108 was observed exiting from a resident's room that was on droplet/ contact precautions, and a lift machine was noted inside the room. Inspector asked the PSW what care was provided, and the PSW stated they assisted with transferring the resident from the bed to their personal assistive device. Separate interviews with PSWs #108, #110, and RA #109, revealed that PSW #108 transferred resident #002 using the lift machine, unassisted.

During an interview, Assistant Director of Care (ADOC) #111 acknowledged the inspector's observation, and indicated that the resident was a two person transfer with a lift. The ADOC stated that transferring a resident using a lift, unassisted, posed a risk for safety and risk for potential injuries.

Sources: Inspector #653's observation; Interviews with PSWs #108, #110, RA #109, and ADOC #111. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 23rd day of June, 2021

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	ROMELA VILLASPIR (653)
Inspection No. / No de l’inspection :	2021_823653_0013
Log No. / No de registre :	006405-21, 007497-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 23, 2021
Licensee / Titulaire de permis :	Southlake Residential Care Village 690 Grace Street, Newmarket, ON, L3Y-8V7
LTC Home / Foyer de SLD :	Southlake Residential Care Village 640 Grace Street, Newmarket, ON, L3Y-8V7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Anne Deelstra

To Southlake Residential Care Village, you are hereby required to comply with the following order(s) by the date(s) set out below:

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) (a)

Linked to Existing Order / Lien vers ordre existant: 2021_838760_0011, CO #001;

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 the O. Reg. 79/10.

Specifically, the licensee must:

1. Post the appropriate additional precautions signages on, or near the entrance door of affected residents that indicate that the residents are on additional precautions.

2. Ensure that Personal Protective Equipment (PPE) caddies are properly stocked.

3. Conduct monitoring in all home areas to ensure staff and visitors adhere to the appropriate Infection Prevention and Control (IPAC) practices.

4. Provide on the spot education to staff and/ or visitors not adhering with the appropriate IPAC measures.

Grounds / Motifs :

1. Compliance Order (CO) #001 related to O. Reg. 79/10, s. 229 (4) from Inspection 2021_838760_0011 issued on April 14, 2021, with a compliance due date of May 12, 2021, is being re-issued as follows:

The licensee has failed to ensure that the staff participated in the implementation of the home's Infection Prevention and Control (IPAC) program.

The following observations were conducted by Inspector #653:

-A resident's room was on droplet/ contact precautions. Following care provision, Personal Support Worker (PSW) #108 stepped outside the room wearing full Personal Protective Equipment (PPE), and doffed their gown over their gloves. The PSW did not perform hand hygiene after doffing their gloves, and did not change their mask after leaving the room.

-A resident's room was on droplet/ contact precautions. There was no PPE caddy outside the room, and no PPE disposal bin inside the room. The IPAC Lead confirmed the resident in the room was supposed to be on contact precautions.

-Physiotherapy Assistant (PTA) #113 wore gloves and transported a resident in their wheelchair from the common area to their room. PTA #113 assisted with exercises inside the room. Afterwards, the PTA did not doff their gloves before leaving the room, and did not perform hand hygiene.

-A resident's room was on droplet/ contact precautions, and the PPE caddy outside did not have disinfectant wipes.

-A resident's room was on droplet/ contact precautions, and the PPE caddy outside did not have disinfectant wipes. Housekeeper (HK) #114 was inside cleaning the washroom, not wearing a gown. Subsequently, the HK did not clean and disinfect their face shield, nor change their mask after leaving the room.

-A droplet/ contact signage was placed on top of the PPE caddy, underneath the box of gloves, and Alcohol Based Hand Rub (ABHR) pump. The PPE caddy also did not have disinfectant wipes.

-A resident's room was on droplet/ contact precautions. As per Registered Practical Nurse (RPN) #115, the signage was supposed to be contact precautions.

-PSW #116 exited from a resident's room, wearing gloves while pushing the lift machine in the hallway, and returned to the room wearing the same gloves.

-Three staff members were observed wearing their eye protection on their

heads,

-PTA #117 disinfected a supportive device, doffed their gloves, and donned a new pair of gloves without performing hand hygiene in between.

-PSW #118 doffed gloves outside of a resident's room, and proceeded to the next room without performing hand hygiene, until inspector prompted them.

-Resident Assistant (RA) #119 was observed donning gloves while walking in the hallway. After checking the residents' rooms, the RA doffed their gloves on the other side of the unit, and donned new gloves without performing hand hygiene in between.

During an interview, the IPAC Lead acknowledged the inspector's observations, and indicated that the risk associated to the staff not participating in the implementation of the home's IPAC program was the potential for transmission of infection.

Sources: Inspector #653's observations; Review of clinical health records; Interviews with the staff, and the IPAC Lead.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents because there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was isolated because the fewest number of staff were involved, and the identified situations occurred in a very limited number of locations in the LTCH.

Compliance History: The licensee continues to be in non-compliance with s. 229 (4) of the O. Reg. 79/10, resulting in a CO being re-issued. CO #001 was issued on April 14, 2021, (Inspection 2021_838760_0011) with a compliance due date of May 12, 2021. In the past 36 months, COs were issued to a different section of the legislation, which had been complied. (653)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Jul 22, 2021

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:

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.

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

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 23rd day of June, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Romela Villaspir

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