Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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

Toronto Service Area Office
55 St. Clair Avenue West, 8th Floor
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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Mar 23, 26, 27, 28, 29, 30, Apr 2, 10, 2012	2012_078202_0005	Critical Incident

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - ETOBICOKE
70 HUMBERLINE DRIVE, ETOBICOKE, ON, M9W-7H3

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

VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Nurse Manager, Registered Social Service Worker, Registered Nurses, Registered Practical Nurses, Personal Support Workers and Residents

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, educational records, home policies related to Zero Tolerance of Abuse/Neglect and Behaviour Management

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents are protected from physical abuse and neglect.

March 2012 the licensee reported to the Director that a Personal Support Worker (PSW) A had pushed resident A1 in the bedroom washroom and hit resident A1 on the head with a wash basin while in bedroom.

March 2012 resident A1 left the dining room after lunch and proceeded to resident room to be toileted. Staff interviews confirmed that the resident A1 had pulled the call bell several times from the bedroom washroom which was heard ringing by staff in the dining room.

Personal Support Worker (PSW) B, heard resident A1's bedroom washroom call bell ringing from in the dining room.
(PSW) B attended to the resident A1's call bell by turning it off and stating to the resident A1 that a nurse would assist shortly.
(PSW) B returned to the dining room and revealed that resident A1's call bell was heard ringing again from resident A1's bedroom washroom.

Staff interviews confirm that in March 2012, Personal Support Worker (PSW) A and Personal Support Worker (PSW) C were providing personal care to resident B1 in resident room while resident A1 was wheeling in and out of the bedroom washroom with wheelchair, repeatedly pulling the call bell.

(PSW) C witnessed (PSW) A push resident A1 into the bedroom washroom and stated to resident A1 that if there was a lock on the washroom door it would be locked. (PSW) A then held the washroom door closed with resident A1 inside. (PSW) A released the hold on the door and then returned to the bedside of resident B1.

(PSW) C witnessed (PSW) A leave the bedside of resident B1 with a wash basin, requested that resident A1 move out of the way from the bedroom washroom door and then hit resident A1 over the head with a wash basin.

(PSW) C reported the incident immediately to the Registered Practical Nurse (RPN) in charge.

The (RPN), dismissed (PSW) A from the resident home area, reported the incident to administration and police were notified. The home conducted an immediate investigation into the incident.

Staff interview confirmed that identified resident A1 provided the home with a statement that revealed (PSW) A had hit resident A1 on the head with a wash basin and that resident A1 was locked in the bedroom washroom in March 2012.

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. 6. Plan of care

Specifically failed to comply with the following subsections:

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective.

Resident A's written plan of care identifies resident A as physically and verbally abusive, exhibits agitated behaviour and is socially inappropriate.

Progress notes and annual care conference notes reviewed for July 2011- March 2012, revealed that resident A was physical aggressive with other residents on November 25, 2011, January 03, 2012, March 16, 2012 and March 23, 2012 and to staff on July 23, 2011, December 17, 2011, February 11, 2012, and March 05, 2012 was not reassessed.[s.6.(10)(b)]

Weekly behaviour notes for July 01, 2011 to March 2012 identifies resident A as physically, verbally and socially inappropriate daily and will kick staff and other residents was not reassessed.[s.6.(10)(b)]

Staff interviews revealed that the written interventions for resident A's plan of care have not been effective. Staff revealed that providing care for resident A is challenging and difficult and they no longer know how to provide care for resident A. [s.6.(10)(c)]

Administration confirmed through an interview that resident A does have behavioural issues and stated that there have been ongoing isolated incidents of physical and verbal aggression to staff and other residents.

Administration directs staff to monitor resident A's behaviour weekly, and send a referral to the responsive behavioural lead in the home when incidents of aggression occur.

The responsive behaviour lead confirmed receipt of two staff referrals in March 2012 identifying that resident A had exhibited aggressive incidents and confirmed that resident A had not been reassessed.
2. The licensee failed to ensure that the written care plan set out in the plan of care is provided to the resident as specified in the plan.

Resident A's care plan identifies resident A as verbally and physically aggressive when has to wait for care. Resident A's written plan of care directs staff to assist resident A with toileting after lunch between 1300 hours to 1330 hours. Resident A's written plan of care identifies that resident A is to ambulate using own wheelchair to personal bedroom washroom after lunch and to alert staff for assistance by using the call bell.

Staff revealed through interview that they hear resident A's call bell from in the dining. Staff confirm responding to resident A's call bell by turning it off and requesting that resident A wait.

Staff interviews confirmed that resident A is not provided toileting assistance between 1300 hours and 1330 hours daily as outlined in the written plan of care. Staff revealed that the residents in the dining room are served and escorted back to their bedrooms before he is toileted which is frequently after 1400 hours.

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 resident is reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective, to be implemented voluntarily.

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

Specifically failed to comply with the following subsections:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to provide annual training in behaviour management to direct care staff pursuant to section O.Reg 79/10 s.221 (2).

Direct care staff interviews confirmed that behaviour management training had not been provided to them in the home. Direct care staff revealed that they were not aware of a responsive behaviours program in the home.

Educational record review for 2011 confirmed that a responsive behaviours management in service was provided in the home on February 3, 2011 with only 3 direct care staff in attendance.

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 all staff who provide direct care to residents receive training in behaviour management, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours.

The plan of care for resident A identifies resident A as verbally and physically aggressive toward staff and residents. Clinical record review and staff interviews confirmed that resident A did not have procedures or interventions in place to assist residents and staff that minimize the risk of altercations or potentially harmful interactions.

Annual care conference notes and progress notes reviewed identified that resident A was physically aggressive to other residents on November 25, 2011, January 03, 2012, March 16, 2012 and March 23, 2012 and to staff on July 23, 2011, December 17, 2011, February 11, 2012, March 05, 2012.

Staff interviews revealed that in March 2012 during a meal service resident A had kicked resident B in the leg. Resident B confirmed through an interview that resident A had kicked resident B's leg March 2012 during a meal service. Resident B revealed that resident A frequently kicks resident B's legs from under the table during meals. Resident B stated that on days when not in the dining before resident A, resident A will kick resident B's legs out of the way from under the table.

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 procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or are harmed as a result of a resident's behaviours, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that written approaches to care were developed to meet the needs of an identified resident with responsive behaviours.

Staff interviewed confirmed that the home has a responsive behaviour program.
Through interview the responsive behaviour lead in the home verified that resident A identified as behavioural and was included in the home's responsive behaviour program.

The responsive behaviour lead verified that resident A identified with responsive behaviours was not assessed or reassessed and did not have written strategies developed to meet the needs of his responsive behaviours. [r.53.(1) 1]

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 written approaches to care meet the needs of residents with responsive behaviours, to be implemented voluntarily.

Issued on this 12th day of April, 2012

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

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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) :	VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2012_078202_0005
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Mar 23, 26, 27, 28, 29, 30, Apr 2, 10, 2012
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	LEISUREWORLD CAREGIVING CENTRE - ETOBICOKE 70 HUMBERLINE DRIVE, ETOBICOKE, ON, M9W-7H3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LORA PALMER

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must protect and prevent residents from physical abuse and neglect. The licensee shall prepare, submit and implement a plan to ensure that all residents are protected from abuse by anyone.
Please submit plan to Valerie.Johnston@ontario.ca by May 04, 2012.

Grounds / Motifs :

1. 1. The licensee failed to ensure that residents are protected from physical abuse and neglect.

March 2012 the licensee reported to the Director that a Personal Support Worker (PSW) A had pushed resident A1 in the bedroom washroom and hit resident A1 on the head with a wash basin while in bedroom.

March 2012 resident A1 left the dining room after lunch and proceeded to resident room to be toileted. Staff interviews confirmed that the resident A1 had pulled the call bell several times from the bedroom washroom which was heard ringing by staff in the dining room.

Personal Support Worker (PSW) B, heard resident A1's bedroom washroom call bell ringing from in the dining room. (PSW) B attended to the resident A1's call bell by turning it off and stating to the resident A1 that a nurse would assist shortly.
(PSW) B returned to the dining room and revealed that resident A1's call bell was heard ringing again from resident A1's bedroom washroom.

Staff interviews confirm that in March 2012, Personal Support Worker (PSW) A and Personal Support Worker (PSW) C were providing personal care to resident B1 in resident room while resident A1 was wheeling in and out of the bedroom washroom with wheelchair, repeatedly pulling the call bell.

(PSW) C witnessed (PSW) A push resident A1 into the bedroom washroom and stated to resident A1 that if there was a lock on the washroom door it would be locked. (PSW) A then held the washroom door closed with resident A1 inside. (PSW) A released the hold on the door and then returned to the bedside of resident B1.

(PSW) C witnessed (PSW) A leave the bedside of resident B1 with a wash basin, requested that resident A1 move out of the way from the bedroom washroom door and then hit resident A1 over the head with a wash basin.

(PSW) C reported the incident immediately to the Registered Practical Nurse (RPN) in charge.

The (RPN), dismissed (PSW) A from the resident home area, reported the incident to administration and police were notified. The home conducted an immediate investigation into the incident.

Staff interview confirmed that identified resident A1 provided the home with a statement that revealed (PSW) A had hit resident A1 on the head with a wash basin and that resident A1 was locked in the bedroom washroom in March 2012. (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 04, 2012

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

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

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

Ministère 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

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 10th day of April, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Valerie Johnston

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