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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 28, 2018	2018_617148_0012	002362-18, 003103-18	Critical Incident System

Licensee/Titulaire de permis

Corporation of the City of Cornwall
1900 Montreal Rd. CORNWALL ON K6H 7L1

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

Glen-Stor-Dun Lodge
1900 Montreal Road CORNWALL ON K6H 7L1

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

AMANDA NIXON (148)

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): April 5, 6 and 9, 2018

This inspection included two critical incident reports (CIR) both related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Registered Nurses, Registered Practical Nurses (RPN), Staff Development/Health and Safety Officer, Recreation Supervisor, Recreation Aide, Personal Support Workers and residents.

In addition, the Inspector reviewed documents related to the identified incidents including internal incident reports and the licensee's policy to promote zero tolerance of abuse and neglect of residents. The Inspector reviewed identified resident health care records and observed resident to resident interactions.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone.

Specifically, the licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents is complied with and contains, at a minimum, the required contents as set out by section 20 (2) of the LTCHA.

Staff member RPN #102, failed to comply with the licensee's Resident Non-Abuse policy in that an alleged incident of physical abuse was not immediately reported to supervisory staff.

A critical incident report (CIR) was submitted to the Director on a specified date, describing that on the previous day during the evening shift, resident #002 sustained injury after an unwitnessed incident of alleged abuse involving resident #001.

In an interview with RPN #102, who responded to the incident on the specified date, the RPN acknowledged the incident to be alleged physical abuse. After the incident, RPN #102 said that care was provided to the injured resident and that an internal incident report was completed, which RPN #102 left for the DOC's review. In discussion related to the reporting of alleged abuse, RPN #102 could not recall having reported the incident to the RN supervisor on staff that evening. In review of the internal incident report and progress note completed by RPN #102, there was no indication that supervisory staff were notified immediately of the alleged abuse. On the day following the alleged abuse, the incident was reported to supervisory staff member #103, at which time the CIR was submitted to the Director.

The home's DOC identified the licensee's policy to promote zero tolerance of abuse and neglect of residents as the Resident Non-Abuse policy, #MM-0704-08. The policy includes the following statement under the heading "MANDATORY STAFF REPORTING - INVESTIGATIVE PROCEDURE":
1. In any case of suspected, alleged or witnessed incidents of abuse or neglect causing harm or risk of harm to a resident, the employee or any other person witnessing or having knowledge of an Incident must report the incident immediately to their department supervisor or immediate supervisor, or, during evening and night hours, to the most senior supervisor available. The Supervisor shall initiate medical aid if necessary and contact the DOC/Administrator to establish if incident meets the definition.

RPN #102 did not comply with the licensee's Resident Non-Abuse policy when the RPN failed to immediately report an incident of alleged abuse to supervisory staff.

2) The licensee has failed to ensure that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 to make mandatory reports.

The identified policy to promote zero tolerance of abuse and neglect of residents, Resident Non-Abuse policy, #MM-0704-08, last revised March 2017, was reviewed by the Inspector.

As noted above, the policy includes the following statement under the heading "MANDATORY STAFF REPORTING - INVESTIGATIVE PROCEDURE" as item #1:
In any case of suspected, alleged or witnessed incidents of abuse or neglect causing harm or risk of harm to a resident, the employee or any other person witnessing or having knowledge of an incident must report the incident immediately to their department supervisor or immediate supervisor, or, during evening and night hours, to the most senior supervisor available. The Supervisor shall initiate medical aid if necessary and contact the DOC/Administrator to establish if the incident meets the definition.

In addition to this statement, there is the following statement as item #3:
The Administrator/Department Supervisor/DOC/Designate must be notified and in turn will notify the Director (Ministry of Health and Long Term Care) by way of Critical Incident Report within ten days of the licensee becoming aware of alleged, suspected or witnessed incidents, or at a time required by the Director.

The explanation of section 24 within the Resident Non-Abuse policy, does not include that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, shall immediately report the suspicion and the information upon which it is based to the Director.

In addition, the explanation of section 24 does not include the requirement to make mandatory reports related to section 24(1) paragraphs 1, 3, 4 or 5.

The licensee failed to protect resident #001 in that a staff member did not follow the licensee's policy to promote zero tolerance of abuse and neglect and whereby the licensee's policy to promote zero tolerance of abuse did not contain an explanation of the duty under section 24 to make mandatory reports.

(Log 002362-18) [s. 19.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of resident is complied with.

Staff member RPN #102, failed to comply with the licensee's Resident Non-Abuse policy

in that an alleged incident of physical abuse was not immediately reported to supervisory staff.

A critical incident report (CIR) was submitted to the Director on a specified date, describing that on the previous day during the evening shift, resident #002 sustained injury after an unwitnessed incident of alleged abuse involving resident #001.

In an interview with RPN #102, who responded to the incident on the specified date, the RPN acknowledged the incident to be alleged physical abuse. After the incident, RPN #102 said that care was provided to the injured resident and that an internal incident report was completed, which RPN #102 left for the DOC's review. In discussion related to the reporting of alleged abuse, RPN #102 could not recall having reported the incident to the RN supervisor on staff that evening. In review of the internal incident report and progress note completed by RPN #102, there was no indication that supervisory staff were notified immediately of the alleged abuse. On the day following the alleged abuse, the incident was reported to supervisory staff member #103, at which time the CIR was submitted to the Director.

The home's DOC identified the licensee's policy to promote zero tolerance of abuse and neglect of residents as the Resident Non-Abuse policy, #MM-0704-08. The policy includes the following statement under the heading "MANDATORY STAFF REPORTING - INVESTIGATIVE PROCEDURE":

1. In any case of suspected, alleged or witnessed incidents of abuse or neglect causing harm or risk of harm to a resident, the employee or any other person witnessing or having knowledge of an Incident must report the incident immediately to their department supervisor or immediate supervisor, or, during evening and night hours, to the most senior supervisor available. The Supervisor shall initiate medical aid if necessary and contact the DOC/Administrator to establish if incident meets the definition.

RPN #102 did not comply with the licensee's Resident Non-Abuse policy when the RPN failed to immediately report an incident of alleged abuse to supervisory staff.

2) The licensee has failed to ensure that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 to make mandatory reports.

The identified policy to promote zero tolerance of abuse and neglect of residents, Resident Non-Abuse policy, #MM-0704-08, last revised March 2017, was reviewed by the Inspector.

As noted above, the policy includes the following statement under the heading "MANDATORY STAFF REPORTING - INVESTIGATIVE PROCEDURE" as item #1:
In any case of suspected, alleged or witnessed incidents of abuse or neglect causing harm or risk of harm to a resident, the employee or any other person witnessing or having knowledge of an incident must report the incident immediately to their department supervisor or immediate supervisor, or, during evening and night hours, to the most senior supervisor available. The Supervisor shall initiate medical aid if necessary and contact the DOC/Administrator to establish if the incident meets the definition.

In addition to this statement, there is the following statement as item #3:
The Administrator/Department Supervisor/DOC/Designate must be notified and in turn will notify the Director (Ministry of Health and Long Term Care) by way of Critical Incident Report within ten days of the licensee becoming aware of alleged, suspected or witnessed incidents, or at a time required by the Director.

The explanation of section 24 within the Resident Non-Abuse policy, does not include that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, shall immediately report the suspicion and the information upon which it is based to the Director.

In addition, the explanation of section 24 does not include the requirement to make mandatory reports related to section 24(1) paragraphs 1, 3, 4 or 5.

(Log 002362-18) [s. 20. (1)]

Issued on this 8th day of June, 2018

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA NIXON (148)
Inspection No. / No de l'inspection :	2018_617148_0012
Log No. / No de registre :	002362-18, 003103-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 28, 2018
Licensee / Titulaire de permis :	Corporation of the City of Cornwall 1900 Montreal Rd., CORNWALL, ON, K6H-7L1
LTC Home / Foyer de SLD :	Glen-Stor-Dun Lodge 1900 Montreal Road, CORNWALL, ON, K6H-7L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Norm Quenneville

To Corporation of the City of Cornwall, you are hereby required to comply with the following order(s) by the date(s) set out below:

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. Duty to protect

Order / Ordre :

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

Specifically, the licensee shall ensure:
1) The policy to promote zero tolerance of abuse and neglect of residents is revised to include an explanation of section 24 (1) of the LTCHA; and
2) The revised policy to promote zero tolerance of abuse and neglect is communicated to all staff, residents and residents' substitute decision-makers.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents are protected from abuse by anyone.

Specifically, the licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents is complied with and contains, at a minimum, the required contents as set out by section 20 (2) of the LTCHA.

Staff member RPN #102, failed to comply with the licensee's Resident Non-Abuse policy in that an alleged incident of physical abuse was not immediately reported to supervisory staff.

A critical incident report (CIR) was submitted to the Director on a specified date, describing that on the previous day during the evening shift, resident #002 sustained injury after an unwitnessed incident of alleged abuse involving resident #001.

In an interview with RPN #102, who responded to the incident on the specified date, the RPN acknowledged the incident to be alleged physical abuse. After the incident, RPN #102 said that care was provided to the injured resident and that an internal incident report was completed, which RPN #102 left for the DOC's

review. In discussion related to the reporting of alleged abuse, RPN #102 could not recall having reported the incident to the RN supervisor on staff that evening. In review of the internal incident report and progress note completed by RPN #102, there was no indication that supervisory staff were notified immediately of the alleged abuse. On the day following the alleged abuse, the incident was reported to supervisory staff member #103, at which time the CIR was submitted to the Director.

The home's DOC identified the licensee's policy to promote zero tolerance of abuse and neglect of residents as the Resident Non-Abuse policy, #MM-0704-08. The policy includes the following statement under the heading "MANDATORY STAFF REPORTING - INVESTIGATIVE PROCEDURE":
1. In any case of suspected, alleged or witnessed incidents of abuse or neglect causing harm or risk of harm to a resident, the employee or any other person witnessing or having knowledge of an Incident must report the incident immediately to their department supervisor or immediate supervisor, or, during evening and night hours, to the most senior supervisor available. The Supervisor shall initiate medical aid if necessary and contact the DOC/Administrator to establish if incident meets the definition.

RPN #102 did not comply with the licensee's Resident Non-Abuse policy when the RPN failed to immediately report an incident of alleged abuse to supervisory staff.

2) The licensee has failed to ensure that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 to make mandatory reports.

The identified policy to promote zero tolerance of abuse and neglect of residents, Resident Non-Abuse policy, #MM-0704-08, last revised March 2017, was reviewed by the Inspector.

As noted above, the policy includes the following statement under the heading "MANDATORY STAFF REPORTING - INVESTIGATIVE PROCEDURE" as item #1:
In any case of suspected, alleged or witnessed incidents of abuse or neglect causing harm or risk of harm to a resident, the employee or any other person witnessing or having knowledge of an incident must report the incident

immediately to their department supervisor or immediate supervisor, or, during evening and night hours, to the most senior supervisor available. The Supervisor shall initiate medical aid if necessary and contact the DOC/Administrator to establish if the incident meets the definition.

In addition to this statement, there is the following statement as item #3:
The Administrator/Department Supervisor/DOC/Designate must be notified and in turn will notify the Director (Ministry of Health and Long Term Care) by way of Critical Incident Report within ten days of the licensee becoming aware of alleged, suspected or witnessed incidents, or at a time required by the Director.

The explanation of section 24 within the Resident Non-Abuse policy, does not include that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, shall immediately report the suspicion and the information upon which it is based to the Director.

In addition, the explanation of section 24 does not include the requirement to make mandatory reports related to section 24(1) paragraphs 1, 3, 4 or 5.

The licensee failed to protect resident #001 in that a staff member did not follow the licensee's policy to promote zero tolerance of abuse and neglect and whereby the licensee's policy to promote zero tolerance of abuse did not contain an explanation of the duty under section 24 to make mandatory reports.

(Log 002362-18) [s. 19.] (148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 17, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 28th day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector /
Nom de l'inspecteur : AMANDA NIXON

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