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 prévue 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
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5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 25, 2019	2018_766500_0021	004381-17, 011172-17, 007424-18, 008405-18, 012509-18, 017586-18, 031710-18	Critical Incident System

Licensee/Titulaire de permis

Kristus Darzs Latvian Home
11290 Pine Valley Drive Woodbridge ON L4L 1A6

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

Kristus Darzs Latvian Home
11290 Pine Valley Drive Woodbridge ON L4L 1A6

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

NITAL SHETH (500)

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): December 19, 20, 21, 24, 27, 31, 2018, January 2, 3, 4, 7, 2019.

The following intakes were inspected during this inspection: follow-up log #008405-18, # log #031710-18, CIS #C533-000015-18 related to prevention of abuse, log #17586-18, CIS #C533-000013-18, #012509-18, CIS # C533-000011-18, and #007424-18, CIS-C533-000006-18 related to falls.

The following intakes were completed in this Critical Incident System Inspection: log # 004381-17, CIS #C533-000002-17, and log #011172-17, CIS #C533-000013-17 related to falls.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Quality Lead, Resident Assessment Instrument (RAI)-Coordinator, Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers, and Residents.

During the course of the inspection, the inspector observed the residents home environment, and reviewed the residents' and the home's records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_712665_0004	500

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-term Care (MOHLTC). A review of the report alleged that on an identified day, the resident was emotionally and physically abused by a staff member.

A review of the resident's Minimum Data Sheet (MDS) assessment and written plan of care indicated that the resident required two plus people for an identified care.

During an interview, Personal Support Worker (PSW) #108 indicated that they provided the identified care to the resident by themself and did not get assistance from another staff member. PSW #108 indicated that the resident required one or two people for the identified care.

Interviews with PSW #118, and #119, PSW #120, Registered Practical Nurse (RPN) #117, and Resident Assessment Instrument (RAI)-Coordinator indicated that the resident required two people assistance for the identified care since the resident was admitted to the home.

Interview with the Director of Care (DOC) indicated that the staff are expected to follow the resident's plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan had not been effective.

A review of CIS report indicated that resident #004 had an un-witnessed fall on an identified day. The PSW went to see the resident as a result of a sound of a specified device and found the resident on the floor with an injury. The Registered Nurse (RN) on duty assessed the resident and transferred the resident to the hospital. The resident passed away in the hospital.

A review of the resident's written plan of care indicated that the resident was at high risk for falls, and staff to encourage the resident to use a specified assistive device properly, ensure the environment was free from clutter, keep the bed at the lowest position, ensure the assistive devices were in place, and to monitor the resident for safety.

A review of the resident's risk management and progress notes indicated that the resident had seven falls in an identified month. The major cause of six out of seven falls was the resident ambulating without assistance. The cause of the seventh fall was an environmental hazard. There were eight identified falls prevention interventions in place.

A review of progress note indicated that the falls prevention action plan for the resident included considering moving to more visible areas for close monitoring, if possible.

A note made on an identified day indicated that the Executive Director (ED) reached out to another family to ask if they were willing to relocate to accommodate resident #004 for close monitoring.

Interview with PSW #127, RPN #122, #123, RNs #106, #121, and the DOC indicated that the resident had all falls prevention interventions in place, however the resident would keep getting up without asking for assistance and continue having falls. The resident had specified devices in place, and by the time staff would reach there, the resident would already be on the floor. The resident's care plan was not effective as the resident experienced multiple falls. The home tried to relocate the resident to a more visible area by the nursing station for closer monitoring, but it did not happen during the resident's stay in the home. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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 and secure environment for its residents.

A review of CIS report indicated that resident #004 had an un-witnessed fall on an identified day. The PSW went to see the resident as a result of a sound of a specified device and found the resident on the floor with an injury. The Registered Nurse (RN) on duty assessed the resident and transferred the resident to the hospital. The resident passed away in the hospital.

A review of the resident's risk management and progress notes indicated that on an identified day, the resident was being taken to their room by the staff. The resident's wheelchair bumped on a specified device on the floor, and the resident fell out resulting in an injury. The resident was sent to the hospital and received treatment.

A review of the resident's written plan of care indicated that the resident was at high risk for falls, and staff to encourage the resident to use assistive device properly, ensure the environment was free from clutter, keep the bed at the lowest position, ensure the assistive devices were in place, and to monitor the resident for safety.

Interview with PSW #127 indicated that at the time of the incident, they assisted the

resident to use the washroom, and was taking the resident back to their bed using a wheelchair. They saw the specified device, beside the resident's bed on the floor, and continued pushing the resident's wheelchair. The wheel turned sideways at the same time the resident was trying to reach out to the bed. The resident fell from the wheelchair and sustained an injury. PSW #127 confirmed that they should have removed the specified device and the incident could have been prevented.

Interviews with RPN #122, RN #121, #107, and Physiotherapist (PT) indicated that the environment should have been free from clutter, and the PSW should have removed the specified device before pushing the resident's wheelchair. They also indicated that the specified device is required to be in place only when the resident is in the bed.

A review of the home's policy entitled, "Resident Safety", review date, May 4, 2018, indicated that the home is committed to a safe environment ensuring residents' rooms are free from any objects that may put residents at risk of harm. Staff to ensure residents' rooms are free from any objects that may put residents at risk for harm.

Interview with the DOC indicated that the home conducted an investigation of the incident and confirmed that the staff member failed to maintain the resident's safety. [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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A Critical incident system (CIS) report was submitted to the Ministry of Health and Long-term Care (MOHLTC). A review of the report alleged that on an identified day, the resident was emotionally and physically abused by a staff member. A review of the CIS report indicated that the report was not immediately submitted to the MOHLTC and submitted 157 days later.

Interview with the DOC and the ED indicated the CIS report was submitted after a few months as they were involved in conducting the incident's investigation and forgot to report to the MOHLTC about the incident. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

A Critical incident system (CIS) report was submitted to the Ministry of Health and Long-term Care (MOHLTC). A review of the report alleged that on an identified day, the resident was emotionally and physically abused by a staff member. A review of the CIS did not indicate police had been notified of this incident.

Interview with the DOC, and ED indicated that the police should have been notified for the above mentioned incident, but the home missed it. [s. 98.]

Issued on this 5th day of February, 2019

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

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

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) :	NITAL SHETH (500)
Inspection No. / No de l'inspection :	2018_766500_0021
Log No. / No de registre :	004381-17, 011172-17, 007424-18, 008405-18, 012509-18, 017586-18, 031710-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 25, 2019
Licensee / Titulaire de permis :	Kristus Darzs Latvian Home 11290 Pine Valley Drive, Woodbridge, ON, L4L-1A6
LTC Home / Foyer de SLD :	Kristus Darzs Latvian Home 11290 Pine Valley Drive, Woodbridge, ON, L4L-1A6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lauma Stikuts

To Kristus Darzs Latvian Home, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

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. 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).

Order / Ordre :

The licensee must be compliant with s. 6. (10) (c) of the LTCHA. Specifically the licensee must:
1) Identify all residents who are high risk for falls in the home.
2) Develop, document and implement a system that will minimize the risk of falls for residents at high risk for falls. This system should be developed with at minimum, collaboration between the Personal Support Workers (PSWs) and registered staff. The system will identify the contributing factors for falls and develop appropriate interventions to prevent more falls.
3) Develop, document and implement a system for evaluating the effectiveness of each resident's falls prevention interventions, including any revisions made based on the outcome of the evaluation.
4) Assign a staff member/designate to conduct an audit and maintain a record to evaluate effectiveness of the above mentioned system once it is in place and in residents' plan of care in falls prevention.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan had not been effective.

A review of CIS report indicated that resident #004 had an un-witnessed fall on an identified day. The PSW went to see the resident as a result of a sound of a

specified device and found the resident on the floor with an injury. The Registered Nurse (RN) on duty assessed the resident and transferred the resident to the hospital. The resident passed away in the hospital.

A review of the resident's written plan of care indicated that the resident was at high risk for falls, and staff to encourage the resident to use a specified assistive device properly, ensure the environment was free from clutter, keep the bed at the lowest position, ensure the assistive devices were in place, and to monitor the resident for safety.

A review of the resident's risk management and progress notes indicated that the resident had seven falls in an identified month. The major cause of six out of seven falls was the resident ambulating without assistance. The cause of the seventh fall was an environmental hazard. There were eight identified falls prevention interventions in place.

A review of progress note indicated that the falls prevention action plan for the resident included considering moving to more visible areas for close monitoring, if possible.

A note made on an identified day indicated that the Executive Director (ED) reached out to another family to ask if they were willing to relocate to accommodate resident #004 for close monitoring.

Interview with PSW #127, RPN #122, #123, RNs #106, #121, and the DOC indicated that the resident had all falls prevention interventions in place, however the resident would keep getting up without asking for assistance and continue having falls. The resident had specified devices in place, and by the time staff would reach there, the resident would already be on the floor. The resident's care plan was not effective as the resident experienced multiple falls. The home tried to relocate the resident to a more visible area by the nursing station for closer monitoring, but it did not happen during the resident's stay in the home.

This non-compliance is warranted because the plan of care was not reviewed and revised when it was determined to not be effective as the resident continued getting-up unassisted and experienced falls in one month.

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 1 as an isolated incident. The compliance history of the issue was at level 2, with previous unrelated non-compliance. (500)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019

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
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 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

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 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 25th day of January, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nital Sheth

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