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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 18, 2022	2021_780699_0019 (A1)	007361-21, 007769-21, 009170-21	Critical Incident System

Licensee/Titulaire de permis

Advent Health Care Corporation
541 Finch Avenue West North York ON M2R 3Y3

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

Valleyview Residence
541 Finch Avenue West North York ON M2R 3Y3

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

Amended by PRAVEENA SITTAMPALAM (699) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance Order #001 compliance due date extended to March 24, 2022.

Issued on this 18th day of February, 2022 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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Valleyview Residence
541 Finch Avenue West North York ON M2R 3Y3

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

Amended by PRAVEENA SITTAMPALAM (699) - (A1)

Amended 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): September 29, October 1, 5-8, and 12, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:

Log 009170-21 [CIS: 2954-000007-21] related to use of glucagon with transfer to hospital; and

log 007769-21 [CIS: 2954-000005-21] related to alleged physical abuse.

The following Follow up intake was inspected:

Log 007361-21 related to Compliance order #001 from inspection #2021_780699_0006.

Inspector Stephanie Luciani (#707428) attended this inspection on orientation.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Nurse Practitioner (NP), Resident Care Manager (RCM), Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

During the course of the inspection, the inspector conducted observations of the home, including resident home areas, staff to resident interactions, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of the original inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 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. 6. (7)	CO #001	2021_780699_0006	699

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure the Diabetic Emergencies policies and procedures included in the required Medication management system were

complied with, for three residents.

O. Reg. 79/10 s.114 (1) requires an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

O. Reg. 79/10, s. 114 (2) requires that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the home’s policy and procedure "Diabetic Emergencies: Hypoglycemia", dated February 2021.

1. A Critical Incident System (CIS) report was submitted to the Director, related to the use of glucagon for severe hypoglycemia for a resident.

Review of the resident’s blood sugar levels over a three month period, showed that there were 16 instances where the resident’s blood sugar was documented as below 3.9 millimoles per litre (mmol/L).

2. For the purposes of expanding scope for non-compliance identified with a resident, a second resident was reviewed.

Review of the resident’s blood sugar level over a three month period, showed that there were seven instances where the resident’s blood sugar was documented as below 3.9mmol/L.

3. For the purposes of expanding scope for non-compliance identified with two residents, a third resident was reviewed.

Review of the resident’s blood sugar level over a three month period, showed that there were 21 instances where the resident’s blood sugar was documented as below 3.9mmol/L.

Staff did not comply with the policy and procedure during these identified times for the three residents identified. Specifically, they did not:

-Check blood sugar every 15 minutes until it was greater than 4mmol/L;

-call the prescriber at the first opportunity, once the resident was stable; and
-document immediate actions to assess and maintain residents health (description of the hypoglycemic episode, including resident response time to treatment; notifications of physician and substitute decision-maker (SDM); and if 911 was called, treatment provided (carbohydrates/glucagon) blood glucose levels obtained).

Staff indicated the Diabetic Emergency policy was a part of the medication management system and staff were expected to comply with the policy. They acknowledged that for the above residents, the policy was not complied with.

Sources: Residents clinical health records, progress notes, blood sugar documentation, medication administration records; “Diabetic Emergencies: Hypoglycemia” NRS-02-020 effective date: February 2021; High-Alert Medication, Policy #4.16, revision date: June 2021; Response to Hypoglycemic Emergencies, Policy #4.17, revision: May 11, 2020; and staff interviews.

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A CIS was submitted to the Ministry of Long-term Care (MLTC) related to alleged physical abuse.

The resident required two person assistance with an of activity of daily living (ADL) . A PSW assisted the resident with their ADLs without another staff member. The resident pulled their hand away during care, resulting in altered skin integrity. The PSW reported to the RPN when the altered skin integrity was noted. A diagnostic test revealed an injury. The RCM acknowledged that the resident's plan of care was not followed.

The incident occurred prior to the compliance due date (CDD) for compliance order (CO) #001 that was issued in inspection report #2021_780699_0006, with a CDD of August 31, 2021. This non-compliance is additional evidence to support CO #001.

Sources: CIS report, the resident's clinical health record, flow sheet documentation, care plan, and staff interview with staff. [s. 6. (7)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister

Specifically failed to comply with the following:

174.1 (1) The Minister may issue operational or policy directives respecting long-term care homes where the Minister considers it to be in the public interest to do so. 2017, c. 25, Sched. 5, s. 49.

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia, the licensee was required to ensure that, as of the effective date of April 15, 2020, referenced in section 2(a)(b) and 8(1)(1), all uses of glucagon are reviewed, analyzed, and that the Director is informed no later than one business day after the occurrence of a resident who is administered glucagon which results in the resident being taken to a hospital.

A CIS was submitted to the Director related to the use of glucagon for severe hypoglycemia for a resident. The incident was submitted to the Director eight days later. The RCM indicated that the report was submitted to the Director within 10 days however were not aware that the incident had to be reported to the Director within one business day of the incident occurring.

Review of the resident's incident report did not indicate that the use of glucagon was reviewed or analyzed. Staff verified that this was not completed for the resident.

Sources: CIS report, the resident's Incident Report-Hypoglycemic Event (BS < 3.9mmol/L), and staff interviews with staff. [s. 174.1 (1)]

Issued on this 18th day of February, 2022 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by PRAVEENA SITTAMPALAM (699) - (A1)
Inspection No. / No de l'inspection :	2021_780699_0019 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	007361-21, 007769-21, 009170-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 18, 2022(A1)
Licensee / Titulaire de permis :	Advent Health Care Corporation 541 Finch Avenue West, North York, ON, M2R-3Y3
LTC Home / Foyer de SLD :	Valleyview Residence 541 Finch Avenue West, North York, ON, M2R-3Y3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Elizabeth Bryce

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

To Advent Health Care Corporation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8 (1) of O.Reg. 79/10.

Specifically, the licensee must:

1. Provide education to all registered staff, including resident care managers, on the home's "Diabetic Emergencies: Hypoglycemia" policy. A record must be kept of the training that was provided, who provided the training and staff that completed the training.

2. Develop and implement an auditing process to ensure that the policy is implemented when a resident is identified with hypoglycemia. The audit must include the resident's name, name(s) of staff audited, date of the audit, name of the auditor, issues identified and what corrective actions were taken. This audit must be done monthly for one resident, who has a diagnosis of diabetes and on insulin therapy, on each floor until no issues are found for three consecutive months. Audit results must be made available to the Inspector.

Grounds / Motifs :

1. The licensee has failed to ensure the Diabetic Emergencies policies and procedures included in the required Medication management system were complied

with, for three residents.

O. Reg. 79/10 s.114 (1) requires an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

O. Reg. 79/10, s. 114 (2) requires that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the home's policy and procedure "Diabetic Emergencies: Hypoglycemia", dated February 2021.

1. A Critical Incident System (CIS) report was submitted to the Director, related to the use of glucagon for severe hypoglycemia for a resident.

Review of the resident's blood sugar levels over a three month period, showed that there were 16 instances where the resident's blood sugar was documented as below 3.9 millimoles per litre (mmol/L).

2. For the purposes of expanding scope for non-compliance identified with a resident, a second resident was reviewed.

Review of the resident's blood sugar level over a three month period, showed that there were seven instances where the resident's blood sugar was documented as below 3.9mmol/L.

3. For the purposes of expanding scope for non-compliance identified with two residents, a third resident was reviewed.

Review of the resident's blood sugar level over a three month period, showed that there were 21 instances where the resident's blood sugar was documented as below 3.9mmol/L.

Staff did not comply with the policy and procedure during these identified times for the three residents identified. Specifically, they did not:

-Check blood sugar every 15 minutes until it was greater than 4mmol/L;
-call the prescriber at the first opportunity, once the resident was stable; and
-document immediate actions to assess and maintain residents health (description of the hypoglycemic episode, including resident response time to treatment; notifications of physician and substitute decision-maker (SDM); and if 911 was called, treatment provided (carbohydrates/glucagon) blood glucose levels obtained).

Staff indicated the Diabetic Emergency policy was a part of the medication management system and staff were expected to comply with the policy. They acknowledged that for the above residents, the policy was not complied with.

Sources: Residents clinical health records, progress notes, blood sugar documentation, medication administration records; "Diabetic Emergencies: Hypoglycemia" NRS-02-020 effective date: February 2021; High-Alert Medication, Policy #4.16, revision date: June 2021; Response to Hypoglycemic Emergencies, Policy #4.17, revision: May 11, 2020; and staff interviews.

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

Severity: There was minimal harm to the residents as a result of not complying with the policy as the resident's blood sugar levels improved after implementation of interventions.
Scope: For three out of three residents reviewed, staff did not fully implement the policy, indicating a widespread issue in the home.
Compliance History: One Compliance Order (CO), one Voluntary Plan of Correction (VPC) and one Written Notification (WN) were issued to the same subsection in the past 36 months. (699)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 24, 2022(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 18th day of February, 2022 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by PRAVEENA SITTAMPALAM (699) - (A1)

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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