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

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

Hamilton Service Area Office
119 King Street West 11th Floor
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 5, 2015	2015_267528_0006	H-001945-15	Complaint

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD THOROLD ON L2V 4T7

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

LINHAVEN
403 Ontario Street St. Catharines ON L2N 1L5

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

CYNTHIA DITOMASSO (528)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 3 and 4, 2015.

This inspection included findings from Critical Incident Inspection # 2015_267528_0007/H-000955-14, which was completed concurrently.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), Physiotherapist (PT), and residents and families.

The inspector also toured the home, observed the provision of care and services, reviewed documents including but not limited to: policies and procedures, and clinical health records.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident's right to be properly sheltered, fed,

clothed, groomed and cared for in a manner consistent with his or her needs was fully respected and promoted.

In December 2014, resident #001 was admitted to the home from hospital with an indwelling catheter. Hospital discharge notes, found in the clinical health record, indicated that the catheter was removed while in hospital, however, due to urinary was reinserted.
i. After ten days in the home, the resident requested to have his/her catheter removed and the following physician order was noted "Discontinue the foley catheter today per resident request. Staff to report if any issues voiding on own."
ii. The catheter was removed by registered staff on that same morning. The action was documented in the progress notes along with a note describing physician's concern of urinary retention.
iii. Review of the resident's voiding diary report, completed by direct care staff, identified that the resident was "dry, toileted and voided" or "wet, toileted and voided" approximately sixteen hours following catheter removal. For three days following the catheter removal, the resident was documented to void eight out of 59 times. All other documented voids noted that the resident was either "dry, toileted and did not void" or "dry, checked and not toileted" or "not applicable"
iv. The progress notes completed by registered staff included an assessment of voiding on the day of catheter removal, identifying the resident had toileted independently and staff were unable to measure urine output.
v. No documentation was completed by registered staff related to voiding on the first day following the catheter removal. A progress note by night staff was completed on the morning of the second day following catheter removal, which documented that the resident was up to the bathroom six times during the night and was unable void.
v. The physician was into assess the resident on the second day following catheter removal. The plan of care did not include any documentation that the physician was aware of the resident's inability to void.
iv. Interview with two registered staff confirmed that resident was not assessed for voiding on the first, second, or third day following the catheter removal, and therefore, the physician was not notified of any difficulty voiding as requested in the initial physician order.
v. On the third day following catheter removal the resident had a decrease in level of consciousness and a change in vital signs. Two calls were placed to the physician by registered staff and the resident was transferred to the hospital.
vi. Interview with the DRC confirmed that the resident was at high risk for urinary retention and was not consistently assessed by registered staff after removal of his/her

indwelling catheter.
vii. Interview with the physician identified that registered staff did not notify them of any difficulty voiding. The physician also confirmed that the resident was hospitalized three days after the catheter was discontinued and the hospital removed over a litre of urine from the resident's bladder.

Resident #001 was not cared for in a manner consistent with his/her needs after the indwelling catheter was removed. Registered staff did not consistently assess the resident's voiding and when difficulty was identified, the physician was not notified. [s. 3. (1) 4.]

2. In July 2014, RPN #001 was transporting resident #100 down the hallway when the resident's foot got caught under the wheelchair. A PSW witnessed the incident because she heard the resident call out in pain.

i. The plan of care for the resident identified that they required limited assistance of one staff for their activities of daily living, however, was noted to be independent with locomotion on the unit by propeling themselves in their wheelchair.
ii. Review of progress notes did not include an assessment of the resident's foot until the following day, when RPN #002 documented that the resident's foot was bruised and swollen.
iii. Interview with RPN #002, revealed that the following the PSW informed her of the incident. RPN #002 confirmed that she did not notify the physician of the bruising and swelling to the resident's foot.
iv. The physician was not aware of the incident until two days after the incident when the RN assessed further bruising, swelling and pain, and obtained orders from the physician for x-rays.
v. Interview with RPN #001 confirmed that she did not apply the foot rests to the wheelchair with the resident's feet in position, as required by the home for safe transport. As a result, the resident's foot got caught under the wheelchair causing pain. RPN #001 also indicated that the resident's foot was assessed immediately, however, the incident was not documented or reported to oncoming staff as no injury was immediately apparent.

Resident #100 was not cared for in a manner consistent with their needs when RPN #001 did not apply foot rests for safe transporting, and the resident sustained an injury. Furthermore, since the registered staff did not report or document the incident to the oncoming staff, care was not consistent with the resident's needs post injury. Follow up

assessment was not completed until the following day when the PSW informed RPN #002 and the physician was not notified until the second day at which time additional diagnostic testing was ordered. [s. 3. (1) 4.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

In December 2014, resident #001 was admitted to the home from hospital.
i. Physician orders on admission included daily weights for seven days, with an follow up order on the fifth day for daily weights to continue for an additional seven days.
ii. Review of the plan of care included daily weights for four out of the seven days following the follow up order.
iii. Interview with the DOC confirmed that daily weights were not completed as ordered by the physician.
The staff did not ensure that care was provided to resident #001 related to daily weights ordered by the physician. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 2nd day of March, 2015

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
C DiTomasso #528

Original report signed by the inspector.

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) :	CYNTHIA DITOMASSO (528)
Inspection No. / No de l'inspection :	2015_267528_0006
Log No. / Registre no:	H-001945-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 5, 2015
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF NIAGARA 2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7
LTC Home / Foyer de SLD :	LINHAVEN 403 Ontario Street, St. Catharines, ON, L2N-1L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TOM HUNTER

To THE REGIONAL MUNICIPALITY OF NIAGARA, 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

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

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. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

Every resident is to be cared for in a manner consistent with his or her needs by ensuring:
i. assessments are completed after the removal of an indwelling catheter, those assessments are to be documented in the resident's clinical health record, and action is to be taken if the resident has difficulty voiding.
ii. assessments are completed after pain, bruising, or swelling are noted, those assessments are to be documented in the resident's clinical health record and communicated to staff.

Grounds / Motifs :

1. The licensee failed to ensure that every resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was fully respected and promoted.

In December 2014, resident #001 was admitted to the home from hospital with an indwelling catheter. Hospital discharge notes included in the resident's plan of care indicated that the catheter was removed while in hospital, however, due to urinary retention was reinserted.
i. After ten days in the home, the resident requested to have his/her catheter removed and the following physician order was noted "Discontinue the foley catheter today per resident request. Staff to report if any issues voiding on own."
ii. The catheter was removed by registered staff on that same morning, the action was documented in the progress notes, as well as, the physician's concern of urinary retention.

iii. Review of the resident's voiding diary report, completed by direct care staff, identified that the resident was "dry, toileted and voided" or "wet, toileted and voided" approximately sixteen hours following catheter removal. For three days following the catheter removal, the resident was documented to void eight out of 59 times. All other documented voids noted that the resident was either "dry, toileted and did not void" or "dry, checked and not toileted" or "not applicable"
iv. The progress notes completed by registered staff included an assessment of voiding on the day of catheter removal, identifying the resident had toileted independently and staff were unable to measure urine output.
v. No documentation was completed by registered staff related to voiding on the first day following the catheter removal. A progress note by night staff was completed on the morning of the second day following catheter removal, which documented that the resident was up to the bathroom six times during the night and was unable void.
v. The physician was into assess the resident on the second day following catheter removal. The plan of care did not include any documentation that the physician was aware of the resident's inability to void.
iv. Interview with two registered staff confirmed that resident was not assessed for voiding on the first, second, or third day following the catheter removal, and therefore, the physician was not notified of any difficulty voiding as requested in the initial physician order.
v. Noting a deterioration in the resident's condition on the third day following catheter removal, the resident was transferred to hospital for assessment and treatment.
vi. Interview with the DRC confirmed that the resident was at high risk for urinary retention and was not consistently assessed after removal of his/her indwelling catheter.
vii. Interview with the physician identified that registered staff did not notify them with any difficulty voiding. The physician also confirmed that the hospital removed over a litre of urine from the resident's bladder.

Resident #001 was not cared for in a manner consistent with his/her needs after the indwelling catheter was removed. Registered staff did not consistently assess the resident's voiding and when difficulty was identified, the physician was not notified.

2. In July 2014, RPN #001 was transporting resident #100 down the hallway when the resident's foot got caught under the wheelchair. A PSW witnessed the incident because she heard the resident call out in pain.

i. The plan of care for the resident identified that they required limited assistance of one staff for their activities of daily living, however, was noted to be independent with locomotion on the unit by propeling themselves in their wheelchair.
ii. Review of progress notes did not include an assessment of the resident's foot until the following day, when RPN #002 documented that the resident's foot was bruised and swollen.
iii. Interview with RPN #002, revealed that she was working the following day when the PSW informed her of the incident. RPN #002 confirmed that she did not notify the physician of the bruising and swelling to the resident's foot.
iv. The physician was not aware of the incident until two days after the incident when the RN assessed further bruising, swelling and pain, and obtained orders from the physician for x-rays.
v. Interview with RPN #001 confirmed that she did not apply the foot rests to the wheelchair with the resident's feet in position, as required by the home for safe transport. As a result, the resident's foot got caught under the wheelchair causing pain. RPN #001 also indicated that the resident's foot was assessed immediately, however, the incident was not documented or reported to oncoming staff as no injury was immediately apparent.

Resident #100 was not cared for in a manner consistent with their needs when RPN #001 did not apply foot rests for safe transporting, and the resident sustained an injury. Furthermore, since the registered staff did not report or document the incident to the oncoming staff, care was not consistent with the resident's needs post injury. Follow up assessment was not completed until the following day when the PSW informed RPN #002 and the physician was not notified the second day at which time additional diagnostic testing was ordered. (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 05, 2015

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
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 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
Performance Improvement and Compliance 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 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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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.

Ontario

Ministry of Health and Long-Term Care

Ministère 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

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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 5th day of February, 2015

Signature of Inspector / Signature de l'inspecteur : C DiTomasso #528

Name of Inspector / Nom de l'inspecteur : Cynthia DiTomasso

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