Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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
Oct 15, 2019	2019_771609_0016	009058-19, 010848-19, 012041-19, 014516-19, 016429-19	Critical Incident System

Licensee/Titulaire de permis

Tendercare Nursing Homes Limited
20 High Park Blvd. TORONTO ON M6R 1M7

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

Tendercare Living Centre
1020 McNicoll Avenue SCARBOROUGH ON M1W 2J6

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

CHAD CAMPS (609), AMY GEAUVREAU (642)

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 23-27, 2019.

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

-Three Logs related to resident falls; and
-Two Logs related to allegations of staff to resident abuse.

A Complaint inspection #2019_771609_0017 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Directors of Care (ADOCs), Social Worker (SW), Scheduler, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members, and residents.

The Inspector(s) also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, policies, personnel files, program evaluations as well as staff and resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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)**

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).

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 (CI) was reported to the Director which indicated that resident #006 had a fall, that resulted in an injury.

Inspector #642 reviewed the home's investigation documentation which included an interview between Assistant Director of Care (ADOC) #103 and Personal Support Worker (PSW) #121. The interview note indicated that PSW #121 had stated to ADOC #103 that they had not completed a specific fall intervention.

The Inspector reviewed resident #006's care plan in effect at the time of the incident and found that resident #006 had the specified intervention and that staff were to ensure it was completed at start of each shift.

The Inspector interviewed PSW #121, who stated that they had not completed the fall intervention on the particular day, as they had not known that resident #006 needed the specified fall intervention.

The Inspector interviewed ADOC #103, who stated staff were required to follow the residents' care plans and provide the care that was indicated. The ADOC verified PSW #121 had not followed resident #006's plan of care. [s. 6. (7)]

2. A CI was reported to the Director which stated that resident #005 had been found sliding off the left side of their bed. They were clinging to the bed rail, with the bed noted to be in a specific position. The resident sustained an injury.

A review of the home's internal investigation notes found that the home was unable to determine how resident #005 was injured, but the report from the hospital indicated that the injury was consistent with a fall.

Inspector #642 reviewed resident #005's care plan that indicated that the resident was at a risk for falls and required the bed be kept at a specific position.

The Inspector interviewed RN #122, who stated that resident #005's bed was not at the position specified in the resident's plan of care when the incident occurred.

The Inspector interviewed ADOC #102, who investigated the incident. They stated that they could not identify who had left the bed out of the specified position or for how long. The ADOC stated the resident's bed should always be left in the specified position after

personal care was provided. [s. 6. (7)]

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A CI report was submitted by the home to the Director, which alleged that PSW #107 witnessed PSW #106 physically abuse resident #002, who was crying at the time. Please refer to Written Notification (WN) #2, item #2 and WN #4, item #1 for further information.

A review of resident #002's health care records by Inspector #609 found a progress note dated on the particular day, which described how the resident was heard screaming and crying during the shift.

Ontario Regulation 79/10 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

During an interview with PSW #106, they denied the allegations of being rough towards resident #002. The PSW acknowledged that the resident was crying while they provided care.

A review of the home's internal investigation found an interview with PSW #107, which described how they had observed resident #002 cry as PSW #106 was providing care.

A review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program" last updated June 2019 indicated that all residents were to be treated with dignity and respect and were protected from all forms of abuse or neglect at all times.

During an interview with ADOC #102, they indicated that the home's internal investigation on the incident verified that PSW #106 was rough with resident #002. [s. 20. (1)]

2. A CI report was submitted by the home to the Director on a particular day, which alleged that PSW #106 physically abused resident #002. Please refer to WN #1, item #2 and WN #4, item #1 for further information.

Inspector #609 reviewed the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" last updated June 2019 required the Manager/designate immediately advise the employee alleged to have abused, that they were removed from the work schedule, pending the investigation.

During an interview with the Executive Director (ED), they verified that the RN would be considered the Manager/Designate on night shifts.

A review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" last updated June 2019 required any employee who became aware of an alleged resident incident of abuse to immediately report it to the Administrator/designate/reporting manager.

During interviews with RN #108 and RN #122, they both verified that they were made aware of allegations that PSW #106 had physically abused resident #002, on the particular day. The two RNs further verified that they should have removed PSW #106 from caring for resident #002 when they became aware of the allegations and immediately report the allegations to the Director of Care (DOC).

During an interview with ADOC #102, they indicated that the two RNs should have immediately removed PSW #106 from caring for resident #002 as well as immediately reported the allegations to the DOC, which did not occur. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

A CI report was submitted by the home to the Director, which described how PSW #105 was witnessed improperly transferring resident #003. The PSW was alone and had not used the required equipment for the transfer.

Inspector #609 reviewed resident #003's health care records and found that the resident had been diagnosed with an injury, the day after the improper transfer.

A review of resident #003's plan of care at the time of the transfer required two staff to provide physical assistance while using a required piece of equipment.

During an interview with PSW #105, they described how they could not find anyone to help them transfer resident #002 on the particular day and proceeded to transfer the resident alone and without the use of the required equipment.

During an interview with ADOC #102, they indicated that the results of the home's internal investigation found that PSW #105 had unsafely transferred resident #003 on the particular day when they performed the transfer alone and without the required equipment. [s. 36.]

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 staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #4: 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 any person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A CI report was submitted by the home to the Director which alleged that PSW #107 reported to RN #108 that they witnessed PSW #106 treat resident #002 improperly while providing care. The resident was observed crying during the incident which. Please refer to WN #2, item #1 and WN #2, item #2 for further information.

The CI report was submitted by the Director of Care (DOC) when they became aware of the allegations of abuse through a complaint they reviewed over 2.5 days after the incident occurred.

1) Inspector #609 interviewed RN #108, who outlined how allegations of physical abuse were reported to them by PSW #107 during the early hours of the particular day. PSW #107 described to them how they had observed PSW #106 being "rough" while providing care to resident #002, who was crying at the time.

Ontario Regulation 79/10 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

A review of the home's policy titled "Critical Incident Reporting" last updated June 2019 required anyone to make an immediate report to the Director where there was reasonable suspicion that abuse of a resident by anyone occurred or may occur by using the Critical Incident System and after-hours pager number.

RN #108 acknowledged that they reported the allegations to RN #122 (i.e. Charge RN) and should have immediately called the after-hours pager to report the allegations.

2) Inspector #609 interviewed RN #122, who verified that RN #108 reported to them that someone was witnessed being rough with a resident on the particular day.

The home's "Critical Incident Reporting" policy was reviewed with RN #122 who stated, "it was our mistake" acknowledging they should have immediately called the after-hours pager to report the allegations.

During an interview with ADOC #102, they outlined that on night shift the RNs were considered the manager/designate. The ADOC indicated that it was the responsibility of RN #108 and #122 to have reported the allegations of abuse on the particular day, by calling the after-hours pager, which did not occur. [s. 24. (1)]

Issued on this 16th day of October, 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

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

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) :	CHAD CAMPS (609), AMY GEAUVREAU (642)
Inspection No. / No de l'inspection :	2019_771609_0016
Log No. / No de registre :	009058-19, 010848-19, 012041-19, 014516-19, 016429-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 15, 2019
Licensee / Titulaire de permis :	Tendercare Nursing Homes Limited 20 High Park Blvd., TORONTO, ON, M6R-1M7
LTC Home / Foyer de SLD :	Tendercare Living Centre 1020 McNicoll Avenue, SCARBOROUGH, ON, M1W-2J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Francis Martis

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

To Tendercare Nursing Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the Long Term Care Homes Act (LTCHA), 2007.

Specifically, the licensee must:

a) Ensure that all staff who provide direct care to residents are aware of and comply with a specified plan of care providing bed height directions for every resident;

b) Ensure that every bed, chair and/or room alarm required by a resident of the home is applied and operational at all times that the alarm(s) is deemed necessary.

Grounds / Motifs :

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 (CI) was reported to the Director which indicated that resident #006 had a fall, that resulted in an injury.

Inspector #642 reviewed the home's investigation documentation which included an interview between Assistant Director of Care (ADOC) #103 and Personal Support Worker (PSW) #121. The interview note indicated that PSW #121 had stated to ADOC #103 that they had not completed a specific fall intervention.

The Inspector reviewed resident #006's care plan in effect at the time of the incident and found that resident #006 had the specified intervention and that

staff were to ensure it was completed at start of each shift.

The Inspector interviewed PSW #121, who stated that they had not completed the fall intervention on the particular day, as they had not known that resident #006 needed the specified fall intervention.

The Inspector interviewed ADOC #103, who stated staff were required to follow the residents' care plans and provide the care that was indicated. The ADOC verified PSW #121 had not followed resident #006's plan of care. (642)

2. A CI was reported to the Director which stated that resident #005 had been found sliding off the left side of their bed. They were clinging to the bed rail, with the bed noted to be in a specific position. The resident sustained an injury.

A review of the home's internal investigation notes found that the home was unable to determine how resident #005 was injured, but the report from the hospital indicated that the injury was consistent with a fall.

Inspector #642 reviewed resident #005's care plan that indicated that the resident was at a risk for falls and required the bed be kept at a specific position.

The Inspector interviewed RN #122, who stated that resident #005's bed was not at the position specified in the resident's plan of care when the incident occurred.

The Inspector interviewed ADOC #102, who investigated the incident. They stated that they could not identify who had left the bed out of the specified position or for how long. The ADOC stated the resident's bed should always be left in the specified position after personal care was provided.

The severity of the issue was determined to be a level three as there was actual harm or actual risk of harm to the residents. The scope of the issue was a level two; pattern, as it was related to two of five residents reviewed. The home had a level three history of non-compliance which indicated one or more non-compliances, one of which is the same subsection or section being cited:

-Voluntary Plan of Correction (VPC), in May 2019 cited in inspection report

#2019_626501_0010;
-Compliance Order (CO), in February 2018 cited in inspection report #2018_642606_0001; and
-CO, in August 2017 cited in inspection report #2017_420643_0012. (609)

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

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 15th day of October, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chad Camps

Service Area Office /
Bureau régional de services : Central East Service Area Office