Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Amended Public Report Cover Sheet (A2)

Amended Report Issue Date: May 9, 2024	
Original Report Issue Date: March 25, 2024	
Inspection Number: 2024-1327-0001 (A2)	
Inspection Type: Complaint Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Southwood Lakes, Windsor	
Amended By Terri Daly (115)	**Inspector who Amended Digital Signature** Terri Daly Digitally signed by Terri Daly Date: 2024.06.03 12:13:04 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Compliance Order (CO) #002 and #003 were amended to revise the compliance due dates as requested by the long-term care home to August 1, 2024.
Compliance Order #001 was included in this report for reference; however, was not amended; therefore, the served date remains March 28, 2024.

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Lead Inspector Jennifer Bertolin (740915)	**Additional Inspector(s)** Julie D'Alessandro (739) Terri Daly (115) Adriana Tarte (000751)
Amended By Terri Daly (115)	**Inspector who Amended Digital Signature** Terri Daly Digitally signed by Terri Daly Date: 2024.06.03 12:14:39 -04'00'

AMENDED INSPECTION SUMMARY

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Compliance Order (CO) #002 and #003 were amended to revise the compliance due dates as requested by the long-term care home to August 1, 2024.
Compliance Order #001 was included in this report for reference; however, was not amended; therefore, the served date remains March 28, 2024.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 13-16, and 20-23, 2024

The following intake(s) were inspected:
- Intake: #00099895-[Critical Incident (CI): 2842-000043-23] -Prevention of abuse and neglect
- Intake: #00100050 -[CI:2842-000044-23]: Falls prevention & management
- Intake: #00102588 -[CI: 2842-000047-23] - Skin and wound prevention & management
- Intake: #00104064 -[CI: 2842-000049-23]- Falls prevention & management
- Intake: #00107217 -[CI: 2842-000003-24] -Falls prevention & management
- Intake: #00100788 -Complaint related to reporting and complaints
- Intake: #00101462 -Complaint related to resident care and support services

The following intakes were completed in this inspection:
Intake #00102498/CI: 2842-000046-23 and Intake: #00101728/CI: 2842-000045-23 were related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home

Staffing, Training and Care Standards
Reporting and Complaints
Recreational and Social Activities
Falls Prevention and Management
Resident Charges and Trust Accounts

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

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.

Introduction:

The licensee failed to ensure that care was provided to a resident as outlined in their plan of care.

Summary and Rationale:

A progress notes in Point Click Care (PCC) on a specific date and time indicated that a resident was being transferred by one staff member and sustained an injury during the transfer.

A review of the resident's plan of care prior to the incident, revised prior to incident, indicated that the resident was to be transferred by two staff members and to use

leg straps when the sit to stand mechanical lift is used.

During an interview with the resident , they stated that only one staff member was present during transfer and the legs straps were not used.

During an interview with a registered staff member, they indicated that a direct care staff member provided care to the resident by themselves and that the legs straps were not placed on resident 's legs prior to transfer. The registered staff member stated that the resident was to have two staff members present for transfers.

During an interview with a management team member they acknowledged that the resident should have been provided care by two staff members and was not.

The failure to adhere to the plan of care for the resident increased the risk of injury, further complications, and jeopardized the resident's well-being and quality of care.

Sources: Resident progress notes and plan of care as well as interviews with staff and management team members
[740915]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 21.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences.

Introduction:
The licensee failed to ensure that the plan of care for two residents included sleep patterns and preferences.

Rationale and Summary:
During a tour of a specific unit at a specific date and time, it was observed that the two resident's were in bed with their bedroom lights off. The plan of care for these residents had not included sleep patterns and preferences.

A direct care staff member reviewed the plan of care for both resident's and stated that their sleep patterns and preferences were not included.

A management team member acknowledged that the plan of care for these residents did not include sleep patterns and preferences and should have.

Not including sleep preferences in the plan of care puts the resident at risk of their rights being violated related to preferred sleep and wake times.

Sources: resident's plan of care and staff interviews.
[739]

WRITTEN NOTIFICATION: Unsafe Positioning Techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Introduction:

The licensee has failed to ensure that staff used safe positioning techniques when assisting a resident during perineal care.

Rationale and Summary
A review of the resident's care plan indicated that the resident required two staff members to complete perineal care. This intervention was created in their care plan, prior to the incident.

A direct care staff member acknowledged that on a specific date they provided perineal care to the resident using one person assist. A management team member confirmed that the resident required two person assist for perineal care at the time of the incident.

Failure to use safe positioning techniques during perineal care resulted in injury to a resident.

Sources: Resident's care plan, interdisciplinary team care conference and interviews with staff members.
[000751]

WRITTEN NOTIFICATION: Housekeeping

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with

evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

Introduction:
The licensee failed to ensure that procedures were implemented for cleaning lifts and electronic vital signs machines in the home.

Rationale and Summary:
During a tour on a unit on a specific date , it was noted that the bases of the Sara and maxi lifts were unclean and had dust, debris and dried fluid on them. It was also observed that the electronic vital signs machine had a base that was unclean with dust and dried fluid on it. This was also shown to a several management team members.

The Resident Care Equipment Policy stated in part that, "all resident care equipment will be cleaned/sanitized prior to and between resident use". During an interview with a management team member they stated that the vital signs machine, Sara and maxi lifts were not cleaned and should have been.

Not cleaning resident equipment between each use increases the risk for the spread of infection.

Sources: Observation, policy review, and staff interviews.
[739]

WRITTEN NOTIFICATION: Housekeeping

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (ii)

Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

Introduction:
The licensee failed to ensure that procedures were implemented for cleaning wheelchairs in the home.

Rationale and Summary:
During a tour on a unit on a specific date, it was noted that the cushion of a resident's wheelchair was soiled with dried food and fluid debris. The resident's wheelchair should have been cleaned the previous night as it was their bath day. During a tour on a different unit and on a different date, it was noted that a resident was resting in bed and their wheelchair cushion was soiled with fluid and dried food. Pictures of both cushions were shown to a management team member.

During an interview with a management team member, they stated that the home's procedure was that wheelchairs were to have been cleaned thoroughly the night before a resident's bath day and wiped down by staff when they were visibly soiled.

Not cleaning resident wheelchairs increases the risk for the spread of infection.

Sources: Observation and staff interviews.
[739]

WRITTEN NOTIFICATION: Hazardous Substances

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

Introduction:
The licensee failed to ensure that all hazardous substances at the home were always kept inaccessible to residents.

Rationale and Summary:
On a specific date, Inspector #739 observed a bottle of Arjo General Purpose Disinfectant on the ledge in the entrance vestibule of the home. The disinfectant was labelled as poisonous and corrosive. Inspector #739 brought the bottle to a management team member and showed a picture of where the bottle had been found. Management team member stated that the bottle of cleanser should not have been in the main vestibule and acknowledged that it was accessible to residents.

During a tour on a unit on a specific date, Inspector #739 noticed an open supply room door with Arjo Spa Cleaner, which indicated on the label that it was corrosive, in a spray bottle on the counter. A direct care staff member stated that the storage room door should not have been left open and acknowledged that the cleaner would have been accessible to residents.

Having hazardous substances accessible to resident increases the risk of harm to residents if the substances is improperly handled or ingested.

Sources: Observation and staff interview.
[739]

WRITTEN NOTIFICATION: Reporting to the Director

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 1.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

Introduction:
The licensee failed to ensure that the Director was informed when a resident was missing from the building for less than three hours.

Rationale and Summary:
On two separate occasions, the same resident was found walking in the parking lot of the home. The resident was returned to the home by staff.

A review of the critical incident (CI) reports submitted to the Ministry of Long-Term Care (MLTC) by the home did not include a report for either incident of the resident missing from the home.

A management team member acknowledged that a critical incident should have been submitted for both incidents but was not.

Not submitting a CI report when a resident is missing from the home puts the resident at risk for increased incidents without follow-up from the MLTC.

Sources: Resident's clinical chart, review of submitted critical incidents, and staff interview.
[739]

COMPLIANCE ORDER CO #001 Accommodation Services

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:
Specifically, the licensee shall prepare, submit and implement a plan to maintain the home, furnishings and equipment and ensure they are kept clean and sanitary.
1. Completing an audit of all the Resident Home Areas (RHA) to identify baseboards, floors and walls, or other areas of uncleanliness.
2. Complete a checklist of the cleaning to be done which includes where, how, who would be responsible for completing the work, when the work will be started, when it will be completed and how it will be maintained.
3. Ensure that the leadership team participates in creating the plan, including the Administrator, DOC, and Environmental Service Manager (ESM).

Please submit the written plan for achieving compliance for inspection #2024-1327-0001 to Terri Daly #115
LTC Homes Inspector, MLTC, by email to londondistrict.mltc@ontario.ca by March 26, 2024.
Please ensure that the submitted written plan does not contain any PI.

Grounds
The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

Rationale and Summary:
During observations in the home on during a specific time period, the following areas and furnishings were noted to be unclean.

Home Area Dining Rooms
-home area dining rooms were found to have food splatter on walls, on support pillars, resident dining room chairs, table legs, staff stools, and the soiled clothing protector carts.
-perimeter and corner areas of the dining room floors were found to have a build up a dust, dirt and grime.

Resident TV Lounges
-some lounge furniture found to have stains, and visible dried spillage on them.

Resident Rooms, Spa Rooms and Home Area Hallways
-floors found to have a build up a dust, dirt and grime, most notably around resident room door frames, hallway and room corners.
-windows at the ends of the Essex Home area covered with dirt and grime making

visibility to the outside difficult.
-many resident rooms found to have dried debris splatter on bedroom and bathroom walls, perimeter and corner areas of the room floors were found to have a build up a dust, dirt and grime.
-privacy curtains in resident rooms found to be soiled and stained with unknown substances.
-resident room bathroom ceiling tiles water stained.
-live ants and bug carcasses found in St. Clair, Walkerville dining rooms, in the window sill of the Huron spa room and resident rooms.
-nursing equipment including the bases of the resident transfer lifts and the vital signs monitoring mobile device on the Devonshire home area were found with unknown dried debris and dust.
-exterior of the buildings white siding has a green moss like coloured substance.

During an interview with a staff member, they indicated that they do not have enough time to get to everything cleaned.

A review of the home's Environmental Services Manual policies and procedures found the following:
Statement of Purpose
Revised: February 1, 2022
"We strive to maintain an environment which is clean, neat, safe and free from odours. All sanitation practices, policies and procedures are devised to minimize health hazards to all residents, staff and visitors".

A review of the home's complaints showed three emails from families related to the cleanliness of a resident's room on August 8, 2023, housekeeping concerns, ants in a resident room on November 1, 2023 and the cleanliness of the dining room chairs on January 12, 2024.

During a walkthrough of the Huron and Devonshire home areas, with management team members, neither could provide a reason for the uncleanliness of the home and both agreed the conditions were unacceptable.

Failure to ensure that the home was kept clean and sanitary may increase the potential for risks associated with infectious diseases and pest infestations, and potentially impacts the resident's right to live in a safe, clean environment in a dignified matter.

Sources Interviews, complaint record review, policies and procedures and observations.
[115]

This order must be complied with by May 10, 2024

(A2)
The following non-compliance(s) has been amended: NC #009

COMPLIANCE ORDER CO #002 Accommodation Services

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 201. [FLTCA, 2021, s. 155 (1) (b)]:

The plan must include but is not limited to;
Specifically, the licensee shall prepare, submit and implement a plan to maintain the home, furnishings and equipment to ensure they are kept in a safe condition and in a good state of repair.
The plan must include but is not limited to:
1. Completing an audit of all the RHAs to identify baseboards, cabinets/shelving, floors and walls, or other areas of disrepair.
2. Complete a checklist of the work to be done which includes where, how, who would be responsible for completing the work, when the work will be started, when it will be completed and how it will be maintained.
3. Ensure that the leadership team participates in creating the plan, including the Administrator, DOC, and the ESM.

Please submit the written plan for achieving compliance for inspection #2024-1327-0001 to Terri Daly
#115, LTC Homes Inspector, MLTC, by email to londondistrict.mltc@ontario.ca by **March 26, 2024**.
Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds
The licensee has failed to ensure that the home, furnishings and equipment were maintained and a safe condition and in a good state of repair.

Rationale and Summary
During observations in the home the following areas were noted to be in disrepair:
-multiple areas of damaged walls were noted in resident and common areas that included but was not limited to, multiple areas of damaged drywall, unpainted drywall, paint repairs poorly colour matched, areas of chipped and scuffed paint, black marks on walls.

-most wood surfaces on the top of the tv cabinets and shelving in the lounge areas noted to have finish coming off, leaving bare, porous wood exposed, creating a potential issue for cleaning and infection control concerns.
-handrails throughout all home areas are scuffed and finish coming off exposing bare porous wood, creating a potential issue for cleaning and infection control concerns.
-a number of resident home areas with part baseboards missing or baseboards coming away from the walls.
-curtains in resident room windows coming of the tracks.

Essex Home Area
-black material under resident dining room chair coming away from underneath the seat and hanging down.
-caulking around base of toilet cracked and discoloured in the visitor bathroom.
-corner crack from the ceiling to the floor upon entry of the unit outside a resident room.
-door to janitor closet has tape holing the acrovyn in place.

Huron Home Area
-spa Room counter missing tiles.
-a resident's room missing closet door.

Walkerville Home Area
-a resident's room floor tiles lifting, orange duct tape on the toilet tank and window crank is missing.
-a resident's room duct tape used as a transition strip into bathroom from bedroom.

A review of the home's Preventative Maintenance program and policies noted that Policy MNTC-01-01-01 Last Revised February 2022 indicated the following:

"PURPOSE - This policy establishes a requirement for a program to maintain the building and equipment in a condition that provides a safe, comfortable and pleasant environment for the occupants."

During a walkthrough of the Huron and Devonshire home areas, with several management team members, neither could provide a reason for the maintenance concerns in the home, but both agreed the conditions were unacceptable and a management team member indicated that the online Maintenance Care Program in the home is not always being used to alert and track building and maintenance concerns/repairs.

Failure to maintain the interior and exterior of the home in a safe condition and a good state of repair had a potential impact on the resident's right to live in a safe, clean and comfortable environment in a dignified matter.

Sources: Interviews, observations, complaint records and policies and procedures. [115]

This order must be complied with by August 1, 2024.

(A2)
The following non-compliance(s) has been amended: NC #0011

COMPLIANCE ORDER CO #003 Communication and Response System

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically the licensee must;
a) ensure the Resident-Staff Communication and Response System (RSCRS) can be easily seen, accessed, and used by residents, staff, and visitors at all times, and is properly calibrated so that the level of sound is audible to staff.
b) take corrective actions to ensure that pagers are available or the home has a plan in place when pagers are not available to ensure care staff are being immediately alerted to a call that has been made by a resident.
c) documented audits of the call bell response time records (from pull cords) for one resident per resident home area per day on each shift per day, with documented follow up action to determine the root cause when the call bell remains unanswered for an escalated period without action, as identified by the auditor.
d) audits shall continue, and documentation retained, until the MLTC has complied this order.

Grounds
The licensee failed to ensure that that the home is equipped with a RSCRS that can be easily seen, accessed and used by residents, staff and visitors at all times.

Rationale and Summary
On a specific date Inspector #739 and #115 noted that a direct care staff member was utilizing a pager to respond to call bells, however only one PSW on the home area had access to a pager.

At the time of the inspection, the home was equipped with a RSCRS that provided

residents a means to call for assistance by pulling the pull cord at their bedside or in their bathroom. Calls made by pulling the cord went to a marquis screen at the nursing desks and to pagers carried by staff, there was an audible noise from the marquis screen and the pager to alert staff to look at the RSCRS notification. When the pull cord was activated, a red light on the wall outside of the resident room illuminated to demonstrate that the device had been activated.

During an interview with several direct care staff members, both indicated that pagers to alert staff to call bells had been misplaced or no longer functioning and not replaced. Both staff stated that without the use of more pagers staff cannot hear the call bell nor can they see the location of the call bell alarm as the marquise screen is located at the nursing desk and is not visible from the resident hall ways.

Inspector #739 and #115 tested the RSCRS and found that the call bell lights outside the resident room doors could not be seen from various points down the resident hall ways, that the marquis screen was only visible from the dining room and the nursing desk, and that the call bells were not audible if you weren't close to nursing desk.

An interview with several management team members confirmed that they were aware of the communication call bell response concerns. The Administrator indicated that they expressed concerns and reached out to their Extendicare Regional Team in the past, however, their understanding was that the funds were being used towards other systems in the home.

A review of the Family Council meeting minutes from January 24, 2024, showed council's concerns to staff's slow response to resident call bells was submitted to the home on February 4, 2024.

Failure to ensure that the RSCRS can be easily seen, accessed and used by residents and staff, and the level of sound is audible to staff contributed to resident safety risks, resident stress and anxiety, and delayed staff responses.

Sources: Complaints, Family Council Meeting Minutes, interviews and observations. [115]

This order must be complied with by August 1, 2024.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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