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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
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# Amended Public Report Cover Sheet (A1)

| Amended Report Issue Date: June 18, 2024 |
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| Original Report Issue Date: March 21, 2024 |
| Inspection Number: 2024-1352-0001 (A1) |
| Inspection Type:<br>Proactive Compliance Inspection |
| Licensee: CVH (No. 4) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.) |
| Long Term Care Home and City: Manoir Marochel, Ottawa |

## AMENDED INSPECTION SUMMARY

This report has been amended to provide Compliance Order (CO) #003, served to the Licensee on March 21, 2024, with a compliance due date of June 18, 2024, has been extended as per the Licensee's request to October 31, 2024.

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## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 10, 11, 12, 15, 16, 17, 18, 19, 22 and 23, 2024.
The inspection occurred offsite on the following date(s): January 29, 2024 and March 15 and 19, 2024.

The following intake(s) were inspected:

- Intake: #00102885 was related to a Proactive Compliance Inspection (PCI).

The following Inspection Protocols were used during this inspection:

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement
Pain Management
Falls Prevention and Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

## AMENDED INSPECTION RESULTS

## Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (c)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;

The licensee has failed to ensure that the long-term care home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home, in a conspicuous and easily accessible location.

Rationale and Summary

On January 10, 2024, during an initial tour of the home, the home's policy titled Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct (RC-02-01-01) (last reviewed August 2023) was in a glass case in the main lobby that was locked.

On January 23, 2024, the Administrator unlocked the glass case.

The required information was in the glass case, but the lock was left disengaged so that the case could be opened and the information accessible.

Sources: Observations and interview with the Administrator.

[551]

Date Remedy Implemented: January 23, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (d)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(d) an explanation of the duty under section 28 to make mandatory reports;

The licensee has failed to ensure that the explanation to the duty under section 28 to make mandatory reports was posted in the home, in a conspicuous and easily accessible location.

Rationale and Summary

On January 10, 2024, during an initial tour of the home, an explanation to the duty under section 28 to make mandatory reports was not located in the home.

On January 23, 2024, the Administrator, posted RC-02-01-02, Zero Tolerance of Resident Abuse and Neglect: Response & Reporting, RCM, which explained the duty to make mandatory reports, in the glass case with the policy to promote zero tolerance of abuse and neglect of residents.

The required information was in the glass case, but the lock was left disengaged so that the case could be opened and the information accessible.

Sources: Observations and interview with the Administrator.

[551]

Date Remedy Implemented: January 23, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (r)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(r) an explanation of the protections afforded under section 30; and

The licensee has failed to ensure that an explanation of the protections afforded under section 30 was posted in the home, in a conspicuous and easily accessible location.

Rationale and Summary

On January 10, 2024, during an initial tour of the home, an explanation of the protections afforded under section 30 was not located in the home.

On January 23, 2024, the Administrator posted the Whistleblower Policy in the glass case with the policy to promote zero tolerance of abuse and neglect of residents.

The required information was in the glass case, but the lock was left disengaged so that the case could be opened and the information accessible.

Sources: Observations and interview with the Administrator.

[551]

Date Remedy Implemented: January 23, 2024

## WRITTEN NOTIFICATION: Residents' Rights

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 11.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to live in a safe and clean environment.

The licensee has failed to ensure that the right to live in a safe and clean environment was fully respected and promoted for two residents.

Rationale and Summary

1) The drain in a shower stall was blocked resulting in a pool of slow to drain and/or back flowing water and debris.

A Personal Support Worker (PSW) reported that a resident's feet had rested in the pool of slow to drain and/or back flowing water and debris during a shower, and they expressed regret that this had occurred.

Staff reported that the drain had been blocked for a matter of weeks before it was unblocked.

2) A soiled fitted sheet was noted on a resident's bed. The resident stated that it had

been there for a period of hours. A PSW acknowledged the soiled sheet and stated that it would be changed. The soiled remained on the resident's bed for a matter of hours.

The resident stated that they wished the soiled sheet had been removed as soon as the incident happened, hours earlier.

The resident's right to live in a safe and clean environment was not fully respected and promoted when their feet were exposed to the contents of the slow to drain and/or back flowing drain water and debris, and when soiled bed linen remained on their bed for several hours after the incident occurred.

Sources: Observations and interviews with the resident and PSWs.

3) A resident used a specialized device in the shower, and when seated their feet rested on the floor of the shower stall.

When the resident received a shower, their feet rested in a pool of slow to drain and/or back flowing water and debris as there was a blockage in the shower stall drain, and the wastewater was not draining properly. It was reported by a PSW that the resident was upset because of their shower experience.

The resident confirmed that their feet rested in a pool of accumulated water when the drain was blocked.

The resident's right to live in a safe and clean environment was not fully respected and promoted when their feet were exposed to the contents of the slow to drain and/or back flowing water and debris during their shower.

Sources: Interviews with a resident and a PSW. [551]

## WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the plan of care provided clear directions to staff for a resident's toileting and continence care needs.

Rationale and Summary

The resident was observed sitting in their wheelchair, and they were turning themself which potentially increased their risk of a fall.

It was reported that the resident was not brought to the bathroom for toileting, as per their schedule, or have their brief changed and insufficient toileting resulted in their continence care product being oversaturated.

When the inspector observed that the resident had their legs over the armrest of their wheelchair and a grimace on their face, the resident was asked, and they voiced that they needed to go to the bathroom. A Registered Nurse (RN) indicated that when the resident turned in their wheelchair, it was a cue that they need to be toileted. The resident was brought down the hallway for staff to toilet them. The resident was later observed at the end of the hallway, and there was liquid on the

floor beneath the wheelchair that was indicative that their continence care product was saturated and leaking.

On a different day, the inspector observed cues indicating that the resident needed to go to the bathroom. When asked, the resident voiced that they did need to go to the bathroom.

The resident's plan of care indicated what level of assistance they required for for toileting while in bed, and there was an intervention for night staff to change the resident's continence care product at specific times during their shift. There was no planned schedule for toileting or brief changes during the day or evening shifts.

Failing to provide the resident with sufficient toileting opportunities and continence care product changes for their comfort may have increased their risk of agitation, which increased their risk of falling.

Sources: Observations, a review of the resident's health care record and interviews with staff and others. [000725]

## WRITTEN NOTIFICATION: Plan of Care

NC #006 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.

The licensee has failed to ensure that the care set out in the plan of care related to activities was provided to two residents as specified in the plan.

1) Rationale and Summary

It was reported that a resident was previously included in activities such as one to one (1:1) visits, which were helpful in keeping them calm and decreasing their responsive behaviours, however this activity had not been offered to the resident in the last few months.

It was observed that the resident was included in a coloring activity during the inspection.

The resident's plan of care indicated they were to be provided 1:1 visits/programs, and specific activities that the resident enjoyed were identified as some of the activities to be offered.

As per a list of all of the activities that the resident had participated in over a three month period, only four were 1:1 activities, the resident's preferred type of activity. There was no specific schedule for the resident to receive 1:1 visits/programming.

Failing to ensure that the resident plan of care for activities was provided increased their risk of experiencing responsive behaviours.

Sources: Observations, a review of the resident's health care record and interviews

with staff and others. [000725]

2) Rationale and Summary

The resident's plan of care indicated they were to be provided 1:1 visits/programs, and that they preferred quiet areas. Specific activities that the resident enjoyed were identified as some of the activities to be offered to enhance memory and support their self-expression and identity.

It was reported that the resident responded to musical programs, however they were resting when this activity was offered. There was no specific schedule for the resident to receive 1:1 visits/programming. The resident enjoyed a sensory based activity, however this activity had become unavailable and was not replaced with another.

Failing to provide the resident with restorative stimulation through their preferred activities, posed a potential risk for the resident to become isolated and withdrawn.

Sources: Observations, a review of the resident's health care record and interviews with staff. [000725]

## WRITTEN NOTIFICATION: Plan of Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed.

Rationale and Summary

A resident had a device to assist in managing their continence care needs.

The device was discontinued.

At the time of the inspection, the resident's plan of care directed PSW staff to manage their continence care needs as if the device was being used.

The resident stated that continence care was not provided for prolonged periods of time when it was required. It was observed that the resident required clothing changes with continence care due to the saturation of their continence care product.

The resident's plan of care was not reviewed and revised when their continence care needs changed. The resident may not have received sufficient continence care product changes to remain clean, dry and comfortable.

Sources: Observations, a review of the resident's health care record and interviews with the resident and staff. [551]

## WRITTEN NOTIFICATION: Communication and Response System

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that the resident-staff communication and response system (RSCRS) could easily be used by residents, staff and visitors at all times in room 118.

Rationale and Summary

1) In a resident's shared room, the RSCRS (commonly called the call bell) was not activated by using the call bell cord or pushing the button on the panel on the wall.

A Registered Practical Nurse (RPN) indicated that the resident had broken the button at the end of the call bell cord, resulting in it not working, and they would need to replace the call bell cord.

2) A resident's call bell was not functioning at their bedside.

It was reported by a family member that they did not think that the resident's call bell worked as it not attract the staff's attention, and the resident had to wait for long periods for care to be provided.

An RPN indicated that the resident's call bell often required to be reset, and they

reset the call bell.

Failing to have a RSCRS (call bell) that could be easily used by residents, visitors and staff at all times posed a risk to residents in the case of resident care needs or emergencies.

Sources: Observations and interviews with staff. [000725]

## WRITTEN NOTIFICATION: Personal Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 36
Personal care
s. 36. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

The licensee has failed to ensure that a resident received individualized personal care on a daily basis.

Rationale and Summary

The resident indicated that they had to wait for long periods of time to have their calls answered for assistance with toileting or transfers using the resident-staff communication and response system (RSCRS) (the call bell). They stated that they got tired of waiting and transferred themself which had resulted in falls.

The inspector observed that the resident's call bell light was on, an audible alarm was sounding. They found the resident laying sideways in their bed and unable to sit

up on their own. The resident stated that they had been waiting for 40 minutes to have their call bell answered.

An RPN stated that the resident's call bell was active on the main RSCRS panel inside the the nursing office, and an audible alarm was sounding. They went to see what the resident needed and returned without having assisted the resident. They indicated they would get staff assistance, as the resident's continence care product needed to be changed.

The resident's plan of care specified what level of assistance they required, by how many staff, for transfers and for weight bearing assistance with dressing and toileting. For falls prevention, the resident required staff to remind them to use their call bell for assistance.

Failing to provide the resident with individualized personal care and responding to their call bell in a timely manner posed a falls risk to the resident.

Sources: Observations, a review of the resident's health care record and interviews with the resident and staff. [000725]

## WRITTEN NOTIFICATION: Bathing

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of

the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of their choice.

Rationale and Summary

During the course of the inspection, which spanned a period of three weeks, neither of the two bathtubs in the home were functional.

In one wing, the bathtub could not be filled with water. The residents who preferred a tub bath were seated in the bathtub, and the handheld shower head was used to wet and rinse them.

In the other wing, the bathtub hydraulics were not functional, and the bathtub was not used. It was noted that there was an accumulation of dust and debris in the bathtub.

A review of the home's bathing schedules showed that there were many residents who were scheduled to receive tub baths.

None of the residents in the home, with a preference for a tub bath, had their preference accommodated for a duration of at least three weeks.

Sources: Observations, interview with staff and review of the bathing schedules.
[551]

## WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #011 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.

The licensee has failed to ensure that a PSW used safe positioning techniques when assisting a resident.

Rationale and Summary

The resident was observed to be leaning to the side while seated in their wheelchair. While the resident was being assisted to eat their meal, the PSW repositioned the resident to a centered position using a technique that was not safe, and the resident verbalized pain by saying, ouch.

The PSW indicated that resident leaned to one side, and they required repositioning often.

The resident's plan of care did not provide direction related to their repositioning needs while in their wheelchair.

Failing to use safe positioning techniques caused the resident pain and the potential for injury.

Sources: Observations, review of the resident's health care record and interview with

a PSW. [000725]

## WRITTEN NOTIFICATION: Personal Items and Personal Aids

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and

The licensee has failed to ensure that a resident had their personal items labelled within 48 hours of acquiring them, in the case of new items.

Rationale and Summary

It was reported that the resident could not have personal items, as they were often taken and lost, including toothbrushes, toothpaste, hair brushes, deodorant, shampoo and their preferred body wash.

Unlabelled personal items were observed in the resident's bedroom. In the resident's shared washroom, two plastic containers contained various personal items, and a third plastic container with personal items belonged to a resident who did not live in that room and contained an unlabelled toothbrush. Additional plastic containers and unlabelled personal items were noted in the resident's washroom on a different day.

A PSW reported that the resident often lost their personal items, and they did not know which plastic container or personal items belonged the resident, as they were not labelled. The PSW indicated that residents' items were to be labelled with a marker. They did not know where to locate a permanent marker, as none was observed in their clean utility room.

An RPN indicated that nursing staff were expected to label residents' personal items with a marker, so they could be returned if located in another resident's room. The RPN stated that all of the unlabelled items in the plastic containers in the resident's washroom would have to be discarded.

The DOC indicated that all personal items for residents should be labelled with a black permanent marker, as per their policy.

Failing to label resident's personal items posed a risk for residents' personal items being used by other residents, with the potential impact for cross contamination and infection.

Sources: Observations and interviews with staff. [000725]

## WRITTEN NOTIFICATION: Bedtime and Rest Routines

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 45
Bedtime and rest routines
s. 45. Every licensee of a long-term care home shall ensure that each resident of the home has the resident's desired bedtime and rest routines supported and

individualized to promote comfort, rest and sleep.

The licensee has failed to ensure that a resident's desired bedtime and rest routines were supported and individualized to promote comfort, rest and sleep.

Rationale and Summary

It was reported that the resident's routines for getting up in the morning and going to bed in the evening were not consistent. The resident preferred not to get out of bed before 0700 to 0800 hours, and they preferred not to go to bed in evening before 1900 to 2000 hours.

A PSW indicated that, on that morning, the resident was up before they arrived for their day shift.

The resident's plan of care indicated their sleep routine preferences as preferring to get up at 0800 hours and preferring to go to bed at 2000 hours. This plan of care also indicated to get the resident up at 0600 hours.

As such, the home did not support or promote the resident's individualized preferences for desired bedtime and rest routines to promote comfort, rest and sleep.

Sources: Review of the resident's health care record and interviews with staff and others. [000725]

## WRITTEN NOTIFICATION: Skin and Wound Care

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated; and

The licensee has failed to ensure that a resident, who was dependent on staff for repositioning, was repositioned every two hours or more frequently as required.

Rationale and Summary

On two different days, the resident was observed to be seated leaning to the same side in their wheelchair, in the same position, for a period of almost three hours. Their position was changed slightly, after a period of almost three hours, when they were brought to the dining room at a mealtime and to take oral medication.

A PSW reported that the resident always leaned to the same side in their wheelchair, and they required repositioning often. A PSW stated that the resident did not have altered skin integrity or open areas.

The resident's care plan did not specify their repositioning needs while in the wheelchair. It provided direction to staff to ensure that the resident was not always in a tilt position.

Failing to reposition the resident, who was dependent on staff for repositioning in their wheelchair, posed a significant risk for the resident to experience discomfort, injury and skin breakdown.

Sources: Observation, review of the resident's health care record and interviews with staff. [000725]

## WRITTEN NOTIFICATION: Dining and Snack Service

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The licensee has failed to ensure that the process, to ensure that food service workers and other staff assisting residents were aware of the residents' diets, special needs and preferences, was complied with.

Rationale and Summary

The licensee used a food service software program, and a Meal Service Report listed each residents' diet. Food allergies or intolerances were on the list.

As per the Meal Service Report, two residents had a food intolerance.

The residents were observed eating foods that were contrary to their assessed need.

Failure to follow the Meal Service Report resulted in residents being served foods

that they had an intolerance to.

Sources: Observations and review of residents' health care records and the Meal service Report. [551]

## WRITTEN NOTIFICATION: Dining and Snack Service

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that the home's dining and snack service included, at a minimum, food and fluids being served at a temperature that was palatable to a resident.

Rationale and Summary

A resident was fed their texture modified meal by a PSW.

The PSW combined the resident's beverage to their texture modified meal and fed it to the resident.

Combining the resident's cold beverage with their hot meal may have affected the taste, temperature and palatability of the resident's meal.

Source: Observations. [551]

## WRITTEN NOTIFICATION: Dining and Snack Service

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 7.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
7. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

The licensee has failed to ensure that the home's dining and snack service included, at a minimum, course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

Rationale and Summary

1) A resident was fed their entree by a PSW in the dining room.

Dessert was provided while the resident was eating their entree.

The PSW fed the resident a bite of dessert then resumed feeding the entree.

The resident's plan of care was reviewed, and there was no indication that they were not to be served their meal course by course.

The Nutrition Manager stated that course by course service of meals for each resident was expected.

Sources: Observations, review of a resident's health care record and interview with the NM. [551]

2) A resident was served their soup. Before any of the soup was eaten, their entree was served, and a PSW sat to assist them to eat.

The resident did not attempt to eat on their own before the PSW sat with them. When the PSW began to assist the resident to eat their soup, it had been sitting on the table for 15 minutes.

The resident's plan of care was reviewed, and it indicated that the resident fed themself independently. It stated that smaller portions at once could be provided to facilitate intake. Smaller portions were not served at once in the context of an intervention to facilitate intake as the resident made no attempt to feed themself before the PSW sat to assist them.

Sources: Observations and review of the resident's health care record. [551]

3) A resident received their soup while they appeared to be sleeping.

They were served their entree and dessert before any soup was eaten.

The resident's plan of care was reviewed, and there was no indication that they were not to be served their meal course by course.

Sources: Observations and review of the resident's health care record. [551]

## WRITTEN NOTIFICATION: Dining and Snack Service

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee has failed to ensure that the home's dining and snack service included, at a minimum, proper techniques to assist residents with eating.

Rationale and Summary

PSWs fed residents their texture modified entrees and desserts from a standing position.

One resident coughed intermittently, and at the end of the meal, the cough was wet sounding.

An Activity Aide assisted a resident to eat from a standing position. Midway through the meal, the staff member pulled over a chair and sat to feed the resident.

The NM stated that staff should be seated when feeding residents at mealtime.

Sources: Observations and interview with the NM. [551]

## WRITTEN NOTIFICATION: Dining and Snack Service

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

Rationale and Summary

1) A resident's plan of care stated that they required extensive assistance to eat and drink with physical assistance.

The resident was served soup. Twelve minutes after the soup, which had not been eaten, their entree was served.

A staff member put the resident's fork on the plate and encouraged them to eat. A PSW cut the resident's entree into bite size pieces and encouraged them to eat. Several staff provided verbal cueing to eat as the resident appeared to be sleeping and had not taken any bites of the soup or entree.

Approximately 20 minutes after their soup was served, and eight minutes after their entree was served, the resident had not picked up a utensil to initiate eating and had not been provided with physical assistance to eat or drink. An RPN offered the resident soup followed by a bite of their entree, and the resident pushed their hand away.

For a twenty-minute period, physical assistance was not provided to the resident to eat or drink.

By serving the meal before someone was available to provide the assistance they required, it may have not been optimally palatable to the resident.

Sources: Observations and review of the resident's health care record. [551]

2) A resident was reliant on staff for assistance with eating and drinking.

The resident's meal was placed on the bedside table while the PSW delivered meals to other residents who were eating in their rooms, after which they returned to assist the resident.

By assisting the resident to eat 12 minutes after their meal was served, it may not have been optimally palatable to them.

Sources: Observations and review of the resident's health care record. [551]

3) A resident was served their soup. Before any of the soup was eaten, their entree was served, and a PSW sat to assist them to eat.

The resident did not attempt to eat on their own before the PSW sat with them. When the PSW began to assist the resident to eat their soup, it had been sitting on the table for 15 minutes.

By assisting the resident to eat soup, 15 minutes after it was served, it may not have been optimally palatable to them.

Source: Observations. [551]

## WRITTEN NOTIFICATION: Housekeeping

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (d)
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,
(d) addressing incidents of lingering offensive odours.

The licensee has failed to ensure that the organized program of housekeeping had procedures developed and implemented for addressing incidents of lingering offensive odours.

Rationale and Summary

Two residents' bed linens and mattresses had a strong persistent odour of urine. A seat cushion in a resident's room was covered with a towel, and the towel and seat cushion were wet in places and soiled.

A housekeeper stated that there was a schedule for deep cleaning residents' rooms. To address lingering odours of urine, they had an air freshener spray.

The policy and procedure regarding how the home addressed incidents of lingering offensive odours indicated that all reports of lingering offensive odours would be investigated . The Administrator and DOC were aware of these rooms with lingering

offensive odours and stated that one resident's room required a deep clean, and that it was a challenge for staff to enter the other resident's room as they were possessive of their space. No investigations into the lingering odours were completed.

Failing to follow the home's policy and procedure for dealing with lingering offensive odours posed potential infection risks to residents and did not deal with the root cause of the odours, including their continence issues. The use of an air freshener spray would not remove the actual urine noted in these areas and cleaning was required.

Sources: Observations, review of the policy titled Odours and interviews with the DOC and Administrator. [000725]

## WRITTEN NOTIFICATION: Laundry Service

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (c)
Laundry service
s. 95 (1) As part of the organized program of laundry services under clause 19 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and

The licensee has failed to ensure that, as part of the organized program of laundry services under clause 19 (1) (b) of the Act, linens were maintained free from stains.

Rationale and Summary

During the inspection, stained linens were observed on the fitted and top sheets on residents' beds. Multiple, large rings of discoloration were observed on linens in residents' rooms.

A Laundry Aide stated the home used to have a process to deal with stains, but this practice had been discontinued. They stated that visibly stained linens were to be discarded and not put back into circulation for resident use.

Residents' bed linens were not kept free from stains.

Sources: Observations and interview with a Laundry Aide. [551]

## WRITTEN NOTIFICATION: Hazardous Substances

NC #022 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.

The licensee has failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

Rationale and Summary

1) A jug of Excel Intervention was located in an unlocked cupboard in an activity room. Several days later, the IPAC Lead removed the jug and stated that it should not have been left there.

2) The roll-top hood on a housekeeping cart was fully open, and the cart was unattended in a dining room while staff were in a meeting in the other wing of the home.

A resident wandered into the dining room. Four bottles of cleaning products and an air freshening spray were in the unlocked housekeeping cart and were accessible to the resident.

On a different day, a Housekeeper stated that the roll-top hood on the housekeeping cart had to be kept closed and locked when unattended.

3) A housekeeping closet was unlocked and was not being supervised by staff. All cleaning products in the closet were accessible to residents.

4) A therapeutic room door was unlocked, and the room was not being supervised by staff. The room was being painted, and there was open paint on a cart. A resident was wandering near by.

Hazardous substances were not kept inaccessible to residents, and the exposure to or ingestion of a hazardous substance could have had serious repercussions on a resident.

Sources: Observations and interviews with staff. [551]

## WRITTEN NOTIFICATION: Infection Prevention and Control

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) standard, issued by the Director, was followed by PSWs related to hand hygiene (HH), as required by Routine Practices.

Rationale and Summary

1) A PSW was feeding a resident in the dining room. They went to assist a resident at the next table with their plate preparation and returned to resume feeding the resident. The PSW went to the servery counter and got a meal for another resident, cut-up the food, served it to the resident, and they then assisted a co-resident at the same table. No HH was performed by the PSW at any moment between these four residents.

2) A PSW cleared and scraped the plates for three residents, and they wiped their hands with a dry dinner style napkin. The PSW served desserts to residents at two tables. They then wiped their hands with a dinner style napkin.

The IPAC Lead indicated that all staff assisting residents with meals were required to perform HH between resident interactions, and that HH was required before and after all contact with residents or their environment such as tables, chairs, plates and cutlery during the meal. They demonstrated having portable bottles of hand sanitizer, wall sanitizer stations and a hand washing sink for staff use. The IPAC Lead stated that using dinner napkins was not considered appropriate HH as there was no cleaning solvent in the napkins.

The failure to perform HH as required by the four moments of hand hygiene could have increased the risk of infection transmission among residents and staff.

Sources: Observations and interview with the IPAC Lead. [000725]

## WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee has failed to ensure that medication incidents involving two residents were (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse

in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider.

Rationale and Summary

A resident reported that they had an allergy and only consented to receive the flu vaccine if the nurse confirmed that it did not contain the allergen. The resident stated that the nurse told them the allergen was not present in the flu vaccine and proceeded to administer their most recent flu vaccine.

An RPN indicated that if a resident had an allergy, it was the responsibility of the registered nursing staff administering the vaccine to verify any allergies before providing the vaccine.

The health care records of two residents were reviewed with the IPAC Lead. Both residents had a specific allergy listed, and both residents received the flu vaccine in 2023. The vaccines were administered by the home's registered nursing staff.

According to the manufacturers' instructions, the administration of the specific type of flu vaccine was contraindicated in anyone with a known, systemic hypersensitivity reaction after previous administration of any influenza vaccine or to any component of the vaccine (including the specific allergen).

Providing residents who had an allergy with a vaccine that contained the allergen posed a significant risk to these residents' health and well-being related to the potential for adverse and allergic reactions. These medication incidents had not been identified or documented in the home posing further risk to residents receiving vaccinations.

Sources: Review of resident health records, medication container and manufacture's instructions and interviews with a resident and the IPAC Lead. [000725]

## COMPLIANCE ORDER CO #001 Doors in a Home

NC #025 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

A) Develop and complete daily audits, including on weekends and holidays, and on different shifts, to ensure that all doors leading to non-residential areas are kept closed and locked (unless being directly supervised by staff).
B) Document the daily audits and ensure that any person conducting an audit signs and dates the audit document.
C) Take immediate corrective action if doors leading to non-residential areas are found to be unlocked and not directly supervised by staff, which is to include following up with staff who have responsibility to lock the door(s).

D) Complete the daily audits until such time that the Ministry of Long-Term Care has deemed that the licensee has complied with this order.
E) Keep a written record of A, B, C and D.

Grounds
The licensee has failed to ensure that all doors leading to non-residential areas were locked when they were not being supervised by staff.

Rationale and Summary

The following doors leading to non-residential areas were observed to be unlocked with no staff in the area supervising the doors:

1) The main kitchen was accessed through the dining rooms of each wing of the home. Each servery had a swing door that was equipped with a locking mechanism. Before leaving the kitchen, a Dietary Aide put a nourishment cart in the doorway of a servery, propping open the swing door.

For a period of time, while the kitchen was not supervised by staff, it was fully accessible through the servery doors. A steam table was on, and there was access to a commercial kitchen and its equipment, and slipping and tripping hazards.

The NM stated that the servery doors were never locked. They stated that there was a resident who entered the kitchen and would get water from the hot water dispenser, despite being asked not to, due to safety risks.

Residents' access to the kitchen, a non-residential area, was not restricted.

2) The door to a clean linen walk-in closet was not locked. In subsequent follow-up

observations, the door was consistently found to be unlocked and unsupervised by staff.

3) A staff washroom was not locked. The room was not equipped with a resident-staff communication and response system (RSCRS). Due to structural changes affecting the door, it could not physically be closed.

4) In the basement, which is a resident accessible area, by using the elevator, the staff room was not locked and was not being supervised by staff. The IPAC Lead's office was not locked and was not being supervised by staff. Neither room was equipped with a RSCRS.

5) A housekeeping closet was unlocked and was not being supervised by staff. Cleaning products were observed in the closet.

6) A nursing room was propped open with a garbage pail. The room was unattended. There were government stock items, including lactulose bottles, a puffer and multiple prescribed tubes of ointments and creams. IPAC Lead stated that the door should have been locked when unattended, and they locked the door. A short time later, the room was found to be unlocked, and it was unattended by staff. An RPN indicated that the door was locked, but the lock was not engaged as the door had not latched when it was closed.

7) A therapeutic room door was closed and unlocked, and the room was not being supervised by staff. The room was being painted, and there was open paint on a cart. There was a resident wandering near by.

Residents were at risk of gaining unsupervised access to high-risk non-residential areas.

Sources: Observations and interviews with staff. [551]

This order must be complied with by April 23, 2024

## COMPLIANCE ORDER CO #002 Home to be Safe, Secure Environment

NC #026 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall remove slide bolt latch locks on the outside of doors as identified in the grounds of this order.

A) Visually inspect all resident-accessible washroom doors to ensure that no resident could be locked or trapped in the washroom. This includes, but is not limited to, ensuring that there are no slide bolt latch locks on the outside of doors.
B) Immediately remove any locks found as part of A.
C) Continue to visually inspect all resident-accessible washroom doors until the licensee is satisfied that the components of parts A and B have been fully complied with.
D) Keep a written record of A, B and C.

Grounds

The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Rationale and Summary

Slide bolt latch locks were observed on the outside of the washroom doors in two resident rooms. The slide latch locks were positioned approximately three quarters from the top of the door frame.

One room was a semi-private that shared a washroom with another room. There was no slide latch lock on the washroom door in room next door.

One room was a basic room with a single washroom shared by two residents, and it was accessed by a single door.

PSWs stated that the locks had been put on the washroom doors, at the request of residents who had previously resided in the rooms. The locks had not been removed when the residents who had requested them no longer resided at the home.

The slide bolt latch on the outside of the residents' washroom doors presented the risk of a resident being locked or trapped in the washroom without the ability to release the lock from the inside.

Source: Observation and interviews with PSWs. [551]

This order must be complied with by April 16, 2024

## COMPLIANCE ORDER CO #003 Accommodation Services

NC #027 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 comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall remediate all areas of concern that have been identified within the grounds of this order.

A) Conduct a comprehensive audit of all areas in the home,
i) including but not limited to, all resident rooms and common areas,
ii) including all surfaces (i.e. walls, floors), fixtures (i.e. lights, sinks, toilets, windows), equipment and furnishings.
B) Identify any area of the home, furnishings and equipment that are not in a safe condition or good state of repair
C) Implement corrective actions to address and remediate the items identified by the licensee's comprehensive audit of the home, furnishings and equipment.
D) Keep a written record of A, B and C. Ensure that the audit document includes the name of the person(s) who conducted the audit(s), the audit date(s) and remediation dates.

Note: This compliance order does not supersede the requirements under O. Reg 246/22, s. 356.

Grounds

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

Rationale and Summary

Throughout the course of the inspection, multiple observations were made pertaining to the home, furnishings and equipment that were not maintained in a safe condition and in a good state of repair. The observations were prevalent throughout the home and included:

The flooring in the tub/washroom/shower rooms of both wings was in an unsafe condition and poor state of repair. The vinyl sheet flooring was nailed to the wall and was not flush and created spaces that could not be properly cleaned. Rips or tears in the flooring were covered with tape. There was a tear in a seam of the floor, exposing the wood underneath.

In the one wing, the floor was raised and buckling and spongy in areas. It was reported that the floor had been in this state of disrepair for about a year, and that there was no way to clean the perimeter, so dust and debris accumulated along the edges.

In the other wing, the flooring around the floor drain near the bathtub was bubbled and cracked. Brown matter was weeping from the cracked floor and had collected in the floor drain cap. A piece of rubber stripping, that ran along a metal transition plate, and the transition plate were not flush with the floor. Tiles were chipped.

The bathtubs in the south and west wings were not functional during the course of the inspection.

In one wing, the hydraulics of the bathtub did not function. There was a hole in the upper edge, at the foot of the bathtub, with jagged edges. The protective trim on the bathtub was separated from the tub in places. There was debris along the edge of the bathtub where the trim had separated.

In the other wing, the bathtub stoppers were missing, and the bathtub could not be filled with water. Residents who preferred a tub bath were seated in the tub chair in the bathtub, and the handheld shower head was used to wet and rinse them. The hose connected to the wall mounted cleaning product dispenser to disinfect the tub was discolored with a brown-coloured substance.

The window screens in one shower room and one tub room were soiled with debris. In one wing, the caulking between the window frame and edging was cracked, and in the other wing, the crank to open and close the window was missing.

A shower drain was blocked. The staff indicated that it had been this way for a matter of weeks. At least two residents' feet had rested in the pool of slow to drain and/or back flowing drain water and debris. The drain was unblocked on January 12, 2024.

A staff washroom door could not close or lock.

In resident rooms, there were spots of discoloration on the floor in the rooms and the ensuite washrooms.

In one resident room, in the washroom, a piece of stripping on the bracket for the shelf, between the toilet and sink, had separated, exposing the wood underneath. The flooring under the sink was buckled. There was brown colored debris on the floor, in the corners of the door frame and along the transition plate, in the

washroom. The bottom corner of the washroom door was worn, and the wood underneath was exposed. A hole had been cut to facilitate the piping for an air conditioning unit. The dry wall was crumbly and not flush with the wall.

In a resident room, there were cracks and scratches along the walls and door frames.

In a resident room, the doorway ramp into the shared bathroom was in significant disrepair. The residents who shared this bedroom indicated that the maintenance staff tried to fix the doorway edge by adding a small ramp, that was not secured to the floor, posing a significant tripping hazard, and it prevented the door from fully closing for privacy. Both residents indicated the doorway edge had been in disrepair for a number of months. A Maintenance Staff stated that they planned to fix it in the next day. Failing to ensure the residents had a safe doorway entering their shared bathroom posed significant risk to these residents for injury.

The home's ice machine was not functional. Ice for residents' beverages was not available. The lack of an ice machine in good repair meant that residents' preferences for iced beverages was not accommodated.

A resident's wheelchair headrest and therapeutic seat cushion were not kept in good repair. The resident's wheelchair headrest was turned away from the resident, and it was very loose. The resident was leaning significantly to one side in their wheelchair. It was reported that the resident's headrest had been in disrepair since a few days, and the resident always leaned to one side and required repositioning. It was reported that the resident's headrest required tightening regularly as it was in disrepair. The home's maintenance logbook was reviewed, and there was no indication that the resident's headrest was in disrepair. The resident's headrest was added to the maintenance book and repaired after it was brought it to the home's

attention by the inspector.

The resident's therapeutic seat cushion was deflated in the center. A PSW indicated they would have to ask evening staff to re-inflate it. Four days later, the resident's therapeutic seat cushion was deflated in the centre. An RPN stated they would ask a staff member to re-inflate it. Failing to maintain a resident's equipment and positioning aid in a good state of repair posed a significant risk to the resident for pain, discomfort and alteration in skin integrity.

The widespread nature of the observed non-compliance presented a risk to residents as their home furnishings and equipment were not maintained in a safe condition and in a good state of repair.

Sources: Observations, interviews with residents and staff and review of the maintenance book. [551] [000725]

This order must be complied with by October 31, 2024

## REVIEW/APPEAL INFORMATION

TAKE NOTICEThe 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

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

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.