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

Original Public Report

Report Issue Date: September 6, 2023

Inspection Number: 2023-1168-0004

Inspection Type:
Complaint
Critical Incident

Licensee: AXR Operating (National) LP, by its general partners

Long Term Care Home and City: Elmwood Place, London

Lead Inspector	**Inspector Digital Signature**
Julie Lampman (522)	Julie Lampman Digitally signed by Julie Lampman Date: 2023.09.11 08:51:00 -04'00'

Additional Inspector(s)
Cheryl McFadden (745)
Tatiana Pyper (733564)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 1, 2, 4, 8, 9, 10, 2023.
The inspection occurred offsite on the following date(s): August 3, 4, 8, 9, 10, 14, 2023.

The following intake(s) were inspected:

- Intake #00084801/Critical Incident (CI) #3054-000005-23 related to improper/incompetent treatment of a resident.
- Intake #00089340/CI #3054-000013-23 related to falls prevention and management.
- Intake #00093468/CI #3054-000022-23 related to a missing resident.
- Intake #00092460 Complainant related to resident care and neglect.
- Intake #00093507 Complainant related to resident neglect.
- Intake #00093544 Complainant related to resident neglect.

The following intake(s) were completed in this inspection:

Intake #00093533/CI #3054-000021-23; Intake #00090600/CI #3054-000017-23; Intake #00085626/CI #3054-000006-23; Intake #00087753/CI #3054-000012-23 related to falls prevention and management.

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

Falls Prevention and Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Medication Management
Reporting and Complaints
Resident Care and Support Services
Skin and Wound Prevention and Management
Staffing, Training and Care Standards

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 (4) (a)

The licensee has failed to ensure that staff involved in the different aspects of care of a resident collaborated with each other, in the assessment of the resident so that their skin and wound assessments were integrated and were consistent with and complemented each other.

Rationale and Summary
A resident had several areas of altered skin integrity. The resident's skin and wound assessments were not consistent. Although two areas of altered skin integrity had healed, the assessments indicated the areas of altered skin integrity were still present.

The Assistant Director of Care (ADOC) #110 reviewed the resident's skin and wound assessments and confirmed they were not consistent.

Sources:
A Critical Incident report, the resident's clinical record, the home's "New Skin Impairment/ New Wound Assessment" policy CARE12-O10.02 last reviewed March 31, 2023, the home's "Skin and Wound Re-Evaluation" policy CARE12-O10.07 last reviewed March 31, 2023, and interviews with ADOC #110 and other staff. [522]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the care provided to a resident was documented.

Rationale and Summary
A) A resident was ordered a supplement. The resident's electronic Medication Administration Record (eMAR) for a two month period, noted that the resident had received the supplement twice daily.

Review of the resident's Point of Care (POC) documentation noted the amount of the supplement the resident had consumed was not documented for 69% of the administrations.

B) POC Documentation indicated that the resident had a specific falls intervention in place for approximately two months. On a specific date, documentation was missing over the course of two shifts, and there were 19 other occasions where the intervention was not documented.

The Director of Care (DOC) confirmed the missing POC documentation for the resident. The DOC stated the registered staff were required to document the amount of supplement taken in POC and there had been issues with staff doing this.

Sources:
Review of the resident's clinical record and interview with the DOC. [522]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

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

Rationale and Summary
The home's "Resident Non-Abuse Program" policy stated if there was any allegation towards a staff member, they would be suspended with pay immediately until an investigation was completed. The

policy indicated the home's "Toolkit for Conducting an Alleged Abuse Investigation" would be used as a resource.

A) A resident's family had made a complaint to the home regarding care of the resident.

The home submitted a Critical Incident (CI) report which indicated that staff members would be interviewed and put off work pending the investigation.

The Resident Services Coordinator (RSC) stated the staff members had not been put off working pending the investigation and as per the home's policy the staff members should have been off work.

B) The home's "Resident Non-Abuse Toolkit for Conducting an Alleged Abuse and/or Neglect Investigation" stated that if an allegation of neglect was reported the incident and surrounding circumstances, including family member statements and the condition of the resident, must be documented in the resident's electronic health record.

There was no documentation of the complaint or assessment of the resident in the resident's clinical record.

The Director of Care (DOC) acknowledged that they had not put staff off pending an investigation and did not document the complaint in the resident's clinical record.

Sources:
Review of the CI report, the home's "Resident Non-Abuse Program" policy ADMIN1-P10-ENT last reviewed March 31, 2023, the home's Resident Non-Abuse Toolkit for Conducting an Alleged Abuse and/or Neglect Investigation dated December 2021, the staff schedule for March and April 2023, the resident's clinical records, and interviews with the accused staff members, the RSC and the DOC. [522]

WRITTEN NOTIFICATION: Training

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 1.

The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in abuse recognition and prevention, at the intervals provided for in the regulations.

Rationale and Summary
O. Reg 246/22 s. 261 (2) states the licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act annually.

The Resident Services Coordinator (RSC) stated that Registered Nurse (RN) #106 had not completed the annual retraining on abuse and neglect and PSW #105 had not completed the in person portion of the training.

Sources:
Review of a Critical Incident report and interview with the RSC. [522]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident, who was experiencing altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
A resident had several areas of altered skin integrity. The areas of altered skin integrity were not assessed on a weekly basis.

In separate interviews, both Wound Champion (WC) #107 and Assistant Director of Care (ADOC) #110 confirmed there were missing skin and wound assessments for the resident. WC #107 stated staff did not always complete the skin and wound assessments when the WC was off.

Sources:
Review of a Critical Incident report, the resident's clinical record, the home's "Skin and Wound Re-Evaluation" policy CARE12-O10.07 last reviewed March 31, 2023, and interviews with Wound Champion #107 and ADOC #110. [522]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (a)

The licensee has failed to ensure that a documented record was kept in the home that included the nature of a verbal complaint from a resident's family member.

Rationale and Summary
A Critical Incident (CI) report indicated that the Director of Care (DOC) received a verbal complaint from the resident's family member regarding the resident's care.

The home's "Management of Concerns, Complaints, Compliments and Requests" policy, noted that the home had a Complaint Management Program binder with a Concern, Complaint, Compliment & Requests Log. If a concern could not be resolved immediately, the individual who was first aware of the concern would initiate the Client Service Response (CSR) Form.

The home's 2023 complaints binder did not include a record of the complaint made by the resident's family member.

The (DOC) stated that they had received the complaint and initiated an investigation but did not complete a CSR form.

Sources:
Review of a CI report, the home's 2023 complaints binder, the home's "Management of Concerns, Complaints, Compliments and Requests" policy ADMIN3-O10.01 with a review date of March 31, 2021, and interviews with the DOC and other staff. [522]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)

The licensee has failed to ensure that a documented record was kept in the home that included the type of action taken to resolve the complaint related to the resident, including the date of the action, time frames for actions to be taken and any follow-up action required.

Rationale and Summary
The Critical Incident (CI) report indicated that a meeting would be set up with the resident's family to review all aspects of the resident's plan of care to ensure that all of the residents' needs were met. Once the care plan was developed all staff that worked with the resident would review the care plan and sign off that they had completed this.

There was no documented record that included the type of action taken to resolve the complaint from the resident's family member, including the date of the action, time frames for actions to be taken and any follow-up action required.

The Director of Care acknowledged that they had no documentation of the meeting with the resident's family or documentation that staff had reviewed and signed off on the resident's revised care plan.

Sources:
Review of a CI report, the home's 2023 complaints binder, the home's "Management of Concerns, Complaints, Compliments and Requests" policy ADMIN3-O10.01 with a review date of March 31, 2021, and interviews with the DOC and other staff. [522]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (d)

The licensee has failed to ensure that a documented record was kept in the home that included the final resolution of a complaint.

Rationale and Summary
There was no documented record that included the final resolution of the complaint from the resident's family member.

The DOC acknowledged that there was no documented record of the final resolution of the complaint.

Sources:
Review of the home's complaints binder, the home's "Management of Concerns, Complaints, Compliments and Requests" policy ADMIN3-O10.01 with a review date of March 31, 2021, and interviews with the DOC and other staff. [522]

WRITTEN NOTIFICATION: Reporting and complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)

The licensee has failed to ensure that a documented record was kept in the home that included every date on which any response was provided to the complainant and a description of the response.

Rationale and Summary
There was no documented record that included any response provided to the resident's family member and a description of the response.

The DOC acknowledged there was no documentation of the response provided to the resident's family member.

Sources:
Review of the home's 2023 complaints binder, the home's "Management of Concerns, Complaints, Compliments and Requests" policy ADMIN3-O10.01 with a review date of March 31, 2021, and interviews with the DOC and other staff. [522]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (f)

The licensee has failed to ensure that a documented record was kept in the home that included any response made in turn by the complainant.

Rationale and Summary
There was no documented record that included any response made by the resident's family member.

The DOC acknowledged there was no documented record of any response made by the resident's family member.

Sources:
Review of the home's 2023 complaints binder, the home's "Management of Concerns, Complaints, Compliments and Requests" policy ADMIN3-O10.01 with a review date of March 31, 2021, and interviews with the DOC and other staff. [522]

WRITTEN NOTIFICATION: REPORTING CRITICAL INCIDENTS

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 3.

The licensee has failed to ensure that an incident in which a resident was missing for three hours or more was reported immediately to the Director.

Rationale and Summary
A Critical Incident (CI) report was submitted to the Ministry of Long-Term Care (MLTC) related to a resident, who was missing for more than 3 hours. The home reported the resident was missing to the Director four days after the resident went missing.

The Director of Care (DOC) acknowledged that the incident should have been reported immediately to the Director.

There was potential risk to the resident when the home did not report them to be missing for three hours or more immediately.

Sources:
Review of a CI report, the resident's clinical records, and interview with the DOC. [733564]

WRITTEN NOTIFICATION: Training and Orientation Program

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 257 (1)

The licensee has failed to ensure that the training and orientation program for the home was implemented to provide the training required under section 82 of the Act.

Rationale and Summary
The Resident Services Coordinator (RSC) and the Director of Care (DOC) both confirmed that direct care staff had not completed annual retraining on falls prevention and management, skin and wound care, continence care and bowel management, pain management, minimizing of restraining and mental health issues.

Sources:
Review of Revera's National Annual Mandatory Overview dated January 2020, and interviews with the RSC and the DOC. [522]

COMPLIANCE ORDER CO #001 Duty to Protect

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

A) Complete specific care audits weekly for a resident until the order is complied. Ensure documentation including the dates, times and the outcome of the audits is kept on file.
B) Complete weekly skin and wound care assessment audits for a resident until the order is complied. Ensure documentation including the dates, times and the outcome of the audits is kept on file.
C) Complete a detailed multidisciplinary assessment for a resident within five business days from the inspection report being served. Develop a plan to ensure the resident is provided with the care they require.
D) Ensure communication strategies for a resident are developed to facilitate communication between the resident and direct care staff, so that the resident better understands the care being offered and provided to them.

Grounds
The licensee has failed to ensure that a resident was not neglected by the staff of the home.

Rationale and Summary
Ontario Regulations 246/22 states that “neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents

A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to care concerns for the resident.

The resident’s plan of care identified that they had responsive behaviours when care was provided. Review of the resident's care plan noted that staff were to reapproach the resident when they refused care. The resident’s progress notes indicated that on several occasions the resident had refused care, and no attempt to reapproach the resident at a later date was made by staff members of the home.

Review of the resident's Documentation Survey Report noted that resident specific care had not been provided on numerous occasions during a one month period.

Review of the resident's electronic Treatment Administration Record (eTAR) for the same month, noted required daily skin and wound care was not completed for most of the month and required weekly skin and wound assessments had not been completed for several areas of altered skin integrity.

The resident stated that they had difficulties communicating with staff and the resident's care plan noted specific interventions that were in place. The Director of Care (DOC) stated that the home was able to communicate with the resident at times, with the help of a specific staff member. Review of the resident's care plan noted that the home did not have a plan in place to effectively communicate with the resident when the specific staff member was not present.

The resident stated that they had ongoing concerns related to the lack of care that they received at the home. The resident stated that they refused care on occasion due to concerns they had that staff were completing their care correctly.

Physician #109 stated that their expectation was that when the resident refused care, that the staff were to reapproach the resident two or three times to provide care at a later time and document their attempts in the resident's electronic medical record.

The DOC acknowledged that resident specific care and skin and wound care and assessments for the resident were not completed as required during the specific month. The DOC acknowledged that there was no documentation in the resident's chart to support the staff had reapproached the resident when they refused care during the month.

There was actual risk to the resident when care and skin and wound assessments for were not completed for a month.

Sources:
Review of the resident's clinical records, and interviews with Physician #109 and the DOC. [733564]

This order must be complied with by October 4, 2023

COMPLIANCE ORDER CO #002 Required Programs

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must be compliant with O. Reg 246/22 s. 53 (1) 1.
Specifically, the licensee must ensure:

A) A resident has a head injury routine (HIR) completed as per policy, when it is required.
B) The resident's plan of care is updated to include current falls interventions in place for the resident.
C) The process for acquiring a mobility device for the resident is completed, as per Physiotherapist #113's recommendations.
D) All registered staff on a specific Home Area receive retraining on the home's HIR policy.
E) All direct care staff receive retraining on the home's Falls Prevention Program.
F) Training must be documented, including the name of the staff members who attended, the content of the training, and the date the training occurred.

Grounds
The licensee has failed to comply with the home's falls prevention and management policy related to head injuries, falls prevention, and injury reduction, included in the required falls prevention and management program in the home, for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure they were complied with.

Specifically, staff did not comply with the home's "Post Fall Management" policy CARE5-O10.05 with a review date of March 31, 2023; the home's "Head Injury Routine" policy CARE5-O10.06 with a review date March 31, 2023; and the home's "Fall Prevention and Injury Reduction Program" policy CARE5- P10 with a review of March 31, 2023.

Rationale and Summary
A) The home's "Post Fall Management" policy stated if a fall was un-witnessed or the resident was witnessed hitting their head during the fall, a head injury routine would be initiated.

The home's "Head Injury Routine" policy stated the nurse would complete the Neurological Flowsheet

(NF) as per the frequency indicated on the flowsheet or as determined by the Physician or regional requirement.

The NF stated checks were to be completed every 30 minutes for 2 hours, every 1 hour for 6 hours, every 4 hours for 8 hours, every 8 hours for 56 hours for a total of 72 hours.

A resident had numerous falls during a five month period. Review of the resident's NFs after unwitnessed falls, noted on one occasion there was no record of the NF. On several other occasions there was missing documentation on the NF and several times 'sleeping' was documented and the checks were not completed.

Registered Practical Nurse (RPN) #108 confirmed the missing documentation on the NFs. RPN #108 stated if a resident had been restless, they would let them sleep instead of waking them to complete the head injury routine.

Assistant Director of Care (ADOC) #110 stated that the NF should be completed at the required intervals, and staff should not enter sleeping or leave blanks.

Sources:
A Critical Incident report, the resident's clinical record, the home's "Post Fall Management" policy CARE5-O10.05 with a review date of March 31, 2023, the home's "Head Injury Routine" policy CARE5-O10.06 with a review of March 31, 2023, and interviews with RPN #108 and ADOC #110.

B) The home's "Fall Prevention and Injury Reduction Program" policy indicated that a falling feather logo was used for residents at risk of falls.

The resident was assessed as a high risk for falls. Observation of the resident's room noted there was no feather logo posted at the resident's bedside.

PSW #111 and RPN #108 both stated that there was no feather logo at the resident's bedside and that there should be due to the resident's risk of falls.

Sources:
Observations of the resident, review of the home's "Fall Prevention and Injury Reduction Program" policy CARE5- P10 with a review of March 31, 2023, and interviews with PSW #111, RPN #108 and other staff.

C) The home's Post Fall Management policy stated after a fall, the resident's most recent Fall Risk

Assessment was to be reviewed immediately to determine any change in resident risk and action was to be taken accordingly. This might include further assessment, referrals, immediate implementation of fall prevention and injury reduction strategies, team communication and collaboration and updating of the resident's individualized plan of care.

i) The resident had several falls interventions implemented post fall. The resident's care plan did not indicate the falls interventions that had been put in place for the resident.

ADOC #110 acknowledged the resident's care plan was not up to date and stated registered staff were responsible to update the resident's care plan with new falls interventions.

ii) After an unwitnessed fall, the resident's post fall assessment indicated that the resident needed a specific intervention put in place. There was no documentation in the resident's care plan that they used the intervention or that intervention had been trialed for the resident.

PSW #111 and RPN #108 both stated the resident did not use the intervention and that it had never been trialed for the resident.

ADOC #110 stated the intervention should have been initiated for the resident and if staff did not know where to get the specific intervention, they could have contacted the ADOC or DOC.

iii) The resident had numerous falls during a five month period. A Physiotherapist (PT) referral was not made until after the resident had a fall with injury. PT #113 had assessed the resident and documented that the resident needed a specific mobility device.

Observations of the resident noted the resident did not use the specific mobility device. This was confirmed by PSW #111 and RPN #108.

PT #113 confirmed a referral had been sent after the resident had a fall with injury. PT #113 stated they had stated the resident needed a specific mobility device and were unaware the resident had not received the mobility device. PT #113 stated they were not aware of the process and thought once they documented their referral response that registered staff reviewed their notes and would initiate the process for the resident to receive the mobility device.

Assistant Director of Care (ADOC) #110 stated a PT referral should have been made sooner for the resident due to their number of falls and the PT should have communicated with the Occupational Therapist regarding the mobility device for the resident.

Sources:
Observations of the resident, review of the resident's clinical record, the home's "Post Fall Management" policy CARE5-O10.05 with a review date of March 31, 2023, and interviews with PSW #111, RPN #108, PT #113, ADOC #110 and other staff.

There was actual risk to the resident as their plan of care was not up to date, and recommended falls interventions had not been put into place. Staff not completing the required neurological checks placed the resident at risk as staff had the potential to miss post fall injuries. [522]

This order must be complied with by October 16, 2023

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.