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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: May 17, 2024	
Inspection Number: 2024-1071-0001	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Oshawa, Oshawa	
Lead Inspector Najat Mahmoud (741773)	**Inspector Digital Signature**
Additional Inspector(s) Chantal Lafreniere (194) Patricia Mata (571) Rita Lajoie (741754)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 8 to 12, 15 to 19 and 22 to 25, 2024

The following intake(s) were inspected:

· Intakes for a Compliance Order under O. Reg 246/ 22, s. 140 (2) related to medication administration, Compliance Due Date (CDD) Nov 3, 2023, and O. Reg. 246/22, s. 23 (4) (b), related to temperature. (CDD) Feb. 28, 2024.
· Critical Incident Report (CI) intake related to unlawful conduct that resulted in harm/risk of harm to a resident.

- Five CI intakes related to prevention of abuse and neglect.
- A complaint related to housekeeping, and resident bill of rights.
- A complaint related to resident care.
- A complaint related to resident care, food production, prevention of abuse and neglect, and the residents' bill of rights.
- A complaint from related to infection prevention and control, and prevention of abuse and neglect.
- A complaint related to resident prevention of abuse and neglect, and resident care.

Note: Non-compliances related to FLTCA, 2021, s. 24(1), s. 28(1)2, O. Reg 246/22 s. 138(1)(a)(ii), s. 140(2), were identified in this inspection and have been issued in a concurrent inspection #2024-1071-0002.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1071-0003 related to O. Reg. 246/22, s. 140 (2) inspected by Najat Mahmoud (741773)

Order #001 from Inspection #2023-1071-0005 related to O. Reg. 246/22, s. 23 (4) (b) inspected by Najat Mahmoud (741773)

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

Continence Care
Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management

Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Reporting and Complaints
Falls Prevention and Management

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) (b)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure the physiotherapy staff collaborated with each other in the implementation of resident #010's plan of care related to physiotherapy.

Summary and Rationale

A complaint was received by the licensee. The Substitute Decision Maker (SDM) of resident #010 indicated the resident was not receiving physiotherapy services.

In December 2023, former Physiotherapist (PT) #136 documented that resident

#010 was to receive exercises and ambulation training three times per week to prevent a decline in physical abilities.

The Director of Care (DOC) indicated that the investigation revealed the resident had not been receiving physiotherapy as per the resident's plan of care for approximately six weeks. Physiotherapy Assistant (PTA) #142 was no longer able to provide consistent physiotherapy to the resident. The PTA did not communicate to the PT, or the other PTA who provided physio services that a change in assignment would be beneficial to ensure resident #010 received their physiotherapy as per their plan of care. Resident #010's physical abilities did deteriorate during that time.

By failing to ensure physiotherapy staff collaborated with each other, resident #010 was put at risk of physical deterioration.

Sources: CI, resident #010's clinical health records, interview with DOC, review of licensee investigation. [571]

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.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee failed to ensure that when the provision of physiotherapy services to resident #010 was not provided, documentation was done to indicate this.

Summary and Rationale

A complaint was received by the licensee. The SDM of resident #010 indicated the resident was not receiving physiotherapy services.

A review of the physiotherapy daily attendance records indicated that over an approximately six-week period, resident #010 received 15 minutes of therapy on approximately 16 occasions.

The DOC indicated through their investigation, they discovered resident #010 was not receiving the physiotherapy and documentation that the resident was receiving physiotherapy services was falsified.

By failing to ensure the PTA and PT documented the resident was not receiving physiotherapy as per their plan of care, the resident was put at risk for physical deterioration.

Sources: CI, resident #010's clinical health records, interview with DOC, review of licensee investigation. [571]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(b) appropriate action is taken in response to every such incident; and

The licensee has failed to take appropriate action in response to verbal and emotional abuse of a resident by staff.

Rationale and Summary

A review of resident #005's progress notes indicated that a Registered Practical Nurse (RPN) witnessed and documented an incident of Personal Support Worker (PSW) to resident verbal and emotional abuse. The incident was not reported to the Director but was identified by the Inspector following inspection of a CI with a related concern.

A review of the licensee's investigation file indicated the resident reported the allegation of verbal and emotional abuse to a staff member.

The incident was not reported, investigated, or acted upon until approximately seven weeks later when the matter was brought to the attention of the licensee by the Inspector.

The Administrator acknowledged the allegation of verbal and emotional abuse should have been immediately reported. The PSW continued to provide care to the resident for approximately seven weeks before action was taken. In addition, the PSW did not receive re-education as assigned by the licensee regarding Resident Rights, Zero Tolerance and power imbalance after the investigation was concluded as the licensee.

Failure to take immediate action and follow through with the re-education of PSW #114 could put other residents for whom they provide care at risk of verbal or emotional abuse.

Sources: CI, LTC home's internal investigation notes, resident #005's progress notes, PSW #114's education file, interviews with Administrator and PSW #114. [741754]

WRITTEN NOTIFICATION: Screening Measures

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 81 (2)

Screening measures

s. 81 (2) The screening measures shall include police record checks, unless the person being screened is under 18 years of age.

The licensee failed to ensure that housekeeping staff member (HS) #135 provided a police record check upon hiring.

Rationale and Summary

The licensee submitted a CI report to the Director related to unlawful conduct that resulted in harm / risk of harm to resident. HS #135 gave resident #004 a THC gummy.

A review of HS #135's personnel file demonstrated that an offer of employment was made. There were two written requests submitted to HS #135 to provide Police Record Check with vulnerable sector check. A review of the file indicated that there was no Police Record Check with vulnerable sector check provided by the employee.

In an interview the Administrator confirmed to Inspector #194 that HS #135 did not have a Police Record Check in their personnel file.

Failure to obtain a Police Record Check for HS #135 put the residents' safety at increased risk.

Sources: Interview with administrator, review of CI, the licensee's internal investigation notes, personnel file. [741754]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #005 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 failed to ensure that safe transferring techniques were utilized when resident #011 was transferred using a mechanical lift.

Rationale and Summary:

A complaint was received by the Director related to an injury that the resident acquired during a transfer with a mechanical lift.

PSW #132, and RPN#124 confirmed that the resident acquired the injury when the lift was lowered too low.

Failure to use safe techniques when transferring resident #011 resulted in injury.

Sources: Resident #011's clinical records, Risk Management, Interviews with PSW #132, and RPN #124 [741773]

WRITTEN NOTIFICATION: Skin And Wound Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee failed to ensure that resident #011 received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection as required.

Rationale and Summary:

A complaint was received by the Director related to a wound that the resident acquired.

Resident #011's clinical records indicated that there were no treatment orders entered into the residents Treatment Administration Record (TAR) until 15 days after the injury. Clinical records also indicated that RPN #124 applied a dressing to the resident's wound. The licensee's Skin and Wound program was reviewed and the dressing that RPN #124 applied was incorrect for the assessed injury.

The Skin Wellness Associate Nurse (SWAN) RPN #125 indicated that an incorrect dressing was used. SWAN RPN #125 and Assistant Director of Care (ADOC) #106 indicated that utilizing the incorrect dressing could cause a delay with wound healing.

RPN #124 and ADOC #106 also indicated that the TAR should have been updated immediately to reflect the treatment for the resident's wound. ADOC #106 further indicated that the TAR alerts the registered staff on which supplies were required to treat the residents wound.

Failure to update the TAR, and utilize the licensee's guidelines to treat resident #011's wound, placed the resident at risk and did not provide for effective skin and wound care interventions to promote healing.

Sources: Resident #011's clinical records, Risk Management, The licensee's Skin and Wound Program, Interviews with RPN #124, SWAN RPN #125 and ADOC #106 [741773]

WRITTEN NOTIFICATION: Skin and Wound

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee failed to ensure that resident #011 was reassessed at least weekly by a member of the registered staff

Rationale and Summary:

A complaint was received by the Director related to a wound that resident #011

acquired.

Clinical records indicated that there were no assessments for resident #011 on three separate dates. SWAN RPN #125 and ADOC #106 confirmed that the expectation was that the registered staff assessed the resident's wound weekly using the Weekly Impaired Skin Integrity Assessment. This would have assisted with determining if the wound was healing or deteriorating.

Failure to complete weekly assessments placed the resident at risk for further deterioration of their skin tear.

Sources: Resident #011's clinical records, Risk Management, The Licensee's Skin and Wound Program, Interviews with RPN #124, SWAN RPN #125 and ADOC #106 [741773]

WRITTEN NOTIFICATION: Continence care and bowel management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (1) 4.
Continence care and bowel management
s. 56 (1) The continence care and bowel management program must, at a minimum, provide for the following:
4. Strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids.

The licensee failed to ensure that strategies were used to maximize the resident's comfort and dignity, including supplies.

Summary and Rationale

A CI report was submitted to the Director after a PSW used a product not intended for continence care while providing care to resident #013.

Another CI was submitted when the incident occurred a second time.

ADOC #106 and the DOC indicated that using the product did not promote dignity and put the resident at risk of skin deterioration. Furthermore, the DOC indicated there are appropriate products for the staff to use.

Failing to ensure that products designed for continence care were used, did not promote the residents' comfort and dignity.

Sources: Two CI reports, the licensee's internal investigation documents, Interviews with ADOC #106, and the DOC. [741773]

WRITTEN NOTIFICATION: Therapy Services

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 65 (a)
Therapy services
s. 65. Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 13 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and

The licensee failed to ensure that on-site physiotherapy services was provided to resident #010 based on the resident's assessed needs.

Summary and Rationale

A complaint was received by the licensee. The SDM of resident #010 indicated the resident was not receiving physiotherapy services.

Former Physiotherapist (PT) #136 documented that resident #010 was to receive physiotherapy three times per week to prevent physical decline.

The DOC indicated that their investigation revealed the resident had not been receiving physiotherapy for approximately six weeks as per their plan of care.

By failing to ensure resident #010 received physiotherapy services as per the plan of care, the resident was put at risk of physical deterioration.

Sources: CI, resident #010's clinical health records, interview with DOC, review of licensee investigation. [571]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 2.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the

circumstances.

The licensee failed to provide an acknowledgement of receipt of a complaint including the date by which the complainant can reasonably expect a resolution and a follow-up response that complies with paragraph 3, for complaints that cannot be investigated and resolved within 10 business days.

Rationale and Summary:

A complaint was received by the Director. The complaint was related to resident care and dining experience which the complainant felt were unsatisfactorily addressed by the licensee. The complaints which were shared with the management team, were then escalated to the Regional Director.

The complainant later reached out to the Regional Director as they had not received a response. A formal response was not provided to the complainant until approximately five weeks after the Regional Director received the complaint,

The DOC indicated that not all of the complainant's concerns were resolved immediately and indicated that the licensee's process is to acknowledge all complaints that cannot be addressed within 24 hours with a formal written response.

Failure to provide the complainant with an acknowledgement of receipt of their complaint including the date by which the complainant can reasonably expect a resolution and a follow-up response caused a delay in addressing their complaints.

Sources: Email correspondences, CIR, Internal Complaints Investigation Forms, interview with the DOC. [741773]

COMPLIANCE ORDER CO #001 Reporting certain matters to Director

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

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

The licensee shall:

1) The Director of Care shall provide re-education to RPN #124, and ADOC #106 on reporting requirements and legislative timelines.

2) The DOC shall review the Risk Management System and report to the Director any improper or incompetent treatment or care of a resident. The DOC shall document once a week, for a period of four weeks, that a review of the Risk Management System was completed and if any reports were made to the Director.

3) Completed audits and training records shall be kept and provided to inspector immediately upon request.

Grounds

The licensee failed to ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident has occurred shall immediately report the suspicion and the information upon which it is based to the Director.

Summary and Rationale

1. A CI was submitted to the Director to report an allegation of improper or incompetent treatment or care of a resident that resulted in a risk of harm. The incident was reported to ADOC #106 alleging that a PSW used a product not intended for continence care when providing care to resident #013.

ADOC #106 and the DOC indicated that the improper care or treatment of the resident did not promote dignity for the resident and could cause skin breakdown. The ADOC #106 and the DOC indicated that the incident was never reported to the Director.

Failing to ensure that the allegation of improper resident care or treatment was immediately reported increased the risk of further incidences.

Sources: CI, the licensee's internal investigation documents, Interviews with ADOC #106, and the DOC. [741773]

Summary and Rationale

2. A complaint was submitted to the Director regarding a wound that resident #011 sustained.

Resident #011's clinical records indicated the resident sustained a wound during a

transfer using a mechanical lift. RPN #124 documented the incident and indicated that the incident was due to improper care of the resident. Witness statement by PSW #132 indicated that the lift was lowered too low when the sling was applied which resulted in a wound.

RPN #124, RPN #125, ADOC #106 and the DOC indicated that the incident should have been reported to the Director as a critical incident since the resident was harmed as a result of the improper care.

Failing to ensure that the allegation of improper resident care or treatment was immediately reported increased the risk of further incidences.

Sources: Resident #011's clinical records, Risk Management, Interviews with staff, ADOC #106, and the DOC. [741773]

This order must be complied with by June 26, 2024

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) The IPAC lead or designate shall develop and implement a written procedure specific to resident hand hygiene during nourishment.
2) The IPAC lead or designate shall complete audits during nourishment. The audits shall be completed once a week (weekends included) for a period of four weeks on the third floor. Completed audits shall include the name of who is completing the audit, date, time, the unit, the resident name, and the name of the staff supporting the resident with hand hygiene. Corrective action taken when noncompliance is identified will be documented on the audits.
3) The IPAC Lead will prepare and implement a written plan to ensure that hand sanitizers in the LTCH are not expired.
4) The IPAC lead or designate shall complete audits of the ABHR twice a week (weekends included) for a period of four weeks in various locations. Completed audits shall include the date of the audit, location, expiration dates and the name of the auditor. Corrective action taken when ABHR is expired, is to be documented with a follow up audit to be completed if the ABHR is not replaced within 24 hours.
5) Completed audits and training records shall be kept and provided to inspector immediately upon request.

Grounds

1. Non-compliance with: O. Reg. 246/22 s. 102 (2) (b), IPAC Standard section 10.4. (h)

The licensee has failed to ensure that a standard issued by the Director with respect to IPAC was implemented.

Rationale and Summary:

In accordance with the Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, dated April 2022 (IPAC Standard), section 10.4 states, the

licensee shall ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as: h) Support for residents to perform hand hygiene prior to receiving meals and snacks.

A PSW was observed providing afternoon nourishment without performing hand hygiene for the residents.

Two PSW's indicated that the residents should have had their hands sanitized prior to receiving their nourishment, to prevent transmission of infectious disease.

Interviews with IPAC Lead and the DOC indicated the expectation of staff when providing nourishment was to support the residents with sanitizing their hands.

Failing to ensure that the residents were supported with hand hygiene prior to receiving nourishment increased the risk of transmission of infections.

Sources: Observations, interviews with PSW #122, RPN #123, IPAC Lead and the DOC [741773]

2. Non-compliance with: O. Reg. 246/22 s. 102 (2) (b), IPAC Standard section 10.1. The hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

The Licensee failed to ensure that the Alcohol Based Hand Rub (ABHR) in the home were not expired.

Rationale and Summary

During the inspection, the Long-Term Care Home was experiencing a Parainfluenza respiratory outbreak on the second floor.

Inspector #194 conducted a tour of the home and observed six resident rooms, a stairwell, a hallway, an area near the nursing station and an activity lounge with expired ABHR.

The IPAC lead and the DOC acknowledged that the ABHR was expired and indicated that utilizing ABHR that was expired increased the risk of transmission of infection.

Failing to ensure that the home provided ABHR that was 70-90% at the point of care, increased the residents risk of infection during the outbreak at the home.

Sources: Observations, interviews with IPAC Lead and the DOC [741773]

This order must be complied with by June 26, 2024

REVIEW/APPEAL INFORMATION

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

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

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

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

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

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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