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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: October 12, 2023
Original Report Issue Date: September 27, 2023
Inspection Number: 2023-1498-0002 (A1)
Inspection Type: Complaint Critical Incident
Licensee: Royal Canadian Legion District 'D' Care Centres
Long Term Care Home and City: Tony Stacey Centre for Veterans' Care,Toronto

Amended By	**Inspector who Amended Digital Signature**
Reethamol Sebastian (741747)	Reethamol Sebastian Digitally signed by Reethamol Sebastian Date: 2023.10.13 15:59:26 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

The Compliance Due Date (CDD) for Compliance Order (CO) #001, CO #002, and CO #003 was changed from November 8, 2023, to November 27, 2023, as per the licensee's request and providing clarity to part 5) of CO #003.

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Lead Inspector Reethamol Sebastian (741747)	**Additional Inspector(s)** Rexel Cacayurin (741749) Ana Best (741722)
Amended By Reethamol Sebastian (741747)	**Inspector who Amended Digital Signature** Reethamol Sebastian Digitally signed by Reethamol Sebastian Date: 2023.10.13 15:59:48 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

The Compliance Due Date (CDD) for Compliance Order (CO) #001, CO #002, and CO #003 was changed from November 8, 2023, to November 27, 2023, as per the licensee's request and providing clarity to part 5) of CO #003.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 15-18, 21-25, 28-29, 2023.

The following intake(s) were inspected:

• An intake related to a complaint from the coroner related to concerns with skin and wound care prior to death and neglect.
• An intake related to a complaint from the Patient Ombudsman related to concerns with skin and wound care resulting in death.
• An intake related to a complaint from family related to staff to resident neglect and concern with pain management, skin, and wound.

- Three intakes related to staff to resident neglect.
- An intake related to late reporting of a resident's medication administration related to a medical condition

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

Skin and Wound Prevention and Management
Medication Management
Prevention of Abuse and Neglect
Palliative Care
Reporting and Complaints
Pain Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Dealing with complaints

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

1. The licensee has failed to ensure that a response was made to the complainants within 10 business days of the written complaints regarding a resident's skin and wound care management.

Rationale and Summary

A written complaint was submitted to the Long-Term Care Home (LTCH) via email to the previous Director of Care (DOC). The Acting DOC, Acting Administrator, and the Critical Incident Report (CIR) all indicated that the previous DOC's email address was no longer in use. A copy of the original written complaint was delivered to the home via mail. A second written letter was received at the home, both written complaints were regarding concerns with the resident's skin and wound care management.

The licensee's complaints procedure policy directed that a written response to the complaint shall be provided within 10 business days of the receipt of the complaint. The Acting DOC and Acting Administrator confirmed that they did not respond to both written complaints within the required 10 business days.

There was no risk to the resident at the time of the written complaint as the family submitted the complaint after the resident had passed away.

Sources: CIRs, Complaints procedure policy, and interviews with Acting Administrator and Acting DOC.

[741747]

2. The licensee has failed to ensure that a response was made to the complainant within 10 business days of the written complaint regarding a resident's pain and palliative management.

Rationale and Summary

A written complaint was submitted to the LTCH and was received regarding concerns with the resident's pain and palliative care management.

The licensee's complaints procedure policy directed that a written response to the complaint shall be provided within 10 business days of the receipt of the complaint. The Acting DOC and Acting Administrator confirmed that they did not respond to the complaint within the required 10 business days.

There was no risk to the resident at the time of the written complaint as the family submitted the complaint after the resident had passed away.

Sources: CIRs, Complaints procedure policy, and interviews with the Acting Administrator and Acting DOC.

[741747]

WRITTEN NOTIFICATION: General requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.

The licensee has failed to ensure that a written record was kept of the date of the evaluation, names of persons who participated, and a summary of the dates the changes were made and implemented regarding the evaluation of the skin and wound care program.

Rationale and Summary

The licensee's skin care program and wound management policy directed that evaluation of the program and stats shall be performed at least quarterly. The Acting DOC confirmed that the annual skin and wound care program evaluation for the year 2022 was incomplete as such, the licensee was unable to provide a written record of the evaluation.

There was a risk of harm to the residents when the skin and wound care program was not evaluated to determine if wound care standards were being met in accordance with current evidence-based practices.

Sources: Skin Care Program Wound Management Policy, Skin and Wound Care Program Evaluation, version March 2022, and an interview with Acting DOC.

[741747]

WRITTEN NOTIFICATION: Pain management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.

1. The licensee has failed to ensure that they complied with the communication and pain assessment methods for a resident who had cognitive impairment and required skin and wound care.

Rationale and Summary

A complaint was submitted to the Director related to concerns that a resident's pain was not managed properly when they required wound care.

In accordance with O. Reg. 246/22, s. 11 (1)(b), the licensee was required to ensure the pain management program, at a minimum, provided communication and assessment methods for residents who are unable to communicate their pain or who was cognitively impaired, and must be complied with.

Specifically, the registered staff did not comply with the licensee's pain management policy when the clinically appropriate instrument for pain assessment was not completed to determine if the resident was experiencing nonverbal cues of discomfort, especially when interacting with the resident who was cognitively impaired.

The resident returned from the hospital with a change in health status and required wound care. The resident was not able to communicate if they were experiencing pain due to cognitive impairment.

The physician communication log indicated the request for pain medication for the resident as they always complained of pain in the extremity and the Most Responsible Physician (MRP) ordered pain medication.

The resident’s clinical records indicated their cognitive performance scale (CPS) was identified as three (a moderate impairment). There were no documented records of the pain assessment being completed

since the resident's return from the hospital with a change in health status due to an altered skin integrity.

The Acting DOC acknowledged the resident's pain was not assessed using the clinically appropriate assessment tool, and the staff failed to follow the Pain Management policy when the resident had a change in health status and complained of pain.

By failing to ensure the internal policy entitled "Pain Management Program Policy" was complied with, the resident was placed at risk of experiencing uncontrolled pain.

Sources: A resident's progress notes, pain assessments, Medication Administration Records (MAR), Digital Prescriber's Orders, Minimum Data Set (MDS) Resident Assessment Protocols (RAP) Summary, Pain Management Policy, and interviews with registered staff, MRP and Acting DOC.

[741747]

2. The licensee has failed to ensure that they complied with the communication and pain assessment methods for a resident who had a cognitive impairment and required palliative care due to a decline in health status.

Rationale and Summary

A complaint was submitted to the Director related to concerns that a resident's pain was not managed properly when they required palliative care.

In accordance with O. Reg. 246/22, s. 11 (1)(b), the licensee was required to ensure the pain management program, at a minimum, provided communication and assessment methods for residents who are unable to communicate their pain or who was cognitively impaired, and must be complied with.

Specifically, the registered staff did not comply with the licensee's pain management policy when the clinically appropriate instrument for pain assessment was not completed to determine if the resident was experiencing nonverbal cues of discomfort, especially when interacting with the resident who was cognitively impaired.

After the resident returned home from the hospital, with a decline in health status, the resident was not provided nor assessed with the pain assessment tool until their family member expressed concerns about their pain. Two days had passed until the resident received an appropriate pain assessment and interventions were then ordered to relieve their pain. The Acting DOC acknowledged the resident's pain was not assessed using the clinically appropriate instrument for pain and the staff failed to follow the Pain Management policy when the resident had a change in health status.

By failing to ensure the internal policy titled “Pain Management Program Policy” was complied with, the resident was placed at risk of experiencing uncontrolled pain.

Sources: A resident’s progress notes, pain assessments, Palliative Care Assessment, MAR, Treatment Administration Records (TAR), Digital Prescriber’s Orders, MDS RAP Summary, Palliative Care Program Policy, interviews with registered staff, and Acting DOC.

[741747]

WRITTEN NOTIFICATION: Palliative care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 61 (3)

The licensee has failed to ensure that the resident’s substitute decision-maker was provided with an explanation of the palliative care options that were available based on the assessment of the resident’s palliative care needs.

Rationale and Summary

A complaint was submitted to the Director related to concerns with a resident's palliative care.

The licensee’s palliative care program policy indicated that " The interprofessional team will initiate goals of care discussions with the resident, the resident's SDM(s) and anyone else whom the resident, when capable, requests to be involved in the discussion, where the resident has been identified as having a life-limiting illness (i.e., imminent death within 12 months or less). These valued-based discussions focus on ensuring an accurate understanding of the illness, its progression, and treatment options so that the resident or incapable resident's SDM has the information they need to give or refuse consent as the resident transitions through the end-of-life process.".

The Palliative Care Assessment was the instrument used to assess the resident's current health status, and symptom management on admission and with changes in their condition.
The resident was readmitted to LTCH from the hospital with a comfort approach due to a decline in health condition.

The resident’s family requested pain medication and the MRP ordered pain medication. The clinical record identified that the resident was not assessed for palliative care when identified to be palliative. A registered staff and the Acting DOC confirmed that the Palliative Care Assessment was not completed on the resident’s readmission. The SDM/ family did not get a chance to discuss the care needs with the interdisciplinary team regarding their physical and emotional needs, despite the changes to their treatment plan.

A Palliative care assessment was done by registered staff after four days and the resident passed away at LTCH due to a decline in their health.

Failure to involve the resident's substitute decision-maker and family with an explanation of the palliative care options that were available delayed the delivery of palliative care needs to the resident in a timely manner.

Sources: A resident's progress notes, Palliative Care Assessment, MAR, TAR, Digital Prescriber's Orders, MDS RAP Summary, Palliative Care Program Policy, and interviews with registered staff, MRP, and Acting DOC.

[741747]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 7.

The licensee failed to ensure that the Director was informed of an incident in the home of severe hypoglycemia or unresponsive hypoglycemia in respect of which the resident was taken to hospital, for no later than one business day after the occurrence of the incident.

Rationale and Summary

A CIR was submitted to the Director related to severe hypoglycemia resulted in a resident being taken to a hospital.

In a progress note by a registered staff, the resident's blood sugar was low, was unresponsive, and was sent to the hospital.

The Acting DOC indicated that the home's expectation was to report the incident of severe hypoglycemia to the Director immediately after the resident was sent to the hospital. Further, they acknowledged that the critical incident was reported late.

Failure to report the incident of severe hypoglycemia to the Director posed a low risk to the resident.

Sources: CIR, resident's progress notes, Interview with Acting DOC.

[741749]

WRITTEN NOTIFICATION: Medication management system

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee failed to ensure the written policies and protocols for the medication management system were implemented.

Rationale and Summary

A CIR was submitted to the Director related to an incident resulting in a resident being taken to a hospital.

The LTCH policy indicated that registered staff are responsible for logging all medication use from the emergency drug box and for reordering medication used from the box.

In a progress note by registered staff, the resident's blood test was low, was unresponsive, unable to swallow, and sent to the hospital. Furthermore, they indicated that there was no supply of the emergency medication in the emergency drug box at the time of the incident, hence, it was not given to the resident. They also acknowledged that they did not reorder the emergency medication at that time and that they were responsible for reordering.

The registered staff shared the resident had the same incident on a specific date and there was no emergency medication available at the time.

The home was unable to provide records indicating they had reordered the emergency medication.

The Acting DOC and clinical pharmacist acknowledged that registered staff were responsible for reordering expired and missing medications in the emergency drug box. In addition, the clinical pharmacist indicated that the emergency drug box was being audited every six months.

Failing to ensure registered staff reordered missing medication in the emergency drug box caused delays in response during an emergency which puts residents' safety at risk.

Sources: CIR, resident's progress notes, Interviews with Acting DOC, registered staff, clinical pharmacist, and Medication Emergency box Policy.

[741749]

(A1)
The following non-compliance(s) has been amended: NC #007

COMPLIANCE ORDER CO #001 Skin and wound care

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

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

The licensee shall:

1) Review the contents of the compliance order with all registered nursing staff at the first floor A wing resident home area (RHA).

2) Designate a Registered Nurse (RN) or nursing management lead to educate all registered nursing staff working on the first floor A wing RHA on completing the skin and wound assessment tool and app in its entirety as required by the home's skin and wound care policy.

3) Keep a documented record of the educational content provided to the registered staff, including the individual who provided the education, those who attended, and the date of the training. This document must be maintained in the home.

4) Designate an RN or management lead to conduct on-site audits for a two-week period to ensure that registered staff are adhering to the training. Analyze audit results and provide re-education/training, as needed. Maintain a documented record of the audits conducted.

Grounds

The licensee has failed to ensure that a resident who was exhibiting altered skin integrity, was assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary

A complaint was received by the Director with allegations that the resident's wounds were not being managed properly.

The resident was returned from the hospital and required a new altered skin integrity treatment due to a decline in their skin integrity. The licensee's Skin and Wound Program policy directed registered nursing staff to complete a skin assessment on residents at risk for altered skin integrity when there was a change in health status that affected the resident's skin integrity. The skin and wound evaluation assessment was the instrument used to assess the location, type, progress, goal of care, and current

measurements that included the area, length, width, depth, undermining, tunneling, wound bed, exudate, peri wound, pain, treatment, orders, and progress of the resident's altered skin integrity.

The resident's altered skin integrity required changes to their skin integrity care treatment due to the deterioration of their skin integrity. The Acting DOC the wound care lead, and registered staff confirmed staff were required to use the skin and wound evaluation note when completing the weekly wound assessment, which included taking a picture of the wound. A review of the resident's TAR identified the resident's skin integrity was documented as completed by a registered staff, however, there were several incomplete skin and wound assessment notes. The Acting DOC and the wound care lead confirmed the staff were not using the clinically appropriate instrument for skin and wound. The wound care lead acknowledged that further training on how to document using the skin and wound care program was required, due to a lack of understanding.

There was an increased risk for altered skin integrity deterioration when the effectiveness of the wound care treatment was not evaluated using the clinically appropriate instrument for skin and wounds.

Sources: A resident's progress notes, TAR, Digital Prescriber's Orders, and interviews with registered staff, the wound care lead, and the Acting DOC.

[741747]

This order must be complied with by November 27, 2023

(A1)
The following non-compliance(s) has been amended: NC #008

COMPLIANCE ORDER CO #002 Skin and wound care

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

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

The licensee shall ensure:

1) Review the contents of the compliance order with all registered nursing staff at the first floor A wing RHA.

2) Designate an RN or nursing management lead to ensure registered nursing staff at the first floor A wing RHA receive education on the home's Skin and Wound Care Program policies and procedures, specifically as it relates to completing an assessment of skin condition by completing Head to Toe Skin Assessments for residents who are exhibiting altered skin integrity upon readmission from hospital.

3) Keep a documented record of the educational content provided to the registered staff, including the date provided, who it was provided by, who attended, and the content of the education. This document must be maintained in the home.

4) Compile a list of residents in the first floor A wing RHA who exhibit altered skin integrity upon readmission from the hospital. Designate an RN or management lead to conduct weekly audits of skin and wound assessments, including but not limited to head to toe skin assessments, to ensure its completion and documentation as outlined as per the home's skin and wound care program. Analyze the results of the audits and provide corrective actions on concerns identified. This audit should be conducted for a minimum of four weeks. A record of audits must be maintained in the home, and include the date of the audits, the person responsible, and any actions taken for incomplete care and/or documentation.

Grounds

The licensee has failed to ensure that the resident who was at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, upon their return from the hospital.

Rationale and Summary

A complaint was received by the Director with allegations that a resident’s wounds were not being managed properly.

The resident was transferred to the hospital related to a medical condition and recurrent falls. An altered skin integrity was discovered during hospital admission. The resident was treated for infection and returned to LTCH with an altered skin integrity.

The licensee's skin and wound program indicated that registered staff were to complete skin assessments when residents returned from the hospital. The resident did not receive a skin assessment upon return from the hospital. Policy reviews and interviews with the Acting DOC identified the resident’s skin assessment should have been completed upon the resident’s return from the hospital.

There was an increased risk for wound deterioration when the resident’s readmission skin assessment was not completed as the resident was at high risk for altered skin integrity and had an identified wound.

Sources: Coroner’s Investigation Statements, Resident’s progress notes, Skin Care Program/Wound Management Policy, Head to Toe Skin Assessment, and interviews with the registered staff, Skin and Wound Care Lead, the Coroner, and Acting DOC.

[741747]

This order must be complied with by November 27, 2023

(A1)
The following non-compliance(s) has been amended: NC #009

COMPLIANCE ORDER CO #003 Skin and wound care

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

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

The licensee shall:

1) Review the contents of the compliance order with all registered nursing staff at the first floor A wing RHA.

2) Designate a Registered Nurse (RN) or nursing management lead to conduct skin and wound assessment audits once weekly to ensure that registered nursing staff are completing the weekly skin and wound assessments for the residents who are exhibiting altered skin integrity at the first floor A wing RHA. The date of the audit, the person responsible, and the results of the audit must be documented. Analyze the results of the audit to identify any gaps or omissions, action is taken, and the results of the action are documented. Conduct this audit for a period of four weeks.

3) Review and re-train all registered nursing staff working on the first floor A wing resident home area on weekly skin and wound assessments to be completed in its entirety as per legislative requirements and the home's skin and wound care program.

4) Complete the annual evaluation of the home’s skin and wound care program as per legislative requirements.

5) Maintain a written record of reviews and training provided to all registered nursing staff at the first floor A wing RHA that includes who attended the training, the content, and the date of training was completed.

Grounds

The licensee has failed to ensure that a resident’s altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff when an area of altered skin integrity was identified.

Rationale and Summary

A complaint was received by the Director related to concerns with a resident's skin and wound care management.

The licensee's skin and wound program policy directed registered nursing staff to complete a weekly skin and wound assessment on residents for all types of skin and pressure injuries. The skin and wound evaluation note was the instrument used to assess the location, type, progress, goal of care, and current measurements that included the area, length, width, depth, undermining, tunneling, wound bed, exudate, peri wound, pain, treatment, orders, and progress of the resident's altered skin integrity.

The resident returned from the hospital and required a new wound care treatment due to a decline in their wound status.

A weekly skin and wound evaluation note was completed by a registered staff. However, the note did not document the staging of the wound, progress, and goal of care for the altered skin integrity.

The Enterostomal Therapy (ET) nurse updated the recommendation for wound care for the altered skin integrity stage as four.

A skin and wound assessment was initiated by a registered staff but was incomplete and indicated the resident's altered skin integrity as stage two and did not include the depth of the wound. The documentation indicated the resident's altered skin integrity had an odour with moderate drainage. The wound care policy directed registered staff to notify the physician if there were any evidence of infection which included an odour of the altered skin integrity.

The resident was transferred to the hospital and the coroner confirmed that the resident passed away due to a medical condition related to the altered skin integrity.

The registered staff confirmed that weekly wound assessments should be completed by the registered staff every week by taking a picture of the wound using the skin and wound application. The wound care lead acknowledged that registered staff required further skin and wound education as there were several weekly skin and wound assessments that were incomplete.

The resident was at an increased risk for wound deterioration when registered staff did not measure the depth of the wound using the skin, and wound application was designed for skin and wound assessments weekly for several weeks.

Sources: Coroner's Investigation Statements, a resident's progress notes, MAR, TAR, Digital Prescriber's Orders, MDS RAP Summary, Skin Care Program/ Wound Management Policy, and interviews with PSW, registered staff, Skin and Wound Care Lead, the Coroner and Acting DOC.

[741747]

This order must be complied with by November 27, 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.