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

Public Report

Report Issue Date: April 9, 2025

Inspection Number: 2025-1157-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Tendercare Nursing Homes Limited

Long Term Care Home and City: Tendercare Living Centre, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 26 - 28, 31, 2025 and April 1 - 4, 8 - 9, 2025.

The inspection occurred offsite on the following date(s): April 7, 2025

The following intake(s) were inspected:
An intake and a Critical Incident (CI) were related to improper care of a resident.

An intake and a Critical Incident (CI) were related to a resident-to-resident interaction with injury.

An intake and a Critical Incident (CI) were related to an allegation of resident neglect.

An intake and a Critical Incident (CI) were related to a medication incident.

An intake and a Critical Incident (CI) were related to a resident fall with injury.

An intake was related to a complaint of the home's constructions.

An intake was related to a complaint of the home's dietary manager, menu planning, and food production.

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

Medication Management
Housekeeping, Laundry and Maintenance Services

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting and complaints

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to forward the written complaint to the Director, submitted by a family member on an identified date regarding the construction in the third-floor dining room servery.

Sources: Interview with the Administrator, complaints.

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) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure that Dietary Services program and its policies were evaluated and updated annually. The policies and procedures were last reviewed January 2022.

Sources: Interviews with Dietary Manager, and policy review.

WRITTEN NOTIFICATION: General requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that actions taken with respect to the resident, under the Falls Prevention and Management Program, including the resident's response to a fall prevention intervention, were documented.

The resident's plan of care indicated that they were required to have a fall prevention intervention implemented. An observation was made where the resident did not have the fall intervention implemented. The Nurse Manager stated that the resident was known to refuse the intervention and confirmed that their response to the intervention was not documented.

Sources: Clinical records for the resident, observation, interview with the Nurse Manager.

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to comply with the home's falls prevention and management program when the Clinical Monitoring Record for the resident, in relation to a fall that occurred on an identified date, was initiated late and not completed at the designated intervals as per the home's policy.

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

Specifically, the home's falls policy indicated that the Clinical Monitoring Record shall be initiated for an unwitnessed fall and that residents were to be monitored every hour for four hours and then every eight hours for 72 hours.

The resident had experienced a fall and required to be sent to a local medical facility hours later. The resident had returned to the long-term care facility after being medically stable. When reviewed, the required Clinical Monitoring Record was not completed at the intervals prior to and after returning from the local medical facility. The Clinical Nurse Manager confirmed the same and acknowledged that the Clinical Monitoring Record was to be completed at the required intervals.

Sources: Clinical Records for the resident, Home's Falls Prevention and Management Program Policy, Interview with the Clinical Nurse Manager.

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that a post-fall assessment was conducted using a clinically appropriate assessment instrument when the resident had fallen on an identified date. As per the home's policy and an interview with the Assistant Director of Care (ADOC), staff were required to complete a post-fall assessment tool electronically when a resident had experienced a fall.

Sources: Resident's electronic chart, and staff interview with the ADOC.

WRITTEN NOTIFICATION: Responsive behaviors

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that actions taken, including resident assessment, were documented when the resident exhibited responsive behavior over a period of time. A behavioral intervention was initiated with the purpose of monitoring the resident's behavior. When reviewed, the intervention tool contained multiple undocumented sections where the behavior was not charted.

Sources: Resident's electronic progress notes and the intervention tool, and staff interviews with the BSO Lead and the ADOC.

WRITTEN NOTIFICATION: Altercations and other interactions

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

(b) identifying and implementing interventions.

The licensee has failed to ensure interventions were implemented to minimize the risk of altercations between two residents. The residents had fallen on to the floor as a result of their interaction. The home's policy on responsive behavior directed the staff to complete an assessment tool but it was not completed for the identified episode.

Sources: Residents' electronic chart, and staff interviews with the BSO Lead and the ADOC.

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (c) (iii)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,
(c) is approved for nutritional adequacy by a registered dietitian who is a member of the staff of the home, and who must take into consideration,
(iii) current Dietary Reference Intakes (DRIs) relevant to the resident population. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that each menu cycle is approved for nutritional adequacy by a registered dietitian (RD) who is a member of the home's staff, prior to implementation. The RD must consider the current Dietary Reference Intakes (DRIs) relevant to the resident population.

The home's current menu cycle, dated Fall/Winter 2022-2023, has been in effect for over a year without evaluation or approval by the RD in accordance with the DRIs

pertinent to the resident population. Despite multiple requests, the licensee was unable to provide evidence of the menu's evaluation and approval. Both the RD and the Administrator confirmed that the menus have not been reviewed by an RD in the past year.

Sources: Home's menu and interviews with the Dietary Manager, Registered Dietitian and the Administrator.

WRITTEN NOTIFICATION: Dining and snack service

NC #009 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 failed to ensure that the resident was not served their meal prior to a staff member being available to provide the required assistance to the resident. The resident's plan of care indicated that the resident required staff's assistance with meal consumption. On an identified date, the resident was served a plate of food and the staff only became available to assist with their eating some time later.

Sources: Plan of care for the resident, review of the home's camera footage, interviews with the ADOC and the home's Director of Care (DOC).

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) 3. ii. A.

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:
3. The response provided to a person who made a complaint shall include,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or

The licensee failed to ensure that a response provided to a complainant included an explanation of what the licensee has done to resolve the complaint. A written complaint was submitted to the home's Administrator but a response was never provided to the complainant explaining what had been completed to resolve the complaint.

Sources: Critical Incident Report, Written Complaint, Home's Acknowledgement of Receipt of the Complaint, and interview with the DOC.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)
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

The licensee of a long-term care home shall ensure that every medication incident involving the resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health. The Registered Practical Nurse (RPN) did not carryout a medical intervention as scheduled during a shift and no further follow-up action was taken by the staff.

Sources: Resident's electronic health records, home's internal investigation files, and staff interview with the DOC.

COMPLIANCE ORDER CO #001 Safe and secure home

NC #012 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)]:
Specifically, the licensee shall:
1. Establish a multidisciplinary team (MDT) who will participate in Construction Renovation Maintenance and Design (CRMD) projects, including planning, design, implementation phases, commissioning, occupancy, and maintenance. The licensee is to ensure that MDT is engaged in review of projects, risk assessment, conduct the daily inspections of the construction site and provide guidance for the project management team to protect residents from hazards generated by the construction.
2. The MDT shall include at minimum IPAC Lead, Administrator and Management staff with expertise in infection prevention and control, direct patient care, risk management, facility design, construction, ventilation
3. The home will develop and implement a written procedure to ensure that the all construction projects are planned, led and inspected by the MDT to ensure a safe

condition of the facility during the construction, manage traffic flow, ensure integrity of the construction site is maintained, and ensure safety of the residents.
4. The home will develop and implement forms for daily inspections of construction site, document the daily inspections , and any remedial actions, the date of the inspection and who completed the inspection of the construction site

Grounds
The licensee failed to ensure that the home had a safe and secured environment for its residents when the active construction site did not provide adequate barriers.

Rationale and Summary
During a tour of the third-floor dining room, a new steam table was observed. Video recordings in an identified time period showed protective barriers in place; however, the bottom of the barrier was not secured to the floor. The unsecured poly barrier failed to prevent airborne dust dispersion into the dining room during residents' meal times. Additionally, the poly barrier lacked an access door and there was no adhesive (dust collection) mat at the entrance of the contained work area. The construction site was unsecured allowing staff to enter the construction site. Additionally, dietary staff and dietary manager were observed using the servery during construction to deliver and serve food to residents from the active construction site.

The IPAC lead could not verify if the barriers were secured as inspection of the construction site was not completed. There was no documentation of daily inspections available when requested.

Failing to ensure that barriers were implemented around an active construction site at the home created an unsafe and unsecured environment for the residents.

Sources: Review of the homes camera footage, ICRA tool, interviews with staff.

This order must be complied with by July 8, 2025

COMPLIANCE ORDER CO #002 Accommodation services

NC #013 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)]:
Specifically, the licensee shall ensure the following:
1. The IPAC lead or designate will develop and implement a process for storing Personal Protective Equipment (PPE) and personal care items to maintain their cleanliness and integrity.
2. All PPE and personal care items must be stored in a dry space, protected from moisture, dust accumulation, potential sources of environmental contamination, and pests.
3. Regular checks must be implemented to ensure storage conditions remain optimal, maintaining the cleanliness of the storage space and the integrity of the PPE and personal care items.

Grounds
The licensee failed to ensure that the home had provided a dry and adequate storage for Personal Protective Equipment (PPE) and personal care items to maintain their cleanliness and integrity.

Rationale and Summary

During an initial tour of the home, personal protective equipment (PPE) had been observed to be stored on the floor of clean supplies room, personal care items (toothbrushes, washbasins) were stored under the counter cupboard with dark spots and moisture damage. Similarly, used washbasins used on resident for personal hygiene were observed in various locations of residents' rooms, tucked in behind towel racks, on top of the wardrobes, below sinks. A follow-up tour was conducted but PPE and personal care items remained stored on the floor and under the sink in a cupboard where a mousetrap and flower vase were observed. The gaps identified have been acknowledged by the Administrator and the IPAC Lead. Both, the IPAC lead and the administrator agreed that placement of clean supplies was inadequate and unsafe. The IPAC Lead was unfamiliar with the requirements for storage of clean supplies in healthcare settings.

Improper storage of clean, single-use items poses a medium risk and impact of contamination when kept in inadequate environmental conditions, compromising the integrity of their packaging. Environmental factors such as moisture, vermin, and air movement can affect the sterility of these supplies.

Sources: Observations, Interviews with staff.

This order must be complied with by July 8, 2025

COMPLIANCE ORDER CO #003 Food production

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78

(3).

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

The licensee shall ensure the following:

1. The Dietary Manager or their designate will provide in-person training to all dietary staff, including any staff cross-trained to work as dietary staff, on the following:
2. Reviewing food shipments for potential damage to food packaging and educating staff on the proper characteristics of food contact surfaces.
3. Proper food handling practices during preparation and service.
4. Training sessions will be documented, including the content, trainer's name, and attendees.
5. The Dietary Manager or their designate will complete an inspection of all kitchenware and utensils, including but not limited to tableware, china, cutlery, cups, glasses, and mugs, to identify all pitted and damaged items. They will ensure replacements meet residents' needs and are easily cleanable, smooth, nonabsorbent, compatible with cleaning and sanitizing chemicals, and in compliance with all applicable legislation. The Dietary Manager will establish a comprehensive process to ensure that identified damaged and pitted items are replaced promptly.
6. Develop and implement tools, guidelines and checklists for staff to inspect food deliveries for damaged packaging and signs of food adulteration before storage.
7. The Dietary Manager or their designate will create and implement an auditing process to review the integrity of tableware minimum weekly, for a period of eight weeks. Analyze the audit results at minimum monthly, and if deficiencies are noted, implement corrective actions to ensure compliance.
8. The Dietary Manager will conduct reviews and updates to training materials and inspection protocols for the food service program as per evidence based practice or if non prevailing best practices.
9. Assign a leadership team member from outside the dietary team to complete audits and report findings to the administrator weekly for eight weeks.

10. Maintain documentation of the audits, analyses, and any corrective actions implemented, and make them available to inspectors upon request.

Grounds
The licensee has failed to ensure the provision of tableware, serving utensils, and storage containers that are free of cracks and damage.

Rationale and Summary
The home's dishes and tableware were observed to be in poor condition. The dishes used for residents' meals were broken, cracked, and deteriorating, with the outer layer of plastic peeling away to reveal the metal core. Serving utensils were severely damaged and pitted, and lids intended to cover plates were cracked and broken. Additionally, food cans in the dry storage area were significantly dented, raising concerns about their integrity and safety. The manager acknowledged the state of the dishes but was unaware that dented cans were unsafe for food storage. Furthermore, during the tour of main kitchen, the sanitizing process for the dishes was found to be insufficient due to the food debris and dirty water being used in the sanitizing cycle.

The failure to provide undamaged tableware and utensils, along with the absence of a process to replace damaged items, increases the risk of food adulteration and contamination, places residents at heightened risk of foodborne illnesses.

Sources: Observations and interviews with staff.

This order must be complied with by July 8, 2025

COMPLIANCE ORDER CO #004 Construction, renovation, etc., of homes

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 356 (3)

Construction, renovation, etc., of homes

s. 356 (3) A licensee may not commence any of the following work without first receiving the approval of the Director:

1. Alterations, additions or renovations to the home.
2. Other work on the home or work on its equipment, if doing the work may significantly disturb or significantly inconvenience residents.

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

1. The home will establish a Multidisciplinary Team (MDT) with expertise in infection prevention and control, direct patient care, risk management, facility design, construction, and ventilation to create and implement the policy. The MDT shall include, at a minimum: IPAC Lead, Administrator, Project Manager, and Management staff.
2. The home shall develop and implement a comprehensive policy and procedure for home maintenance, including assessments of both the interior and exterior of the home.
3. The Corporate Designate with expertise in Construction, Renovation, Maintenance and Design (CRMD) and IPAC Hub, will provide in person education and training related to CRMD to the members of MDT. The training shall include education on the requirements related to:
4. The regulatory requirements associated with different types of maintenance work;
5. Definitions related to the type of maintenance work that requires prior approval;
6. Ministry of Long Term Care notification requirements when planning to conduct any type of maintenance work within their Long Term Care Homes; and
7. Submission requirements for review, timelines for review, and the review process
8. Documentation of education must include:
9. First and last name of person providing education.

10. Contents of the education that was provided.
11. Name of staff educated and their signatures.
12. Date when the education was provided.
13. These records are to be produced upon Inspector request.

Grounds
The licensee failed to obtain the Director's approval before starting any home alterations, additions, renovations, or other work that could significantly disturb or inconvenience residents.

Rationale and Summary
An anonymous complaint was submitted to the Director regarding construction work that displaced due to construction barriers dividing the dining room into two separate sections, and inconvenienced the residents by generating excessive dust and noise. An inspector observed the newly installed steam table and replaced flooring tiles in the third floor servery.

In addition to the anonymous complaint, another complaint was filed with the home concerning the noise and dust related to the construction. During this period of construction, residents were forced to have their meals outside of their usual dining routine, residents reported unrest, headaches, and discomfort.

The construction included the replacement of the steam table, flooring in the entire servery, hot water tank replacement, plumbing work, and painting. The project divided the dining room into two separate areas.

The Administrator, IPAC Lead, and Dietary Manager confirmed that the work was completed without obtaining the Director's approval prior to the commencement of the project.

The lack of prior approval from the Director before starting construction resulted in

missed opportunities to address health and safety risks for residents during the construction phase.

Sources: Observations and interview with staff.

This order must be complied with by July 8, 2025

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.