

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée**

**Long-Term Care Operations Division  
Long-Term Care Inspections Branch**

**Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**

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**Public Copy/Copie du rapport public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Feb 10, 2020	2020_643111_0006	002397-20	Complaint

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**Licensee/Titulaire de permis**

AXR Operating (National) LP, by its general partners  
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON  
L4W 0E4

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**Long-Term Care Home/Foyer de soins de longue durée**

Bay Ridges  
900 Sandy Beach Road PICKERING ON L1W 1Z4

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

LYNDA BROWN (111)

**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): January 30, February 3, 4, 5 and 7, 2020.**

**The following intake was inspected during this inspection:**

**Log # 002397-20: related to a complaint related to RN staffing.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Associate Director of Care (ADOC), Registered Nurses (RN) and Ward Clerk.**

**During the course of the inspection, the inspector reviewed staffing schedules and 24 Hour RN checklists.**

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

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

**Findings/Faits saillants :**

The licensee has failed to ensure that there was at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times, except as provided for in the regulation.

Under O.Reg. 79/10, s. 45(1)(2) ii, The following are the exceptions to the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, as required under subsection 8 (3) of the Act:

For homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds, ii. In the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if, (a) the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and (b) a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home. O. Reg. 79/10, s. 45 (1).

Ontario Regulation 79/10 section 45. (2) indicates that "emergency" means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

A anonymous complaint was received by the Inspector, indicating the home did not have a Registered Nurse (RN) working in the building and had been occurring frequently.

Bay Ridges is a 124 bed long-term care home. Inspector #111 requested and received from the ADOC, the home's schedule of RNs who worked during a specified time period and the 24 Hour RN checklist. A review of the RN schedules and the 24 Hour RN checklist indicated the home did not have an RN working in the building at all times on a number of dates and shifts during the specified time period. On each of the dates/shifts where there was no RN on site, the shift was replaced with an RPN.

During an interview with the Ward Clerk, they confirmed the home had been working without an RN on site on a number of occasions and mainly occurred on a specified shift. The Ward Clerk confirmed there had not been any RN vacancies and the RN short staffing was due to sick calls. The Ward Clerk indicated the home did not use agency staffing for replacement of staff. The Ward Clerk indicated whenever the home was

working without an RN in the building, a 24 hour RN staffing checklist was to be completed and the management notified. The Ward Clerk confirmed after reviewing the schedule and the 24 hour RN staffing checklists, there were a number of dates during a specified period, on specified shifts, when the home was working without an RN present in the building. The Ward Clerk indicated when there was no RN, they would replace the shift with an RPN.

During an interview with the DOC, they confirmed the home had been working without an RN on site occasionally but was replaced by a RPN and an RN or RN manager who was on-call. The DOC was unable to indicate how often this occurred, when it occurred or which shift. The DOC indicated the ward clerk was responsible for managing the nursing schedule and would be able to identify the dates and shifts. The DOC confirmed there were no RN vacancies in the home and indicated the home did not use agency staff.

The licensee has failed to ensure that there was at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times during a specified period.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there was at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times, unless there was an allowable exception to this requirement, to be implemented voluntarily.***

**Issued on this 12th day of February, 2020**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**