Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 17, 18, 22, 30, 31, Jun 11, 13, 14, 2012	2012_080189_0019	Complaint

Licensee/Titulaire de permis

YORK CENTRAL HOSPITAL ASSOCIATION
10 TRENCH STREET, RICHMOND HILL, ON, L4C-4Z3

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

YORK CENTRAL HOSPITAL / LONG TERM CARE UNIT
10 TRENCH STREET, RICHMOND HILL, ON, L4C-4Z3

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

NICOLE RANGER (189)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Physiotherapist, Registered Dietitian, Food Service Manager, Registered Staff, Personal Support Workers

During the course of the inspection, the inspector(s) Reviewed health care records, observed resident activation programs, reviewed food service plans,

The following Inspection Protocols were used during this inspection:

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Ontario

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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.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The plan of care for a resident directs staff to provide extensive assistance of 2 staff for transferring, toileting, resident balance. Staff to stay with resident until she is finished.

On May 17th, 2012, at 1137am, inspector observed PSW wheel resident into his/her room. Inspector stood outside the door and observed the PSW assist the resident from wheelchair to washroom without a second person assisting. Inspector observed the PSW leave the resident in the washroom alone as he/she proceeded to come outside the resident's room to the linen cupboard and take some linen out of closet. PSW then returned to the room and proceeded to make the resident's bed while the resident still remained in the washroom. Inspector walked into the room and observed the resident on the toilet. Inspector observed the 2 person transfer logo above the resident's bed and also 2 person transfer logo by the wooden shelf near the washroom. At 1202pm, Inspector observed the PSW did not request the assistance another staff member, transferred the resident back from washroom to wheelchair and proceeded to wheel the resident out of his/her room into the dining room.

During interview with the PSW, PSW confirmed to the inspector that the resident is a 2 person transfer and PSW did not call for assistance for the transfers.

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 14th day of June, 2012

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