Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 5, 2013	2013_178102_0021	001273-12	Critical Incident System

Licensee/Titulaire de permis

HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION
7199 Gelert Road, Box 115, HALIBURTON, ON, K0M-1S0

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

HYLAND CREST
6 McPherson Street, P.O. Box 30, Minden, ON, K0M-2K0

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

WENDY BERRY (102)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 22, 2013

This critical incident inspection is related to an equipment malfunction which occurred in 2012. During the inspection, issues were identified involving infection prevention and control practices.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Director Facilities and Projects, several staff and residents.

During the course of the inspection, the inspector(s) reviewed information related to lifting equipment; observed portable lifts used in tub rooms; toured tub and shower rooms; reviewed practices involving residents' grooming and hygiene supplies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance

Infection Prevention and Control

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

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 LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The following potential cross infection risks to residents were identified in the communal tub rooms:

-unlabelled, shared use combs immersed in glass jars containing diluted "Barbicide" solution. 2 of the 4 observed jars had debris build up present in the solution containers. Posted instructions within the tub room identify that "Each containers chemical will be changed once a month". The Barbicide product's instructions for use as a disinfectant are not being followed which includes: "thoroughly clean tools and surfaces prior to complete immersion for 10 minutes....Prepare a fresh solution daily". The instructions are clearly identified on the product's original containers, also located in tub rooms;
-unlabelled electric shavers were present in several tub rooms. Debris build up was present under the razor heads, which are removable;
-used, unlabelled deodorant sticks were present in tub room cupboards and on shelves;
-used, unlabelled nail clippers were present in and on cabinets in several tub rooms. Debris build up was evident on some of the nail clippers.

Measures are not in place to prevent the transmission of infections. [s. 86. (2) (b)]

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 best practice based measures, including cleaning, disinfection and sterilization of resident care equipment and supplies, are in place and monitored to prevent the potential transmission of infections, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. Schedules and procedures are not in place for routine, preventative and remedial maintenance of portable lifts. This was confirmed by management staff who were present at the time of inspection. Schedules and procedures for the maintenance of the lifts were requested, but could not be provided. [s. 90. (1) (b)]

2. Manufacturers' specifications related to portable Arjo Allenti lifts were provided for review at the time of inspection.
It was confirmed through discussions with staff that the procedures set out for maintaining and cleaning the lifts, specifically the lift wheels, were not being followed; for example: lift wheels are to be removed once per month for cleaning. This procedure is not being done.

Critical incident report (CIR) # M542-000005-12 identifies that on May 20, 2012, the wheel of a portable lift came off while transferring a resident in a tub room. The CIR identifes that "the lift collapsed on resident's lower left leg".

Lifts are not being cleaned and maintained at a level that meets manufacturers' specifications, at a minimum. The lift in use on May 20, 2012 was not kept in good repair. [s. 90. (2) (a)]

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 schedules and procedures are developed and implemented for the routine, preventative and remedial maintenance and cleaning of mechanical lifts which, at a minimum, meets manufacturers' specifications, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. Point of care hand hygiene agents were not provided in residents' bedrooms at the time of inspection.
It was identified by the Director of Care and the Director Facilities and Projects that dispensers for the hand hygiene agents had been obtained, were on site and would be installed in residents' bedrooms within 1 to 2 weeks of this inspection. [s. 229. (9)]

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 hand hygiene agents are accessible at point of care locations, to be implemented voluntarily.

Issued on this 5th day of November, 2013

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