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
Jun 4, 2014	2014_378116_0003	T-88-14	Resident Quality Inspection

Licensee/Titulaire de permis

Rose of Sharon (Ontario) Retirement Community
165 Vaughan Road, TORONTO, ON, M6C-2L9

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

Rose of Sharon Korean Long Term Care
17 Maplewood Avenue, TORONTO, ON, 000-000

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

SARAN DANIEL-DODD (116), JULIENNE NGONLOGA (502), SOFIA DASILVA (567), TIINA TRALMAN (162)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 15, 16, 20, 22, 23, 26, 27, 28, 2014.

Inspection for log# T-73-13 (critical incident) was conducted during this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care, Nurse Manager, Office Manager, registered staff, personal support workers, registered dietitian, food service manager/environmental manager, cook, food handlers, recreational manager, recreational staff, housekeeping staff, family members and residents.

During the course of the inspection, the inspector(s) conducted a tour of the home, observed meal service, observed resident care, staff-resident interactions, medication administration, reviewed relevant home records, relevant policy and procedures, training materials and records, employee records and resident health records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

The written plan of care for resident #778 does not provide directions to staff regarding the requirement to use a magnifying lens for reading due to vision impairments as per reassessment. Interviews with personal support workers (PSW) confirmed they were not aware that the resident had vision impairments. [s. 6. (1) (c)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

On a specified date, in an identified dining room at lunch, the inspector observed and

registered staff confirmed that resident #817 requires close monitoring, encouragement and verbal cues to eat.

The plan of care indicates the resident requires extensive assistance and staff are to use repetitive verbal step by step cues through each step of eating.

A review of the resident's health record revealed that the registered dietitian (RD) did not address the resident's need for assistance and monitoring at meal times. The RD confirmed he/she was not aware of the change in the written plan of care. [s. 6. (4) (a)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #787's written plan of care relating to vision was not revised. The written plan of care initiated on a specified date, indicated the resident had impaired vision as evidenced by inability to focus on objects and blurry vision. Following surgery, the resident's plan of care was not revised to reflect the change in resident's change in vision.

The registered staff confirmed that the written plan of care was not revised. [s. 6. (10) (b)]

4. Resident #778 is identified at high risk for falls. A reassessment was conducted indicating the resident requires a clear pathway to minimize risks related to falls due to impaired vision.

Interviews held with PSW's confirmed they were not aware that the resident had vision impairments.

The registered staff confirmed that the plan of care was not revised to reflect vision impairments for the resident. [s. 6. (10) (b)]

5. The written plan of care for resident #817 was not revised to reflect the physician's order to increase nutritional supplement.

Interview with the registered staff indicated that resident #817's appetite and intake has been in decline for the past two to three months. An interview with the RD

confirmed that a diet order to increase the supplement was made to improve nutritional intake and prevent weight loss, which was carried out as per resident intake records. However, the written plan of care was not revised. [s. 6. (10) (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 that:
1. the plan of care set out clear directions to staff and others who provide direct care to the resident,
2. staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, and
3. the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone.

On a specified date, the licensee submitted a critical incident report to the Director, containing allegations of verbal and physical abuse by staff to residents of an specified unit.

A review of internal investigation notes, conducted by the home and interviews conducted during the Resident Quality Inspection with an identified registered staff, revealed inappropriate comments were made to residents by PSW #1 and PSW #2. [s. 19. (1)]

2. An interview with the Administrator confirmed the allegations of alleged abuse to be founded. PSW #1 and PSW #2 were terminated upon completion of the investigation. [s. 19. (1)]

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 protect residents from abuse by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director.

Although the Administrator reported incidences of suspected verbal and physical abuse upon becoming aware, within a critical incident report, it was confirmed during interview that many of the incidents took place three months prior to being reported by an identified PSW. The PSW failed to immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

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 any person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident of the home is restrained, in any way, for the convenience of the licensee or staff.

On a specified date, the licensee submitted a critical incident to the Director, containing allegations of verbal and physical abuse to residents of a specified unit.

A review of the home's internal investigation, interviews held with an identified registered staff and the Administrator/DOC confirmed that between a specified period of time, PSW #2 restrained resident #5 while providing care.

Review of resident #5's health record confirmed there was no physician's order in place to physically restrain the resident.

PSW #2 resigned his/her position during the homes internal investigation. [s. 30. (1) 1.]

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 no resident of the home is restrained, in any way, for the convenience of the licensee or staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the recreation and social activities program includes the development and implementation of a schedule of recreation and social activities that are offered during evenings.

Interviews held with residents #6, #762, #792, families and the program manager confirmed that recreational activities are not offered in the evenings. [s. 65. (2) (b)]

2. Record review of recreational activity schedule for the month of May 2014, identified that the last daily organized activity is scheduled to end at 16:00 hours. [s. 65. (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 that the recreation and social activities program includes the development and implementation of a schedule of recreation and social activities that are offered during evenings, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has a dining service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

On a specified date, the inspector observed residents #768 and #791 during the lunch meal service in an identified dining room.

The inspector observed an identified registered staff assisting resident #768 while seated on a high stool and #791 while standing above resident's eye level. Residents #768 and #791 were seated with their head positioned between the elbow and shoulder level of the registered staff forcing them to raise their chin to receive food.

The written plans of care for residents #768 and #791 indicate they are identified at high nutritional risk related to chewing/swallowing problems, require full feeding assistance and are to be positioned sitting upright at 90 degree angle for feeding.

A review of the home's policy, titled Feeding and Hydration 4.9, requires staff to sit beside the resident at about the same height.

Interview with the registered staff feeding both residents confirmed that they used unsafe techniques while feeding the residents. [s. 73. (1) 10.]

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 the home has a dining service that includes, proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision-maker (SDM) was notified within 12 hours upon becoming aware of the alleged, suspected or witnessed incident of abuse of the resident.

On a specified date, the licensee submitted a critical incident to the Director, containing allegations of verbal and physical abuse involving resident #5.

A review of the home's internal investigation, interviews held with an identified registered staff and the Administrator/DOC confirmed that between a specified period, PSW #2 restrained resident #5 while providing care. In addition, PSW #2 verbally abused resident #5 by making negative comments.

A discussion with the Administrator confirmed that resident #5's SDM was not notified after becoming aware of the suspected incident of verbal and physical abuse involving resident #5 reported to the home. [s. 97. (1) (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 that all resident's substitute decision-maker (SDM), if any, and any other person specified by the resident, are notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse of the resident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

On two occasions, the following observations related to access to non-residential areas were observed:

On a specified date, the inspector observed that the door leading to the servery in an identified dining room was open and unsupervised; the inspector was able to gain access to a hot water machine, coffee brewing from the coffee machine, and as well the service elevator. Furthermore, the inspector observed the service elevator was not equipped to restrict resident access to other non-residential areas. Fifteen minutes later, the servery remained accessible and unsupervised while residents were coming to the dining room for lunch service.

Interviews with an identified PSW and a cook confirmed that the door should be closed and locked at all times.

In addition, on another occasion, the inspector observed that the door leading to the servery in an identified dining room was open and unsupervised; the inspector was able to gain access to a hot water machine.

Interviews with an identified registered staff member and the food service manager (FSM) confirmed that the door to the servery should be locked at all times. [s. 9. (1) 2.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, can be easily accessed and used by residents at all times.

On a specified date, the inspector along with an identified registered staff observed that the call bell cords for both residents #1 and #774 were placed behind the head of the bed and inaccessible to both residents. The registered staff confirmed that the call bells should be within reach and accessible to the residents. The registered staff readjusted the placement of the call bell cords so that it would be within reach and accessible to the residents. [s. 17. (1) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home offers an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident's SDM, if payment is required.

Record review revealed that residents #762, #773 and #800 were not offered an annual dental assessment or other preventive dental services in the last twelve months.

Inspectors #162 and #502 contacted SDM's for residents #762, #773 and #800 who confirmed that the home did not inform or offer an annual dental assessment for the residents. [s. 34. (1) (c)]

2. An interview held with an identified registered staff member revealed that the annual dental assessment is offered only to SDM's of residents with dental problems. [s. 34. (1) (c)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

An interview held with the Administrator confirmed that the satisfaction survey is developed without the input of the Resident's Council. [s. 85. (3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area of the medication cart.

On a specified date, at three different times, the inspector observed the single locked narcotic bin containing controlled substances deemed for destruction stored in the charge nurse's office. The office door was open and unsupervised.

On the same date, at a later time, an interview with the charge nurse confirmed that the door to the office should be locked. After speaking with the charge nurse regarding the accessibility to the narcotic bin, the charge nurse left the office. Inspectors returned to the office and found the door unlocked. [s. 129. (1) (b)]

WN #13: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program.

On a specified date, the inspector observed an identified housekeeper exit the elevator and enter an identified unit wearing gloves. The housekeeper indicated that he/she was cleaning the independent apartment units on the main floor. The housekeeper confirmed that the gloves should have been removed prior to entering the long-term care unit.

On the same date, the inspector observed an identified PSW wearing the same gloves while completing multiple tasks on an identified unit. The PSW entered the janitorial room, then entered the clean supply room and then walked down the hallway wearing the same gloves. The PSW confirmed that the gloves should have been removed after completing each task. [s. 229. (4)]

2. On a separate occasion, the inspector observed an identified housekeeping staff wearing gloves while cleaning residents' rooms on an identified unit. The housekeeping staff did not change gloves or perform hand hygiene prior to entering subsequent residents' rooms. The inspector observed the housekeeping staff cleaning a resident's washroom, mopping the floor and dusting furniture surfaces.

An interview with the identified housekeeping staff confirmed that the same gloves were used to clean residents' rooms and indicated it was acceptable to sanitize the gloves with alcohol-based hand rub prior to performing tasks in subsequent resident rooms.

An interview with the FSM confirmed that housekeeping staff are not required to wear gloves while cleaning resident rooms. However, they must perform hand hygiene. [s. 229. (4)]

Issued on this 23rd day of June, 2014

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