Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 22, 2017	2017_547591_0001	035071-16	Resident Quality Inspection

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

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

Tullamore Care Community
133 KENNEDY ROAD SOUTH BRAMPTON ON L6W 3G3

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

NATASHA JONES (591), DARIA TRZOS (561)

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): January 4, 5, 6, 9, 10, 12, 13, 16 and 17, 2017.

The following Follow-up inspections were inspected concurrently with the Resident Quality Inspection (RQI).

-Log #031007-16 - related to Abuse
-Log #031009-16 - related to Hydration Policy

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Services Manager (ESM), Registered Dietitian (RD), Dietary Supervisor, registered staff, maintenance technician, personal support workers (PSWs), environmental team members, residents and family members.

During the course of the inspection, Inspectors reviewed resident health records, investigative notes, complaints logs and files, maintenance logs and audits, infection control surveillance documentation, staff files, staff education records, program evaluations, policies and procedures, toured the home, and observed residents and care.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
8 WN(s)
7 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_449619_0022	591
O.Reg 79/10 s. 8. (1)	CO #002	2016_449619_0022	561

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).

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.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to be afforded privacy in treatment and in caring for his or her personal needs.

Resident #008 was observed on a specified day in January 2017, while a PSW #104 assisted the resident to the bathroom in their room. The PSW left the door to the bathroom wide open while the resident was using it. Another resident was present in their shared room. The Inspector questioned the PSW, who then closed the door to provide for privacy. The current written plan of care was reviewed and did not indicate that the resident preferred the bathroom door to be left open while they were using it. Resident #008 could not be interviewed. In an interview, registered staff #102 confirmed that the PSW should have ensured that the resident was provided with privacy when using the bathroom.
The licensee failed to ensure that resident #008 was afforded privacy in caring for their personal needs. [s. 3. (1) 8.]

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 every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #2: 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. (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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident’s plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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 has failed to ensure that the staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Resident #017's current written plan of care indicated that the resident was considered to be at high risk for falls. Personal Support Worker (PSW) #110 was interviewed and confirmed that the resident was at risk for falls and was able to walk with a walker; however most of the falls occurred as a result of the resident going to the bathroom by themselves. The PSW also stated that the resident was on a toileting plan. The written plan of care indicated that the resident required limited assistance with toileting. An additional intervention was added to the written plan of care in November 2016, to implement a toileting routine and encourage and assist the resident to use the bathroom

frequently; however the written plan of care did not state what the routine was. The Point of Care (POC) was reviewed and did not indicate the toileting routine.

Review of a Physiotherapy assessment, dated November 2016, advised staff to monitor the resident closely for fall risk related to their medical condition and to set up toilet training or scheduling.

Registered staff #100 and two other PSWs assigned to the unit were not aware that the resident was on a toileting plan and stated that the resident was able to toilet them self. The DOC was interviewed and indicated that if the residents are on a toileting plan that information was to be added to the written plan of care and would be automatically set up on the POC for PSWs to document and ensure that the intervention was followed. This was not done for this resident.
The licensee failed to ensure that the staff collaborated with each other in the assessment of the resident so that the assessments were consistent with each other. (561) [s. 6. (4) (a)]

2. The licensee has 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 changed or care set out in the plan was no longer necessary.

A) Resident #005 was observed on two specified days in January 2017, and a Long Term Care Homes (LTCH) Inspector observed an intervention in place. The written plan of care at the time of the observation indicated that the resident was to have the intervention in place. On a later date in January 2017, the intervention was no longer observed to be in place. The health care records were reviewed, and there was no documentation in the progress notes indicative of any changes in relation to the implementation of this intervention. Results of a diagnostic test reviewed in the resident's chart confirmed that the intervention was no longer required. Registered staff #102 was interviewed and confirmed that as a result of the diagnostic test in December 2016, the resident no longer required the intervention. The written plan of care was reviewed and was not revised to reflect that the resident was clear of infection and no longer required the intervention. Registered staff #102 confirmed the written plan of care should have been revised when there was a change in resident #005’s condition.

B) During stage one of the inspection, an LTCH Inspector observed that resident #005’s room had one assist rail that was in guard position and the other assist rail in the transfer position. The resident was not in bed at the time of the observation.

PSW #107, who provided direct care to the resident was interviewed and stated that the resident used both rails; one in the transfer position (down) and the other in the guard position (up). In an interview, registered staff #108 indicated that the resident used both rails; one was always down and the other was always up as the resident used it for transferring. The written plan of care was reviewed and did not include the use of both rails. The written plan of care indicated that the resident used one quarter bed rail for bed mobility and positioning. The Restraint/PASD Assessment dated July 2016, indicated that the resident used one quarter side rail (left side of bed) for positioning and mobility. The maintenance technician who was responsible for testing the bed rails for zones of entrapment was interviewed and stated that the resident had only one bed rail at one point and then another one was added, but could not recall when. The DOC confirmed that the resident was assessed and the care plan revised to include the use of both rails when the resident originally used both rails.
The licensee has failed to ensure that the plan of care was revised when the care needs for resident #005 changed. [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 staff and others who provide direct care to a resident are kept aware of the contents of the plan of care, and to 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 the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's disposal of discontinued medications policy was complied with.

The home's policy titled "Disposal of Discontinued Medications", index number: 02-06-20, last reviewed June 23, 2014, indicated "narcotic and controlled substances to be destroyed are to be stored in a double locked storage area within the facility, separate from any narcotic and controlled substance available for administration to a resident". Regulation 136. (2) 1 of the Act, indicates that the home's drug destruction and disposal policy shall include that drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

During an observation of the medication pass in January 2017, an LTCH Inspector found that a controlled substance belonging to a resident that was discontinued in January 2017, was stored in the narcotic medication bin in the medication cart with other controlled substances for administration. Registered staff #105 indicated that once a narcotic was discontinued it was given to the Director of Care (DOC) for destruction.

In an interview with the DOC, they indicated that once a narcotic medication was discontinued it was kept in the medication cart and given to them from the registered staff once they were available. If a narcotic medication was discontinued over the weekend, it was stored with the other narcotic medication in the medication cart until Monday or the next shift that they would be available.

The licensee failed to ensure that their "Disposal of Discontinued Medication" policy was complied with. [s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's Falls Prevention policy was complied with.

Regulation 48(1) of the Long Term Care Homes Act, 2007 states that every licensee of the a long term care home shall ensure that the falls prevention and management program is developed and implemented in the home and regulation 48(2) (a) and (b) of the Long Term Care Homes Act, 2007, states that the program must provide for screening protocols and assessment and reassessment instruments.

The policy #VII-G-30.00, titled "Falls Prevention", revised January 2015, stated "registered staff will initiate a head injury routine (HIR) if a head injury is suspected or if the resident fall is unwitnessed; monitor head injury routine as per the schedule on the form post fall for signs of neurological changes".

Resident #005 had an unwitnessed fall in September 2016, as per their clinical health records. The clinical health records were reviewed and a HIR could not be found after the resident fell. Registered staff #108 was interviewed and indicated that the HIR was to be initiated after any unwitnessed fall and when a resident who fell sustained a head injury. The DOC confirmed that the HIR should have been initiated for resident #005 after they sustained an unwitnessed fall. [s. 8. (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 the home's disposal of discontinued medications policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident’s linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment was kept clean and sanitary.

Observations on three specified days in January 2017, revealed the wheelchair cushion for resident #018 was dirty, and the walker for resident #017 was also dirty.

A review of policy #Vii-H-10.30, titled "Equipment Maintenance and Cleaning - Nursing and Resident Care", revised January 2015, directed staff to observe the cleanliness and safety of equipment and clean as required according to the “Nursing and Resident Care Equipment Cleaning - Frequency Schedule”, complete cleaning and inspection audits as assigned and forward them to Director of Care".
A review of point of care (POC) for resident #017 revealed there was no section for cleaning of their walker. Walker cleaning was not included in the schedule. This was confirmed by the DOC. A review of POC for resident #018 revealed it was documented that their wheel chair seat cushion was cleaned on specified days in December 2016 and one day in January 2017.
A review of the document "Nursing & Resident Care Equipment Cleaning Frequency", did not include wheelchairs, walkers, or any other gait aids as items scheduled to be cleaned.
In interviews, PSWs #109, #112, #113 and registered staff #100 confirmed the above mentioned equipment were not clean, and indicated it was the responsibility of the night shift PSW staff to clean the wheel chairs and walkers as scheduled. The ADOC presented a document titled “Wheel chair Schedule” which they stated the night shift PSWs signed when they had cleaned the wheelchairs; however, walkers were not included on the schedule. The ADOC confirmed there was no cleaning schedule for walkers.
In an interview, the DOC confirmed the above mentioned equipment for resident #017 and #018 were not clean, that ambulation equipment were not included on the cleaning schedule, and the walker for resident #017 was not included in the POC documentation. The licensee failed to ensure that the ambulation equipment for resident's #017 and #018 were kept clean. [s. 15. (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 equipment is kept clean and sanitary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

Resident #005's bed was observed to have one assist rail by the window that was in transfer position (down) and the other was in the guard position (up). PSW #107 and registered staff #108 were interviewed and indicated that the resident used both rails; however, one was always down and the other always up. The Restraint/PASD Assessment dated July 2016, indicated that the resident used one quarter bed side rail (left side of bed) for positioning and mobility. The maintenance technician who was responsible for testing the bed rails for zones of entrapment was interviewed and stated that the resident had one bed rail at one point and then another one was added, but could not recall when. The bed entrapment audit completed in March 2016, indicated that the resident's bed passed all the zones of entrapment. The DOC confirmed that the resident was not assessed for the use of both bed rails when the second bed rail was added.
The licensee failed to ensure that resident #005 was assessed for bed rail use when there was a change in the number of rails being used to minimize risk to the resident. [s. 15. (1) (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 where bed rails are used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #6: 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 has failed to ensure that drugs were stored in an area or a medication cart,
i. that was used exclusively for drugs and drug-related supplies.

In January 2017, following the observation of the medication pass, the medication cart on a specified unit was checked. An LTCH Inspector found three rings and an envelope with money in the narcotic bin of the medication cart. In an interview, registered staff #105 stated that the rings should have been placed in the "lost and found" in the medication room; however, money was usually kept in the medication cart.
The licensee did not ensure the medication cart was used exclusively for drugs and drug-related supplies.

2. The licensee has failed to ensure that drugs were stored in an area or a medication cart,
iv. that complied with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting).

A) During observation of a medication cart in January 2017, an LTCH Inspector found 4 specified bottles of eye drops prescribed for an identified resident without the date that they were opened on them.

The pharmacy's manual titled "Audits-Medication Storage and Insulin", Index Number 06-02-60, last reviewed June 2, 2014, stated "eye drops/eye ointments and injections are labeled with an open/start date and discarded when expired".

In an interview, registered staff #116 confirmed that all eye drops that were opened should have the date that they were opened written on the bottle.

B) In January 2017, an LTCH Inspector observed the storage area where government stock medications were kept in the home and found three bottles of a specified medication that had expiration dates of September 2016, and 16 bottles of another specified medication that had expiration dates of September 2016.
The DOC disposed of the expired medications and confirmed that the medications should have been disposed of when they expired. [s. 129. (1) (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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

In January 2017, an LTCH Inspector observed the room where the home kept the discontinued controlled substances awaiting destruction. The narcotic bin was stored in the DOC's office. The DOC indicated that they were the only one with a key to the narcotic bin. In interviews, the Environmental Services Manager (ESM) and the maintenance technician both stated that the keys to all of the offices in the home, including the DOC's office, were kept in the reception area. The administrative staff confirmed they had access to those keys. Although the narcotic bin with the controlled substances that were discontinued were kept double locked, the room where the narcotic bin was stored (the DOC's office) was accessible to persons who were not permitted to dispense, prescribe or administer drugs in the home.
The licensee failed to ensure all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator. [s. 130. 2.]

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 all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (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. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) The health care records for resident #005 were reviewed and indicated that a Head Injury Routine (HIR) form was initiated in December 2016, after they sustained a fall. The HIR was reviewed and indicated that between specified hours, the form was blank and staff did not document the assessment during those hours. Registered staff #108 was interviewed and confirmed that the HIR was to be initiated after each fall if the resident hit their head or the fall was unwitnessed and the HIR form was to be filled out as per the schedule.
The policy titled "Head Injury Routine", policy #VII-G-10.40, revised January 2015, directed staff to complete the HIR as per the schedule outlined or as ordered by the Physician. The policy titled “Falls Prevention", policy #VII-G-30.00, revised January 2015, directed to monitor HIR as per the schedule on the form after falls for signs of neurological changes.
The licensee failed to ensure that the assessments and responses to the interventions for resident #005 were documented post fall.

B) Resident #005 had a written plan of care which indicated that the resident used a quarter rail while in bed for positioning and mobility as a PASD. A review of the resident's clinical health care record revealed that the consent form signed by the Substitute Decision Maker (SDM) consenting to the use of PASD was missing information related to what type of PASD was used. Registered staff #102 confirmed in an interview that the SDM was aware that the resident used the bed rail as a PASD and that the consent form should have indicated the type of PASD used before the SDM signed it.
The home failed to ensure that when resident #005 was assessed for the use of the bed rail as a PASD, the type of PASD was documented on the consent form signed by the SDM. [s. 30. (2)]

Issued on this 22nd day of February, 2017

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

Original report signed by the inspector.