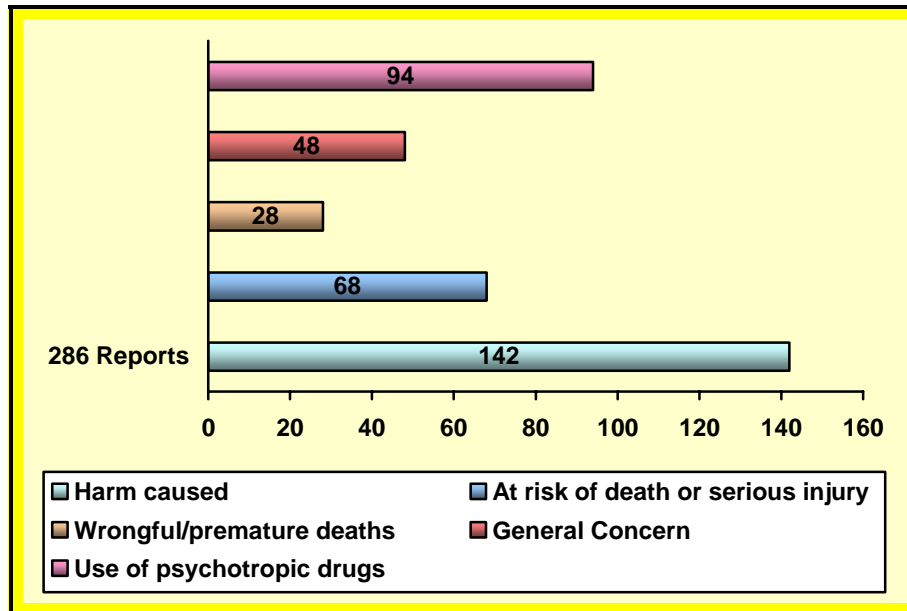


## Experiences of Residents in Long-Term Care Facilities in Alberta

Source: Database of Complaints by Residents and Families Documented and Categorized by Bev McKay, Founder  
Families Allied to Influence Responsible Eldercare (FAIRE)



### Examples of residents' experiences resulting in injury, illness, trauma and health decline [ 142 reports ]

- Physical/emotional/sexual abuse
- Pressure sores resulting in infection or surgical closure
- Undetected/untreated medical conditions including infection, pain, fractures, pneumonia, sepsis, malnutrition and dehydration
- Life-threatening bowel obstruction caused by fecal impaction associated with inadequate fluid intake, poor diet, medications
- Overuse of major tranquilizers causing toxicity, swallowing difficulties, loss of functioning, muscle rigidity, neurological disorders, fecal impaction, coma, falls resulting in bruising, fractures and loss of mobility
- Muscle contraction and atrophy due to the use of physical restraints and/or the lack of exercise, physiotherapy
- Mouth thrush, gum disease and full-tooth extraction due to inadequate or no mouth care
- Injuries resulting from unskilled/inappropriate handling of mechanical lifts.
- Skin excoriation and/or urinary tract infection resulting from infrequent changing of incontinent wear.

### Examples of residents placed at risk of injury, illness, trauma or death [ 68 reports ]

- Units are left unsupervised; call bells for assistance go unanswered; inadequate training in fire drill procedures
- Colostomies rupture and catheter tubes plug due to inadequate monitoring.
- Residents are not given adequate assistance or time to finish their meals; meals are taken away untouched.
- Unplanned weight loss and life-threatening health decline due to inadequate food intake, undetected swallowing difficulties or medical condition.
- No monitoring for, or recognition of, adverse drug reactions; administering wrong medications or multiple medications; nurses dispense medication but do not ensure residents take it; medication carts are left unlocked and unsupervised.
- Inadequate monitoring of blood sugar levels in diabetic residents
- Residents wander out of the facility unnoticed.
- Residents are immobilized by chemical and/or physical restraints.
- Oxygen tanks run empty or are not turned on.
- Residents are made to stay in their beds for hours, even days, at a time.

### Examples of premature deaths [ 28 reports ]

- A paralyzed respirator-dependent resident died when staff failed to respond to alarm monitors indicating respirator failure.
- A resident wandered unnoticed out of the nursing home and was later found dead in a nearby field.
- A resident died of asphyxiation after becoming trapped between her mattress and the bed rails.
- A resident died after being dropped from a mechanical lift.
- A resident died following three unassessed falls.
- A resident died after failing to receive treatment for a gangrenous foot.
- Two residents died after failing to receive treatment for 1) a reported gastrointestinal bleed 2) reported symptoms of pneumonia.
- A resident died as a result of 3<sup>rd</sup> degree burns associated with a smoking incident.
- A resident died after being placed in scalding bathwater.
- A resident died as a result of a fatal adverse drug reaction associated with the overuse of psychotropic drugs.