Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Public Report

Report Issue Date: February 7, 2025

Inspection Number: 2025-1576-0001

Inspection Type:
Complaint
Critical Incident

Licensee: City of Greater Sudbury

Long Term Care Home and City: Pioneer Manor, Sudbury

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 3-7, 2025.

The following intake(s) were inspected:

- One intake was related to a medication incident concerning a resident.
- One intake was related to an injury of resident.
- One intake was related to a complaint regarding the care of a resident.
- One intake was related to a missing controlled substance.
- One intake was related to a fall of resident resulting in injury.
- One intake was related to an improper care of resident by staff.
- One intake was related to physical abuse of a resident by staff.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Continence Care
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a resident was transferred using safe techniques.

Sources: A resident's electronic medical record; the home's internal investigation notes.

WRITTEN NOTIFICATION: Administration of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber. This incident

resulted in a significant change to the resident's condition.

Sources: The home's investigation file; a resident health care records; and interviews with staff members.