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: April 28, 2025

Inspection Number: 2025-1576-0002

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): April 7 to 11, and 14 to 15, 2025.

The following intake(s) were inspected:

- One complaint intake related to the provision of resident care;
- One intake related to an alleged improper/incompetent care of a resident by staff members;
- One intake related to an outbreak in the home, and
- One intake related to an alleged abuse of a resident towards another resident.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 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 staff were to use safe transferring and a positioning device when assisting a resident.

A CI report was submitted to the Director involving a Personal Support Worker (PSW), who had transferred a resident that resulted in an injury. Care plan record and interview with the resident indicated that they require a specific assistance from staff with the use of a device but, was not provided at that time.

Sources:
Review of the Critical Incident (CI) record; review of the resident's clinical records; the home's policy, and interview with the resident, PSW staff, and the Manager of Resident Care (MORC).

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident

has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident has fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CI was submitted to the Director related to a resident's fall incident that resulted in an injury. The resident's assessment record was reviewed and no post-fall assessment was identified.

Sources:
Review of the CI, review of the resident's clinical records, review of the home's internal investigation, and interview with the Scheduler.

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