



**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**

**Health System Accountability and  
Performance Division  
Performance Improvement and  
Compliance Branch**

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**Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
performance et de la conformité**

**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Oct 16, 2013	2013_204133_0027	S-000222-13	Critical Incident System

**Licensee/Titulaire de permis**

**THE CITY OF GREATER SUDBURY  
200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3**

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

**PIONEER MANOR  
960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4**

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

**JESSICA LAPENSEE (133)**

**Inspection Summary/Résumé de l'inspection**



The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 7th - 9th, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Manager of Physical Services, the Housekeeping, Laundry and Materials Control Supervisor, and Registered and Non Registered nursing staff.

During the course of the inspection, the inspector(s) reviewed a resident's health care record, observed a resident's bedroom, observed bath and shower rooms on the York, Ramsey and Scenic care units, reviewed the home's "Missing Resident" emergency plan, reviewed Critical Incident Report #M566-000034-13, reviewed the missing resident incident form and associated documentation related to the reported Critical Incident of May 2013, reviewed a missing resident incident form and associated documentation for an incident that occurred in February 2012.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Safe and Secure Home

There are no findings of Non-Compliance as a result of 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



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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.

**Issued on this 16th day of October, 2013**

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

*Jessica Lapensée*