EXECUTIVE SUMMARY

Pioneer Manor is committed to providing a safe, healthy, and supportive environment by treating residents, families, visitors and employees, with respect and fairness. The Home strives towards finding a balance between ensuring resident safety and that the quality of life is not being adversely affected by the safety measures put into place.

GOOD NEWS STORIES

Beginning June 18, 2020, long-term care homes were allowed outdoor visits of one person per resident, each week at a minimum. In July, the Ministry expanded the visitation policy to two persons per resident, for visits outdoors and inside the Home. The visiting policy was further updated in September, which clarified that caregivers are considered to be essential visitors and important partners in care who provide direct care to residents; such as helping with feeding, mobility, hygiene, or cognitive stimulation and include family members or friends, privately hired caregivers, paid companions and/or translators. The updated policy permits up to two caregivers to visit the Home at any time, including during an outbreak, and without time limits.

Picture retrieved from CBC news article "Pioneer Manor visits reunite loved ones" https://www.cbc.ca/news/canada/sudbury/sudbury-pioneer-manor-long-term-care-visits-resume-1.5622691

Ministry of Long-Term Care (MOLTC)

Inspections conducted by MOLTC (see reference 1 below for definitions)

During the third quarter of 2020, the MOLTC contacted Pioneer Manor once to follow up on eight (8) critical incidents that had been submitted. No areas of noncompliance were found.

Between July 6 and 10, 2020, the MOLTC inspectors were on site to conduct a "Critical Incident" and a "Complaints" inspection resulting in the Home receiving zero (0) compliance orders (CO), two (2) voluntary plan of correction (VPC) and one (1) written notification (WN). The Home has put a plan in place to address all areas of non compliance. In addition, the inspectors conducted a "Follow up" inspection to a compliance order the Home received in January 2020. The Home was found to be in compliance and the order was lifted.

Critical Incident Reports

All critical incidents (CI) involving residents must be reported to the Director [under the Act] as designated under the *Long-Term Care Homes Act 2007*. The incidents are documented within the on-line Mandatory Critical Incident System (CIS) and received by the the MOLTC (see reference 2 below for definitions).

2020 Q3 CIs Relating to "Alleged/Actual Abuse/Assault"		
Number of CIs Submitted	13	
Number of CIs Resident to Resident	6	46%
Number of CIs Staff to Resident	6	46%
Number of Staff to Resident allegations **substantiated**	1	17%
Number of CIs Visitor to Resident	1	8%
2020 Q3 Other CIs Submitted		
Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status	9	
Controlled Substance missing/unaccounted	2	
Outbreak	1	
Improper/Incompetent treatment	1	
Missing Resident < 3 hours	0	
Unexpected Death	0	
Unlawful Conduct	0	

Complaints/Concerns

As per section 56 (2) of the Long-Term Care Homes (LTCH) Act 2007, the Home has a duty to respond in writing within ten (10) days of receiving a concern, request, or recommendation from either the Resident or Family Councils.

Due to the COVID-19 pandemic, Resident and Family Council meetings have been suspended since March, 2020.

As per O. Reg. 79/10, s. 101, every written or verbal complaint made to the Home or a staff member concerning the care of a resident or operation of the Home is investigated and resolved where possible, and a response indicating what the licensee has done to resolve the complaint, or that the Home believes the complaint to be unfounded and the reasons for the belief within ten (10) business days of the receipt of the complaint.

Seven (7) written concerns were submitted by residents' family members in relation to care issues. All concerns were investigated and family members received a written response to their concerns. All family members were satisfied with the response received.

Ministry of Labor (MOL)

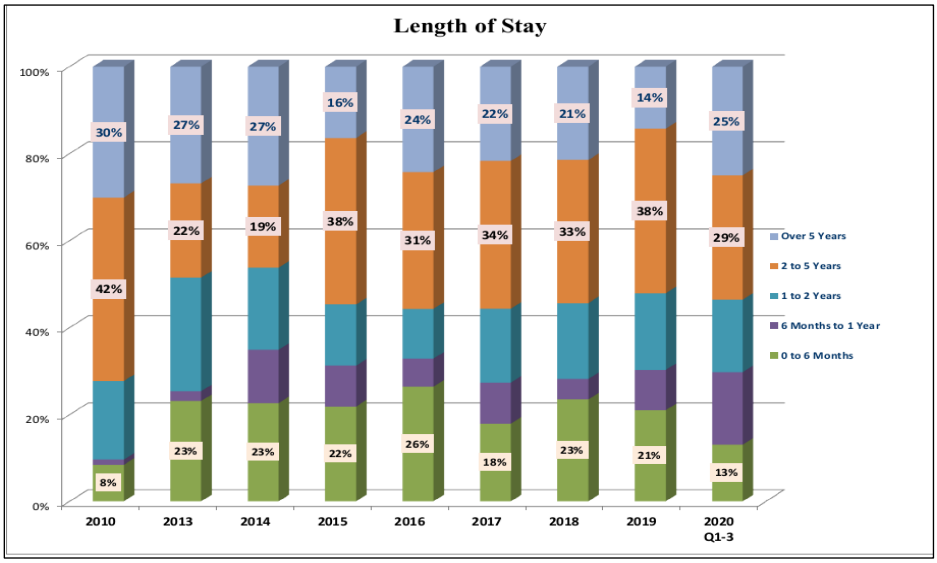
Due to a Pioneer Manor employee testing positive for COVID-19, the MOL was on site on August 13th to respond to a notice of occupational illness and outbreak made to the Ministry of Labour, Training, and Skills Development. No orders were issued to the Home.

Key Performance Indicators

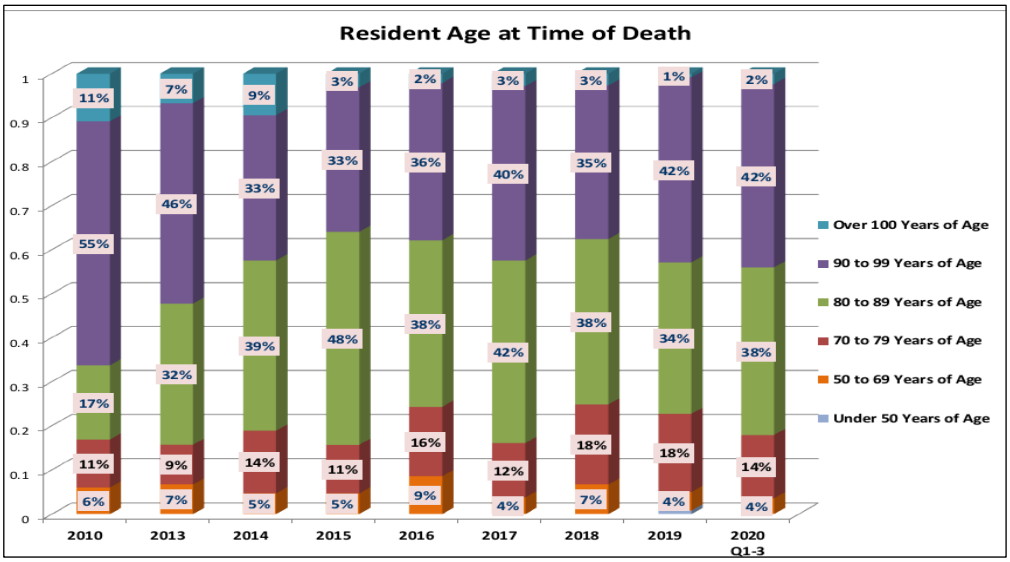
Long-Term Care Home Availability (as of May 2020)					
Facility Name	**Beds**	**# on waitlist for Basic Bed**	**# on waitlist Private Beds**	**Average beds available/month**	**Total # waiting**
Pioneer Manor	433	457	201	10	608
North East LHIN	1555			3	1174

Resident Care Stats (433 Residents)		**2018**	**2019**	**2020 Q1-3**
Admissions	Total	144	134	67
Discharges	Total	9	11	5
Deaths	Total	149	119	84
Internal Transfers	Total	107	100	71
Occupancy Rate	Required to maintain >97%	99%	99%	96.36

From January 1 to September 30, 2020, 93% of residents who passed at away did so at the Home (versus the hospital) compared to 86% in 2019 and 81% in 2018.



From January 1 to September 30, 2020, 51% of residents who passed away were residents at Pioneer Manor longer than two years compared to 72% in 2010. This is reflective of residents being admitted to the Home with higher acquity.



From January 1 to September 30, 2020, 46% of residents were over 90 years of age at time of death compared to 66% in 2010

Infection Control

Tracking of infection control rates and analysis of the information to identify clusters (note inherited cases are brought into the Home from the community) continued during the third quarter of 2020.

During the third quarter of 2020, Pioneer Manor had one (1) outbreak declared by Public Health Sudbury and Districts (PHSD).

The Home received confirmation of a positive COVID-19 test result for a staff member at Pioneer Manor. As per the most recent provincial directives, Public Health assesses each unique situation in determining if an outbreak should be declared. Due to the nature of the job duties of the staff member and their contact with numerous residents in different areas of the Home, PHSD declared Pioneer Manor to be in a facility wide outbreak on July 29, 2020. In addition, PHSD directed Pioneer Manor to obtain COVID-19 swabs on all residents and staff in the Home. Pioneer Manor was in the midst of doing surveillance swabs for all staff on July 29th and 30th. On July 30th, all resident and staff members swabs were completed. All test results returned negative and no further transmission was identified throughout the duration of this outbreak.

In consultation with PHSD, it was determined that the staff member who had tested positive had two (2) identified employees as close contacts. Both close contacts were advised to remain at home (away from work) until fourteen (14) days post date of exposure.

All indoor and outdoor visits for residents were cancelled for the duration of the outbreak, as were small group activities. Daily outbreak management teleconferences were held for the outbreak management group.

The COVID-19 outbreak at Pioneer Manor was declared over on August 11, 2020. The duration of this outbreak was fourteen (14) days.

COVID-19 Pandemic

On March 17, 2020, a state of emergency was declared in Ontario under the Emergency Management and Civil Protection Act relating to the COVID-19 Pandemic. Pioneer Manor has been vigilant in its efforts to protect its residents, as well as staff and visitors. "Appendix A" provides specific details relating to Pioneer Manor's Response to COVID-19.

Public Health Sudbury & Districts (PHSD) Visits

During the third quarter of 2020, PHSD attended the Home six (6)times to conduct various routine inspections.

On July 14th and 15th, PHSD was in to conduct an institutional food safety compliance inspection on all serveries, the Bistro and main kitchen. No violations were issued to the Home.

On September 15th and 16th, PHSD was in to conduct an institutional food safety compliance inspection on all serveries, the Bistro and main kitchen. The Home received one violation; it was noted that the Tulip Home Area ceiling vents were observed with dust accumulated above the hot table and above the dishwashers. A follow visit occurred on October 1st and no violations noted.

On September 29th PHSD conducted an inspection as per Provincial direction that all LTC homes be inspected. They reviewed the following: enteric specimen kits to ensure not expired, cleaning schedules, cleanliness of resident rooms, spa rooms etc, laundry procedures, fire plans, COVID distancing, overall cleanliness and presence of hot and cold water in resident rooms. No violations were issued to the Home.

Falls Prevention

Number of Residents	Q3 2020
Using chair or chair pad sensors	110
Using bed sensors or bed pad sensors	153
Using infrared sensors	6

Monthly audits of universal precautions were completed by committee members. Among the concerns needing attention were; loose bed rails, light not working, call bell in washroom not working, bedrail photo missing, and mats left on floor. All areas of concerns were reviewed and issues addressed.

Facility Services

Remedial painting continued throughout the Home. A generator test was completed during each month of the third quarter of 2020.

Fire Sprinkler

Tender for the supply, delivery, installation and commissioning an extension of the existing fire sprinklers at Pioneer Manor (in the basement) was issued June 12, 2020 and closed on July 15, 2020. The contract has been awarded and construction is expected to begin during the fourth quarter of 2020.

Emergency Preparedness

During the third quarter of 2020, fire drills on all three shifts occurred each month. There were nine (9) Code Whites (situation with an actual or potential violent or out of control person). In addition, there were zero (0) Code Yellow (missing resident), three (3) Code Reds (fire), and zero (0) Code Blue (medical emergency).

Reference 1

The Long-Term Care Home Quality Inspection Program (LQIP) safeguards residents' well-being by continuously inspecting complaints and critical incidents, and by ensuring that all Homes are inspected at least once per year. This is achieved by performing unannounced inspections and enforcement measures as required, and ensuring that actions taken by the government are transparent. The MOHLTC conducts complaint, critical incident, and follow up, comprehensive and other types of inspections. An RQI inspection is a comprehensive, systematic two-stage inspection.

For each instance where 'non-compliance' with the legislation has been identified during an inspection a decision must be made by the inspector on the appropriate action to take, including whether to impose a sanction that is an Order. At minimum the inspector will issue a **Written Notification of Non-Compliance (WN**). Whether further action is required is based on an assessment of the following factors; severity and scope of harm (or risk of harm) resulting from the non-compliance and the licensee's past history of compliance for the last 36 months. Actions taken may include; **Voluntary Plan of Correction (VPC),** which is a written request for the Home to prepare a written plan of correction for achieving compliance to be implemented voluntarily. The Home is not required to submit the plan to the ministry. There is no required compliance date set out in the inspection report. **Compliance Order (CO)**, which is an order for the licensee to do anything, or refrain from doing anything to achieve compliance with a requirement under this Act or; prepare, submit, and implement a plan for achieving compliance with a requirement under this Act. The Home is required to follow the Order to achieve compliance with the LTCHA within the timelines for compliance set out in the Order. **Work and Activity Orders (WAO)**, which is an order for the Home to allow employees of the ministry, or agents or contractors acting under the authority of the ministry, to perform any work or activity at the LTC Home that is necessary, in the opinion of the person making the order, to achieve compliance with a requirement under this Act; and to pay the reasonable costs of the work or activity. The Home is required to follow the Order to achieve compliance with the LTCHA within the timelines for compliance set out in the Order. **Written Notification and Referral to the Director (WN & Referral**) is a written notification to the Home that they have referred the matter to the Director for further action by the Director. *(LTCHA, 2007, C.8 s. 152 – 154).*

Reference 2

The LTCH Act defines a CI as an event which poses a potential or actual risk to the safety, security, welfare and/or health of a resident or staff member or to the safety and security of the facility which requires action by staff and/or outside agencies.

- A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the MOLTC Director:
  - Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident,
  - Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident,
  - Unlawful conduct that resulted in harm or a risk of harm to a resident
  - Misuse or misappropriation of a resident's money,
  - Misuse or misappropriation of funding provided to a licensee under this Act,
  - An emergency, including fire, unplanned evacuation, or intake of evacuees that affect the

provision of care or the safety, security or well being of one or more resident of a LTC Home.

- A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall within one (1) business day report the information upon which it is based to the MOHLTC Director:
  - An unexpected or sudden death, including a death resulting from an accident or suicide,
  - A resident who is missing for three hours or more,
  - Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing,
  - An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act,
  - Contamination of the drinking water supply,
  - An environmental hazard, including a loss of essential services, flooding, breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours,
  - A missing or unaccounted for controlled substance,
  - A medication incident or adverse drug reaction in respect of which a resident is taken to hospital,
  - An injury in respect of which a person is taken to hospital and that resulted in a significant change in the resident's health condition.