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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: April 17, 2025

Inspection Number: 2025-1585-0003

Inspection Type:
Complaint
Critical Incident
Director Order Follow Up (DOFU)

Licensee: Regional Municipality of Waterloo

Long Term Care Home and City: Sunnyside Home, Kitchener

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 3-4, 7-11, 15-17, 2025

The following intake(s) were inspected:
- Intake: #00138315, Intake: #00141550, and Intake: #00141927 - Related to allegations of abuse.
- Intake: #00140236 - Complaint related to care of a resident.
- Intake: #00140541 - Related to Enteric Outbreak.
- Intake: #00140624 - Complaint related to allegations of abuse.
- Intake: #00140740 - DOFU #: 1 - O. Reg. 246/22, s. 53 (1) 2.
- Intake: #00142373 - Complaint related resident care.
- Intake: #00143052 - Complaint related application to waitlist refusal

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Director Order #001 related to O. Reg. 246/22, s. 53 (1) 2.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Palliative Care
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care: Involvement of resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to give a resident's substitute decision maker (SDM) an opportunity to participate in the plan of care.

Sources: Resident's progress notes, interview with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) 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 Director:
2. 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.

A) The licensee has failed to ensure that an allegation of abuse was reported immediately to the Director.

Sources: Critical Incident Report, interview with SDM and staff member.

B) The licensee has failed to ensure that an allegation of abuse was reported immediately to the Director.

Sources: Critical Incident Report, Complaint Form, interview with staff member.

WRITTEN NOTIFICATION: Dealing with complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the

home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that a response was provided to a complainant within 10 business days when they made a complaint alleging abuse.

Sources: Critical Incident System, Complaint Form, interview with staff member.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The Licensee failed to ensure that an outbreak of a disease of public health significance was immediately reported to the Director.

Sources: Critical Incident Report and home's Critical Incident binder related to same report, Home's policy, Interview with Infection Control Coordinator.

WRITTEN NOTIFICATION: Administration of drugs

NC #006 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 medication for a resident was administered as per a physician's note.

Sources: Resident's progress notes and clinical records, interviews with staff members.

WRITTEN NOTIFICATION: Approval by licensee

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 179 (3) 2.
Approval by licensee
s. 179 (3) Subject to subsections (4) and (5), the licensee shall, within five business days after receiving the request mentioned in clause (1) (b), do one of the following:
2. If the licensee is withholding approval for the applicant's admission, give the written notice required under subsection 51 (9) of the Act to the persons mentioned in subsection 51 (10) of the Act.

The Licensee failed to review a resident application within five business days of receiving their application to home's waitlist.

Sources: Email communications, Application refusal letter, interviews with complainant, staff and Manager Patient Services Ontario Health at Home.

COMPLIANCE ORDER CO #001 Palliative care

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 61 (4) (d)
Palliative care
s. 61 (4) The licensee shall ensure that, based on the assessment of the resident's palliative care needs, the palliative care options made available to the resident include, at a minimum,
(d) end-of-life care, if appropriate.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure all registered nursing staff, working on a specified unit, receive education on staff roles and responsibilities for end of life and palliative care, including specified. Maintain a record of the following:
1) Content of the education provided
2) Date(s) and time(s) the education was held
3) Who provided the education
4) Registered nursing staff working on the unit
5) Signatures of staff who attended the education, including the date of attendance

Grounds

The licensee failed to ensure end of life care options were made available to residents based on assessment of their palliative needs.

On more than one occasion, more than one resident was not assessed in accordance with the home's policy when they were designated palliative.

When staff did not proceed as the home's policies directed, the residents did not receive care as per their assessed needs.

Sources: Resident's clinical records, Palliative Care Policy, Palliative Philosophy and End of Life Care Policy, Oxygen Therapy Policy; Interviews with staff.

This order must be complied with by May 31, 2025

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.