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
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Public Report

Report Issue Date: October 16, 2025

Inspection Number: 2025-1585-0006

Inspection Type:
Critical Incident

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): October 1-3, 7-10, 14-16, 2025

The following intake(s) were inspected:

- Intake: #00151802, intake #00158170, intake #00154530 and intake #00154645 related to prevention of abuse and neglect
- Intake: #00151984 and intake #00156012 - related to fall prevention and management
- Intake: #00155737 - related to Infection Control and Prevention

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect a resident from abuse. O. Reg. 246/22 s. 2 defines abuse as (b) any non-consensual touching, behaviour or remarks or exploitation directed towards a resident by a person other than a licensee or staff member.

A resident had a history of responsive behaviours. The resident had interventions in place to assist with managing their behaviours. Several times the resident displayed responsive behaviours towards another reisdent. One of the interventions was not in place at the time of the incident.

In addition, the home did not immediately notify police related to the incident.

Sources: Progress notes, interview with Professional Practice Specialist

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A registered staff responded to an incident they believed to be verbal abuse and neglect but did not follow the home's abuse policy and procedures when they failed to report it immediately to the manager on-call and did not document any assessments or a description of the incident in the resident's record.

Sources: Critical Incident Report, Resident Abuse & Neglect Zero Tolerance Policy, Interview with Registered nurse and others.

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.

The licensee failed to immediately report allegations of abuse of a resident to the Director.

Several incidents of potential abuse of a resident by another resident were observed but were not reported to the Director until several days later.

Sources: CIS report, interview with Professional Practice Specialist

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee failed to ensure that staff followed behavioural interventions that were in place for a resident that had a history of responsive behaviours. By not implementing the interventions consistently the resident displayed responsive behaviours towards a co-resident.

Sources: clinical record for a resident, Responsive Behaviour Protocol, interviews with a registered nurse and others.