

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: December 18, 2025

Inspection Number: 2025-1585-0007

Inspection Type:

Complaint
Critical Incident
Follow up

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): December 9-12, 15-18, 2025

The following intake(s) were inspected:

- Intake: #00156397 -Follow-up related to pain management
- Intake: #00159603/ #00159614 -Concerns related to a discharge of a resident.
- Intake: #00161011/#00162643 -Prevention of abuse and neglect

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1585-0005 related to O. Reg. 246/22, s. 53 (1) 4.

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

Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 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.

An incident of improper care towards a resident was not reported until a day after.

Sources: CIS and interview with Professional Practice Specialist.

WRITTEN NOTIFICATION: When Licensee Shall Discharge

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 158 (4) (a)

When licensee shall discharge

s. 158 (4) A licensee shall discharge a long-stay resident if,

(a) the resident is on a medical absence that exceeds 30 days;

A resident was discharged from the home before their 30-day medical absence was completed.

Source: Clinical records, Letter of Discharge and interviews with staff.

WRITTEN NOTIFICATION: Requirements on Licensee Before Discharging a Resident

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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Non-compliance with: O. Reg. 246/22, s. 161 (1) (a)

Requirements on licensee before discharging a resident

s. 161 (1) Except in the case of a discharge due to a resident's death, every licensee of a long-term care home shall ensure that, before a resident is discharged, notice of the discharge is given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct,

(a) as far in advance of the discharge as possible; or

A notice of discharge was given to the resident's Power of Attorney (POA) the same day as the resident was discharged from the home, which did not provide advance notice.

Source: Clinical records, Letter of Discharge and interview with staff

WRITTEN NOTIFICATION: Requirements on Licensee Before Discharging a Resident

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 161 (2) (b)

Requirements on licensee before discharging a resident

s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,

(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;

Alternate arrangements were not made for the accommodations, care and safety required by a resident before their discharge from the home.

Source: Critical Incident Report and interview with staff

WRITTEN NOTIFICATION: Requirements on Licensee Before Discharging a Resident

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 161 (2) (c)

Requirements on licensee before discharging a resident

s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,

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(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that their wishes are taken into consideration; and

The home conducted two meetings related to the discharge of a resident, however, the resident's POAs were not given the opportunity to participate in the discharge planning or to communicate their wishes during these meetings.

Source: Communication Email and interviews with staff

COMPLIANCE ORDER CO #001 Duty to protect

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall ensure :

1 - Ensure that all care staff on a specified unit are educated on a resident's responsive behaviour plan of care, including what actions to take when the resident displays verbal and physical responsive behaviours. A record must be kept of the training, including the contents of the training, the dates of the training, the name of the trainer, and the staff members who completed the training.

2 - Ensure that the specified resident meets with the Assistant Manager of Care (AMOC) and the Social Worker on a weekly basis for four weeks, or as otherwise deemed necessary according to their plan of care. Each meeting must be documented, and records should include the meeting details and the residents' progress

Grounds

According to O. Reg. 246/22 s. 2 physical abuse is defined as "the use of physical force by a resident that causes physical injury to another resident."

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a) A resident to resident altercation resulted in a injury to a specified resident, which made them upset, scared and overwhelmed after the incident.

Sources: clinical records, interview with staff

b) A staff member provided improper care to a resident, causing the resident to call out and be scared.

Sources: CIS, record review, interview with staff

“emotional abuse” means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

c) When a specified resident requested for assistance, a staff member would leave the resident unattended, calling out for help. The staff member was also observed responding loudly to the resident when they asked questions, which escalated the resident’s behaviour.

Sources: CIS , record review, and interview with staff

This order must be complied with by January 29, 2026

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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

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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.



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**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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