



**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 prévue  
sous la Loi de 2007 sur les foyers  
de soins de longue durée**

**Long-Term Care Homes Division  
Long-Term Care Inspections Branch**

**Division des foyers de soins de  
longue durée  
Inspection de soins de longue durée**

Central West Service Area Office  
500 Weber Street North  
WATERLOO ON N2L 4E9  
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Centre-Ouest  
500 rue Weber Nord  
WATERLOO ON N2L 4E9  
Téléphone: (888) 432-7901  
Télécopieur: (519) 885-9454

## **Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Dec 17, 2018	2018_508137_0030	004554-18, 009343-18, 013002-18, 015031-18, 018442-18, 018577-18, 019578-18, 020623-18, 021004-18, 023858-18	Critical Incident System

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### **Licensee/Titulaire de permis**

Regional Municipality of Waterloo  
150 Frederick Street KITCHENER ON N2A 4J3

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

Sunnyside Home  
247 Franklin Street North KITCHENER ON N2A 1Y5

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

MARIAN MACDONALD (137)

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

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

**This inspection was conducted on the following date(s): November 21-22 and 26-28, 2018**

**During the course of the inspection, the inspector(s) spoke with Manager Resident Care, Resident Care Coordinators and Personal Support Workers (PSW).**

**The Inspector also observed resident care provision and fall prevention interventions, reviewed resident clinical records, internal investigative records and relevant policies and procedures.**

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

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**



**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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.



**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6.  
Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC), where an identified resident sustained a fall with injury.

The plan of care stated that the identified resident required two persons for care. An identified staff member continued to independently provide care to the resident and the resident sustained a fall with injury.

The Resident Care Coordinator (RCC) said the staff member should have stopped care until the other staff member returned. The RCC said the identified staff member did not provide care to the resident, as specified in the plan of care.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**Issued on this 17th day of December, 2018**

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

**Original report signed by the inspector.**