Public Report

Report Issue Date: March 25, 2025
Inspection Number: 2025-1513-0001
Inspection Type: Critical Incident
Licensee: Unionville Home Society
Long Term Care Home and City: Union Villa, Unionville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 12, 14, 19 - 21, 24, 25, 2025

The following intake(s) were inspected:
- Two intakes related to Physical abuse
- Two intakes related to Disease Outbreak.

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

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.

The licensee failed to report to the Director immediately when abuse or neglect was suspected by a resident towards co-resident.

A Critical Incident Report (CIR) was submitted by the Director of Care (DOC) related to allegations of abuse of a resident towards co-residents. The CIR was not reported immediately to the Director.

Sources: CIR, resident's clinical records and interview with the DOC.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee failed to ensure that resident's symptoms indicating the presence of infection were monitored on every shift during an infectious disease outbreak.

A CIR was submitted to the Director related to a declared outbreak in the home.

The Registered Practical Nurse (RPN) and the Infection and prevention and control (IPAC) lead back up indicated that registered staff should monitor and document symptoms on every shift, in Point Click Care (PCC) under progress notes,

The resident's progress notes confirmed that the registered staff were not monitoring resident 's infectious disease symptoms on every shift.

Sources: CIR, resident 's progress notes, interview with RPN, and IPAC lead back up.

WRITTEN NOTIFICATION: POLICE NOTIFICATION

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

1) The licensee failed to ensure that the appropriate police service was immediately notified of an allegation of abuse by a resident towards co-residents.

A CIR was reported to the Director, concerning alleged physical abuse by a resident towards co- residents.

The investigation records and the DOC indicated the allegation of abuse was not substantiated. Additionally, the DOC confirmed the police was not notified of the incident.

Sources: Resident's electronic medical records, the home's investigation notes, CIR, and interview with DOC.

2) The licensee failed to ensure that the appropriate police service was immediately notified of an allegation of abuse towards a resident.

A CIR was reported to the Director, concerning an alleged abuse by PSW towards a resident.

The investigation records, and the DOC indicated the allegation of abuse was substantiated. Additionally, the DOC confirmed the police was not notified of the incident.

Sources: Resident's electronic medical records, the home's investigation notes, CIR, and interview with DOC.

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

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