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 East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: November 25, 2025
Inspection Number: 2025-1513-0005
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): November 12-14, 18-19, 21, 24-25 2025.

The following intake(s) were inspected:
-one intake regarding neglect of a resident

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

Prevention of Abuse and Neglect

INSPECTION RESULTS

COMPLIANCE ORDER CO #001 Duty to Protect

Non- 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)]:
1) The licensee will develop and implement a plan to educate all registered staff on the

management of diabetes including but not limited to the signs and symptoms of hyperglycemia and hypoglycemia and the associated complications.
a) The education plan will include at a minimum, how to administer powered glucagon and the homes process for treating hypoglycemia and hyperglycemia states. The plan should outline the objectives of the training, topics and areas to be covered, the timeline for implementation, delivery method and evaluation approach.

2) a) The licensee will provide education to the Registered Practical Nurse (RPN) including but not limited to nursing clinical assessments, diabetes management and critical thinking skills. This education must be evaluated with success and return to front line duties with mentorship. The licensee will develop and implement a written plan to further support the RPN with critical thinking skills, clinical assessments and diabetes management.
b) The licensee will keep a documented record- part 2a) of the order.

Grounds

A critical incident report (CIR) was received by the Director for a complaint received by the family of a resident. Specifically, the family communicated concerns regarding a recent visit to the hospital.

The Ontario Regulation 246/22 defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents

The resident was first admitted to the long-term care facility several months prior to this incident. The residents' care plan identified a specific diagnosis. Days surrounding this incident, the resident experienced a change in health status, and no proper assessment was completed by the RPN. The Personal Support Worker (PSW) informed the RPN, that there was a change in the resident's baseline. The RPN did not complete a nursing assessment for the resident. The Registered Nurse (RN) confirmed a head-to-toe assessment was to be completed for the resident as per the home's expectation.

In an interview with the RPN, they could not identify a specific health condition. The RPN identified a progress note as an assessment. The RPN confirmed no order for a specific intervention was received for the resident on admission. The RPN confirmed

the resident had the intervention once on admission and by the paramedics on arrival to the home. The RN indicated that the resident had abnormal results on admission and required a physician order for a specific intervention. Another RN confirmed they were not aware of the resident's condition and did not request the RPN to provide a specific intervention.

The RN indicated that a reassessment of certain medication was not completed after three months. Both RNs confirmed an order for the specific intervention was not required once there was a change in the residents' health status. The home's medication administration policy states that residents must be reassessed quarterly when taking medications to identify opportunities to further improve quality and safety measures.

The home's investigation did not occur immediately and occurred 15 days after the incident when the Director of Care (DOC) returned from their absence. The Clinical Quality Educator (CQE) confirmed the same.

The Human Resources Lead and HR Manager confirmed the RPN was not put on a paid leave while the investigation was conducted. Review of the RPN's employee file found multiple written warnings related to their performance.

The administrator and CQE confirmed the home did not have a policy for the specific medical condition and provided partial education on the condition. The home is currently developing said policy.

Sources: Review of the resident's plan of care, interview with staff, review of the homes medication administration policy and the progressive discipline policy.

This order must be complied with by January 30, 2026.

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.