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: January 16, 2026
Inspection Number: 2026-1513-0001
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): January 7, 8, 9, 12, 13, 14, 16, 2026
The inspection occurred offsite on the following date(s): January 15, 2026

The following intake(s) were inspected:

- Three intakes related to allegation of physical abuse.
- One intake related to Fall of resident with injury.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

1) Resident's care plan indicated they were assessed to use a specific device.

The personal support worker (PSW) assisted an agency PSW, and they proceeded to use a specific device that was not assessed and the resident fell during the transfer and sustained a head injury.

Sources: Resident's clinical records, the home's investigation file, interviews with PSW, RPN and PT.

2) Resident's written plan of care indicated that no male PSWs were to provide care to resident.

The PSW confirmed that they were aware of resident's written plan of care indicating no male PSWs to provide care but proceeded to participate in a specific aspect of care.

Sources: Resident's clinical records, the home's investigation file, interviews with resident, PSW and DOC.

WRITTEN NOTIFICATION: Transfer and Positioning Techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

1) Resident fell and sustained a head injury while being transferred with a specific device.

The resident was assessed as requiring a specific device for transfers. The PSW confirmed that they were performing one part of the task instead of moving the lift and the agency PSW was not guiding the resident safely when the resident fell.

Sources: Critical Incident Report (CIR), resident's clinical records, the home's investigation file, interviews with PSW, PT and DOC.

2) The pre-start checklists for lifts on a resident home area were not completed on multiple dates.

The DOC confirmed that the staff are expected to complete the pre-start checklist before the lift is used on each shift, but the staff still need to check the lift prior to each lift. The pre-start checklists were observed to not be completed up to date of observation.

Sources: the home's Minimal Lift Policy, pre-start checklists, interview with DOC.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Dementia Observation System (DOS) monitoring for a resident was not completed.

The DOS assessment was incomplete.

Behavioral Support Coordinator confirmed that the DOS form should be filled out completely, and each time slot should be individually initialed at time of observation.

Sources: Resident's clinical records, interview with Behavioral Support Coordinator.

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