Ontario

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

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: August 23, 2023	
Inspection Number: 2023-1183-0002	
Inspection Type: Critical Incident	
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership	
Long Term Care Home and City: The Village Green Nursing Home, Selby	
Lead Inspector Carrie Deline (740788)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 16 - 18, 2023

The following intake(s) were inspected:

- Intake: #00090280 – CIS #2681-000007-23 – Alleged Verbal and emotional abuse of a resident by a staff member.
- Intake: #00090828 – CIS #2681-000009-23 – Alleged Neglect of a resident by a staff member.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee failed to ensure their zero tolerance of abuse and neglect policy was complied with.

Rationale and Summary
On a particular date, staff were informed by a resident that another staff member said alleged abusive comments to them and then removed their call bell. Staff did not report the incident to a supervisor. The staff failed to immediately report the information to their most direct manager as per the licensee's Zero Tolerance of Abuse and Neglect of Residents Policy. Management was notified on a later date and the Director were alerted then. Failure to immediately report alleged abuse delays investigation into the incident and taking appropriate action to ensure a safe and supportive environment for residents.

Sources: Critical Incident System (CIS) report, investigation documentation, resident progress notes, interviews with the Administrator, and other staff.
[740788]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that a suspicion of Abuse or Neglect was immediately reported to the Director.

Rationale and Summary
On a particular date a resident reported to a staff member an interaction with another staff member that was reported the following day as an alleged abuse or neglect interaction. This alleged abuse was not immediately reported to the Director. Failure to immediately report alleged abuse delays investigation into the incident and taking appropriate action to ensure a safe and supportive environment for residents.

Sources: Critical Incident System (CIS) report, investigation documentation, resident progress notes, interviews with the Administrator, and other staff.
[740788]