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

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Public Report

Report Issue Date: March 20, 2025
Inspection Number: 2025-1183-0002
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 17-20, 2025

The following intake(s) were inspected:

- Intake: #00137351 - CI #2681-000001-25 - Medication incident resulting in hospitalization
- Intake: #00138176 - CI #2681-000002-25- Enteric outbreak

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with additional requirement 9.1 (e) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the Licensee shall ensure that there is point-of-care signage indicating that enhanced IPAC control measures are in place.

On a day in March, 2025, Inspector observed two residents who were on additional precautions with no point-of-care signage in place. Inspector observed a resident who was on additional precautions with incorrect point-of-care signage in place.

Sources: Inspector's observations, a resident's progress notes on PointClickCare (PCC), a resident's care plan on PCC, and an interview with the IPAC Lead.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 5.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
5. A medication incident or adverse drug reaction in respect of which a resident is

taken to hospital.

The licensee has failed to ensure that a medication incident that resulted in a resident being taken to hospital was reported to the Director within one business day.

The incident occurred on a day in January, 2025 and was submitted to the Director four days later.

Sources: Review of Critical Incident Report, a resident's progress notes on PCC, and an interview with the Administrator.

WRITTEN NOTIFICATION: Medication management system

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to comply with the home's Handling of Medications-High Alert Medications policy for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) b, the licensee is required to ensure that their written policy related to medication management is complied with.

Specifically, the home's High-Alert Medications policy indicated that nursing staff are responsible for implementing an independent double check (IDC) in the home when administering high-risk medications. Staff did not comply with this policy on a

day in January, 2025, when the nurse administering a resident's high risk medication did not have a second nurse verify the medication.

Sources: A resident's progress notes on PCC, the home's medication incident report, the home's Handling of Medications-High Alert Medications policy #6.6, reviewed July 31, 2024, and an interview with the Administrator.