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

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

Public Report

Report Issue Date: May 15, 2025
Inspection Number: 2025-1183-0003
Inspection Type: Complaint Critical Incident
Licensee: Omni Quality Living (East) Limited Partnership by its general partner, Omni Quality Living (East) GP Ltd.
Long Term Care Home and City: The Village Green Nursing Home, Selby

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 5 - 6, 8 - 9, 13 - 15, 2025

The following intake(s) were inspected:

- Intake: #00142618 - CI #2681-000004-25 - Alleged improper/ incompetent treatment of a resident
- Intakes: #00144200 and #00144449 - Complaints regarding resident care

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

Resident Care and Support Services
Whistle-blowing Protection and Retaliation
Staffing, Training and Care Standards
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that the Residents' Bill of Rights was upheld for a resident in regards to an interaction with a staff member on a specified day in March 2025. Upon investigating this allegation, the home substantiated that the treatment of the resident by the staff member was not in alignment with a component of the Residents' Bill of Rights.

Sources: Review of the home's investigation closing letter to the staff member and an interview with a staff member

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that a resident's care plan included specified Activities of Daily Living (ADL) focuses.

Sources: Review of the resident's care plan and an interview with a staff member

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that they immediately forwarded the Director a written complaint that was received concerning the care of a resident. A specified staff member received an email from a resident's Power of Attorney (POA) that was sent on a specified day in April 2025, that included concerns regarding the care of the resident, which was not forwarded to the Director.

Sources: Interview with a staff member, interview with the resident's POA, and a

review of associated emails

WRITTEN NOTIFICATION: Dealing with complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that the response to a written complaint made by a resident's Power of Attorney (POA), that was received by the home on a specified day in March 2025, was provided within ten business days of the receipt of the complaint.

Sources: Interview with a staff member, and a review of the response letter provided to the resident's POA

WRITTEN NOTIFICATION: Dealing with complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that the Ministry's toll-free telephone number for making complaints about homes and its hours of service, and the contact information for the patient ombudsman under the Excellent Care for All Act, 2010, was provided in the response to a written complaint made by a resident's Power of Attorney (POA), that was received by the home on a specified day in March 2025.

Sources: Interview with a staff member, and a review of the response letter provided to the resident's POA