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: November 13, 2025
Inspection Number: 2025-1183-0004
Inspection Type: Complaint
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): July 2 - 3, 7 - 11, 14 - 16, 2025

The following intake(s) were inspected:
-Intake: #00148854 - Complaint related to the home's complaint response process and request for release of resident health records

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

Reporting and Complaints
Residents' Rights and Choices

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) 19. iv.
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:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure that the Residents' Bill of Rights was fully respected and promoted. On specified days in March and April 2025, a resident's Power of Attorney (POA) requested access to the resident's records containing personal health information. In an interview on a specified day in July 2025, with the home's Executive Director (ED), it was identified that the resident's POA had not received the requested records. On a specified day in November 2025, the resident's POA indicated that the requested records had been received.

Sources: Review of workspace records and an interview with the ED

WRITTEN NOTIFICATION: Dealing with complaints

NC #002 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), which was received by the home on a specified day in April 2025, was provided within ten business days of the receipt of the complaint.

Sources: Interview with the Executive Director (ED) and review of the response letter to the resident's POA