



**Ministry of Health and
Long-Term Care**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 16, 2018	2018_702197_0004	026695-17, 029615-17	Critical Incident System

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of OMNI Health Care Limited
Partnership
2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

Long-Term Care Home/Foyer de soins de longue durée

THE VILLAGE GREEN NURSING HOME
166 Pleasant Drive P.O. Box 94 Selby ON K0K 2Z0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 12, 13 and 14, 2018

During the course of the inspection, the inspector(s) spoke with the Administrator, the RAI Coordinator, the Clinical Care Coordinator, the Life Enrichment Coordinator, Registered Nurses (RN) and Personal Support Workers (PSW).

The inspector also reviewed resident health care records, an internal investigation file, abuse education records and observed resident care.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend

WN – Written Notification
VPC – Voluntary Plan of Correction
DR – Director Referral
CO – Compliance Order
WAO – Work and Activity Order

Legendé

WN – Avis écrit
VPC – Plan de redressement volontaire
DR – Aiguillage au directeur
CO – Ordre de conformité
WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

2. A description of the individuals involved in the incident, including,

- i. names of all residents involved in the incident,**
- ii. names of any staff members or other persons who were present at or discovered the incident, and**
- iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).**

Findings/Faits saillants :

1. The following finding is related to log 029615-17:

The licensee has failed to comply with O. Reg. 79/10, s. 104(1)2ii. in that a report made to the Director under subsection 23(2) of the Act, did not include the names of all staff members present at the incident.

The home submitted a Critical Incident Report alleging staff to resident abuse on a specified date. The home later amended the report with the outcome of the abuse investigation.

Upon review of the Critical Incident by Inspector #197, it was noted that the accused staff member was not named on the report.

Inspector #197 called the home to inquire about the alleged abuse and at this time the Administrator disclosed the name of the accused staff member.

A description of the individuals involved in the incident, including the names of all staff members present, was not included in the report as required. [s. 104. (1) 2.]



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Issued on this 16th day of February, 2018

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.