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: July 16, 2025	
Inspection Number: 2025-1183-0005	
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

This is a modified Public IR. The change that has been made is the title of NC #003 to reflect the correct legislative reference of Reporting certain matters to Director.

The inspection occurred onsite on the following date(s): July 2 - 3, 7 - 11, 14 - 16, 2025

The following intake(s) were inspected:

- Intake: #00147024 - CI #2681-000010-25- Alleged neglect of residents by a staff member
- Intake: #00149585 - CI #2681-000014-25- Fall of a resident resulting in injury
- Intake: #00149805 - Complaint regarding fall of a resident and the function of equipment

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect residents from neglect.

"Neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On a specified day in May 2025, it was alleged that a staff member was neglectful and did not provide specified care to two residents during their shift, which was immediately reported to the unit nurse. A staff member confirmed that the staff member alleged of neglect continued to work a specified number of shifts, subsequent to the alleged incidents of neglect. On a different specified day in May 2025, a third allegation of neglect by the staff member, towards a different resident,

was reported to a staff member. Upon completion of the investigation into the incidents by the home, the allegations of neglect were founded.

Sources: Review of the Critical Incident Report, the home's staff schedules, the home's internal investigation closing letter, and interviews with staff members

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure the their Zero Tolerance of Abuse and Neglect of Residents policy was complied with.

The licensee's Zero Tolerance of Abuse and Neglect of Residents policy defines neglect as failure to provide a resident with the treatment, care, services, or assistance required for health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents.

On a specified day in May 2025, it was alleged that a staff member was neglectful towards two residents and did not provide specified care to these residents during their shift, which was reported to the unit nurse.

Specifically, staff did not comply with procedures in the licensee's Zero Tolerance of Abuse and Neglect of Residents policy regarding assessments and subsequent documentation for the alleged incidents of neglect.

A staff member confirmed that assessments were not completed for either resident.

Sources: Review of the Critical Incident Report, progress notes for the residents, documentation survey reports for one of the residents, the licensee's Zero Tolerance of Abuse and Neglect of Residents policy, and interviews with staff members

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that when neglect of two residents by a staff member was suspected on specified day in May 2025, it was immediately reported to the Director.

Sources: Review of the Critical Incident Report and interviews with staff members

WRITTEN NOTIFICATION: Falls prevention and management

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NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with their written policy related to falls prevention and management 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 falls prevention and management is complied with.

Specifically, a Post Fall Investigation Assessment was not completed for a resident's fall that occurred on a specified day in June 2025, until a specified day in July 2025. The home's policy indicated that the post fall assessment is to be completed within 24 hours of the fall.
Also, upon review of the resident's Neurological Vital Signs Post Head Injury assessments for their June 2025, fall, there was no documented completion of a specified required check for the Neurological Vital Signs Post Head Injury assessment.

Sources: Review of the resident's Post Fall Investigation Assessment and their Neurological Vital Signs Post Head Injury assessments, Resident Falls and Post Fall Assessment policy, and interviews with a staff member

WRITTEN NOTIFICATION: Continence care and bowel management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

The licensee has failed to ensure that the resident, who required assistance for a specified task some of the time, received assistance from staff with the specified task. On a specified day in May 2025, a staff member refused to assist the resident with the specified task when the resident had requested assistance.

Sources: Review of the Critical Incident Report, the home's investigation closing letter, and interviews with staff members

WRITTEN NOTIFICATION: Continence care and bowel management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee has failed to ensure that two residents, who required specified care, received that care. On a specified day in May 2025, two residents were found to have not received their required care; and at this time one of the resident's verbalized discomfort. It was alleged that the staff member was neglectful and did not provide the specified care to these residents during their shift, which was founded by the home.

Sources: Review of the Critical Incident Report, review of a resident's progress notes, the home's internal investigation closing letter, and interviews with staff members

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (3)
Licensees who report investigations under s. 27 (2) of Act
s. 112 (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director.

The licensee has failed to provide a final report to the Director within a period of time specified by the Director.

On a specified day in May 2025, a critical incident report was submitted regarding three alleged incidents of staff to resident neglect, two of which occurred on a specified day in May 2025, and the third having occurred on a different specified day in May 2025. The licensee failed to provide a final report to the Director upon

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completion of the home's investigation into the incidents on a specified day in June 2025.

Sources: Review of the Critical Incident Report and an interview with a staff member