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

**Toronto District**
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
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# Public Report

**Report Issue Date:** March 7, 2025

**Inspection Number:** 2025-1431-0001

**Inspection Type:**
Other
Complaint
Critical Incident
Follow up

**Licensee:** Friuli Long Term Care

**Long Term Care Home and City:** Villa Leonardo Gambin, Woodbridge

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 24 - 28, 2025 and March 3 - 7, 2025

The following intakes were inspected:

- Intake: #00133230, Critical Incident System (CIS) #2947-000048-24, related to alleged abuse of a resident.
- Intake: #00137454, CIS #2947-000001-25, related to fall prevention and management
- Intake: #00137572, CIS #2947-000002-25, related to a disease outbreak.
- Intake: #00137139 related to Follow-up of Compliance Order (CO) #001 for plan of care from inspection #2024-1431-0004.
- Intake: #00137732, related to a Complaint related to resident care.
- Intake: #00139617, related to Outstanding Emergency Planning Annual Attestation.

The following intakes were completed:

- Intake: #00135917, CIS #2947-000052-24, related to a disease outbreak.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1431-0004 related to FLTCA, 2021, s. 6 (7)

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

# INSPECTION RESULTS

## Non-Compliance Remedied

**Non-compliance** was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
**Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)**
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

The licensee has failed to ensure that the hand soap dispenser for the handwashing sink in a home area was in working order during meal service.

**Sources:** Observation and interviews with staff members.

Date Remedy Implemented: February 24, 2025

## WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (10) (c)**
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident was reassessed, and their plan of care was reviewed and revised when the use of an equipment was not effective. A specific equipment was identified as one of the falls prevention interventions in the resident's care plan. Staff indicated the equipment was no longer effective, therefore the plan of care should have been reviewed and revised.

**Sources:** Observation, resident's clinical records and interviews with staff members.

## WRITTEN NOTIFICATION: Duty to protect

NC #003 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 ensure that a resident was protected from emotional abuse by a visitor.

Section 2 of the Ontario Regulation 246/22 defines emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident".

A review of video surveillance footage showed a resident exhibited a responsive behaviour towards another resident. A visitor reacted by making threatening and intimidating gestures towards the resident who exhibited the behaviours.

**Sources**: Video footage of the incident, resident's health records and interviews with staff members.

## WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 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 that home's policy to promote zero tolerance of abuse was complied with when head-to-toe and pain assessments were not completed for a resident, after they experienced abuse.

**Sources:** Home's policy for Prevention of Abuse and Neglect, resident's health records and interviews with staff members.

## WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 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 abuse of a resident that resulted in harm or risk of harm was immediately reported to the Director. A resident experienced harm or risk of harm when an altercation involving the visitor of another resident occurred, however the home did not immediately report the incident to the Director.

**Sources:** Video footage, resident's health records and interviews with staff members.

## WRITTEN NOTIFICATION: Responsive behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)**
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive

behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

1) The licensee has failed to ensure that 1: 1 (one-to-one) supervision was provided to a resident when an altercation involving the visitor of another resident occurred.

**Sources:** Resident's health records, Video footage of the incident and interviews with the staff members.

2) The licensee has failed to ensure that 1:1 (one-to-one) supervision was provided to a resident as a strategy to manage their responsive behaviours.

**Sources**: Observation, resident's health records and interviews with staff members.

## WRITTEN NOTIFICATION: Attestation

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 270 (3)**
Attestation
s. 270 (3) The licensee shall ensure that the attestation is submitted annually to the Director.

The licensee failed to submit the annual attestation related to emergency plans that was required under section 90 of the Act before December 31, 2024.

The home's Administrator confirmed that the required emergency planning review activities had been completed but the form was not sent to the Ministry of Long-Term Care (MLTC).

**Sources**: Email correspondence and interview with the Administrator.

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