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
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Public Report

Report Issue Date: May 30, 2025
Inspection Number: 2025-1431-0002
Inspection Type: Critical Incident
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): May 26-30, 2025

The following intake(s) were inspected:

- Intake: #00145127 - CI #2947-000009-25 - Fall of resident with injury
- Intake: #00145122 - CI #2947-000008-25 - Fall of resident with injury
- Intake: #00145464 - CI #2947-000010-25 - Acute respiratory infection outbreak

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident's plan of care related to wearing non-slip socks as a falls prevention intervention was provided to the resident on a day in April 2025, as specified in the plan.

Sources: A resident's care plan and an interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented.

In accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), section 6.7- additional requirement, the licensee has failed to ensure that staff were complying with applicable masking requirements, specifically related to the home's direction for staff to wear surgical masks when they are working on a unit that is declared in a respiratory outbreak.

On a day in May 2025, Inspector observed two staff members not wearing surgical

masks while working on a resident home area that was in a respiratory outbreak.

Sources: Inspector's observation, and an interview with the IPAC Lead and a housekeeper.