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
Telephone: (866) 311-8002

Public Report

Report Issue Date: August 21, 2025
Inspection Number: 2025-1431-0004
Inspection Type:
Complaint
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): July 30-31, 2025 and August 1, 5-8, 11-15, 18-21, 2025
The inspection occurred offsite on the following date(s): August 14, 20, 2025

The following intake(s) were inspected in this Critical Incident inspection:
-Intake: #00151888/ Critical Incident (CI) #2947-000017-25 and Intake: #00154685/ CI #2947-000023-25 were related to abuse of multiple residents.

The following intake(s) were inspected in this Complaint inspection:
-Intake: #00152039 was related to alleged abuse of a resident.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that a resident's written plan of care sets out the planned care for the resident. The resident required a specific intervention to manage their responsive behaviour, however the intervention was not included in their plan of care.

Sources: Resident's clinical records, interviews with Personal Support Worker (PSW), Registered Nurse (RN), and Behaviour Support Ontario (BSO) Coordinator.

WRITTEN NOTIFICATION: Plan of care

NC #002 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 monitoring intervention was provided to a resident, as required by their plan of care.

A monitoring intervention was initiated following an incident in which a resident exhibited responsive behaviour. However, this intervention was not implemented when it was required as per their plan of care.

Sources: Video surveillance, resident's clinical records, interviews with the PSW and Director of Care (DOC).

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 immediately report an allegation of abuse of a resident to the Director.

In accordance with s. 28 (1) 2 of the Fixing Long-Term Care Act, and pursuant to s. 154 (3), the licensee is vicariously liable for staff members failing to comply with s. 28 (1).

A recreation staff member witnessed when a resident exhibited inappropriate behaviour towards another resident; however, the staff did not immediately report the allegation to the Director.

Sources: Video surveillance, interviews with the recreation staff and DOC.

WRITTEN NOTIFICATION: Training

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee has failed to ensure that a recreation staff, who received initial training under subsection (2), received annual retraining on the home's policy to promote zero tolerance of abuse and neglect of residents in the specified year.

Sources: Staff training records, interviews with the recreation staff and DOC.

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 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

The licensee has failed to ensure that when two specified residents demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours.

Both residents had a history of exhibiting specific responsive behaviours. The residents' responsive behaviours were not assessed by staff, and no strategies were developed or implemented to respond to these behaviours.

Sources: Residents' clinical records, and interviews with the RN, and BSO Coordinator.

COMPLIANCE ORDER CO #001 Duty to protect

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 24 (1) [FLTCA, 2021, s. 155 (1) (b)]:

The licensee shall prepare, submit and implement a plan to ensure the specified residents are protected from abuse by anyone.

The plan must include but is not limited to:

A) Develop written strategies to support the monitoring and supervision of residents using the specified room on the specified floor.

B) Review and revise (where applicable) strategies and interventions to support the management of the specified resident's responsive behaviours.

C) Provide education to PSWs and Nurses on the specified floor, recreation staff, and BSO staff on the following:
i) Staff responsibilities for identifying sexually expressive responsive behaviours.
ii) Staff responsibilities for reporting and documenting new sexual responsive behaviours to registered staff and BSO staff.
iii) Staff responsibilities for initiating behaviour assessments, including the Dementia Observation System (DOS).

Please submit the written plan for achieving compliance for inspection #2025-1431-0004 to MLTC, via email at TorontoDISTRICT.MLTC@ontario.ca by September 05, 2025.

Please ensure that the submitted written plan does not contain any Personal Information (PI) or Personal Health Information (PHI).

Grounds

The licensee has failed to protect multiple residents from abuse by a resident.

According to O. Reg., 246/22, s. 2 (1) (b) “sexual abuse” is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A review of video surveillance revealed a resident exhibited inappropriate behaviours towards two residents on multiple occasions when no staff were present in an identified room.

A staff member witnessed one of these incidents but did not separate the residents or report the incident. Shortly after, the resident exhibited inappropriate behaviour towards another resident when the staff left the room.

The home’s investigation and DOC interview substantiated that the resident abused multiple residents.

When staff failed to take the required actions to protect multiple residents from abuse, it jeopardized the residents' health, safety, and well-being.

Sources: Video surveillance; residents' clinical records; home's investigation notes; and interviews with multiple staff.

This order must be complied with by October 6, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.