Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
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Toronto, ON, M2M 4K5
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Public Report

Report Issue Date: January 27, 2026
Inspection Number: 2026-1431-0001
Inspection Type:
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): January 6-9, 12-14, 16, 20-21, and 27, 2026.
The inspection occurred offsite on the following date(s): January 15, 22, and 23, 2026.

The following intakes were inspected in this Critical Incident System (CIS) inspection:
-Intake: #00160519 (CISs #2947-000028-25/2947-000029-25) was related to improper care of a resident by staff.
-Intakes: #00162525 (CIS #2947-000038-25), and #00163478 (CIS #2947-000041-25) were related to falls prevention and management.
-Intake: #00162580 (CIS #2947-000039-25) was related to resident to resident abuse.
-Intakes: #00164605 (CIS #2947-000042-25) and #00165648 (CIS #2947-000049-25) were related to disease outbreaks.
-Intakes: #00164917 (CISs #2947-000044-25/2947-000045-25) was related to a resident's fall and other care concerns.

The following intake was inspected in this Follow-Up inspection:
-Intake #00161857- Follow-up - Compliance Order (CO) #001 was related to falls prevention and management program.

The following intakes was inspected in this complaint inspection:
-Intake: #00164936 was related to a resident's falls and other care concerns.
-Intake: #00165102 was related to a resident's fall and other care concerns.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1431-0006 related to O. Reg. 246/22, s. 53 (1) 1.

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) 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: FLTCA, 2021, s. 6 (10) (b)
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,
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or

A resident's care plan was not revised or reviewed to reflect the use of a specific intervention as part of their falls prevention interventions.

The care plan was revised on January 7, 2026, to include the intervention.

Sources: Observations, resident's clinical records, and interviews with the Registered Practical Nurse (RPN) and Personal Support Worker (PSW).

Date Remedy Implemented: January 7, 2026

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

a) Video footage revealed that some minutes before a resident fell, their specific fall intervention was triggered, however a staff member did not attend to the resident's needs.

b) The Bed Activity Report indicated that there were delays in staff response when the resident's alert system triggered on several occasions. The Associate Director of Care (ADOC) acknowledged that the resident was not assisted according to the home's established procedures, leading to their care needs not being addressed promptly.

c) Video Footage indicated that a resident was calling out periodically and making attempts to change a position. However, staff did not respond immediately. The Director of Care (DOC) acknowledged that the staff's response should have been timelier to meet the resident's care needs.

Sources: Resident's clinical records, Bed Activity Report, Video footage, interviews with the ADOC, and DOC.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
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,
(c) clear directions to staff and others who provide direct care to the resident; and

A resident’s care plan indicated two conflicting care directions for staff to implement. The DOC acknowledged that the care plan directions were unclear for staff to follow.

Sources: Resident's clinical records, Video footage, interviews with the PSW, Physiotherapist (PT), and DOC.

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

The resident’s Substitute Decision-Maker (SDM) was not provided an opportunity to participate in the development and implementation of a resident's plan of care when staff identified new skin alteration.

Sources: Resident's clinical records, interviews with the PSW, Registered Nurse (RN), and ADOC.

WRITTEN NOTIFICATION: Plan of Care

NC #005 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.

a) A resident's care plan indicated to keep the assistive device close to the resident. On a specified date, the intervention was not implemented by staff. As a result, the resident experienced a negative health outcome.

b) A resident's care plan indicated to have a specific intervention in place, however, on a specified date, the intervention was not applied.

c) A resident's care plan indicated to apply specific fall interventions when the resident was in the bed. However, the interventions were not implemented

Sources: Resident's clinical records, Video footage; interviews with the PSW, RN , ADOC, and DOC.

WRITTEN NOTIFICATION: Plan of Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

A resident required specific staff assistance for an Activity of Daily Living (ADL). However, the resident's care plan had not been revised or reviewed to reflect the required specific staff assistance.

Sources: Resident's clinical records, and interviews with the RPNs.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

A resident was identified with a skin alteration. The registered staff did not complete a skin assessment using the home's skin and wound assessment tool when the skin alteration was reported to them by staff members.

Sources: Resident's clinical records, home's policy "Skin & Wound Care Management Protocol, interviews with the PSW, PT, ADOC and other staff.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions are documented.

Dementia Observation System (DOS) monitoring assessments initiated for two residents had missing documentation entries.

Sources: Residents' clinical record, DOS Worksheet for residents, and interview with the Behavioural Support Ontario (BSO) RPN.

WRITTEN NOTIFICATION: Behaviours and Altercations

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident’s behaviours, including responsive behaviours, and to minimize the risk of altercations

and potentially harmful interactions between and among residents; and

A resident had a history of responsive behaviours. On an specified date, the resident exhibited responsive behaviours towards another resident. The resident's care plan indicated that the strategies to reduce responsive behaviours were not developed prior to the incident, despite their history.

Sources: Resident's clinical records; and interview with the BSO RPN.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The home experienced communicable disease outbreaks over several weeks. Staff were required to monitor infectious symptoms every shift for the affected residents, however this did not occur for multiple residents during this period.

Sources: Residents' clinical records, Public Health line listing, and interview with the Infection Prevention and Control (IPAC) Lead.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the

resident is taken to a hospital and that results in a significant change in the resident's health condition.

a) A resident was found by staff with a significant skin alteration and was sent to the hospital. They were diagnosed with injury that required hospital treatment and resulted in a significant change in their condition. However, the incident was not reported to the Director.

Sources: Resident's clinical records; and interview with the ADOC.

b) A resident was found with a change in their health status, was subsequently sent to the hospital, and diagnosed with an injury. This resulted in a significant change in the resident's condition; however, the incident was not reported to the Director.

Sources: Resident's clinical records; and interview with the ADOC.

WRITTEN NOTIFICATION: Requirements Relating to Restraining by a Physical Device

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2)
Requirements relating to restraining by a physical device
s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition themself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining

evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

A resident was observed restrained by a physical device on two occasions. The resident's clinical records indicated that requirements were not met when they were restrained under section 35 of the Act.

Sources: Observations, Home's policies titled "DEFINITIONS, TYPES & CONSIDERATIONS FOR USE OF RESTRAINT" and "Restraint Implementation Protocols, resident's clinical records; interviews with the Power of Attorney (POA), RN, PSW and ADOC.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

Recommendations issued by the Chief Medical Officer of Health (CMOH) for Outbreak Prevention and Control (February 2025) indicated that cleaning and disinfection should be completed moving from clean areas to dirty areas.

The housekeeper was observed cleaning the room of residents on a confirmed Respiratory outbreak unit. They moved from cleaning the room of a resident on additional precautions to cleaning the room of a resident who was not on additional precautions.

The IPAC Lead confirmed that the rooms with residents who were not on precautions should have been cleaned before the rooms of residents under precautions.

Sources: Recommendations for Outbreak Prevention and Control in Institutions and

Congregate Living Settings, Ministry of Health effective February 2025, observations; and interview with the IPAC Lead.

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1a. Re-train specified PSWs on the home's Safe Resident Handling policy, including but not limited to how to operate the different lifting devices used in the home, safe transferring and lifting techniques, safe positioning techniques, the number of staff required to perform each transfer technique, and include hands-on demonstrations where applicable. Additionally, review the care planned transfer status and interventions for the identified residents with the PSWs.

1b. Re-train a specified PSW on how to use safe positioning techniques while caring for a resident, including how to support them during the indicated activity.

2.Maintain a record of all the training and reviews provided as specified above in items 1a and 1b, including the training content, date, name and signature of attending staff, and the name of the person(s) who provided the education.

3. Develop and implement an audit to ensure that the specified PSWs are using safe transferring and positioning techniques when assisting their respective residents in accordance with their care plans. The audit should be conducted at minimum, once a week for a period of three weeks following the service of this order.

4. Maintain a record of the audits completed, including dates, shift times, audit time, the name of the person completing the audits, resident and staff names being audited, resident's care plan transfer directions, observations made, audit findings and content of on-the-spot education provided and/or other corrective actions taken where required.

Retain all records until the Ministry of Long-Term Care (MLTC) has deemed that this order has been complied with.

Grounds

a) A PSW performed an unsafe transfer of a resident by using a specific device without assistance from another staff member, which resulted in the resident sliding off the device.

Sources: Critical Incident, resident's plan or care, the Long-Term Care Homes (LTCH) internal investigation file, Safe Resident Handling policy, and interview with the ADOC.

b) A resident’s care plan indicated that specific staff assistance was required for ADL. On an specified date, the PSW assisted the resident with a specific activity without using the required staff assistance.

Sources: Resident's clinical records, video surveillance; interviews with the PT and DOC.

c) When a resident was unsafely positioned by a PSW, they experienced a negative health outcome.

Sources: Resident’s clinical records, the home’s investigation files, and interviews with the PSW and PT.

d) A resident's care plan indicated that they required specific staff assistance with the use of a specific device. On an specified date, the PSW assisted the resident without using the required staff assistance.

When staff failed to provide the residents with safe transferring and positioning techniques, there was increased risk of harm and injury to the residents.

Sources: Resident’s clinical records, the home’s investigation files, and interviews with the PSW and PT.

This order must be complied with by March 6, 2026

COMPLIANCE ORDER CO #002 Required Programs

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1.Re-train specified RPNs on the home's falls prevention and management program. The education must include:
-A review of what preliminarily assessments are to be completed before mobilizing a resident following a fall incident
-A hands-on demonstration on how to assess a resident following a fall incident, including the specific preliminarily head to toe assessments that must be completed to rule out hip fracture and other fractures, determine appropriate transfer status, assess verbal and non-verbal signs of pain, and any other signs of injury.
-A review of actions to be taken when there is suspicion or evidence of injury, including who needs to be notified, for instance, Physician, Nurse Practitioner or any others as per policy.
-How to support safe transferring of the resident post-fall using the appropriate lifting procedure.
-A review of what assessments need to be completed when the resident is deemed safe to be transferred.
-How and where to document the different types of post fall assessments and their results including the preliminarily assessments, transfer assessment and method or devices used, and any other required post-fall assessments noted in the home's policy.
2. Re-train specified PSWs on the home's falls prevention and management program. The education must include:
-PSWs role and responsibilities after a resident's fall.
-When and how to mobilize the resident post-fall using the appropriate lifting procedure.
3. Keep a record of the education provided for item #1 and #2, including the staff members who received the education, the person(s) providing it, the content of the education, the date(s) it was provided, and names of attendees with signatures

indicating that they completed the education.

Grounds

The home did not comply with their Falls Prevention & Management policy related to performing a proper preliminary assessment, using the appropriate lifting procedure and notifying the Physician or Nurse Practitioner when there was evidence of injury after two residents fell.

a) On an specified date, the resident had an unwitnessed fall and experienced a change in health status, however the nurse did not notify the Physician or Nurse Practitioner.

The ADOC acknowledged that the RPN was required to follow the home's Falls Prevention & Management policy and to notify the Physician or Nurse Practitioner of their assessment findings.

Sources: Resident's clinical records, the home's investigation file, Falls Prevention & Management policy, interviews with the RPN and ADOC.

b) When a resident experienced a fall, the preliminarily assessment was not completed properly and the appropriate transfer was not performed as per the home's policy.

There was increased risk of harm and further injuries to the residents when staff failed to implement the home's falls program and policies.

Sources: Resident's clinical records, Video footage, Home's Falls Prevention & Management Policy, and interviews with the PSW, ADOC, and DOC.

This order must be complied with by March 6, 2026

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

CO (HP) was issued on 2025-11-04 during the inspection #2025-1431-0006.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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.