

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: August 13, 2025

Inspection Number: 2025-1556-0004

Inspection Type:
Critical Incident

Licensee: The Regional Municipality of Halton

Long Term Care Home and City: Allendale, Milton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 29, 30, 31, 2025 and August 1, 5, 6, 7, 8, 12, 13, 2025.

The following intake(s) were inspected:

-Intake: #00149970 - Critical Incident (CI) #M536-000030-25 - related to resident care and support services.

-Intake: #00150253 - CI #M536-000031-25 - related to infection prevention and control.

-Intake: #00151029 - CI #M536-000033-25 - related to prevention of abuse and neglect.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

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

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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 the care set out in the plan of care for a resident related to bed mobility, dressing and the level of assistance for eating was provided to the resident as specified in the plan.

Sources: Review of resident's clinical records, home's investigation notes; interviews with staff.

WRITTEN NOTIFICATION: General requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (2)

General requirements

s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that the assessment and any actions taken, related to a resident having an altered skin integrity were documented.

Sources: Review of resident's clinical records; interview with SNM.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 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 any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

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Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) additional personal protective equipment (PPE) requirements including appropriate selection, application, removal, and disposal.

A staff member failed to don a gown during care of a resident who was on contact precautions and failed to doff gloves in the garbage by the entrance to the resident's room after care was provided.

Sources: Observations; review of resident's plan of care, home's policy "Precaution Systems Protocol, Procedure" and "Donning and Doffing" (revised February 2024); interviews with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to immediately inform the Director of an outbreak in the home that was declared by the public health unit.

Sources: Review of critical incident (CI), interview with Infection Prevention and Control (IPAC) Lead.

COMPLIANCE ORDER CO #001 Duty to protect

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

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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. 155 (1) (b)]:

The plan must include but is not limited to:

-what long term actions will be undertaken to ensure an identified resident is protected from abuse.

Please submit the written plan for achieving compliance for inspection #2025-1556-0004 to LTC Homes Inspector, MLTC, by September 3, 2025.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The licensee has failed to ensure that a resident was protected from physical and emotional abuse by staff in the home.

O. Reg. 246/22, s. 2 (1) identifies different types of abuse and contains definitions of the types of abuse.

There was an allegation brought forward related to abuse of a resident in the home. The home's investigation identified different situations with evidence of abuse of this resident.

The home failed to protect the identified resident from abuse.

Sources: Review of investigation notes, review of resident's clinical records; interviews with staff.

This order must be complied with by September 24, 2025

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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

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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.