

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: April 16, 2026
Inspection Number: 2026-1556-0002
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): March 31, 2026 and April 1, 2, 7-9, 13, 15, 16, 2026.

The following intake(s) were inspected:

- Intake: #00167835 -Critical Incident (CI) #M536-000005-26 - Related to prevention of abuse and neglect;
- Intake: #00169538 -CI #M536-000010-26 - Related to skin and wound prevention and management;
- Intake: #00172243 - CI #M536-000017-26 -Related to prevention of abuse and neglect.

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

- Contenance Care
- Skin and Wound Prevention and Management
- Prevention of Abuse and Neglect

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Nursing and personal support services

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

Non-compliance with: FLTCA, 2021, s. 11 (1) (b)

Nursing and personal support services

s. 11 (1) Every licensee of a long-term care home shall ensure that there is,
(b) an organized program of personal support services for the home to meet the assessed needs of the residents.

A) The home did not ensure that their personal support services program met a resident's assessed care needs when a staff member inaccurately documented several times that they provided such care on a certain day, despite not providing the care.

Sources: Resident's clinical records, home's policy on Standards for Documentation, home's investigation notes and interview with staff.

B) The home did not ensure that their personal support services program met a resident's assessed care needs when staff inaccurately documented that care was provided during a particular shift on a specified date, despite not providing the care.

Sources: Resident's clinical records; home's investigation notes; home's Standards for Documentation policy; interview with staff.

WRITTEN NOTIFICATION: Duty to protect

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NC #002 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.

Ontario Regulations (O. Reg.) 246/22, section (s.) 7 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents:

A) On a particular date, staff did not provide individualized care needs for a resident at the required intervals, and scheduled safety checks were not completed throughout a certain shift.

Sources: Resident's clinical records; home's investigation notes & analysis; interview with staff.

B) On a certain date, the home did not ensure that a resident was not neglected by staff when their multiple requests for a specific care need was not addressed by staff, and was further deferred for the next shift staff to perform. When the next shift staff provided the resident with care, they were found to be upset, in discomfort and their need had been unmet.

Sources: Resident's clinical records, home's investigation notes and interviews with staff.