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

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Public Report

Report Issue Date: October 27, 2025
Inspection Number: 2025-1556-0005
Inspection Type: Critical Incident Follow up
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): October 17, 20-24 & 27, 2025.

The following intake(s) were inspected:
-Intake: #00155302 - Follow-up #: 1 - 2025-1556-0004, CO (HP) #001, related to Prevention of Abuse and Neglect, FLTCA, 2021 - s. 24 (1)- CDD: September 24, 2025.
-Intake: #00155816 - Critical Incident (CI) #M536-000040-25 - related to Prevention of Abuse and Neglect.
-Intake: #00156473 -CIS #M536-000041-25 - related to Prevention of Abuse and Neglect.
-Intake: #00157376 - CIS #M536-000044-25 - related to Prevention of Abuse and Neglect.
-Intake: #00156537 - CIS #M536-000042-25 - related to Responsive Behaviors.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1556-0004 related to FLTCA, 2021, s. 24 (1)

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

Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Staff and others to be kept aware

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that staff providing direct care to a resident were made aware of the contents of the plan of care related to the resident's Activity of Daily Living (ADL) routine.

Sources: Review of the CI #M536-000044-25, resident's health records, investigation notes of the home, interviews with staff.

WRITTEN NOTIFICATION: Duty to protect

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.

1) The licensee has failed to ensure that the resident was protected from physical abuse by another resident when on an identified date, the resident used physical force on the other resident, which resulted in physical injury.

Ontario Regulation (O Reg) 246/22, s. 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Sources: Review of resident's progress notes, head to toe assessments; and interview

with staff.

2) The licensee has failed to protect a resident from abuse which resulted in an injury.

O. Reg. 246/22, s. 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Sources: Review of the CI #M536-000040-25, resident's health records; interviews with staff.

3) The licensee has failed to ensure that a resident was not neglected by staff.

O. Reg. 246/22, s. 2 (1) 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.

Sources: Review of the CI #M536-000044-25, resident's health records, investigation notes of the home; interviews with staff.

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) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that the Director was immediately informed upon becoming aware of an incident of improper or incompetent treatment or care of the resident that resulted in a risk of harm to the resident on an identified date.

Sources: Review of CI #M536-000042-25, resident's progress notes and interview with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 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 sexual abuse towards a resident to the Director.

Sources: Review of resident's progress notes; interview with staff.

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) (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.

The licensee has failed to ensure that actions were taken, including assessments, reassessments and interventions, when a resident demonstrated responsive behaviours on an identified date.

Sources: Review of CI #M536-000042-25, resident's electronic health records and interview with staff.