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

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

Public Report

Report Issue Date: July 9, 2025
Inspection Number: 2025-1432-0003
Inspection Type: Complaint Critical Incident
Licensee: 955464 Ontario Limited
Long Term Care Home and City: Millennium Trail Manor, Niagara Falls

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 25-27, 30, 2025 and July 2-4, 7-9, 2025

The following intake(s) were inspected:

- Intake #00143973/Critical Incident (CI) #2948-000013-25: related to falls prevention and intervention.
- Intake #00148461: complaint related to staffing, resident care and support services, and nutrition.
- Intake #00149098: complaint related to resident care and support services.
- Intake #00150905: complaint related to air temperatures.
- Intake #00151161/CI #2948-000024-25: related to the prevention of abuse and neglect.

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

Resident Care and Support Services
Food, Nutrition and Hydration

Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and 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: O. Reg. 246/22, s. 35 (4)
Nursing and personal support services
s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that the written staffing plan evaluation for 2025 included a summary of changes and dates that those changes were implemented.

On July 3, 2025, the evaluation was updated to include this information.

Sources: 2025 staffing plan evaluation.

Date Remedy Implemented: July 3, 2025

WRITTEN NOTIFICATION: Integration of assessments, care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that staff and others involved in the different aspects of care for a resident collaborated with each other in the assessment of the resident so that their assessments were consistent and complemented each other. A resident had several falls on specified dates. A falls risk assessment was completed on an identified date, and staff documented under the history of falls there were no falls in the last 12 months and this led to the resident being identified as low risk rather than high for falls.

Sources: A resident's clinical record, interview with the Resident Assessment Instrument (RAI) Coordinator, a Critical Incident (CI) Report.

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee has failed to ensure that the outcomes of care set out in a resident's plan of care were documented when a Personal Support Worker (PSW) documented for four safety checks that a resident was not available when they were present in the home.

Sources: A resident's clinical record, interviews with a PSW and the DOC.

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 ensure that an allegation of abuse towards a resident was immediately reported to the Director when on a specified date, a resident reported an allegation of abuse to a registered staff member.

Sources: A resident's clinical records and an interview with the DOC.

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