

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: September 8, 2025

Inspection Number: 2025-1432-0005

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 dates: August 27-29, 2025 and September 2-4, 8, 2025. The inspection occurred offsite on the following dates: September 2, 3, 2025.

The following intakes were inspected:

- Intakes #00149743 and #00151840 related to prevention of abuse and neglect.
- Intake: #00149801 – Complaint related to staff qualifications.
- Intake: #00151836 - Complaint related to prevention of abuse and neglect.

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

- Prevention of Abuse and Neglect
- Responsive Behaviours
- Staffing, Training and Care Standards

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 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.

The licensee has failed to ensure that a resident was protected from physical abuse by another resident.

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

On a specified date, a resident pushed another resident which resulted in the resident falling to the ground and sustaining an injury.

Sources: Residents' clinical records, Critical Incident Report, and interview with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 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

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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 report to the Director where a staff person had reasonable grounds to suspect that abuse of a resident by a fellow resident had occurred.

Sources: Resident's progress notes, risk management, Ministry of Long-Term Care Critical Incident Reporting System and interview with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 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,

The licensee has failed to ensure that a resident, who was noted on a specified date to have a new area of skin impairment, received 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.

Sources: Resident's progress notes and skin and wound assessments, Policy RC-23-01-02 Skin and Wound Program: Wound Care Management (October 2023) and

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interview with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 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 the Dementia Observation System (DOS) was documented as set out in the plan of care for a resident.

On a specified date, a resident's plan of care indicated that DOS charting was to be initiated for 72 hours following a possible physical altercation with a fellow resident. DOS charting was not completed during the specified time period in the plan of care.

Sources: Resident's progress notes and DOS charting.