

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: February 12, 2026

Inspection Number: 2026-1432-0002

Inspection Type:

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): February 9-12, 2026

The following intake(s) were inspected:

- Intake: #00166267, Critical Incident (CI) #2948-000044-25 related to the prevention of abuse and neglect and responsive behaviours; and
- Intake: #00166274, CI #2948-000045-25 related to resident care and support services.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

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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.

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.

An incident occurred where a resident caused an injury to another resident.

Sources: CI report; resident clinical records; interview with the Director of Care (DOC) and other staff.

WRITTEN NOTIFICATION: Responsive behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (2) (c)

Responsive behaviours

s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,

(c) co-ordinated and implemented on an interdisciplinary basis.

The Responsive Behaviours policy identified that a Responsive Behaviour Debrief Tool was to be completed following an episode of new or escalated responsive behaviour. The home has not implemented the comprehensive assessment tool, rather documents the occurrence of incidents in the progress notes.

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Sources: Responsive Behaviours policy; interview with the DOC.