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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: April 23, 2025

Inspection Number: 2025-1116-0003

Inspection Type:
Critical Incident

Licensee: Glen Hill Terrace Christian Homes Inc.

Long Term Care Home and City: Glen Hill Strathaven, Bowmanville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 15, 16, 17, 22, 2025

The following intake(s) were inspected:
An intake related to improper care of a resident
An intake related to an outbreak of disease of public significance
An intake related to a medication incident/adverse drug reaction

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

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the blood work ordered for a resident was collected. The Director of Care (DOC) indicated that documentation to support the blood work was collected could not be found.

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

WRITTEN NOTIFICATION: Weight changes

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 75 1.
Weight changes
s. 75. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.

The licensee failed to comply with the homes monitoring of resident weights policy for a resident. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for their organized program of nutritional care and dietary services are complied with. Specifically, the home's monitoring of resident weights policy directs staff to immediately reweigh residents who have over a five percent change in body weight over 30 days. The DOC acknowledged that this should have been done.

Sources: a resident's clinical health records, and an interview with the DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee did not ensure that staff adhered to the home's Infection Prevention and Control (IPAC) program. Specifically, staff failed to notify the on-call manager or public health authorities when the number of resident cases met the outbreak definition.

Over a three-day period, 14 residents displayed signs and symptoms of an infectious disease. The IPAC Lead was not informed of the increased number of resident cases until late in the evening on the third day. The suspected outbreak was not reported to Public Health until the fourth day. The IPAC Lead stated that staff did not follow the home's IPAC process and failed to notify the on-call manager when resident cases met the outbreak definition outlined in the home's outbreak policy.

Sources: record review of outbreak line list, outbreak debrief, the licensee's outbreak management policy and an interview with the IPAC Lead.

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (1)

Administration of drugs

s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee failed to ensure that no drug was administered to a resident unless prescribed. A resident was given the wrong medication in error and required assessment and monitoring.

Sources: resident clinical health records, licensee's investigation records, and medication error report.

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