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: July 23, 2025

Inspection Number: 2025-1116-0005

Inspection Type:
Complaint
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): July 16, 17, 21, 22, 23, 2025

The following intake(s) were inspected:

- An intake related to a fall.
- An intake related to a complaint of residents' care.

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

Resident Care and Support Services
Infection Prevention and Control
Residents' Rights and Choices
Falls Prevention and Management

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 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that resident's plan of care provided clear direction for checking of a medical support device. The doctor's order indicated to check the medical support device on a specific day while the care plan indicated a different day. Additionally, the clinical record only reflected checking on one of those days. Director of Care (DOC) acknowledged that plan of care should be clear and consistent.
Sources: Care plan, clinical records, and interview with DOC.

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