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: September 12, 2025
Inspection Number: 2025-1116-0006
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): September 8, 9, 10, 11, 12, 2025

The following intake(s) were inspected:
-Intake: #00153921 - CIR - Fall of a resident.
-Intake: #00156351 - Complaint regarding care concerns.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
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 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-

maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure that a resident's substitute decision-maker (SDM) was provided an opportunity to participate in the development and implementation of the resident's plan of care related to the use and removal of an intervention for pressure relief.

Sources: Resident's clinical records; interview with the resident's SDM, and interview with a registered practical nurse.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when a resident's care needs changed or care set out in the plan was no longer necessary. Specifically, the plan of care for the resident was not revised when an intervention for pressure relief was no longer necessary.

Source: Inspector's observation, resident's clinical record and interview with the Director of Care.

WRITTEN NOTIFICATION: Required Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg.

246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee failed to ensure that the pain management program was implemented.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that the Pain Management policy of the long-term care home was complied with.

Specifically, a comprehensive pain assessment was not completed for a resident when the resident was readmitted to the home.

Sources: Pain Assessment and Management Policy, the resident's clinical records, and an interview with the Director of Care.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 3. v.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
v. the outcome or current status of the individual or individuals who were involved in the incident.

The licensee failed to ensure that a Critical Incident Report (CIR) specific to a fall incident of a resident included the outcome or current status of the resident.

The resident had surgical repair following an injury and passed away four weeks later. The Director of Care confirmed that this information was not included in the Critical Incident Report submitted to the Director.

Sources: CIR, the resident’s clinical records, and an interview with the Director of Care.

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