

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: January 12, 2026

Inspection Number: 2026-1116-0001

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 dates: January 6 - 9, 12, 2026

The following intakes were inspected:

- An intake regarding a fall with significant change in condition.
- An intake regarding an allegation of resident to resident abuse.

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

Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls prevention and management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

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A resident had an unwitnessed fall. Their assistive device was not within reach at the time of the fall. The Assistant Director of Care (ADOC) confirmed that the resident's assistive device was to be kept within reach as part of their fall prevention measures.

Sources: Clinical records, interview with 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 (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.

A critical incident was submitted to the Director related to resident to resident altercation. A review of the resident's documentation showed that an assessment was incomplete. An interview with staff confirmed the assessment was to be completed.

Sources: Clinical records, interview with staff.



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**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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