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 24, 2025
Inspection Number: 2025-1629-0004
Inspection Type: Critical Incident
Licensee: Glen Hill Terrace Christian Homes Inc.
Long Term Care Home and City: Glen Hill Terrace, Whitby

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 17-19, 22-24, 2025

The following intake(s) were inspected:
- Physical abuse of resident by resident .
- Unwitnessed fall of resident resulting in Hospital Transfer.
- Injury from unknown cause to resident with injury to left shoulder.

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

Resident Care and Support Services
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)
Reports re critical incidents
s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one

business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22, s. 115 (4).

In August 2025, a resident sustained two unwitnessed falls within the home and was subsequently transferred to hospital. Although the licensee met the requirement to contact the hospital within three calendar days, the injury remained undetermined. As per the regulation, the licensee was still required to inform the Director no later than three business days after the incident. In this case, no report was submitted, until seven days later.

Sources: Resident Clinical Records, CIR: 3053-000014-25, Interview with Director of Quality and Innovation.

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