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: October 27, 2025
Inspection Number: 2025-1629-0005
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): October 21, 22, 23, 24, 27, 2025

The following intake was inspected:

- CI # 3053-000017-25 - Unwitnessed fall of resident resulting in fractures

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' bill of rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 22.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
22. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person

receive that information immediately.

The licensee failed to provide the Substitute Decision Maker (SDM) with information concerning a resident's transfer to hospital for assessment after a fall. The resident returned to the home after assessment. The SDM did not receive information immediately that resident had been sent to hospital for assessment.

Sources: Critical Incident (CI) #3053-000017-25, resident's clinical record

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other when staff did not follow up on accessing a discharge summary and follow up instructions when the resident returned from the hospital and when orders for appropriate follow up care to manage the Xray findings were not obtained.

Sources: Critical Incident (CI) #3053-000017-25, resident's clinical record, interview with the Director of Care (DOC)

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect a resident from neglect when they were not provided with analgesic to relieve pain after three elevated pain ratings were indicated on the day the fall was sustained, and when they did not receive an in person assessment from the physician or the physiotherapist until six days after sustaining a fall that resulted in injury.

Sources: Critical Incident #3053-000017-25, resident's clinical record, review of home's Fall Prevention & Management Policy, interviews with DOC and Director of Quality Improvement

WRITTEN NOTIFICATION: Pain management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to comply with the home's Pain and Symptom – Assessment and Management Protocol when a resident's symptoms were not monitored hourly for a 24 hour period when their pain medication was changed.

In accordance with O.Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that written policies developed for the pain and symptom – assessment and management protocol were complied with.

Specifically, the home's pain policy indicated that when pain medication is changed a 24 hour Pain and Symptom Monitoring Tool is to be initiated.

Sources: Critical Incident #3053-000017-25, resident's clinical record, home's Pain and Symptom – Assessment and Management Protocol (Policy # VII-G-70.00, revised April,

2021), interview with DOC

WRITTEN NOTIFICATION: Administration of drugs

NC #005 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 when a medication was ordered to be discontinued that it was discontinued. A resident continued to receive a medication that had been discontinued which elevated the their medication level above the specified limit of 3 Grams in a 24 hour period.

Sources: Critical Incident (CI) #3053-000017-25, review of resident's clinical record, interview with DOC.

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