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: May 28, 2025
Inspection Number: 2025-1069-0003
Inspection Type: Critical Incident
Licensee: Omni Quality Living (East) Limited Partnership by its general partner, Omni Quality Living (East) GP Ltd.
Long Term Care Home and City: Springdale Country Manor, Peterborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 26 - 28, 2025

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- An intake related to abuse

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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) 4.
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:
4. Every resident has the right to freedom from abuse.

The licensee failed to ensure that resident's rights to freedom from abuse are fully respected and promoted.

A critical incident was reported to the director regarding a resident-to-resident altercation that resulted in significant injury and transfer to the hospital.

Source: Interview with multiple staff, Home's records, and 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 (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 the plan of care for the resident provided clear directions to staff for interventions.

A resident exhibited responsive behaviour. The care plan for the resident did not include clear directions regarding who was responsible for implementing behaviour management interventions to protect other residents during the incidents of escalation and responsive behaviours.

Source: Interview with multiple staff, Resident's clinical records, and Home's records

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