

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 14, 2025

**Inspection Number:** 2025-1069-0006

**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): October 8, 9, 10, 14, 2025

The following intake(s) were inspected:

- A Critical Incident Report (CIR) - related to a fall with injury.

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

Infection Prevention and Control  
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Documentation

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

**Non-compliance with: FLTCA, 2021, s. 6 (9) 1.**

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

The licensee failed to ensure that the provision of the care set out in the plan of care for a resident was documented. A resident had specific interventions for their falls

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prevention that required documentation in their Treatment Administration Record (TAR). The TAR had several missing entries for these interventions. Staff indicated that this should have been documented in the residents TAR.

**Sources:** Clinical records, Interview with staff.

### **WRITTEN NOTIFICATION: Care Plans and Plans of Care**

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 27 (3) (a)**

24-hour admission care plan

s. 27 (3) The licensee shall ensure that the care plan sets out,  
(a) the planned care for the resident; and

The licensee failed to ensure that the care plan set out the planned care for a resident's identified skin issue. A resident had an identified skin issue which required weekly assessments and a specified intervention. There was no indication of this in their care plan. Staff indicated that the information should have been in the resident's care plan.

**Sources:** Clinical records, Interview with staff.

### **WRITTEN NOTIFICATION: Skin and wound care**

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)**

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,  
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,  
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that there were weekly skin assessments completed for a resident's identified skin issue on several dates. Staff indicated that an initial skin assessment for a resident was incomplete and thus could not generate a weekly schedule to prompt the registered staff to complete assessments.



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**Sources:** Clinical records, Interview with staff.



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