

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:** February 13, 2026

**Inspection Number:** 2026-1069-0001

**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): February 9, 11 - 13, 2026  
The inspection occurred offsite on the following date(s): February 10, 2026

The following intake(s) were inspected:

- One intake related to outbreak
- One intake related to allegation of abuse

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

Infection Prevention and Control  
Prevention of Abuse and Neglect

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Responsive behaviours

NC #001 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,

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reassessments and interventions and that the resident's responses to interventions are documented.

A specific assessment was initiated for monitoring a resident for a specified timeframe. However, the specific assessment was not fully completed and analyzed for the specified timeframe.

**Sources:** Resident clinical records, Critical Incident Report (CIR), and the home's policy

### **WRITTEN NOTIFICATION: Infection prevention and control program**

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

**Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)**

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The home did not ensure they recorded symptoms for a specified number of residents for a specified time frame to reduce transmission of infection and isolate residents.

**Sources:** The home's policy, resident clinical records, and interviews with staff

### **WRITTEN NOTIFICATION: Reports re critical incidents**

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

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**Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.**

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The Director was not immediately informed by the home of a critical incident when a specified number of residents presented with symptoms prior to the reporting of an outbreak on a specified date.

**Sources:** CIR, the home's policy, resident clinical health records, and interviews with staff



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

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