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

London District
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Public Report

Report Issue Date: February 18, 2026

Inspection Number: 2026-1583-0001

Inspection Type:
Critical Incident
Follow up

Licensee: The Corporations of the City of Stratford, The County of Perth and The Town of St. Mary's

Long Term Care Home and City: Spruce Lodge Home for the Aged, Stratford

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: February 17 and 18, 2026.

The following intakes were inspected:

-Intake: #00164439 - Follow-up #: 1 - Compliance Order (CO) #001 from inspection 2025-1583-0006 related to O. Reg. 246/22 - s. 58 (4) (c), Responsive behaviours

-Intake: #00167890 - Critical Incident (CI) #M575-000002-26 related to a disease outbreak

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1583-0006 related to O. Reg. 246/22, s. 58 (4) (c)

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

Infection Prevention and Control
Responsive Behaviours

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 (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 license did not ensure a disease outbreak of a communicable disease was immediately reported to the Director. The local public health unit declared the home was in an outbreak, but the outbreak was not reported to the Director for two days.

Sources: Record review of CI #M575-000002-26, and an interview with the home's Infection Prevention and Control Lead.