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

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Public Report

Report Issue Date: December 9, 2025

Inspection Number: 2025-1286-0005

Inspection Type:
Complaint
Critical Incident

Licensee: Land O'Lakes Community Services

Long Term Care Home and City: Pine Meadow Nursing Home, Northbrook

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 19-21, 24-28, 2025 and December 1-3, 8-9, 2025

The following intake(s) were inspected:
- Intake: #00158617/ CIR: 2796-000020-25: Fall of a resident resulting in injury.
- Intake: #00158742/ CIR: 2796-000022-25: Alleged neglect of a resident by staff.
- Intake: #00158740/ CIR: 2796-000021-25: Alleged neglect of resident by staff.
- Intake: #00161162/ CIR: 2796-000027-25: Alleged Improper/Incompetent treatment of two residents by staff.
- Intake: #0016127: Complaint with concerns regarding a resident's plan of care and staff shortages.

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

Resident Care and Support Services
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1)
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,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve;
(c) clear directions to staff and others who provide direct care to the resident; and
(d) any other requirements provided for in the regulations.

A review of a resident's written plan of care, including the Kardex, indicated there was no documented planned care or goals related to their specified need. A staff member and the Assistant Director of Care (ADOC) confirmed that the Personal Support Worker's (PSW's) would reference a resident's Kardex for clear direction related to a resident's care needs.

Sources: A resident's written care plan and Kardex in PointClickCare (PCC), and interviews with a staff member and the and ADOC.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A resident's plan of care indicated they had a specified falls prevention intervention initiated on a specified date in October 2025. On two specified dates in November 2025, the resident's specified falls prevention intervention was not in place.

Sources: A resident's care plan on PCC, Inspector's observations, and interviews with staff and the ADOC.

WRITTEN NOTIFICATION: Documentation

NC #003 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.

Documentation of the BETT (Bathing, Eating, Transferring, Toileting) task for a resident, which is required to be completed on every shift as set out in their plan of care, was omitted on twenty-four evening shifts and eighty-four night shifts during a specified period in 2025.

Sources: A resident's Documentation Survey V2 in PCC, and interviews with a staff member and the DOC.

WRITTEN NOTIFICATION: When PASD may be used

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 36 (3)
PASDs that limit or inhibit movement
s. 36 (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

On two specified dates in November, 2025, a resident was positioned in their specified assistive device in a specified manner. Staff indicated that the resident positioned in the specified manner, in their specified assistive device, was a specified safety intervention. The ADOC indicated that the resident's specified assistive device was to be positioned in a specified manner and this was used for comfort as a personal assistance service device (PASD). Upon review of resident #001's written plan of care, there was no indication that the resident had a specified assistive device as a PASD.

Sources: A Resident's care plan, Kardex and progress notes in PCC, and interviews with staff and the ADOC.

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

On a specified date in September 2025, a resident sustained a fall and was sent to

the hospital for assessment. The ADOC confirmed that when a resident sustains a fall, the registered staff member completes the Falls-Post Incident Assessment within PCC, which is their clinically appropriate assessment instrument used for falls. There was no post fall assessment identified for the resident on a specified date in September 2025.

Sources: A resident's progress notes and Falls-Post Incident Assessments on PCC, and interviews with a staff member and the ADOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #006 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;

A resident, who was exhibiting altered skin integrity and skin breakdown, beginning on a specified date in August 2025, did not receive weekly reassessments by a member of the home's registered nursing staff, using either the Wound/Ulcer initial and weekly evaluation, or the Skin Integrity Assessment and Reevaluation assessment tools in PCC for five-consecutive-weeks spanning through September and October, 2025.

Sources: A resident's progress notes, Wound/Ulcer initial and weekly evaluation and Skin Integrity Assessment and Reevaluation assessments in PCC, and interviews

with staff, the ADOC and the DOC.

WRITTEN NOTIFICATION: Medication management system

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee's written Medication Management Policy, specifically the "Use of Oxygen Therapy Policy" was not implemented for resident a resident.

According to the Licensee's Use of Oxygen Therapy Policy # RC-16-01-16 - Last Reviewed November 2025, contained within the homes Medication Management Manual # KB0013522- v2.0 (Latest Version), it indicates the plan of care must clearly indicate the method of administration, flow rate, duration, and monitoring assessments required. Document the initiation of oxygen therapy on the Physician/NP orders within the Electronic Medication Administration Record (eMAR), or Electronic Treatment Administration Record (eTAR) and interdisciplinary progress notes.

Specifically, a resident's plan of care regarding their oxygen therapy was unclear. The special instructions and care plan sections of their plan of care provided conflicting information regarding the flow rate and did not include a duration. Additionally, the order for oxygen therapy was not added to their eMAR or eTAR as per the licensee's policy.

Sources: A resident's special instructions, care plan eMAR, and eTAR within their electronic medical record on PCC, prescriber digi order within their physical chart, and interviews with a staff member and the DOC.