

Ministry of Long-Term Care  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

North District  
159 Cedar St, Suite 403  
Sudbury, ON, P3E 6A5  
Telephone: (800) 663-6965

## Public Report

**Report Issue Date:** September 11, 2025

**Inspection Number:** 2025-1306-0002

**Inspection Type:**  
Critical Incident

**Licensee:** Riverside Health Care Facilities Inc.

**Long Term Care Home and City:** Rainy River Health Centre, Rainy River

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 27, 28, 2025

The inspection occurred offsite on the following date(s): September 8, 2025

The following intake(s) were inspected:

- An intake related to alleged improper/incompetent care of a resident by staff.
- An intake related to an Acute Respiratory Infection (ARI) Outbreak.
- An intake related to an Enteric Outbreak.
- An intake related to a fall of a resident resulting in an injury.

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

Resident Care and Support Services  
Infection Prevention and Control  
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: General requirements

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

**Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.**

General requirements

s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11

Ministry of Long-Term Care  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

North District  
159 Cedar St, Suite 403  
Sudbury, ON, P3E 6A5  
Telephone: (800) 663-6965

to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:

3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee failed to ensure that the required falls prevention and management program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

**Sources:** A review of the home's Falls Prevention and Management Program Policy; and an Interview with the home's Nursing Supervisor.

## **WRITTEN NOTIFICATION: Falls prevention and management**

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

### **Non-compliance with: O. Reg. 246/22, s. 54 (1)**

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to comply with the home's falls prevention and management program policy which provided for strategies to reduce or mitigate falls, included in the required falls prevention and management program in the home, for a resident.

In accordance with O. Reg 246/22 s. 11 (1) b. the licensee was required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure they were complied with.

Specifically, staff did not comply with the licensee's "Falls Prevention and Management Program Policy".

A resident did not have any fall prevention interventions or strategies indicated in their care plan prior to or after an incident involving a fall.

Ministry of Long-Term Care  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

North District  
159 Cedar St, Suite 403  
Sudbury, ON, P3E 6A5  
Telephone: (800) 663-6965

**Sources:** A review of a resident's care plan, progress notes, assessments, and medical records; A review of the home's Falls Prevention and Management Program Policy; and Interviews with a Registered Practical Nurse, and the home's Nursing Supervisor.

## WRITTEN NOTIFICATION: Housekeeping

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

**Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)**

Housekeeping

s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for, (b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(iii) contact surfaces;

The licensee failed to ensure that procedures were developed and implemented for cleaning and disinfection of contact surfaces with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices.

Specifically, the home did not have a policy or procedure containing the required frequency for cleaning and disinfecting contact surfaces including handrails in the home, and a Housekeeper confirmed handrails are cleaned and disinfected weekly.

Public Health Ontario (PHO)'s Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings. #rd. Edition, April 2018, required contact surfaces to be cleaned and disinfected at minimum once daily when a home is not in an outbreak.

**Sources:** A review of the home's policy titled, Surface Cleaning Procedure; a review of email communication from the home's Acting Administrator; and interviews with a Housekeeper, and the home's Acting Administrator.

## WRITTEN NOTIFICATION: Reports re critical incidents

Ministry of Long-Term Care  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

North District  
159 Cedar St, Suite 403  
Sudbury, ON, P3E 6A5  
Telephone: (800) 663-6965

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

**Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.**

Reports re critical incidents

s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):

4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee failed to ensure that the director was informed within one business day of a critical incident which involved a significant change for a resident.

The Director had not been informed of the incident until a report required under subsection (5) was received several days after the incident had occurred.

**Sources:** Review of a Critical Incident (CI) report; and an interview with the home's Nursing Supervisor.



**Ministry of Long-Term Care**  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

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

**North District**  
159 Cedar St, Suite 403  
Sudbury, ON, P3E 6A5  
Telephone: (800) 663-6965