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

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

# Public Report

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| **Report Issue Date:** July 28, 2025 |
| **Inspection Number:** 2025-1527-0001 |
| **Inspection Type:**<br>Critical Incident |
| **Licensee:** Riverside Health Care Facilities Inc. |
| **Long Term Care Home and City:** Rainycrest, Fort Frances |

## INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 22-24, 2025.

The following intakes were inspected:

- One Intake related to a fall of a resident;
- One Intake related to an allegation of neglect of a resident by staff; and
- Two Intakes related to outbreaks.

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

## INSPECTION RESULTS

## Non-Compliance Remedied

**Non-compliance** was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
**Non-compliance with: O. Reg. 246/22, s. 272**
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee failed to ensure that all recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act were followed in the home.

Specifically, Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings requires that Alcohol Based Hand Rub (ABHR) in use within the home must not be expired. On July 24, 2025, an expired ABHR was observed outside of a resident room on a cart.

**Sources:** Observations in the home. [196]

Date Remedy Implemented: July 24, 2025

## WRITTEN NOTIFICATION: IPAC

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

**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to implement additional requirements 9.1 (b) and (d) of the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, last revised September 2023, issued by the Director with respect to infection prevention and control.

Specifically, staff did not comply with the following:

a.) Use of Personal Protective Equipment (PPE)
b.) Use of Alcohol Based Hand Rub (ABHR)
c.) Additional precautions signage

**Sources:** Review of the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, last revised September 2023; Interview with the IPAC lead; and observations made in the home. [196]

## WRITTEN NOTIFICATION: Reporting

NC #003 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 licensee had failed to ensure an enteric outbreak was immediately reported to the Director.

**Sources:** A Critical Incident (CI); and an Interview with the Administrator. [196]

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