Ontario

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
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Public Report

Report Issue Date: October 30, 2025
Inspection Number: 2025-1527-0003
Inspection Type: 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 date(s): October 27 - 30, 2025.

The following intake(s) were inspected:
-An intake related to alleged improper/incompetent care of residents by staff.
-An intake related to a medication incident of a resident by staff.
-An intake related to a fall of a resident resulting in injury.

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

Medication Management
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident’s care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident’s care needs changed or when the care set out in the plan was no longer necessary.

Sources: Review of a resident’s clinical health record and plan of care; Interview with staff and Director of Care (DOC).

WRITTEN NOTIFICATION: Administration of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee failed to ensure that a resident only received medications that had been prescribed for the resident.

Sources: Review of a resident's progress notes, assessments and electronic Medication Administration Record (eMAR); Review of the home's internal investigation; Review of Critical Incident; and Interviews with registered staff, and DOC.