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

Original Public Report

Report Issue Date: October 18, 2024
Inspection Number: 2024-1527-0003
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 7 - 11, 2024

The following intake(s) were inspected:

- Two intakes related to an infectious disease outbreak; and
- Two intakes related to alleged physical and verbal abuse of residents.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that residents were protected from incidents of abuse by staff members.

Sources: Critical Incident (CI) reports; resident health records; Long-term Care Home (LTCH) investigation file; LTCH policy titled "Abuse and Neglect Zero Tolerance Policy", last reviewed July, 2023; interviews with Administrator and staff. [721027]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that incidents of abuse were immediately reported by LTCH staff.

Sources: CI reports; resident health records; Long-term Care Home (LTCH) investigation file; LTCH policy titled "Critical Incident and Mandatory Reporting in Long-Term Care Policy" last reviewed September 2023; interviews with Administrator and staff. [721027]