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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: October 23, 2025
Inspection Number: 2025-1470-0006
Inspection Type: Critical Incident
Licensee: Oneida Nation of the Thames
Long Term Care Home and City: Oneida Nation of the Thames Long-Term Care Home (Tsi' Nu: yoyantle' Na' Tuhuwatisni), Southwold

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 22 & 23, 2025

The following intake(s) were inspected:
-Intake #00158902 / CI 3042-000012-25 related to an unexpected death

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

Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.
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):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee has failed to ensure that the Director was immediately informed following the unexpected death of a resident.

Sources: Critical Incident System (CIS) report; Resident clinical records; and interviews with staff.

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