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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: September 18, 2025
Inspection Number: 2025-1026-0002
Inspection Type: Critical Incident
Licensee: Golden Years Nursing Homes (Cambridge) Inc.
Long Term Care Home and City: Golden Years Nursing Home, Cambridge

INSPECTION SUMMARY

The inspection occurred offsite on the following date(s): September 12, 15-17, 2025

The following intake(s) were inspected:

- Intake: #00156318 - Resident Care and Services

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

Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 3.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right to have their participation in decision-making respected.

The licensee failed to ensure that a resident's right to have their participation in decision-making was respected.

A residents participation in decision-making was not respected related a request they made concerning their care.

Sources: clinical records and interview with the resident and staff

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff used safe positioning techniques when assisting a resident resulting in an injury.

Sources: clinical records and interview with the resident and staff

WRITTEN NOTIFICATION: Reports Re Critical Incidents

NC #003 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 no later than one business day of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Sources: clinical records and interview with staff

WRITTEN NOTIFICATION: Reports Re Critical Incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,

ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee who was required to inform the Director of an incident failed to make a report in writing to the Director setting out a description of the individuals involved in the incident, including, the names of any staff members or other persons who were present at or discovered the incident.

Sources:clinical records and interview with staff

WRITTEN NOTIFICATION: Reports Re Critical Incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 4. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
ii. the long-term actions planned to correct the situation and prevent recurrence.

The licensee who was required to inform the Director of an incident failed to make a report in writing to the Director which included the long-term actions planned to correct the situation and prevent recurrence.

Sources: clinical records and interview with staff