

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: October 2, 2025

Inspection Number: 2025-1057-0003

Inspection Type:
Critical Incident

Licensee: Norwood Nursing Home Limited

Long Term Care Home and City: Norwood Nursing Home, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 22-24, and October 2, 2025.

The following Critical Incident (CI) intake was inspected:

Intake: #00154593/2201-000003-25 was related to infection prevention and control.

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 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).

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The licensee has failed to ensure that Routine Practices and Additional Precautions were followed in accordance with the Infection Prevention and Control (IPAC) Standard.

1) Specifically, two staff members did not perform hand hygiene before and after resident and their environment contact as required by Additional Requirement 9.1 (b) under the IPAC Standard.

Sources: Observations; and a review of IPAC Standard for Long-Term Care Homes, Revised September 2023.

2) Specifically, the hand sanitizing wipes used for assisting residents to perform hand hygiene before meals did not include 70-90% Alcohol-Based Hand Rub (ABHR) as required by Additional Requirement 10.1 under the IPAC standard.

Sources: Observations; review of product label and IPAC Standard for Long-Term Care Homes, Revised September 2023; interview with relevant staff.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

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

Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2).

The licensee has failed to ensure that on every shift, a resident's symptoms indicating the presence of infection were monitored.

The symptoms of infection for a resident on additional precautions were not monitored on every shift as required.

Sources: Resident's clinical records and Critical Incident System (CIS); and interview with relevant staff.

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WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)

Infection prevention and control program

s. 102 (11) The licensee shall ensure that there are in place,

(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts.

The licensee has failed to comply with the home's IPAC program when they did not immediately report a suspected outbreak to the public health unit (PHU).

In accordance with O. Reg 246/22 s.11. (1) b, the licensee was required to ensure the IPAC program had in place an outbreak management system for detecting, managing, and controlling infectious disease outbreaks including reporting protocols based on requirements under the Health Protection and Promotion Act and complied with.

Specifically, the home did not comply with the licensee's "Outbreak Prevention and Control-Outbreak Management" policy when they failed to report to the PHU after the case definition of an outbreak was met.

Source: Review of the home's policy "Outbreak Prevention and Control-Outbreak Management", NUM-ICM-II-02, reviewed March 28, 2025, and the home's outbreak Line List ; and interview with relevant staff.