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 East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: August 25, 2025
Inspection Number: 2025-1273-0004
Inspection Type: Critical Incident
Licensee: Shepherd Village Inc.
Long Term Care Home and City: Shepherd Lodge, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 21-22, 25, 2025

The following intake(s) were inspected:

- An intake related to Responsive behaviours and prevention of abuse

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

Infection Prevention and Control
Responsive Behaviours
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 protect a resident from physical abuse by another resident.

In accordance with O. Reg 246/22, s. 2 (1) (c),"physical abuse" is defined as use of physical force by a resident that causes physical injury to another resident; ("mauvais traitements d'ordre physique")

On a specific date, a resident was observed pushing another resident who was in front of them and talking to them. This action caused the co-resident to fall which resulted in significant injuries to them.

Sources: A Critical Incident Report (CIR), both residents' clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (2) (a)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents;

The licensee failed to ensure that, written interventions and strategies to prevent or minimize responsive behaviour of a resident, were integrated into the care that was

provided to the resident.

The resident was known to have a specific responsive behaviour which required certain interventions to be in place related to that behaviour.
Based on the evidence provided to the Inspector, such interventions were not fully integrated into the care of that resident on a certain date. The resident exhibited the responsive behaviour towards a co-resident which resulted in significant injuries to the co-resident.

Sources: A CIR, the home's investigation notes, both residents' clinical records, and interviews with staff.

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