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: December 15, 2025
Inspection Number: 2025-1273-0007
Inspection Type: Critical Incident Follow up
Licensee: Shepherd Village Inc.
Long Term Care Home and City: Shepherd Lodge, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 3, 8, 15, 2025
The inspection occurred offsite on the following date(s): December 12, 2025
The following intake(s) were inspected:
-Follow-up #: 1 - O. Reg. 246/22 - s. 261 (1) 5. CDD December 1, 2025.
-one intake for a resident fall with injury

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #01 from Inspection #2025-1273-0006 related to O. Reg. 246/22, s. 261 (1) 5.

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4)
Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The resident experienced an unwitnessed fall and was sent to hospital as requested by the substitute decision maker (SDM). The resident returned from hospital with discharge instructions including signs and symptoms that would warrant the resident to return to hospital.

The Assistant Director of Care (ADOC) confirmed the Registered Practical Nurse (RPN) did not review the discharge information when the resident returned and was not aware of the signs and symptoms that would require the resident to return to hospital.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The resident's care plan identified them as a high risk of falls with interventions in place. The Personal Support Worker (PSW) failed to check the functionality of assistive devices being utilized.

The resident experienced an unwitnessed fall while receiving care. The resident was being assisted with care when the PSW left the resident to retrieve supplies, and they returned to find the resident on the floor. The PSW confirmed they were not aware that the resident was using assistive devices.

The Physiotherapist recommended early morning toilet routine which was not reflective in the care plan.

Sources: Review of the resident's plan of care, review of staff discipline decisions and interview with staff.

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