

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: February 24, 2026

Inspection Number: 2026-1273-0001

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): February 12 -13, 16 - 20, 23 - 24, 2026

The inspection occurred offsite on the following date(s): February 18, 2026

The following intake(s) were inspected in this Critical Incident (CI) inspection:

Two intakes related to staff-to-resident physical abuse.

An intake related to an Outbreak

An intake related to a complaint of resident neglect.

An intake related to a fall of a resident

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

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) 4.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of

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residents are fully respected and promoted:

4. Every resident has the right to freedom from abuse.

On a specific date, staff used unauthorized physical force on the resident, despite the resident's resistance, resulting in distress and emotional harm.

Source: Home's investigation records, interview with staff

WRITTEN NOTIFICATION: Infection prevention and control program

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

Non-compliance with: FLTCA, 2021, s. 23 (2) (a)

Infection prevention and control program

s. 23 (2) The infection prevention and control program must include,

(a) evidence-based policies and procedures;

Home used trigger-spray bottles to clean resident rooms and other areas in the home. The Provincial Infectious Diseases Advisor Committee (PIDAC) Best Practices indicated that cleaning chemicals are not to be applied by aerosol or trigger sprays.

Sources: PIDAC Best Practices, policies, CIR, observations, and interviews with staff.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

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

Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

Licensee must investigate, respond and act

s. 27 (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,

On a specific date, physical abuse was reported to the home. The home did not follow the Abuse and Neglect Policy by failing to immediately initiate an investigation, clinically

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assess the resident, and notify the police and the Director in a timely manner.

Source: Resident's clinical records, Home's Abuse and Neglect Policy, interviews with staff.



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**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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