RHRA Retirement Homes Regulatory Authority

55 York Street, Suite 700
Toronto, ON. M5J 1R7

COMPLIANCE ORDER SUMMARY
TO BE MADE AVAILABLE IN HOME

Pursuant to the *Retirement Homes Act, 2010* S.O. 2010, Chapter 11, section 90.

Shepherd Village Inc.
o/a Shepherd Terrace Retirement Residence
3758 Sheppard Avenue E.
Toronto, ON M1T 3K9

COMPLIANCE ORDER NO. 2026-T0012-90-01

Under section 90 of the *Retirement Homes Act, 2010* (the "Act"), if the Registrar of the Retirement Homes Regulatory Authority (the "Registrar" and the "RHRA", respectively) believes on reasonable grounds that a licensee has contravened a requirement under the Act the Registrar may serve an order on a licensee ordering it to refrain from doing something, or to do something, for the purpose of ending the contravention and achieving compliance, ensuring that the contravention is not repeated, and that compliance is maintained. The Registrar issues this Compliance Order (the "Order") to ensure Shepherd Village Inc. (the "Licensee") operating as Shepherd Terrace Retirement Residence (the "Home") comes into compliance and maintains compliance with the Act and Ontario Regulation 166/11 under the Act (the "Regulation").

CONTRAVENTION

The Deputy Registrar has reasonable grounds to believe that the Licensee is not in compliance with the following sections of the Act and Regulation:

- Section 62(4)(b)(i), (ii), and (iii) of the Act: The Licensee did not ensure that there was a written plan of care for each resident that set out the planned care services for the resident, including the details of the services, the goals that the services were intended to achieve, and clear directions to staff who provided direct care to the resident.
- Section 62(12)(b) and (c) of the Act: The Licensee did not ensure that a resident was reassessed, and that the plan of care was reviewed and revised, when the resident's care needs changed or when the care services set out in the plan had not been effective.
- Section 23(1)(c) of the Regulation: The Licensee did not ensure that there was a written behaviour management strategy that included strategies for monitoring residents who had demonstrated behaviours that posed a risk to themselves or others in the Home.

BRIEF SUMMARY OF FACTS

An inspection was conducted at the Home on February 17, 2026, in response to a report of a missing resident. The resident moved into the Home with cognitive impairment and exit-seeking behaviours that posed a risk of elopement. Although the Licensee took some steps to mitigate risk and responded appropriately once the resident was reported missing, it did not reassess based on the resident's escalating behaviours, revise the plan of care, or implement a structured heightened monitoring strategy.

REQUIRED ACTION

Pursuant to section 90 of the Act, the Deputy Registrar orders the Licensee to comply with the following:

1. Within 90 days of this Order, ensure that all management and staff of the Home who provide direct care to residents participate in a training session, provided by a third party acceptable to the RHRA, related to identifying and managing behaviours that may pose a risk of harm to the resident or others in the Home. The training must address wandering and exit-seeking behaviours, as well as the development and implementation of appropriate behaviour management strategies, techniques, interventions, and monitoring.

2. Within 90 days of this Order, conduct an audit of all resident plans of care to confirm that each resident who demonstrates behaviours that may pose a risk to themselves or others in the Home has a behaviour management strategy in place.

Issued on June 10, 2026.