
ADMINISTRATIVE PENALTY ORDER SUMMARY TO BE MADE AVAILABLE IN HOME

Pursuant to the *Retirement Homes Act, 2010* S.O. 2010, Chapter 11, section 93.

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

ADMINISTRATIVE PENALTY ORDER 2026-T0012-93-01

The Registrar of the Retirement Homes Regulatory Authority (the “Registrar” and the “RHRA”, respectively) has reasonable grounds to believe that Shepherd Village Inc. (the “Licensee”) operating as Shepherd Terrace Retirement Residence (the “Home”) has contravened sections of the *Retirement Homes Act, 2010* (the “Act”) and Ontario Regulation 166/11 (the “Regulation”).

The Deputy Registrar issues this Order to Pay an Administrative Penalty under section 93 of the Act to encourage the Licensee to comply with the requirements under the Act and Regulation.

CONTRAVENTION

The Deputy Registrar has reasonable grounds to believe that the Licensee contravened 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 67(2) of the Act: The Licensee did not ensure that the Licensee or staff of the Home did not neglect a resident.
- 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. As a result, the Licensee did not protect the resident from neglect.

ADMINISTRATIVE PENALTY FACTORS

The Deputy Registrar considered the factors contained in subsection 60.1(1) of the Regulation in determining the amount of the Administrative Penalty:

a) **Severity of Adverse Effect / Potential Adverse Effect:**

The Licensee's non-compliance involved a failure to protect Resident A from a known and escalating risk of wandering and elopement, despite repeated incidents indicating that existing measures were ineffective. This likely contributed to Resident A exiting the Home and subsequently being found deceased. The adverse effect is appropriately categorized as major.

b) **Mitigation of Contravention:**

Mitigating factors include that the Licensee identified Resident A's elopement risk early, communicated concerns and recommended safeguards to the POA, sought external supports including long-term care placement, responded promptly to incidents, and was limited by the family's decision not to pursue recommended safety precautions.

c) **Previous Contraventions:**

The Licensee does not have a relevant history of non-compliance. This is a mitigating factor in determining the amount of the administrative penalty.

d) **Economic Benefit:**

There is no evidence that the Licensee received direct economic benefit from the non-compliance.

e) **Purpose of Administrative Penalty:**

The administrative penalty is intended to encourage the Licensee to achieve and maintain compliance with the Act and Regulation.

Issued on June 10, 2026.