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.

Chartwell Master Care Corporation
o/a Chartwell Tranquility Place Retirement Residence
436 Powerline Road
Brantford, ON N3T 5L8

COMPLIANCE ORDER NO. 2026-S0057-90-01

Under section 90 of the *Retirement Homes Act, 2010* (the "Act"), if the Deputy Registrar of the Retirement Homes Regulatory Authority (the "Deputy Registrar" and the "RHRA", respectively) believes on reasonable grounds that a licensee has contravened a requirement under the Act the Deputy 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 Deputy Registrar issues this Compliance Order (the "Order") to ensure Chartwell Master Care Corporation (the "Licensee") operating as Chartwell Tranquility Place 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(8)(b) of the Act: the Licensee did not ensure that there are protocols to promote the collaboration between the staff, external care providers and others involved 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.
- Section 62(10) of the Act: the Licensee did not ensure that the care services that the licensee provides to the resident are set out in the plan of care and are provided to the resident in accordance with the plan and the prescribed requirements, if any.
- Section 67(2) of the Act: the Licensee did not ensure that the staff of the Home did not neglect the residents.

- Section 29(b) of the Regulation: the Licensee did not ensure that no drug is administered by the licensee or the staff to the resident in the home except in accordance with the directions for use specified by the person who prescribed the drug for the resident.
- Section 32(a) of the Regulation: the Licensee did not ensure that the person who administered the drug or other substance prepares a written record noting the name and amount of the drug or other substance, the route of its administration and the time and date on which it was administered.
- Section 47(5) of the Regulation: the Licensee did not ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care if the resident's care needs include dementia care, skin and wound care or the use of a personal assistance services device.

BRIEF SUMMARY OF FACTS

Two inspections were conducted at the Home on August 21, 2025, and October 23, 2025, concerning activities related to skin and wound care and medication administration. Both inspections identified gaps in collaboration between Home staff and external care providers, which impacted the administration of prescribed topical creams to two residents.

REQUIRED ACTION

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

1. Within 30 days of this Order, develop or enhance current skin and wound care and medication administration protocols to clearly define staff responsibilities with respect to applying topical medications or other substances to residents, including in instances when a resident may also receive skin and wound care from an external care provider.

Issued on February 6, 2026.