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**COMPLIANCE ORDER SUMMARY  
TO BE MADE AVAILABLE IN HOME**

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

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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 require Chartwell Master Care Corporation (the “Licensee”) operating as Chartwell Tranquility Place Retirement Residence (the “Home”) to come into and maintain 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 contravened the following sections of the Act and Regulation:

- Section 67(2) of the Act: The Licensee did not ensure that staff of the Home do not neglect the residents.
- Section 30(a)(ii) of the Regulation: The Licensee did not ensure that drugs or other substances are stored in an area or a medication cart that is locked and secure.
- Section 31(1) of the Regulation: The Licensee did not ensure that a medication management system was established which includes written policies and procedures to ensure that all drugs and other substances to be to residents of the home are acquired, received in the home, stored, dispensed, administered, destroyed and disposed of correctly as required by law and in accordance with prevailing practices.
- Section 32(a) of the Regulation: The Licensee did not ensure that the person who administered the drug prepares a written record noting the name and amount of the drug, the route of its administration and the time and date on which it was administered.

## **BRIEF SUMMARY OF FACTS**

The Order relates to an inspection carried out at the Home on February 12, 2026. During this inspection, it was found that staff did not adhere to the Home's medication administration protocols, resulting in one resident being given another resident's medication and requiring emergency medical assistance as a result. The inspection identified communication gaps that affected the timeliness and effectiveness of the Home's response to the medication error. The inspection also identified omissions in medication administration records.

## **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, demonstrate that all staff administering medications to residents have received training on procedures to be followed upon identification of a medication error, including timely resident assessment, monitoring, and escalation, to ensure that necessary care or emergency response is provided.
2. For a period of 12 months, the Health and Wellness Manager must conduct weekly audits to ensure that:
  - a. Staff administering drugs are doing so in accordance with the prescriber's order.
  - b. Staff administering drugs are accurately documenting the time and date the medication is administered.
  - c. Submit the results of these audits to RHRA Compliance Monitor every two months.

**Issued on April 7, 2026.**