
ADMINISTRATIVE PENALTY ORDER SUMMARY TO BE MADE AVAILABLE IN HOME

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

Chartwell Master Care Corporation
o/a Chartwell Barton Retirement Residence
17290 Leslie Street
Newmarket, ON L3Y 3E1

ADMINISTRATIVE PENALTY ORDER 2026-T0086-93-01

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

The 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 Registrar has reasonable grounds to believe that the Licensee contravened the following sections of the Act and Regulation:

- [s. 74\(a\)\(ii\) and \(b\) of the Act](#) – The Licensee failed to ensure that (1) every alleged, suspected or witnessed incident of neglect of a resident is immediately investigated and (2) that appropriate action is taken in response.
- [s. 75\(1\) of the Act, paragraphs 1 and 2](#) – A person who has reasonable grounds to suspect the following shall immediately report the suspicion to the Registrar: (1) improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident or (2) abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident.
- [s. 67\(2\) of the Act](#) – The Licensee did not ensure that the Licensee and the staff of the Home did not neglect the residents.

- [s. 65\(4\) of the Act](#) – The Licensee did not ensure that persons who are required to receive the training described in subsection (2) receive on-going training as described in that subsection at the times required by the regulations.
- [s. 14\(2\) of the Regulation](#) – The Licensee did not ensure, for the purposes of s. 65(4) of the Act, that persons who are required to receive training under s. 65(2) of the Act receive the training at least annually.

BRIEF SUMMARY OF FACTS

A resident of the Home was injured after being exposed to chemical residue on a teacup. Home staff did not make appropriate inquiries into the root cause of the resident's symptoms and failed to follow available chemical safety guidance. The resident's symptoms worsened over a matter of days, resulting in emergency medical services being contacted. There was no evidence that the matter was reported to the RHRA as required, or that staff involved in the food and beverage service had received the required training. In the circumstances, there are reasonable grounds to believe that the Licensee did not ensure that the resident was not neglected.

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:

A resident of the Home was injured as part of tea service. There are reasonable grounds to believe the resident ingested a chemical that could cause burns if ingested. The chemical was discontinued by the Licensee but remained in use at the Home. The resident reported the matter to Home staff immediately upon ingestion and sought treatment from Home nursing staff thereafter. Home staff did not make appropriate inquiries into the root cause of the Resident's symptoms and failed to follow available chemical safety guidance. The resident's symptoms worsened over a matter of days, resulting in EMS being contacted. There is no evidence that the matter was reported to the RHRA as required. There is also no evidence that staff involved in tea service had completed the required training. Ultimately, there were deficiencies in the incident response, resident monitoring, documentation, reporting, and training compliance. The severity of the impact to the resident can be classified as "major".

b) Mitigation of Contravention:

Following the incident, the Licensee took substantial corrective action, including providing re-training to and re-education of its staff. This is a mitigating factor in determining the quantum amount.

c) Previous Contraventions:

The Licensee has not previously been found non-compliant with s. 67(2) of the Act (or the other provisions of the Act and Regulation noted above). This is a mitigating factor in determining the quantum amount.

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 maintain compliance with the Act and Regulations going forward and to emphasize the importance of preventing future instances of non-compliance. Due to the adverse effect on the resident, and the underlying systemic failures and numerous missed opportunities to mitigate the same, the Registrar has determined that a monetary penalty is required to maintain compliance with the Act and Regulation.

Issued on October 7, 2026.