Regulation	Change	Action Required
8 (2)– Policies & Records	**NEW -** Where the Act or Regulation requires the licensee to keep a record, the licensee shall ensure that the record is kept in a readable and useable format that allows a complete copy of the records to be readily produced	Records should be easily accessible to an inspector. Fairmount records are kept on-site according to the timelines set out in the County's retention by-laws.
12 (2)(a) – Furnishings	Resident beds have a firm, comfortable mattress that is at least 10.16 cm thick unless contraindicated as set out in the resident's plan of care	This has been communicated to the staff responsible for purchasing mattresses.
14 – Shower Grab Bars	Every resident shower has at least two easily accessible grab bars with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall	The second grab bars were installed.
15 (1)– Bed Rails	The resident is assessed and his or her bed system is evaluated in accordance with evidence-based practice and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; steps must be taken to prevent resident entrapment taking into consideration all potential zones of entrapment; ensure other safety issues related to the use of bed rails are addressed including height and latch reliability	The process is in place for assessment of bed rails and we have received clarification from the Ministry as to when bed rails are to be considered a restraint. Our restraint policy has been amended to reflect this clarification.
16 - Windows	Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 10 centimeters	Windows have been checked and meet the requirements
18 – Lighting	Corridors & stairwells – "continuous consistent" lighting	Compliant
20 – Cooling Requirements	Ensure that a written hot weather related illness prevention & management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, & is implemented when required to address the adverse effects on residents related to heat. Shall ensure that, if central air conditioning is not available in the home, the home has at least one separate designed cooling area for every 40 residents.	The home has air conditioning so we are compliant
23 – Compliance with manufacturer's instructions	Ensure that staff use all equipment, supplies, devices, assistive aids & positioning aids in the home in accordance with manufacturers' instructions	This was included in the staff orientation to the *Act* and is included in new staff orientation. A process to ensure easy access to manufacturer's instructions to be developed.
24 – Renamed from Initial Plan of	**NEW** - Must include…any risks the residents may pose to others,	Review current written policies to ensure includes requirements of

Care to 24-hour Admission Care Plan	including any potential behavioural triggers, and safety measures to mitigate those risks; drugs & treatments required; known health conditions including allergies and other conditions of which the licensee should be aware upon admission including interventions; skin condition including interventions; diet orders including food texture, fluid consistencies and food restrictions.	24-Hour Admission Care Plan
25 – Initial Plan of Care	NEED TO REVIEW THIS SECTION AS COMPLETELY REVISED	Review current written policies to ensure includes requirements of Initial Care Plan
26 – Plan of Care	There is a requirement for the dietitian to do the nutritional assessment upon admission & whenever there is a significant change in the resident's health and do the assessments on nutritional status including height, weight and any risks relating to nutrition care; hydration status & any risks relating to hydration	Review current policies to ensure compliance; the role of the Dietitian was reviewed with the new Dietitian.
29 – Changes in Plans of Care - Consent	**NEW**- requirement that if a resident is reassessed and the plan of care is reviewed & revised, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to "a course of treatment" or a "plan of treatment" under that Act, that is relevant, including a regulated document under paragraph 2 of subsection 227(1) of this regulation is reviewed &, if required, revised.	Ensure policies and procedures updated and process in place to ensure compliance
30 – General Requirements for Programs	Ensure that the following is complied with in respect of each of the organized programs under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this regulation (falls, skin, continence, pain)	Programs include nursing & personal support; restorative care; recreation; dietary services & hydration; medical services; information & referral assistance; religious & spiritual practices; accommodation services; volunteer program; falls prevention; skin & wound care; continence care & bowel management; pain management – working on updating current goals and objectives based on outcome of strategic planning; review evidence based practices
30 – 1-1	There must be a written description of the program that includes its goals & objectives and relevant policies, procedures & protocols and provides for methods to reduce risk and monitor outcomes including protocols for the referral or residents to specialized resources where required	
30-1-2	Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the	

	resident based on the resident's condition	
30-1-3	The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.	
30-1-4	Keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date those changes were implemented	Currently developing & confirming evaluation tools
30-2	Ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions & the resident's responses to interventions are documented.	This was included in staff orientation to the *Act* and is included in new staff orientation.
31 – Staffing Plan	Include a back-up plan for nursing and personal care staff that addresses situations when staff, including RN, cannot come to work and must be evaluated & updated annually in accordance with evidence based practices &, if there are none, in accordance with prevailing practices. Must keep the date of the evaluation, who participated, a summary of the changes made & the date the changes were implemented	Staffing plan was updated to reflect staffing reductions and is based on current practice. Evaluation to be based on MOHLTC inspection reports; resident & staff satisfaction surveys and incidents/complaints related to staffing levels.
36 – Transferring & positioning techniques	Staff shall use safe transferring & positioning devices or techniques when assisting residents	This was included in staff orientation to the *Act* and is included in new staff orientation.
37 – Personal items & personal aids	**NEW -** Must be labeled within **48** hours of admission and acquisition and must be cleaned as required	This was included in staff orientation to the *Act* and is included in new staff orientation. A policy has been developed and distributed.
42 – End of Life Care	**NEW -** Every resident receives EOL care when required in a manner that meets their needs. Removed the requirement to respond to the immediate needs of other residents, family & staff following the death of a resident.	This was included in staff orientation to the *Act* and is included in new staff orientation.
43 – Communication Methods	Strategies must be developed and implemented - now includes strategies for residents with cognitive impairment	This was included in staff orientation to the *Act* and is included in new staff orientation.
47 – Qualifications of PSW	Program must be at least 600 hours (school & placement)	Confirmed
48 – Required Programs	Falls prevention & management; skin & wound care; continence care & bowel management; pain management. Must provide for screening protocols & assessment & reassessment instruments. There are additional requirements for all of the four programs	Ministry confirmed must be a "program" – staff must be able to find information from start to end in one place. We currently have a variety of policies and procedures for each program in place but we are currently brining all the documentation together and determining how the programs are to be evaluated.

		Nurse Practitioner has developed the Pain Management program and is currently implementing across the home after an initial trial on one unit. Program was presented to family members during the family information session.
53 – Responsive Behaviours	Many additional requirements including internal reporting protocols; written information;	The policy was revised and shared with staff during orientation to the *Act*. It is also part of the new staff orientation.
54 – Altercations & other interactions between residents	Enhanced to cover potentially harmful altercations & must be an interdisciplinary assessment	The policy was revised and shared with staff during orientation to the *Act*. It is also part of the new staff orientation.
55 – Behaviours & altercations	**NEW**– must have procedures & interventions to assist residents & staff who are at risk of harm or who are harmed as a result of a resident's behaviours; requirement for advising staff of residents with behaviours at the beginning of shift	As noted above this is in place within the policy. A new shift report format was developed to ensure communication of responsive behaviours occurs at the beginning of each shift.
57 – Integration Restorative Care	RC approaches must be integrated into the care that is provided to all residents	This was shared with staff during orientation to the *Act* and is also part of the new staff orientation. Policy review still to be undertaken.
58 – transferring & positioning	**NEW** – when transferring & positioning residents, staff shall use devices & techniques that maintain or improve, wherever possible, the residents' weight bearing capability, endurance & ROM	This was shared with staff during orientation to the *Act* and is also part of the new staff orientation.
62 – Social Work	Need to ensure written description of the social work & social work services provided in the home & that the work meets the residents' needs	We need to review our current policy.
64 – Designated Lead – Restorative Care	The designated lead is over the entire restorative program, including therapy services. Changed registration with the "appropriate" college of a regulated health profession to "a" college….	The lead is the Restorative Care RPN.
65 – Rec & social programs	Must provide information to residents about community activities that may be of interest to them	This is being done through Residents' Council and community bulletin board.
66 – Designated Lead – Recreation	Qualifications only apply to leads designated after July 1, 2010	Designated lead is current the Director of Resident Care.
68 – Nutrition care & hydration	The development of P&P must be with a registered dietitian who is a "member of the staff" at the home. Have added the requirement for a system to monitor & evaluate the food & fluid intake of residents with identified risks related to nutrition & hydration	We will ensure that dietitian is involved in policy and procedure development in this area.
70 – Dietary Services	Includes "snack" planning	The snack menu is in place.
71 – Menu Planning	Includes snacks; requires that the "planned menu items" are offered & available at each meal & snack	The meal and snack menus are in place. Cooks are documenting anytime a substitution is required.
72 – Food Production	**NEW** – requirements to keep for seven years weekly records that	We need to update our policy and procedure however these

	specify the number of meals prepared for non-residents and the revenue & internal recoveries made related to the sale or provision of any food and beverage prepared in the home, including revenue & internal recoveries made from cafeteria sales & catering. Also need P&P for the safe operation and cleaning of equipment related to the food production system & dining & snack service	records will be kept for the required time on site. The new dietary manager will be reviewing the policies and procedures for cleaning of the equipment.
73 – Dining & snack services	Have added “proper techniques to assist residents with eating, including safe positioning of residents who require assistance”. Also added “appropriate seating for staff who are assisting residents to eat”	During the mock inspection the inspectors noted a concern related to positioning of residents in one home area however no further information was provided. This requirement was shared with staff during orientation to the *Act* and is also part of the new staff orientation.
75 – Nutrition Manager	Revised the formula – 40.96 hours required at FMT – is up to the Director how the hours per week fulfilling non-manager duties impacts on the required hours	Current manager is contracted through Sodexo and is on site 40 hours/week.
76 – Cooks	Changed the requirement from one cook on site daily to one cook who works at least 35 hours per week in that position on-site at the home. The cook must have chef training or culinary management diploma from a program that meets the standard established by the Ministry of Training, Colleges and Universities	The requirements set out in our job description meets the requirements. We have two cooks on each day.
77 – Food Service Workers	Changes the requirement – 403.2 per week required at FMT – the Director can take into consideration the number of hours per week spent on non-resident food production when determining compliance.	Currently 413 hours/week which would include the hours for the café and Meals 2 Go. We will need to wait for our formal inspection to see how the Ministry determines the time spent on non-resident food production.
78 - FSW Training & Qualifications	Must have the Food Service Worker training program or have completed within 3 years of being hired; FSW who are employed at the home before Oct 1/10 & do not have the FSW program must complete a food handler training program within 3 months	We have changed our job offer letters to reflect the three years the staff has to complete the FSW program.
81 – Individualized medical directives & orders	**NEW** – no medical directive or order can be used with respect to a resident unless it is individualized to the resident’s condition & needs	Compliant
82 – Attending Physician or RN EC	Attending regularly at the home to provide services – includes assessments	Compliant
85 – Religious & Spiritual Practices	Additional requirements re hearing & visual impairment; different requirements for designated lead	The Coordinator of Religious & Spiritual Care is the designated lead. A hearing system is available for the hearing impaired and large print and overheads are available for those with visual impairment.

86 – Accommodation Services	**NEW** – requirement to have written agreements with service providers who are not employees; written P&P to monitor and supervise persons who provide occasional maintenance or repair service to the home pursuant to the written agreement required. These P&P may take into account whether the person is subject to the requirements for a criminal reference check and declarations set out in subsections 215 (1) to (5)	Contracts are in place. Contractor orientation packages were issued. Policy and procedures in place for regular monitoring of contractors.
90 – Maintenance	Additional references to the maintenance of mechanical lifts; equipment, devices, assistive aids and positioning aids; HVAC systems must be inspected at least every six months; gas or electric fireplaces are inspected by a qualified individual at least annually; temp of water serving all bathtubs, showers & hand basins used by residents does not exceed 49 degrees C and not less than 40 degrees C; excludes maintenance of residents' personal belongings	Appropriate processes are in place. We need to ensure written policies and procedures reflect the current practice. The heat units in the electric fireplaces have been disconnected therefore they do not need to be inspected.
92 – Designated Lead – EVS	Clarifies can be one person leading housekeeping, laundry & maintenance. The educational requirements are only in force for leads hired after the Act comes into force	Current lead is Manager of Environmental Services. We will need to update the qualifications in the job description.
93 – Pets	**NEW** – must have a written policy	We comply as we already have a policy. We must ensure that proof of immunization is on file.
94 – Volunteer program	A staff member must monitor or direct a volunteer whenever it is necessary to ensure the safety of a resident	Compliant.
96 – Policy to promote zero tolerance	Additional requirements for policy including training on the relationship between power imbalances between staff & residents	This was shared with staff during orientation to the *Act* ; is included in our zero tolerance for abuse/neglect policy and is also part of the new staff orientation.
97 – Notification re incidents	Must notify the resident's POA immediately if we become aware of an alleged, suspected or witnessed incident of abuse/neglect that resulted in a physical injury or pain that causes distress to the resident; must notify within 12 hours (was 24) of any other alleged, suspected or witnessed abuse.	Contained in revised policy
98- Police Notification	Must notify police of alleged, suspected or witnessed abuse or neglect if we suspect it may constitute a criminal offence.	Contained in revised policy
99 – Evaluation	Requirements for analysis/evaluation	Contained in revised policy
101 – Dealing with complaints (verbal & written)	Must be immediate investigation if the complaint alleges harm or risk of harm to one or more residents. **NEW -** There is no requirement to document & trend verbal complaints if they are	This was shared with staff during orientation to the *Act* and is also part of the new staff orientation. Our complaint policy was updated.

	resolved within 24 hours of the complaint being received	
107 – Critical Incidents	Need to review current policy to ensure compliance with Regulations	Policy has been updated.
109 – Minimizing of Restraining	Policy needs to deal with the use of physical devices; need to do detailed review of rest of section as many references to the Act added	Policy has been revised and shared with staff during orientation to the *Act* and is also part of the new staff orientation. We are awaiting clarification from the Ministry on when a bedrail is considered a restraint.
115 – Quarterly medication management system review	If the pharmacy service provider is a corporation a pharmacist from the pharmacy must participate	Contained in current policy.
116 – Annual Evaluation	There must be an annual interdisciplinary evaluation of the effectiveness of the medication management system using an instrument designed specifically for this purpose	We need to review current policies and procedures and confirm the evaluative instrument to be used.
117 – Medical Directives & Orders – Drugs	Must be reviewed at any time the resident's condition is assessed or reassessed in developing or revising the resident's plan of care; no medical directive or order for the administration of a drug to a resident can be used unless it is individualized to the resident's condition & needs.	We need to review current policies and procedures.
118 – Information	Removed the requirement to have antidote information in every Resident Home Area	We need to check to see what is posted in each RHA meets the requirements
119 – Pharmacy Service Provider	If the provider cannot provide drugs on a 24-hour/7day/week basis they must arrange for the provision by another pharmacy	Compliant
138 – Absences	Except in an emergency a physician or NP has to authorize the medical or psychiatric absence, in writing. If a medical or psychiatric absence notice must be given within 24 hours before the resident leaves the home to the resident's substitute decision-maker, if any, and to any other person as the resident or SDM designates. If circumstances don't permit the 24-hours notice then as soon as possible. **NEW** – if the resident leaves the home for a casual/vacation absence the care required must be provided in writing by the physician or NP to the resident; staff must communicate the need to take all reasonable steps to ensure that the care required to be given is received; that the home will not be responsible for the care, safety and well-being of the resident during the absence and that the resident/SDM assumes full responsibility; the need to notify the	Our policies and procedures have been updated as well as the resident welcome booklet. This was shared with staff during orientation to the *Act* and is also part of the new staff orientation.

	Administrator if the resident is admitted to hospital during the absence or if the resident's date of return changes	
215 – Criminal Reference Check – July 1/11	**New** - Staff/Volunteers – for all over 18 must be conducted by a police force & be conducted within six months before hired/accepted and must include a vulnerable sector screen. Must make a declaration as set out in 215(4) if conducted within last six months. Not required for Medical Directors or NP's	Our processes have been amended to reflect the changes. HR is currently rewriting the policy.
216 – Training & Orientation	Must ensure volunteers & staff receive training & orientation as set out in section 76 & 77 of the Act (see attached). Program must be evaluated & updated annually.	Staff received a full orientation to the *Act*. The management team met in May to start to develop the training program for staff to ensure compliance. The volunteer orientation program has been revised to meet the *Act*.
218 – Orientation	Includes written procedures for handling complaints & the role of staff in dealing with complaints; safe & correct use of equipment including therapeutic equipment, mechanical lifts, assistive aids and positioning aids that is relevant to the staff member's responsibilities; cleaning & sanitizing of equipment relevant to staff member's responsibilities.	New staff orientation package updated. New staff now meet with manager prior to end of orientation period.
219 – Retraining	Annual retraining required but retraining on mission & Acts, Regs & policies of Ministry not required unless there has been a change in the person's responsibilities. Annual training assessments shall be conducted annually. Training & retraining in IP&C must include hand hygiene; modes of infection transmission; cleaning & disinfection practices & use of PPE.	Management team met in May to start to develop the training program for staff to ensure compliance. Work is ongoing.
221 – Additional training – Direct Care staff	There is additional training required – must be annual and there are specifics for responsive behaviours & restraints	As noted above.
223 – Orientation for Volunteers	Orientation requirements are set out in section 77 of the Act and this Regulation provides the additional information required to be provided at the time of orientation.	Compliant
224 – Information	Lists the information required to be provided to residents, family members & persons of importance in addition to that under section 78 of the Act	The resident welcome booklet was updated. During mock inspection noted that the phone number for the "licensee" (head of Council) was not in the booklet. We have updated this with the County's main phone number.
225 – Posting of Information	Information to be posted in the home in addition to that set out in section 79 of the Act.	Information is posted as set out.
227 – Regulated Documents	Defines regulated documents referred to in section 80 of the Act – need to review.	Our admission agreement was reviewed and revised by legal. During the mock inspection it was noted that when unfunded

		charges change there must be firm documentation of notice of change and confirmation of charge from the resident. As well in several areas e.g. dine outs a specific price is not listed so must change to reflect a range of possible costs.
228 – Continuous Quality Improvement	Sets out requirements for QI program	QI Program now in place and first meeting of the Quality Assessment & Assurance Committee has been held.
229 – IP&C Program	Sets out requirements for program	Our current policies and procedures were reviewed and the need to ensure that resident immunization includes diphtheria and tetanus has been added.
230 – Emergency Plans	Set out in section 87(1) of the Act – sets out how plans shall be developed and tested.	We have reviewed our current plan to identify gaps and establish a training plan. Identified gaps included a chemical spills plan (not completed) and a violent outburst plan (we have one for violent residents but not for violent intruders). A tabletop violent outburst scenario to assist us in developing our plan is being scheduled for October.
233 – Retention of Resident Records	Must be kept for 10 years after discharge	Current retention by-law being reviewed by Deputy Clerk.
234 – Staff Records	Sets out the minimum requirements for the record	Current retention by-law being reviewed by Deputy Clerk.
236 – Retention of Staff Records	Must be kept for at least 7 years after employment ceases	Current retention by-law being reviewed by Deputy Clerk.
241 – Trust Accounts	Must be non-interest bearing (by January 1/11); cannot hold more than $5k for a resident, comingle funds or charge a service fee (Jan 1/11); must have written P&P for the management of the trust accounts & petty cash trust money (specific requirements included) and provide a copy to each resident & person acting for the resident who has money in the trust account – need to forward to Treasury	Compliant.
245 – Non-allowable resident charges	Defines non-allowable charges	This is included in the resident admission agreements
Section – Charges for Accommodation; Statements; Accounts & Records; Non-arm's length transactions		Have forwarded to Treasury