

Long-Term Care Homes Program Manual

Ministry of Health and Long-Term Care

Created: December 20, 1993
Consolidated: April 2006
Last Revised: November 2007



LONG-TERM CARE HOMES PROGRAM MANUAL

AMENDMENT RECORD SHEET

DATE OF AMENDMENT	SECTION	SUBJECT
November 2007	0809-02	High Intensity Needs Fund Manual <i>Replaces previous version dated July 2007</i>
July 2007	0809-02	High Intensity Needs Fund Manual <i>Replaces previous version dated February 2001</i>
January 2007	1014-01	Dietary Services: Standards and Criteria
January 2007	9901-01	Glossary
April 2006	0903-01	B. Resident Care and Services: Standards and Criteria <i>Replaces previous versions of:</i> <ul style="list-style-type: none"> • 0903-01, Standards and Criteria B1, B2, B3, B4 and B5 • 1008-01, Standard and Criteria J1, Dental Services • 1009-01, Standard and Criteria K1, Foot Care Services • 0903-02, Standard S and Criteria, dated September 2005

USER'S GUIDE**HOW TO USE YOUR MANUAL****SUMMARY**

This manual is designed to be easy to use, easy to reference and easy to update. It is divided into:

TABS Major divisions physically separated by numbered dividers;

SECTIONS Divisions of Tabs;

SUBJECTS Divisions of Sections

FINDING INFORMATION

To find information in this manual:

1. Turn to the Subject Index (0301-01),
2. Look up the desired subject,
3. Turn to the indicated location number,
4. If unable to find a subject, turn to the Table of Contents (0201-01)

Note: As a further retrieval aid, this manual includes a Forms Index (0301-02), which is located behind the Subject Index.

USER'S GUIDE**HOW TO USE YOUR MANUAL****NUMBERING SYSTEM**

This manual uses a numbering system which combines TAB, SECTION and SUBJECT numbers.

For example, **0402-03**

04	-	is the Tab number
02	-	is the Section number
03	-	is the Subject number

TABS

Tabs are the major divisions of the manual. They are physically separated by dividers, showing the number of that particular tab. The tab number appears at the top of each page as part of the procedure number.

SECTIONS

Each tab is divided into sections. The section number appears at the top of each page as the middle two digits of the procedure number.

SUBJECTS

Each section is divided into subjects. The subject number appears at the top of each page as the last two digits of the procedure number.

**UPDATING AND
AMENDING**

This system does away with the need to keep covering letters. When you receive amendments with a Manuals Amendment Notice, turn to the Amendment Record Sheet (0000-02).

CHANGES TO CONTENT

If you notice any information in this manual which you know to be inaccurate, please notify your Residential Services Branch Regional Office or Long-Term Care Area Office.

**DISTRIBUTION
OF MANUALS**

Manuals are identified by a Manual Locator Number on the inside cover of the binder at the bottom of the spine. Manuals are shared. They should not be removed from the location in the event of employee changes.

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INTRODUCTION

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INTRODUCTION

Redirection of Long Term Care:

In October 1991, the Government of Ontario, through the Minister of Community and Social Services, the Minister of Health and the Minister of Citizenship, announced a major redirection of the long-term care and support service system currently serving elderly people and adults with physical disabilities.

LONG-TERM CARE SERVICES

Long-term care refers to a very broad range of personal care, support and health services provided to people who have limitations that prevent them from participating in every day activities. The people who use long-term care services are usually the elderly, people with disabilities, and people who have a chronic or prolonged illness.

Long-term care and support services cover a wide array of services in a variety of settings. The services include health, personal care, homemaking and respite services provided in people's homes, community support services such as meals-on-wheels, transportation, security checks, friendly visiting, caregiver support, adult day programs, supportive housing programs and long-term care facilities.

There are also specialized services which are related to long-term care provided by physicians and health professionals or by services associated with health facilities such as: Regional Geriatric Programs, psychiatric and mental health services, day hospitals and chiropody services.

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PRINCIPLES OF LONG-TERM CARE

The principles and goals of the new Long Term Care System were developed in recognition of the concerns and values expressed in the consultation process.

- Respecting and supporting people's desire to be healthy and independent.
- Integrating long-term care health and social services.
- Ensuring greater consumer participation and control of services.
- Promoting racial equity and cultural sensitivity.
- Giving preference to a system that delivers service on a not-for-profit basis.

GOALS OF LONG-TERM CARE

The following goals have been identified as the focus of the new long-term care system:

- Locally planned service delivery based on population health and needs.
- Improved coordination of long-term care and support services.
- Creation of community alternatives to institutions.
- Funding equity across the province.
- High-quality service.
- More effective management of human, financial and other resources.
- Improved accountability in the system.

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- Protection of the rights and security of service workers.
- Increased support for training and placement of displaced hospital workers.

Long-term care facilities are, and will remain, an important part of the service system needed by elderly people. Their primary purpose will continue to be the provision of care and services to elderly persons who require services that are provided in a facility setting and whose needs cannot be met through in-home services.

PURPOSE OF THE MANUAL

This manual presents Government's expectations for facility services.

New care, program, and service standards and criteria have been developed to guide facilities in providing quality care, service and programs to persons residing in long-term care facilities. These standards and criteria recognize and support the choices and rights of each individual resident.

The experiences of service providers and Government staff in using this manual will assist in the refinement and clarification of standards, criteria, and expectations on an ongoing basis to ensure that they are workable, practical and effective in achieving the desired results.

It is anticipated that some of these expectations will result in legislative changes designed to support and govern an improved facility service system.

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RELEVANT LEGISLATION

Nursing Homes and Charitable and Municipal Homes for the Aged are governed by either the Nursing Home Act, the Charitable Institutions Act, or the Homes for the Aged and Rest Homes Act, as amended by Bill 101, The Long Term Care Statutes Law Amendment Act, 1993.

This Legislation has been amended in order to implement, among other changes, a new funding formula in nursing homes and charitable and municipal homes for the aged, a new resident accommodation payment policy, a province-wide system for coordinating and managing access to facility services and a consistent framework for nursing homes and homes for the aged.

These amendments require changes to existing regulations and the development of new regulations to implement these initial reform strategies.

Future legislative change is expected to result in a repeal of several existing statutes and regulations and the creation of a comprehensive new framework encompassing both facility and community long-term care services.

Users of this manual are obligated to comply with provisions in the current Acts as amended by Bill 101, and applicable Regulations.

OTHER LEGISLATIVE REQUIREMENTS NOT INCLUDED

This manual does not include requirements which facilities must meet as established through other legislation. Some examples include legislation concerning fire safety, occupational health and safety, health protection and promotion, and workplace hazardous materials.

Reference should be made to provincial legislation applicable to long-term care facilities in addition to the Long-Term Care Statutes Law Amendment Act, 1993.

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FRENCH LANGUAGE SERVICES ACT

The French Language Services Act (FLSA) was adopted by the Ontario Legislative Assembly on November 18, 1986 and was proclaimed on November 19, 1989. It guarantees all persons and corporate bodies the right to communicate and to receive services in French from the following:

- head or central offices of Ontario Government agencies or ministries;
- offices of Ontario Government agencies or ministries serving one of twenty-two areas designated under the FLSA;
- public services agencies which have requested and received designation under the FLSA.

The FLSA represents a commitment from the Government of Ontario to deliver its programs and services in the French language, in recognition of its status as "an historic language in Ontario and an official language in Canada". Also recognized is the contribution of French-speaking Ontarians to the heritage and development of this province.

The FLSA provides ministries with a framework to develop and enhance services in the French language, in partnership with transfer payment agencies and municipalities located in or serving the twenty-two designated areas.

In the case of services funded by the Ministry of Health, this is achieved through a regional planning process led by District Health Councils. Identified agencies or programs are asked to implement policies and procedures that support the provision of linguistically and culturally sensitive services to French-speaking Ontarians.

INTRODUCTION

INTRODUCTION TO THE MANUAL

Consequently, all policies, procedures, standards and safeguards contained in this manual should be implemented in a manner that reflects the requirements and expectations of the Ministry of Health for the delivery of French language services.

Facilities should contact their program supervisor or compliance advisor for further clarification and for information about assistance that may be made available to facilities.

INTRODUCTION

INTRODUCTION TO THE LONG-TERM CARE DIVISION

INTRODUCTION

This section of the manual describes the Long-Term Care Division's organizational structure with particular reference to residential services.

CORPORATE OFFICE

The Corporate Office of the Long-Term Care Division consists of the:

- Office of the Executive Director
- Residential Services Branch
- In-Home Services Branch
- Long-Term Care Policy Branch
- Management Support Unit.

In addition, there are 14 Long-Term Care Area Offices across the province.

INTRODUCTION

INTRODUCTION TO THE LONG-TERM CARE DIVISION

RESIDENTIAL SERVICES BRANCH

**RESIDENTIAL SERVICES
BRANCH**

The Residential Services Branch was created in May 1990 to consolidate the Ministry of Health's Nursing Home Program and the Ministry of Community and Social Services' Homes for the Aged (Charitable and Municipal) Programs.

The Branch operates centrally with corporate offices in Toronto and three regional offices in London, Ottawa, and Toronto. The Branch is made up of five units: Administration, Compliance, Enforcement, Operations Support, and Information.

ADMINISTRATIVE UNIT

The Administrative Unit oversees personnel and financial details, and provides clerical and secretarial support.

**COMPLIANCE
MANAGEMENT UNIT**

This unit ensures that long-term care facilities provide care and services according to established Ministry requirements (see section on Accountability Framework).

Compliance Advisors in the three regional offices monitor and evaluate the programs and services provided by long-term care facilities. They also clarify Ministry expectations to long-term care facilities, using a consultative and collaborative approach.

Compliance Advisors also investigate complaints, review building plans for new nursing homes, conduct public meetings, conduct pre-sale reviews of nursing homes, evaluate bed proposals and may attend inquests and Review Boards as expert witnesses.

INTRODUCTION**INTRODUCTION TO THE LONG-TERM CARE DIVISION****RESIDENTIAL SERVICES BRANCH****OPERATIONS SUPPORT
UNIT**

The Operations Support Unit provides professional and technical expertise in facility care, service and program issues. Staff in the unit contribute to the development of new policy, programs and services through the provision of professional/technical support and by facilitating the flow of information to and from Ministry staff and facility service- providers.

The Operations Support Unit provides professional/technical expertise in the areas of dietary, environmental health, finance, medicine, nursing and planning. Long-Term Care Division staff contact the Operations Support Unit staff directly to seek advice, to ask for information, or to engage in a problem-solving process.

In addition to these functions, staff of the unit are responsible for undertaking the annual Levels of Care Classification which is used to determine the level of facility funding for residents' nursing and personal care requirements in nursing homes and homes for the aged.

ENFORCEMENT UNIT

The Enforcement Unit investigates very serious complaints and incidents, implements sanctions in cases of continuing and serious non-compliance, and conducts pre-licence reviews and other inspections. Enforcement Officers are skilled in investigative techniques, with specific expertise in nursing, dietary, and environmental health disciplines.

INFORMATION UNIT

This unit is responsible for producing and maintaining information on the nursing homes and homes for the aged program (e.g. number and location of facilities and beds, licensees/Board of directors, key personnel). The unit also processes all licence applications for nursing homes.

INTRODUCTION

INTRODUCTION TO THE LONG-TERM CARE DIVISION

LONG-TERM CARE AREA OFFICES

LONG-TERM CARE AREA OFFICES

The Long-Term Care Area Managers are responsible for program administration and operation at the community level including facilities to support seniors and adults with physical disabilities.

The Area Office functions include but are not limited to:

- Providing consumer and community support (e.g. providing information on provincial policy);
- Supporting community planning and local decision-making (e.g. providing information on population data, operations, provincially funded programs and their delivery);
- Implementing the initiatives of the reform (e.g. local plans and models developed) including facility funding;
- Administering the District funding envelope and providing financial support (e.g. ensuring consistent application of funding policies and practices); and
- Providing program administration and support (e.g. supervising, monitoring and evaluating program delivery and performing program and administrative reviews).

The Program Supervisors are considered the primary Area Office contact for transfer payment agencies within the service system.

INTRODUCTION

INTRODUCTION TO THE LONG-TERM CARE DIVISION

LONG-TERM CARE AREA OFFICES

LONG-TERM CARE AREA OFFICES (cont.)

The primary functions of Program Supervisors include:

- Supervising, monitoring and evaluating the delivery of all programs;
- Negotiating budgets with transfer payment agencies;
- Clarifying provincial legislation, policy, and service standards;
- Technical and management consultation;
- Identifying the need for service delivery changes.

The Manager of Finance and Administration provides advice, financial planning, analysis and controllership to support transfer payment agencies and the Area Office.

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TAB 05 ADMISSIONS

SECTION	SUBJECT	DATE OF AMENDMENT
0501	INTRODUCTION	
	01 Introduction	20 December 1993
0502	ROLE OF PLACEMENT COORDINATION SERVICE	
	01 Introduction, Objectives and Functions	20 December 1993
	Amendments	
	Alternating Admissions to Ward Accommodation	20 January 1994

ADMISSIONS

INTRODUCTION

INTRODUCTION

The following subjects are contained in the Placement Coordination Service Manual.

- Eligibility Criteria for admission to a long-term care facility
- The Eligibility Determination process
- Waiting List Management
- Admission Process
- Facility/PCS Collaboration.

All LTC facilities will receive a copy of the Placement Coordination Service Manual.

ADMISSIONS

ROLE OF PLACEMENT COORDINATION SERVICE

INTRODUCTION

This section of the manual will outline the role, objectives, and functions of the Placement Coordination Service.

ROLE OF PLACEMENT COORDINATION SERVICE

The Long Term Care Statute Law Amendment Act, 1993 (Bill 101) makes amendments to the Nursing Homes Act, the Charitable Institutions Act, and the Homes for the Aged and Rest Home Act to enable the Minister to designate one or more persons, classes of persons or other entities as placement coordinators.

The intent is that Placement Coordination Services program staff, where such programs exist, will be designated as placement coordinators.

Additional PCS programs are being introduced so that the services are Province wide.

These new programs also will be designated as placement coordinators under the Charitable Institutions Act, (or Nursing Homes Act, or Homes for the Aged and Rest Home Act).

The Minister may change the designation when so desired. In the future designations could be changed to include Band Councils or Multi-Service Agencies.

Within the context of Provincial legislation, regulations and policies, PCS undertake the following key responsibilities:

- determine eligibility for admission to LTC facilities;
- authorize admission to LTC facilities;
- Classify in order of priority persons for admission to LTC facilities;
- manage the waiting list for admission to LTC facilities

ADMISSIONS

ROLE OF PLACEMENT COORDINATION SERVICE

The designated placement coordinators may authorize the admission of a person to a Long-Term Care Facility only if:

- *the placement coordinator has determined, within the six months preceding authorization, that the person is eligible for admission to a long-term care facility;*
- *the long-term care facility to which the person's admission is to be authorized approves the person's admission to the facility; and,*
- *the person consents to being admitted to the facility.*

Provincial policies outlined in this manual have been developed to ensure a consistent approach for eligibility determination, the admission process, the establishment of priorities, and waiting list management approaches.

The policies in this manual represent the Ministry's requirements of placement coordinators,

- in the interim, while admission to LTC facilities for persons requiring Long-Term Care services is handled by PCS programs;
- in the future, when admission to LTC facilities for persons requiring long-term care services will be handled by the multi-service agency.

OBJECTIVES

The objectives of the PCS are as follows:

- to ensure that persons most in need of long-term care facility beds are served;
- to ensure that the best possible admission is made, that will meet the person's care requirements and personal wishes under the existing circumstances;

ADMISSIONS

ROLE OF PLACEMENT COORDINATION SERVICE

- to ensure that the person's preferences relating to admission based on ethnic, spiritual, linguistic, familial and cultural factors are taken into consideration;
- to ensure that community based services are examined on behalf of persons and their caregivers, as part of the eligibility determination process;
- to assist persons and their families in understanding the service options that are available in their communities, and which services are most appropriate for meeting their needs;
- to facilitate the admission process for persons and their families by providing one point of contact for facility admission;
- to provide a consistent process for determining eligibility;
- to provide a consistent admission process;
- to participate in community planning, consensus building and priority setting in the delivery of long-term care services.

Note: The above objectives have not been listed in ranked order of priority.

FUNCTIONS

The functions of the PCS are as follows:

1. Determine eligibility for admission to a long-term care facility. This includes the following:
 - determining whether the person meets provincial eligibility criteria for admission to long-term care facilities;

ADMISSIONS

ROLE OF PLACEMENT COORDINATION SERVICE

- compiling medical information, functional assessments, reports and other relevant assessments and social information from the person, their family, health professionals and service providers;
 - ensuring that the person or his/her lawfully authorized substitute have a clear understanding of the eligibility criteria, admission process and the person's rights;
 - working collaboratively with Home Care, community support services, hospitals, long-term care facilities and other providers to minimize unnecessary assessments and utilize existing expertise;
 - participating in appeal processes.
2. Assist persons in finding community based alternatives where these exist and are appropriate in meeting the person's needs.

This includes the following:

- being aware of all community based services in their respective communities and what they provide as well as program admission criteria and scope of services;
- referral to and/or assisting clients in obtaining community based services;
- working closely with community based services, LTC facilities, hospital based providers and voluntary associations to develop joint service approaches that will enable people to remain in the community;

ADMISSIONS

ROLE OF PLACEMENT COORDINATION SERVICE

- assisting people who have expressed a wish to leave long-term care facilities, with finding community based services as an alternative, where appropriate;
 - assisting people with finding alternative services when they would be inappropriately served in LTC facilities, through collaboration with other service systems, e.g. the mental health system, the system for people with developmental handicaps;
 - providing feedback to community service agencies about consumer complaints brought to the attention of the PCS, regarding the provision of community services (with the person's consent).
3. Assist the person and his/her lawfully authorized substitute during the admission process, to ensure the best possible admission in keeping with the person's preferences under is made the existing circumstances.

This includes the following:

- being knowledgeable about the programs and services provided by LTC facilities in their respective areas so that this information may be conveyed to persons or their lawfully authorized substitutes;
- discussing with a person/lawfully authorized substitute his/her facility preferences, taking into consideration ethnic, spiritual, linguistic, familial and cultural factors and other preferences;
- providing follow up after a person has been admitted to a LTC facility to ensure the person's satisfaction;
- working with other institutional providers to

ADMISSIONS

ROLE OF PLACEMENT COORDINATION SERVICE

develop service alternatives for hard to serve persons who may be inappropriately served in a LTC facility, or if already served in a LTC facility, may require support and assistance from other providers to meet their needs, (e.g. hospitals, provincial psychiatric hospitals, facilities for persons with developmental handicaps);

- assisting a person and their family with an admission when the person is from another area;
- undertaking the admission process for other long-term care facilities, in keeping with previous agreements (e.g. chronic care hospitals);

4. Determine priorities for admission and manage the waiting list for LTC short-term (e.g. respite, supportive stay) and long-term facility admissions.

This includes the following:

- assessing risk factors to ensure that persons in emergency situations are admitted first;
- ensuring consistent and equal treatment of all people waiting for admission to LTC facilities;
- updating the waiting list.

5. Act as the admission agent to LTC facilities and work collaboratively with them during the admission process.

This includes the following:

- being knowledgeable about the LTC facilities in their areas, regarding physical plant considerations, services provided, unique facility features and ethnic, spiritual, linguistic, familial and cultural factors;

ADMISSIONS

ROLE OF PLACEMENT COORDINATION SERVICE

- providing LTC facilities with adequate opportunity to review the needs of people expressing an interest in residing in their facility;
 - providing feedback to facilities about consumer complaints brought to the attention of the PCS regarding the provision of facility services (with the person's permission);
 - working jointly with LTC facilities to find service options for people who may be difficult to serve.
6. Act as a key community resource to health professionals, district health councils, community planning bodies and Government, and a source of information to the general public on services related to long-term care.

This includes the following:

- providing program and statistical information for planning purposes;
- providing advice to planning bodies (e.g. district health councils) that can be used to determine what new services are required in any given community;

This includes:

- community based service shortages and gaps, which, if services were developed, could assist persons to remain in their homes;
- facility service availability and the types of facility services required to meet people's needs (e.g. people who may be difficult to serve, need for facility services to meet the needs of ethnic or religious groups);

ADMISSIONS

ROLE OF PLACEMENT COORDINATION SERVICE

- participating in training, public relations and educational undertakings to explain the role and functions of the PCS;
- providing information to people or referring them to other information resources that may exist in their community.

The above responsibilities of the PCS, as listed, are the key services to be undertaken, and for which funding is provided by the Ministry.



Ministry
of
Health

Ontario

Ministry of
Community and
Social Services

Long-term Care
Division

Ministère
de
la Santé

Ministère des
Services sociaux
et communautaires

Division des soins de
longue durée

80 Grosvenor Street
Toronto, Ontario M7A 1E9
Telephone: 327-7352
Fax: 326-1218

January 20, 1994

Dear Administrator:

As you know, on July 1, 1993 a new charging policy for long-term care facility beds was implemented. This charging policy resulted in an increase in the number of residents in long-term care facility preferred accommodation beds requesting a transfer to ward accommodation.

At the same time, the number of people on facility waiting lists or Placement Coordination Service (PCS) waiting lists requesting ward accommodation has increased.

Long-term care facilities are trying to meet the requests of their residents within the facility to move to a ward rate bed. This means that in some areas of the province, it is very difficult for people in the community to access ward rate beds in long-term care facilities.

In order to address this issue, it is necessary to implement a policy on an interim basis to provide fair access to ward accommodation for both residents currently in long-term care facilities and for people waiting for admission.

This policy comes into effect immediately and will be in effect until further notice.

POLICY: ALTERNATING ADMISSIONS TO WARD ACCOMMODATION

When ward accommodation beds become available they must be filled on an alternating basis with persons who are transferring from a preferred accommodation bed within the facility and persons on facility or PCS waiting lists.

For facilities that currently work with a PCS, when a bed is filled from within the facility, the admission to the resulting vacant preferred accommodation bed will be done by the PCS. The next vacant ward bed would also be filled by the PCS from the PCS waiting list.

For facilities in areas where the PCS is not yet operational, or which do not currently work with their PCS, the facility will be responsible for filling its own preferred accommodation bed.

All long-term care facilities must apply this policy and document their actions to ensure compliance with this policy.

If you have any questions regarding this policy, please contact Paul Tuttle at (416) 326-8213 or Esther Levy at (416) 326-9753.

Sincerely,

Sandy Knipfel
Sandy Knipfel
Acting Director
Residential Services Branch

- cc LTC Area Office Managers
- RSB Regional Office Managers
- PCS Directors
- Ontario Nursing Home Association
- Ontario Association of Non-Profit Homes and Services for Seniors
- Association of Placement Coordination Services of Ontario

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	01 Financial Accountability	30 November 1995
0603	FACILITY SERVICE AGREEMENT PROCESS	
	01 Submission of Service Agreement	30 November 1995
	02 Subsidy Calculation Worksheet	30 November 1995
	03 Per Diem Components	30 November 1995
	Amendments	
	Incontinence Supplies & Medical Director Fees	31 July 2002
	Physician On-Call Program	21 November 2005, 2 February 2006 & 22 February 2006
	04 Resident Days	30 November 1995
	05 Occupancy Targets	30 November 1995
	06 Expenditure Forecasts	30 November 1995
	07 Revenue Forecasts	30 November 1995
	08 Red Circle Provision	20 December 1993
	09 Cash Flow Calculation	30 November 1995
	10 Direct Deposit	30 November 1995
	11 Staffing Schedule/Accommodation Staffing Report	30 November 1995
0604	FACILITY SERVICE AGREEMENT COMPONENTS	
	01 Service Agreement Components	30 November 1995
0605	MONITORING AND REPORTING	
	01 Quarterly Reports	30 November 1995
	02 Facility Annual Report	30 November 1995
	03 Subsidy Reconciliation Recoveries	30 November 1995
	Amendments	
	Recovery Standards (<i>see 0603-03 for 22 February 2006 amendment</i>)	22 February 2006
	04 Ad Hoc Reports	30 November 1995
0606	FINANCIAL POLICIES	
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NEW>	02 Asset Management	30 November 1995
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	List of Furnishings and Equipment	29 December 1995
	03 Purchase of Supplies and Equipment	August 1997
	Amendments	
	Security Cameras	25 April 2005
	04 Disposition of Furnishings and Equipment	30 November 1995
	06 Subsidy for Basic Accommodation Rate Reductions	28 November 1996
	07 Accrual of Retroactive Salary Awards	30 November 1995
	08 In-Year Occupancy Based Recovery	6 July 2005
Amendments		
	In-Year Occupancy Based Recovery & Adjusted Advance Cash Flow for Low Occupancy Homes (<i>see 0603-03 for 22 February 2006 amendment</i>)	23 November 2005 & 22 February 2006
NEW>	09 Occupancy Based Funding	31 March 2005, 24 May 2005, 13 December 2005 & 21 February 2006
0607	RESIDENT CHARGES	
	01 Introduction	30 November 1995
	02 Allowable Charges	30 November 1995
	03 Income Testing	30 November 1995
	04 Application for Rate Reduction	30 November 1995
	05 Persons Unable to Pay the Basic Accommodation Fee	30 November 1995
	06 Alternative Documentation - Rate Reduction	30 November 1995
	07 Residents Unable to Pay the Reduced Accommodation Rate	30 November 1995
	08 Bed Holding	30 November 1995
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	Leave of Absence & Bed Holding Prior to Admission	10 February 1995 & 20 April 1995
	Funding Policy for Suspensions of Admissions Due to Outbreaks in LTC Homes	7 November 2005
	09 Resident Payment Policy for Short-Stay Programs	30 November 1995
	10 Previous Debt	30 November 1995
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	11 Preferred Accommodation Charges	30 November 1995
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	Preferred Accommodation Charges	5 June 2000
0608	FACILITY SERVICES	
	01 Basic Services	30 November 1995
	02 Optional Services	30 November 1995
0609	RESIDENT' TRUST ACCOUNTS	
	01 Legislation	July 1998
0610	CAPITAL ASSISTANCE	
	01 Eligibility	30 November 1995
	02 Capital Process and Procedures	30 November 1995
0611	SUPPLEMENTARY FUNDING	
	01 Introduction	30 November 1995
	02 Municipal and Capital Tax Allowance	30 November 1995
	03 Compliant Facility Debt Services/ Rent Allowance	30 November 1995
	04 Structural Compliance Premium	30 November 1995
	05 Supplemental Nursing and Personal Care	30 November 1995
NEW>	06 Construction Cost Funding	April 1999

FINANCIAL MANAGEMENT AND ADMINISTRATION**INTRODUCTION****GOVERNING
LEGISLATION**

The Charitable Institutions Act, the Homes for the Aged and Rest Homes Act and the Nursing Homes Act, as amended by the Long Term Care Statute Law Amendment Act, 1993 (the "Act") establish the operating financial management rules for the Long-Term Care Facility Program.

The Long Term Care Statute Law Amendment Act 1993 also amends the Nursing Homes Act to enable the payment of capital grants to not-for-profit nursing homes. Capital grants for homes for the aged will continue to be governed by the provisions of the Charitable Institutions Act and the Homes for the Aged and Rest Homes Act.

Financial management provisions governing the operation of LTC facilities are summarized in this section of the manual.

FINANCIAL MANAGEMENT AND ADMINISTRATION**FINANCIAL ACCOUNTABILITY****DEFINITION**

Accountability has been defined as *the obligation to answer for a responsibility that has been conferred. It presumes the existence of at least two parties: one who allocates responsibility and one who accepts it with the undertaking to report upon the manner in which it has been discharged. (Office of the Auditor General of Canada: Report of the Independent Review Committee, Ottawa 1975)*

Policies that delineate the financial accountability relationship between Long-Term Care Facilities and the Province are contained in this section of the Manual.

**LONG-TERM CARE
FACILITY SERVICE
AGREEMENT**

The Long-Term Care Facility Service Agreement identifies the legislation that establishes the legislative authority for the program, and sets out the expectations, rights and responsibilities of the parties to the agreement.

A Long-Term Care Facility Service Agreement will be negotiated with each facility annually.

The agreement contains a description of the programs and services that are to be provided by the facility during the term of the agreement. In signing the agreement the Long-Term Care Facility (LTC Facility) is entering into an agreement to provide care, programs and services in accordance with the applicable acts, regulations, and standards and criteria contained in the Long-Term Care Facility Program Manual and other policies and directives governing the program. It also includes provisions relating to funding, records, reporting and corrective actions that may be taken.

FINANCIAL MANAGEMENT AND ADMINISTRATION

FINANCIAL ACCOUNTABILITY

QUARTERLY REPORTING

LTC facilities are required to submit quarterly reconciliation reports to enable a review of their activity and financial performance during the year.

These reports are used to compare actual expenditures with the approved budget. Variances may be identified and discussed with the facility.

YEAR-END REPORTING

Each LTC facility is required to submit an audited annual reconciliation report to their designated LTC Area Office.

This report is used to determine if a final cash adjustment is necessary, as well as to enable a full comparison of the budgeted resident days and forecasted expenditures with the actual results for the year.

AD HOC REPORTING

The Long-Term Care Division may request ad hoc reports. These reports may be requested when Long-Term Care Division staff need specific written information and statistics on the services provided by a facility.

POSTING OF DOCUMENTS IN THE FACILITY

The following financial documents must be posted in a prominent place in the facility that is easily accessible to residents and the general public:

- A copy of the approved Service Agreement along with the Subsidy Calculation Worksheet, Program Schedule and Staffing Schedule for the current year.

If the Service Agreement has not been approved for the current year, the most recently approved service agreement, subsidy calculation worksheet, program schedule and staffing schedule must be posted.

FINANCIAL MANAGEMENT AND ADMINISTRATION

FINANCIAL ACCOUNTABILITY

**POSTING OF
DOCUMENTS IN THE
FACILITY (CONT'D)**

Under the provisions of the *Freedom of Information and Protection of Privacy Act* and the *Municipal Freedom of Information and Protection of Privacy Act*, the salary schedules must be amended to provide confidentiality for individuals' salaries.

- A copy of the Annual Report for the most recent fiscal year.

**TRUST ACCOUNT
MANAGEMENT**

The *Charitable Institutions Act*, the *Homes for the Aged and Rest Homes Act* and the *Nursing Homes Act* have specific provisions regarding the management of residents' funds.

These are designed to ensure that facility administrators are accountable for the management of resident funds that are held in trust by facilities.

INSPECTION

The *Charitable Institutions Act*, the *Homes for the Aged and Rest Homes Act* and the *Nursing Homes Act* all make provision for Long-Term Care Division staff to inspect a facility.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
SUBMISSION OF SERVICE AGREEMENT

**SUBMISSION OF
SERVICE AGREEMENT**

The Long-Term Care Area Office will initiate the Service Agreement process by forwarding a Service Agreement package to the LTC facility.

The components of the package are as follows:

- 1) Service Agreement
- 2) Subsidy Calculation Worksheet
- 3) Instructions for the completion of the Subsidy Calculation Worksheet
- 4) Program Description
- 5) Staffing Schedule
- 6) Accommodation Staffing Report.

A covering letter, signed by the Area Manager, accompanies the package. The letter specifies the target date for completion and return of the Service Agreement package.

The LTC facility completes the forecast of expenditures and revenues for the upcoming operating period on the Subsidy Calculation Worksheet. Once the LTC facility has completed the Subsidy Calculation Worksheet it is forwarded to the applicable LTC Area Office for review.

REVIEW

The Program Supervisor, the Manager, Finance and Administration, and the Compliance Advisor responsible for the LTC facility, review the submission for consistency with provincial standards. During the review of the Subsidy Calculation Worksheet, issues may arise that require resolution between staff of the Long-Term Care Division and the LTC facility, for example:

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
SUBMISSION OF SERVICE AGREEMENT

REVIEW (CONT'D)

- proposed changes in the LTC facility's operating capacity
- participation in the Short-Stay Program
- allocation of red-circle funding between budget components
- LTC facility plans to increase or decrease staffing levels.

APPROVAL PROCESS

When outstanding issues have been successfully resolved between both parties, the Program Supervisor prepares and forwards two copies of the Subsidy Calculation Worksheet and supporting schedules and two copies of the Service Agreement to the LTC facility for the appropriate authorizing signature.

Once the LTC facility has signed the Service Agreement it is returned to the LTC Area Office for the Area Manager's signature. One original copy of the budget package is sent to the LTC facility and one original copy is retained by the LTC Area Office. A copy of the Service Agreement package is forwarded to the facility's Compliance Advisor.

Once the Service Agreement is signed, the Province shall then provide operating subsidies to the LTC facility based on the terms and conditions of the agreement.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
SUBMISSION OF SERVICE AGREEMENT

COST COMPONENTS

Operating subsidies are calculated annually for each LTC facility based on four major cost components as follows:

- 1) Nursing and Personal Care
 - direct care
 - administration
- 2) Program and Support Services
- 3) Raw Food
- 4) Other Accommodation
 - housekeeping
 - building and property
 - dietary services
 - laundry and linen services
 - general and administrative
 - facility costs.

Each cost component is reflected in the Subsidy Calculation Worksheet on a per diem basis.

Under the long-term care facility program, a significant portion of a LTC facility's operating subsidy funding is based on the levels-of-care requirements of its residents. This recognizes differences in the average level of care requirements of the residents in a LTC facility when compared with other facilities.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
SUBMISSION OF SERVICE AGREEMENT

COST COMPONENTS
(CONT'D)

The calculation of a LTC facility's nursing and personal care per diem is calculated by multiplying the base nursing and personal care per diem by the LTC facility's case mix index.

A maximum program and support services per diem is established for all facilities that are not red-circled. LTC facilities are encouraged to develop programs to take advantage of this funding.

This component of the operating subsidy may be renegotiated during the year if a LTC facility decides to offer additional program and support services up to the limit set for non red-circled facilities.

The accommodation per diem includes a separate per diem for raw food. The Long-Term Care Division establishes a minimum per diem expenditure on raw food for all LTC facilities.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
SUBSIDY CALCULATION WORKSHEET

INTRODUCTION

Each LTC facility completes a Subsidy Calculation Worksheet. The Subsidy Calculation Worksheet includes the LTC facility's forecast of resident days (long-stay and short-stay days), expenditure levels and anticipated revenues.

Information supplied by the LTC facility will be reviewed and incorporated, as required, into the calculation of the subsidy. Forecasted expenditures do not determine subsidy. A pre-determined per diem for each component will be used to calculate the maximum subsidy available.

**COMPONENTS OF THE
SUBSIDY CALCULATION
WORKSHEET**

Base Levels-of-Care Per Diem

The Base Levels-of-Care Per Diem is established each year for the purposes of calculating the funding levels for LTC facilities.

The Base Levels-of-Care Per Diem represents the total of the four budget components, namely Nursing and Personal Care, Program and Support Services, Raw Food and Other Accommodation. The Base Levels-of-Care Per Diem represents the per diem amount for a facility that has been classified with a CMI equal to 100.00.

Calculation of Facility Levels-of-Care Per Diem

Ministry staff will provide each LTC facility with a calculation of its own Levels-of-Care Per Diem. The calculation is based on information in the last Resident Classification for the facility. A LTC facility's levels-of-care per diem is based on the Base Levels-of-Care Per Diem that is in effect for the funding period under consideration.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
SUBSIDY CALCULATION WORKSHEET

NUMBER OF CLIENTS

In determining the Levels-of-Care Per Diem for LTC facilities the Case Mix Index (CMI) for each facility is calculated.

The calculation of the CMI is based on the results of the resident classification.

The results of the classification for each LTC facility are provided on the Subsidy Calculation Worksheet. Each of the categories represents the seven levels of care of the Alberta Patient Classification System A through G. The number of residents in each of the categories and the total number of residents classified is reported.

In the case of a new facility for which no classification has taken place, this section is left blank on the Subsidy Calculation Worksheet.

CASE MIX MEASURE

The Case Mix Measure is determined by the resident classification process. This is a measure of the levels of care required for the resident population in a facility. This is calculated by determining the number of residents of the facility who were classified into each of the seven categories during the classification process in the previous year; dividing the number of residents in each category by the total number of residents of the facility who were classified during the classification process in the previous year; multiplying the quotient obtained for each category by the weighting factor for the category; and adding the products.

There is no Case Mix Measure for a new facility when no classification has been completed.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
SUBSIDY CALCULATION WORKSHEET

CASE MIX INDEX

The Case Mix Index is calculated from the Case Mix Measure and converts that scale into a scale which has an average equal to 100.

The Case Mix Index for a LTC facility is determined by dividing the Case Mix Measure for the facility by the Provincial Case Mix Measure and multiplying by 100.

The Provincial Case Mix Measure is the measure calculated for all residents of nursing homes under the *Nursing Homes Act*, approved charitable homes for the aged under the *Charitable Institutions Act* or homes under the *Homes for the Aged and Rest Homes Act* (municipal homes), who were surveyed in the previous year's resident classification process.

The Case Mix Index is used to express the Levels-of-Care requirements of each LTC facility, and represents the basis upon which Nursing and Personal Care expenditures are authorized.

For a new facility for which no classification exercise was completed in the previous year, the CMI will be the average CMI specific to the sector to which the facility belongs.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
PER DIEM COMPONENTS

GENERAL

There are four budget components that comprise the Levels-of-Care Per Diem. These are Nursing and Personal Care, Program and Support Services, Raw Food and Other Accommodation.

Of the four components only the Nursing and Personal Care per diem varies with the care requirements of a facility's residents.

The remaining three components are set at flat rates and are determined each year by the Province.

**NURSING AND
PERSONAL CARE
PER DIEM**

The Nursing and Personal Care Per Diem is calculated by multiplying the Base Nursing and Personal Care Per Diem by the facility's Case Mix Index.

The Nursing and Personal Care Per Diem is to provide for the salary and benefit costs of registered nurses, registered practical nurses and health care aides who are involved in direct resident care, and for the Nursing and Personal Care Administration costs including salary and benefit costs for the Director of Nursing, Nurse Managers and Unit Clerks, and the cost of medical and nursing supplies, and equipment.

**PROGRAM AND
SUPPORT SERVICES
PER DIEM**

This is the provincial per diem rate to cover program and support service expenditures as specified in the regulations. This is a fixed rate and does not vary with the Case Mix Index.

The per diem for a facility will be provided up to the flat rate established by the province depending on the nature and availability of program and support services in the facility.

**FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
PER DIEM COMPONENTS**

**PROGRAM AND
SUPPORT SERVICES
PER DIEM (CONT'D)**

For cultural or religious reasons a portion of the Program and Support Services per diem may be used for the purchase of program specific raw food. The purchase would be reflected in the Subsidy Calculation Worksheet or an amendment to the Service Agreement if applicable.

RAW FOOD PER DIEM

This is the provincial rate for expenditures on raw food as specified in the regulations.

This is a fixed rate that does not vary with the Case Mix Index.

**OTHER
ACCOMMODATION
PER DIEM**

This is the provincial rate for expenditures on Housekeeping, Dietary Services, Building and Property Operations and Maintenance, Laundry and Linen, General and Administrative Expenses, and Facility Use Costs.

This is a fixed rate that does not vary with the Case Mix Index. The rate is specified in the regulations.

**ACCREDITATION
DIFFERENTIAL**

Long-Term Care Facilities that are accredited by the Canadian Council on Health Services Accreditation (CCHSA), will receive a differential in the amount as determined by the Ministry.

This will be paid in addition to Other Accommodation.

Homes not accredited by the CCHSA are not entitled to the differential.

July 31, 2002

Memorandum To: Administrators of Long Term Care Facilities

From: <name of regional director>
Regional Director
<name of region>

RE: August 1, 2002 Increase in the "Other Accommodation" and
Nursing and Personal Care Per Diem Rate

This is to confirm that the funding per diem rate for the other accommodation envelope will be increased by \$0.87 effective August 1, 2002. Funding for your facility will be adjusted effective the August 2002 payment notices to reflect the increase in the other accommodation per diem rates.

This is also to advise you that the funding for the nursing and personal care envelope will be increased by \$6.33 per resident per day effective August 1, 2002. Funding for your facility will be adjusted effective the September 2002 payment notices to reflect the increase in the nursing and personal care per diem rates, retroactive to August 1, 2002.

The new funding per diem rates for long-term care facilities are:

Funding Envelope	Current Per Diem as of July 31, 2002	Increase in per diem on August 1, 2002	New Per Diem on August 1, 2002
Nursing and personal care (based on CMI 100)	\$53.48	\$6.33	\$59.81
Programming and support services	\$5.35	N/A	\$5.35
Raw food	\$4.49	N/A	\$4.49
Other accommodation	\$40.21	\$0.87	\$41.08
Total	\$103.53	\$7.20	\$110.73

I would also like to advise you that we are changing our funding policy for incontinence supplies, and for Medical Directors fees. Effective August 1, 2002, Medical Directors fees (\$0.30 per resident per day) and incontinence supplies (maximum of \$1.20 per resident per day) will be eligible expenses to be reported/funded under the nursing and personal care envelope rather than the other accommodation envelope. There will be no corresponding decrease in funding for the other accommodation envelope (see chart above).

All facilities will be expected to pay Medical Directors fees of at least \$0.30 per resident per day beginning August 1, 2002. Facilities that currently pay, or wish to begin to pay, more than \$0.30 per resident per day in Medical Directors fees should continue to do so. Funding from the other accommodation envelope must be used to fund any amount over \$0.30 per resident per day.

Should you require any further information or clarification, our Regional Finance Manager <name of regional finance manager>, would be pleased to assist you.

<name of regional director>

c: <name of regional finance manager>

July 31, 2002

Memorandum To: Administrators of Long Term Care Interim Beds

From: <name of regional director>
Regional Director
<name of region>

RE: August 1, 2002 Increase in the "Other Accommodation" and
Nursing and Personal Care Per Diem Rate – Interim Beds

This is to confirm that the funding per diem rate for the other accommodation envelope will be increased by \$0.87 effective August 1, 2002. Funding for your facility will be adjusted effective the August 2002 payment notices to reflect the increase in the other accommodation per diem rates.

This is also to advise you that the funding for the nursing and personal care envelope will be increased by \$6.33 per resident per day effective August 1, 2002. Funding for your facility will be adjusted effective the September 2002 payment notices to reflect the increase in the nursing and personal care per diem rates, retroactive to August 1, 2002.

The new funding per diem rates for long-term care interim beds are:

Funding Envelope	Current Per Diem as of July 31, 2002	Increase in per diem effective August 1, 2002	New Per Diem on August 1, 2002
Nursing and personal care (based on CMI 100)	\$61.27	\$6.33	\$67.60
Programming and support services	\$5.35	N/A	\$5.35
Raw food	\$4.49	N/A	\$4.49
Other accommodation	\$40.21	\$0.87	\$41.08
Total	\$111.32	\$7.20	\$118.52

I would also like to advise you that we are changing our funding policy for incontinence supplies, and for Medical Directors fees. Effective August 1, 2002, Medical Directors fees (\$0.30 per resident per day) and incontinence supplies (maximum of \$1.20 per resident per day) will be eligible expenses to be reported/funded under the nursing and personal care envelope rather than the other accommodation envelope. There will be no corresponding decrease in funding for the other accommodation envelope (see chart above).

All facilities will be expected to pay Medical Directors fees of at least \$0.30 per resident per day beginning August 1, 2002. Facilities that currently pay, or wish to begin to pay, more than \$0.30 per resident per day in Medical Directors fees should continue to do so. Funding from the other accommodation envelope must be used to fund any amount over \$0.30 per resident per day.

Should you require any further information or clarification, our Regional Finance Manager <name of regional finance manager>, would be pleased to assist you.

<name of regional director>

c: <name of regional finance manager>

To:	All Administrators - Long-Term Care Homes All Medical Directors – Long-Term Care Homes
From:	Dr. Wayne Tanner – OMA co-chair Hospital On-Call Coverage Committee (HOCC) Ms. Suzanne McGurn – MOHLTC co-chair Hospital On-Call Coverage Committee (HOCC)
Re.:	Long-Term Care On-Call Program

November 21, 2005

Dear Medical Director and Long-Term Care Home Administrator,

As you may be aware, the 2004 Physician Framework Agreement negotiated between the Ministry of Health and Long-Term Care (MOHLTC) and the Ontario Medical Association provides \$8.2M in funding for on-call services provided in long-term care homes in Ontario (Appendix I, section 3. a.).

This funding is being established in recognition of the need to ensure availability of physician on-call services to long-term care homes.

Commencing in October 2005 all long-term care homes will be eligible for funding under this program based upon the criteria set out under the terms of the 2004 Physician Services Agreement. Annual funding will be provided at a level of \$100 per funded bed with a minimum payment of \$10,000 and a maximum payment of \$30,000. Funding for this on-call program will be retroactive to October 1, 2005.

The Hospital On-Call Coverage Committee (HOCC) has been charged with the responsibility of developing and implementing this on-call program. The HOCC Committee is currently in the process of finalizing the details of this program. Additional information will be provided to you shortly.

If you have any questions regarding the Long-Term Care Homes On-Call Program, please contact Honorata Bittner at the Physician Services Committee Secretariat at (416)340-2254 or by e-mail at Honorata_Bittner@physician-services-committee.ca. We thank you for your continued patience and collaboration as we move forward with this important initiative.

Physician Services Committee Secretariat
4th Floor, 525 University Avenue
Toronto, ON M5G 2K7

Tel: (416) 340-2255
Fax: (416) 340-2933
Email: Secretariat@Physician-Services-Committee.ca

Long-Term Care On-Call Program

February 2, 2006

Long-Term Care Home Administrator
Medical Director
<Name of Legal Entity that has signed the Service Agreement>
Address Line 1 Address Line 2
<City> ON <Postal>

Dear Long-Term Care Home Administrator & Medical Director,

As you may be aware, the 2004 Physician Framework Agreement negotiated between the Ministry of Health and Long-Term Care (MOHLTC) and the Ontario Medical Association (OMA) contemplates funding for physicians who provide after-hours on-call service in Long-Term Care (LTC) Homes in Ontario (Appendix I) (the “Program”).

The Hospital On-Call Coverage Committee (HOCC) has been charged with the responsibility of developing and implementing this Long-Term Care On-Call Program. This letter summarizes the terms and conditions of the Program which each participating Long-Term Care Home must agree to, should it decide to participate in the Program:

1. Only Long-Term Care Home operators in Ontario that have current Service Agreements signed with the Ministry of Health and Long-Term Care are eligible to participate in the Program (each a “LTC Home”);
2. Funding for the Program is provided to a LTC Home for physician remuneration for physician after-hours on-call availability and services only, not other services or programs.
3. Each LTC Home acknowledges and agrees that the Service Agreement is hereby amended as follows:
 - a. Funding for the Program shall be deemed to fall within and form part of the Nursing and Personal Care Envelope as contemplated under the Service Agreement;
 - b. Funding provided pursuant to the Program shall be governed by the terms and conditions of this letter, the Service Agreement, and all applicable laws. For the purposes of the Service Agreement, the funding provided hereunder shall be deemed to form part of the “Estimated Provincial Subsidy” in the Service Agreement;
 - c. All other terms and conditions of the Service Agreement shall apply to the Program; and

- d. For greater clarity and without limiting the applicability of the terms and conditions of the Service Agreement, any funding paid by the Ministry to a LTC Home to cover the Program which: (i) was used by the LTC Home for purposes other than this Program, or (ii) exceeds the actual cost of the Program incurred by the LTC Home, shall be a debt due and owing by the LTC Home to the Crown in the right of Ontario which shall be paid by the LTC Home to the Crown in right of Ontario and, in addition to any other methods available to recover the debt, the MOHLTC may deduct the amount of the debt from any subsequent amounts or funding provided by the MOHLTC to the LTC Home.
4. The funding amount will be \$100 per licensed/approved funded bed for a minimum of \$10,000 and a maximum of \$30,000 annually per eligible LTC Home during the term of the Program. The first payment will be on February 22, 2006 and will cover the period from October 1, 2005 to March 31, 2006. Monthly payments will begin April 2006.
5. Payment for the period of October to December 2005 will be based upon licensed/approved funded beds as of October 1, 2005. Starting in January 2006, funds will be based on licensed/approved funded beds as of January of each year. Any fluctuation in licensed/approved funded beds of 10% or more will be adjusted on an ongoing basis.
6. Reconciliation will be based upon the weighted average of licensed/approved funded beds for the period reconciled.
7. An on-call schedule must exist and be available at the LTC Home. The call schedules must be retained by the LTC Home Administration for a period of seven (7) years and be provided to the HOCC Administration or other Ministry representative upon request. A summary including the number of physicians and amounts paid under the Program each year must also be maintained.
8. The LTC Home's Medical Director(s) will be in charge of identifying the physicians at their LTC Home who may be eligible to receive the Program funding.
9. Physicians must be available to provide on-call coverage to the LTC Home after hours (after hours is defined as the time period from 1700 hrs to 0700 hrs Monday to Friday, and 24 hour coverage on weekends and holidays).
10. The physicians providing on-call coverage must be available by phone during the call period, and be available to come in person to the LTC Home in a timely manner if medically necessary in the opinion of the physician (e.g. physically able to attend to the patient at the LTC home if required).
11. A physician may cover more than one LTC Home at the same time, provided (s)he can attend the LTC Home as required in timely fashion (see #10).

12. Similarly, a physician may cover both a LTC Home and a Hospital, as long as a physician can respond in a timely manner to the LTC Home if required. The HOCC Hospital On-Call Program and the HOCC Long-Term Care On-Call Program are separate initiatives, and a physician can be part of both on-call programs so long as the respective program criteria are fulfilled.
13. Division and distribution of funding between the physicians who provide on-call will be accomplished locally by the Administration of the LTC Home in collaboration with the Home's Medical Director in accordance with these terms and conditions. Payment (i.e. cheques) to physicians will be processed at the local level.
14. Any problems or disputes regarding this Program must be addressed at the local level first. If all local mechanisms have been exhausted, and the issue is still not resolved, the HOCC Committee will serve as the dispute resolution body.
15. Any conflict or inconsistency between the terms and conditions of this letter and those of the Service Agreement shall be interpreted by giving priority to the terms and conditions of this letter.
16. If you are in agreement with the terms and conditions of this letter regarding the Long-Term Care On-Call Program and wish to participate, please sign back this letter below and return it by <date> to:

<name of Senior Financial Analyst>
<Position>
<region> Regional Office
<Address Line 1> <Address Line 2>
<City> ON <Postal Code>

If you have any questions regarding the Long-Term Care On-Call Program, please contact Kathleen Clements via e-mail at HOCC@oma.org or by telephone: (416) 599-2580, ext. 3991 or toll free: (800) 268-7215, ext. 3991. We thank you for your continued patience and collaboration as we move forward with this important initiative.

Sincerely,



Dr. Wayne Tanner
OMA Co-Chair, HOCC Committee



Ms. Suzanne McGurn
MOHLTC Co-Chair, HOCC Committee

HOCC Program
4th Floor, 525 University Avenue
Toronto, ON M5G 2K7

Tel: (416) 599-2850, ext. 3991
Fax: (416) 340-2933
Email: HOCC@oma.org

**ACKNOWLEDGED AND AGREED TO THIS _____ DAY OF _____,
2006 BY**

[INSERT LEGAL NAME OF OPERATOR OF LTC HOME]

I have authority to bind the Operator

Name:

Title:

HOCC Program
4th Floor, 525 University Avenue
Toronto, ON M5G 2K7

Tel: (416) 599-2850, ext. 3991
Fax: (416) 340-2933
Email: HOCC@oma.org

Long-Term Care Homes Program Bulletin

Occupancy Based Funding Program

A memorandum to the LTC sector was issued on February 21, 2006 announcing the 2006 OBF program which will be retroactive to January 1, 2006.

The primary objective for the OBF program is to fund at actual care levels but provide an additional 3% in funding to help eligible homes focus on retaining staff.

Eligible operators wishing to enroll in the OBF program for 2006 must agree to comply with the program's terms and conditions, and complete and return the 2006 OBF application forms by March 31, 2006 to:

Community Health Division
Long-Term Care Homes Branch
Homes Support Unit
4th Floor, 5700 Yonge Street
Toronto ON M2M 4K5
Attention: Joanne Gosling

The 2006 OBF application forms are available on the www.ltchomes.net website. Alternatively, please call Joanne Gosling at 416-326-8887 who can forward you a copy.

The 2006 OBF application forms are available on the www.ltchomes.net website. Alternatively, copies are available from Joanne Gosling. She can be reached by phone at 416-326-8887.

If the application is received after March 31, 2006, and the LTC home is eligible for enrollment, the registration will commence from the date the ministry received the application.

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Low Occupancy Policy and Recovery Standards

Policy for Adjusting Advance Cash Flow for Low Occupancy LTC Homes

A new policy to adjust the advance cash flow for Long-Term Care (LTC) homes with low occupancy levels will become effective May 1, 2006.

The objectives of this new policy are to continue the delivery of quality care and service levels to residents in LTC homes while improving the cash management strategy for the LTC homes program.

The new policy applies to LTC homes with expected occupancy levels of 80% or below, as measured by the most recent Revenue Occupancy Report. Effective May 1, 2006, low occupancy LTC homes with a reported average occupancy level of 80% or below will receive monthly funding based on their actual occupancy level plus 10%.

In the event that occupancy increases by more than 5% for more than one month, LTC homes are advised to consult with their regional office regarding an increase in monthly subsidy payments.

Recovery Standards

The ministry will continue the current process of the in-year recovery of surplus funds based on the Revenue Occupancy Report with cash flow adjustments being made in December (for the Revenue Occupancy reporting period January 1 to September 30) and March (for the Revenue Occupancy reporting period of January 1 to December 31) of next year.

The following timelines apply to all recoveries by the ministry:

Recoverable amounts of:	Recovered over:
Under \$50,000	1 month
\$50,000 - \$200,000	1 to 3 months
\$200,000 - \$1 million	3 to 6 months
Over \$1 million	6 to 9 months

The ministry will notify low occupancy homes 30 days in advance regarding their new adjusted cash flow. For further information, a "Question & Answer" document called "Policy for Adjusting Advance Cash Flow for Low Occupancy LTC Homes and Setting Recovery Standards" has been posted on the ministry's website at www.ltchomes.net.

Long-Term Care On-Call Program - Clarification

Earlier this month, the Hospital On-Call Coverage Committee issued a letter to all LTC homes outlining the terms and conditions of the Long-Term Care On-Call Program. The following provides clarification to the administrative requirements of the Long-Term Care On-Call Program.

As noted in #7 of the terms and conditions, an on-call schedule must exist and be available at the LTC home. At the commencement of the Program in October 2005, some LTC homes may have provided on-call services in the absence of an on-call schedule. In these situations, Operators will be expected to provide other supporting documentation. On a one-time basis, the ministry will accept written confirmation signed by the home Administrator and Medical Director for the purpose of documenting the provision of on-call services and associated expenditures between October 2005 and January 2006. Effective February 2006, Operators are expected to maintain on-call schedules to be eligible for funding.

In addition, Operators may report eligible expenditures relating to the Long-Term Care On-Call Program in the Nursing and Personal Care envelope; however, the expenditure cannot exceed the on-call allocation. Where a LTC Home has used funding from the Other Accommodation envelope for services provided under the Long-Term Care On-Call Program for the period of October 2005 to February 2006, the Home should transfer the expenditure from the Other Accommodation envelope to the Nursing and Personal Care envelope. Costs incurred above the allocation must be reported under the Other Accommodation envelope. If actual expenditures are less than the allocation, the difference will be recovered.

Funding for the provision of on-call funding must only be used in accordance with the terms and conditions of the Long-Term Care On-Call

Program. Funding that is not utilized for physician on-call services will be recovered.

Operators will be expected to report actual expenditures for the period of October – December 2005 on the 2005 Annual Reconciliation Report.

Diagnostic Medical Equipment - Important Update about Payment

Please note that DME payments will be processed on March 15th 2006, instead of February 22, 2006 as previously indicated.

Standards Education Session - Reminder

The March 2, 2006 Education Session is fast approaching. Important information about the session is posted on www.ltchomes.net Click on the link “ministry communications to homes” to access the ministry memo to homes, posted on February 14, 2006. Following is some important information to note:

1. **Only providers electing to attend the French session** scheduled from 11 a.m. -12 noon on March 2, 2006, need to register by email. Registration is due **February 22, 2006**. Email registration should be sent to ltcstandards@moh.gov.on.ca
2. **Questions and comments about the session must be emailed by tomorrow, February 22, 2006**, so as to inform the content of the March 2, 2006. Questions and comments should be emailed to ltcstandards@moh.gov.on.ca.
3. Materials related to the Education Session will be posted on www.ltchomes.net during the week of **February 20, 2006**. Homes will be notified by email, as soon as they are available.

Contact Manager - Update

As announced in the January Program Brief, the ministry is initiating a process to improve the contact management system for long-term care

homes and to create a “one-window” approach for homes to submit this information. In order to make sure homes receive timely information targeted to the appropriate audience e.g. DOC versus Provider or Board Member, within the final week of this month, the ministry is initiating a process that will see that contact information is complete and up to date, and enabling homes to have a more direct role in this process.

Over the next several weeks, every home will be contacted to verify the accuracy and completeness of our contact information. Homes will be required to verify the contact information for their respective Provider Name (Board member); Administrator; Director of Care; Food Services Supervisor and, Medical Director.

Once this phase is completed and a complete contact information profile has been created by the ministry, homes will be responsible for maintaining complete and up to date information on-line through the www.ltchomes.net.

Your questions and comments are important – please email them to comments@ltchomes.net

Program Brief – Next Issue

Published every quarter, the next issue of the Program Brief will be released in April 2006. An email notification will be sent to homes once the Program Brief is published and posted online @ www.ltchomes.net



Tim Burns

Director, Long-Term Care Homes Branch

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
RESIDENT DAYS

INTRODUCTION

The total number of resident days is calculated for each facility annually. The number of resident days is important in the calculation of the Provincial Subsidy amounts because each component of the Subsidy Calculation Worksheet is expressed as a per diem.

OPERATING CAPACITY

There will be cases where the number of beds in operation in the facility will vary during the year. This usually occurs when renovations, expansions or downsizing of the facility are planned. Facilities are required to provide a forecast of the operating capacity for each quarter that reflects the fluctuations in capacity.

The operating capacity is based on the number of beds in operation for each period as agreed to by the Program Provider and the Ministry. This number is not to exceed the number of licensed beds in Nursing Homes.

MAXIMUM RESIDENT DAYS

The maximum resident days for a facility is calculated by multiplying the number of beds in operation (operating capacity) by the number of days in the period under consideration.

Note: If 2 or more residents occupy a bed on the same day it is counted as one resident day.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
OCCUPANCY TARGETS

GENERAL

In the Subsidy Calculation Worksheet package, occupancy targets are expressed by allocating the maximum resident-days into the three categories listed below.

- Target Long-Stay Resident-Days
- Allowable Long-Stay Vacancy Days
- Allowable Short-Stay Resident Days

The setting of occupancy targets is done by the area office.

The area office negotiates these targets with the facility. As part of this process, requirements for short-stay services within communities as specified by the District Health Councils in their role as planning bodies for Long-Term Care Services will be taken into consideration.

**TARGET LONG-STAY
RESIDENT DAYS**

This represents the minimum number of resident-days the facility must provide service for either long-stay or short-stay residents, to receive full funding based on the maximum resident days.

**ALLOWABLE LONG-
STAY VACANCY DAYS**

This is the number of long-stay bed-days that the Ministry will allow as vacancies for which funding is provided.

**ALLOWABLE SHORT-
STAY RESIDENT DAYS**

The Allowable Short-Stay Resident-Days is the number of short-stay bed-days that the Ministry will fund for the purposes of respite care or supportive care. Please refer to the appropriate section in the Manual for additional details on this definition. (Section 0805-01).

Where the facility has an approved short-stay program, the description of the program must be included on the LTC Facility Program Description.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
OCCUPANCY TARGETS

ALLOWABLE SHORT-STAY RESIDENT DAYS (CONT'D)

The facility is funded for these days regardless of whether the bed is filled. The number of Allowable Short-Stay Resident-Days in previous budgets (commencing in 1993) will be compared with actual utilization.

The number of Allowable Short-Stay Resident-Days should correspond to an established number of short-stay beds for the period being funded. For example, if a facility has 2 beds designated as short-stay, for a 365 days year, the number of Allowable Short-Stay Resident-Days would be 730.

BASIS OF REIMBURSEMENT FOR SHORT-STAY RESIDENT DAYS

Facilities will be reimbursed up to the allowable short-stay resident days for care, programs, services or goods provided to short-stay residents through the annual operating subsidy, on condition that:

- the facility has been approved by the Minister or their designate to provide short-stay accommodation,
- the facility does not unreasonably refuse admission to short-stay residents, and
- the facility operates and promotes the short-stay program as agreed to in the LTC Facility Program Description.

All short-stay residents will be expected to pay the short-stay rate.

Facilities will be reimbursed for care provided to short-stay residents at the same rate as long-term care residents.

**FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
OCCUPANCY TARGETS**

**RELATIONSHIP TO
OCCUPANCY TARGET**

Any approval for short-stay reduces the occupancy target from the level that allows for the 3% vacancy rate.

For example a 100 bed home with no short stay would have the following approvals in Section 2B of the Subsidy Calculation Worksheet:

Target long-stay resident days	35,405	97%
Allowable long-stay vacancy days	1,095	3%
Approved short-stay resident days	0	0%
Total	36,500	100%

If it had 2 beds (nominally, as approval is by resident day not bed) approved for short-stay, then Section 2B of the Subsidy Calculation Worksheet would be:

Target long-stay resident days	34,675	95%
Allowable long-stay vacancy days	1,095	3%
Approved short-stay resident days	730	2%
Total	36,500	100%

Where a Short-Stay Program exists, the number of resident days approved for the short-stay program is separate from the approval for the 3% vacancy rate. The 3% exists regardless of the number of short-stay resident days that are approved.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
EXPENDITURE FORECASTS

GENERAL

For the period covered by the Service Agreement, each facility is required to submit a detailed forecast of expenditures for:

- Nursing and Personal Care
- Program and Support Services
- Raw Food

This forecast covers all anticipated expenditures in the facility. This forecast and subsequent reconciliations must be prepared in conformity with the modified cash basis of accounting.

MODIFIED CASH BASIS OF ACCOUNTING

Under the modified cash basis of accounting some expenditures are inadmissible for the purpose of reconciliation of the provincial subsidy.

The modified cash basis of accounting recognizes expenses/revenue paid/received within thirty days after the fiscal year end specified by the Ministry for goods and services received during the fiscal year. This would include staff salaries for days employed during the period and settled salary awards.

INADMISSIBLE EXPENDITURES FOR THE PURPOSE OF FORECASTS

The following are examples of cash and non-cash expenditures which are considered to be inadmissible expenditures under the modified cash basis of accounting:

- Appropriations
- Bonuses, Gifts and Honoraria
- Cost of Non-Essential Items for Residents
- Cost of Prescription Drugs
- Donations
- Fund-raising costs
- Sick Leave or Vacation Accruals
- Provision for Anticipated Wage Settlements
- Interest
- Depreciation
- Contingencies

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
EXPENDITURE FORECASTS

**INADMISSIBLE
EXPENDITURES FOR THE
PURPOSE OF FORECASTS
(CONT'D)**

Further revisions may be issued, as the requirements for the year-end audited statements are defined.

A non red-circled facility with operating costs in the Other Accommodation component that are less than the per diem allocated to this component may spend the surplus on these items.

**ADMISSIBLE
EXPENDITURES**

Within the majority of the Admissible Expenditure categories of the Subsidy Calculation Worksheet, the following three items are included:

Salaries and Wages:

This includes the salaries and wages of full-time, part-time and replacement workers including payments for overtime and paid leaves of absence. This does not include staff employed by 3rd party placement agencies. These figures will include any expected Pay Equity costs that will be incurred within the year.

Employee Benefits:

This includes employer contributions for C.P.P., U.I.C., W.C.B., Employer Health Tax, other pension plans and other insurance plans.

Purchased Services:

This includes costs incurred for persons other than staff members within each cost centre, excluding management fees, medical director's fees, professional fees (e.g., legal), and allocated administration expenses.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
EXPENDITURE FORECASTS

**"OTHER" EXPENDITURE
CATEGORY**

The list of specific expenditures (e.g., salaries, benefits, purchased services, etc.) is not an exhaustive list of admissible expenditures but rather a list of commonly used expense items within long-term care facilities.

Accordingly, the "Other" category has been provided to address unique situations which may exist in some facilities based on existing financial, organizational or structural systems.

These unique expenditures are admissible if they meet the following criteria:

- a) The facility can clearly demonstrate that the expenditure item is relevant and appropriate to the cost centre to which it is applicable,
- b) The facility can clearly demonstrate that the expenditure item will enhance or improve the provision of services to the resident(s), and
- c) The expenditure is approved by the Ministry.

**EXPENDITURE
RECOVERIES
CATEGORY**

Within each of the cost centres there is an entry for expenditure recoveries. In this entry, only those expenditure recoveries generated by the utilization of Ministry funded resource(s) should be included.

"Ministry funded resources" means any real or personal, tangible or intangible asset or human resource with respect to which the Ministry, either directly or indirectly has provided either capital financial assistance or operating subsidy.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
EXPENDITURE FORECASTS

**EXPENDITURE
RECOVERIES
CATEGORY (CONT'D)**

Expenditure recoveries must be reported within the applicable departmental accounts to provide a net expenditure position for each of the cost centres. Expenditure recoveries are subtracted from forecasted expenditures to yield net expenditures.

The following is a list of examples of expenditure recoveries:

- a) Transportation fees received from residents or program recipients
- b) Staff and visitor meal charges

Note: The cost of the raw food used to prepare these meals is an expenditure recovery for the raw food cost centre, the balance of the charges is an expenditure recovery in dietary services.

- c) Tax preparation fees
- d) Trust management fees
- e) Staff and visitor parking
- f) Sales tax refunds
- g) Gasoline tax rebates
- h) Purchase discounts
- i) Rental of space or equipment
- j) Consulting or training fees where the facility provides services to other organizations and where a fee is charged for appearances, consulting services or other programs

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
EXPENDITURE FORECASTS

**EXPENDITURE
RECOVERIES
CATEGORY (CONT'D)**

- k) Property tax rebates
- l) Service fees where the facility has established service contracts with other organizations or the general public (maintenance contracts, transportation)
- m) Personal grooming fees
- n) Government grants (e.g., energy conservation programs, training and employment grants)
- o) Fund raising activities in which government funded resources are utilized by the facilities. For example, if a resource funded by the government (staff member) is used for fund raising activities, then his/her salary must be offset against revenue raised by the activity.

If there is any doubt as to how revenue should be treated the facility is advised to contact the local Long-Term Care Area Office for clarification.

In non-red-circled facilities, expenditure recoveries in the Other Accommodation cost centres of Housekeeping Services, Building and Property - Operations and Maintenance, Dietary Services, Laundry and Linen, General and Administrative and Facility Use do not affect the calculation of approved provincial subsidy in the quarterly and annual reconciliations.

RESIDENTS COUNCILS

Commercial activities (e.g., fund raising, craft sales, bazaars) undertaken by residents councils are to be encouraged so the residents councils may have access to discretionary funds. However, other than ensuring the appropriate use of LTC facilities, office equipment, supplies, facility volunteers, and staff, neither the Ministry nor the LTC facility may have any involvement in a council's commercial affairs.

**FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
EXPENDITURE FORECASTS**

**RESIDENTS COUNCILS
(CONT'D)**

All revenue accruing from commercial activities of the residents council are to be spent at the discretion of residents council members. Similarly, all out-of-pocket expenses undertaken to generate income are also the council's sole responsibility.

Residents councils are encouraged to run their affairs in a business-like fashion, i.e., set up bank accounts, establish a petty cash fund, provide minutes of meetings, give receipts for donations or sales, and account for all of the financial transactions.

**FORECASTED
EXPENDITURES -
NURSING AND
PERSONAL CARE**

This section of the Subsidy Calculation Worksheet provides two cost centres for the facility to forecast expenditures related to this component of the Levels-of-Care Per Diem. The cost centres are Nursing and Personal Care - Direct Care and Nursing and Personal Care - Administration.

**NURSING AND
PERSONAL CARE -
DIRECT CARE**

This cost centre includes expenditures on salaries, benefits and purchase of services for nursing and personal care staff involved in direct patient care. Included are expenditures on:

- Registered Nurses, Registered Practical Nurses, Health Care Aides and Nursing Attendants.
- The costs of any additional nurses, practical nurses or aides requested by individual residents but not required by the Service Agreement are inadmissible.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
EXPENDITURE FORECASTS

**NURSING AND
PERSONAL CARE
ADMINISTRATION**

This cost centre includes expenditures for administration of the nursing and personal care function.

This includes salaries and benefits for the director of nursing, nurse managers and unit clerks dedicated to the provision of services to the nursing units, medical supplies, medical equipment, etc.

Administrative supplies and expenses are not included in the Nursing and Personal Care Administration cost centre.

Training costs for Nursing and Personal Care staff may be included under Nursing and Personal Care Administration. (For example, training costs related to the provision of care.)

"Other" expenditures may include the cost of non-prescription drugs and devices where these have not been funded under other government programs.

**FORECASTED
EXPENDITURES -
PROGRAM AND SUPPORT
SERVICES**

A cost centre for the facility to report forecasted expenditures on the Program and Support Services component is included in the Subsidy Calculation Worksheet.

This cost centre includes expenditures on salaries, benefits, purchase of service, supply and equipment costs for physiotherapy, speech therapy, occupational therapy, recreation programs, volunteer coordination, staff development, pastoral care and program specific raw food costs.

Expenditure recoveries should include, for example, program and support services provided to another organization for a fee or proceeds of craft sales if that activity is utilizing government funded resources.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
EXPENDITURE FORECASTS

**FORECASTED
EXPENDITURES - RAW
FOOD**

A cost centre for the facility to report forecasted expenditures on the raw food component is included in the Subsidy Calculation Worksheet.

This cost centre includes expenditures on food materials only.

"Food materials" are defined as materials used to sustain life including supplementary substances such as condiments and prepared therapeutic food supplements ordered by a physician for a resident.

The total raw food expenditures must exclude any costs related to other programs. For example, where a facility is operating another program such as a retirement home or a meals on wheels program the facility must show the total food purchases and an expenditure recovery representing the food purchased for the other program. Similarly, charges for staff meals must also be reported as an expenditure recovery so that this cost centre only reflects those costs related to resident food.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
REVENUE FORECASTS

GENERAL

Facilities must provide on the Subsidy Calculation Worksheet a forecast of the anticipated revenues that the facility will receive from various sources. The primary revenue source is from resident revenue. Such revenues will be from charges for preferred and basic accommodation.

**FORECASTED
PREFERRED
ACCOMMODATION
REVENUE**

Facilities are required to prepare a forecast of preferred accommodation revenue.

Preferred Accommodation Revenue is the revenue generated from accommodation fees charged to residents in semi-private or private accommodation. Preferred accommodation revenue is in excess of the amount that these residents pay for the maximum rate for basic accommodation.

The facility is to forecast the amount of preferred accommodation revenue the facility expects to collect from residents for the budget period under consideration.

The area office will review the forecast given:

- previous preferred accommodation revenue for the facility,
- changes in preferred accommodation policies, and
- forecasts of preferred accommodation revenue based on the quarterly reports.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
REVENUE FORECASTS

**BASIC
ACCOMMODATION
REVENUE**

Facilities must provide a forecast of basic accommodation revenue for the year for all residents, except those who are Status Indians funded by the Federal Government.

The forecast is based upon expected basic accommodation revenue as determined through the income test of residents, expected revenue from preferred accommodation fees not included as preferred accommodation revenue, and the expected occupancy of the facility.

Revenues included in this section are those revenues that are deducted from the approved budget when determining the amount of provincial subsidy for purposes of subsidy calculation and subsequent reconciliation.

The forecast of Accommodation Revenue does not include preferred accommodation revenue, or revenue from other charges to residents.

The Area Office will verify the reasonableness of the revenue forecast given occupancy targets, number of beds, the demand for preferred accommodation, and the expected average contribution per resident.

OTHER REVENUE

Some revenue may be retained by the facility and excluded from the subsidy calculation. Other revenue is considered to be non-retainable by the facility and will be included in the forecasted revenue so as to reduce the provincial subsidy.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
REVENUE FORECASTS

**OTHER REVENUE
 (CONT'D)**

The rule is that any revenue generated utilizing Ministry funded resource(s) is non-retainable by the facility, except for the facility share of preferred accommodation revenue.

"Ministry funded resources" means any real or personal, tangible or intangible asset or human resource with respect to which the Ministry, either directly or indirectly, has provided either capital financial assistance or operating subsidy.

The following are examples of Other Revenue items that are not retainable by the facility.

- a) Estate recoveries - For amounts owing prior to July 1, 1993, the percentage of the estate recovery equal to the percentage on which the contribution by the Province in respect of the amount recovered is based.
- b) Disposal of Ministry funded assets
- c) Provincial funding for Homes for Special Care Residents

**FEDERAL GOVERNMENT
 SUBSIDY OF STATUS
 INDIANS**

The facility's revenue forecast must account for subsidy amounts that are provided by the Federal Government to Status Indians. This is not actual revenue but is a reduction in subsidy payable by the Province for those beds that are occupied by First Nations members who are legally Status Indians for whom funding is provided by the Federal Government.

The amount is calculated by multiplying the forecast resident days for these residents based on the number at time of budget submission by the approved per diem rate for the facility.

**FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
REVENUE FORECASTS**

**MUNICIPAL/
CHARITABLE SHARE
(DOES NOT PERTAIN TO
NURSING HOMES)**

This is applicable to Municipal and Charitable Homes for the Aged. This is the amount of funding provided by the municipality or charitable organization over and above the Levels-of-Care funding.

The municipal/charitable subsidy share will be held at its 1992 (municipal) or 1992/93 (charitable) level, or the difference between Levels-of-Care funding and the approved red-circle expenditure, whichever amount is lower.

Where a facility is not red-circled there will be no municipal/charitable contribution required for the facility to receive funding at the Levels-of-Care per diem.

The municipal/charitable share for residents funded by the Federal Government is assumed when the full per diem is used in the estimate of revenue pertaining to those residents.

**REVENUE EXCLUDED
FROM PROVINCIAL
SUBSIDY CALCULATION**

This section of the Subsidy Calculation Worksheet is for facilities to report on revenue that is considered to be retainable by the facility and is therefore not included in the determination of the provincial subsidy.

This section includes the portion of preferred accommodation revenue that is retainable by the facility.

It also provides for the facility to report on revenue generated by the facility from the provision of services to the residents for which the Service Agreement permits the facility to charge a fee.

This section also provides for the facility to report "Other" revenue. The following are examples of Other Revenue items that are retainable by the facility.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
REVENUE FORECASTS

**REVENUE EXCLUDED
FROM PROVINCIAL
SUBSIDY CALCULATION
(CONT'D)**

- a) Revenue from fund raising activities where no Ministry funded resource(s) have been utilized.
- b) Interest on investment of retainable funds.
- c) Capital donations.
- d) Facility share of estate recoveries.

**ESTIMATED
PROVINCIAL SUBSIDY**

This is the estimated provincial subsidy payable to the facility for the period of the budget. This amount is subject to reconciliation under the terms of the funding formula, and is used initially as a basis upon which cash flows are determined.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
RED CIRCLE PROVISION

RED-CIRCLE PROVISION

As part of the transitional arrangements developed with the introduction of Levels-of-Care Funding, the provincial government has provided that facilities would not receive any less combined provincial funding/basic resident revenue than they received under the past system. This level of funding is referred to as "red-circling".

A home for the aged is considered to be red-circled where the combined Provincial Subsidy and Resident Basic Co-payment, from the last completed fiscal year prior to the introduction of Levels-of-Care funding, when calculated as a per diem, is greater than the per diem derived by the application of the Levels-of-Care funding formula.

A nursing home is considered to be red-circled when the Extended Care rate in effect as of March 31st, 1993 is greater than the per diem arrived at by the application of the Levels-of-Care funding formula.

The "Red-Circle" per diem will be calculated for the period April 1, 1992 - March 31, 1993 for Charitable Homes and January - December 31, 1992 for Municipal Homes.

Total red-circled expenditures are limited to the Extended Care cap for capped homes plus the approved gross pay equity dollars above the Extended Care CAP plus total Residential Care Expenditures.

Total red-circled expenditure for Charitable Homes are limited to a 3% increase over 1991/92 expenses for uncapped Charitable Homes, which received a Special Grant in 1992/93.

Total red-circled expenditures are limited to actual 1992 expenditures for uncapped Municipal Homes and 1992/93 for uncapped Charitable Homes that did not receive a Special Grant in 1992/93.

**FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
RED CIRCLE PROVISION**

**STEPS INVOLVED IN THE
PROCESS OF
RED-CIRCLING
MUNICIPAL HOMES**

Steps involved in the process of Red-Circling Municipal Homes

Step 1:

Calculate the 1992 approved per diem

Step 2:

Reconcile the 1992 approved per diem in Step 1 to the various sources of funding (i.e., resident revenue, provincial subsidy, municipal contribution). The reconciliation also determines the **potential** Red-Circled Per Diem (the combined provincial funding and Basic Resident Revenue)

Step 3:

Determine whether the Home is Red-Circled under the new Levels-of-Care funding formula.

**STEPS INVOLVED IN THE
PROCESS OF RED-
CIRCLING CHARITABLE
HOMES**

Step 1:

Calculate the 1992 approved per diem

Step 2:

Reconcile the 1992 approved per diem in Step 1 to the various sources of funding (i.e., resident revenue, provincial funding, Charitable Home's contribution). The reconciliation also determines the **potential** Red-Circled Per Diem.

Step 3:

Determine whether the Home is Red-Circled under the new Levels-of-Care funding formula.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
CASH FLOW CALCULATION

**CASH FLOW
CALCULATION**

A facility's yearly provincial subsidy for cash flow purposes is calculated by deducting the forecast of revenue from the approved operating costs.

The monthly operating cash flow is based on approximately one-twelfth of the approved annual provincial subsidy under the long-term care funding arrangements, plus or minus any adjustment, such as:

- (i) the results from previous years reconciliations
- (ii) the opening or closing of the facility during the year
- (iii) the suspension of admissions by the Director
- (iv) the introduction or cessation of a resident care program during the year
- (v) the recovery from a facility of charges to residents that are in excess of the charges permitted under the applicable legislation, or where a service was inadequately provided or not provided at all

and adjustments may be made to the monthly cash flow during a year when warranted by, for example:

- (i) a facility's financial situation,
- (ii) the number of residents in a facility,
- (iii) the need to recover charges to residents that are in excess of the charges permitted under the applicable legislation, or
- (iv) a breach of the Service Agreement.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
CASH FLOW CALCULATION

**CASH FLOW
 CALCULATION (CONT'D)**

Any adjustments to the monthly cash flow will only be made following notification to the facility.

When a subsidy has not been determined for a calendar year before the beginning of that year, the monthly cash flow to a facility shall be the same as the cash flow for the previous December, plus or minus any adjustment, such as:

- (i) the results from previous and current year's reconciliations
- (ii) the opening or closing of the facility during the year
- (iii) the suspension of admissions by the Director
- (iv) the introduction or cessation of a resident care program during the year
- (v) the average levels of care required by residents of the facility is either increasing or decreasing as determined by a resident classification exercise subsequent to the one upon which the previous budget was based
- (vi) the need to recover any payments that are in excess of the charges permitted under the applicable legislation
- (vii) one-time adjustment to the previous December payment
- (viii) in the case of leap years the facilities will be funded on the basis of 366 days.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT PROCESS
DIRECT DEPOSIT

DIRECT DEPOSIT

All facilities will receive their monthly operating cash flow by direct deposit to an account in a Canadian Financial Institution designated by the facility.

Facilities will be provided with a schedule of direct deposit dates each fiscal year.

FINANCIAL MANAGEMENT AND ADMINISTRATION

SERVICE AGREEMENT PROCESS

STAFFING SCHEDULE/ACCOMMODATION STAFFING REPORT

- PURPOSE** The purpose of the LTC Facility Staffing Schedule is to identify the forecasted staffing level in each facility. The schedule provides staffing levels by funding envelope and the total compensation cost for each staff category.
- COST CENTRES** Facilities are to complete the staffing information for each of the following cost centres:
- Nursing and Personal Care - Direct Care
 - Nursing and Personal Care - Administration
 - Program and Support Services
- Facilities are also requested to provide a report on staffing for the following cost centres in the Other Accommodation envelope:
- Housekeeping Services
 - Building and Property - Operations and Maintenance
 - Dietary Services
 - Laundry and Linen Services
 - General and Administrative
- JOB CLASSIFICATIONS** In each of the above cost centres, facilities are requested to provide detail on the job classifications listed in each section. If the job classification does not fit the description or title of a particular job, please use the other category and provide a description.
- NUMBER OF EMPLOYEES** On the Staffing Schedule facilities are requested to report the number of full-time and part-time employees for each job classification. A full-time employee is defined as an employee who is regularly scheduled for work 70 hours or more on a bi-weekly basis. Part-time employees are defined as those employees that are scheduled for work less than 70 hours on a bi-weekly basis. For those employees that work in more than one job classification, allocate employment status to only one job classification.

FINANCIAL MANAGEMENT AND ADMINISTRATION

FACILITY AGREEMENT PROCESS

STAFFING SCHEDULE/ACCOMMODATION STAFFING REPORT

SCHEDULED STAFF HOURS PER WEEK

For each job classification, provide the total paid and on-site hours scheduled per week. On-site hours may exceed paid hours where staff are not paid for break periods within their normal schedule. For example:

Scheduled Paid Hours	Un-Paid Breaks	Scheduled On-site Hours
7.5 hrs	0.5 hrs	8.0 hrs

ANNUAL TOTAL SALARY AND BENEFIT COST

Facilities are to report the total cost of both salary and benefits of providing weekly scheduled staff hours on an annualized basis. This includes:

- Basic salary
- Overtime
- Shift premiums
- Call-back premiums
- On-call premiums
- Weekend premiums
- Long-term illness
- Vacation
- Statutory holiday pay
- Staff orientation and development pay
- Health and safety pay
- Union duty
- Bereavement
- Jury duty
- Modified pay
- UIC/ CPP/WCB/EHT
- Pensions
- Weekly indemnity
- Extended health
- Long-term disability life insurance
- Vision/dental/uniform allowances
- Maternity sub-plan
- Other applicable benefits

FINANCIAL MANAGEMENT AND ADMINISTRATION

SERVICE AGREEMENT PROCESS

STAFFING SCHEDULE/ACCOMMODATION STAFFING REPORT

**ANNUAL TOTAL SALARY
AND BENEFIT COST
(CONT'D)**

In circumstances where contract agreements will be implemented in the coming fiscal year or where contract settlements have been arbitrated but not yet implemented, facilities will experience costs over and above current salaries and benefits. If this is the case, please estimate the incremental cost of the settlement above current staffing costs and include these costs in the annual total salary and benefits costs.

PURCHASE OF SERVICE

If applicable, provide the total weekly scheduled hours of purchased services along with the total annual purchase of service cost.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT
SERVICE AGREEMENT COMPONENTS

INTRODUCTION

Long-Term Care Facilities are required to negotiate a Service Agreement annually. The Service Agreement sets out the program, service and financial relationship between the Ministry and the Long-Term Care Facility.

The Service Agreement and the Subsidy Calculation Worksheet include detailed information on the facility's planned expenditures, revenues, services and provincial funding.

LTC FACILITY PROGRAM AND SERVICES (SECTION 2)

The Program Provider is required to provide accommodation, care, services, programs, and goods in accordance with

- *Homes for the Aged and Rest Homes Act* and Regulation 637 made under the Act or,
- *Charitable Institutions Act* and Regulation 69 made under the Act or,
- *Nursing Homes Act* and Regulation 832 made under the Act,

and in accordance with:

- Terms and Conditions of the Program Provider's approved care, programs, and services description, staffing, and budget schedules.

The Program Provider also agrees to take all reasonable steps to achieve compliance with the standards and criteria contained in the Long-Term Care Facility Manual.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT
SERVICE AGREEMENT COMPONENTS

CONSULTATION
(SECTIONS 3.1, 3.2)

The relationship between the Program Provider and the Long-Term Care Division is a collaborative one. As such Ministry staff will be available to the Program Provider and facility staff for consultation on matters of common interest.

At the same time facility staff must make themselves available upon reasonable notice to discuss issues identified by Ministry staff.

This expectation extends to the governing bodies of Long-Term Care Facilities and includes members of management boards, corporations, and/or licensees.

Long-term Care Division staff are available to provide advice and consultation to facilities when they require assistance to deal with an operational issue or for any other reason.

FUNDING
(SECTION 4.1)

The amount funded to Long-Term Care Facilities will not exceed the amount specified on the Subsidy Calculation Worksheet. This funding will be subject to a reconciliation process.

The Ministry will determine the amount, times and method of the subsidy payment. The Ministry also reserves the right to withhold or reduce payments if the terms of the agreement have been breached by the facility.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT
SERVICE AGREEMENT COMPONENTS

**TRANSFER OF FUNDS
BETWEEN BUDGET
COMPONENTS
(SECTION 4.2)**

The Program Provider may not transfer funds between the four components of the budget:

- Nursing and Personal Care
- Program and Support Services
- Raw Food
- Other Accommodation

other than for the transfers specified below:

- The Program Provider may transfer funds from the Other Accommodation component of the budget to the Nursing and Personal Care, Program and Support, and Raw Food envelopes.

Such transfers may only take place if the facility has complied with the standards and criteria for Accommodation as set out in the Long-Term Care Facility Manual.

**CHANGES IN SUBSIDY
(SECTION 4.3)**

The amount of subsidy stipulated in the Subsidy Calculation Worksheet may change as a result of legislative and regulatory amendments by Ontario.

**TERM OF SERVICE
AGREEMENT
(SECTION 5.1)**

The Service Agreement is in force from January 1 until December 31 for the year the agreement applies, or until it is terminated, superseded or replaced by a subsequent agreement.

**TERMINATION OF
AGREEMENT
(SECTION 5.2)**

The Service Agreement may be terminated by the Program Provider by giving ninety (90) days written notice.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT
SERVICE AGREEMENT COMPONENTS

CORRECTIVE ACTIONS
(SECTION 5.3)

Please refer to Service Agreement for details.

REFUND ON
TERMINATION
(SECTION 5.5 AND 5.6)

If the agreement is terminated the Program Provider will refund to Ontario any monies advanced and income earned on the advance that have not been spent in accordance with the agreement. In the event of termination, Ontario shall pay to the Program Provider any monies owing by Ontario.

EXTENSION
(SECTION 5.8)

At the end of the term of the agreement it is automatically extended for a period of one year subject to the availability of resources and legislative and regulatory amendments.

AMENDING AGREEMENT
(SECTION 5.9)

If the agreement is extended automatically the parties will enter into an Amending Agreement within 90 days (or longer if agreed to by Ontario) confirming the terms of the agreement and any agreed upon modifications. If an Amending Agreement is not entered into within the 90 days, Ontario may terminate the agreement by giving written notice to the Program Provider.

SUBSIDY PAYABLE
(SECTION 5.10)

If the Ministry has provided notice of an increase in subsidy for the subsequent year of the agreement, or where the Ministry and the Program Provider have agreed in writing to an increase in the subsidy, the subsidy payable by the Ministry will be at the increased rate.

RECORDS AND REPORTS
(SECTION 6.1)

The Program Provider is required to maintain proper financial records and books of account respecting use of funds provided by Ontario to the Facility under the terms and conditions of the Service Agreement.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT
SERVICE AGREEMENT COMPONENTS

INSPECTION

The Program Provider must permit Ministry staff to inspect and audit the books and records of the Facility at all reasonable times.

The Ministry's right to inspect the books and records of the Facility is not limited to the term of the Service Agreement.

**WORKSHEET
(SECTION 6.2)**

The Program Provider will submit annually the Long-Term Care Facility Subsidy Calculation Worksheet.

**AUDITED FINANCIAL
INFORMATION
(SECTION 6.3)**

The Program Provider must submit to the Ministry an audited financial information and reconciliation report annually.

The cost of preparing the financial statement and report is the responsibility of the Program Provider unless the Ministry otherwise agrees.

**FINANCIAL REPORTS
(SECTION 6.4)**

The Program Provider must prepare and submit quarterly financial reports.

Ministry staff may also request ad hoc financial reports. These reports will not be otherwise inconsistent with the Program Provider's reporting requirements.

**RECORD RETENTION
(SECTION 6.5)**

The Program Provider must retain the records and books of account for a period of six years.

**OTHER RECORDS AND
REPORTS
(SECTION 6.7)**

The Program Provider will submit to Ontario annually:

- a) The Long-Term Care Facility Staffing Schedule
- b) The Long-Term Care Facility Program Description, and
- c) The Long-Term Care Facility Accommodation Staffing Report

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT
SERVICE AGREEMENT COMPONENTS

CONFIDENTIALITY
(SECTION 7.1)

The Program Provider, its directors and officers shall not disclose or release to any person at any time during or following the term of the agreement, except where required by law, any information or document that identifies any individual in receipt of services without obtaining the written consent of the individual or his or her lawful representative prior to the release or disclosure of such information or document. Furthermore, the Program Provider shall take all reasonable steps to ensure that its employees, agents, and volunteers maintain confidentiality.

LIABILITY
(SECTION 8.1)

Ontario shall not be liable for any claim, damages or otherwise to the Program Provider, its officers, employees, independent contractors, subcontractors, agents or assigns arising from or connected with the Service Agreement including any consequences that may occur as a result of the termination of the Service Agreement.

INDEMNIFICATION
(SECTION 8.2)

The Program Provider, and not the Province of Ontario is responsible for all costs, losses, damages, judgements, claims, demands, suits, actions, complaints or other proceedings, occasioned by or attributable to anything done or omitted to be done by the Program Provider, its officers, employees, independent contractors, subcontractors, agents or assigns in connection with services provided, purported to be provided or required to be provided by the Program Provider pursuant to the agreement.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT
SERVICE AGREEMENT COMPONENTS

INSURANCE
(SECTION 9)

The Program Provider shall obtain and maintain in full force and effect during the term of the Service Agreement general liability insurance acceptable to Ontario in an amount of not less than \$1,000,000.00 per occurrence in respect of the services provided pursuant to this agreement. The insurance policy shall,

- include as an additional insured "Her Majesty the Queen in right of Ontario" in respect of and during the provision of services by the Program Provider pursuant to the agreement.
- contain a cross-liability clause endorsement; and
- contain a clause including liability arising out of contract or agreement.
- The Program Provider shall submit to Ontario, upon request, proof of insurance.

REPRESENTATIONS,
COVENANTS AND
WARRANTIES
(SECTION 10)

The Program Provider agrees that it meets and will continue to:

- a) hold necessary licenses and permits to perform its obligations under the agreement.

Where the Program Provider is a corporation it agrees that it meets the following:

- a) is a valid corporation
- b) has authority to enter into the service agreement

Ontario has the right to demand correction of any breach of the above and can terminate the agreement after 30 days written notice if the breach is not corrected within a reasonable period of time.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT
SERVICE AGREEMENT COMPONENTS

**DISPOSITION OF
FURNISHINGS AND
EQUIPMENT
(SECTION 11)**

This section stipulates that the Program Provider shall not sell, change the use, or otherwise dispose of any item, furnishing or equipment specifically listed in any schedule relating to the nursing and personal care and program and support services funding envelopes (additions to "any items listed" since January 1, 1995), as well as any furnishings and equipment purchased by a capital grant in all funding envelopes, pursuant to the Service Agreement and paid for in whole or in part by Ontario, without the prior written consent of Ontario, which consent may be subject to such terms and conditions as Ontario may deem advisable.

**SCHEDULES
(SECTIONS 12,13)**

All of the terms and conditions of the Schedules are incorporated into the Service Agreement.

The Schedules include the Subsidy Calculation Worksheet, Program Description Schedule and Staffing Schedule.

Upon signing the Service Agreement all other written agreements in respect of the subject matter in the Service Agreement between the Ministry and the Program Provider are no longer in effect.

**HEADINGS
(SECTION 14)**

Headings are included for convenience and are not part of the agreement

**RELATIONSHIP TO THE
CROWN (SECTIONS 15.1,
15.2)**

Neither the Program Provider nor any of its Representatives are employees, agents, partners of, or in joint venture with Ontario.

In addition, the Program Provider, its agents or employees shall not portray themselves as Crown Agents or allow themselves to be portrayed as such.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT
SERVICE AGREEMENT COMPONENTS

**SURVIVAL OF CERTAIN
TERMS (SECTION 16)**

Certain sections of the agreement survive the termination of the agreement and relate to the following provisions:

- rights or remedies are not waived by the Program Provider upon termination of the agreement by the Program Provider; any obligations on behalf of Ontario survive the termination of the agreement (section 5.2)
- the Program Provider must refund any monies not expended in accordance with the agreement (section 5.5); any monies owing by Ontario must be paid to the Program Provider (section 5.6)
- rights or remedies are not waived by Ontario upon termination of the agreement by Ontario; any obligations on behalf of the Program Provider survive the termination of the agreement (section 5.7)
- the Program Provider must maintain proper financial records (section 6.1) and retain such records for a period of six years (section 6.5)
- the Program Provider remains subject to the provisions regarding confidentiality (sections 7.1, 7.2)
- provisions regarding liability and indemnification also survive the termination of the agreement (sections 8.1, 8.2)
- the provisions regarding the disposition of furnishings or equipment survive the termination of the agreement (section 11).

**PROVISIONS SEVERABLE
(SECTION 17)**

If a lawful authority declares any provision of the agreement invalid the other provisions will remain in full force.

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICE AGREEMENT
SERVICE AGREEMENT COMPONENTS

WAIVER
(SECTION 18)

Provisions of the agreement can only be waived if a signed waiver has been given.

NON-ASSIGNMENT OF
SERVICE AGREEMENT
(SECTION 20)

The Program Provider shall not assign the Service Agreement, or any part thereof, without the prior written approval of Ontario, which approval may be withheld by Ontario in its sole discretion or given subject to such terms and conditions as Ontario may impose.

DESIGNATED
REPRESENTATIVES
(SECTION 21)

The Service Agreement states who are the designated representatives who will communicate for the purposes of the agreement.

NOTICE
(SECTION 22)

This section of the agreement defines the provisions regarding notice being required under the agreement. Specifically any notice, request, demand, consent, approval, correspondence or other communications must be:

- in writing;
- sent by courier, facsimile or other electronic message that provides a hard copy;
- to the address of the designated representative.

SIGNATORIES
(SECTION 26)

To execute the Service Agreement, the Service Agreement must be dated, signed, sealed and delivered by the authorized signing officers of the Service Provider. The agreement must be signed and dated by a Ministry staff who is authorized to enter into an agreement on behalf of Ontario.

A witness is required where the Program Provider is a sole proprietor or a partner.

FINANCIAL MANAGEMENT AND ADMINISTRATION
MONITORING AND REPORTING
QUARTERLY REPORTS

QUARTERLY REPORTS

A LTC facility's activity and financial performance is monitored during the year by means of quarterly reports. These reports are used to compare actual results against the approved budget. Variances may be identified and discussed with the LTC facility. This process is used to adjust the cash flow to a more appropriate level based on actual occupancy levels, expenditures and revenues, and to identify potential problem situations.

PURPOSE

The purpose of requesting quarterly reports from LTC facilities is:

- To monitor a LTC facility's activity and financial performance.
- To identify potential problem situations.
- To adjust cash flow, if applicable.

SUBMISSION OF REPORTS

Completed quarterly reports must be submitted to the appropriate LTC Area Office by the 45th day following the end of the quarter to which the report applies.

VARIANCES

If significant variances between subsidy entitlement and subsidy paid are identified, the LTC facility will be contacted for an explanation. Where warranted, adjustments to cash flow may be made. LTC facilities will be notified of any adjustments in advance.

CERTIFICATION

Authorized official(s) of the LTC facility must sign that the report is correct and that the report is in agreement with the records of the LTC facility.

FINANCIAL MANAGEMENT AND ADMINISTRATION
MONITORING AND REPORTING
FACILITY ANNUAL REPORT

PURPOSE OF ANNUAL REPORT

The purpose of the annual report is to enable the Ministry to reach a final settlement with a facility for a specified funding period. This requires the submission of an audited reconciliation report to the facility's designated Long-Term Care Area Office.

PROCESS FOR SUBMISSION

The Long-Term Care Area Office will initiate the process by forwarding a copy of the Long-Term Care Facility Annual Report to the facility. The facility is to complete the information requested in the report.

When submitted, the report must be signed and dated by the Licensee/Executive Director/Administrator of the facility and the Chairperson of the Board, as applicable. The Annual Report must also be audited and signed by a Licensed Public Accountant.

Once the Annual Report has been completed, it is to be forwarded to the facility's Long-Term Care Area Office for review.

AREA OFFICE REVIEW

Upon receipt of the Annual Report, the Area Office will conduct a review of the submission. This review involves a check for completeness of the schedules, appropriate signing authorities and auditor sign-off. The Area Office reviews the financial information contained in the report. Once the review is complete, the Area office will calculate a final settlement for the funding period under review. The Area Office will then notify the facility of the final settlement along with the method of payment or recovery of any outstanding amounts as applicable.

FINANCIAL MANAGEMENT AND ADMINISTRATION
MONITORING AND REPORTING
FACILITY ANNUAL REPORT

AUDITOR'S REPORT

It is a requirement that the Annual Report be audited by a licensed Public Accountant. The facility's auditor is required to sign a statement in the form provided by the Ministry attesting that they have audited the Annual Report of the facility for the funding period in question. The auditor must also attest that the audit was conducted in accordance with generally accepted auditing standards. If necessary the auditor may include any explanatory notes to the Annual Report. The Auditor's statement must be signed and dated by a licensed Public Accountant.

**MANAGEMENT'S
STATEMENT**

The management of the facility are required to attest that the information contained in the Annual Report was prepared by management. The management statement attests that the report adheres to the Long-Term Care Facility Annual Report Technical Instructions and Guidelines as provided by the Ministry of Health. The management statement must also state, by way of reference to the notes to the report, the basis or bases of accounting that the report has been prepared in accordance with. Furthermore, management must provide assurance to the Ministry that the facility has in place acceptable systems of internal accounting control. The management statement must be signed and dated by the Licensee/Executive Director/Administrator of the facility and the Chairperson of the Board, as applicable.

**PRO-RATING
EXPENDITURES**

Where a facility has a year-end other than December 31, the facility may provide an allocation of expenditures on a straight line basis for the long-term care Annual Report that cover(s) the full period of the Annual Report, provided:

- (a) the method of allocation is disclosed; and
- (b) the allocation schedule is attached to the Annual Report.

FINANCIAL MANAGEMENT AND ADMINISTRATION
MONITORING AND REPORTING
SUBSIDY RECONCILIATION RECOVERIES

**RECOVERY OF SUBSIDY
OVER-PAYMENTS**

If upon the completion of the annual reconciliation process it is determined that a facility was over-paid with respect to the amount of provincial subsidy the Area Office will initiate recovery of such over-payment.

As a general guideline the Ministry will recover amounts of up to \$50,000 immediately following the completion of the reconciliation. However, if the facility has less than 70 beds then recoveries may be spread out over the course of the year.

Amounts in excess of \$50,000 will be recovered over a period of 3 months or as otherwise negotiated with the Area Office.

Recovery of over-payments will only take place following notification being provided to the facility.

**REIMBURSEMENT OF
SUBSIDY
UNDER-PAYMENTS**

If upon the completion of the annual reconciliation process it is determined that a facility was under-paid with respect to the amount of provincial subsidy the Area Office will initiate payment of the amount at the earliest possible date.

FINANCIAL MANAGEMENT AND ADMINISTRATION

MONITORING AND REPORTING

AD HOC REPORTS

AD HOC REPORTS

The Long-Term Care Division may request ad hoc reports. These reports may be requested when Long-Term Care Division staff need specific written information and statistics on the services and/or operations of a facility, for example:

- a concern that the services delivered by a facility are not in accordance with the provisions or intent of its service agreement
- a special study, e.g., a preferred accommodation survey or when the government wishes to undertake a study of the financial position of the long-term care industry

The form of ad hoc reports will vary according to the need. They may use existing reporting forms, or a special form or format may be requested. Under certain circumstances the Division may request that the information be audited by a licensed Public Accountant.

FINANCIAL MANAGEMENT AND ADMINISTRATION**FINANCIAL POLICIES****FINANCIAL RECORDS****FINANCIAL RECORDS**

The following records must be kept by a facility:

- 1) Complete and accurate current books of account for all transactions related to the facility in sufficient detail to allow the Ministry to reconcile provincial funding with Ministry reporting requirements.
- 2) All records of accounts including financial statements, reconciliation reports and audited financial statements of the facility must be retained for at least six years.
- 3) A separate account of transactions must be maintained for all non-arms length transactions
- 4) Records showing the amounts residents have been charged for care, programs, services or goods
- 5) Records that are sufficient to substantiate that residents have received the services and accommodation described under "basic services" and "charges - care, programs, services or goods."
- 6) The facility shall allow Ministry staff or such other persons appointed by Ontario to inspect and audit said books and records at all reasonable times.
- 7) The facility must post a copy of the service agreement, copies of the financial statements, reports and returns filed with the Minister that the regulations require to be posted, and all other documents and information that the regulations require to be to posted.

FINANCIAL MANAGEMENT AND ADMINISTRATION

FINANCIAL POLICIES

FINANCIAL RECORDS

**FINANCIAL RECORDS
(CONT'D)**

- 8) The home must maintain a list of all furnishings and equipment purchased, using funding provided by the Province in the nursing and personal care and support services envelopes, since January 1, 1995, as well as any furnishings and equipment purchased by a capital grant in all funding envelopes, showing each addition and removal and the reasons therefor.

FINANCIAL MANAGEMENT AND ADMINISTRATION

FINANCIAL POLICIES

ASSET MANAGEMENT

**LIST OF FURNISHINGS
AND EQUIPMENT**

The Ministry of Health Policy Directive PD 0401-05 details requirements for asset management. This policy is applicable to all Ministry organizational units, agencies, boards and commissions.

Under this directive Long-Term Care Facilities must maintain a list of all furnishings and equipment purchased using funding provided by the Province in the nursing and personal care and program and support services funding envelopes since January 1, 1995, as well as any furnishings and equipment purchased by a capital grant in all funding envelopes.

Items with a purchase price of less than \$500 are not required to be included in the list.

Ministry Ministère
of de
Health la Santé

Residential Services Branch
5700 Yonge Street, 7th Floor
North York ON M2M 4K5

Tel: (416) 327-7357
Fax: (416) 327-7364

December 29, 1995

MEMORANDUM TO: Long-Term Care Facility Administrators
Nursing Home Licensees
Homes for the Aged Boards of Management

FROM: Astrida Florins
Acting Director

RE: Changes in Asset Reporting and Surplus Fund Approval

This is to advise you of our decision to increase the dollar amounts on reported assets and the approval level required on surplus funds in the Nursing and Personal Care and Programming and Support Services funding envelopes.

Following a review of the recommendations presented by both the Ontario Nursing Home Association (ONHA) and the Ontario Association of Non-Profit Homes and Services For Seniors (OANHSS) to consider increases in both areas, we are implementing the following adjustments.

1. Asset Management

The Ministry of Health has a requirement for asset management applicable to all agencies funded by the Ministry. Under this policy, all long-term care facilities must maintain a list of all furnishings and equipment purchased using provincial funds in the funding envelopes for Nursing and Personal Care and Program and Support Services, or purchased through capital grants since January 1, 1995.

To date, only items with a purchase price over \$500 have been required to be included on the list. The policy has now been changed to reflect an increase in the purchase price from \$500 to \$1000 for items which must be maintained on the list.

2. Purchasing of Supplies and Equipment from Surplus Funds

The second increase applies to the approval level required for expenditures using surplus funds from the Nursing and Personal Care and/or the Program and Support Services funding envelopes.

Effective immediately a facility may use surplus funds to purchase items costing up to \$2,000 without prior approval of the Ministry. This increase doubles the previous level of \$1,000 requiring approval from the Ministry.

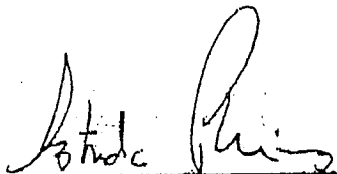
Please note that nursing homes receiving supplemental funds to provide 2.25 hours of nursing and personal care continue to be ineligible to use surplus funds for equipment in the nursing and personal care envelope.

With respect to red-circled homes for the aged, in keeping with the past practice, this also extends to purchases made in the Accommodation funding envelope. Ministry approval is still required for expenditures from surplus funds from the Accommodation envelope, with the difference that the amount has increased from \$1,000 to \$2,000.

A limit of \$400.00 per bed to a maximum of \$50,000 per facility continues to be the upper limit on total surplus funds allowed to be spent from the Nursing and Personal Care and the Program and Support Services envelopes, i.e., total amount from either one or both envelopes (not \$50,000 from each). This maximum spending limit also applies to any surplus funds from the Accommodation envelope which would be added to the total spending limit in red-circled homes for the aged.

The details of the two-above policies are set out in the Financial Section of the Long-Term Care Facility Program Manual. The Financial Section will be amended to reflect the increases in amounts; the remaining explanatory information which relates to the two processes will remain unchanged. These amendments are in effect for the fiscal year 1995/96.

Please contact your local Long-Term Care Area Office should you require further clarification.



Astrida Florins

cc: Ontario Nursing Home Association
Ontario Association of Non-Profit Homes and Services for Seniors
Area Managers, Long-Term Care Area Offices
RSB Managers

FINANCIAL MANAGEMENT AND ADMINISTRATION

FINANCIAL POLICIES

PURCHASE OF SUPPLIES AND EQUIPMENT

PURPOSE

The purpose of this section is to list the types of equipment and/or supplies that may be provided in each funding envelope. The list is not exhaustive, but outlines where various types of items will be charged.

SCHEDULING FOR PURCHASES

For the purchase and/or replacement of major equipment and supplies, it is necessary for a facility to plan for these expenditures to allow sufficient funds to be available during the coming year or, even into the next fiscal period.

Each facility will be expected to outline in the LTC Subsidy Calculation Worksheet (the “Budget”), their annual budget for equipment and the budget for supplies in each of the Nursing and Personal Care, and Program and Support Services envelopes. The facility is expected to list the equipment it plans to purchase. This plan will be reviewed and discussed during the service agreement process. After approval by the Regional Office, the facility may purchase the listed items without further approval.

USE OF SURPLUS FUNDS

Surplus funds are now calculated semi-annually. Facilities wishing to purchase equipment from surplus funds are subject to an annual limit of \$400 per bed. This limit represents the amount of surplus funds which may be applied from the Nursing and Personal Care and Program and Support Services funding envelopes.

Note: There should not be a need for large year-end surpluses, since the surplus will be anticipated earlier in the year.

If a facility has a surplus in either the Nursing and Personal Care or Program and Support Services funding envelopes, they may purchase items costing up to \$2,000 without prior approval by the Regional Office.

FINANCIAL MANAGEMENT AND ADMINISTRATION

FINANCIAL POLICIES

PURCHASE OF SUPPLIES AND EQUIPMENT

While red-circling is still in effect, red-circled homes for the aged will continue to require Ministry approval for expenditures of surplus funds totaling \$2000 or more from the Accommodation envelope.

The following conditions must be met before any purchases from surplus funds can be made in either the Nursing and Personal Care, or the Program and Support Services envelopes and later recognized during the reconciliation process:

- Use of funds must not compromise the ongoing provision of resident care i.e. staffing levels must not be reduced.
- The items will be a direct benefit to the provision of resident care. There must be prioritization of items in the overall plan for delivery of resident care.
- The purchases must be made with funding from the allotted budget for the specific envelopes, with the exception of funds from the Accommodation envelope, which may be used for purchases in any envelope and do not require prior approval.

EQUIPMENT AND SUPPLIES LIST: NURSING AND PERSONAL CARE ENVELOPE

Within the Nursing and Personal Care envelope, the facility is expected to provide a range of basic equipment and supplies to meet the majority of residents' needs.

Note: See A2.9 (0902-01) for a list of equipment and supplies which must be provided to residents at no additional cost.

*If a resident requires specialized equipment and supplies that are beyond the basic equipment and supplies the facility is required to provide, **and** the items are for dedicated personal use and are therefore not available for use by other residents, the resident is responsible for the cost of these items.*

FINANCIAL MANAGEMENT AND ADMINISTRATION

FINANCIAL POLICIES

PURCHASE OF SUPPLIES AND EQUIPMENT

Any costs incurred must be authorized in writing by the resident/representative.

Alternatives to specialized equipment for dedicated personal use should be investigated to determine the most cost-effective alternative available.

The items that may be charged to the Nursing and Personal Care component of the funding model include but are not limited to the following:

- Equipment and supplies for personal hygiene and grooming, including shower chairs
- Diagnostic equipment and supplies
- Supplies for medication administration, dressings and treatments, including but not limited to intravenous equipment and the supplies for enteral feeding; i.e. tubing and solution bags
- Supplies for creating and maintaining residents' care records, including computer hardware and software for the sole purpose of nursing and resident care service delivery

Note: If computer hardware and software will be used by staff other than in nursing services, the cost must be prorated to that other department.

- Skin protection/pressure relieving equipment and supplies
- Elimination and toilet aid supplies, including commode chairs, and excluding incontinence supplies
- Transfer and mobility aids, including lifts and slings

FINANCIAL MANAGEMENT AND ADMINISTRATION

FINANCIAL POLICIES

PURCHASE OF SUPPLIES AND EQUIPMENT

- Specialized seating items such as geriatric chairs (including reclining geriatric chairs) for general use
- Emergency equipment, such as suction equipment
- Infection control supplies

EQUIPMENT AND SUPPLIES LIST: PROGRAMS AND SUPPORT SERVICES ENVELOPE

Within the Programs and Support Services envelope, the facility is expected to provide a range of basic equipment and supplies to meet the majority of residents' needs. However, a resident may be asked to purchase an item if he/she requires specialized equipment that is beyond the basic supply and is for dedicated personal use and is therefore not available for use by other residents.

The items that may be charged to the Program and Support Services component of the funding model include but are not limited to the following:

- Therapy equipment and supplies
- Assistive feeding devices
- Recreation programs supplies and equipment
- VCRs for general resident use or for use in recreation programs
- Large screen television for general resident use
- Staff education supplies and equipment
- Supplies and equipment for the provision of spiritual and religious programs, therapy services, volunteer programs, and specialized services

Computer hardware and software for the sole provision of Program and Support Services.

FINANCIAL MANAGEMENT AND ADMINISTRATION

FINANCIAL POLICIES

PURCHASE OF SUPPLIES AND EQUIPMENT

Note: If computer hardware and software will be used by staff other than Program and Support Services staff, the cost must be prorated to that other department.

EQUIPMENT AND SUPPLIES LIST: ACCOMMODATION ENVELOPE - RAW FOOD

Charges to the Accommodation - Raw Food envelope include:

- Raw food, including approved nutritional supplements

EQUIPMENT AND SUPPLIES LIST: OTHER ACCOMMODATION ENVELOPE

The items charged to the Other Accommodation component of the funding model include the following (as well as other categories of items not specified in the Nursing and Personal Care and Programs and Support Services envelopes):

- Continence care products and supplies are included here as supplies and equipment in the laundry and linen section to cover the purchase and laundering. Continence care products that meet residents' needs for comfort and dignity are to be provided to residents without charge.

Note: Where residents who require continence care products are purchasing alternate products, this issue should be addressed through the quality management program to determine resident/representative satisfaction with the products provided without charge by the facility.

- Indoor furnishings
- Outdoor furniture, awnings
- Dietary services supplies and equipment
- Equipment and supplies for the operation and maintenance of the facility, including maintenance, laundry and housekeeping services

FINANCIAL MANAGEMENT AND ADMINISTRATION

FINANCIAL POLICIES

PURCHASE OF SUPPLIES AND EQUIPMENT

- Safety equipment, including restraints, smoking aprons for general use, plastic identification bracelets, wandering control systems, door alarms
- Bathing facilities, including therapeutic or whirlpool tubs
- Computer hardware and software.

**Ministry of Health
and Long-Term Care**

Community Health Division
Long-Term Care Homes Branch
80 Grosvenor Street
5th Floor, Hepburn Block
Queens Park
Toronto ON M7A 2C4

**Ministère de la Santé
Et des Soins de longue durée**

Division de la santé communautaire
Direction des foyers de soins de longue durée
80, rue Grosvenor
5^e étage, édifice Hepburn
Queens Park
Toronto ON M7A 2C4



Date: Monday, April 25, 2005

MEMORANDUM TO: Administrators of Long-Term Care Homes

FROM: Tim Burns
Director, Long-Term Care Homes Branch

RE: Purchasing Security Cameras with NPC Funds

It has come to the ministry's attention that some LTC homes are using funds from the Nursing and Personal Care (NPC) or Programming and Support Services (PSS) envelopes for the purchase and installation of security and surveillance cameras.

This is not an eligible expenditure within the NPC or PSS envelopes. Building security costs / equipment, as all 'equipment and supplies for the operation and maintenance of the home' should be purchased from the Other Accommodation envelope as per Section 0606-03 of the Long-Term Care Program Manual.

In addition, please be reminded that you **MUST** obtain regional office approval **prior** to purchasing any equipment costing over \$3000 from the NPC or PSS envelopes.

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Burns", written over the word "Sincerely,".

Tim Burns
Director, Long-Term Care Homes Branch

cc. Donna Rubin, Chief Executive Officer, Ontario Association of Non-Profit Homes and Services for Seniors
Karen Sullivan, Executive Director, Ontario Long Term Care Association
Donna Pier Falotico, Divisional Finance Manager
Regional Program Managers

FINANCIAL MANAGEMENT AND ADMINISTRATION**FINANCIAL POLICIES****DISPOSITION OF FURNISHINGS AND EQUIPMENT****DISPOSITION OF
FURNISHINGS AND
EQUIPMENT**

Records detailing the disposition of furnishings and equipment must be maintained and include date of disposition, proceeds, original purchase price and Provincial share of cost, and purchaser (if related party or non-arms length transaction) and such other information as is necessary to ensure an adequate audit trail. This policy applies to furnishings and equipment purchased in the nursing and personal care and program and support services funding envelopes since January 1, 1995, as well as any furnishings and equipment purchased by a capital grant in all funding envelopes. This policy only applies to those items where Ontario has contributed to the original purchase price.

Where Ontario had contributed to the original purchase price of disposed furnishings and equipment, the percent share of Ontario's contribution must be applied to the proceeds and credited to the Levels-of-Care funding envelope that reflects the disposed asset. The relevant amount should be recorded as an Expenditure Recovery under that Levels-of-Care Component.

Where Ontario has not contributed to the original purchase price of the disposed asset, the proceeds will be treated as non-recoverable revenue.

Where assets are disposed of as a trade-in to purchase of similar or like assets, the fair market value should be recorded as the disposition amount and be treated the same as assets that have no replacement as detailed in the previous paragraphs.

Where Ontario has an interest, no assets may be disposed of without the prior written consent of Ontario.

Where Ontario has an interest, all assets disposed of must be disposed of at fair market value.

This policy does not apply to items with a purchase price of less than \$500.

Residential Services Branch
5700 Yonge Street, 7th floor
North York ON M2M 4K5

Phone: (416) 327-7352
Fax: (416) 327-7364

November 28, 1996

TO: Long-Term Care Facility Administrators
Nursing Home Licensees
Homes for the Aged Boards of Management/Boards of Directors

FROM: Sandy Knipfel
Acting Director, Residential Services Branch

RE: Ministry Subsidy for Residents Who Pay Less Than the Regulated
Maximum Basic Accommodation Fee

Please find attached a copy of the Ministry of Health's policy on accommodation envelope subsidies for residents who pay less than the regulated maximum basic accommodation fee. This policy will be inserted into the "Financial Policies" section of the LTC Facility Program Manual, as Section 0606-05, Accommodation Subsidy for Rate Reductions.

In accordance with the regulations related to maximum resident charges for accommodation, a facility may charge:

- a) the maximum rate for long-stay or short-stay residents;
- b) the income tested reduced rate for long-stay residents or the exceptional circumstances rate; or
- c) a discretionary amount, less than either of the above amounts, which is subsidized entirely at the facility's own expense.

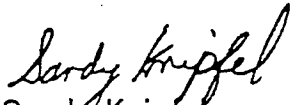
Under the previous accommodation subsidy policy, if a resident paid less than the maximum rate, the Ministry subsidized the difference between the amount charged and the guaranteed accommodation per diem (currently \$38.87). Effective January 1, 1996, the Ministry of Health no longer subsidizes a discretionary rate reduction, namely the amount indicated in c) above.

The Ministry subsidizes the difference only between the guaranteed accommodation per diem and the income tested reduced rate for long-stay residents. Also, if the resident is eligible for an exceptional circumstance rate reduction, the Ministry subsidizes the difference between the guaranteed accommodation per diem and the exceptional circumstance resident charge approved by the local Long-Term Care Manager. Any further reduction in the rate which is less than the income tested amount or, in the case of exceptional circumstance reductions, less than the amount authorized by the local Long-Term Care Manager, is not subsidized by the Ministry of Health.

The technical instructions and guidelines for the year end reconciliation report for 1996 will be amended to reflect this policy.

Should you have any questions, please contact the Finance Manager in your local Long-Term Care Office.

Yours sincerely,



Sandy Knipfel
Acting Director

cc: Ontario Nursing Home Association
Ontario Association of Non-Profit Homes and Services for Seniors
Ontario Association of Residents' Councils
Association of Municipalities of Ontario
Association of Placement Coordination Services of Ontario
SEIU, OPSEU, CUPE, UFCW, USWA, CLAC, ONA, OFL, HSTAP
Area Managers, Long-Term Care Offices
RSB Managers

FINANCIAL MANAGEMENT AND ADMINISTRATION

FINANCIAL POLICIES

SUBSIDY FOR BASIC ACCOMMODATION RATE REDUCTIONS

INTRODUCTION

The regulations under long-term care facility legislation set maximum rates for basic accommodation. A reduced rate, either the reduced income tested rates or the Ministry authorized exceptional circumstances rate, may be paid by a resident in a long-stay bed who does not have sufficient income to pay the maximum. The reduced income tested rate or the Ministry authorized exceptional circumstances rate is determined in accordance with policies defined in section 0607-03 of the Long-Term Care Facilities Program Manual. There is no rate reduction for short stay residents.

MAXIMUM AND DISCRETIONARY CHARGES

As the regulations set the maximum rates for accommodation, a facility may charge:

- a) the maximum rate for long-stay or short-stay residents;
- b) the income tested reduced rate or the exceptional circumstances rate for long-stay residents; or
- c) a discretionary amount less than either of the above amounts, which is subsidized entirely at the facility's own expense.

SUBSIDY FOR REDUCED ACCOMMODATION CHARGES

The following policy clarifies how the Ministry calculates the subsidy in the accommodation envelope for people who pay less than the maximum regulated rate, depending upon whether the facility charges the amount indicated in b) or c) above.

The Ministry's subsidy for people who pay less than the maximum rate is equal to the guaranteed per diem in the accommodation envelope minus

amount b) above (the income tested reduced rate or the exceptional circumstances rate for long-stay residents). The Ministry does not subsidize discretionary rate reductions for short-stay residents (including crisis care), or residents who do not qualify for an income tested rate reduction.

**INCOME TESTED
RESIDENTS**

When a resident has been income tested for payment of a specified amount, it is Ministry policy that the resident will be charged the income tested amount. The Ministry will subsidize the difference between the income tested rate and the guaranteed per diem in the accommodation envelope.

**EXCEPTIONAL
CIRCUMSTANCE RATE
REDUCTIONS**

If a resident is eligible for a rate reduction in accordance with the Application for a Rate Reduction in Basic Accommodation Fees-Exceptional Circumstances (form issued in September/1995), the Ministry will subsidize only the difference between the rate approved by the local LTC Area Manager and the guaranteed amount in the accommodation envelope.

**DISCRETIONARY RATE
REDUCTIONS**

The Ministry will not subsidize any additional or discretionary rate reduction beyond the amount that is determined in accordance with the income test or the exceptional circumstance rate authorized by the LTC Area Manager.

**SUBSIDY FOR BAD
DEBTS**

Bad debts will be subsidized by the Ministry in accordance with the bad debt funding policy, as described in the "Resident Charges" section of the LTC Facility Program Manual, Section 0607-10, Bad Debts.

If a facility chooses to charge a resident who is entitled to a rate reduction an amount less than the income tested amount, only the difference between the amount charged and the amount collected will be eligible for the bad debt subsidy.

If a facility chooses to charge a resident who is entitled to an exceptional circumstances rate an

amount less than the amount approved by the LTC Area Manager, the Ministry will only consider the difference between the amount charged and the amount collected as eligible for the bad debt subsidy.

If a facility chooses to charge a resident who is not eligible for a rate reduction an amount less than the maximum basic accommodation rate specified in the regulations, the Ministry will only consider the difference between the amount charged and the amount collected as eligible for the bad debt subsidy.

**APPLICATION TO LONG
STAY PROGRAM AND
BED RETENTION**

This policy applies to resident co-payments for the long-stay program and resident payments for bed retention.

**REPORTING
REQUIREMENTS**

The reporting requirements related to this policy will take effect with the 1996 Long-Term Care Facility Annual Report, the 1996 Year End Reconciliation Report, and with the subsequent Long-Term Care Facility Semi-Annual Report, and the associated Technical Instructions and Guidelines.

FINANCIAL MANAGEMENT AND ADMINISTRATION

FINANCIAL POLICIES

ACCRUAL OF RETROACTIVE SALARY AWARDS

RETROACTIVE SALARY ACCRUAL POLICY

In general, the current modified cash basis of accounting policy allows for accruals of expenditures that are paid within 30 days of the reporting year end. However, salary awards and settlements are often made for periods of 1 year or more and on a retroactive basis.

Under Levels of Care funding salary settlements may be accrued from one financial period to another in order to avoid the recovery of surplus funding.

This policy is intended to provide Long-Term Care facilities with the flexibility to accrue funding that is under-spent in the Nursing and Personal Care and Program and Support Service funding envelopes beyond the 30 day period as specified by the Modified Cash Basis of Accounting.

Facilities are required to complete the Accrual of Retroactive Salaries Verification Schedule and return to the Long-Term Care Area Office. This schedule must be certified by an auditor for reasonableness. The facility will maintain a statement of this account which will be readjusted annually to reflect any settlements that may have occurred.

EXAMPLES OF HOW POLICY OPERATES

Over-accrual of retroactive salaries/budget target met:

- accrual of \$20,000 at year end;
- actual expenses without accrual are \$80,000
- approved Nursing and Personal Care is \$100,000
- final actual salaries are only \$15,000 resulting in an over-accrual of \$5,000

Result in current fiscal year is that there is no recovery of surplus and the home keeps the full \$100,000.

FINANCIAL MANAGEMENT AND ADMINISTRATION

FINANCIAL POLICIES

ACCRUAL OF RETROACTIVE SALARY AWARDS

In the following fiscal year the salary accrual account would indicate a surplus of \$5,000 (assuming no additional retroactive salary awards are accrued as most arbitrations cover more than 1 year).

Expenses in the second year would be \$90,000 made up of:

- \$95,000 current year (\$80,000 plus \$15,000 additional new cost)
- less \$5,000 over-accrual from prior year

A recovery of \$10,000 would be made (\$5,000 under-spending for current year and \$5,000 over-accrual from prior year).

Over the two years the home would receive \$190,000 against actual expenses of \$190,000.

Under-accrual of retroactive salaries/budget target met:

- Accrual of \$15,000 at year end;
 - actual expenses without accrual are \$85,000
 - approved Nursing and Personal Care is \$100,000
 - final actual salaries are \$20,000 resulting in an under-accrual of \$5,000

Result in current fiscal year is that there is no recovery of surplus.

In the following fiscal year the salary accrual account would indicate an expense of \$5,000 from the prior fiscal year's under-accrual.

FINANCIAL MANAGEMENT AND ADMINISTRATION**FINANCIAL POLICIES****ACCRUAL OF RETROACTIVE SALARY AWARDS**

Assuming no inflation or expansion of program, expenses would be \$105,000 for second year, plus \$5,000 for the under-accrual, for a total of \$110,000 with a budget of \$100,000. No additional funding would be paid for the \$10,000 shortfall, however, \$5,000 of it was paid the prior year. The home would need to absorb the net \$5,000 shortfall the second year.

- During the two years the home would receive \$200,000 against actual expenses of \$210,000. The home could not be paid for costs over the budget of \$200,000.

JUL 06 2005

MEMORANDUM TO: Administrators of Long-Term Care Homes

FROM: Tim Burns
Director, Long-Term Care Homes Branch

RE: **In-Year Occupancy-Based Recovery Process**

This memorandum is to provide you with an outline of the in-year occupancy-based recovery process being implemented by the Ministry. The objective of this new process is to improve the use of program funds by recovering surplus funding over the course of the year rather than recovering the funds only upon the completion of the annual reconciliation report.

Details of the in-year occupancy-based recovery process are as follows:

- The Ministry will continue to use the current Revenue-Occupancy Reporting process, already familiar to you, to determine occupancy levels on a home by home basis. In October 2005, all homes will be required to report actual resident days and actual basic resident revenue for the period of January 1, 2005 to September 30, 2005.
- Using the revenue and occupancy data provided by LTC homes, the Ministry will calculate the occupancy for the period and calculate an interim recoverable amount if applicable. This amount will be adjusted for any funding eligible under the Short Term Sustainability Grant Program, Transitional Support Program, and/or the Occupancy Based Funding Program
- The Ministry will notify homes of the interim amount recoverable, if any, and will initiate recoveries starting in November 2005. (As per current practice, the Ministry may recover amounts under \$50,000 immediately following the interim reconciliation. Amounts over \$50,000 will usually be recovered over 3 months or as otherwise negotiated with the Regional Office.)

- In January 2006, a second Revenue-Occupancy report will be issued to assess actual resident days and basic resident revenue for the period of January 1, 2005 to December 31, 2005.
- The Ministry will make all necessary adjustments when determining interim occupancy levels (for outbreaks, changes in capacity, etc).
- Please note that all homes will still be required to complete the Annual Reconciliation Report.

Thank you in advance for your cooperation in implementing this new process.

Sincerely,



Tim Burns
Director, Long-Term Care Homes Branch

- c. Karen Sullivan, OLTC
Donna Rubin, OANHSS
George Zegarac, Assistant Deputy Minister, Community Health Division
Regional Directors, Community Health Division
Regional Senior Financial Analysts

DATE: November 23, 2005

MEMORANDUM TO: Operators of Long-Term Care Homes

FROM: Tim Burns
Director, Long-Term Care Homes Branch

RE: **Re: In-Year Recoveries/Occupancy Based Funding Program**

Further to my memorandum dated July 6, 2005, I am writing to remind you of the new in-year occupancy-based recovery process that the ministry is implementing in December 2005.

As stated in my previous memorandum, which contained the details of the new process, the objective of the new in-year recovery process is to improve the use of program funds by recovering surplus funding over the course of the year rather than upon the completion of the Annual Reconciliation Report. The amount to be recovered by the ministry will be adjusted for any funding eligible under the Short-Term Sustainability Grant and/or the Occupancy Based Funding Programs.

The ministry will notify homes of the amount recoverable, if any, and recoveries will commence in December 2005. A second recovery may occur in February 2006 based on the occupancy rate for the entire 2005 calendar year. All in-year recoveries are interim. Final recoveries are subject to the annual reconciliation process.

Thank you for your cooperation in implementing this new process.

Sincerely,



Tim Burns
Director, Long-Term Care Homes Branch

- c. John McKinley, Assistant Deputy Minister, Community Health Division
- Karen Sullivan, Executive Director, OLTCA
- Donna Rubin, Chief Executive Officer, OANHSS
- Regional Directors, MOHLTC

**Ministry of Health
and Long-Term Care**

Community Health Division
Long-Term Care Homes Branch
80 Grosvenor Street
5th Floor, Hepburn Block
Queens Park
Toronto ON M7A 2C4

**Ministère de la Santé
Et des Soins de longue durée**

Division de la santé communautaire
Direction des foyers de soins de longue durée
80, rue Grosvenor
5^e étage, édifice Hepburn
Queens Park
Toronto ON M7A 2C4



March 31, 2005

MEMORANDUM TO: Operators of Long-Term Care Homes

FROM: Tim Burns
Director, Long-Term Care Homes Branch

RE: **Re: 2005 Occupancy Based Funding Program**

I am writing to inform you about the new Occupancy Based Funding (OBF) Program, which will take effect on April 1, 2005, replacing the Short-Term Sustainability Grant Program. I want to emphasize that one of our primary objectives for this program is to fund at actual occupancy levels but provide an additional 3% in funding to help eligible homes focus on retaining staff.

The application documents are being prepared and will be available to you shortly. However, I want to provide you with some of the following key elements of the new OBF Program:

- As with the Sustainability Program, OBF will be available to long-term care (LTC) homes with "B", "C", and redeveloping "D" class beds.
- For 2005, OBF shall be effective from April 1, 2005, to December 31, 2005. In order to be eligible, operators must apply and, if approved, agree to comply with the program's terms and conditions.
- Operators wishing to be eligible for enrollment effective from April 1, 2005, will – upon the Ministry's release of the application documents – have four weeks to submit their application to the Ministry. If an application is received after this period, registration in the program will commence from the date the Ministry receives the application.

- Homes in the OBF Program will be eligible to retain Ministry funding based on their actual occupancy plus 3%. The 3% additional funding will be allocated to the funding envelopes based on the following split for the period April 1, 2005, to December 31, 2005:
 - Nursing and Personal Care, 75%
 - Program and Support Services, 7%
 - Other Accommodation, 18%.
- For 2005, LTC homes will continue to receive advance cash flow from the Ministry based on 100% occupancy. (Homes may elect to receive less than a 100% initial cash flow to more accurately reflect their current occupancy levels and to reduce the impact of recovery).
- Under the OBF Program, the first interim recovery of the Ministry's advanced cash flow for occupancy purposes will occur in November 2005, and will cover the period January 1, 2005, to September 30, 2005. A second interim recovery will occur at the end of December based on the occupancy rate for the entire 2005 calendar year.
- The Revenue/Occupancy Reporting process will be used as the primary reporting mechanism to determine occupancy levels for recoveries. Under the OBF Program, the 3% additional funding will be calculated at the time when each recovery amount is determined. The additional 3% funding will be an offset against any recoveries of Ministry funding based on occupancy.
- OBF will continue to be funded based on actual occupancy plus 3% for 2006. However, the Ministry will be evaluating the program later in the year to re-assess how the 3% additional funding will be allocated to the funding envelopes for 2006. Any changes to the OBF Program will be effective for January 2006.

I hope this addresses some of your concerns about the new OBF program until the application documents and the full terms and conditions are available.

Sincerely,



Tim Burns

Director, Long-Term Care Homes Branch

**Ministry of Health
and Long-Term Care**

Community Health Division
Long-Term Care Homes Branch
80 Grosvenor Street
5th Floor, Hepburn Block
Queens Park
Toronto ON M7A 2C4

**Ministère de la Santé
Et des Soins de longue durée**

Division de la santé communautaire
Direction des foyers de soins de longue durée
80, rue Grosvenor
5^e étage, édifice Hepburn
Queens Park
Toronto ON M7A 2C4



May 24, 2005

MEMORANDUM TO: Operators of Long-Term Care Homes

FROM: Tim Burns
Director, Long-Term Care Homes Branch

RE: **2005 Application Form - Occupancy Based Funding Program**

Further to my memorandum of March 31, 2005, eligible operators wishing to enroll in the new Occupancy Based Funding (OBF) Program Occupancy for 2005 must agree to comply with the program's terms and conditions, as per the attached 2005 application form. The application form is available on the www.facilities.net web-site. Alternatively, call Joanne Gosling at 416-326-8887 who can forward you a copy.

Eligible operators wishing to be eligible for enrollment effective from April 1, 2005, must complete and return the application form to the address below by June 30, 2005. If your application is received after June 30, 2005, and you are eligible for enrollment, your registration will commence from the date the Ministry received your application.

Please submit your completed application form to the following address:

**Community Health Division
Long-Term Care Homes Branch
Homes Support Unit
4th Floor, 5700 Yonge Street
Toronto ON M2M 4K5
Attention: Joanne Gosling**

As I mentioned in my March 31, 2005 memo, our primary objective for the OBF program is to fund at actual occupancy levels but provide an additional 3% in funding to help eligible homes focus on retaining staff.

To reiterate, some of the key elements of the OBF Program are:

- As with the Sustainability Program, OBF will be available to long-term care (LTC) homes with "B", "C", and redeveloping "D" class beds.
- In order to be eligible, operators must apply and, if approved, agree to comply with the program's terms and conditions.
- Homes in the OBF Program will be eligible to retain Ministry funding based on their actual occupancy plus 3%. The 3% additional funding will be allocated to the funding envelopes based on the following split for the period April 1, 2005, to December 31, 2005:
 - Nursing and Personal Care, 75%
 - Program and Support Services, 7%
 - Other Accommodation, 18%.
- For 2005, LTC homes will continue to receive advance cash flow from the Ministry based on 100% occupancy.
- Under the OBF Program, the first interim recovery of the Ministry's advanced cash flow for occupancy purposes will occur in November 2005, and will cover the period January 1, 2005, to September 30, 2005. A second interim recovery will occur at the end of December based on the occupancy rate for the entire 2005 calendar year.
- The Revenue/Occupancy Reporting process will be used as the primary reporting mechanism to determine occupancy levels for recoveries. Under the OBF Program, the 3% additional funding will be calculated at the time when each recovery amount is determined. The additional 3% funding will be an offset against any recoveries of Ministry funding based on occupancy.

If you have any questions please call Joanne Gosling, OBF Program Registration, at (416) 326-8887.

Sincerely,



Tim Burns
Director, Long-Term Care Homes Branch

c: Donna Rubin, Chief Executive Officer, OANHSS
Karen Sullivan, Executive Director, OLTCA

**Ministry of Health
and Long-Term Care**

Community Health Division
Long-Term Care Homes Branch
56 Wellesley Street West, 9th Floor
Toronto ON M7A 2JA

**Ministère de la Santé
Et des Soins de longue durée**

Division de la santé communautaire
Direction des foyers de soins de longue durée
56, rue Wellesley Ouest, 9^e étage
Toronto ON M7A 2JA



DATE: December 13, 2005

MEMORANDUM TO: Operators of Long-Term Care Homes

FROM: Tim Burns
Director, Long-Term Care Homes Branch

RE: **2006 Occupancy Based Funding Program**

This is to remind homes that the 2005 Occupancy Based Funding (OBF) Program expires on December 31, 2005. The 2006 OBF Program information and application documents will be available early in 2006.

Although the application documents for the 2006 OBF Program will not be available prior to January 1, 2006, the program will be retroactive to January 1, 2006.

Our primary objective for the OBF Program is to fund at actual care levels but provide an additional 3% in funding to help eligible homes focus on retaining staff.

Again, we will provide you with more information about the 2006 OBF Program in the New Year.

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Burns", written over a horizontal line.

Tim Burns
Director, Long-Term Care Homes Branch

- c. John McKinley, Assistant Deputy Minister, Community Health Division
- Karen Sullivan, Executive Director, OLTC
- Donna Rubin, Chief Executive Officer, OANHSS

FEB 2 1 2006

MEMORANDUM TO: Operators of Long-Term Care Homes

FROM: Tim Burns
Director, Long-Term Care Homes Branch

RE: **2006 Occupancy Based Funding Program – Application Form**

I am writing to inform you about the 2006 Occupancy Based Funding (OBF) program which will be retroactive to January 1, 2006. Registrations under the 2005 OBF program expired on December 31, 2005.

Eligible operators wishing to enroll in the OBF program for 2006 must agree to comply with the program's terms and conditions, as per the attached 2006 application form. The application form is also available on the www.ltchomes.net website. Alternatively, please call Joanne Gosling at 416-326-8887 who can forward you a copy.

Operators wishing to be eligible for enrollment effective January 1, 2006 must complete and return the application form to the following address by March 31, 2006:

**Community Health Division
Long-Term Care Homes Branch
Homes Support Unit
4th Floor, 5700 Yonge Street
Toronto ON M2M 4K5
Attention: Joanne Gosling**

If your application is received after March 31, 2006, and you are eligible for enrollment, your registration will commence from the date the ministry received your application.

I want to emphasize that one of our primary objectives for this program is to fund at actual care levels but provide an additional 3% in funding to help eligible homes focus on retaining staff.

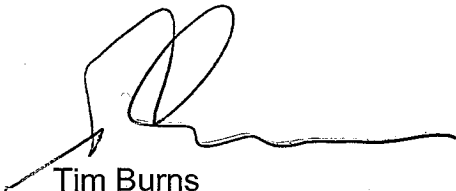
To reiterate, some of the key elements of the OBF program are:

- The 2006 OBF program will be available to LTC homes with "B", "C", and redeveloping "D" class beds.

- In order to be eligible, operators must apply and, if approved, agree to comply with the program's terms and conditions.
- Homes in the OBF Program will be eligible to retain Ministry funding based on their actual occupancy plus 3%. The 3% additional funding will be allocated to the funding envelopes based on the following split for the period January 1, 2006, to December 31, 2006:
 - Nursing and Personal Care, 75%
 - Program and Support Services, 7%
 - Other Accommodation, 18%.
- Under the OBF Program, the first interim recovery of the Ministry's advanced cash flow for occupancy purposes for 2006 will occur in December 2006, and will cover the period January 1, 2006, to September 30, 2006. A second interim recovery will occur in March 2007 based on the occupancy rate for the entire 2006 calendar year.
- The Revenue/Occupancy Reporting process will be used as the primary reporting mechanism to determine occupancy levels for recoveries. Under the OBF Program, the 3% additional funding will be calculated at the time when each recovery amount is determined. The additional 3% funding will be an offset against any recoveries of Ministry funding based on occupancy.

If you have any further questions, please call Joanne Gosling, OBF program registration, at 416-326-8887.

Sincerely,



Tim Burns
Director, Long-Term Care Homes Branch

- c. John McKinley, Assistant Deputy Minister, Community Health Division
Karen Sullivan, Executive Director, OLTCA
Donna Rubin, Chief Executive Officer, OANHSS

OCCUPANCY BASED FUNDING PROGRAM APPLICATION

2006 APPLICATION FORM

PROVIDER INFORMATION

	Name: (Registered and/or legal name) (the "Provider")	
Contact (for this application)		
	Name:	
	Title:	
	Mailing Address:	
	City:	
	Postal Code:	
	Contact Phone #:	() -
	Fax #:	() -

HOME INFORMATION

FMIS # and LTCID #	
Name of Home (Registered Legal Name)	
Date Home Opened	(Month, day, year)
Street Address (physical location):	
City:	
Name of Administrator	
Phone # for Administrator	() -

Indicate the classification of the Home and the number of beds (**not** rooms) by type in the form below. If the Home has different classifications (multi-class homes), please provide the bed number breakdowns for each separately classified section of the Home.

Home (or Section 1 of the Home) Classification	B: <input type="checkbox"/> C: <input type="checkbox"/> D: <input type="checkbox"/>
# Private Beds	# Basic Beds
# Semi-private Beds	# of RHAs or RCUs

Section 2 of the Home Classification (if applicable)	B: <input type="checkbox"/> C: <input type="checkbox"/> D: <input type="checkbox"/> A: <input type="checkbox"/>
# Private Beds	# Basic Beds
# Semi-private Beds	# of RHAs or RCUs

Section 3 of the Home Classification (if applicable)	B: <input type="checkbox"/> C: <input type="checkbox"/> D: <input type="checkbox"/> A: <input type="checkbox"/>
# Private Beds	# Basic Beds
# Semi-private Beds	# of RHAs or RCUs

Total # of Long-stay Beds (excluding ELD CAP, Short-stay, Interim Beds & Beds in Abeyance)
--

# Interim Beds	# Beds in Abeyance
# Short Stay Beds	# ELD CAP Beds

of Beds in Home:
of Beds in Home Occupied as of the date of this Application:

Terms and Conditions of the Occupancy Based Funding Program
Application Outline, 2006

All Funding awarded by the Ministry is governed by terms and conditions. The general terms and conditions governing Funding awarded under the **Occupancy Based Funding Program (OBFP)** are contained in this Application. By signing this Application, the Provider agrees to be bound by these general terms and conditions.

In addition to these terms and conditions, the Ministry may specify some other terms and conditions which will be contained in subsequent correspondence from the Ministry. To continue to be eligible for Funding, the Provider will be required to agree to those terms and conditions by signing and returning that correspondence to the Ministry. Once the Provider signs that correspondence, the contents of the correspondence will form part of the terms and conditions governing the Funding herein.

All Funding applications submitted to the Ministry are subject to the *Freedom of Information and Protection of Privacy Act*, as amended (the "**Act**"). The Act provides every person with a right of access to information in the custody or under the control of the Ministry, subject to a limited set of exemptions. One such exemption is set out in section 17 of the Act which relates to information that reveals a trade secret or scientific, technical, commercial, financial or labour relations information supplied in confidence, where the disclosure could reasonably be expected to result in certain harms ("**Third Party Information**").

If a Provider believes that any of the information contained in its Application or otherwise submitted to the Ministry in connection with the Funding reveals Third Party Information, and the Provider (or another party to whom the information relates) wishes to protect the confidentiality of such information, this Third Party Information should be clearly marked as confidential. Before the Ministry grants a request for access to a record that it has reason to believe might contain such information, the Ministry will use commercially reasonable efforts to notify the Provider so that it may, if it so chooses, make representations concerning the disclosure.

The Provider is advised that the names and addresses of Funding recipients, the amount of Funding awards, and the purpose for which Funding is awarded is information that will be made available by the Ministry to the public.

Copies of the Act are available from Publications Ontario at 880 Bay Street, Toronto, ON M7A 1N8, telephone (416) 326-5300 or 1-800-338-9938 or at E-laws at www.e-laws.gov.on.ca.

1.0 Definitions

1.1 In this Application the following words shall have the following meanings unless the context requires otherwise:

- (a) **“Application”** means this completed and executed Occupancy Based Funding Program Application made by the Provider and includes: (i) the terms and conditions stated herein; (ii) the information contained in the Application Form on page 1 and the Application Outline on page 2 of this Application which are hereby incorporated into this Application as terms and conditions hereof, (iii) the Provider’s Certificate attached hereto as Schedule “A”, and (iv) any instrument amending this Application;
- (b) **“Applicable Law”** means all statutes, regulations, orders, approvals, licenses, guidelines, policies, manuals and codes of the Province of Ontario, and, where applicable, the federal government, related to a long-term care homes, including the *Charitable Institutions Act*, the *Homes for the Aged and Rest Homes Act*, and the *Nursing Homes Act*, all as amended;
- (c) **“CCAC”** means a Community Care Access Centre as defined in the *Community Care Access Corporations Act, 2001*, as amended which is the placement co-ordinator designated for the Home under the *Charitable Institutions Act*, the *Homes for the Aged and Rest Homes Act*, or the *Nursing Homes Act*;
- (d) **“Convalescent Care Program”** means the program announced by the MOHLTC on February 10, 2005 which supports additional care to be provided for individuals in acute care facilities who need to recover the strength and functioning to return home;
- (e) **“Director”** means the Director appointed for the purposes of the *Charitable Institutions Act*, the *Homes for the Aged and Rest Homes Act* or the *Nursing Homes Act*;
- (f) **“ELDCAP Beds”** means any beds at a Home that is listed in Schedule 1 of Regulation 832 under the *Nursing Homes Act*;
- (g) **“Excluded Beds”** means:
 - (i) any beds in a Home or any part thereof that is classified as an “A” Home;
 - (ii) any beds in a Home or any part thereof that is classified as a “D” Home where the requirements of Section 3.1(b) are not met;

- (iii) any ELDCAP Beds;
- (iv) any beds at the Home that are used for a short-stay program under Applicable Law, including the Convalescent Care Program; or
- (v) any beds in abeyance at the Home;
- (h) **“Funding”** means the funding provided to the Provider by the Ministry pursuant to the Occupancy Based Funding Program in respect of the occupied beds at the Home that has been registered with the Ministry, other than Excluded Beds;
- (i) **“Home(s)”** means the Long-Term Care Home of the Provider which is operated under the Applicable Law and which is named in the Application Form;
- (j) **“Interim Beds Program”** means the program announced by the MOHLTC on February 10, 2005 which facilitates the discharge of hospital patients to Long-Term Care Homes in communities with long-term care bed shortages;
- (k) **“Long-Term Care Home”** means an approved charitable home for the aged under the *Charitable Institutions Act*, a home under the *Homes for the Aged and Rest Homes Act* or a nursing home under the *Nursing Homes Act*;
- (l) **“Ministry”** means Her Majesty the Queen in right of Ontario as represented by the Minister of Health and Long-Term Care;
- (m) **“Personal Information”** means personal information as defined in the *Freedom of Information and Protection of Privacy Act* R.S.O.1990, c. F-31, as amended;
- (n) **“Provider”** means the person named as the Provider on the Application Form which is approved or licensed under Applicable Law to operate the Home;
- (o) **“Reconciliation”** means the end of year reconciliation process and any related interim recoveries as set out in a Service Agreement;
- (p) **“Registration Date”** means the date the Ministry receives the Application from the Provider to register the Home under the Occupancy Based Funding Program, according to the date stamp of the Ministry, if the Ministry registers the Home pursuant to Section 2.2;

- (q) **“Service Agreement”** means the service agreement for each calendar year between the Ministry and the Provider in respect of the Home as described by the Applicable Law;
- (r) **“Transition Support Program”** means the Ministry program and related Guidelines launched in January, 2002 in respect of the “2002 D Bed Program”;
- (s) **“Waiting List”** means a waiting list kept by the CCAC for the Home pursuant to Applicable Law.

1.2 Unless the context requires otherwise, a word or phrase that is used in this Application shall have the same meaning as the word or phrase is defined or used in the *Charitable Institutions Act*, the *Homes for the Aged and Rest Homes Act* or the *Nursing Homes Act* and related regulations.

2.0 Timing of Submission of Application and Registration of the Home

2.1 By submitting this Application to the Ministry, the Provider makes an application for the Home to be registered under the Occupancy Based Funding Program and agrees to comply with the terms and conditions set out herein in respect of the Home applied for herein.

2.2 After receiving the Application from the Provider, the Ministry shall register the Home under the Occupancy Based Funding Program if the criteria set out in Article 3.0 are met. The Ministry shall notify the Provider in writing as soon as practicable of its determination of the registration of the Home.

2.2.1 Despite the foregoing or anything else contained herein to the contrary, the Provider shall submit the Application to the Ministry for approval within four (4) weeks from the date the Ministry first publicly makes this Application available, in which case, the Ministry shall consider the Home’s registration as being effective from January 1, 2006.

2.2.2 Where the Provider submits the Application to the Ministry for approval after four (4) weeks from the date the Ministry first publicly makes this Application available, the Ministry shall consider the Home’s registration as being effective on the date the Ministry receives the Provider’s Application and Funding, if any, will be adjusted to reflect the Home’s shorter term within the Occupancy Based Funding Program.

3.0 Registration Criteria

3.1 The Home shall be registered under the Occupancy Based Funding Program if:

- (a) the Home or any part thereof is classified as,
 - (i) a “B” home;
 - (ii) a “C” home; or
 - (iii) a “D” home;provided that the Home in either (i), (ii) or (iii) above is not enrolled in the Interim Beds Program.
- (b) in respect of a Home or any part thereof that is classified as a “D” home where,
 - (i) the Provider has entered into with the Ministry and is in compliance with a Development Agreement or a Memorandum of Understanding to redevelop the “D” Home; or
 - (ii) the Provider has entered into with the Ministry and is in compliance with an Upgrade Agreement to upgrade the “D” Home, and the Ministry has approved the Upgrade Plan;
- (c) in the discretion of the Ministry, the Provider materially complies with the Service Agreement and Applicable Law in respect of the Home; and
- (d) the Home has not previously been registered under the Occupancy Based Funding Program in 2006, and the Provider has terminated or the Home has had its registration terminated in 2006 for any reason.

3.2 Despite Section 3.1 above, the Home shall not be registered or continue to be registered under the Occupancy Based Funding Program if:

- (a) the Home’s Provider has failed to comply with Ministry reporting requirements, including but not limited to, the Annual Reports, Staffing Reports and those contained in the Service Agreement all as required by Applicable Law;
- (b) the Home has citations from 2005 or 2006 for non-compliance matters that have not been rectified to the Ministry’s satisfaction, arising in respect of:
 - (i) Section A1.11 (Resident’s Rights) of the Long-Term Care Facility Program Manual; or
 - (ii) Any Applicable Laws.

- (c) The Home's admissions were suspended by the Ministry due to compliance issues in either 2005 or 2006 and the home has not corrected all related compliance issues and has not had its operations reinstated by the Ministry;
- (d) Since 2003, the Home underwent an inspection and/or audit that evidenced irregularities or potential irregularities, as determined in the Ministry's sole discretion, involving the misallocation of Ministry or resident funding/monies.
 - (i) Despite the foregoing, Homes that are currently being inspected and/or audited by the Ministry may apply for Funding except that no amounts will be paid to the Home under the Occupancy Based Funding Program until the Ministry has received 2005 audited financial statements for the Home and the Ministry is satisfied in its sole discretion, that the inspection and/or audit findings do not trigger the application of subsection (d) above.

3.3 Despite section 3.1, the Minister shall not register a Home in 2006 until the Provider has submitted to the Ministry:

- (a) audited and completed Annual Reconciliation Reports for this Home for 2004; and
- (b) the January 2006 Revenue Occupancy Report for this Home.

3.4 Despite section 3.1, the Minister shall terminate the registration of a Home subject to Section 12.0 if the Provider has not provided to the Minister by the deadline set by the Ministry the following:

- (a) an audited and completed Annual Reconciliation Report for this Home for 2004 and an audited and completed Annual Reconciliation Report for this Home for 2005 if requested by the Ministry;
- (b) any Revenue Occupancy Report for this Home requested by the Ministry for 2006; and
- (c) such other future Revenue Occupancy Reports within timelines set by the Ministry.

4.0 Eligibility Criteria for Funding

4.1 After the Registration Date, to be eligible for Funding, the Provider shall comply with the criteria set out in Articles 3.0 and 4.0.

- 4.2 At all times when the Home is registered under the Occupancy Based Funding Program, if a private or semi-private room, other than an Excluded Bed, becomes vacant at the Home and no person, who is eligible to be admitted to the Home, is prepared to occupy that private or semi-private room and pay the applicable preferred accommodation charge for that private or semi-private room, then:
- (a) the Provider shall admit a person to the private or semi-private room who is prepared to pay the standard accommodation charge for a standard room at the Home on the terms and conditions set-out herein (the “**Admitted Person**”);
 - (b) the Provider shall only charge the Admitted Person the standard accommodation charge in accordance with Applicable Law for the private or semi-private room, unless the Admitted Person subsequently requests the type of accommodation at the Home that is the same as the type of accommodation as the private or semi-private room;
 - (c) the Provider shall not change the Admitted Person’s type of accommodation unless,
 - (i) there is another appropriate room available at the Home for the Admitted Person; and
 - (ii) there is another person, who is eligible to be admitted to the Home and who is prepared to pay the applicable preferred accommodation charge for the Admitted Person’s private or semi-private room, and there is no other appropriate vacant private or semi-private room, as applicable, at the Home for the person;
 - (d) when the Provider notifies the CCAC in accordance with Section 4.3(a) of an available private or semi-private room at the Home, the Provider shall advise the CCAC to advise the Admitted Person that the Provider may require the Admitted Person to vacate the private or semi-private room and move to another room, including a standard room, at the Home in accordance with this Section 4.2; and
 - (e) the Provider shall obtain the Admitted Person’s written consent, prior to the Admitted Person becoming a resident at the Home, to the change in accommodation permitted by Section 4.2(c) and an acknowledgment of the receipt by the Admitted Person of the information referred to in Section 4.2(d).
- 4.3 A Provider shall comply with the Applicable Law in respect of the Home, including the following requirements:

- (a) the Provider shall notify the CCAC of available accommodation in the Home within 24 hours after the accommodation becomes available;
 - (b) the Provider shall approve a person's admission into the Home unless,
 - (i) the Home lacks the physical facilities necessary to meet the person's care requirements; or
 - (ii) the staff of the Home lack the nursing expertise necessary to meet the person's care requirements; and
 - (c) if the Provider withholds or withdraws approval of the admission of a person to the Home, the Provider shall give written notice to the person, the Director and the CCAC setting out the ground or grounds on which the approval is being withheld or withdrawn and a detailed explanation of the supporting facts.
- 4.4 The Provider shall give the notice referred to in Section 4.3(c) no later than 5 days after receiving the request to approve the admission of the person to the Home in accordance with Applicable Law.
- 4.5 The Provider shall ensure that the Home is available to approve the admission of residents to the Home every day, including Saturdays, Sundays and holidays, and for no less than 8 continuous hours during the day-time.
- 4.6 The Provider shall not be eligible to receive Funding in respect of a Home if:
- (a) the Provider has not submitted, within a reasonable period of time as determined in the discretion of the Ministry, a compliance plan for the Home that is acceptable to the Ministry for any non-compliance with the Service Agreement or Applicable Law;
 - (b) the Provider does not comply with the compliance plan in respect of the Home in a reasonable period of time, as determined in the discretion of the Ministry;
 - (c) admissions to the Home are suspended by the Ministry due to ongoing non-compliance;
 - (d) the management of the Home has been taken over by the Ministry pursuant to Applicable Law;
 - (e) the Ministry suspends or revokes an approval or licence under Applicable Law or gives notice of its intention to suspend or revoke an approval or licence under Applicable Law in respect of the Home;

- (f) a receiver, receiver-manager, trustee or other official with similar powers is or has been appointed for the Provider or the Home or any person moves to appoint a receiver, receiver-manager, trustee or other official with similar powers for the Provider or the Home;
- (g) any bankruptcy, reorganization, insolvency, liquidation or winding-up proceeding or proceeding for the benefit of creditors is or has been instituted by or against the Provider, including an assignment, proposal, compromise or arrangement for the benefit of creditors; or
- (h) the Provider uses the Funding to pay for termination or severance payments to staff at the Home.

4.7 The Ministry may, in its discretion, waive the eligibility requirements set out in Sections 4.6(f) or (g) for the Home.

4.8 If a Home or any part thereof is registered under the Occupancy Based Funding Program and it is classified as a "D" home,

- (a) the Provider shall not receive Funding for those beds at the Home that receive Occupancy Reduction Protection under the Transition Support Program Guidelines (August 2002) of the Ministry during the period of time when such beds receive such protection; and
- (b) the number of beds at the Home which are eligible to receive Funding under the Occupancy Based Funding Program shall be reduced accordingly for the period of time when any beds receive Occupancy Reduction Protection under the Transition Support Program Guidelines (August 2002).

5.0 Funding Payment Terms

5.1 The amount of the Funding, if provided, shall be determined upon Reconciliation for 2006.

5.2 The Funding shall be set-off against any amount due and owing by the Provider to the Ministry upon Reconciliation.

5.3 Subject to the allocation process described in Section 5.4, the amount of the Funding, if provided, for a Home while it is eligible under the Occupancy Based Funding Program shall be calculated pursuant to the following formula:

$$0.03 \times \sum [(A_n \times B_n) \times C_n]$$

where,

"A" is the number of beds at the Home, other than Excluded Beds;

“B” is the number of days in period n when the Home is registered and eligible to receive funding under the Occupancy Based Funding Program;

“C” is the sum of the Nursing and Personal Care, Program and Support Services, and the Other Accommodation envelopes payable each day by the Ministry to the Provider in respect of a bed at the Home, other than an Excluded Bed, pursuant to a Service Agreement;

“n” is a period of time in 2006 when the sum of the three funding envelopes referred to in “C” above is unchanged and the number of beds referred to in “A” is unchanged.

5.4 The Ministry shall adjust the amount of the Funding calculated pursuant to Section 5.3 such that the Funding shall be allocated to the following envelopes and in the following proportions:

- (a) Nursing and Personal Care, 75%;
- (b) Program and Support Services, 7%; and
- (c) Other Accommodation, 18%.

Except with respect to the amount of the Funding allocated to the Other Accommodation envelope, the amount of the Funding payable to the Provider as allocated in respect of each envelope shall be reduced on Reconciliation by any amount in respect of each envelope which has not been spent by the Provider or which has not been spent by the Provider in accordance with the Service Agreement or Applicable Law.

Participants registered within the Occupancy Based Funding Program will be subject to the same Revenue/Occupancy reporting and adjustment procedures as set out in the Service Agreement or Applicable Laws, as the case may be.

6.0 Provider Warranties and Representation

6.1 The Provider warrants and represents that:

- (a) the Provider has full power and authority to submit this Application and to observe, perform, and comply with the terms and conditions of this Application, and all necessary acts and procedures have been taken in order to authorize this Application;

- (b) if the Provider is a corporation, it is duly organized, registered, and validly existing under the laws of Ontario or Canada, and is qualified to do business whenever necessary to carry out the terms and conditions of this Application, and has not been dissolved; and
- (c) if the Provider is a partnership, all appropriate registrations have been made and will be maintained, and that the partnership is qualified to do business wherever necessary to carry out the terms and conditions of this Application.

7.0 Further Conditions and Changes to the Application Terms and Conditions

7.1 The Ministry may impose such additional terms or conditions or change the terms and conditions to obtain Funding, which it considers appropriate upon thirty (30) days prior notice to the Provider, and the Provider shall agree to such terms and conditions in order to continue to be eligible under the Occupancy Based Funding Program.

8.0 Records, Information Provision and Inspection

8.1 The Provider:

- (a) shall keep and maintain all records and other documents relating to the Funding in a manner consistent with generally accepted accounting principles or clerical practices, as the case may be, and shall maintain such records and keep them available for review by the Ministry for a period of six (6) years from the Registration Date;
- (b) shall maintain all records relating to the Funding that contain Personal Information, including any records it receives about the residents it serves, in a confidential manner consistent with all Applicable Law;
- (c) hereby authorizes the Ministry to enter upon the Provider's premises at all reasonable times to inspect and/or copy any records, invoices and other documents in the possession or under the control of the Provider which relate to this Application and the Funding.

8.2 The Ministry's right of inspection in this Application includes the right to perform an audit of any kind.

8.3 The Provider shall provide any other information to the Ministry reasonably requested by the Ministry to monitor compliance with this Application and to determine eligibility for and the amount of a Funding.

9.0 Expiry of the Registration of the Home

The registration of the Home under the Occupancy Based Funding Program for 2006 expires on December 31, 2006.

10.0 Termination of Registration by the Provider

The Provider may at any time terminate the registration of the Home by giving 30 calendar days' prior written notice of termination to the Ministry.

11.0 Termination by the Ministry for Convenience

11.1 The Ministry may, without liability, cost or penalty, terminate the Occupancy Based Funding Program at any time, for any reason, upon giving at least sixty (60) days written notice to the Provider.

12.0 Termination of Registration by the Ministry

12.1 The Ministry may, in its sole discretion, without liability, cost or penalty, and without prejudice to any other rights or remedies of the Ministry under this Application or at law or in equity, terminate immediately the registration of a Home under the Occupancy Based Funding Program upon giving written notice to the Provider, if:

- (a) in the opinion of the Ministry:
 - (i) the Provider has knowingly provided false or misleading information regarding this Application or in connection with any other communication with the Ministry; or
 - (ii) the Provider breaches any term or condition of this Application; or
- (b) up to the date thereof the Provider or the Home ceases to carry on business.

12.2 If the Ministry, in its sole discretion, considers the nature of the breach under Section 12.1 to be such that it can be remedied and that it is appropriate to allow the Provider the opportunity to remedy the breach, the Ministry may give the Provider an opportunity to remedy the breach by giving the Provider written notice;

- (a) of the particulars of the breach;
- (b) of the period of time within which the Provider is required to remedy the breach; and
- (c) that the Ministry shall terminate the registration of the Home:

- (i) at the end of the notice period provided for in the notice if the Provider fails to remedy the breach within the time specified in the notice; or
- (ii) prior to the end of the notice period provided for in the notice if it becomes apparent to the Ministry that the Provider cannot completely remedy the breach within that time or such further period of time as the Ministry considers reasonable, or the Provider is not proceeding to remedy the breach in a way that is satisfactory to the Ministry.

12.3 If the Ministry has provided the Provider with an opportunity to remedy the breach under Sections 12.1 and 12.2, and

- (a) the Provider does not remedy the breach within the time period specified in the notice;
- (b) it becomes apparent to the Ministry that the Provider cannot completely remedy the breach within the time specified in the notice or such further period of time as the Ministry considers reasonable; or
- (c) the Provider is not proceeding to remedy the breach in a way that is satisfactory to the Ministry,

the Ministry may immediately terminate the registration of the Home for any Funding by giving written notice of termination to the Provider.

12.4 In the event of termination of registration pursuant to this section, the effective date of termination shall be the last day of the notice period, the last day of any subsequent notice period or immediately, as the case may be.

13.0 Funding Upon Termination or Determination of Non-Eligibility

13.1 If the Home's registration is terminated pursuant to Article 12.0, or if it is found that the Provider was not eligible for Funding in respect of a Home after the Funding has been paid to the Provider or set off against any amount payable upon Reconciliation, the Ministry shall:

- (a) cancel all further Funding payments to the Provider; and
- (b) demand the repayment of any Funding or any part of the Funding that has been paid to the Provider or set-off as determined by the Ministry.

- 13.2 If the Ministry demands the repayment of any part of the Funding, the amount demanded shall be deemed to be a debt due and owing to the Ministry and the Provider shall pay the amount to the Ministry immediately unless the Ministry directs otherwise.
- 13.3 The Ministry may demand interest on any amount owing by the Provider at the then current rate charged by the Province of Ontario on accounts receivable.
- 13.4 The Provider shall repay the amount demanded by cheque payable to the **“Minister of Finance”** and mailed to the Ministry to the attention of the Ministry representative as provided for in Article 15.0, or the Ministry may set-off that amount against any amounts owing by the Ministry to the Provider, including any amounts under any Service Agreement with the Provider.

14.0 Provider’s Obligations Upon Expiry or Termination

- 14.1 The Provider shall comply with Section 4.2 and Article 8.0 at all times after:
- (a) the registration of the Home expires pursuant to Article 9;
 - (b) the Provider terminates the registration of the Home pursuant to Article 10.0;
 - (c) the Ministry terminates the Occupancy Based Funding Program pursuant to Article 11; or
 - (d) the Ministry terminates the registration of a Home pursuant to Article 12.
- 14.2 If the Provider does not comply with Section 14.1, the Ministry may, in addition to any other rights or remedies that it may have,
- (a) demand from the Provider the repayment of the Funding or any part of the Funding; or
 - (b) add any amount that, in the discretion of the Ministry, is reasonable to any amount owed by the Provider upon Reconciliation in any year,

and Sections 13.2, 13.3 and 13.4 apply with necessary modifications.

15.0 Notices

- 15.1 Any notice or communication required or permitted to be given in respect of this Application or the Occupancy Based Funding Program shall be in writing and shall be served personally, delivered by courier or sent by certified or registered mail, postage prepaid (not with return receipt requested), or sent by facsimile addressed to the other party at the address provided below or at such other

address as either party shall later designate to the other in writing. All notices shall be addressed as follows:

(a) To the Ministry:

Ministry of Health and Long-Term Care
Long-Term Care Home Support
4th Floor, 5700 Yonge Street
Toronto, Ontario M2M 4K5

Attention: Program Manager

Fax: (416) 326-3142

Telephone: (416) 326-8887

(b) To the Provider, at the location and to the telephone and fax numbers and the person named in the Application Form.

15.2 All notices shall be effective:

- (a) at the time the delivery is made if the notice is delivered personally, by courier or by fax; and
- (b) three business days after the deposit in the mail of the notice if the notice is sent by mail. A "business day" means any day between Monday and Friday, except public or statutory holidays or a day when the Ministry is closed for business.

16.0 Liability and Waiver

16.1 A waiver of any failure to comply with any term of this Application must be written and signed by the Provider or by the Ministry as the circumstances dictate. Each waiver must refer to a specific failure to comply and shall not have the effect of waiving any subsequent failures to comply.

16.2 The Ministry is not liable for any indirect, incidental, special or consequential damages whatsoever arising out of or in connection with this Application (including lost profits, anticipated or lost revenue, loss of data, loss of use of any information system, failure to realize expected savings or any other commercial or economic loss, or any third party claim), whether arising in negligence, tort, statute, equity, contract, common law or any other cause of action or legal theory even if the Ministry has been advised of the possibility of those damages.

17.0 Independent Parties

17.1 The Provider and the Ministry are and shall at all times remain independent and are not and shall not represent themselves to be the agent, joint venturer, partner or employee of the other. No representations shall be made or acts taken by either party which could establish or imply any apparent relationship of agency, joint venture, partnership or employment and neither party shall be bound in any manner whatsoever by any warranties or representations made by the other party to any other person nor with respect to any other action of the other party.

18.0 Assignment of Funding

18.1 The Provider shall not assign this Application or the Funding or any part thereof without the prior written consent of the Ministry.

19.0 Governing Law

19.1 This Application and the rights, obligations and relations of the parties hereto shall be governed by and construed in accordance with the laws of the Province of Ontario.

20.0 Circumstances Beyond the Control of Either Party

20.1 A party shall not be responsible for damage caused by delay or failure to perform under the terms of this Application resulting from matters beyond the control of the party and which cannot be reasonably foreseen or provided against. Such events include strike, lockout or any other action arising from a labour dispute, fire, flood, act of God, war, riot or other insurrection, lawful act of public authority, or delay or default caused by a common carrier provided such events meet the tests of this Article 20.0.

21.0 Survival

21.1 The provisions in Articles 13, 14 and 16.2 shall survive the expiry or termination of the registration of a Home, or the termination of the Occupancy Based Funding Program.

Schedule "A"

Provider's Certificate

On behalf of and with the authority of the Provider, I/we certify that:

- a. the information given in support of this Application is true, correct and complete in every respect;
- b. the Provider has read, understood and agrees to abide by the terms and conditions of the Application and those terms in any subsequent correspondence from the Ministry delivered pursuant to Section 7.1;
- c. the Provider is aware that the information contained herein can be used for, among other things, the assessment of registration under the Occupancy Based Funding Program, the assessment of Funding eligibility, auditing purposes and for statistical reporting; and
- d. the Provider understands that the information contained in this Application or submitted to the Ministry in connection with the Occupancy Based Funding Program is subject to disclosure under the provincial *Freedom of Information and Protection of Privacy Act*, as amended.

One or more authorized Officer (s) for each Provider must sign this Application in accordance with the corporate governance rules of each Provider.

Authorized Signing Officer (for Provider)

Name:	Position or Title:	Signature:	Date:
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Authorized Signing Officer (for Provider)

Name:	Position or Title:	Signature:	Date:
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If more than two signatures are required, please photocopy this page.

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENT CHARGES

INTRODUCTION

INTRODUCTION

The Province has adopted a standard rate policy for basic accommodation in long-term care facilities. Under this policy a maximum rate for basic accommodation is set annually by the Government. This rate will be paid by persons with sufficient income to pay the maximum rate for basic accommodation. A reduced rate may be paid by a resident without sufficient income to pay the maximum. The Government will fund the subsidy required by residents eligible for the rate reduction.

There will be no asset testing. An income test will be used to determine ability to pay for those who cannot afford the basic accommodation rate.

Resident accommodation charges for basic accommodation are subject to change July 1 of each year.

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENT CHARGES

ALLOWABLE CHARGES

ALLOWABLE CHARGES

People residing in facilities are charged only for accommodation costs.

No charges for provincially funded nursing and personal care are permitted.

Homes will be prohibited from charging more than the maximum amount allowed in the regulations for basic and preferred accommodation.

There is no relationship between the care received and the amount paid by the consumer for accommodation.

A long-stay resident may apply for a rate reduction in the fee payable by the resident for basic accommodation. (See Income Testing below.)

OTHER CHARGES

There is an additional charge for preferred accommodation.

The province establishes the maximum rates for preferred accommodation. There is no rate reduction available for residents in preferred accommodation. There is no provision for a comfort allowance for residents in preferred accommodation.

Charges continue for services or goods which a resident may choose to purchase and which are not traditionally paid for by the facility, for example, hairdressing, dry cleaning and some types of transportation.

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENT CHARGES

INCOME TESTING

INCOME TESTING

Residents applying for a rate reduction will be income tested at the time of application and annually thereafter. The annual rate reduction will be effective July 1.

Accommodation fees are set annually by the Province.

A person may request an assessment or re-assessment at any time if their circumstances change so that their ability to pay is reduced.

Residents in preferred accommodation are not income tested.

WHO DOES INCOME TESTING

For persons in Long-Term Care Facilities the test will be applied to residents by the facility administrators or their designates.

For persons requesting admission to LTC facilities, the Placement Coordination Service (PCS):

- explains the rates the person may be required to pay;
- explains the income testing procedure to the person if the person is requesting a rate reduction;
- determines whether the consumer is interested in obtaining preferred accommodation;
- informs the applicant about any income supplements, benefits, or other social assistance, that may be available.

The PCS undertakes this process so that:

- information may be forwarded to the facility regarding the type of accommodation the person is requesting;

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENT CHARGES

INCOME TESTING

- the person is made aware of the rate structure prior to admission.

If the person is requesting a rate reduction, the income testing will be undertaken by the facility at the time of admission.

DETERMINATION OF ACCOMMODATION FEES

Eligibility for a rate reduction will be determined by the application of a simple income test. The Application for Reduction in Long-Term Care Facility Accommodation Fees (the "Reduction Application") and accompanying Application for Reduction in Long-Term Care Facility Accommodation Fees Worksheet (the "Reduction Worksheet") are designed with several objectives in mind.

The purpose of the income test is to:

1. Assess eligibility for a rate reduction.
2. Determine the amount of the rate reduction.
3. Monitor ongoing eligibility on an annual basis.

In addition the income test is designed to:

- consider only income (not assets)
- be as simple as possible
- be as non-intrusive as possible
- be verifiable.

FINANCIAL MANAGEMENT AND ADMINISTRATION**RESIDENT CHARGES****APPLICATION FOR RATE REDUCTION****REDUCTION
APPLICATION AND
REDUCTION
WORKSHEET**

The Reduction Application requires a resident to produce and attach to the application form a copy of his/her Notice of Assessment for the immediately preceding year. The Notice of Assessment is a confirmation sent from Revenue Canada to an individual subsequent to the filing of a Federal and Ontario return of income (income tax return). The actual and daily rates are calculated on the Reduction Worksheet and transferred to the form.

The Reduction Worksheet contains identification information, signatures and applicable daily and monthly rates. The Reduction Worksheet is the document on which all the calculations of the rate are carried out. Once completed, the Reduction Worksheet must be attached to the signed form for the application to be valid.

**APPLICANT
INFORMATION**

The Reduction Application must contain information to identify the resident for whom the application is for, identify the facility and identify a contact person for the resident.

**APPLICANT INCOME
STATEMENT**

Income verification is by means of a Notice of Assessment from Revenue Canada. If an individual is not required to file an income tax return with Revenue Canada, alternative documentation may be accepted to validate income. Any alternative documentation used must be approved by the facility's designated Long-Term Care area office. (See section on Alternative Documentation)

**APPLICANT
CERTIFICATION**

In order for the Reduction Application to be valid, the applicant and/or witness must sign and date the form. If the applicant signs with an X, the administrator must obtain a signature of a witness. Please ensure that the witness' full-name, address and telephone number is obtained.

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENT CHARGES

APPLICATION FOR RATE REDUCTION

CALCULATED RATE

This calculated rate section in the Reduction Worksheet is to be completed by the LTC facility administrator or designate. The monthly and daily amounts are calculated on the Reduction Worksheet and then transferred to the Reduction Application. This section must also be signed by the administrator or designate and dated for the application to be valid.

WORKSHEET

To calculate the monthly rate please refer to the Reduction Worksheet.

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENT CHARGES

PERSONS UNABLE TO PAY THE BASIC ACCOMMODATION FEE

PERSONS UNABLE TO PAY THE BASIC ACCOMMODATION FEE

Options are available to assist persons who cannot afford the basic accommodation fee. These are outlined below.

PERSONS 65 AND OVER INELIGIBLE FOR OAS

Persons aged 65 and over may qualify for Family Benefits if they are ineligible for Old Age Security (OAS), Spouse's Allowance or an allowance under the Ontario Guaranteed Annual Income System (GAINS-A). For example, an immigrant who does not meet the residency requirements under these other programs may be eligible for Family Benefits.

Persons in receipt of Family Benefits are automatically reminded to apply for OAS six months before turning age 65.

Note: The Family Benefits Act and Regulation provide for an allowance and benefits to be paid to a person who qualifies under a test of financial need and is included under one of the groups authorized under the legislation.

PERSONS 65 AND OVER NOT RECEIVING GIS

Persons 65 and Over Not Receiving GIS/OAS pensions with no income or only a limited amount of income apart from OAS may upon annual application receive full or partial GIS benefits.

Recipients of GIS benefits must reapply annually.

There are two GIS rates. One applies to single pensioners (which includes widowed, divorced or separated persons as well as individuals who have never married) and also to married pensioners whose spouses are not in receipt of either the basic OAS pension or spouse's allowance.

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENT CHARGES

PERSONS UNABLE TO PAY THE BASIC ACCOMMODATION FEE

PERSONS 65 AND OVER INELIGIBLE FOR OAS (CONT.)

The other rate applies to spouses in married couples (which includes both legally married couples and, in some instances, couples living in common-law relationships) where both spouses are pensioners. Married couples who are forced by circumstances to live apart may be paid at the single rate.

GAINS-A

GAINS-A provides a monthly benefit to Ontario residents in receipt of GIS who meet certain income and residence requirements. A person must have lived in Ontario for the year prior to qualifying for GAINS-A, or for at least 20 years after turning 18 years of age. No application is required as eligibility is automatically established based on GIS entitlement.

PERSON 65 AND OVER ENTERING LTC FACILITY WHILE SPOUSE 65 AND OVER REMAINS IN COMMUNITY

In cases where a couple is receiving the GIS and one of the couple enters a long-term care facility both partners may be paid at the single rate since they are forced by circumstances to live apart.

INVOLUNTARY SEPARATION

The Federal Department of Health and Welfare has a provision for treating married couples as single for Guaranteed Income Supplement purposes when:

- only one is a client and it is to the client's advantage to be treated as single, or
- both are clients and it is to their advantage to be treated as single.

Involuntary separation is a term used only to indicate that as a result of circumstances beyond their control, married couples are required to live apart.

This term does not change the couple's marital status.

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENT CHARGES

PERSONS UNABLE TO PAY THE BASIC ACCOMMODATION FEE

INVOLUNTARY SEPARATION (CONT'D)

A person can be considered involuntarily separated from his/her spouse if:

- one person is in a LTC facility or in a chronic care hospital,
- the couple is living in separate dwellings for economic or medical reasons,
- the couple is living in separate single accommodations in the same LTC facility and both pay the same as single persons living in that home, or
- one person is hospitalized in a regular active treatment hospital waiting for a room in a LTC facility.

APPLICATION

Application for involuntary separation is made by written application from the consumer, spouse, trustee or lawful representative to one of the three regional offices of the Income Security Programs Branch, Department of Health and Welfare (See Page 7).

Persons must provide:

- a social insurance number (if they do not have a S.I.N. number, they usually have an assigned number);
- verification that the involuntary separation is a long term or permanent arrangement.

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENT CHARGES

PERSONS UNABLE TO PAY THE BASIC ACCOMMODATION FEE

PERSON 65 AND OVER ENTERING LTC FACILITY WHILE SPOUSE 60-64 REMAINS IN COMMUNITY

The spouse of a GIS pensioner may be eligible upon application for spouse's allowance if that spouse is 60 to 64 years of age and has 10 years' residence in Canada after age 18.

Spouse's allowance may be full or partial, in accordance with the OAS residence requirements. Once the residence requirements have been met, eligibility is subject to an income test similar to that for GIS. Recipients of spouse's allowance are required to re-apply annually.

The spouse's allowance ceases in the month in which the OAS pensioner dies. The widowed spouse may be eligible upon application for Widowed Spouse Allowance, based on his or her income.

An amendment to the *Old Age Security Act* provides for payments of spouse's allowance to any widow or widower who is between the ages of 60 and 64, has been a Canadian resident for at least 10 years after age 18 and meets the income eligibility and residency status criteria.

SPOUSES 60 AND OVER RESIDING IN COMMUNITY

A spouse of a OAS recipient may apply for Family Benefits when he/she is:

- aged 60 or over;
- living with the OAS recipient, or
- apart from the OAS recipient, where the OAS recipient is a patient or resident in a hospital or institution listed below for a continuous period of six months or more:
 - an institution under the *Mental Hospitals Act*;
 - a sanatorium under the *Sanatoria for Consumptives Act*;

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENT CHARGES

PERSONS UNABLE TO PAY THE BASIC ACCOMMODATION FEE

SPOUSES 60 AND OVER RESIDING IN COMMUNITY (CONT.)

- a hospital for the chronically ill;
- a nursing home;
- a home for the aged under the *Homes for the Aged and Rest Homes Act* or the *Charitable Institutions Act*.

Note: Family Benefits may be considered for persons 60 years and over who are not eligible for Federal Income Security programs.

A person who is resident in Ontario is eligible for an allowance and other benefits calculated in accordance with the *Family Benefits Act* if he or she is a person in need who has attained the age of 60 years but not attained the age of 65 years.

PERSONS 60-64 IN LTC FACILITIES

Family Benefits may be considered for persons 60 years and over who are not eligible for Federal Income Security programs.

PERSONS WITH DISABILITIES AGED 18-64

Blind or disabled persons may qualify for Family Benefits.

Note: A "blind person" is defined under the *Family Regulation* to mean a person with visual acuity in both eyes which, with proper refractive lenses, is 20/200 (6/60) or less with Snellen chart or equivalent, or a person having the greatest diameter of the field of vision in both eyes of less than twenty degrees, where the diameter of the field of vision is determined by the use of,

- a tangent screen at a distance of one metre using a ten millimetre white test object,

or

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENT CHARGES

PERSONS UNABLE TO PAY THE BASIC ACCOMMODATION FEE

PERSONS WITH DISABILITIES AGED 18-64 (CONT'D)

- *a perimeter at a distance of one-third of a metre using a three millimetre white test object; (ref. Sec. 1(3)(a) Reg.)*

Generally, any blind person who is registered with the Canadian National Institute for the Blind is eligible under this group.

PERSONS WITH DISABILITIES

A "disabled person" is defined under the Family Benefits Regulation to mean a person who has a major physical or mental impairment that is likely to continue for a prolonged period of time and who, as a result thereof, is severely limited in activities pertaining to normal living, as verified by objective medical findings accepted by the Medical Advisory Board. (Ref. Sec. 1(3)(b) Reg).

Generally, a disabled person is one who has a major physical or mental handicap that severely limits the person in carrying out normal activities and the disability is of a permanent nature.

Persons who are blind, disabled or permanently unemployable may be single or married persons with or without dependent children.

PERSONS WITH DISABILITY PENSION

For persons with a disability pension from an insurance program whose income is too low to pay the basic accommodation fee, the individual would be eligible:

- for FBA (GAINS-D) payments in an amount equal to the institutional rate
- plus the comfort allowance
- minus their other sources of income.

FINANCIAL MANAGEMENT AND ADMINISTRATION**RESIDENT CHARGES****PERSONS UNABLE TO PAY THE BASIC ACCOMMODATION FEE****IMMIGRANT
SPONSORSHIP
BREAKDOWN
(UNDER 65)**

In cases of sponsorship breakdown accepted by FBA the previously sponsored immigrant may be eligible for:

- for FBA (GAINS-D) payments in an amount equal to the institutional rate
- plus the comfort allowance
- minus their other sources of income.

A sponsor is normally deemed to be able to pay at least \$500 per month. FBA administrators may deem the sponsor to be able to pay any amount up to and including the institutional rate.

**FURTHER
INFORMATION ON
FEDERAL PROGRAMS**

Income Security Programs Branch:

- Town Centre Court
200 Town Centre Court, Suite 1100
Scarborough, Ontario M1P 4X8
- Southwestern Ontario Region
Southwestern Ontario Processing Centre
65 William Street South
Chatham, Ontario N7M 6B2
- Northern Ontario Region
P.O. Box 2013
70 Cedar Street South
Timmins, Ontario P4N 8C8

**FURTHER
INFORMATION ON
PROVINCIAL PROGRAMS**

Further Information on Provincial Programs can be obtained from the Income Maintenance Supervisors at the 13 Ministry of Community and Social Services Area Offices.

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENT CHARGES

ALTERNATIVE DOCUMENTATION - RATE REDUCTION

**ALTERNATIVE
DOCUMENTATION**

Although a resident is required to provide his/her Notice of Assessment to receive a rate reduction, it is understood that there will be circumstances where this is not available. Furthermore, there will be situations where the resident's Notice of Assessment does not reflect his/her current income.

Under these circumstances the Ministry is willing to accept alternative documentation to the Notice of Assessment.

In general, alternative documentation should be provided by an independent third party to substantiate the resident's income level.

The following are some examples of acceptable alternative documentation:

- Confirmation letter from Human Resources, Canada Income Security Branch
- Confirmation from the Ministry of Community and Social Services (Social Assistance Programs)

It is the responsibility of the administrator to verify the income of the resident by way of a Notice of Assessment the following year and make any adjustments necessary to the resident's accommodation rate for the period to which the alternative documentation applies.

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENT CHARGES

RESIDENTS UNABLE TO PAY THE REDUCED ACCOMMODATION RATE

**EXCEPTIONAL
CIRCUMSTANCES
REDUCTION**

A long-stay resident may apply for a further reduction under the provisions of the Exceptional Circumstances regulation by submitting an Application for Reduction in Long-Term Care Accommodation Fees - Exceptional Circumstances (the "Exceptional Circumstances Reduction").

The regulation ensures that:

1. The comfort allowance is guaranteed for those who are eligible for the exceptional circumstances reduction. People who do not maximize their income OR have it reduced because of income they received and disposed of in the previous year (usually this is a reduction in GIS) are not eligible.
2. Spouses (including those spouses who reside in the same room in a long-term care facility) will not be forced to legally separate in order to improve their financial position.
3. Relief is provided to eligible spouses in the community.

The Exceptional Circumstances Application is submitted to the Director (local long-term care area manager or designate). The Director reviews the application and has the authority to ask for more information, if deemed necessary.

The Director has the authority to approve or deny the request and set the term, if any.

The applicant who has a spouse in the community must transfer the amount of the exceptional circumstances reduction to his/her spouse.

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENT CHARGES

RESIDENTS UNABLE TO PAY THE REDUCED ACCOMMODATION RATE

**EXCEPTIONAL
CIRCUMSTANCES
REDUCTION (CONT'D)**

The subsidy will terminate the earliest of:

1. the first June 30 following the submission of the Exceptional Circumstances Application;
2. the last day of the month immediately preceding the month in which the next Exceptional Circumstances Application is submitted;
3. the last day of the month immediately preceding the month in which the next Exceptional Circumstances Application is submitted to the administrator;
4. the termination date, if any, specified by the Director at the time of the processing of the Exceptional Circumstances Application; and
5. the date of termination the Director must specify in circumstances where the applicant does not transfer an amount equivalent to the reduction to his/her spouse.

The role of the facility administrator is to assist the resident **to complete** their Exceptional Circumstances Application, if necessary. The **completed** Exceptional Circumstances Application **should be** forwarded to the appropriate area office for review and decision by the area manager or their designate.

FINANCIAL MANAGEMENT AND ADMINISTRATION**RESIDENT CHARGES****BED HOLDING****BED HOLDING PRIOR TO ADMISSION**

When a Placement Coordination Service (PCS) notifies a person that a long-stay bed is available and the person consents to being admitted to the facility, the PCS may authorize the admission if the person agrees in writing to move into the facility before noon of the third day following the Day of Notification and pay the applicable resident charges as set out below. For the purposes of the following discussion, Day 1 refers to the Day of Notification by the PCS.

The person may be admitted on the Day of Notification (Day 1), and if so, begins to pay the accommodation fee.

If the person chooses not to be admitted on the Day of Notification (Day 1):

- a) the person may hold the bed until noon of the third day following the Day of Notification (Day 4);
- b) no accommodation fee is payable for the Day of Notification; and
- c) an accommodation fee and, where applicable, a bed holding fee, are payable for the day or days following the Day of Notification as set out below:
 - If the person is admitted on the first day following the Day of Notification (Day 2), the person begins to pay the accommodation fee.
 - If the person is admitted on the second day following the Day of Notification (Day 3), the person pays the accommodation fee for two days: for the first day following the Day of Notification (Day 2), as well as for the Day of Admission (Day 3).

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENT CHARGES

BED HOLDING

**BED HOLDING PRIOR TO
ADMISSION (CONT'D)**

- If the person is admitted before noon of the third day following the Day of Notification (Day 4), the person pays the accommodation fee for three days, plus a bed holding fee, that is: the accommodation fees for the two days following the Day of Notification (Days 2 and 3), the accommodation fee for the Day of Admission (Day 4), and the bed holding fee.

The following table illustrates the sequence of events once a bed becomes available and the resident charges that are applicable.

FINANCIAL MANAGEMENT AND ADMINISTRATION
RESIDENT CHARGES
BED HOLDING

DAY	PERSON'S DECISION REGARDING ADMISSION AND RESIDENT CHARGES THAT ARE APPLICABLE
Day 1	Person A's last day in facility. Person B is notified that a bed is available, decides to be admitted, and pays the accommodation fee for Day 1, or Person B accepts the offer of a bed, but chooses not to be admitted on this day.
Day 2	Person B decides to be admitted and pays the accommodation fee for Day 2, or Person B chooses not to be admitted on this day.
Day 3	Person B decides to be admitted and pays the accommodation fees for Days 2 and 3, or Person B chooses not to be admitted on this day.
Day 4	Person B must be admitted by noon and pays the accommodation fees for Days 2, 3, and 4, as well as the bed holding fee, or Person B chooses not to be admitted and must pay the accommodation fees for Days 2, 3, and 4, as well as the bed holding fee. In addition, the person's authorization for admission is cancelled by the PCS.

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENT CHARGES

BED HOLDING

**BED HOLDING
FOLLOWING LEAVE
OF ABSENCE**

Medical or Psychiatric Leaves:

A resident may hold a bed for up to 30 days in addition to the number of days provided for medical or psychiatric leaves. The resident will be charged the bed holding amount plus the accommodation, including any preferred accommodation for each day of bed holding. The resident will continue to be responsible for the payment of other charges for services previously authorized (i.e., cable television, telephone, etc).

**FACILITY CLOSED BY
PUBLIC HEALTH**

Some residents become "stranded" in hospital beyond the 21-day medical or 30-day psychiatric leave, because their "home" facility is in an outbreak situation. In this situation, Public Health will not usually permit the hospitalized residents to return to the facility until the outbreak is under control. The resident is not to be charged bed-holding fees in this situation. For audit purposes the facility will keep track of those residents to whom bed holding fees were not charged due to the inability to be readmitted.

**OCCUPANCY RATE
UNDER PUBLIC HEALTH
CLOSURE**

If Public Health suspends admissions to a facility during an outbreak, facilities may not be able to meet their occupancy target. If the suspended admissions will cause a home to not meet its occupancy target for a particular quarter, the facility should notify the Area Office of the situation in writing to avoid a possible adjustment to cash flow for that particular quarter.

If at the year-end the facility does not meet its occupancy target, a review by the Area Office will be conducted. If the failure to meet the occupancy target was a direct result of the suspension of admission by the Public Health Unit, the Area Office will revise the occupancy target accordingly.

Ministry Ministère
of de
Health la Santé

Residential Services Branch
5700 Yonge Street, 7th Floor
North York, Ontario M2M 4K5

Tel: (416) 327-7357
Fax: (416) 327-7364

February 10, 1995

MEMORANDUM TO: Long-Term Care Facility Administrators
Long-Term Care Facility Directors of Care

FROM: Sandy Knipfel
Acting Director

RE: **LONG-TERM CARE FACILITY INFORMATION UPDATE**

Attached for your review is the second issue of the **Long-Term Care Facility Information Update**. The purpose of this Update is to provide information to the long-term care facility sector about various aspects of Long-Term Care Redirection that have a direct impact on facility operations.

This issue of the Update addresses:

- I. 1994 Levels of Care Classification
- II. Nursing and Personal Care Provider Study
- III. Long-Term Care Facility Manual Working Group
- IV. Placement Coordination Services (questions and answers)
- V. Policy Issues and Clarifications
 1. Leave of Absence
 2. Overbedding
 3. Short Stay Program
 4. Bed Holding
 5. Assistive Devices
 6. Power of Attorney

... 2

It is anticipated that future issues of the Update will be distributed on an as needed basis as questions arise and the Long-Term Care Redirection proceeds.

Thank you for your cooperation.



Sandy Knipfel
Acting Director

Enclosure

cc: Geoff Quirt
LTC Area Office Managers
RSB Managers
Placement Coordination Services
ONHA
OANHSS
Labour Organizations

AP/>

LONG-TERM CARE FACILITY INFORMATION UPDATE

I. 1994 LEVELS OF CARE CLASSIFICATION

The 1994 Levels of Care Classification of 54,964 residents in Long-Term Care Facilities was completed at the end of October. The facility Case Mix Measure and Case Mix Indices were sent to all facilities in mid-January. The Provincial Case Mix Measure for 1994 was 76.31. The Provincial CMM for 1993 was 76.39, which indicates a change of $-.08$, less than the value of one.

From the Levels of Care Project Team's perspective, training, scheduling and reliability testing ran smoothly. As well, the majority of facilities were well prepared for the classifiers arrival and made the classifiers welcome in their facilities.

This year and for the first time, the Ministry detailed all of the instructions on completing the Resident Classification Form (RCF) that the classifiers received during their one-week training session before classification. These instructions were developed for the trainers to teach the classifiers how to collect data from facility documentation.

The instructions on completing the RCF were sent to all facilities in December 1994 but it should be noted that the instructions do not address documentation requirements of facilities for classification.

B. NURSING AND PERSONAL CARE PROVIDER STUDY (formerly Care Provider Study)

Please note that the Care Provider Study has been renamed to reflect the focus on the nursing and personal care staff in Long-Term Care Facilities.

Dr. Linda-Lee O'Brien-Pallas and her research team were successful in recruiting staff and named four data collection teams. Each team was made up of six data collectors (Registered Practical Nurses) and two data supervisors (Registered Nurses). All were trained and the pilot project completed by early November.

The actual Study of twenty-two randomly selected Long-Term Care Facilities began in the second week of November in different sections of the province. Each team spent one week in each of their assigned facilities, with the data collection phase of the project completed by December 17, 1994.

The next stage, data analysis and report writing will take place during the early part of the new year. The Steering Committee made up of representatives of the service provider associations, labour organizations, and Long-Term Care Division staff expect to receive a draft report in early spring.

For further information, please contact Barbara Fisher at (416) 326-9740.

III. LONG-TERM CARE FACILITY MANUAL WORKING GROUP

1. Smoking Rooms

Given that the implementation of the Manual is tied to completion of the service agreements, the timing requirements for compliance with smoking room designations and ventilation standards have been extended beyond the dates set in the 1993 draft LTC Facility Program Manual.

In recognition of expectations under the Tobacco Control Act, the compliance requirements under the Manual have been adjusted to coincide with the timing requirements under the Tobacco Control Act. Therefore, the compliance date for meeting ventilation standards in smoking areas is set for January 1, 1996.

2. Industrial Washers and Dryers

Again, in recognition of the service agreement process, the compliance date for provision of industrial washers and dryers has been extended to January, 1997.

3. Hexachloridine Mouthwash

The guideline for the use of hexachloridine as a mouthwash has come into question because of certain side effects which have been noted with a number of LTC facility residents. In recognition of these side effects, it is suggested that prior to application, consideration be given to the ability of some residents to effectively use this product.

The LTC Division is presently reviewing other mouthwashes which have similar results as hexachloridine that may be used as alternatives. Should you have any questions or comments on this issue, please address with the Compliance Advisor assigned to your respective facility.

IV. PLACEMENT COORDINATION SERVICES

In order to provide clarification and respond to issues which have been raised regarding the new responsibilities, policies and procedures of the placement coordination process, the following set of questions and answers has been developed:

Q1. I turned my waiting list over to the PCS on July 1, 1994. What is the status of this list of people?

A1. If a person on your waiting list had an Extended Care Certificate issued in 1993, that person is automatically considered eligible by the Placement Coordination

Service (PCS) and remains on the waiting list. If someone on the waiting list did not have an Extended Care Certificate, the PCS must determine eligibility in accordance with the regular eligibility criteria in the regulations. If that person is determined to be eligible, he/she remains on the waiting list.

People on the waiting list are not automatically "taken off" the waiting list after a certain point in time, nor is eligibility redetermined every six months.

In practical terms, what happens is that when a person's name is close to the top of a waiting list, the PCS updates the functional information to make sure that the person is still eligible for admission to a long-term care facility. In most cases, the person will remain eligible. However if the applicant's care needs change significantly, that person may be determined ineligible at that time.

Q2. What happens if I admit people to my home without an Authorization for Admission from the Placement Coordination Service?

A2. The new placement co-ordination scheme, which came into force on July 1, 1994, makes it mandatory that all persons admitted to a nursing home or home for the aged on or after July 1, 1994 be authorized for admission by the PCS designated for the particular home. The PCS authorizes a person's admission by issuing a form entitled "Authorization for Admission". This form must be kept on file in the long-term care facility. It is the proof that the resident has been admitted through the PCS.

For purposes of financial reconciliation, resident days will be counted only for those residents who have been admitted into the facility in accordance with the legislation. These resident days will be used to determine the achievement of occupancy targets and, where occupancy targets have not been met, to determine provincial subsidy.

Q3. Can the Medical Form provided by the PCS be considered the medical assessment that the facility is referred to in section 090301 of the Long-Term Care Facility Program Manual?

A3. No. The medical form used by the PCS is strictly for the purposes of determining eligibility for admission. The Medical Director or attending physician is responsible for completing a medical assessment within seven (7) days of admission. The information contained in the PCS medical form may be used by the medical director/attending physician as a source of information about a newly admitted resident, but he/she would be responsible for the admission assessment.

Q4. Can a Long-Term Care Facility require a person whose name has been placed on its waiting list to be seen by the Medical Director for the chosen facility(ies) prior to the person being admitted to that facility?

A4. No. The home cannot require the person to be seen by the facility's Medical Director or attending physician prior to admission. In addition, the home cannot require further screening/assessment by its Medical Director prior to the person's admission to the facility. However, if the home receives additional information from the PCS about that person, the home retains the option of withdrawing approval for admission.

The facility is not prohibited from requesting that the applicant be seen by the Medical Director. This decision rests with the applicant. The facility cannot withhold or withdraw approval of an admission because the applicant did not agree to be seen by the Medical Director.

During the period when the person is waiting for an appropriate bed in the facility, the PCS is responsible for keeping each applicant's record up-to-date. In the event that the person's condition changes to a degree where there is concern that the long-term care facility may not be able to appropriately serve him/her, such information would be provided by the PCS to the facility prior to admission.

Q5. In my area, the acute care hospitals have adopted a "first bed available" policy. This creates a great deal of work for the facility in terms of doing the admission assessment and plan of care, only to have the person transfer to another facility within a short period of time.

A5. In many areas of the province, acute care hospitals have adopted "first bed" policies. This creates a difficult situation for the Placement Coordinator who is under a statutory obligation to work with applicants and authorize admission to the homes of choice.

Given that hospital policies in this regard vary across the province, it is suggested that the best approach is for long-term care providers, hospital providers and PCS to discuss the issue and try to develop a reasonable solution within their area.

Q6. My home was originally designed primarily for residential care clients. We are not able to meet the care needs of the new type of client who is determined eligible by the PCS because we lack the physical plant or the nursing expertise. This means that we will not be able to meet our occupancy target which will result in our being in a financial deficit. What does the government propose to do about this?

A6. Seniors have indicated a preference to remain in their homes for as long as possible prior to consideration for facility placement. The focus of the Long-Term Care Redirection is to respond to consumer preferences, and therefore adjustments were made to the admission eligibility process. Long-Term Care Facilities are meant to offer care and services for those who meet the eligibility criteria.

If a home is unable to meet the needs of eligible applicants, for example, a home which has historically offered services that were geared towards a residential care population, it is suggested that the home examine what options are available to move towards providing higher levels of care or becoming community residential alternatives.

The Long-Term Care Area Offices and the Regional Offices of the Residential Services Branch are sources of advice and information on issues such as:

- staff deployment;
- operational efficiencies which may be adapted from other long-term care facilities; and
- options for capital redevelopment.

Q7. I have a continuum of care available from apartments and supportive housing through to a long-term care facility. With the new PCS rules, people residing in one part of the continuum have no guarantee of being admitted to a long-term care bed within the same complex. In many cases, people residing in the apartment or supportive housing unit have been counting on the ability to move to the long-term care facility in the event that their care needs change. How is this system better for consumers?

A7. Once again, we need to stress the fact that it is the consumer who chooses the home or homes to which he or she wishes to apply. The PCS is simply the agent that determines eligibility and forwards the application to the home.

The system does allow for people who are currently residing in your continuum to have access to your long-term care beds if this is their facility of choice. However, depending on the needs of consumers within the overall system, this same person may or may not necessarily be the first priority for admission.

Under the previous system, it was not possible for a facility with a continuum of care to assure immediate admission of a resident to a long-term care bed. In such cases, a waiting period would have to elapse until such time as an appropriate bed

became available, with admission taking place on a priority basis. From this perspective, the new system and the old system are somewhat similar, with the exception that placement now has to go through the PCS and the broader community perspective is considered.

Q8. There are occasions when there is a difference of opinion between the long-term care facility and the PCS regarding the appropriateness of a client, for example, where safety may be an issue. What is the process for resolution of issues between a PCS and a long-term care facility?

A8. The PCS Manual outlines a process for conflict resolution that should be used. The first step is for the facility and the PCS to address the issues and attempt to reach agreement on an appropriate course of action.

The Long-Term Care Area Offices have been delegated the responsibility of maintaining the accountability relationship between the Ministry and the respective PCS's in their areas.

Where resolution cannot be reached between the facility and the PCS though initial dialogue, the Long-Term Care Area Office and if appropriate, the Residential Services Branch Regional Office, may be requested to participate in further discussions in order to reach an acceptable conclusion.

Q9. What happens if a person is authorized for admission, and after admission, the facility determines that the care needs of the applicant cannot be met in that home?

A9. The long-term care facility may contact the PCS and request help in finding alternative accommodation for the resident if the resident or lawfully authorized substitute consents. The PCS may work with the facility, however, it should be acknowledged that some persons may be difficult to serve, and alternative arrangements may not be able to be found.

The regulations permit the long-term care facility to discharge a resident if the facility is informed by the interdisciplinary team providing the resident's care that the resident's continuing care requirements can no longer be met in the home, and other arrangements are made to provide the accommodation and care required by the resident.

V. POLICY ISSUES AND CLARIFICATIONS

1. Leave of Absence

In keeping with the relevant regulated provisions, the person must be a resident of the Long-Term Care facility in order to qualify for casual or vacation leave. The intent of casual and vacation leave is to provide residents with the opportunity of being away from the facility for certain periods of time and having their bed status maintained on return.

Casual leave or vacation leave cannot be used by an applicant to extend pre-admission bed-holding. Pre-admission bed-holding allows time for a resident to prepare for moving into a facility. The leave provisions may not be applied to pre-admission bed holding. They apply only after the person has been lodged in the home as a resident in keeping with the legislated process.

2. Overbedding

The Long-Term Care Division may approve the overbedding of a long-term care facility in order to provide for additional beds above the licensed/approved capacity for that facility under specific circumstances and in emergency situations.

All applicants that are the subject of a request and approval for overbedding must be admitted by the PCS in accordance with the legislation.

3. Short Stay Program

a. Funding Policy

Long-term care facilities may choose to offer a short stay program with the approval of the respective Long-Term Care Area Office.

Currently the funded vacancy rate for long-stay beds is 3 percent of the approved/licensed capacity. In facilities that offer an approved short-stay program, in addition to this 3 percent vacancy, approved short-stay resident-days are paid for regardless of occupancy.

This means that the province pays the approved per diem for vacant short-stay beds, which includes the nursing and personal care, raw food, accommodation and program and support services funding. For occupied short-stay beds the province pays the approved per diem less the resident charge of \$26.94. There is no preferred accommodation under the short-stay program.

It is important to note that the province does not pay any preferred accommodation on vacant beds funded when facilities achieve their long-stay occupancy targets and the same applies to the short-stay program.

The determination of achievement of the occupancy target for long-stay beds is not impacted by the occupancy of the short-stay beds. A detailed letter on this subject has been sent to all administrators.

b. Tuberculosis Testing for Short Stay Residents

The issue of completing a two-step tuberculosis skin test on residents who are in the facility for less than 21 days is under review, as it is recognized that it takes between 14 and 21 days to complete the test.

It is anticipated that there will be changes to the LTC Facility Program Manual and regulations to provide for a person who is admitted for less than 21 days. This change has not yet occurred. When it takes effect, all long-term care facilities will be notified.

c. Documentation Requirements for Short Stay Residents

At present, the documentation requirements for short stay and long stay residents are the same. This issue is also under review. OANHSS and ONHA have met with the Ministry to discuss this issue and make recommendations for changes to these requirements. When the changes are finalized they will be communicated to the facilities.

4. Bed holding

At this time, the wording in the bed-holding sections of the PCS Manual and Long-Term Care Facility Program Manual are different. Please note that the PCS Manual correctly interprets the recent amendment to regulations on bed-holding. The facility Manual is out-of-date and will be amended to reflect policy and regulations.

The PCS Manual needs to be clarified somewhat as well. The statement on page 9 of the PCS manual (0504-05) indicates that the Ministry considers the day the person is informed of the vacancy as a vacant day and that the Ministry pays both the government subsidy and basic co-payment. This statement should be qualified in the following way: The government will only pay the basic co-payment and the government subsidy if the facility meets its occupancy target. Otherwise the government will not pay anything towards the cost of the bed. This works out in the reconciliation process and because of the definition of "resident-day" which is found in the Technical Instructions and Guidelines that accompany the facility annual report forms.

5. Assistive Devices

GWA will not provide funding for residents of facilities who may require funds for all or part of the cost of devices such as a wheelchair.

GWA would only consider providing assistance if the device or aid in question would enable the resident to leave the facility and reside in the community.

6. Power of Attorney

It has recently come to the attention of the Residential Services Branch that certain facilities are insisting that, as a requirement of admission, all residents have executed a power of attorney (for property), a continuing power of attorney for property, or a power of attorney for personal care. The importance of residents making such documents is recognized, especially in light of the approaching proclamation of the Substitutes Decisions Act in the spring. However, the legislation governing nursing homes and homes for the aged does not enable a facility to make admissions conditional upon the existence of any of these documents.

Ministry Ministère
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Residential Services Branch
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April 20, 1995

MEMORANDUM TO: Long-Term Care Facility Administrators
Long-Term Care Facility Directors of Care

FROM: Sandy Knipfel
Acting Director

RE: MEDICAL LEAVES

This is to advise you of a recent policy decision with regard to long-term care (LTC) facility residents on medical leave during an outbreak of illness at their respective facilities.

Over the past few weeks, there have been several reported outbreaks of illness in LTC facilities. This is not unusual given the time of year and the trends in the community. Each winter, there is always a marked increase in outbreaks of influenza (upper respiratory and gastro-intestinal) in LTC facilities and such outbreaks are not unexpected.

In some situations, the local Medical Officer of Health may choose to restrict or freeze admissions to a facility as an outbreak control measure. When such occurs, residents who are away from the facility may be prohibited from returning because of the public health order. In most cases, this affects residents who have been sent to hospital.

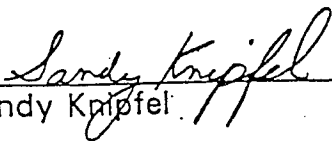
This is to advise you that Ministry funding will be extended past the 21 days for residents who are unable to return to a facility from hospital because of a public health order restricting admissions. Since the affected residents do not have a choice of placement, they should not be penalized as a result and should not have to pay a bed-holding fee to retain their accommodations.

Please note that it is not possible to extend the regulated medical leave beyond the 21 days. In this case, the Ministry is providing the bed-holding fee to the facility on behalf of those residents with expired medical leaves. The affected residents will continue to pay their accommodation rate and the Ministry will provide its portion of the per diem to maintain the bed. The number of resident days will be counted as occupied beds for purposes of the occupancy target.

The Ministry's funding support will continue for the number of days that the public health order remains in effect past each expired 21 day leave so that residents on medical leave are able to maintain accommodations in their respective facilities. Once the Medical Officer of Health lifts the admission ban, the extended funding support for each resident will cease effective that date.

Any LTC facility in an outbreak situation with residents on medical leave who are or may be impacted by a public health order should contact their respective LTC Area Offices. The LTC Area Office will make the necessary arrangements for continued funding support on behalf of residents impacted by the above-described circumstances.

Should you have any questions or comments with respect to the above, please contact your Residential Services Branch Regional Office or your LTC Area Office.


Sandy Kröpfel

cc: Ontario Nursing Home Association
Ontario Association of Non-profit Homes and Services for Seniors
Ontario Association of Residents' Councils
Concerned Friends of Ontario Citizens in Care Facilities
CLAC, CUPE, OFL, OPSEU, ONA, SEIU, UFCW, USWA
HSTAP
Association of Municipalities of Ontario
Association of Placement Coordination Services of Ontario
Area Managers, Long-Term Care Area Offices
Financial Managers, Long-Term Care Area Offices
RSB Managers

DATE: November 7th, 2005

MEMORANDUM TO: Long-Term Care Home Administrators

FROM: Tim Burns
Director, Long-Term Care Homes Branch

RE: **Funding Policy for Suspensions of Admissions Due to Outbreaks in LTC Homes**

The purpose of this memorandum is to outline the ministry's policy for funding during suspension of admissions due to an outbreak as well as the related documentation requirements. The following will provide further detail to the outline provided in the October 2005 Long-Term Care Homes Program Brief.

Funding Support

The intent of the ministry's outbreak funding policy is to support continuity of operations through the outbreak period. The ministry provides two types of resident day credits in the calculation of a home's subsidy:

- A) For vacancies that occur **within the period of closure** – from the date of each vacancy (within the closure period) to the end of the closure period.
- B) Credit is not given for vacancies in the homes at the start of the outbreak period. However, homes may receive credit for **potential new residents** who could have been placed in the home (based on the resident's first choice of placement) **prior to the start of the closure period** but who had not yet been admitted.

Total credited days are applied as a reduction to the occupancy target during the ministry's reconciliation process. It is therefore essential that the ministry receive the required documentation in order to establish the credits to be applied. If a home fails to meet the revised target, the credited days are added to actual resident days in determining allowable funding.

Partial Closures

In the event of a partial closure (i.e. a wing, floor, or residential home area), the ministry only provides credit to the areas affected by the outbreak as stipulated by the Public Health Department order. If the partial closure or some other aspect of the outbreak disrupts admissions to the home as a whole, the home may apply to the Regional Office requesting an expansion of the coverage area for outbreak funding.

Documentation Required

Homes are required to submit the following documentation as soon as possible after the end of an outbreak period to the Regional Office:

- A completed Schedule of Vacancies (a copy is attached. It is also available from the Regional Office and online at www.ltchomes.net)
- A copy of a letter from the local Public Health Authority stating the start and end dates of the closure
- A letter from the local Community Care Access Centre (CCAC) verifying whether or not potential residents were on the home's waiting list who could have been admitted during the closure period (This documentation is required whether or not there are potential applicants on the waiting list as it is needed by the Ministry to monitor the impact of outbreaks).

If applicable, the documentation from the CCAC will also confirm the number of individuals who could have been placed in the home (based on the potential resident's first choice of placement) prior to the start of the closure period but who had not yet been admitted.

To ensure that records are complete in advance of any in-year or other recoveries, the ministry requires all homes that have not previously reported any outbreak closures for 2005 to do so as soon as possible using the Schedule of Vacancies, unless outbreak funding credits have already been confirmed by your regional office.

Please note that the documentation requirements set out above may be in addition to other reporting requirements that may be necessary under the compliance management program. If you have any questions, please contact your Regional Office.

Sincerely,



Tim Burns
Director, Long-Term Care Homes Branch

Attachment: Long-term Care Homes - Schedule of Vacancies

LONG-TERM CARE HOMES SCHEDULE of VACANCIES

During
Outbreaks, Bed Closures, Etc.

Overview:

In order that a home's occupancy target can be reduced by the number of days that beds were closed to admittance due to circumstances beyond the home's control, or approved closure by the ministry, the home must complete the attached LTC Closures/Tracking and the Schedule of Vacancies forms.

If the closure is due to an outbreak of a communicable disease, the following documents must be attached:

1. a copy of a letter from the local Public Health Authority stating the start and end dates of the closure
2. a letter from the local CCAC verifying whether or not potential residents were on the home's waiting list who could have been admitted during the closure period.

If the closure is due to planned / emergency renovations, the closure is to be approved by the ministry in advance.

Information provided in the "Schedule of Vacancies / Closures" will be used in the calculation of occupancy rate during any Reconciliation for the applicable calendar year. Please return the completed schedule to both the Compliance Advisor and Finance Department at your Regional Office as soon as possible upon the completion of the closure.

NOTE: During periods of closure due to Public Health orders, homes will receive credit for vacancies occurring during the closure period. Credit is not given for vacant beds at the start of the period. However, if the CCAC had a potential resident who would have been placed in the home (resident's first choice of placement) prior to the start of the closure period but who had not yet been admitted, the documentation from the CCAC will be used to provide additional credit..

LTC Closure / Outbreak Tracking

LTC Home Name: _____

Reason for Vacancy / Closure:

Planned closure
(Explanation) _____

Outbreak

Type of Outbreak: _____

Number of residents affected: Initial number: _____ Final number: _____

Number of residents hospitalized: _____ Number of resident deaths: _____

Number of staff affected: Initial number: _____ Final Number: _____

Date / Location Closure / Outbreak Initiated: _____

(RHA*) _____ (RHA*) _____

(RHA*) _____ (RHA*) _____

Date Closure/Outbreak Ended: _____

Number Licensed/Approved Beds: _____

Number of Occupied Beds on Date of Closure: _____

Additional Information: (if required) _____

* RHA = Residential Home Area. Specify only the areas affected under the closure order by Public Health (if applicable)

Schedule of Vacancies / Closures during period

Resident / Room #	Date of Vacancy Or Room Closure	Date Completed or Room Opened

If rooms are closed for renovations please specify room number, date closed to admittance for renovation and date reopened to admittance. This will permit the phasing in of beds during renovations.

This form will be used when preparing any Reconciliation for the applicable calendar year. Return to both Regional Finance Department and Compliance Advisor.

Signature _____
 Authorized Home Representative

_____ Date

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENT CHARGES

RESIDENT PAYMENT POLICY FOR SHORT-STAY PROGRAMS

**CHARGES IN
SHORT-STAY
PROGRAMS**

Resident charges for persons placed on a short-term, crisis basis in short-stay programs reflect the fact that most people will also continue to incur expenses related to a community dwelling as they are only in the facility on a short-term basis.

Residents of short-stay programs are charged an amount designed to cover a portion of their accommodation costs.

The amount to be charged is set out in the regulation.

There is no rate reduction available for short-stay programs.

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENT CHARGES

PREVIOUS DEBT

PREVIOUS DEBT

A person who has incurred a debt to the facility prior to the introduction of the new resident charging system remains responsible for the discharge of the debt.

Ministry Ministère
of de
Health la Santé

Residential Services Branch
5700 Yonge Street, 7th floor
North York, Ontario
M2M 4K5

Phone: (416) 327-7352
Fax: (416) 327-7364

November 28, 1996

Memorandum To: Long-Term Care Facility Administrators
Nursing Home Licensees
Homes for the Aged Boards of Management/Boards of Directors

From: Sandy Knipfel
Acting Director, Residential Services Branch

Re: Bad Debt Subsidy

Effective July 1, 1994, the Ministry of Health has been subsidizing bad debts related to accommodation charges for residents in long-term care facilities. The attached document clarifies:

- the criteria that must be met before a resident debt is eligible for a bad debt subsidy;
- how the Ministry calculates the bad debt subsidy; and
- the information that facilities are required to maintain to substantiate the reported bad debt amount.

This policy will be inserted into the "Resident Charges" section of the Long-Term Care Facility Program Manual as Section 0607-10, "Bad Debt Subsidy".

A debt that is considered uncollectible is eligible for a bad debt subsidy in accordance with the following criteria:

- payments are more than three (3) months in arrears;
- no agreement, in writing, has been reached between the facility and the resident which provides for deferred repayment, e.g., the charges to be paid from the resident's estate;

- the facility has attempted to contact the resident or designate to discuss unpaid charges and arrange acceptable terms of repayment;
- the facility has taken legal action where appropriate, e.g., small claims court, a lien on the resident's estate, etc.

Should you have any questions, please contact the Finance Manager in your local Long-Term Care Office.

Yours sincerely,


Sandy Knipfel
Acting Director

cc: Ontario Nursing Home Association
Ontario Association of Non-Profit Homes and Services for Seniors
Ontario Association of Residents' Councils
Association of the Municipalities of Ontario
Association of Placement Coordination Services of Ontario
SEIU, OPSEU, CUPE, UFCW, USWA, CLAC, ONA, OFL, HSTAP
Area Managers, Long-Term Care Offices
Residential Services Branch Managers

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENT CHARGES

BAD DEBT SUBSIDY

FUNDING OF BAD DEBTS

If a resident does not pay the income tested accommodation fee (fully or partially) the facility will be expected to attempt to collect the full amount owing and keep a record of the cumulative debt. If the debt is deemed uncollectible, with substantiation, the amount not collected will be considered to be a bad debt.

A resident bad debt account must meet all of the following criteria before write-off:

CRITERIA

Age of Account

- ▶ Payments are more than three months in arrears.

No Deferred Repayment Plan:

- ▶ No agreement, in writing, has been reached between the facility and the resident which provides for deferred repayment, e.g., the charges to be paid from the resident's estate.

Collection Efforts Are Exhausted:

- ▶ The resident has been notified in writing of the unpaid charges, and advised to apply for all available types of government assistance to which the resident may be entitled,
- ▶ The facility has attempted to contact the resident or designate to discuss unpaid charges and arrange acceptable terms of repayment;
- ▶ the facility has taken legal action where appropriate, e.g., small claims court; a lien on the resident's estate, etc.

REPORTING BAD DEBTS

Summary information concerning bad debt is reported in the Facility Annual Report. Facilities are required to maintain detailed information by resident to substantiate the reported bad debt amount.

JULY - DEC 1993

For the July 1 - December 31, 1993 period, facilities reported resident revenues using the modified cash basis of accounting. Under this method, revenues were based on amounts collected, or anticipated being collected within 30 days of December 31, 1993. Resident "charges" were not reported.

Since provincial funding was provided based on the amounts collected, rather than the amounts charged, the Ministry funded 100% of amounts not collected. Facilities reported collections of outstanding resident charges for the July-December 1993 period in the 1994 Facility Annual Report as "Revenue from Prior Periods."

1994 & 1995

In 1994, facilities reported both "resident charges" and "resident revenues." Resident "charges" were the amounts charged for basic accommodation. Resident "revenues" were the amounts collected under the modified cash basis of accounting. The Ministry funded 100% of the difference between these two amounts for the period January 1 to June 30, 1994. Effective July 1, 1994, bad debts were shared 50/50 between the province and long-term care facilities. For the period July 1 to December 31, 1994 the Ministry funded 50% of the difference between amounts charged and amounts collected.

Collections of outstanding resident charges were reported in the Facility Annual Report as "Revenue from Prior Periods."

JANUARY 1, 1996

Basic accommodation resident revenue will continue to be based on resident charges.

RECOVERY OF BAD DEBT PREVIOUSLY WRITTEN OFF

In addition, facilities will report resident bad debts, e.g., uncollected basic accommodation charges.

In the event a bad debt that has previously been written off is recovered, the recovery will be shared as follows:

- ▶ charges invoiced during the period July 1, 1993 to June 30, 1994: 100% by the Ministry;
- ▶ charges invoiced after June 30, 1994: 50% by the facility and 50% by the Ministry.

REPORTING BAD DEBT AND CALCULATION OF BAD DEBT SUBSIDY

The tables below details the information to be reported in the Long-Term Care Facility Annual Report, beginning with the report covering the 1996 calendar year, and how the bad debt subsidy will be calculated by the Ministry.

1)	<u>BAD DEBTS:</u>	<u>BASIC</u>
a)	No. of Residents:	<u>10</u>
b)	Amount Charged:	<u>\$10,000</u>
c)	Amount Collected:	<u>\$8,000</u>
d)	Bad Debt:	<u>\$2,000</u>

Note: "amounts charged" and "amounts collected" are current year charges and collections. Collections for charges pertaining to periods before January 1, 1996 are reported elsewhere as "Revenue from Prior Periods."

When determining bad debt for a particular resident's account, amounts collected are first applied to basic accommodation charges; and secondly to preferred accommodation; and finally to optional charges, e.g., dry-cleaning etc.

2.)	<u>REPAYMENT OF BAD DEBT</u>	<u>BASIC</u>
a)	No. of Residents	2
b)	Amount Collected	<u>\$500</u>

"Amount collected" relates to payments for charges previously written off as bad debts.

3.)	<u>COLLECTION COSTS:</u>	<u>BASIC</u>
a)	Commissions/legal costs	<u>\$ 300</u>

Collection costs are limited to collection agency commissions and/or legal costs related to Basic Accommodation charges. Facility staff time and office expenses are not included, these charges are charged to the "Other Accommodation" funding envelope.

4.)	<u>BAD DEBT SUBSIDY:</u>	<u>BASIC</u>
a)	Item #1d - #2b + #3a:	<u>\$1,800</u>
b)	Ministry Share:	<u>50%</u>
c)	Ministry Subsidy:	<u>\$900</u>

FINANCIAL MANAGEMENT AND ADMINISTRATION**RESIDENT CHARGES****PREFERRED ACCOMMODATION CHARGES****PREFERRED
ACCOMMODATION**

A facility may designate by internal operating policy up to a maximum of 60% of available beds as preferred accommodation. Such accommodation may be subject to a premium charge.

The maximum premiums for preferred accommodation are intended as ceilings. The prescribed ceiling rates for preferred accommodation are set out in regulation on an annual basis. Facilities may charge less than the maximums in the regulations.

Preferred accommodation premiums can be levied only against available private or semi private rooms.

The maximum number of beds to which preferred accommodation charges may be applied is calculated on individual facilities. Every facility in the province must retain a minimum of 40% of beds at basic accommodation.

Facilities are not required to charge the preferred accommodation maximum. However, to ensure consistency and equality across the Province all facilities are encouraged to adopt a common preferred accommodation policy.

Each facility must advise the Placement Coordination Services of the facility's preferred accommodation policy and maintain ongoing communication to clearly delineate the type and applicable conditions associated with existing vacancies.

FINANCIAL MANAGEMENT AND ADMINISTRATION**RESIDENT CHARGES****PREFERRED ACCOMMODATION CHARGES****PREFERRED
ACCOMMODATION
(CONT'D)**

No resident may be discharged from a facility as a result of a change in personal financial circumstances or changes to the preferred accommodation policy.

If a move from preferred accommodation to basic accommodation must occur the operator has the ability to reduce the preferred accommodation rate charged to the resident while awaiting transfer. The establishment of a very stringent preferred accommodation policy could result in a facility not meeting its occupancy target for levels-of-care funding.

Where a facility cannot fill its preferred accommodation beds with full-paying residents, it is encouraged to admit residents with the ability to pay the basic accommodation charge or residents who can partially pay the preferred accommodation rate, on the understanding that the resident will be moved to basic accommodation upon availability.

Pursuant to the Instructions for Completion relating to the Long-Term Care Facility Subsidy Calculation Worksheet, the preferred accommodation premium is recovered by the province on a pro rata basis. All long-term care facilities, including those that are red-circled will retain 50% of preferred accommodation revenue.

All facilities governed by the provisions of Bill 101 will develop a written policy on preferred accommodation. The policy must comply with the regulations.



Office of the Minister

Bureau du ministre

10th Floor, Hepburn Block
80 Grosvenor Street
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June 5, 2000

The government is committed to ensuring that everyone in the province has access to quality health care throughout their lives. Building 20,000 new long-term care beds by 2004, replacing existing "D" beds, and establishing interim beds are vital initiatives aimed at addressing the needs of Ontario's growing and aging population.

The size and scope of the government's \$1.2 billion long-term care investment is unprecedented in Ontario. To help ensure that the government's commitment is met, we have recently established the Long-Term Care Redevelopment Project. This project will oversee implementation and assist award recipients.

I am pleased to announce that the Ontario government will allow long-term care facility operators to retain 100% of preferred accommodation revenues to enable them to better manage long-term care beds. The base funding will be a permanent adjustment to funding levels and is retroactive to April 1, 2000. Enclosed is a fact sheet that explains the Preferred Accommodation Strategy.

The driving force behind this funding initiative is our goal to ensure that everyone in Ontario has access to quality health care throughout their lives.

Sincerely,

A handwritten signature in black ink, appearing to read "Elizabeth Witmer".

Elizabeth Witmer, MPP
Minister

Fact Sheet

Preferred Accommodation Strategy

1. **What is the Preferred Accommodation Strategy?**

The Ontario government is now allowing long-term care facility operators to retain 100% of preferred accommodation revenues to enable them to better manage long-term care beds.

2. **When does it take effect?**

It is retroactive to April 1, 2000. The base funding will be a permanent adjustment to funding levels.

3. **How does this differ from the current situation?**

Currently, LTC facility operators and the ministry share 50/50 the preferred accommodation revenues collected.

4. **Why the change?**

The government has been listening to its stakeholders and working with long-term care associations to address restructuring issues.

5. **What are the benefits of the change?**

The Ontario government will allow long-term care facility operators to retain 100% of preferred accommodation revenues to enable them to better manage long-term care beds. The base funding will be a permanent adjustment to funding levels and is retroactive to April 1, 2000.

6. **What do residents in long-term care facilities pay?**

Residents are required to pay a preferred accommodation fee of up to \$8 per day for semi-private and \$18 for private accommodation, in addition to the basic accommodation fee - currently at \$42.01 per day.

The existing requirement that at least 40 per cent of long-term care beds be made available at the basic accommodation rate would remain unchanged.

7. **What did the ministry do with its share of the preferred accommodation revenue?**

The ministry's 50% of the preferred accommodation revenue is currently estimated to be \$43 million. It will increase to \$58 million by 2003/04 when the 20,000 new beds are in place.

The ministry used its share of the preferred accommodation revenue, as well as 100% of the basic accommodation fees collected, to offset funding requirements for the long-term care facility program.

8. **What is the government doing to speed up the construction of new long-term care beds?**

To help long-term care facility operators construct the beds as efficiently as possible, the Ontario government has established the Long-Term Care Redevelopment Project which consolidates all resources related to this initiative in one location and works with operators to streamline the implementation process.

The Ontario government is reducing red tape. The Ministry of Health and Long-Term Care has decreased the number of offices operators have to deal with and it is working closely with the long-term care industry. What the ministry has not reduced is its expectations in terms of standards and quality. The driving force behind this funding initiative is the government's goal to ensure that everyone in Ontario has access to quality health care throughout their lives.

FINANCIAL MANAGEMENT AND ADMINISTRATION**FACILITY SERVICES****BASIC SERVICES****INTRODUCTION**

Residents of Long-Term Care facilities are expected to pay the basic accommodation charge. This charge is for the cost of food and for basic accommodation. This section outlines which services are to be included in charge for basic accommodation.

BASIC SERVICES INCLUDED IN CHARGE FOR BASIC ACCOMMODATION

The following is a list of the basic services that residents can expect to receive without additional charge, other than the charge to the resident for basic accommodation

- Nursing and personal care on a 24-hour basis, including care given by or under the supervision of a registered nurse or a registered nursing assistant, the administration of medication and assistance with the activities of daily living
- Medical care that is available in the facility

Note: Residents may continue to have their personal physician provide care to them in the facility. These physicians will be expected to meet the standards and criteria for attending physicians. (Refer to Medical Services)

- Medical supplies and nursing equipment necessary for the care of residents, including the prevention or care of skin disorders, continence care, infection control, and sterile procedures
- Medical devices, such as catheters and colostomy and ileostomy devices

FINANCIAL MANAGEMENT AND ADMINISTRATION**FACILITY SERVICES****BASIC SERVICES****BASIC SERVICES
INCLUDED IN CHARGE
FOR BASIC
ACCOMMODATION
(CONT'D)**

- Supplies and equipment for personal hygiene and grooming, including skin care lotions and powders, shampoos, soaps and deodorant, toothpaste, toothbrushes, denture cups and cleansers, toilette tissue, facial tissue, hairbrushes, combs, razors/shavers, shaving cream, feminine hygiene products
- Equipment for the general use of residents, including wheelchairs, geriatric chairs, canes and walkers, toilet aids and other self-help aids for the activities of daily living
- Meal service and meals, including three meals daily, snacks between meals and at bedtime, special and therapeutic diets, dietary supplements and devices enabling residents to feed themselves
- Social, recreational and physical activities and programs, including the related supplies, equipment and staff
- Laundry, including labelling, machine washing and drying of personal clothes
- Bedding and linen, including firm comfortable mattresses with waterproof covers, pillows, bed linen, washcloths and towels
- Bedroom furnishings, such as beds, adjustable bed rails, bedside tables, comfortable easy chairs, and where a resident is confined to bed, a bed with an adjustable head and foot

FINANCIAL MANAGEMENT AND ADMINISTRATION**FACILITY SERVICES****BASIC SERVICES****BASIC SERVICES
INCLUDED IN CHARGE
FOR BASIC
ACCOMMODATION
(CONT'D)**

- Standard ward accommodation
- The cleaning and upkeep of accommodations
- Suitable accommodation and seating for meetings of the residents' family councils
- Use of the infirmary room, if available

It is not permissible to charge for:

- Prescription pharmaceutical preparations listed in the Drug Benefit Formulary
- Special preparations or medical devices which may be obtained from the Ontario Drug Benefit Program as interim non-formulary benefits
- Insured devices, equipment, supplies and services available to residents through other programs such as the Home Care Program and the Assistive Devices Program
- Non-prescription drugs, medication and treatment products and supplies, that are obtained through the Ontario Government Pharmaceutical and Medical Supply Services upon requisition

FINANCIAL MANAGEMENT AND ADMINISTRATION
FACILITY SERVICES
OPTIONAL SERVICES

INTRODUCTION

Long-Term Care Facilities are permitted to charge residents for optional services that do not form part of the services that are included as basic services.

RESIDENT CHOICE

Residents must have the choice of either using an optional service that is offered by a facility, or making alternative arrangements for themselves.

**GUIDELINES FOR
CHARGING RESIDENTS
FOR OTHER SERVICES**

Facilities may charge a resident who uses an optional service, providing:

1. Each facility, in consultation with its residents, determines the optional services that it is able to make available to its residents.
2. All residents receive a full and clear written explanation of services for which they cannot be charged, as well as optional services available in the facility.
3. All agreements with residents, their family or other representative(s), regarding the purchase of optional services are in writing, and that an agreement can be terminated by either party with 30 days notice in writing.
4. All written agreements describe the obligations of all parties involved.

FINANCIAL MANAGEMENT AND ADMINISTRATION**FACILITY SERVICES****OPTIONAL SERVICES****GUIDELINES FOR
CHARGING RESIDENTS
FOR OTHER SERVICES
(CONT'D)**

5. That optional services are reviewed on a regular basis as part of the facility's quality management program to determine whether the frequency, type and quality of service meets the needs of residents.
6. That residents, their family or other representative(s) are informed in writing 30 days prior to any increase to the fees for optional services.
7. That in areas with a Placement Coordination Service each facility provide the PCS with a copy of its other services and charges.

OPTIONAL SERVICES

Optional services may include but are not limited to:

1. Hairdressing/barbering
2. Dry cleaning
3. Telephone service in a resident's room
4. Purchase of liquor
5. Financial services, including:
 - banking
 - tax return preparation
 - trust account management and audit
6. Transportation services
7. Ironing and mending of clothes
8. Purchase of cable television service.

FINANCIAL MANAGEMENT AND ADMINISTRATION**RESIDENTS' TRUST ACCOUNTS****LEGISLATION****INTRODUCTION**

Residents should be encouraged to:

- manage their own assets or personal funds and/or
- arrange for a system to have their funds managed by their families/authorized representatives or
- arrange to have their funds managed by a financial institution such as a trust company or bank.

The Office of the Public Guardian and Trustee may also be contacted as the last option, if a resident's situation meets the criteria for involvement by that office.

Where possible, a resident's financial arrangements prior to admission should continue, if this is the resident's wish. In some situations, however, arrangements may need to change if, for example, residents enter facilities that are a distance from family, or the persons that have been managing their finances are no longer able to continue this responsibility. These residents may then wish to use a trust account in the long-term care facility.

PURPOSE OF TRUST ACCOUNTS

A trust account is for the convenience of residents who need to have funds maintained in a safe place and readily available for use in the long-term care facility.

Funds in the trust account may be used to pay for facility-related transactions approved by a resident/authorized representative, such as payment of accommodation costs as well as other optional services.

LEGISLATION

All long-term care facilities are required by legislation to provide a trust account for residents' personal needs funds, for those residents who may wish to use this service. Regulations governing trust funds are found in the *Charitable Institutions Act*, the *Homes for the Aged and Rest Homes Act*, and the *Nursing Homes Act*. These regulations specify the requirements that must be met with respect to the management of funds that have been entrusted to a facility for management.

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENTS' TRUST ACCOUNTS

LEGISLATION

LEGISLATION (CONT'D)

As of January 10, 1997, the *Nursing Homes Act*, Sec. 103(1) which prohibits nursing home trust accounts from earning interest, is revoked.

TYPES OF TRUST ACCOUNTS

In long-term care facilities, there are currently two common types of trust accounts:

- a) Trust accounts that have been established in homes for the aged to manage a resident's financial assets and income (referred to as "maintenance trust funds"). Starting November 1, 1998, the Ministry of Health policy will prohibit the management of asset holdings by long-term care facilities for any new residents admitted.

Facilities may continue to manage these types of trust accounts for any residents whose accounts were/are established prior to November 1, 1998. However, since facilities do not have a mandate to act as investors and in order for residents to obtain maximum value for their investments, it is recommended that homes for the aged currently operating asset-holding accounts, tender the administration of these trust accounts with:

- the resident/authorized representative;
- a financial institution; or as the last option,
- the Office of the Public Guardian and Trustee.

- b) Trust accounts that have been set up to manage a resident's personal needs funds. This may include funds from income or from a statutory benefit (e.g., OAS, CPP, FBA) and any funds that are deposited by the resident or by the resident's representative for the resident's personal use.

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENTS' TRUST ACCOUNTS

LEGISLATION

MANAGEMENT OF TRUST ACCOUNTS

Residents' trust accounts must be managed according to the provisions of the *Trustee Act*, April 1995.

The facility must establish policies for management of the trust accounts, including but not limited to the following:

- a system to record authorization for charges that the resident/representative directs the facility to be paid from his/her trust account
- charges for the administration of the trust account (see Charging of Fees for Management of Trust Accounts, Page 4)
- hours when trust account funds are available
- amounts that may be withdrawn in cash, and notice that is required for larger withdrawals
- records management.

Any complaints from the resident/authorized representative or other person, about the handling of residents' personal funds will be investigated by the Ministry of Health staff.

WITHDRAWALS FROM TRUST ACCOUNTS

Residents' trust accounts cannot be billed for **any** charges that are not authorized by the resident/authorized representative in writing and that are not in accordance with legislation.

Each withdrawal from a trust account must be authorized in writing by the individual resident/authorized representative. This can be done at the time each withdrawal is requested by the resident/authorized representative. Authorization can also be provided on a schedule which is part of the admission agreement (with any later changes in direction initialled and dated). In this way, a resident may pre-authorize withdrawals for such items as accommodation charges or optional charges to be paid on a regular basis.

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENTS' TRUST ACCOUNTS

LEGISLATION

RECORDS MANAGEMENT

The administrator shall maintain a separate, detailed record for each resident's trust account. This record shall be retained for at least six years from the date the trust account is closed or becomes inactive, showing the date and amounts of all deposits and withdrawals.

The administrator shall provide the resident/authorized representative with a written receipt for all monies received for deposit in the trust account, and a resident/authorized representative shall provide the administrator with a written receipt for all monies withdrawn from the account. The bank statement may serve as a receipt for pre-authorized payments made from the trust account.

An itemized quarterly statement of money held by the facility on behalf of the resident, charges made to the resident, and the balance in the account, shall be provided to each resident/authorized representative.

Computer records must have back-up records, as required in normal business practice.

The trust account must be audited annually by a licensed public accountant and a copy of the statement by the auditor shall be forwarded to the Regional Office.

CHARGING OF FEES FOR MANAGEMENT OF TRUST ACCOUNTS

Effective November 1, 1998, facilities **may** charge a fee for management of trust accounts. The maximum fee which may be charged is 50 cents per transaction, to a maximum amount of \$5.00 per month.

The fee charged must be specified in the admission agreement with the resident, and agreed to in writing by the resident/authorized representative.

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENTS' TRUST ACCOUNTS

LEGISLATION

INTEREST EARNED BY RESIDENTS' TRUST ACCOUNTS

All trust account funds are required to be maintained in an interest-bearing account in a Canadian financial institution that is CDIC (Canadian Deposit Insurance Corporation) insured. The account should:

- provide the highest interest rate;
- allow the minimum amount of service charges reasonably available during the period the funds are maintained;
- ensure the funds are accessible on short notice without a significant loss of interest.

Interest earned should be regularly credited to individual residents accounts, using acceptable standards of allocation. For example, account balances should be reviewed over three months and all interest actually earned should be allocated on a proportionate basis to individual residents accounts.

MANAGEMENT OF TRUST FUNDS WHEN A RESIDENT IS FINANCIALLY INCAPABLE

A facility shall not require an applicant or resident to have a continuing Power of Attorney for Property or a Guardianship for Property as a condition of admission. However, on admission, if the resident is capable of granting a Continuing Power of Attorney and if there is a person to whom the resident wishes to grant it, the resident should be encouraged to do so.

If a resident has been managing his/her financial affairs and becomes unable to do so, or when there is concern that a resident may be mentally incapable of managing his/her finances, a number of steps can be taken, as follows:

If there is an Existing Continuing Power of Attorney for Property:

A copy of the continuing power of attorney for property must always be requested for review:

- A continuing power of attorney for property that is valid immediately upon being signed can continue to be used by the attorney after the person becomes incapable

FINANCIAL MANAGEMENT AND ADMINISTRATION

RESIDENTS' TRUST ACCOUNTS

LEGISLATION

.MANAGEMENT OF TRUST FUNDS WHEN A RESIDENT IS FINANCIALLY INCAPABLE (CONT'D)

- A continuing power of attorney for property which can only be used after the person is incapable of managing property must be reviewed to ascertain what method is to be used to determine capacity.
 - (a) A continuing power of attorney for property may specify how capacity is to be determined. Where a method is specified, the attorney may not act until incapacity has been confirmed by the method outlined.
 - (b) If the document does not specify a method of determining capacity, capacity to manage property can be assessed as follows:
 - (i) An inpatient in a psychiatric facility must have his/her capacity to manage property assessed pursuant to the *Mental Health Act*. (This method is NOT available to assess residents of long-term care facilities.)
 - (ii) A “capacity assessor” as defined by the *Substitute Decisions Act* can be retained to assess the person’s capacity to manage his/her property. A person has a right to refuse to participate in a capacity assessment.

If there is no Continuing Power of Attorney for Property:

1. If income consists only of certain types of benefits (for example, federal pensions, provincial benefits, etc.) and there are no assets to manage:

FINANCIAL MANAGEMENT AND ADMINISTRATION
RESIDENTS' TRUST ACCOUNTS
LEGISLATION

**MANAGEMENT OF
TRUST FUNDS WHEN A
RESIDENT IS
FINANCIALLY
INCAPABLE (CONT'D)**

Applications for Trusteeships:

- Capacity to manage property is assessed pursuant to the procedures set out in the rules of that benefit plan.
 - (a) A family member or other appropriate third party may apply to the office which administers the benefits to become trustee of the funds; or
 - (b) The Administrator may apply to the Office which administers benefits to become trustee of the funds.
 - (c) The Office of the Public Guardian and Trustee (PGT) intake unit may be contacted where there is no one else available to apply, to determine whether the PGT will consider applying to be trustee according to PGT policy.
2. If there is income consisting of more than the above noted benefits, or if there are assets to be managed:
- (a) Capacity to manage property can be assessed as follows:
 - (1) An inpatient in a psychiatric facility must have his/her capacity to manage property assessed pursuant to the *Mental Health Act*. (This method is NOT available to residents in long-term care facilities.)

FINANCIAL MANAGEMENT AND ADMINISTRATION
RESIDENTS' TRUST ACCOUNTS
LEGISLATION

**MANAGEMENT OF
TRUST FUNDS WHEN A
RESIDENT IS
FINANCIALLY
INCAPABLE (CONT'D)**

- (2) A “capacity assessor” as defined by the *Substitute Decisions Act* can be retained to assess the person’s capacity to manage his/her property (under Section 16 of the *Substitute Decisions Act*). A person has a right to refuse to participate in a capacity assessment.

Note: If a LTC facility retains a capacity assessor, the facility is responsible for paying the cost, as the “requester”. However, the cost of the assessment can be recovered from the resident’s trust funds, if the resident is found to be incapable.

- (b) The capacity assessor will automatically notify the Ontario Public Guardian and Trustee if the person is found incapable of managing his/her property. The Ontario Public Guardian and Trustee automatically becomes the person’s statutory guardian of property.
- (c) Family members may apply to the Office of the Public Guardian and Trustee to replace her as statutory guardian of property.
- (d) The incapable person has a right to a hearing before the Consent and Capacity Board to review a finding of incapacity to manage property made by a capacity assessor.

**APPLICATION TO BE
APPOINTED GUARDIAN
OF PROPERTY**

In unusual circumstances, it may be necessary for a family member or other appropriate third party to apply to the court to be appointed guardian of property. Where there is no family or appropriate third party, the Office of the Public Guardian and Trustee may apply to become guardian of property.

FINANCIAL MANAGEMENT AND ADMINISTRATION
RESIDENTS' TRUST ACCOUNTS
LEGISLATION

**APPLICATION TO BE
APPOINTED GUARDIAN
OF PROPERTY (CONT'D)**

Example:

A guardianship application may occur when there is more than one person who wishes to manage the property, to override a continuing power of attorney for property, where the estate is complex, or where the alleged incapable person refuses to undergo a capacity assessment.

**MANAGEMENT OF
TRUST FUNDS
FOLLOWING DEATH**

When a resident dies, the entire balance of all trust funds becomes part of the estate. If there are any accommodation arrears or other outstanding charges, the facility may make a claim against the estate.

When a resident dies and there is no will and no family or power of attorney, the Office of the Public Guardian and Trustee must be contacted to manage the funds (at (416) 314-1447). Pending involvement of the Office of the Public Guardian and Trustee, if there are urgent disbursements such as funeral expenses that must be made, the long-term care facility administrator/ designate may call the local Regional Office to discuss the issues.

If a resident has been managing his or her financial affairs and becomes unable to do so, the Office of the Public Guardian and Trustee should be contacted if there is no family and no one offering to be guardian for property and health care.

FINANCIAL MANAGEMENT AND ADMINISTRATION**CAPITAL ASSISTANCE****ELIGIBILITY****ELIGIBILITY**

Homes for the aged and not-for-profit nursing homes are eligible to receive grants towards their capital costs.

**SUMMARY OF
LEGISLATION AND
REGULATIONS****Charitable Homes for the Aged**

The *Charitable Institutions Act* provides for capital grants in respect to charitable institutions:

- Covering the cost of constructing buildings or additions, where the site and plans have been approved by the Minister and where all or any part of the new building or the addition is to be used as a charitable institution other than a hostel, up to \$5,000 per bed or such greater amount per bed as is prescribed by the regulations.
- Covering the cost of acquiring or making structural alterations to a building, where this has been approved by the Minister, up to \$1,200 per bed or such greater amount per bed as is prescribed by the regulations.
- Covering the cost of renovating a charitable institution other than a hostel, or purchasing furnishings or equipment in connection with an approved charitable institution other than a hostel, where this has been approved by the Minister, up to \$1,200 per bed or such greater amount per bed as is prescribed by the regulations.

FINANCIAL MANAGEMENT AND ADMINISTRATION

CAPITAL ASSISTANCE

ELIGIBILITY

SUMMARY OF LEGISLATION AND REGULATIONS (CONT'D)

Municipal Homes for the Aged

The *Homes for the Aged and Rest Homes Act* provides for capital grants in respect to municipal homes for the aged:

- Covering 50 per cent, or such higher percentage as the regulations prescribe, of the cost of acquiring, erecting or altering a building for use as a home or joint home, when the site and plans have been approved by the Minister.
- Covering 50 per cent, or such higher percentage as the regulations prescribe, of the cost of other capital expenditures specified in the regulations made under the Act.
- Covering the proportion that is allocated by the regulations to the unorganized parts of the territorial district of the capital expenditure,
 - where a home is established and maintained under section 6 of the Act, or
 - a home is maintained and operated under an agreement with the Minister pursuant to section 10 of the Act,

as long as a payment has not been made under subsection 25(2) of the Act.

Not-For-Profit Nursing Homes

The *Nursing Homes Act* provides for capital grants in respect to not-for-profit nursing homes. The Minister may impose conditions on these grants.

FINANCIAL MANAGEMENT AND ADMINISTRATION

CAPITAL ASSISTANCE

CAPITAL PROCESS AND PROCEDURES

**CAPITAL PROCESS AND
PROCEDURES**

(THE CAPITAL PROCESS IS CURRENTLY UNDER
DEVELOPMENT)

**REGISTRATION OF
A CHARGE**

In order that the Ministry may recover any amount due to it on the sale of an asset for which it has made a capital grant, the Ministry will register a charge against the asset toward which such a grant has been made.

FINANCIAL MANAGEMENT AND ADMINISTRATION
SUPPLEMENTARY FUNDING
INTRODUCTION

INTRODUCTION

The Ministry of Health introduced a supplementary funding initiative for particular accommodation costs in long-term care facilities beginning July 1, 1993 to stabilize the cash flow requirements of qualifying long-term care facilities while the Levels-of-Care funding was in the initial phase of implementation.

The components of this initiative include:

- a) the **Municipal and Capital Tax Allowance**;
- b) the **Compliant Facility Debt Service/Rent Allowance**;
and
- c) the **Structural Compliance Premium**.

FINANCIAL MANAGEMENT AND ADMINISTRATION
SUPPLEMENTARY FUNDING
MUNICIPAL AND CAPITAL TAX ALLOWANCE

PURPOSE

In recognition that some LTC facilities are required to pay municipal and capital taxes while others are exempt from these taxes, the Province has established a fund of \$28.3 million to subsidize a portion of the costs incurred by those LTC facilities that are liable for municipal and capital taxes.

Based on available funds, the province will provide an allowance equal to **the lesser of** 90% of the previous year or current year municipal and capital taxes paid by LTC facilities.

ELIGIBILITY CRITERIA

Long-term care operators of facilities that pay municipal and capital taxes (i.e., municipal realty and business taxes and provincial capital taxes), may be eligible for the Municipal and Capital Tax Allowance.

Applicants will submit an application for the Municipal and Capital Tax Allowance to the Long-Term Care Area Office on a Ministry prescribed form.

Only that portion of the Municipal and Capital Tax expenditure that is attributable to the building(s) or parts of building(s) that are licensed/approved by the Ministry and used as long-term care facilities are eligible for the allowance.

FINANCIAL MANAGEMENT AND ADMINISTRATION
SUPPLEMENTARY FUNDING
MUNICIPAL AND CAPITAL TAX ALLOWANCE

ELIGIBILITY CRITERIA
(CONT'D)

Applicants whose municipal or capital costs are, or may be attributable to, business or personal uses other than LTC facility use will submit:

- an **auditor's certified schedule** attesting to the method in which all expenditures are apportioned to the LTC facility and attesting to the reasonableness of the apportionment, or
- a copy of the most recently completed **audited financial statement**, including all supplementary schedules and auditor's comments/notes, provided the financial statement includes sufficient information for the determination of how expenditures are apportioned to the LTC facility.

The amount of assistance is **the lesser of** 90% of the previous year or current year municipal and capital taxes paid by the applicant.

All payments are subject to Ministry reconciliation and audit.

The Municipal and Capital Tax Allowance is administered under the authority of the *Ministry of Health Act*.

Applicants must identify that portion of their municipal and capital tax expenditure that is attributable to LTC facility use and that proportion that is not attributable (i.e., retirement home, corporate head office, personal and other than LTC facility uses, e.g., adult day care, meals on wheels program) and provide an explanation of the method used to make the attribution, using generally accepted accounting practices.

FINANCIAL MANAGEMENT AND ADMINISTRATION
SUPPLEMENTARY FUNDING
MUNICIPAL AND CAPITAL TAX ALLOWANCE

ELIGIBILITY CRITERIA
(CONT'D)

Area Finance Managers in the Ministry's Long-Term Care Area offices will examine the information provided by the applicant and determine the amount of the Municipal and Capital Tax expenditure that is attributable to LTC facility use and the amount of the allowance to be provided.

Where a dispute arises between the Ministry's Area Office and the applicant concerning the amount that is attributable to LTC facility use, the issue will be referred for final resolution to the office of the Executive Director.

FINANCIAL MANAGEMENT AND ADMINISTRATION
SUPPLEMENTARY FUNDING
COMPLIANT FACILITY DEBT SERVICE/RENT ALLOWANCE

INTRODUCTION

This initiative consists of two components:

- a) Compliant Facility Debt Service/Rent Allowance; and
- b) Structural Compliance Premium.

The purpose of the initiative is to stabilize the cash flow requirements for particular accommodation costs in qualifying long-term care facilities.

ELIGIBILITY CRITERIA

For the purposes of the Compliant Facility Debt/Rent Service Allowance, a structurally compliant nursing home means:

- a) a nursing home that is compliant with structural standards in Regulation 832 under the *Nursing Homes Act*; or
- b) a nursing home with minor structural deficiencies which, although not structurally compliant, has been granted a waiver on the basis of guidelines which were developed by the Compliance Plan Review Board (CPRB) in July 1986, hereafter referred to as the CPRB guidelines.

Nursing homes that, according to Ministry records, were not structurally compliant on June 30, 1993, but became structurally compliant between July 1, 1993 and June 30, 1994 may be eligible for the Debt Service/Rent Allowance based on their qualifying debt interest costs. (See Method of Determination of Eligible Amount).

Nursing homes that, according to Ministry records, were structurally compliant by July 1, 1993 may be eligible for the Debt Service/Rent Allowance based on their qualifying debt interest/rent costs. (See Method of Determination of Eligible Amount.)

FINANCIAL MANAGEMENT AND ADMINISTRATION**SUPPLEMENTARY FUNDING****COMPLIANT FACILITY DEBT SERVICE/RENT ALLOWANCE****ELIGIBILITY CRITERIA
(CONT'D)**

Approved red-circled charitable homes for the aged that have completed a material renovation or addition as of July 1, 1993 may be eligible to receive the Debt Service/Rent Allowance provided they present the Ministry with supporting documentation, acceptable to the Ministry, relating to the material renovation or addition and the material renovation or addition has been inspected and verified by the Ministry. For the purposes of this section, a "material construction, renovation or addition" means a renovation or addition to the physical structure of the approved charitable home for the aged which is equal to or exceeds twenty-five percent (25%) of the total value of the physical structure of the approved charitable home for the aged and which was funded in total without Ministry assistance through capital funding. The Ministry will review the supporting documentation and inspect the facility to determine whether the approved charitable home for the aged has completed a material renovation or addition by July 1, 1993. The Debt Service/Rent Allowance payment is retroactive to July 1, 1993.

Applicants will submit an application for the Debt Service/Rent Allowance to the Long-Term Care Area Office on a Ministry prescribed form.

Only that portion of the debt interest or rent expenditure that is attributable to the building(s) or parts of building(s) that are licensed/approved by the Ministry and used as long-term care facilities is eligible for the Compliant Facility Debt Service/Rent Allowance.

FINANCIAL MANAGEMENT AND ADMINISTRATION

SUPPLEMENTARY FUNDING

COMPLIANT FACILITY DEBT SERVICE/RENT ALLOWANCE

ELIGIBILITY CRITERIA (CONT'D)

Applicants whose debt interest or rental costs are or may be attributable to business or personal uses other than LTC facility use will submit an **auditor's certified schedule** attesting to the method in which all expenditures are apportioned to the LTC facility and attesting the reasonableness of the apportionment, or a copy of the most recently completed **audited financial statement**, including all supplementary schedules and auditor's comments/notes, provided the financial statement includes **sufficient information** for the determination of how expenditures are apportioned to the LTC facility.

Nursing homes and approved charitable homes for the aged that are Red-Circled may be eligible for the Compliant Facility Debt Service/Rent Allowance if they meet all eligibility criteria and if it is more advantageous to them to apply for the Compliant Facility Debt Service Allowance than it is to receive supplemental funding under the Red-Circling provision.

Qualifying facilities will receive the difference between the amount they are entitled to under the Red-Circling provision and the amount they would be entitled to under the Compliant Facility Debt Service/Rent Allowance and the Structural Compliance Premium added to the Levels-of-Care subsidy.

Any increase in debt interest payments that occurred after July 1, 1993 will not be included in the determination of the eligible amount.

- (a) the increase in debt was incurred for approved construction or renovation costs for the purpose of meeting requirements under Regulation 832 under the Nursing Homes Act; and
- (b) the home was compliant with structural standards deemed eligible for the allowance by June 30, 1994

FINANCIAL MANAGEMENT AND ADMINISTRATION
SUPPLEMENTARY FUNDING
COMPLIANT FACILITY DEBT SERVICE/RENT ALLOWANCE

**ELIGIBILITY CRITERIA
 (CONT'D)**

The Ministry of Health is the sole determinant of whether an applicant is structurally compliant.

**METHOD OF
 DETERMINATION OF
 ELIGIBLE AMOUNT**

The Compliant Facility Debt Service/Rent Allowance will be limited to a "maximum approved expenditure" for debt interest and rental payments.

The maximum approved expenditure will be the lesser of \$5.44 per bed per day or the amount determined by the following calculation: \$14.71 per bed per day minus:

- (a) \$4.77 per bed per day
 (This is the amount that is attributable to non-operating costs, exclusive of amounts attributed to municipal and capital taxes, in the long-term care facility cost model)
- (b) 50% of the current year's preferred accommodation revenues;
- (c) \$2.37 per bed per day;
 (This is 90% of the \$2.63 that is attributed to the municipal and capital taxes in the Ministry's LTC facility accommodation cost model.)
- (d) \$0.26 per bed per day, only if the facility is not required to pay Municipal and Capital Taxes;
 (This is the remaining 10% of the amount attributed to municipal and capital taxes identified above).
- (e) The amount of debt interest that is attributable to the facility's operating line of credit;

FINANCIAL MANAGEMENT AND ADMINISTRATION

SUPPLEMENTARY FUNDING

COMPLIANT FACILITY DEBT SERVICE/RENT ALLOWANCE

**METHOD OF
DETERMINATION OF
ELIGIBLE AMOUNT
(CONT'D)**

- (f) The amount of debt interest or rental payments that is attributable to the building(s) or parts of building(s) that are not licensed/approved by the Ministry and used as long-term care facilities;
- (g) The amount of additional debt that was incurred after June 1, 1993 unless such an increase in debt was obtained with the approval of the Director of the Residential Services Branch and to the extent that the debt was incurred for approved construction or renovation costs incurred for the purpose of meeting the structural requirements under Regulation 832 under the *Nursing Homes Act*; and
- (h) In the case of non-arms length transactions with respect to interest and rental payments, the amount of interest or rental payments that is in excess of fair market interest and rent prices as determined by the Ministry.

For the purposes of the Compliant Facility Debt Service Rent Allowance, the definition of non-arms length transactions shall have the same meaning as set out in the definitions of the Funding Application form.

All payments are subject to Ministry reconciliation and audit. Funding for this initiative will be reconciled separately as part of an annual reconciliation process and adjusted from funds available.

**METHOD OF
DETERMINATION OF
ELIGIBLE AMOUNT
(CONT'D)**

The Compliant Facility Debt Service/Rent Allowance is administered under the authority of the *Ministry of Health Act*.

FINANCIAL MANAGEMENT AND ADMINISTRATION**SUPPLEMENTARY FUNDING****COMPLIANT FACILITY DEBT SERVICE/RENT ALLOWANCE****FUND LIMIT**

Total provincial funding for the Compliant Facility Debt Service/Rent Allowance is limited to \$11.0 Million annually. If the amount of the total eligibility for the funding exceeds this limit, the funds provided for facilities will be retroactively pro rated not to exceed \$11.0 Million.

PROCEDURES FOR APPLICATION AND APPROVAL

Applicants will submit an application for the Compliant Facility Debt Service/Rent Allowance to the Long-Term Care Area Office on a Ministry prescribed form and attach a copy of an **auditor's certified schedule** attesting to the method in which all expenditures are apportioned to the LTC facility and attesting the reasonableness of the apportionment, or an **audited financial statement** if it has **sufficient information** for the determination of how expenditures are apportioned to the LTC facility.

Applicants will identify that portion, if any, of the expenditure that is attributable to non-LTC facility use (e.g., retirement home, corporate head office, other than LTC facility use, e.g., adult day care, meals on wheels program) and provide an explanation of the method used to make the attribution, using generally accepted accounting practices.

The Ministry's Finance Manager in the Ministry's Long-Term Care Area offices will examine the information provided by the applicant and determine the amount of the rent or debt interest cost that is attributable to LTC facility use and the amount of the allowance to be provided.

In the case of non-arms length loans and rental payments, the Finance Manager will determine whether any amount of interest or rental payments are in excess of fair market interest and rent prices and the allowable amount of interest or rent that is eligible for the purposes of calculating the Compliant Facility Debt Service/Rent Allowance.

FINANCIAL MANAGEMENT AND ADMINISTRATION

SUPPLEMENTARY FUNDING

COMPLIANT FACILITY DEBT SERVICE/RENT ALLOWANCE

**PROCEDURES FOR
APPLICATION AND
APPROVAL (CONT'D)**

Where a dispute arises between the Ministry's Area Office and the applicant concerning the amount that is attributable to LTC facility use, the issue will be referred for final resolution to the office of the Executive Director.

FINANCIAL MANAGEMENT AND ADMINISTRATION
SUPPLEMENTARY FUNDING
STRUCTURAL COMPLIANCE PREMIUM

ELIGIBILITY CRITERIA

For the purposes of the Structural Compliance Premium, a structurally compliant nursing home means:

- a) a nursing home that is compliant with structural standards in Regulation 832 under the *Nursing Homes Act*; or
- b) a nursing home with minor structural deficiencies which, although not structurally compliant, has been granted a waiver on the basis of guidelines which were developed by the Compliance Plan Review Board (CPRB) in July 1986, hereafter referred to as the CPRB guidelines.

All nursing homes that, according to Ministry records, were compliant with structural standards by June 30, 1993 are eligible to receive the Structural Compliance Premium.

Nursing homes that, according to Ministry records, were not compliant with structural standards by June 30, 1993 but become compliant subsequently may be eligible for the Structural Compliance Premium provided they apply on a Ministry prescribed form, available from the Long-Term Care Office, and provide supporting documentation. The Ministry will review the supporting documentation and inspect the facility to determine whether the nursing home is now compliant with structural standards. If the Ministry determines that the nursing home is compliant with structural standards, the Structural Compliance Premium will become effective on the first day of the month of the calendar quarter following the date of application, namely on January 1st, April 1st, July 1st, or October 1st following the date of application, and will not be retroactive to any prior date.

FINANCIAL MANAGEMENT AND ADMINISTRATION
SUPPLEMENTARY FUNDING
STRUCTURAL COMPLIANCE PREMIUM

**ELIGIBILITY CRITERIA
(CONT'D)**

The Ministry of Health is the sole determinant of whether an applicant is structurally compliant.

All payments are subject to Ministry reconciliation and audit.

The Structural Compliance Premium is administered under the authority of the Ministry of Health Act.

**PROCEDURES FOR
APPLICATION**

All nursing homes will submit an application for the Structural Compliance Premium to the Long-Term Care Area Office on a Ministry prescribed form, indicating the date that, according to their records, they became structurally compliant.

FUND LIMIT

Total provincial funding for the Structural Compliance Premium is limited to \$6.0 million annually. If the amount of total eligibility for funding exceeds this limit, the funds provided to facilities will be retroactively pro rated not to exceed \$6.0 million.

FINANCIAL MANAGEMENT AND ADMINISTRATION
SUPPLEMENTARY FUNDING
SUPPLEMENTAL NURSING AND PERSONAL CARE

PURPOSE	Supplementary Funding is available to eligible applicants who provide a minimum of 2.25 hours of direct Nursing and Personal Care but whose revised CMI funding level is still inadequate at a CMI of 110 to meet payroll and other costs.
ELIGIBILITY	Nursing Homes.
TERM	November 22, 1993 to December 31, 1995.
APPLICATION PROCESS	<p>Applicants are required to fill in a Ministry prescribed form and send it to their LTC Area Office, to the attention of the Financial Manager.</p> <p>All applicants receiving a cash advance will be required to provide an audited financial report detailing that the funds received were spent for the purposes intended and that all funds are fully accounted for.</p>
APPLICATION FORM	<p>The application form is self-explanatory. However, to assist in the completion of the application form the following inclusions are suggested.</p> <p>Salaries:</p> <p>Salaries include payments for DON, RNs, RNA, HCA and other health care professionals.</p>

**FINANCIAL MANAGEMENT AND ADMINISTRATION
SUPPLEMENTARY FUNDING
SUPPLEMENTAL NURSING AND PERSONAL CARE**

**APPLICATION FORM
(CONT'D)**

Benefits:

Benefits include the following items: overtime, shift premiums, call-back premiums, on-call and weekend premiums, long-term illness, orientation and staff development pay, health and safety pay, union duty, bereavement, jury duty, and modified pay, UIC, CPP, WCB, and EHT, pensions, weekly indemnity, extended health, long-term disability, life insurance, vision, dental, uniform allowance, maternity sub-plan and other (as applicable).

Vacation:

Self Explanatory.

Purchase of Service:

Payments to third parties for services rendered by those not considered employees of the Nursing Home.

Supplies:

Nursing and Personal Care supplies.

Individual statements for the periods November 22, 1993 to December 31, 1993 and January 1, 1994 to March 31, 1994 are required.

When completed, the form should be signed by the licensee, designate or management company.

FINANCIAL MANAGEMENT AND ADMINISTRATION**SUPPLEMENTARY FUNDING****SUPPLEMENTAL NURSING AND PERSONAL CARE****CALCULATIONS**

In calculating the Supplementary Funding to meet 2.25 hours of care the Ministry will fund only those days that a Nursing Home meets the required standard. In other words, until the operator achieves a 2.25 hour standard of care, any cost increases above CMI 110, will be ineligible for subsidy.

DOCUMENTATION

The Ministry reserves the right to review all of the operator's working papers and other documentation in regard to the application, performance and year-end settlement procedure. The Ministry's compliance advisors will undertake such measures they deem necessary to verify that the operator meets the 2.25 hour standard. The operator's auditor will verify and comment on the accuracy of the financial information given to the Ministry, in their financial review, (i.e., audited financial statements and notes), a copy of which will be sent to the applicant's Area Office.

METHOD OF ACCOUNTING

Other than costs attributed to vacation, the basis of accounting will be on a modified accrual basis only. Vacation costs can be fully prorated for the period November 22, 1993 to March 31, 1994. Notwithstanding, retroactive payments for salary awards will be accepted only for the period November 22, 1993 to March 31, 1994. Any retroactive salary awards received after April 30, 1994 will not be considered for reimbursement for the period November 22, 1993 to March 31, 1994

RECONCILIATION

All funds received by an applicant should be treated as a cash advance for accounting purposes until the Ministry has received and reconciled the audited Annual Report.

MINISTRY OF HEALTH

**POLICY FOR FUNDING
CONSTRUCTION COSTS
OF LONG-TERM CARE FACILITIES**

April 1999

PART ONE: INTRODUCTION

Effective April 1, 1998, the Ministry of Health implemented a new funding policy entitled the "Policy For Funding Construction Costs of Long-Term Care Facilities" (the "Construction Funding Policy") to support the costs of the construction of new long-term care facilities (nursing homes and homes for the aged) and the renovation of existing long-term care facilities. The Construction Funding Policy supersedes all prior construction funding policies of the Ministry of Health for long-term care facilities.

Implementation of the Construction Funding Policy coincided with the release and implementation of new mandatory design standards for long-term facilities as set out in the "Long-Term Care Facility Design Manual" dated May 1998 (the "Design Manual"). Effective April 1, 1998, these new mandatory design standards supersede all prior structural standards and guidelines for long-term care facility design.

Historically, the Province has provided capital grants for construction, on a cost-shared basis, to non-profit sponsors of long-term care facilities (includes both homes for the aged and nursing homes). In contrast, private sector operators have had to arrange their own financing and manage costs through operating funds when undertaking construction projects.

The Ministry of Health has now introduced one consistent funding approach for managing construction costs (as set out in the Construction Funding Policy) and one set of mandatory design standards (as set out in the Design Manual) for all long-term care facility operators which shall apply in the same manner, regardless of sponsorship. Funding of projects through the capital funding method may still apply in exceptional circumstances as determined by the Ministry of Health for charitable non-profit sponsors of long-term care facilities.

PART TWO: THE CONSTRUCTION FUNDING POLICY

Under the Construction Funding Policy, the Ministry of Health shall provide to a long-term care facility operator the following funding if, and only if; the Ministry of Health determines that the operator meets all eligibility criteria and requirements as set out in this Construction Funding Policy:

1. a per diem of up to \$10.35 in additional operating funds for a) each long-term care bed awarded by the Ministry of Health; and, b) each long-term care bed in an existing out-dated long-term care facility identified by the Ministry of Health as in need for replacement and classified by the Ministry of Health as a Category "D" facility (collectively referred to as "Long-Term Care Facility Beds").

This additional operating fund shall be used to support the payment of loans secured by operators to pay for the construction of Long-Term Care Facility Beds (the "Up to \$10.35 Per Diem"). The Up to \$10.35 Per Diem shall be paid by the Ministry of Health to the operator on a monthly basis for a period of 20 consecutive years based on a maximum construction cost of \$75,000/Long-Term Care Facility Bed. The Up to \$10.35 Per Diem shall only be used by the operator for the payment of actual construction costs relating to the development of facilities for Long-Term Care Facility Beds;

2. in exceptional circumstances as determined by the Ministry of Health, a capital grant to those non-profit charitable organizations that have demonstrated to the Ministry of Health" satisfaction that they have been unsuccessful in securing financing from at least three lending institutions. The amount of the capital grant shall be no more than the amount of operating funds provided through the Up to \$10.35 Per Diem by the Ministry of Health under this Construction Funding Policy.
3. effective April 1, 1998, a new structural premium for those facilities which have been determined by the Ministry of Health as substantially meeting compliance with the new design standards as set out in the Design Manual. These facilities have been classified by the Ministry of Health as Category "A" facilities. The structural premiums for Category "A" facilities shall be as follows:
 - i) a per diem of \$5.00 per resident shall be provided to those operators who have fully financed the construction costs of their long-term care facilities; or
 - ii) a per diem of up to \$3.00 per resident shall be provided to those operators who have received any government grant(s) to build their long-term care facilities. The amount of the structural premium shall be adjusted depending on the amount of the grant or combined grants. For example, if the operator received a 50% capital grant from the Province, the per diem shall be \$1.50 per resident;
4. effective April 1, 1998, a per diem of up to \$2.50 per resident as a structural premium to those long-term care facilities that have been determined by the Ministry of Health as substantially exceeding the 1972 regulated nursing home structural standards, but not meeting the new mandatory design standards as set out in the Design Manual. These facilities have been classified by the Ministry of Health as Category "B" facilities. If an operator received any government grant(s) to build the long-term care facility, then the amount of the premium shall be adjusted depending on the amount of the grant or combined grants. For example, if the operator received a 50% capital grant from the Province, the per diem premium shall be \$1.25 per resident; and

5. effective April 1, 1998, a per diem of up to \$1.00 per resident as a structural premium to those long-term care facilities which have been determined by the Ministry of Health as meeting compliance with 1972 nursing home structural standards. These standards include the regulated nursing home standards in addition to any waivers set out under the "Compliance Plan Review Board Guidelines" (the "Standards"). These facilities have been classified by the Ministry of Health as Category "C" facilities. If an operator received any government grant(s) to build the long-term care facility, the amount of the premium shall be adjusted depending on the amount of the grant or combined grants. For example, if the operator received a 50% grant from the Province, the per diem premium shall be \$.50 per resident.

There shall be no structural premiums paid to long-term care facilities that are not in compliance with the Standards. These facilities have been classified by the Ministry of Health as Category "D" facilities and shall be replaced by the operators with new facilities that conform to the new mandatory design standards as set out in the Design Manual. As noted above, operators of Category "D" facilities are eligible for the Up to \$10.35 Per Diem.

In addition, the Ministry of Health shall phase out the debt service fund for nursing homes over five fiscal years starting in fiscal 1998/99. Each year, the amount of the debt service allowance paid to each nursing home operator now receiving the allowance shall be reduced by one-fifty (1/5) of the amount paid in calendar 1997. The first reduction took place in fiscal year 1998/99. By fiscal 2002/03, the debt service fund shall be reduced to \$0 shall cease to exist.

PART THREE: THE UP TO \$10.35 PER DIEM

(i) Eligibility for the Up to \$10.35 Per Diem

The following are eligible for the Up to \$10.35 Per Diem:

1. Organizations that have been awarded new long-term beds by the Ministry of Health; and
2. Operators of Category "D" facilities.

("Eligible Operators")

(ii) Determination of the Amount of the Up to \$10.35 Per Diem

The Ministry of Health's role is to support the repayment of the Eligible Operators actual construction costs which have been approved by the Ministry of Health through regular monthly payments within specific parameters (e.g. payment of the Up to \$10.35 Per Diem over a period of 20 consecutive years). The actual amount of funding support shall be verified through a Ministry of Health review process of the terms of the financing and the actual construction costs.

Each Eligible Operator must demonstrate that an actual construction cost of \$75,000 per Long-Term Care Facility Bed has been expended by the Eligible Operator in order to receive the maximum available through the Up to \$10.35 Per Diem. For the purposes of demonstrating that \$75,000 per Long-Term Care Facility Bed has been expended, actual construction costs can include the actual cost of construction, furniture, equipment, building permit, development fees, and consulting/professional fees.

If the actual construction cost is less than \$75,000 per Long-Term Care Facility Bed, the Up to \$10.35 Per diem shall be pro-rated against the actual construction costs.

The operator shall be fully responsible for all project costs including, but not limited to:

1. all actual construction costs (including the actual cost of construction, furniture, equipment, building permit, development fees, and consulting/professional fees) above \$75,000 per Long-Term Care Facility Bed; and
2. all costs relating to the land, building, demolition of the building, re-zoning application, audit fees and site survey.

(iii) Commencement of the Funding of the Up to \$10.35 Per Diem

The Ministry of Health shall not be obligated to provide the Up to \$10.35 Per Diem to Eligible Operators unless the Ministry of Health determines that the following terms and conditions have been met:

1. the long-term care facility to be developed for the Long-Term Care Facility Beds has been built in accordance with the mandatory design standards as set out in the Design Manual and in accordance with the plans approved by the Ministry of Health;
2. all terms and conditions set out in the agreement(s) entered into between the Ministry of Health and the Eligible Operator relating to the development of the Long-Term Care Facility Beds have been complied with; and
3. all requirements set out in this Construction Funding Policy have been complied with.

The Ministry of Health may stop the funding of the Up to \$10.35 Per Diem to an Eligible Operator and recover any monies provided by the Ministry of Health to an Eligible Operator relating to the Up to \$10.35 Per Diem in the event that the Ministry of Health becomes aware that the Eligible Operator has not met the terms and conditions set out above in this section.

The Up to \$10.35 Per Diem shall be included in the Subsidy Calculation Worksheet of the Eligible Operator which is attached to and forms part of the Service Agreement between the Ministry of Health and the Eligible Operator.

PART FOUR: LEVELS OF CARE FUNDING

The Up to \$10.35 Per Diem is in addition to the regular operating funding which a facility operator receives through the Province's "Levels of Care" funding system. The Up to \$10.35 Per Diem shall be added to the "Levels of Care" per diem operating funds for each Eligible Operator.

The "Levels of Care" funding entitlement for a new long-term care facility, or an addition to an existing long-term care facility, that is opening as a result of a bed award shall start at the provincial average because the "Level of Care" of residents is not yet known. The provincial average is reflected as a Case Mix (CMI) value of "100". In this case, the Ministry of Health contribution shall include:

1. the regulated base amount for the Nursing and Personal Care Envelope;
2. the regulated fixed per diem for the Program and Support Services Envelope; and
3. the difference between the residents' contribution for basic accommodation and the provincially guaranteed level of accommodation funding.

For a replacement long-term care facility (i.e., replacement of the Category "D" beds in an existing older facility or part thereof), the Provincial compensation shall be calculated in the same manner described above, with the exception that the actual Case Mix Index (CMI) value for the residents already living in the long-term care facility shall be used to determine the regulated Nursing and Personal Care per diem.

New long-term care facilities (includes facilities which are developed from awarded beds and replacement Category "D" beds) being gradually filled with new residents shall be funded on the basis of full occupancy for a two-month start-up period. Following this two-month start-up period, the 97% occupancy rule shall apply as it does to other long-term facilities.

It is important to note that the Up to \$10.35 Per Diem shall be paid based on the total number of Approved or Licensed Beds, and not on the actual occupancy of the long-term care facility. In this context, although the 97% occupancy rule shall not apply to the Up to \$10.35 Per Diem calculation, the 97% occupancy rule shall continue to apply to the other operating funds provided by the Ministry of Health.

PART FIVE: ACCOUNTABILITY STRUCTURE

(i) Review of Construction Plans and Costs

All construction plans for the development of a long-term care facility (this includes plans for a new long-term care facility as well as renovations, additions and/or alterations to an existing long-term care facility) shall be reviewed for acceptability by the Ministry of Health prior to the start of construction. The purpose of the Ministry of Health's plans review process is to ensure that each Eligible Operator's plans conform to the mandatory design standards as set out in the Design Manual. Construction plans that do not meet these mandatory design standards shall not be approved.

In addition, Eligible Operators who have been awarded long-term care beds must construct their new facilities or additions/renovations to existing facilities, as the case may be, in accordance with the "Agreement For Development of Long-Term Care Facility Beds" made between the Minister of Health and the Eligible Operator ("Awardee")

Eligible Operators must clearly demonstrate their construction costs as part of the Ministry of Health's plans review and approval process. If the Ministry of Health requires additional information about the financing of the project, Eligible Operators must submit all such additional information to the Ministry of Health in a timely manner.

Approval for the Up to \$10.35 Per diem funding shall not be given by the Ministry of health prior to completion of the Ministry of Health's review and confirmation of construction costs.

(ii) Site Approval

In the case of an award of beds, the Ministry of Health must approve the selected site for the new long-term care facility. The Ministry of Health shall provide the Eligible Operator with a response on the acceptability of the site within 20 working days of the notice from the Eligible Operator identifying the proposed site.

(iii) Tendering of Project

Once the construction plans have been approved by the Ministry of Health, the project must be approved by the Ministry of Health for tender.

Working drawings and specifications suitable for public tendering must be prepared by the Eligible Operator. These working drawings and specifications must form the basis of the contract between the Eligible Operator and the general contractor approved by the Ministry of Health.

All construction projects must be publicly advertised in the Daily Commercial News and local newspapers. Eligible Operators may “invite” contractors to submit a construction bid as well. The Ministry of Health’s policies and guidelines for tendering are based on a stipulated price contract as per the Canadian Construction Documents Committee (CCDC 2) standard forms and documents. Use of the CCDC2 standard forms is recommended for all aspects of the Eligible Operators tendering process.

After the close of the tender, at least three bids must be reviewed by the Eligible Operator in consultation with the Ministry of Health.

The Ministry of Health shall review the bids selected by the Eligible Operator and approve the selection of the general contractor. The decision on the acceptability of the bid selected by the operator shall be based on the following qualitative criteria:

1. the comparative costs between the selected bid and the other submitted bids for all of the various aspects of the construction project to ensure that an appropriate value is charged for each aspects of the long-term care facility construction project;
2. the comparative costs of the project relative to the typical costs for development of a similar type of project to ensure the best value and quality for the price; and
3. if applicable, the track record and work history of the general contractor for the selected bid.

A Final Estimate of Cost (“FEC”) form (Ministry of Health document) must be prepared by the Eligible Operator and submitted to the Ministry of Health. In addition, the Eligible Operator must submit a spreadsheet identifying bidders, a written recommendation from the Eligible Operator relating to the general contractor selected by the Eligible Operator, and a letter of confirmation from the Eligible Operators lender concerning the terms of financing.

(iv) Project Management

Under exceptional circumstances, the Ministry of Health may approve alternative and innovative concepts for the development of a project to construct long-term care facility beds using a “project management” approach. An Eligible Operator who wishes to use a “project management” approach must submit a written request for approval to the Ministry of Health. The Ministry of Health will review the request and provide the Eligible Operator with a decision within a reasonable time frame.

The Ministry will review any written request based on the following evaluation criteria (the “Evaluation Criteria”):

1. the extent to which the Eligible Applicant is able to demonstrate that this approach serves the best interests of the Province of Ontario;
2. the extent to which the Eligible Applicant is able to demonstrate that this approach is consistent with provincial criteria for the management of public funds and does not compromise the requirement for accountability for public funds;
3. extent to which the Eligible Applicant is able to demonstrate that this approach is the better alternative method for completion of the construction project as opposed to the hiring of a general contractor.
4. whether the written request adheres to the public tendering process as set out in the above **(iii) Tendering of Project** section for each aspect of the construction project (including the hiring of a “project manager”), including,
 - i) the advertisement of the public tenders in Daily Commercial News and local newspapers,
 - ii) a competition open to all interested bidders; and
 - iii) selection of the highest quality, best price bids for each aspect of the construction project;
5. the “level of risk” to the Eligible Operator, including,
 - i) the nature and extent of the liability to be assumed by the Eligible Operator,
 - ii) the financial risk to the Eligible Operator and how this will impact on the financing of the construction project; and
 - iii) the ability of the Eligible Operator to meet the time commitments for development of the long-term care facility beds as set out in “Schedule E” to the Agreement to develop the beds; and
6. any other factor(s) that the Ministry of Health, in its sole discretion, deems relevant.

The Eligible Operator’s written request must adhere to the public tendering process as set out in the above **(iii) Tendering of Project** section and must address all the issues set out in the above Evaluation Criteria. As part of the process to review the request from the Eligible Operator, the Ministry of Health may ask for any additional information from the Eligible Operator which the Ministry, in its sole discretion, deems necessary.

The Eligible Operator shall provide any such additional information to the Ministry of Health in a timely manner.

Each written request from an Eligible Operator will be reviewed by the Ministry of Health on an individual basis based on the above Evaluation Criteria, with decisions made in consideration of the merits of the individual circumstances and the appropriateness of proceeding with this approach.

The Ministry of Health shall have the sole and absolute discretion to approve or reject any written request for the use of the “project management” approach for a particular construction project to develop long-term care beds. The Ministry of Health shall have the sole and absolute discretion to impose any conditions on any approval granted for the use of the “project management” approach for a construction project, including conditions relating to the process and criteria for the selection of the “project manager”. The Ministry of Health shall have the sole and absolute discretion to impose different and unique conditions on similar construction projects to develop long-term care facility beds using the “project management” approach.

(v) Persons Responding to Ministry of Health Requests for Proposal

Persona responding to any Ministry of Health Requests for Proposals to develop long-term care facility beds shall assume that they will be required to retain a general contractor to construct any awarded long-term care beds and shall estimate their construction costs based on the retention of a general contractor.

(vi) Commencement of Construction

Construction shall begin as soon as the tendering process is complete and a contract is awarded and signed. Construction of the project is the responsibility of the general contractor/project manager and must be carried out in accordance with the terms of the contract between the Eligible Operator and the general contractor/project manager.

(vii) Project Completion and Determination of Construction Funding

The Ministry of Health shall carry out a “pre-occupancy” review to confirm that the long-term care facility or the addition thereto has been constructed in accordance with the construction plans approved by the Ministry of Health.

The Eligible Operator shall address any outstanding issues relating to the “pre-occupancy review” to the satisfaction of the Ministry of Health before approval by the Ministry of Health to admit residents shall be given. Once the new facility or addition thereto has passed the “pre-occupancy review”, the Eligible Operator shall be approved by the Ministry of Health to begin admitting long-term facility residents to the new long-term care facility beds.

The Up to \$10.35 Per Diem funding shall begin on the day the first resident or residents is/are admitted to the long-term care facility or the addition thereto. The payment shall

be for the full-approved capacity of the long-term care facility, not the actual occupancy level. For example, if the long-term care facility has an approved capacity of 100 long-term care beds, the Eligible Operator shall be compensated at a rate of up to \$10.35/day times 100 beds from the day the first resident moves into the facility or addition thereto for a period of 20 consecutive years.

The Eligible Operator must submit an audited "Statement of Disbursements and Source of Funds" (this is a Ministry of Health form) to the Ministry of Health. Once the "Statement of Disbursements and Source of Funds" is approved by the Ministry of Health, the Up to \$10.35 Per Diem shall be set or adjusted, if necessary, in the event that the Ministry of Health has been providing the Up to \$10.35 Per Diem based on the Eligible Operators FEC form.

The Eligible Operator must also sign a Service Agreement with the Ministry of Health in order to receive operating funds. The Up to \$10.35 Per Diem for construction financing shall form part of the Service Agreement.

PART SIX: WHAT HAPPENS TO THE UP TO \$10.35 PER DIEM IN THE EVENT OF RECEIVERSHIP AFTER THE COMMENCEMENT OF OPERATIONS

A long-term care facility may be placed under receivership where an operator is unable to meet its financial obligations. The receivership may take place after the Up to \$10.35 Per Diem financing commences (for example, three or four years after opening).

It is the policy of the Ministry of Health to work closely with a receiver to ensure that the needs of the residents are met and the facility is properly maintained. Ministry of Health funding support to the home continues during the receivership period to ensure continuity in the delivery of resident care programs and services.

In most circumstances, the receiver, usually in conjunction with a management firm experienced in operating a long-term facility, continues to operate the facility until such time that a new operator (approved by the Ministry) assumes ownership. The new operator shall assume all obligations of the former operator relating to the operation of the long-term care facility. If the new operator does assume all obligations, the new operator shall be entitled to the same Up to \$10.35 Per Diem from the Ministry of Health as previously provided to the prior operator.

If a new operator cannot be found and the receiver seeks to dispose of the long-term care facility, residents shall be relocated to alternative care settings in accordance with their needs and the long-term care facility shall be closed. In this event, all Ministry of Health funding to the home shall cease (including all funding for construction or capital investment), and the receiver shall be responsible to deal with any creditors in the usual course.

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TAB 07 ACCOUNTABILITY

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0701	INTRODUCTION TO THE ACCOUNTABILITY PROCESS	
	01 Overview	20 December 1993
	02 Components of the Accountability Process	20 December 1993

ACCOUNTABILITY**INTRODUCTION TO THE ACCOUNTABILITY PROCESS****OVERVIEW****DEFINITION OF
ACCOUNTABILITY**

Accountability has been defined as the obligation to answer for a responsibility that has been conferred. It presumes the existence of at least two parties: one who allocates responsibility and one who accepts it with the undertaking to report upon the manner in which it has been discharged. (*Office of the Auditor General of Canada: Report of the Independent Review Committee, Ottawa 1975*).

**MANDATE AND
AUTHORITY OF LTC
DIVISION**

The Long-Term Care Division is responsible for the management of the long-term care facility program. Its mandate for the managing of the long-term care facility program is set out in the legislation governing the program.

Long-term care facilities are governed by the following Acts as amended by Bill 101 (*The Long-Term Care Statutes Law Amendment Act, 1993*).

- Nursing Homes: *Nursing Home Act*, R.S.O. 1990, c.N.7 and Regulations under that Act;
- Municipal Homes for the Aged: *Homes for the Aged and Rest Homes Act*, R.S.O. 1990, c.H.13 and Regulations under that Act;
- Charitable Homes for the Aged: *Charitable Institutions Act*, R.S.O. 1990, c.C.9 and Regulations under that Act.

ACCOUNTABILITY

INTRODUCTION TO THE ACCOUNTABILITY PROCESS

OVERVIEW

**LONG TERM CARE
FACILITIES:
GOVERNING BODIES**

Homes for the Aged

Under current legislation, charitable homes for the aged are governed by a Board of Directors, and municipal homes for the aged are governed by a Committee of Management or a District Board of Management.

Nursing Homes

The licensee is accountable for the care and services provided by the facility. In addition, the administrator has certain statutory obligations as defined by the Act and regulations. Licensees may be non-profit or for-profit operators.

GOVERNANCE

Governance responsibilities include but are not limited to:

- determining the organization's values, mission and purposes
- selecting an administrator and evaluating his/her performance
- ensuring effective organizational planning
- evaluating the effectiveness of the organization's programs and services
- assessing its own performance as a governing body
- enhancing the organization's public image
- ensuring adequate resources and effective use of resources.

ACCOUNTABILITY

INTRODUCTION TO THE ACCOUNTABILITY PROCESS

OVERVIEW

GOVERNANCE FUNCTIONS (cont.)

As part of Phase II legislation, further work will be undertaken in examining the governance function of LTC facilities, in order to develop comprehensive legislation. As part of this process, consultation with the long-term care sector, other stakeholders and interest groups will be undertaken.

In the interim, however, *the Homes for the Aged and Rest Homes Act* and the *Charitable Institutions Act* will remain in effect.

RESPONSIBILITIES OF LONG TERM CARE FACILITIES

Long-term care facilities are responsible to the Long-Term Care Division for:

- the quality of care, programs and services provided to the residents of long-term care facilities in accordance with:
 - applicable Acts and regulations;
 - the terms and conditions of the service agreement between the facility and the Province;
 - the standards and criteria contained in the LTC Facility Programs and Services Manual;
 - Ministry policies and directives.
- the management of public funds received for this purpose; and
- the management of residents' funds held in trust.

ACCOUNTABILITY

INTRODUCTION TO THE ACCOUNTABILITY PROCESS

OVERVIEW

**RESPONSIBILITIES OF
THE LONG-TERM CARE
DIVISION**

The Division's responsibilities include:

- informing residents, staff members and the general public about the long-term care facility program;
- establishing fair and achievable standards of resident care and facility operations;
- providing funding in keeping with the established funding formula;
- monitoring and evaluating facilities' performance based on established standards and criteria; and
- taking action to support achievement of desired outcomes.

**ACCOUNTABILITY
PROCESS**

The Long-Term Care Division recognizes:

- the contribution provided by the involvement of residents, families and facility staff in the planning and evaluation of care, programs, and services;
- the uniqueness of each long-term care facility with respect to its history, ownership and sponsorship;
- the need for flexibility to meet different resident needs and to support innovation in providing resident care, programs and services;
- the need to build upon long-term care facilities' internal and external accountability mechanisms.

ACCOUNTABILITY

INTRODUCTION TO THE ACCOUNTABILITY PROCESS

COMPONENTS OF THE ACCOUNTABILITY PROCESS

COMPONENTS OF THE ACCOUNTABILITY PROCESS

The accountability process has the following components:

- setting expectations
- contracting
- monitoring and evaluation
- taking action if necessary
- informing the public

These components are described in detail below.

SETTING EXPECTATIONS

Standards and criteria which facilities are expected to achieve in the provision of care, programs, and services to residents are defined in Resident Care and Programs and Services sections of the manual.

The following standards have been developed:

- **Resident Safeguards:** They identify residents' rights including privacy, autonomy and freedom from abuse; information about residents' councils, the process for obtaining information, raising concerns, lodging complaints or recommending changes; the information to be provided to residents on admission and the orientation of residents to the facility, environment, programs and services.
- **Resident Care and Services Standards:** They encourage and support residents' involvement in the planning and evaluation of their own care; they describe the care and services which the facility is expected to provide each resident.

ACCOUNTABILITY

INTRODUCTION TO THE ACCOUNTABILITY PROCESS

COMPONENTS OF THE ACCOUNTABILITY PROCESS

SETTING EXPECTATIONS (cont.)

- **Programs and Services Standards:** They describe the resources and support, which the facility organizes to achieve the resident care and services standards. They include standards and criteria for all key aspects of facility operation including administration, professional service provision, programs and services.

Long-Term Care Division staff are available to provide advice and consultation to facilities.

Facilities should contact their Area/Regional Office if they:

- require assistance to interpret and implement the long-term care program standards
- encounter difficulty in achieving or maintaining the standards of care and require assistance to develop an acceptable corrective action plan
- require assistance to deal with an operational issue or for any other reason

CONTRACTING (SERVICE AGREEMENTS)

A service agreement shall be negotiated annually with each facility. The service agreement will include a detailed budget which contains three components:

- nursing and personal care
- program and support services
- accommodation

Homes for the aged and nursing homes share with the government the responsibility for providing services to people requiring long-term care. These responsibilities are established by legislation.

ACCOUNTABILITY

INTRODUCTION TO THE ACCOUNTABILITY PROCESS

COMPONENTS OF THE ACCOUNTABILITY PROCESS

CONTRACTING (SERVICE AGREEMENTS) (cont.)

It is not possible to include in legislation all details of the relationship between these service agencies and the government. Service agreements provide a means by which an agency and the government can clarify this relationship.

Service agreements set out the expectations, rights and responsibilities of the parties to the agreement.

The two main reasons for having service agreements between the government and a service provider are that:

- they can be tailored to meet specific and detailed program needs, whereas the legislation that governs a program is more general in nature
- they can take into account any individual circumstances that exist between a ministry and the service-provider with which it is contracting

Service agreements deal with a number of matters common to all programs, such as:

- the legal authority to enter into the agreement
- maintenance of records and reporting requirements
- confidentiality

In addition, service agreements include matters specific to a service agency. The specific matters are usually contained in schedules that form part of the agreement. The schedules provide:

- a program description
- detailed information on staffing
- a budget

ACCOUNTABILITY

INTRODUCTION TO THE ACCOUNTABILITY PROCESS

COMPONENTS OF THE ACCOUNTABILITY PROCESS

CONTRACTING (SERVICE AGREEMENTS) (cont.)

They also delineate provisions relating to funding, records, reporting and corrective actions that may be taken.

A financial accountability system which supports the provisions of the service agreement for funding and monitoring purposes is spelled out in the Financial Management and Administration section of the manual.

MONITORING AND EVALUATION

The primary objective of LTC facilities is the provision of high quality care and services to residents. Long-Term Care Division staff will assist facilities to achieve this objective through the provision of funding, consultation, interpretation and education as well as monitoring and evaluation activities, as part of a facility review process.

Monitoring refers to the process of observing and reviewing the performance of LTC facilities, to identify strengths and determine any areas which need improvement.

Evaluation consists of comparing the actual delivery of care and services with applicable Acts and Regulations, the terms and conditions of the service agreement, LTC Facility Programs and Services Manual standards and criteria, and Ministry policies and directives.

Compliance advisors and program supervisors have primary responsibility for monitoring and evaluating LTC facility performance.

The monitoring and evaluation processes and tools are described in the Monitoring and Evaluation of Care, Programs, and Services section of the manual.

ACCOUNTABILITY

INTRODUCTION TO THE ACCOUNTABILITY PROCESS

COMPONENTS OF THE ACCOUNTABILITY PROCESS

TAKING ACTION IF NECESSARY

This includes LTC Division staff:

- providing the facility with verbal and written feedback;
- preparing summary reports on the review process, areas reviewed, conclusions and time frames for corrective action and follow up;
- undertaking follow up reviews if necessary to evaluate the effectiveness of corrective action;
- determining what other actions should be considered when facilities do not take action to correct identified problems; this may include further consultation, referral to other resources, or application of sanctions.

INFORMING THE PUBLIC

The Government of Ontario wants to ensure that residents of long-term care facilities and the general public are aware of the programs provided in long-term care facilities, the rights and responsibilities of the various parties, and the results of government monitoring and evaluation activities.

Facilities are required to post the final summary report of the annual and follow-up reviews in a location that is easily accessible to residents, staff and visitors. A copy of the summary report is given to the local Placement Coordination Agency and is also placed in Ministry libraries and is available to the public on request.

The Residents' Bill of Rights must also be posted along with information on the process for making recommendations, raising concerns, and lodging complaints.

Facilities will also be required to post a copy of the service agreement between the facility and the Province.

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0806	REPORTING OF UNUSUAL OCCURENCES	
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NEW>	03	Expenditures – Submission of Claims	13 February 2006
0810	ALTERATIONS, RENOVATIONS OR ADDITIONS TO LTC HOMES		
NEW>	01	Policy on Alternations, Renovations or Additions to Existing LTC Home	September 2004

POLICIES**NURSING AND PERSONAL CARE SERVICES****INTRODUCTION**

Long-term care facilities are required to provide a range of services to meet the needs of the residents.

PROCEDURES AND SERVICES THAT ARE EXPECTED TO BE PROVIDED (LIST A)

All LTC facilities are expected to provide the following procedures to residents who may require such care.

Procedures and services to be provided include but are not limited to:

- nursing and personal care, including partial/total assistance with all activities of daily living
- assisting residents with swallowing disorders to eat
- ambient air concentrators (oxygen concentrators). Oxygen is concentrated from room air and is not under pressure
- suctioning
- use of inhalers and masks
- care of decubitus/vascular ulcers
- routine aseptic dressings
- sterile dressings
- removal of skin closures (sutures and clips)
- care and removal of drains
- colostomy/ileostomy care
- straight and indwelling catheter care

POLICIES

NURSING AND PERSONAL CARE SERVICES

LIST A (cont.)

- suprapubic catheter care
- bladder irrigations
- oral, rectal, subcutaneous and intramuscular medications
- prosthesis care

PROCEDURES AND SERVICES THAT MAY BE PROVIDED (LIST B)

The procedures and services in List B may be provided if:

- staff have current competence in performing the functions;
- sufficient staff hours to provide ongoing monitoring, supervision and continuity of care are available;
- staff education is provided;
- supplies and equipment are made available for the number of residents who will be receiving the care.

When these requirements are met, Long-Term Care facilities may provide the following procedures:

- duodenal tube feedings
- gastric tube feedings
- care of established tracheostomies, including suctioning and cleaning of the canula
- hemovacs
- ileoconduit care

POLICIES

NURSING AND PERSONAL CARE SERVICES

LIST B (cont.)

- liquid oxygen under low pressure (The oxygen is stored in liquid form at -297 degrees Fahrenheit. It is released at room temperature at a pressure of 25 to 30 psi, in contrast to 2200 psi in high pressure cylinders.)

For those procedures listed in List B, the PCS may be of assistance to facilities in organizing and co-ordinating services from hospitals that could assist the long-term care facility in meeting the person's needs.

In cases where a resident could leave a hospital or where a hospital admission could be prevented, the hospital should be asked if they can provide assistance that would enable the long-term care facility to undertake these functions. e.g.

- provision of equipment on a loan basis;
- provision of drugs not covered by the ODB program;
- provision of supplies not customarily provided in nursing homes/homes for the aged;
- training of long-term care staff in the specific procedures required by the resident.

OTHER PROCEDURES

Complex procedures, other than those in List B, may be provided in LTC facilities if:

- staff have current competence in performing the functions;
- sufficient staff hours to provide ongoing monitoring, supervision, and continuity of care are available;
- staff education is provided;

POLICIES

NURSING AND PERSONAL CARE SERVICES

- supplies and equipment are made available for the number of residents who will be receiving the care;
- approval is received from the Residential Services Branch.

**UTILIZATION OF
COMMUNITY-BASED
SERVICES**

Note: The resources of the Ontario Home Care Program may be used to provide support and assistance to LTC facilities in the following cases:

- provide assessments and assistance in service planning for residents in the areas of occupational therapy, speech therapy, and physiotherapy;
- provide education to LTC facility staff in rehabilitative interventions and therapies;
- provide education to LTC facility staff for interventions listed in List B and any other complex procedures not ordinarily provided in LTC facilities where hospitals are unable to provide this training.

POLICIES

RESIDENT LEAVES OF ABSENCE

NHA, Reg. 832, Sec. , HFA and RH Act, Reg. 637, Sec. , CIA, Reg. 69, Sec.

CASUAL LEAVE

A casual leave of absence of up to 48 hours per week is available to residents of a long-term care facility.

Casual leaves are permitted throughout the year in addition to vacation or medical/psychiatric leaves.

For calculation of the period for casual leaves, the first day of the week is considered to be Sunday.

VACATION LEAVE

A vacation leave of absence of twenty-one (21) days a year is available to residents of long-term care facilities upon admission.

Vacation leave described here can be used only in the calendar year in which it is granted and is not cumulative.

The attending physician must document on the resident's record the specific care and treatment instructions required by the resident for the duration of the leave. The facility will give these instructions to the resident or the person accepting responsibility for the resident's care while on leave.

Casual leave of absence days may be combined with vacation leave to extend the period of time available. When the casual leave is combined with vacation leave at the rate of 48 hours per week, it is possible to have up to 31 days of combined leave once a year.

RESPONSIBILITY FOR CARE

For vacation and casual leaves, the administrator of the facility shall receive a signed statement from the resident acknowledging understanding of his or her care requirements. Where it is not possible for the resident to do this, the representative or caregiver during the leave, who is 19 years or older, and who the administrator believes is capable of fulfilling the responsibilities listed below, will acknowledge and accept responsibility to:

POLICIES

RESIDENT LEAVES OF ABSENCE

NHA, Reg. 832, Sec. , HFA and RH Act, Reg. 637, Sec. , CIA, Reg. 69, Sec.

RESPONSIBILITY FOR CARE (CONT'D)

- provide appropriate care for the resident as instructed by the facility;
- notify the administrator if the resident is admitted to a hospital during the leave.

MEDICAL LEAVE

Medical leave for purposes of hospitalization is up to twenty-one (21) days at a time and is available to all residents of long-term care facilities. This leave is for the purpose of medical not psychiatric care.

The authorization of a resident's attending physician is required for all medical leaves. The authorization must state the reason for a transfer to hospital and anticipated length of absence from the facility.

The use of medical leave does not reduce a resident's available vacation or casual leave days.

PSYCHIATRIC LEAVE

NEW >

Psychiatric leave for the purposes of hospitalization for assessment and treatment is up to forty-five (45) days at a time and is available to all residents of long-term care facilities. This leave is for the purpose of psychiatric care not medical care.

The authorization of a resident's attending physician is required for any psychiatric leave. The authorization must state the reason for a transfer to hospital and anticipated length of absence from the facility.

The use of psychiatric leave does not reduce a resident's available vacation or casual leave days.

POLICIES

RESIDENT LEAVES OF ABSENCE

NHA, Reg. 832, Sec. , HFA and RH Act, Reg. 637, Sec. , CIA, Reg. 69, Sec.

**FAMILY/
REPRESENTATIVE
NOTIFICATION**

A resident's family or representative must be notified at least 24 hours prior to a medical or psychiatric leave, or where circumstances do not permit 24-hour notice, as soon as possible.

**TRANSFER OF
INFORMATION**

When residents are transferred to hospital for medical or psychiatric leaves, any relevant information required for the resident's continuing safe care shall be transferred at the same time, unless prohibited by other legislative requirements.

The facility shall obtain the resident's consent to transmit this information to the institution receiving the resident. This consent may be obtained at the time of the admission to the long-term care facility.

**MAINTAINING CONTACT
DURING MEDICAL OR
PSYCHIATRIC LEAVES**

For medical or psychiatric leaves, the administrator shall ensure contact is maintained with the hospital to determine the anticipated date of return.

RECORDS

Each facility shall keep a record of all leaves taken by each resident.

RESIDENT CHARGES

During a leave of absence, a resident will continue to be responsible for the standard charges. This includes accommodation (ward or preferred) and any authorized purchase of other services, unless a decision is made by the resident to be discharged from the facility.

Government will continue to fund the nursing and personal care and program components during a leave of absence.

POLICIES

RESIDENT LEAVES OF ABSENCE

NHA, Reg. 832, Sec. , HFA and RH Act, Reg. 637, Sec. , CIA, Reg. 69, Sec.

DISCHARGE

If the resident's condition or care needs require absence from the facility beyond the available medical or psychiatric leaves and bed holding is not authorized, then the resident shall be discharged from the facility (see Discharge and Bed Holding Policies).

READMISSION

When a resident who is discharged wishes to re-enter the facility or another long-term care facility, the resident/representative must contact the Placement Coordination Service to request admission. This may also be done by the hospital discharge planner.

Residents who have been discharged from a LTC facility following transfer to a hospital shall be ranked in Category II of the waiting list for readmission to the original LTC facility (assuming that the facility may continue to provide appropriate care). It may be necessary for the resident to be admitted to an alternative facility until a bed becomes available in their first facility of choice.

For additional information, see "Priorization Criteria" in the Placement Coordination services Manual.

**MEDICAL LEAVES FOR
SHORT-STAY RESIDENTS**

Medical leave for the purpose of hospitalization for up to fourteen days is available to all short-stay residents.

POLICIES**BED HOLDING**

NHA, Reg. 832, Sec. HFA and RHA, Reg. 637, Sec. , CIA, Reg. 69, Sec.

BED HOLDING PRIOR TO ADMISSION

When a person is notified that a bed is available in a long-term care facility, he/she may need time to finalize arrangements prior to moving into the facility.

Prior to the initial admission to a long-term care facility, if the person chooses to accept the bed, a bed can be held for a maximum of 3 days following the day of notification by the Placement Coordination Service that the bed is available.

The person may move into the facility within the first 24 hours and will only be responsible for the applicable accommodation charges.

If the person does not enter the facility within the first 24 hours, the bed may then be held for up to three additional days, at the person's request. The person must be admitted on the third day following the day of notification: the bed cannot be held for any additional days.

RESIDENT AUTHORIZATION

The person must agree in writing, in advance, to pay the appropriate charges for each day that the bed is held (maximum of three) beyond the first 24 hours. (See Section 0607-06 for bed holding charges.)

BED HOLDING FOLLOWING MEDICAL OR PSYCHIATRIC LEAVE NEW >

A resident may hold a bed for up to 30 days in addition to the available 21-day medical leave or the 45-day psychiatric leave.

Bed holding is not permitted to extend a casual or vacation leave of absence.

POLICIES**BED HOLDING**

NHA, Reg. 832, Sec. HFA and RHA, Reg. 637, Sec. , CIA, Reg. 69, Sec.

RESIDENT CHARGES

During approved medical or psychiatric leaves of absence, Government will continue to fund the nursing and personal care and program components. While on medical or psychiatric leave, the resident will continue to be responsible for the accommodation charges, including the preferred rate if applicable, as well as other services previously authorized. (These other charges could include preferred accommodation, cable television, telephone, etc.). These charges will continue to be the responsibility of the resident until discharge occurs or the resident requests the services be discontinued. (See Discharges/Transfer Policy).

During the bed holding period, the resident will continue to pay the accommodation charges. They will also be required to pay the bed holding rate. (See Section 0607-06 for bed holding charges.)

**RESIDENT
AUTHORIZATION**

To "hold a bed" the resident/representative shall agree in writing for the bed to be held and to be responsible for all applicable charges incurred during the bed-holding period.

DISCHARGE

If a resident is absent from a facility beyond the available medical or psychiatric leave days, and all bed-holding days (if authorized) have been used, the facility is required to discharge the resident.

READMISSION

For residents discharged due to absence beyond the authorized leave or bed-holding limit, application for readmission to a long-term care facility will be through the Placement Coordination Service.

Residents who have been discharged from a long-term care facility following transfer to a hospital shall be ranked in Category II of the waiting list for readmission to the original long-term care facility, assuming this facility can provide the necessary care for the person.

POLICIES

BED HOLDING

NHA, Reg. 832, Sec. HFA and RHA, Reg. 637, Sec. , CIA, Reg. 69, Sec.

READMISSION (CONT'D)

It may be necessary for the resident to be admitted to an alternative facility until a bed becomes available in the facility of his/her first choice. (See Priorization Criteria in the Placement Coordination Services Manual.)

POLICIES

DISCHARGES AND TRANSFERS

HFA and RHA, Reg 637, S. , CIA, Reg 69, S. , NHA, Reg. 832, S.

INTRODUCTION

Once determined eligible for admission and admitted to a long term care facility, a resident remains eligible for long-term care in that facility or any other, assuming that facility can meet the resident's care needs.

As a resident's condition changes, it may be determined that alternative services and settings may serve a resident's care needs better. All facilities shall develop goals for resident care, including the potential for discharge to an alternative setting in the community if it is the wish of the resident to leave the facility.

Note: In this section, "lawfully authorized person" refers to the person who is lawfully authorized to make decisions on behalf of the resident regarding personal care.

DISCHARGE PLANNING

In collaboration with the resident/lawfully authorized person, the facility will endeavour to identify appropriate placement options if this is the wish of the resident. The facility shall act as a liaison with the Placement Coordination Service to assist the resident in coordinating community based services if discharge is planned.

Where possible, adequate accommodation and services must be identified and referral facilitated by the facility prior to a resident's discharge to the community.

TYPES OF DISCHARGE

- Planned discharge to the community
- Self-discharge to the community
- Discharge following transfer to a hospital
- Transfer to alternative long-term care facility

POLICIES

DISCHARGES AND TRANSFERS

HFA and RHA, Reg 637, S. , CIA, Reg 69, S. , NHA, Reg. 832, S.

PLANNED DISCHARGE TO COMMUNITY

A resident's condition may improve sufficiently to consider the possibility of a community living arrangement.

If it is determined that the resident may be able to return to the community, the potential for discharge will be discussed with the resident/lawfully authorized person to determine if this is his/her wish. The resident/lawfully authorized person may also request discharge to be considered due to changes in the resident's condition, or supports now being available in the home, etc.

Note: If the resident/lawfully authorized person does not wish the resident to be discharged to the community, he/she will be able to remain in the facility.

The resident, or where he/she is incapable, the lawfully authorized person, shall consent in writing that he/she wishes to be discharged.

If a resident/authorized person consents, the facility shall make every effort to assist in discharge planning such as:

- helping identify available resources, taking into account the resident's care needs, housing options, and community living skills;
- contacting and referring the resident to appropriate service organizations, including the Placement Coordination Service.

Prior to discharge, the resident's care needs shall be assessed and documented, including but not limited to medical, nursing, and personal care.

POLICIES

DISCHARGES AND TRANSFERS

HFA and RHA, Reg 637, S. , CIA, Reg 69, S. , NHA, Reg. 832, S.

If family members or other representatives are not involved in the discharge planning, the facility shall make every attempt to notify these persons within twenty-four hours prior to the planned discharge, with consent of the resident.

SELF-DISCHARGE TO COMMUNITY

Residents may decide to "self-discharge" against medical advice. A resident's attending physician shall complete a medical summary prior to the discharge, documenting the current status of the resident, and any counselling provided to the resident/representative, including care requirements of the resident.

TRANSFER TO A HOSPITAL

A resident's condition may change, necessitating assessment or treatment in a hospital.

When transferring a resident to a hospital, the attending physician shall complete a medical order indicating the reason for transfer and the anticipated length of absence. (The facility should establish policies for situations when an emergency transfer is required.)

With the resident's/authorized person's consent, medical, nursing and personal care needs shall be included in the transfer record. This consent may be obtained at the time of admission to the Long-Term care facility.

The facility shall notify the family or authorized person within twenty-four hours prior to the resident's transfer. Where circumstances do not permit notification within twenty-four hours, the facility shall be expected to notify the family or authorized person as soon as possible thereafter.

NEW >

Upon transfer to an acute care hospital for medical or surgical care, the resident is entitled to 21 days of medical leave. (See Leave of Absence Policy). Upon transfer to a hospital for psychiatric care, the resident is entitled to 45 days psychiatric leave. (See Leave of Absence Policy).

POLICIES

DISCHARGES AND TRANSFERS

HFA and RHA, Reg 637, S. , CIA, Reg 69, S. , NHA, Reg. 832, S.

A resident or the person who is lawfully authorized to make a decision on behalf of the resident may agree to pay the full Levels of Care per diem, to hold a bed for 30 days beyond the allowable medical or psychiatric leaves of absence. (See Bed Holding Policy).

**DISCHARGE
FOLLOWING TRANSFER
TO A HOSPITAL**

The long-term care facility shall discharge a resident if:

- the hospital indicates that the resident is not able to return to the facility within the available leave of absence period as a result of changes in condition or care requirements (the resident/authorized person will be contacted by the facility to confirm this decision), and the resident/lawfully authorized person chooses not to authorize payment of the full per diem to hold a bed in the long-term care facility;

if the resident or lawfully authorized person does authorize payment of the bed holding rate, to hold a bed for up to 30 days beyond the available leave, discharge will occur if it has been determined that the resident will not be returning to the facility. (The resident/ authorized person will be contacted by the facility to confirm this decision).

- the resident or authorized person indicates that the resident will not be returning to the facility as a result of changes in condition or care requirements. (The hospital will be contacted by the facility to confirm this decision).
- at any time during the medical leave, the resident or lawfully authorized person or physician indicates that the resident will not be returning to the facility. (The hospital or physician will be contacted by the facility to confirm this decision).

POLICIES

DISCHARGES AND TRANSFERS

HFA and RHA, Reg 637, S. , CIA, Reg 69, S. , NHA, Reg. 832, S.

**TRANSFER TO
ALTERNATIVE LTC
FACILITY**

If a resident desires to go to another long-term care facility, the resident or authorized person must contact the local Placement Coordination Service to request the transfer to the other facility. A long-term care facility may also contact the Placement Coordination Service on behalf of the resident, with the consent of the resident or lawfully authorized person.

When the Placement Coordination Service determines a bed is available in the other LTC facility, staff will discuss plans with the resident or lawfully authorized person, and transfer is arranged.

The transferring facility shall forward all pertinent medical, nursing and other care information to the receiving facility.

The resident's consent shall be obtained prior to the sharing of medical and any other care information with the receiving long-term care facility.

POLICIES**SHORT-STAY PROGRAM****INTRODUCTION****INTRODUCTION**

The short-stay program in a long-term care facility is designed for:

- individuals who may require or may benefit from a short-stay in the facility and who are expected to return to their home in the community within a specified period of time.
- the benefit of caregivers by providing relief from their care-giving responsibilities.

Approved short-stay beds must be available at all times and should not be used for long-term placements since this reduces the community's ability to respond to others who need immediate placement.

**SHORT-STAY BED
COMPLEMENT**

The Regional Office, through a local planning process, will determine the limit on the number of short-stay days in the district. An annual evaluation will be carried out to determine the utilization and value of the program in each long-term care service area. The particular variables to be assessed will be the geographic distribution in the area, a needs analysis where appropriate (such as the need for secure units), the ethno-specific needs in an area, resident satisfaction surveys, family evaluations, accessibility, and waiting lists.

In order for a facility to provide a short-stay program, the following criteria must be met:

- The facility must be approved by the Regional Office to provide a short-stay program for an established number of bed days within the existing licensed or approved bed capacity.
- The facility must meet expectations for the provision of resident care, programs and services.

POLICIES**SHORT-STAY PROGRAM****INTRODUCTION****SHORT-STAY BED
COMPLEMENT (CONT'D)**

- The facility must ensure that there is medical coverage for the care of each short-stay resident, including emergency services. Medical care may be provided by the resident's family physician if he/she agrees to meet the facility's requirements for attending physicians, or by the medical director or another attending physician in the facility.

The number of days to be used for the short-stay program in a facility are calculated as a percentage of the number of short-stay resident bed days that have been approved in relation to the beds available.

The following is a sample calculation for a 100-bed facility with approval for one short-stay bed:

Total resident days:
100 x 365 = 36,500

Calculation of target long-stay resident days:
97% x 36,500 = 35,405 (allows for 1,095 vacancy days)

Less approved short-stay days:
35,405 - 365 = 35,040

Long-stay resident days:	35,040
Short-stay resident days:	365
Long-stay vacancy days:	1,095
Total resident days:	36,500

OCCUPANCY TARGETS

For the 1999 calendar year, the utilization target for the short-stay program will be established by the Ministry at a minimum of 50% of the approved short-stay resident days. The ability of a facility to achieve this rate will need to be considered in relation to the following variables:

POLICIES**SHORT-STAY PROGRAM****INTRODUCTION****OCCUPANCY TARGETS
(CONT'D)**

- Whether or not the program is new to the facility or there has been a recent increase in the number of beds, i.e., it may take some lead time to establish the program in a community. For a new program or an expansion of an already existing program, the rate may be lowered for the first twelve months of the program. A facility will then be expected to achieve the minimum of 50% rate for the next year.
- If the program is in a facility which is a remote location in the long-term care service area or the province. (This may have to be evaluated to determine if the program should continue in that facility.)
- Seasonal fluctuations, i.e., families may require the beds only during certain times of the year.

The Regional Office will negotiate the utilization target for each facility in accordance with the established provincial rate (including adjustments for new or expanded programs within the first year of operation) and after reviewing the particular circumstances of the facility and the utilization of the program over the past year.

The Ministry-established utilization target for the short-stay program (minimum of 50% in 1999) will be increased in subsequent years based on the annual evaluation of the program. The evaluation will include a statistical review of the occupancy rates, waiting lists for short-stay, length of stays, number of transfers from short-stay into long-stay beds, the number of people turned away and for what reasons, factors such as last-minute cancellations which affect utilization, program outcomes for clients, and results of evaluations by facilities, residents/families and CCAC placement staff.

POLICIES

SHORT-STAY PROGRAM

INTRODUCTION

CHANGE IN SHORT-STAY BED COMPLEMENT

The number of short-stay beds (i.e., the short-stay resident days) in a region may be adjusted based on the demonstrated need that has been determined in the local planning process.

The number of short-stay resident days available to a facility may be increased if the facility has achieved and maintained the short-stay utilization target set for the facility, the occupancy target, and there is a demonstrated need for the program to expand in the specific region.

If the program is not being utilized, i.e., the number of short-stay resident days have not been achieved, the number of short-stay bed days for that facility will be reduced. Prior to this, the Regional Office and the facility will discuss methods of increasing the utilization of the short-stay program, such as marketing in the community and physicians' offices, and advertising in community service information centres, for example. At that time, a re-evaluation date will be set in order to give the facility time to prepare for the reduction.

LENGTH OF STAY

The maximum length of stay for each person in a short-stay program is 30 days at a time, up to 3 times/year, to a maximum of 90 days. The 30-day period may be extended by the facility in consultation with CCAC under the following circumstances:

- the caregiver requires a longer respite period due to unforeseen or unexpected circumstances, or
- the resident is involved in a program in the facility which could be of benefit for an additional period of time.

If there is an extension of the 30-day period, the following criteria must be met:

- the facility has short-stay bed days available, and
- there is no waiting list for short-stay at this facility.

POLICIES**SHORT-STAY PROGRAM****INTRODUCTION****LENGTH OF STAY
(CONT'D)**

The maximum length of stay is calculated on a 12-month period from the day of admission. This means that if a person enters the program on May 1, he/she will have until April 30 of the next year to use the number of remaining days available to him/her in the program. The program is province wide, i.e., an applicant may not use the maximum number of days in the program in one facility and then apply to another facility for the same number of days.

There is no minimum length of stay that can be required for a resident in a short-stay program. The flexibility in the length of stay is necessary to support the needs of the families and residents who need the program. It will be up to the resident/family, CCAC and facility to negotiate the length of the stay that will best meet the needs of the individual/family.

**TRANSFER TO LONG-
TERM CARE BEDS**

Persons in short-stay beds may not be admitted to long-stay beds without the authorization of the CCAC, since others may be waiting for placement in that facility. Waiting list management policies apply in the same manner to all applicants, including people in short-stay beds, in order to maintain the system's effectiveness in meeting all clients' needs.

Those requesting permanent residency must:

- indicate their interest to the CCAC
- must have their eligibility determined by the CCAC
- must undergo the authorization for admission process

ELIGIBILITY

In order to be eligible for short-stay, the following conditions must be met:

- the applicant's care requirements can be met in the long-term care facility;

POLICIES
SHORT-STAY PROGRAM
INTRODUCTION

ELIGIBILITY (CONT'D)

- the applicant's caregiver requires temporary relief from his/her care-giving duties;

Note: This could be for a vacation, medical reasons, or a rest from the care-giving function.
- it is anticipated that the applicant will be returning to his/her residence within 30 days of admission to the short-stay bed.
- the applicant meets the following criteria:
 - the applicant is at least eighteen years of age
 - the applicant is an insured person under the *Health Insurance Act*:
 - the applicant meets at least one of the following criteria:
 1. the applicant requires that nursing care be available on-site twenty-four hours a day.
 2. the applicant requires assistance each day with activities of daily living.
 3. the applicant requires on-site supervision or monitoring at frequent intervals throughout the day, to ensure his/her safety or wellbeing.
 4. the applicant is at risk of being financially, emotionally (including verbal abuse) or physically harmed if he/she lives at his/her residence.

POLICIES
SHORT-STAY PROGRAM
INTRODUCTION

ELIGIBILITY (CONT'D)

5. the applicant is at risk of suffering harm due to environmental conditions which cannot be resolved, if the applicant continues to live in his/her residence.
6. the applicant may harm someone if he/she lives in his/her residence.

Note: The existence of community-based services need not be examined as part of the eligibility determination process for persons seeking admission to short-stay.

ASSESSMENT

The objective of the short-stay program is to provide safe nursing and/or personal care for the duration of the admission.

Note: For short-stay residents, the goal is to safely support/continue the plan of care and services that has been implemented in the community or hospital prior to admission. Repetition of assessments and care planning are unnecessary. The care plan can be built on previous assessments, information obtained during the pre-admission assessment and initial assessment once admitted. If a resident has used a short-stay program before, the previous care plan may be reactivated and updated. Records from other facilities may also be used.

Staff of the facility will carry out a basic assessment of the care, program, and service needs of the person. This initial assessment should build on any previous assessment information available, such as that from the CCAC, or pre-admission information provided by the resident/representative. Facilities may develop a form to be completed prior to admission by applicants/representatives which would provide such information as care routines, social and recreational interests.

Details of the resident's assessment will then be confirmed in discussion with the resident/representative on admission.

POLICIES

SHORT-STAY PROGRAM

INTRODUCTION

ASSESSMENT (CONT'D)

Realistic goals are negotiated with the resident/representative which are based on the length of the stay and the resources available in the facility.

The basic assessment will include but not be limited to:

- safety and security needs (to be assessed on admission);
- nursing and personal care needs, including activities of daily living (to be assessed within 24 hours);
- identified medical needs, including medications, treatment, and diet orders (to be assessed on admission or within 24 hours).

Note: For short-stay residents, assessments by other care team members are completed only if required to meet the realistic goals which have been negotiated with the resident/representative.

A team conference is not required for the purposes of reviewing and revising the plan of care. The plan of care and the frequency of reassessments may be modified in order to reflect each resident's needs during his or her limited stay. However, reassessment will be necessary if the resident's condition changes; this will be very important if the assessment requires a change in the plan of care or medication/diet orders.

PLAN OF CARE

For the purposes of the short-stay admission, the goal is to safely support/continue the plan of care and services that has been developed and implemented in the community or hospital prior to the admission. It is also an opportunity for a person to access and benefit from the particular expertise that is available in the long-term care facility. This will ensure continuity of care for the individual during the stay as well as allow the setting of realistic expectations for the stay

POLICIES**SHORT-STAY PROGRAM****INTRODUCTION****PLAN OF CARE (CONT'D)**

Building on previous assessments, i.e., from prior admissions or from other community programs (for example, CCAC managed services), the information obtained during the pre-admission assessment and initial assessment will be used to develop a realistic plan of care, programs, and services that reflects the following:

- the person's plan of care previously established in the community, hospital, or previous admission to the facility;
- the realistic goals of care that can be achieved within the length of stay and considering the programs offered in the facility. These are determined during consultation with the resident or his/her representative;
- the care, programs, and services to provide safe care and to meet established goals, recognizing individual choices and preferences;
- referrals to other members of the interdisciplinary team.

Note: Referrals will be made only if required to meet the goals that have been negotiated with the resident/representative.

- TB test results if available.

Note: TB screening is not required prior to admission. If the person will be in the facility for more than 14 days, the TB test will be carried out within the facility, if there are no previous test results available. TB testing should be not be repeated within a one-year period. (See M3.22)

POLICIES**SHORT-STAY PROGRAM****INTRODUCTION****MEDICAL SUPPORT**

A resident in a short-stay program will require medical assessment and evaluation as well as provision of clear directions for the care, including medications, to be provided in the facility.

If a short-stay resident's family physician provides care to the person during the stay in the long-term care facility, this physician must be made aware of the facility's expectations and the physician's responsibilities, including emergency coverage.

It may be difficult for a short-stay resident to obtain the agreement of his/her family physician to meet a facility's requirements for a short length of time. In this case, the facility will be required to provide medical coverage for the short-stay resident. The medical director of a facility or another attending physician in the facility may agree to provide medical care to the resident for the duration of the short stay.

When a short-stay resident is admitted, there will be a certain amount of information provided prior to the admission (for example, previous history, medications, and plan of medical care). The responsibility of the medical director in relation to the planning of this resident's medical care will be to build on the information available at the time of the admission and plan the care accordingly.

DOCUMENTATION

Maintaining a medical record/care plan for a short-stay resident is necessary to record the admission assessment (that has been built on the previous assessments that were provided on admission), the orders for medications, diet, and any treatments to be provided during the stay. As many short-stay residents will use the program on a frequent basis, it is necessary to ensure that any previous available information is provided to assist the facility in assessing and planning care.

Facilities may reactivate previous records and build on the information in the assessment and care planning phase or may access records from other facilities to eliminate unnecessary repetition of assessments and care planning.

POLICIES

SHORT-STAY PROGRAM

INTRODUCTION

.DOCUMENTATION (CONT'D)

Note: For short-stay residents, the goal is to safely support/continue the plan of care and services that has been implemented in the community or hospital prior to admission. Repetition of assessments and care planning are unnecessary. The care plan can be built on previous assessments, information obtained during the pre-admission assessment and initial assessment once admitted. If a resident has used a short-stay program before, the previous care plan may be reactivated and updated. Records from other facilities and community service agencies may also be used.

ACCOMMODATION CHARGES

Residents in short-stay programs will be charged a regulated amount designed to cover a portion of their accommodation costs. The charges will be applied to cover a 24-hour period of stay in the facility. In this way, a facility may establish flexible admission and discharge times for the short-stay program.

Note: For example, a facility may discharge a resident from a short-stay bed in the morning and admit a new resident in the afternoon or evening.

Residents in the short-stay program will be charged a rate that has been calculated at the maximum rate reduction for basic accommodation.

There is no further rate reduction available for the short-stay program.

DEPOSITS

A facility may charge a deposit of up to \$50.00 for individuals applying for admission to a short-stay program. This deposit will be applied to the charges for the first two days' accommodation in the facility.

POLICIES**SHORT-STAY PROGRAM****INTRODUCTION****DEPOSITS (CONT'D)**

If the applicant does not enter the facility on the date set aside, this deposit will not be refunded unless the applicant has notified the facility/CCAC at least two days prior to the admission that he/she will not be entering the facility. Exceptions to this policy will be allowed for conditions that are beyond the control of an individual or caregiver, such as if the applicant has been admitted to another facility or has been admitted to hospital.

**ADMISSION
AGREEMENTS**

An admission agreement should be established for each individual entering a short-stay program which includes the agreed-upon service expectations that the facility and resident agree will be provided, as well as the length of the stay, discharge date, and charges to be paid.

**AMENDMENTS TO
RESIDENT CARE,
PROGRAMS AND
SERVICES**

Refer to following criteria for adjustments that have been made to resident care, programs and services expectations for short-stay residents:

B1.3, B1.4	(Assessments)
B2.3	(Planning)
B5.1	(Documentation)
M3.22	(TB testing)
R7.2	(Taking unused medications home on discharge).

**CALL FOR APPLICATIONS
TO OPERATE INTERIM LONG TERM
CARE (LTC) BEDS**

Ministry of Health and Long-Term Care
August 2005

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PART 1: INTRODUCTION

1.1 Call for Applications (CFA)

The Community Health Division of the Ministry of Health and Long-Term Care as represented by the Minister of Health and Long-Term Care (the “Ministry”) is issuing this Call for Applications (CFA) to Respondents in [insert area] area to provide [insert number] Interim Long-Term Care (LTC) beds.

1.2 Eligibility

The following Respondents are eligible to apply:

- (i) public hospitals governed under the Public Hospitals Act and
- (ii) operators of long-term care homes governed under the Nursing Homes Act, the Homes for the Aged and Rest Homes Act or the Charitable Institutions Act.

1.3 When and Where to Submit a Submission

In order to facilitate the evaluation and selection process, one (1) original and three (3) copies of a submission must be received by 12:00 noon on [insert day and month, 2005] (the “Closing Time”), in a sealed envelope or package at the following address:

Ministry of Health and Long-Term Care
[insert address of receiving office]

The Ministry will not accept or consider submissions transmitted by facsimile or sent by any other electronic means. The Ministry reserves the right to accept or reject, solely at its discretion, any submission that is not received by the Ministry by the Closing Time indicated above.

1.4 Terms, Conditions and Submission Requirements of this Call for Applications

The terms and conditions of this Call for Applications (CFA) may be found in Part 4.

1.5 Background

The Interim Long -Term Care (LTC) Beds Program is designed to facilitate the discharge of hospital patients to long-term care homes. Interim LTC beds are to be implemented in communities where, despite the recent increase in the number of LTC homes, shortages persist. Interim LTC beds will remain in place for a specified period of time.

The purpose of the Interim LTC beds is to ensure that hospital patients, who are currently awaiting transfer to permanent long-term care homes, are cared for in a home-like environment that includes programming and services that are specifically designed to meet their needs. All residents of Interim LTC beds will be transferred to one of their permanent bed choices. The Interim LTC beds are to be established for a temporary period to be determined.

The Interim LTC bed operators will provide quality long-term care programs and services. A separate Service Agreement/Amending Agreement which will outline care, program and service expectations, will be signed between each successful Respondent and the Ministry.

The purpose of the CFA is to seek submissions from interested Respondents and to select the best qualified and most suitable submissions for the operation of Interim LTC beds.

1.6 Overview of Long-Term Care Homes and Residents

Ontario's long-term care homes provide care and services for people who are not able to live independently in their own homes, even with the assistance of community support services and in-home professional care, and who require 24-hour supervision, personal care and support.

Long-term care homes provide a range of services to meet the needs of residents, including accommodation, meals, nursing and personal care, as well as a variety of social and recreational activities.

Residents are predominately widowed women between the ages of 80 to 89 years. The average age of admission for residents is 85 years.

The most prevalent diagnoses are: disorders such as Alzheimers disease, dementia or other psychiatric diagnosis; circulatory diseases and musculoskeletal disabilities such as arthritis. Most of the residents require specific plans of care to manage varying degrees of incontinence.

Most residents require considerable supervision and assistance with activities of daily living such as bathing, toileting, dressing, eating and transferring from bed to chair. The typical resident will take six or more different kinds of medication every day. Over 35% of residents require some form of specialty treatment ordered by a physician and carried out by nursing staff, ranging from the application of topical medications, creams, and ointments to catheters, oxygen and ostomy care.

1.7 Scope of Project

Public hospitals and current long-term care operators are invited to submit submissions for the Interim LTC beds. The Ministry encourages hospitals to partner with operators/managers experienced in providing long-term care home care, programs and services.

Successful Respondents will work with local Community Care Access Centres (CCACs) to ensure that clients for Interim LTC beds have been appropriately assessed for long-term care home placement and that discharge plans are in place.

All admissions to Interim LTC beds will be through the CCAC process. However, eligibility for placement in the Interim LTC beds is restricted to those determined Alternate Level of Care (ALC) in acute care hospitals. Successful Respondents will be expected to comply with all applicable components (in particular, care and services) set out in the Long-Term Care Facility Program Manual dated December 20, 1993, as amended. Each successful Respondent must enter into a Service Agreement/Addendum with the Ministry which sets out the programs and services which are to be provided in exchange for funding from the Ministry.

The Long-Term Care Facility Manual can be obtained from the Long-Term Care Division at (416) 314-1137 for a cost of \$20.00

The Ministry of Health and Long-Term Care will provide funding to support the operation of Interim LTC beds. Capital funding for renovations/construction will not be provided by the Ministry.

1.8 Allocation of Interim Long-Term Care (LTC) Beds

The number of Interim LTC beds has been directed to areas of the province based on need and capacity.

The Community Care Access Centres will determine which residents will be eligible to be placed in the Interim LTC beds. Hospitals cannot take patients currently in ALC beds and transfer them directly to the Interim LTC beds.

1.9 Funding Scheme

The funding scheme for the Interim LTC beds will be as set out in Schedule 1 to this CFA.

1.10 Resident Admission and Discharge Planning Process

The forty-two (42) Community Care Access Centres across the province are responsible for managing the access to both long-term care community and facility services in their respective regions. Any person wishing to apply for admission to the Interim LTC beds must be appropriately assessed by the local Community Care Access Centre and be deemed eligible by the Community Care Access Centre using the provincially established criteria for admission to a long-term care facility. Those persons who have not been assessed or do not meet the admission criteria will not be admitted to an Interim LTC bed.

Eligibility for Interim LTC beds will be restricted to those designated as ALC patients in an acute care hospital (not necessarily the hospital containing the Interim LTC beds). The admission process must also incorporate appropriate discharge planning that reflects the preferences of the client and recognizes the temporary nature of the Interim LTC beds.

Approval of an application for admission is not possible without a valid Ontario Health Insurance Plan (OHIP) number issued by the Ministry of Health and Long-Term Care. In addition, admission is restricted to applicants who are aged 18 years and older.

1.11 Mandatory Legislative and Program Criteria and Standards Compliance

All successful Respondents must be familiar with and comply with the legislative and regulatory framework for Long-Term care as well as the standards and criteria outlined in the Long-Term Care Facility Program Manual. Ministry staff will monitor compliance against standards and criteria during review of programs and services.

PART 2: PROGRAMS, SERVICES AND DESIGN REQUIREMENTS FOR THE INTERIM LONG-TERM CARE (LTC) BEDS

2.1 Mandatory Programs and Services

In addition to the requirement that all successful Respondents must adhere to all legislative requirements for Long-Term Care, the following mandatory programs and services must be taken into account by all Respondents in preparing their submissions for this CFA.

- (i) Nursing and personal care on a 24-hour basis, under the supervision of a registered nurse, medical services organized to meet residents' medical needs which includes the provision of 24 hour medical coverage;
- (ii) Medical supplies and nursing equipment necessary for the care of residents, including the prevention or care of skin disorders, continence care, infection control, and sterile procedures;
- (iii) Pharmacy service on a 24 hour basis that meets the residents' identified needs;
- (iv) Diagnostic services to meet residents' needs as ordered by the physicians;
- (v) Supplies and equipment for personal hygiene and grooming, and required treatments;
- (vi) Equipment for the common use of all residents, including mechanical lifts, wheelchairs, geriatric chairs, canes, walkers, toilet aids and other self-help aids required to support activities of daily living;
- (vii) Meal services, including three meals daily, snacks between meals and at bedtime, special diets including therapeutic and texture modified diets and dietary supplements and devices enabling residents to feed themselves;
- (viii) Social programs, recreational and spiritual programs including supplies, equipment and space necessary to support these activities;
- (ix) Availability of laundry facilities, services for the care of personal clothing;
- (x) Therapy services - arrangements must be made to access therapy services such as physiotherapy, occupational therapy to meet residents' identified therapy needs;
- (xi) An adequate supply of bedding and linen including firm, comfortable mattresses with waterproof covers, pillows, bed linen, wash cloths and towels;
- (xii) Bedroom furnishing such as beds (where the resident is confined to the bed, a bed with an adjustable head and foot section), adjustable bedrails, bedside tables, and a comfortable easy chair;
- (xiii) The cleaning and upkeep of accommodations.

Note: The standards and criteria outlined in the Long-Term Care Facility Program Manual are the requirements upon which nursing and personal care services in Interim LTC bed settings will be evaluated. Applicants must familiarize themselves with these standards and criteria and provide nursing and personal care services in accordance with these requirements.

2.2 Facility Organization and Administration

- (i) The programs and resources of the Operator's Home shall be organized to effectively manage the Interim LTC bed program in keeping with the Ministry Acts, Regulations, Policies and Procedures;
- (ii) An organizational chart is to be developed to represent the structure of the organization and reflect reporting relationships;
- (iii) Current policies and procedures must be consistent with Ministry policies and directives and shall be in place to guide the management and service delivery of each program and service;
- (iv) Opportunities for interdisciplinary and interdepartmental communication and coordination shall be in place;
- (v) There shall be a designated administrator with experience in long-term care service provision;
- (vi) There shall be written job descriptions;
- (vii) There shall be an orientation program and a staff education program; a designated educator shall be part of the management staff;
- (viii) There shall be a quality management program in place;
- (ix) There shall be a risk management program in place;
- (x) There shall be mechanisms in place to monitor resident and family satisfaction with the program and services provided;
- (xi) There shall be contingency plans for responding to internal and external disasters;
- (xii) There shall be an organized program of infection control.

2.3 Nursing and Personal Care Services

The provision of nursing and personal care services for each Interim LTC bed program must include:

- (i) The assessment of each resident's needs for care and services;
- (ii) Planning of each resident's care and services;
- (iii) Provision of care to each resident consistent with the established plan of care;
- (iv) Monitoring and evaluation of each resident's care, services and outcomes of care;
- (v) Documentation of each resident's care and services;

- (vi) Resident involvement in care planning must be incorporated into each Interim LTC bed program and each resident's need for care and services must be determined through an interdisciplinary assessment process;
- (vii) Every Interim LTC bed program will be required to have an organized program of nursing services to meet diverse resident needs. A Director of Care (required to be a registered nurse as a minimum) must be identified to manage and direct nursing care staff in the provision of resident care, programs and services;
- (viii) Typically, nursing care and personal care staff (along with the Director of Care) include registered nurses, registered practical nurses, personal support workers and health care aides. The nursing care team may also include nurse managers and ward clerks;
- (ix) In long-term care home settings, at least one registered nurse is onsite for each shift on a 24 hour basis.(this regulation comes into effect February 1, 2005) On the day shift this is in addition to the Director of Care;
- (x) Nursing staff must ensure that each resident receives at least two baths (tub baths or full body sponge baths) or showers a week, unless there is a medical reason for the resident not to receive the baths or showers (this regulation comes into effect January 1, 2005);
- (xi) Documentation: All significant information about each resident is to be documented in his/her record of personal health information as per Personal Health Information Protection Act. Documentation includes, assessments and identification of residents' needs, a description of the care and services provided to respond to the identified needs of the residents and an evaluation of the residents' response to the care and services provided.

2.4 Dietary Programs and Services

Dietary programs and services for each Interim LTC bed program must be organized in a manner that promotes a home-like ambience for residents and meets the nutritional care needs of the residents.

At least one separate dining area must be provided, and any dining room must be designed and decorated to support familiar eating patterns associated with smaller social gatherings to promote social interaction. In addition, each dining area must be designed to facilitate resident independence and have sufficient space to accommodate a dining place for each resident.

Meal service programs must allow for resident choice and facilitate portioning at the point of service. Congregate dining is encouraged. Bed tray service is only acceptable as part of an individualized plan of care for a resident.

2.5 Recreation and Leisure Programs

Each Interim LTC bed program must provide recreation and leisure programs. These programs must be organized to provide appropriate recreation and leisure opportunities that respond to the diverse abilities, strengths, interests, spiritual, social and cultural needs of residents.

Residents must also be provided with opportunities and assistance to participate in social and community programs which are compatible with their interests and abilities.

Spiritual programs should be offered on site and residents should be supported in maintaining connections with their spiritual community.

2.6 Resident Safeguard / Compliance with Legislation

Consistent with the current long-term care home system, all Respondents to the CFA of the Interim LTC beds will be required to operate the beds in a manner that respects, supports and promotes residents' rights in keeping with the Residents' Bill of Rights, as set out in the Nursing Homes Act, the Charitable Institutions Act, and the Homes for the Aged and Rest Homes Act. These rights emphasize resident participation in the planning and evaluation of the individual resident's care plan, as well as in the planning and evaluation of programs and services.

All residents and "substitute decision maker" – if applicable, must receive on admission, a written agreement outlining the basic care, programs and services which the home shall provide to residents at no additional cost. A copy of the Residents' Bill of Rights must be part of this written agreement.

Each Interim LTC bed operator will be required to publicly post their complaint procedure along with the names and contact information of the Ministry staff, Advocacy Resources and the new 1-866-434-0144 government information number.

In addition, residents are to be given the opportunity and the support to establish and maintain an organized Residents' Council and Family Council.

All unusual occurrences which significantly affect resident safety or the home must be reported to the Ministry. Organizations must develop a restraint policy that is in accordance with the legislation applicable to the home and the Long-Term Care Facility Program Manual. Organizations must develop an abuse policy which is in accordance with the Ministry's requirements in the area.

2.7 Therapy/Restorative Care

Each resident shall receive supervision/assistance and services which promote independence, maintain or improve function in activities of daily living, according to assessed abilities, wishes and preferences.

All residents shall be assessed to identify needs for therapy and restorative care interventions.

Services may be provided by qualified therapists employed by the home or by contractual arrangement.

2.8 Compliance with Legislation

Operators of Interim LTC beds in a hospital setting must comply with relevant legislation including the Public Hospital Act (PHA). Operators of Interim LTC beds in long-term care home settings must comply with relevant legislation including the Nursing Homes Act, the Charitable Institutions Act, and the Homes for the Aged and Rest Homes Act.

Hospitals may engage in revenue generating activities requiring approval under Section 4 of the PHA, subject to Ministry approval.

2.9 Design Standards

2.9.1 Resident Bedrooms

Bedrooms must contain no more than four beds (preference is to have all -one-bed and two-bed bedrooms).

All bedrooms must have:

- (i) A hospital-type bed or a long-term care facility-type bed for each resident of the bedroom;
- (ii) An over bed light for each bed in the bedroom;
- (iii) A window to the outside;
- (iv) A separate two piece (toilet and sink) washroom that is accessible from within the bedroom (i.e., the washroom door is inside the bedroom);
- (v) A clothes closet for every resident in the bedroom which is adequate in size and depth to hang clothes; minimum 4 sq. ft as long as dimensions include 2 ft. to allow for clothes hanging;
- (vi) A chair for every resident of the bedroom;
- (vii) A device at every bed to activate the staff communication and response system (i.e., the call bell system);
- (viii) A bedside table for each resident in the bedroom.

The minimum bedroom space requirements are as follows:

- a) Basic (Ward) Rooms (three or four beds)
 - (i) Three Beds

There must be at least 255 square feet (23.69 square metres) of floor space in a three-bed bedroom, exclusive of any closet(s), the entrance and the washroom. There must be a 2'6" clearance around each bed

(ii) Four Beds

There must be at least 305 square feet (28.33 square metres) of floor space in a four-bed bedroom, exclusive of any closet(s), the entrance and the washroom. There must be a 2'6" clearance around each bed

(iii) Semi-Private Rooms

There must be at least 169 square feet (15.70 square metres) of floor space in a two-bed bedroom, exclusive of any closet(s), the entrance and the washroom. There must be a 2'6" clearance around each bed

(iv) Private Rooms

There must be at least 100 square feet (9.29 square metres) of floor space in a one-bed bedroom, exclusive of any closet(s), the entrance and the washroom. There must be a 2'6" clearance around the bed.

2.9.2 Lounge Space

There must be at least one area for lounge space with window on each floor that accommodates residents. It is preferred that there be at least 15 square feet (1.39 square metres) of lounge space per resident.

2.9.3 Safety Features

All exterior doors leading into stairwells and doors leading to other areas outside of the long-term care unit should be equipped with door alarms and/or magnetic locks.

2.9.4 Staff Work Space

There must be work space for nursing and program staff to carry out their administrative duties, for example, a nursing station. This area could be shared dependent on program delivery requirements and structural limitations.

Staff work space must be sufficient in size to accommodate storage of resident care records, staff resource and reference material, a telephone, and space for documentation activities.

2.9.5 Outdoor Area

There must be as a minimum, one secured outdoor space. There must be an outdoor area which is suitably designed and safe for resident use. This outdoor area does not necessarily have to be at ground level (for example, a roof garden or balcony is an acceptable option).

2.9.6 Other Features

If there are residents who smoke, there must be a designated smoking area which meets the requirements as outlined under the Tobacco Control Act.

2.9.7 Other suggested spaces

Clean utility room
Soiled utility room
Janitor closets
Resident storage

2.10 Related Benefits

2.10.1 Benefits

In addition to long-term care benefits, residents of long-term care homes are eligible to receive other health benefits under specified terms and conditions.

Related benefits include:

- (i) Medical, laboratory and practitioner services under the Ontario Health Insurance Plan
- (ii) Drug benefits under the Ontario Drug Benefit Program
- (iii) Benefits under the Assistive Devices Program
- (iv) Benefits under the Home Oxygen Program

All related benefits provided to residents occupying the Interim LTC beds awarded under this CFA should be provided in compliance with the applicable benefit program policies and procedures for residents in long-term care homes. The rules and regulations that apply to billings for residents in long-term care homes will apply to all residents residing in Interim LTC care beds regardless of where the Interim LTC beds are located.

2.11 Additional / Optional Services

2.11.1 Other Services - Optional

Other services may be provided for a fee as long as the resident agrees in writing to receive these services. Examples of such optional services include, but are not limited to:

- (i) Hairdressing and barber services;
- (ii) Telephone connections and monthly fees, cable television connections and monthly fees;
- (iii) Tuck/gift shop, newspaper delivery;
- (iv) Dry cleaning, mending and ironing;
- (v) Non-prescription drugs, medication and treatment products, and supplies not available through the Ontario Government;
- (vi) Pharmaceutical and Medical Supply Services;
- (vii) Uninsured health care services (for example, specialized foot care and dental care).

2.11.2 Sharing of Space in an Integrated Complex

The resident care areas of the Interim LTC bed program should be completely separate and distinct from space which is used for other purposes. If the Interim LTC bed program space is to be part of a larger integrated complex, for example, a combined complex that includes a hospital and the Interim LTC bed program area, the space allocated for the Interim LTC bed program should be distinct and separate from the hospital.

In an integrated multi-use complex, it is acceptable to share building service areas, such as the kitchen, parking area, outdoor space, staff rooms, laundry, cafeteria, auditorium, place of worship and beauty parlour/barber shop. In addition, it is acceptable to share the internal building systems for water, hydro, sewage, waste disposal, lighting, heating and ventilation.

However, resident care areas and resident space, which includes bedrooms, washrooms, tub and shower rooms, dining areas, lounges and program/activity space should not be integrated with space in a multi-use complex that is designed for other types of care.

The Ministry will accept the sharing of common space when the Respondent is able to demonstrate that this space will enhance and promote quality resident care outcomes.

2.11.3 Washrooms

Every washroom should be large enough to allow a wheelchair to fit into the washroom, and once the wheelchair is in the washroom, the door should be able to be completely closed.

In addition, every washroom which is to be used by residents should have a device at the toilet to activate the staff communication and response system (i.e., the call bell system).

2.11.4 Bathrooms/Shower Rooms

On every floor that accommodates long-term care residents, there should be a minimum of one (1) bathtub and (1) shower for every 32 beds. The bathtub should have a mechanical lift or alternative acceptable solutions for safely permitting access without risk to residents or staff, and there should be adequate space around the bathtub to maneuver residents safely into and out of the bathtub.

In addition, if showers are provided, each shower should be sufficient in size to accommodate a shower chair.

Every bathroom/shower room which is to be used by residents should have a device at the bathtub/shower to activate the staff communication and response system (i.e., the call bell system).

2.11.5 Lounge, Program/Activity space

There must be a 6 square feet (0.55 square metres) of activity space provided per resident. As well there must be 15 sq. ft. of lounge space provided per resident. Space may be combined, but the total minimum lounge and activity space of 21 sq. ft per resident must be provided.

2.11.6 Dining Room

There must be a minimum of 20 square feet (1.85 square meters) of dedicated dining room space per resident, excluding server space (may or may not be located in a dining room but must be close enough to facilitate effective meal service delivery).

2.12 Facility Accountability and Monitoring Program

All long-term care homes in the Province of Ontario are subject to regular and unscheduled review and monitoring by the staff of the Community Health Division.

The Interim LTC bed program will also be subject to and part of the review and monitoring process.

Compliance Advisors (registered nurses with background in long-term care services - work in the Long-Term Care Regional Offices) are responsible for reviewing resident care, programs and services using the Long-Term Care Facility Program Manual. This includes on-site visits to monitor the quality of programs and services provided.

Annual reviews of the Interim LTC beds will be conducted by the Community Health Division of the Ministry of Health and Long-Term Care during the period that the Interim LTC beds are in operation.

In the event of non-compliance, follow-up visits will be made to confirm and evaluate any corrective measures which may need to be implemented. In addition, the Ministry has the right to investigate complaints registered by the public about the operation of the Interim LTC beds.

Alternative mechanisms are available to monitor ongoing serious noncompliance where there is a concern that resident health, welfare and safety are at serious risk.

PART 3 - REQUIRED CONTENT AND EVALUATION PROCESS FOR SUBMISSIONS

This Part contains the requirements, which must be substantially complied with, in order for the Respondent's submission to receive consideration. If, in the view of the Ministry, the submission does not substantially comply with these requirements, the Ministry may eliminate the submission and the submission may not be given any further consideration. For the purposes of this CFA, substantial compliance means compliance with the material components of the requirement and allows only for very minor irregularities.

3.1 General Submission Requirements

Each submission must include:

- (i) One (1) original and three (3) copies of each submission must be provided by each Respondent;
- (ii) The name, address and telephone number of the Respondent(s);
- (iii) The location of the proposed site (street address and city);
- (iv) The proposed number of Interim LTC beds requested;
- (v) The number of long-term care beds the Respondent currently operates;

- (vi) The names(s), and title(s) of individual(s) who will have principal control over the operation of the Interim LTC beds;
- (vii) A description of the nature of partnerships (i.e. hospital/long-term care collaboration), services provided/purchased, and whether space is being leased.-
- (viii) Proposed plan for the opening and closing of Interim LTC beds;
- (ix) If applicable, the name of the management/consulting firm involved in the preparation of this information package;
- (x) If applicable, the name of the anticipated future role of any management/consulting firm in the operation of the Interim LTC beds;
- (xi) If applicable, any proposed construction/renovations which may be needed to meet minimum structural standards;
- (xii) For hospitals submitting either as a single applicant or in partnership with a long-term care provider, signature of the Board Chair or CEO must accompany the submission.
- (xiii) Partnership submissions must be co-signed by a long-term care home officer with signing authority; and
- (xiv) Proposed time line for the opening and operation of the Interim LTC beds on or before **[date required]**

3.2 Partnership and Joint Submission

The Respondent must include in its submission the names of any proposed subcontractor(s), and an indication whether the subcontractor is a sole proprietorship, corporation, partnership, joint venture, or consortium. The Respondent must also indicate in its submission whether a proposed subcontractor is an existing service provider, such as a hospital or long-term care facility, and if so, the proposed subcontractors experience and ability to meet the requirements of this CFA.

If two or more entities make a joint submission, the Respondent must indicate in the submission that it is prepared to take full responsibility for the successful provision of the services under this CFA. The Respondent must describe in the submission how it will take on this responsibility.

The questions below have been provided to indicate the criteria for determining the Respondent's qualifications to operate the Interim LTC beds. (See Weighting Table)

3.3 Conflict of Interest

The Respondent must confirm in its submission that the Respondent:

- (i) Does not and will not have any conflict of interest (actual or potential) between its interest and the interest of the Ministry under this CFA process, in submitting its submission or, if selected, with the contractual obligations of the Respondent under the Service Agreement to be signed with the Ministry. Where applicable, a Respondent must declare in its submission any situation that may be a conflict of interest in submitting its submission or, if selected, with the contractual obligations of the Respondent under the Service Agreement; and
- (ii) Does not and has not had access to any confidential information of the Crown in the Right of Ontario (the "Crown") (other than confidential information disclosed to Respondents in the normal course of the CFA), which is relevant to the services required by the CFA, or the CFA evaluation process and the disclosure of which could result in prejudice to the Crown or an unfair advantage to the Respondent.

3.4 Program and Services Requirements

3.4.1 Qualifications for Providing Long-Term Care Bed Services

Describe your experience and qualifications which make you a suitable and appropriate operator of Interim LTC beds and /or your experience from partnerships with long-term care homes in providing long-term care bed services.

3.4.2 Staffing Requirements

Attach an organizational chart which identifies any staff which may be involved in the operation of the Interim LTC beds and the reporting relationships of each position (other relevant positions may also be included as appropriate).

Please include a brief and concise job description for each position, as applicable (one or two paragraphs for each job description is sufficient. Point form can be used as long as the information is clearly understood).

Please indicate whether any of those positions are full or part-time and where any positions are combined, and include a proposed deployment schedule for this staff.

Provide a description of the orientation procedures for all staff (include non-staff such as community college nurses and volunteers) in the following departments:

- (i) Administration;
- (ii) Activation/recreation;
- (iii) Nursing;
- (iv) Dietary;
- (v) Laundry;
- (vi) Housekeeping; and
- (vii) Maintenance.

Briefly summarize the role and responsibilities for the following professionals:

- (i) Advisory physician;
- (ii) Attending physician(s);
- (iii) Pharmacist; and
- (iv) Dentist.

The position, role and responsibilities of any other professionals should also be indicated (this includes professionals such as dietitians, podiatrists, chiropractors, spiritual care workers and social workers).

The medical care programs and services will be provided by the operator. The operator may consider allowing residents to continue to have their personal physician provide care to them in the facility.

3.4.3 Nursing Care Programs

Provide an overview of the proposed nursing and personal care programs which includes:

- (i) A brief description of the programs relating to nursing and personal care (for example, the continence care program and the restorative care program); and
- (ii) A brief description of the quality assurance procedures for the nursing department.
- (iii) Psychogeriatric program-briefly describe the resources available to assess residents who have behaviour management care needs. Describe linkages developed to assist in the arrangements for provision of care to residents who require the expertise in the field of psychogeriatrics

3.4.4 Dietary Programs

- (i) Briefly summarize the nutritional care and food service programs/services/staff deployment.
- (ii) Indicate and provide detail on the following:
 - (a) dedicated food handler hours per diem and per week
 - (b) supervisory hours on both a per diem and a per week basis; and
 - (c) dietitian hours other than supervisory.
- (iii) Provide an overview of the background/qualifications of the food services supervisor.
- (iv) Describe how the menu program will be developed to meet the needs of residents in a long-term care setting
- (v) Describe the quality assurance procedures in place to ensure that nutritional care and food services programs are met, and the process for resident involvement in the dietary program.

3.4.5 Environmental Health Services

- (i) Briefly describe how the following environmental health services will be provided:
 - a) Laundry;
 - b) Housekeeping; and
 - c) Maintenance.
- (ii) Provide an overview of the quality assurance procedures that will be in effect to ensure acceptable environmental health standards are maintained.

3.4.6 Recreation and Leisure Programs

Summarize the objectives of the recreation and leisure programs and include:

- (i) Proposed recreation and leisure staff hours per resident per day; a brief description of the procedures for monitoring to ensure the success of the programs and the process for resident involvement in the planning of recreation and leisure activities; and
- (ii) Provide a brief description of your volunteer program and include the role of volunteers in relation to the recreation and leisure programs.
- (iii) Descriptions of proposed programs and a schedule outlining events and programs.

3.4.7 Admission Information

Outline the admission information that will be given to a prospective resident, and to relatives of a prospective resident.

3.4.8 Provision of Related Benefits

Briefly describe how the following related benefits will be provided and how you will comply with the policies and procedures related to the delivery of these programs:

- (i) Medical, laboratory and practitioner services under the Ontario Health Insurance Plan
- (ii) Drug benefits under the Ontario Drug Benefit program
- (iii) Benefits under the Assistive Devices Program
- (iv) Benefits under the Home Oxygen Program

Where provision of related benefits under the terms specified above could be reasonably expected to result in undue hardship to residents of the Interim LTC beds or the Respondent or would not be possible given contractual commitments of the Respondent, the Respondent must provide a detailed description of these circumstances and their proposed benefit delivery and funding alternative. Acceptance of such submission may be subject to further negotiations and is solely at the discretion of the Ministry.

The Respondents must provide details in their submission of any third party subcontracting arrangements.

The Respondents may provide in their submission details of how these benefits are to be funded.

3.5 Structural and Financial Requirements

3.5.1 Proposed Site

Describe the location for the Interim LTC beds and its current use.

Describe the timing of any renovations to the current space in order to operate Interim LTC beds.

If the space is currently occupied, describe where the current programs and services will be transferred to, the schedule for the transfer, and whether renovations etc. are required in the area receiving the program/services.

If leasehold improvements/renovations are required, describe the renovation, the estimated time to complete the renovation (schedule), and the cost.

Briefly describe the size, features and location of at least the following:

- (i) All bedrooms (include number of beds in each bedroom);
- (ii) All resident washrooms and bath/shower rooms;
- (iii) Lounge space, dining rooms and activity space; and
- (iv) Staff work space.

If available, please submit a line drawing or simple sketch plan of the area or areas of the building to be used for the Interim LTC bed program showing the above listed rooms/space.

3.5.2 Operating Budget

An operating budget must be provided that reflects one-time start up costs for the time the beds are in operation.

Submissions must include a description of the impact of purchased services by the hospital and identification of the financial impact of the submission on the operations and financial viability of the hospital.

3.6 Other Requirements

3.6.1 Opening and Closing Interim LTC Beds

Provide an explanation as to how the Respondent plans to open the Interim LTC beds and implement the Interim LTC bed program. In addition, provide details as to how the Respondent plans to decommission staff and dispose of equipment when the Interim LTC beds close.

3.6.2 Additional Requirements

- (i) Explain how these Interim LTC beds will provide for better patient flow through the surrounding hospitals and alleviate the emergency department issues in surrounding hospitals.

- (ii) Explain how this submission will improve the quality of patient care in surrounding hospitals.
- (iii) Describe the impact of providing Interim LTC care beds on other programs in the facility.

3.7 Call for Applications (CFA) Weighting Table

For purposes of qualification, the respective weighting of the Submission is as follows:

Requirement Category Total Weighting

A. Program and Service Requirements 75%

- (i) Experience in Providing Long-Term Care Services
- (ii) Staffing Requirements
- (iii) Nursing Care Programs
- (iv) Dietary Programs
- (v) Environmental Health Services
- (vi) Recreation and Leisure Programs
- (vii) Admission Information
- (viii) Related Benefits

B. Structural and Financial Requirements 20%

- (i) Proposed Site
- (ii) Operating Budget

C. Other Requirements 5%

- (i) General Submission Requirements
- (ii) Opening and Closing Interim Care Beds
- (iii) Additional Requirements

3.8 Pre-Occupancy Review and Approval

Prior to Ministry of Health and Long-Term Care approval for funding and operation of the Interim LTC beds, the Community Health Division will complete a pre-occupancy review of any space and operations which are proposed to be used to accommodate the interim care beds. No residents may be admitted to any of the Interim LTC beds until such time as this pre-occupancy review is completed and Ministry of Health and Long-Term Care approval for funding and operation of the Interim LTC beds is received.

PART 4 - TERMS AND CONDITIONS OF CALL FOR APPLICATIONS PROCESS

4.1 Signing of Submission, Amendments and Notice of Withdrawal

Each submission, amended submission, and notice of withdrawal must be signed by a person authorized to do so on behalf of the Respondent. If a notice of withdrawal is not signed, the Ministry shall not regard it as a valid notice of withdrawal.

4.2 Acknowledgement That All Terms of This CFA Apply

The Respondent must indicate in its submission that it has read and understands the CFA and accepts all of the provisions contained in the CFA. Failure of the Respondent to accept all of the provisions contained in the CFA may result in elimination of its submission.

4.3 Withdrawal or Amendment of Submission by Respondent

A Respondent that submits a submission to the Ministry may:

- (i) Withdraw its submission only by giving written notice to the Ministry, at any time prior to the execution of any Service Agreement arising from this selection process, that the Respondent is withdrawing its submission; and
- (ii) Amend its submission only by submitting an amended submission in a sealed envelope to the Ministry before the Closing Time.

The last submission received by the Ministry shall supersede and invalidate any submission previously submitted by the Respondent.

4.4 Ministry's Right to Amend or Cancel the Call for Applications (CFA)

The Ministry may, at any time prior to execution of any Service Agreement arising from this selection process, amend or cancel this CFA without liability, cost, or penalty to the Ministry. All Respondents will be advised in writing by the CFA Coordinator prior to execution of any Service Agreement of any amendments to or cancellation of the CFA.

4.5 CFA Coordinator

The CFA Coordinator is:

[name]

[title]

[address]

Facsimile: [insert fax number].

The Respondent is put on notice that:

- (i) only the CFA Coordinator is authorized by the Ministry to amend or cancel the CFA.
- (ii) under no circumstances shall the Respondent rely upon any information or instructions from the Ministry, its employees, or its agents unless the information or instructions are provided in writing by the CFA Coordinator; and
- (iii) neither the Ministry, its employees, nor its agents shall be responsible for any information or instructions provided to the Respondent, with the exception of information or instructions provided in writing by the CFA Coordinator.

4.6 CFA Clarification

It is the responsibility of the Respondent to seek clarification of any matter it considers to be unclear before submitting its submission.

Respondents that wish to obtain further information must submit their questions in writing by facsimile to the CFA Coordinator.

The Ministry shall accept questions until 12:00 noon on **[date five days prior to close]**.

The Ministry shall reply by facsimile to questions asked by **[date three days prior to close]**.

The Ministry shall not be responsible for any misunderstanding on the part of the Respondent concerning the CFA or its process.

4.7 Ministry's Right to Determine the Number of Interim LTC Beds to be Awarded

Notwithstanding any other provision in this CFA, the Ministry, in its sole discretion, reserves the right

- (i) To determine the number of Interim LTC beds to be awarded for a geographic area or CCAC Region based on a review of the submissions;
- (ii) Not to award any Interim LTC beds for a geographic area or CCAC Region;
- (iii) To award fewer or more beds for a geographic area or CCAC Region than otherwise designated in this CFA;
- (iv) To determine the number of beds to be awarded to any Respondent; and
- (v) Not to award any Interim LTC beds under this CFA

The Respondents acknowledge that the Ministry has the sole and absolute discretion with respect to any policy decisions related to the appropriate geographic distribution of Interim LTC beds within the Province of Ontario.

A Respondent has the option to refuse an award of Interim LTC beds made by the Ministry if the Respondent is awarded fewer or more interim care beds than requested in its submission.

4.8 Ministry Award of Interim LTC Beds

The award by the Ministry of any Interim LTC beds under this CFA does not constitute an award by the Ministry of permanent long-term care beds. The Ministry, in its sole discretion, may terminate the award of any Interim LTC beds awarded under this process.

4.9 Disqualification of Submissions

The Ministry, in its sole discretion, may disqualify any submission before the submission is fully reviewed if, in the opinion of the Ministry,

- (i) the submission contains false information;
- (ii) the submission, on its face, reveals a conflict of interest as described in section 2.5;
- (iii) the Respondent misrepresents any information provided in its submission;
- (iv) the Respondent fails to cooperate with the Ministry in its attempts to verify the Respondent's financial stability;
- (v) the Respondent has breached a contract with the Ministry;
- (vi) the Respondent has failed to complete its obligations under a contract with the Ministry;
- (vii) the Respondent has been convicted of an offence in connection with a contract with the

- Ministry; or
(viii) the Respondent will not be in a position to operate the Interim LTC beds by [insert date]

4.10 Legislative Requirements Must be Followed

Consistent with the current long-term care facility system, all Respondents to this CFA will be required to operate the beds in a manner that is compliant with all applicable legislation as set out in the Nursing Homes Act, the Charitable Institutions Act, and the Homes for the Aged and Rest Homes Act. Requirements within this CFA are for reference only in the submission process and are arranged for convenience to Respondents. For a complete listing of all binding legislative requirements, Respondents should refer to the legislation directly.

4.11 Service Agreement

Each Respondent selected to operate the Interim LTC beds will be required to sign a Service Agreement/Amending Agreement with the Ministry of Health and Long-Term Care. The Service Agreement is a contract between the provider/operator (i.e., the successful Respondent) and the Ministry of Health & Long-Term Care. The Service Agreement sets out the programs and services which are to be provided in exchange for funding from the Ministry of Health & Long-Term Care. The applicant to this CFA, by submitting an application, agrees that the terms of this CFA and their submission are deemed included in the Service Agreement/Amending Agreement notwithstanding any Entire Agreement provisions in the Service Agreement/Amending Agreement.

4.12 Ministry Cancellation of Award

The Ministry, in its sole discretion, may cancel an award made to any Respondent under this CFA if:

- (i) the Respondent fails to obtain any of the permits, licences, consents or authorizations required under section 2.3; or
- (ii) the Respondent is not in a position to operate the Interim LTC beds by [date].

4.13 Governing Law

All submissions, Respondents and its subcontractors must comply with any law which may be applicable to this CFA and the services to be provided.

The Respondent must provide with its submission a declaration from the Respondent as well as separate declarations from each of its subcontractors, stating that the declarant holds or will apply for all permits, licences, consents and authorizations necessary to perform its obligations if the Respondent is selected pursuant to this CFA.

Each declaration must be signed by a person who is authorized to do so on behalf of the declarant.

SCHEDULE 1 - FUNDING SCHEME

1. Sources of Revenue

There will be two main sources of revenue:

- (i) the provincial payment to the Respondent which will be made in keeping with the schedule *and* process set out in the Service Agreement; and
- (ii) the resident co-payment fees which will be collected by the Respondent.

At the sole and absolute discretion of the Respondent, a Respondent may also choose to contribute funds to the operation of the Interim LTC beds through other sources of revenue. There will be no mandatory obligation for a Respondent to contribute funds to the operation of the Interim LTC beds in addition to the provincial contribution and the resident co-payments.

2. Provincial Funding

The Ministry funds 100% of all nursing, personal care, *programming and raw food costs at \$80.13 per diem (as of August, 2005) If the participating institution is accredited by the Canadian Council of Health Services Accreditation as a hospital or long term care home, the per diem will be increased by \$0.33.

The Ministry also guarantees \$44.42 of basic accommodation revenue_per diem. The resident may provide this amount or it may be a combination of resident co-payment and a Ministry subsidy for the difference. Please note that a resident co-payment may be higher than the guaranteed accommodation revenue. Further explanation follows under Resident Revenue.

The rates paid on Interim LTC beds will be increased from time to time to reflect increases in the regular long-term care bed rates.

*Funded amount for the nursing and personal care per diem is based on average care requirements (CMI=100) in long-term care homes only. Where applicable, if a long-term care home has higher than average care levels (CMI>100), the per diem would be greater. If the home has lower than average care levels (CMI<100), the per diem would be less. All other facilities are funded at CMI of 100.

The Interim LTC beds will be eligible to receive structural premiums in accordance with the Ministry of Health's capital funding policy covering A, B, C and D long-term care homes.

3. Resident Revenue - basic and preferred revenue paid to Respondent by residents

The maximum resident fees, which can be charged effective July 1, 2003, are as follows:

<u>Type of Bedroom Accommodation</u>	<u>Resident Rate Per Day (max. charge)</u>
<u>Long Stay</u>	
Basic (up to four beds)	\$48.69
Semiprivate (two beds)	\$56.69
Private (one bed)	\$66.69

Resident revenue is comprised of basic accommodation fees received from residents.

3.1 Basic Accommodation

Residents in basic accommodation may be charged up to the maximum fee - a resident in this type of accommodation may apply for a reduction in his/her accommodation fee. If a resident is approved for a rate reduction, the province pays the difference (accommodation subsidy) between the resident contribution and an amount guaranteed by the province. The rate is determined by completion of application forms, specific to long-term care beds, supplied by the province. These applications cover the following situations:

- (i) a resident requires a rate reduction so he/she can retain a minimum of \$116 per month for discretionary spending (comfort allowance);
- (ii) a resident has a spouse in the community who experiences financial hardship due to the basic accommodation charge;
- (iii) spouses who wish to live in the same room and are unable to afford a semi-private room rate (room is treated as basic accommodation and home is compensated for lost preferred revenue).

3.2 Rate Reduction Process in Basic Accommodation

The province sets out maximum accommodation fees (for 12 months commencing each July 1) for long-term care homes. All residents requesting a rate reduction must complete the Application for Reduction in Long-Term Care Home Accommodation Fees. The completion of this form establishes the rate with no further approvals required.

The minimum rate in basic accommodation has been normally adjusted to the January monthly maximum Federal Old Age Security and Guaranteed Income Supplement plus the Ontario Guaranteed Annual Income System amount minus \$116 (comfort allowance). As of July 1, 2003, this amount is \$963.16. The rate is subject to adjustment.

The maximum basic monthly rate for the period July 1, 2004 to July 1, 2005 is \$1,480.99. A person paying this rate should have at least \$116 left after paying their accommodation fee. Most residents will pay an amount between \$963.16 and \$1,480.99 that will leave them at least \$116.

Residents complete a form which requests basic identifying information and complete the form by referring to their Income Tax Form. The resident's rate reduction is calculated on the form as follows:

- (i) Net Income from line 236
- (ii) Total Payable Federal and Provincial taxes from line 435
- (iii) Disposable Annual Income (subtract item 2 from item 1)
- (iv) From the amount in (3) subtract \$1,392 (yearly comfort allowance) and divide by 12 to determine monthly rate (divide the result by 30.416 to obtain the daily rate)

This form can be ordered from the Ministry at (416) 327-8222 quoting catalogue number 7530-5182 and application form number 2304-69. And is also available on-line at www.health.gov.on.ca

3.3 Rate reductions granted through Exceptional Circumstances

Some residents will need to fill out an additional form called Application for Reduction in Long-Term Care Home Accommodation Fees-Exceptional Circumstances. This form is used for residents who cannot pay the "normal minimum" mentioned above, for married couples who cannot afford a semi-private rate and for a resident for whom the rate is a source of hardship for a spouse/same sex partner in the community. This form requires approval from the Regional office responsible for the area in which the Interim LTC beds are located.

This form may be ordered from the Regional Office.

3.4 Preferred Accommodation

Residents in preferred accommodation pay the maximum basic accommodation plus a premium. The premiums are: maximum of \$8 per day for semi-private maximum of \$18 per day for private accommodation

The Respondent keeps 100% of preferred revenue. The Respondent may set its own preferred premiums provided the rates do not exceed the maximums set by the province.

4. Key Features of Long-Term Care Charging Policy

Province sets maximum rate for all types of accommodation.

Minimum of 40% of resident days must be charged at the basic accommodation rate, regardless of the design of the program space.

Operators may not refuse a resident placement solely on the basis of resident's ability to make the preferred rate payment .

Rate reductions apply only to long-stay residents in basic accommodation.

Only net disposable (after taxes) income is considered in determining resident charges for basic accommodation.

Rate reductions must be calculated on the forms supplied by the Ministry of Health & Long-Term Care for long-term care homes; these forms contain all necessary instructions for determining the rate reduction.

The New Convalescent Care Program

A Supportive Care Program Governed Under
the *Nursing Homes Act, Charitable Institutions
Act, and Homes for the Aged and Rest Homes
Act*

Community Health Division
Ministry of Health and Long-Term Care

Application Package

October 2005

New Convalescent Care Program Application Package - October 2005

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1.0 INTRODUCTION

1.1 The New Convalescent Care Program

The New Convalescent Care Program offers short stay services, housed in long-term care homes (LTCHs), to people who need time to recover strength and functioning. These individuals may be admitted to the program directly from either the community or a hospital setting. The program is a supportive care program governed under the *Nursing Homes Act*, *Charitable Institutions Act*, and *Homes for the Aged and Rest Homes Act*.

The program replaces the current supportive care component of the short stay program in LTCHs. The program does not affect the second component of the short stay program – respite services. The existing short stay respite beds, which provide relief for caregivers of seniors or people with disabilities who are living at home, will continue to operate under the existing rules.

As of a specified date, all current short stay beds will be used for respite; operators wishing to offer or continue offering respite services will, as is now the case, apply annually to their regional office. Those wishing to offer supportive care will apply to their regional office under the New Convalescent Care Program. Residents currently occupying supportive care beds will complete their stay. All new supportive care applicants will be admitted to the New Convalescent Care Program.

The beds for the New Convalescent Care Program come from existing LTC bed stock; operators apply to re-designate these beds from long stay to convalescent care. The re-designation will end on March 31, 2007.

This call for applications document, issued by the MOHLTC regional office, outlines the New Convalescent Care Program's key components - goals, population, processes, funding, and monitoring and evaluation - and provides information to assist operators in completing applications.

It also contains:

- A description of the care model for the New Convalescent Care Program (Appendix A)
- Application form with instructions and applicant's declaration form (Appendix B)
- Terms and conditions (Appendix C)
- An application checklist (Appendix D)

To provide convalescent care services and re-designate some of your long stay beds, complete the attached application and verify that the terms and conditions have been read and agreed to.

This application is strictly for operators who wish to provide convalescent care within the New Convalescent Care Program.

Operators who wish to offer, or continue to offer, respite care are not required to complete this application.

1.2 Who May Apply?

The application process is open to all operators that hold a licence or have a statutory approval to operate LTCH beds in:

- Nursing homes (for-profit and non-profit) governed by the *Nursing Homes Act*
- Municipal homes for the aged, operated under the *Homes for the Aged and Rest Homes Act*
- Charitable homes for the aged, operated under the *Charitable Institutions Act*

1.3 Information and Communication

For further information about the New Convalescent Care Program, please contact your MOHLTC regional office:

<p>CENTRAL EAST (NEWMARKET) REGION 3rd Floor, 465 Davis Dr, Newmarket, ON L3Y 8T2 General Inquiry: 905-954-4700 Toll Free: 800-486-4935 Fax: 905-954-4701</p>	<p>CENTRAL SOUTH (HAMILTON) REGION Ellen Fairclough Bldg 11th Floor, 119 King St W, Hamilton, ON L8P 4Y7 General Inquiry: 905-546-8294 Toll Free: 800-461-7137 Fax: 905-546-8255</p>
<p>CENTRAL WEST (MISSISSAUGA) REGION Ste 301, 201 City Centre Dr, Mississauga, ON L5B 2T4 General Inquiry: 905-897-4610 Toll Free: 866-716-4446 Fax: 905-275-2740</p>	<p>EAST REGION 8th Floor, 10 Rideau St, Ottawa, ON K1N 9J1 General Inquiry: 613-569-5602 Toll Free: 877-779-5559 Fax: 613-569-9670</p>
<p>NORTH REGION 4th Floor, Ste 406, 159 Cedar St, Sudbury, ON P3E 6A5 General Inquiry: 705-564-3130 Toll Free: 800-663-6965 Fax: 705-564-7493</p>	<p>SOUTHWEST REGION Ste 201, 231 Dundas St, London, ON N6A 1H1 General Inquiry: 519-675-7680 Toll Free: 800-663-3775 Fax: 519-675-7685</p>
<p>TORONTO REGION 8th Floor, 55 St Clair Ave W, Toronto, ON M4V 2Y7 General Inquiry: 416-327-8952 Toll Free: 800-595-9394 Fax: 416-327-7763</p>	

During the application process, it is the responsibility of applicants to seek clarification from the MOHLTC regional office on any matter that appears confusing or unclear. The regional office may provide clarification on items related to the application guidelines. The MOHLTC shall not provide advice or assist operators in preparing applications.

2.0 THE NEW CONVALESCENT CARE PROGRAM

2.1 Goals

The New Convalescent Care Program expands the range of options for individuals who do not need acute care but cannot manage at home; these individuals may be coming directly from hospitals or may be living in the community. By providing this care alternative, the program helps reduce hospital pressures and improve system efficiency.

The primary goals of the program are:

- **To provide appropriate, quality care** to people who need time to recover strength, endurance, or functioning before returning home
- **To alleviate hospital pressures** by providing an environment that meets the care needs of people who do not need acute care
- **To make the most effective use of resources**, primarily long-term care beds

2.2 Population

Some program applicants (people who are likely to benefit from the program's services) may come from the community, but many will likely come from an acute care setting. The New Convalescent Care Program operates within current legislation and regulations, which require that the convalescent care resident must:

- be at least 18 years old
- be an insured person under the *Health Insurance Act*
- meet at least one of the following conditions:
 - require the availability of on-site nursing care 24 hours a day;
 - require assistance each day with activities of daily living;
 - require, at frequent intervals throughout the day, on-site supervision or on-site monitoring to ensure safety or well-being;
 - be at risk of being financially, emotionally, or physically harmed if he or she lives in his/her residence;
 - be at risk of suffering harm from environmental conditions that cannot be resolved if he or she lives in his/her residence;
 - be at risk of harming someone else if he or she lives in his/her residence.
- have care requirements that can be met in a LTCH
- need time to recover strength, endurance, or functioning, and be likely to benefit from convalescent care

Note: This program does not serve individuals waiting for admission to a long-term care home.

- be expected to return to his/her residence within 90 days after admission to the LTCH
- be permitted to select the LTCH to which he or she wishes to be admitted
- consent to be admitted to the selected LTCH

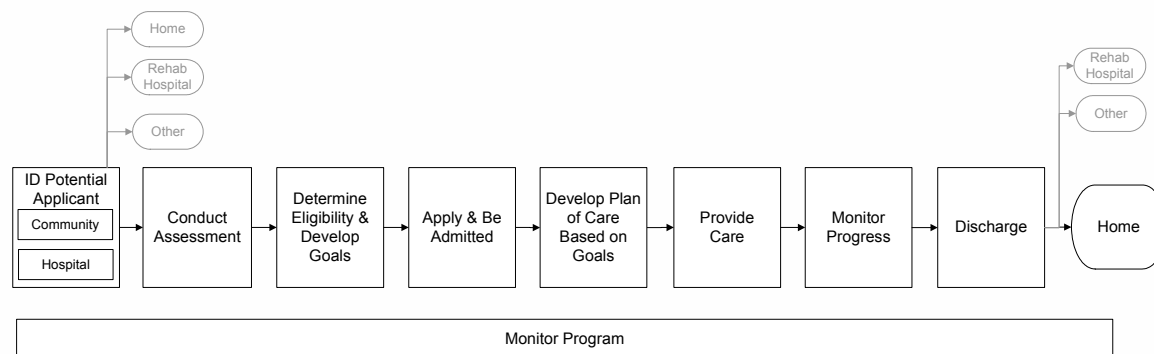
The plan of care to be developed for the convalescent care applicant should include clear, convalescent care goals with realistic timeframes for achieving them.

These eligibility requirements for the New Convalescent Care Program¹ are detailed within the *Homes for the Aged and Rest Homes Act Regulations*², the *Nursing Homes Act Regulations*³, and the *Charitable Institutions Act Regulations*.⁴

2.3 Business Processes

The process followed by an individual from the hospital or community to the New Convalescent Care Program and then home (Figure 1) is as follows:

Figure 1: Convalescent Care Program Process



¹ Different conditions cover the respite component of short stay.

² Sections 8(1) (a)(b)(c)&(e), 8(2), and 9(2) of the *Homes for the Aged and Rest Homes Act*, R.R.O. 1990, Regulation 637.

³ Sections 130(1) (a)(b)(c)&(e), 130(2) and 131(2) of the *Nursing Homes Act*, R.R.O. 1990, Regulation 832..

⁴ Section 61(1) (a)(b)(c)&(e), 61(2) and 62(2) of the *Charitable Institutions Act*, R.R.O. 1990, Reg. 69.

Individuals are assessed in the hospital or community setting for suitability and eligibility; they then apply to the LTCH, are admitted, receive care, and are discharged. A brief description of key points in the process follows.

2.3.1 Identification of Potential Convalescent Care Applicant

The first step is to identify an individual, whether in the hospital or the community, as a potentially suitable candidate for the New Convalescent Care Program. In the hospital, this identification can begin during the acute phase of treatment by anticipating the services that will be needed after this phase. Hospital staff, in consultation with the Community Care Access Centre (CCAC), will determine whether an individual:

- can be sent directly home with supports in place, or
- could benefit from convalescent care in a LTCH before going home, or
- should go to another facility for rehabilitation or complex continuing care, or
- requires other non-acute care services.

It is expected that hospital staff will continue to use their clinical judgment to make these determinations and identify potentially suitable convalescent care applicants. Potentially suitable candidates in the community are most likely to be identified by CCAC-contracted service providers, physicians, or family members. Suitability criteria have been developed to assist hospital staff and health professionals in the community in identifying potential candidates quickly and efficiently.

2.3.2 Assessment, Determination of Eligibility, and Establishment of Goals

When a potential applicant for convalescent care has been identified, and has voluntarily applied to a CCAC to determine whether they are eligible for admission as a short stay resident, an assessment using the RAI-HC is conducted by either the hospital or the CCAC. The CCAC then determines whether the individual is eligible for the program.

Within 24-72 hours of identifying a potential applicant, it is expected that:

- The assessment will be conducted
- Eligibility will be determined
- The potential applicant's goals will be established
- A tentative discharge date from convalescent care will be set

Ideally, these steps should take no more than 24 hours. This may not always be feasible (particularly on weekends), so they should be completed no more than 72 hours after the individual has been identified as potentially suitable.

The discharge of a potential convalescent care applicant from the hospital will continue to be managed by the hospital.

2.3.3 Application and Admission to Convalescent Care

The CCAC will continue to manage the application and admission process, with the goal that transition be as expeditious and seamless as possible. The CCAC will identify the LTCH(s) providing the convalescent care program and discuss the choices with the applicant. Regulations specify that, unlike long stay residents (who, in most circumstances are limited to three choices), potential convalescent care residents may apply to as many LTCHs offering the program as they wish.

When the applicant has selected the LTCH(s), the CCAC prepares an application package and forwards the completed package to the LTCH. It is important that the applicant be admitted as soon as possible to the convalescent care program, so it is critical that the LTCH respond verbally within two hours as to whether it will accept the applicant. Verbal notification is followed by written notification within 24 hours of receiving the application. Under the applicable statutes⁵, the LTCH must approve the admission unless:

- It lacks the physical facilities necessary to meet the person's care requirements, or
- Its staff lack the expertise necessary to meet the person's care requirements

Although the short stay program has a 90-day time frame, the average length of stay for people entering convalescent care is expected to be approximately 30-45 days. It is expected that LTCHs will have the capacity to handle the increase in admissions and turnover.

Once approved by the LTCH selected, the applicant is placed on a waiting list for the LTCH unless a convalescent care bed is immediately available. The applicant is ranked on the waiting list according to the date of application. When a convalescent care bed becomes available and the applicant consents to admission, the LTCH and the hospital (if applicable), with the CCAC's assistance, coordinate the transfer of the convalescent care applicant to the LTCH. A copy of the CCAC's plan of service accompanies each individual being admitted to the LTCH.

2.3.4 Resident Care

Before the convalescent care resident is admitted, the LTCH is responsible for obtaining any necessary supplies and equipment. Under current legislation, each short stay resident is required to undergo a health assessment and have a care plan that meets the resident's requirements. This practice will continue for the New Convalescent Care Program.

The LTCH's interdisciplinary team develops the detailed plan of care. For example, the CCAC plan of service may specify that a convalescent care resident will need a particular type of therapy; the plan of care must specify the frequency and duration of this therapy.

⁵ The same conditions apply to acceptance of long stay residents.

The LTCH shall use its best efforts to complete the assessment and plan of care within 24 hours after the convalescent care resident is admitted and, in any event, must complete it within 48 hours of admission. Meeting this timeline requires collaboration and cooperation with the hospital (if applicable) and CCAC so that necessary information is provided promptly, there is time to plan for discharge from the hospital (if applicable), and the convalescent care resident has a smooth transition to the LTCH. At weekly case conferences, the convalescent care resident is monitored against the plan of care, which is revised as necessary.⁶

Regulations specify that the LTCH must provide each convalescent care resident with access to a physician. This physician may be the resident's family physician, the LTCH's medical director, or another physician identified by the LTCH. The LTCH makes arrangements for any required diagnostic or pharmacy services.

Convalescent care beds will be subject to ongoing MOHLTC inspections.

2.3.5 Discharge

The New Convalescent Care Program focuses on preparing residents to return to home and community, so planning for discharge begins at admission. The convalescent care resident has goals and timeframes for achieving them, as well as an anticipated discharge date, which is monitored and adjusted as necessary throughout the resident's stay.

The convalescent care resident is considered ready to return home when his/her goals are met; some residents will be able to achieve these goals earlier than predicted. The LTCH is responsible for managing the discharge process, and is expected to complete a discharge summary within seven days of a convalescent care resident's discharge. Experience indicates that most individuals discharged from a convalescent care program will need CCAC in-home services, so the CCAC should be involved as early as possible.

The limited length of stay means the LTCH must be able to handle more discharges; those that do not currently have a discharge summary form will need to develop one.

2.3.6 Managing Issues and Resolving Disputes

It is critical for all parties – CCAC(s), hospital(s), and LTCH(s) – to agree on a mechanism for handling program-related and resident-related issues or disputes. These parties should meet regularly to discuss and resolve issues and/or identify opportunities for improvement; establishment of a program steering committee is recommended. MOHLTC regional office involvement and assistance in this process will be important.

⁶ More detailed information is given in the addendum to this document

2.4 Subsidy Model

Funding for the New Convalescent Care Program will be two-pronged, consisting of: 1) the base level of care subsidy per convalescent care bed; and 2) a variable subsidy based on actual convalescent care bed occupancy (as measured by number of resident days).

2.4.1 Base Level of Care Subsidy

Like long stay beds in LTCHs, short stay beds are funded through a series of envelopes. Table 1 shows the four primary envelopes and the conditions attached to each.

Base subsidy for the New Convalescent Care Program beds will be at a case mix index (CMI) of 100 (\$124.55 per convalescent care bed per day)⁷. This amount will continue to be allocated for each approved convalescent care bed according to current proportions in the funding envelopes. Should the base LTC subsidy or its allocation to the funding envelopes change, funding and allocation for convalescent care beds will change accordingly.

Table 1. Current Level of Care Per Diem.

Envelope	Per Diem Amount	Conditions
Nursing and personal care	\$68.19	<ul style="list-style-type: none"> • Amount fixed for convalescent care beds • Reconciled to actual expenditures • Excess returned to MOHLTC
Program and support services	\$6.60	<ul style="list-style-type: none"> • Amount fixed • Reconciled to actual expenditures • Excess returned to MOHLTC
Raw food	\$5.34	<ul style="list-style-type: none"> • Amount fixed • Reconciled to actual expenditures • Excess returned to MOHLTC
Other accommodation	\$44.42	<ul style="list-style-type: none"> • No reconciliation so long as services are provided
TOTAL	\$124.55	

2.4.2 Additional Subsidy

The New Convalescent Care Program residents, who are working to improve functioning and preparing to return home, are expected to require more nursing care and therapies than current LTCH residents. LTCHs offering the program will therefore be eligible for an additional \$61.59⁸ per bed per resident day (based on occupancy as set out in section 2.4.3 below), bringing the total potential subsidy to \$186.14 per bed per resident day.

⁷ As of August 2005.

⁸ This amount is subject to change.

The following table shows the allocation of the additional subsidy to the funding envelopes.

Table 2. New Convalescent Care Program Additional Subsidy.

Envelope	Per Diem Amount
Nursing and personal care	\$39.61
Program and support services	\$16.98
Other accommodation	\$5.00
TOTAL	\$61.59

Capital and equipment expenditures related to offering convalescent care are the responsibility of the LTCH, and are subject to the MOHLTC policies related to LTCH equipment. These expenditures, however, are not eligible for funding from the High Intensity Needs Fund.

2.4.3 Utilization and Reconciliation

Currently, LTCHs apply annually to their MOHLTC regional office for approval to operate short stay beds. The regional office allocates the number of days and funds the resulting beds at 100% for the year. Actual occupancy is calculated retrospectively, and the LTCH is permitted to retain the previous year's funding provided that the LTCH's expenditures reconcile with this funding. A utilization rate of 50% is considered the "target for success"; a LTCH that does not reach this target is less likely to be awarded short stay days in future years. Long stay beds, in contrast, are funded at 100% as long as the LTCH's occupancy rate⁹ is at least 97%; the LTCH's short stay bed days are not included in this calculation.

LTCHs offering the New Convalescent Care Program will initially receive on a monthly basis the base subsidy of \$124.55 (with the addition of other applicable amounts, for example, for equalization and accreditation) per convalescent care bed per day plus 100% of the \$61.59 additional subsidy per convalescent care bed per day. LTCHs will be required to exclude convalescent care bed days and their related expenses from their normal reconciliation process, and will report these days and expenses separately. Separate reporting and reconciliation processes will make it possible to track program costs, which will be incorporated into the evaluation.

Convalescent care resident days and expenditures will be reconciled annually. LTCHs will be permitted to retain 100% of the base funding of \$124.55 per convalescent care bed per day regardless of the actual occupancy of the convalescent care beds. The additional convalescent care subsidy of \$61.59, however, varies according to occupancy in the convalescent care beds.

The first 90 days of the operation of the New Convalescent Care Program in a LTCH is considered an orientation period, and the occupancy rate during this time period will not

⁹ Excluding orientation and fill period.

be included in the first year's calculations. The LTCH will therefore be entitled to retain the full \$61.59 per convalescent care bed per resident day for this 90-day period.

For the remainder of the year:

- A LTCH that has achieved an occupancy rate of at least 80% relating to its convalescent care beds will be permitted to retain the full \$61.59 per convalescent care bed per day.
- If the occupancy rate is 50% or more, but less than 80%, the amount of additional subsidy that the LTCH will be permitted to retain will be reconciled based on actual convalescent care bed resident days.
- If the overall convalescent care bed occupancy is below 50%, the LTCH and MOHLTC regional office program staff will meet to discuss the reasons and next steps, which could include an assessment of the community's need for these convalescent care beds and a possible reduction of bed numbers, with a corresponding reduction in funding.

In accordance with MOHLTC policies, the nursing and personal care, program and support services, and raw food envelopes shall be reconciled to actual expenditures for the full year (including the 90-day orientation period), with any excess amount to be returned to the MOHLTC.

2.4.4 Co-payment

LTCHs will be permitted to operate beds in the New Convalescent Care Program only if they agree not to collect any co-payment from convalescent care residents despite any legal authority to do so. The MOHLTC provides the base per diem and additional convalescent care per diem, so no co-payment is required. The regulations under long-term care home legislation do not permit operators to charge convalescent care residents for preferred accommodation or bed holding.

3.0 MONITORING AND EVALUATION

The LTCH will be responsible for using a pre-established “face-sheet” to collect core data and information for every convalescent care resident, and for entering this information electronically on a form created by the MOHLTC. Following is an example of such a form.

The New Convalescent Care Program: Sample Form	
Applicant/Resident # _____	Age: _____ Gender _____
Date Applicant Identified/Referred to Convalescent Care: _____	
By hospital _____	From community _____
Date Applicant Discharged from Hospital (if applicable): _____	
Date Applicant Assessed for Convalescent Care: _____	
Date Applicant Refused Participation: _____	
Reason for Refusal: _____	
Date LTCH Refused Applicant: _____	
Reason for Refusal: _____	
Date Convalescent Care Applicant Admitted to LTCH: _____	
Care Needs/Goals _____	

Date of Formal Care Review by Interdisciplinary Team: _____	
Date Convalescent Care Resident Discharged from LTCH/Convalescent Care Program: _____	
Date Discharge Summary Completed/Signed: _____	
Discharge Disposition:	
Home/Community _____	
Supports in Home/Community	
No ____ Yes ____ If yes, types of supports _____	
Hospital _____ Type of Hospital _____	
LTCH _____ Died _____ Other (please specify) _____	
PT/OT Therapy Service(s) during Convalescent Care Program Stay (on average):	
<1 hour per week _____ 1-2 hours per week _____ >2 hours per week _____	
Other Therapy Services	
Type (e.g., speech) _____ <1 hour per week ____ 1-2 hours per week ____ >2 hours per week ____	
Convalescent Care Resident Incident(s):	
No falls _____ 1 fall _____ >1 fall (please give number) _____	
No new ulcer _____ Acquired new ulcer _____	
Other incident(s) (type and number) _____	

To preserve the applicant/resident's anonymity, the MOHLTC will program the electronic form to assign a unique identification number. This number will not be tied to any other information about the applicant/resident (e.g., name, OHIP number), but will reflect only the form's order in the total forms completed. For example, the identification number on the LTCH's first form could be [LTCH identifier] - #1, with identification numbers for other applicants/residents following in sequence.

In addition to individual convalescent care resident data, the LTCH will be responsible for calculating and reporting convalescent care vacant bed days and for monthly electronic submission of convalescent care program data to the MOHLTC regional office. The LTCH will work with CCAC and hospital staff to capture all core data for each convalescent care resident.

More formal evaluation is under development; care outcomes and convalescent care resident satisfaction will be included. The LTCH, hospital, and CCAC will be expected to participate fully in all relevant program evaluation activities pertaining to the New Convalescent Care Program.

4.0 LTCH APPLICATION PROCESS

4.1 Submitting the Application

An operator must submit an application to re-designate long stay beds at a LTCH as follows:

1. Use the application form provided in Appendix B.
2. Submit three paper copies and a diskette containing the application. An application that is submitted by electronic mail must be followed by the diskette and signed paper copies. Applications submitted by facsimile will not be accepted.
3. Submit the application to the MOHLTC regional office (see Section 1.3) by Monday, November 14, 2005.

4.2 Application Evaluation and Bed Re-designation

Evaluation of applications and re-designation of beds will follow a six-stage process.

Stage 1: Checking Basic Requirements

Applications will first be assessed to determine whether they meet five basic requirements:

1. The convalescent care beds must be located in a licensed or approved LTCH, governed by the *Charitable Institutions Act*, *Homes for the Aged and Rest Homes Act*, or *Nursing Homes Act*.
2. The LTCH must have a satisfactory compliance record, and its annual compliance review must show either no unmet standards or only some minor unmet standards and a strategy in place to address them to the satisfaction of the compliance advisor.¹⁰
3. Convalescent care resident rooms must be private or semi-private (one or two beds), with a bathroom shared with no more than one other resident.
4. Areas in the LTCH to be used by convalescent care residents must be wheelchair accessible, and bathrooms must be able to accommodate a convalescent care resident in a wheelchair and a staff person at the same time.
5. The proposed budget must not exceed the allocated funding.

Applicants will be notified by electronic mail and letter whether they meet these requirements. Those who do not meet these requirements will be told the reason for their ineligibility and given contact information for further clarification. Those who meet the requirements will advance to Stage 2 of the process. The MOHLTC may seek further clarification of any items pertaining to the operator's application.

¹⁰ Prospective applicants wishing specific information about their compliance history in relation to this criterion are advised to contact their regional office.

Stage 2: Evaluating the Applications

The selection committee will apply 12 criteria within five categories to each application. The committee will be looking for evidence that the applicant can provide quality care in a safe environment, understands the convalescent care philosophy/approach, can put this approach into practice, and has the ability and commitment to do so within the allocated resources. The following table shows the categories, criteria, and types of information to be considered.

Criterion	Considerations
Part A: Compliance History (15%)	
<ul style="list-style-type: none"> Compliance issues 	<ul style="list-style-type: none"> Can the applicant demonstrate compliance with MOHLTC requirements (legislation, regulations, standards, service agreements)? Are there unmet standards or criteria that have been or are being responded to appropriately? Are there unmet standards or criteria that were issued in the past 18 months and remain outstanding?
Part B: Care Delivery (30%)	
<ul style="list-style-type: none"> Understanding and application of convalescent care philosophy, approach, and key principles 	<ul style="list-style-type: none"> Does the applicant understand the convalescent care philosophy and key principles of: 1) interdisciplinary planning and coordination of care; 2) focus on goals, results, education, and re-entry into the community; 3) discharge planning that begins at admission; 4) promotion of wellness and progress toward self-sufficiency; and 5) convalescent care's role within the range of services and its continuity with hospital care and timely hospital discharge? Can the applicant deliver care that is in line with the convalescent care philosophy, differs from traditional long-term care, and requires: 1) interdisciplinary assessments, care plans, case conferencing, monitoring, and discharge summaries; and 2) rapid turnaround times to accommodate a high-turnover population? How will the LTCH work in partnership with other stakeholders? The program's success hinges on successful collaborations among LTCHs, CCACs, and hospitals. What is the applicant's current and previous experience with collaborative relationships?
<ul style="list-style-type: none"> Determining residents' needs 	<ul style="list-style-type: none"> How does the applicant propose to determine the needs of its convalescent care residents? Which team members are involved, and what processes and tools are used?
<ul style="list-style-type: none"> Determining appropriate staff mix and levels 	<ul style="list-style-type: none"> How does applicant propose to determine the appropriate staff mix and levels to meet its convalescent care residents' needs? Which team members are involved, and what processes and tools are used?
<ul style="list-style-type: none"> Meeting needs for diagnostic and laboratory services 	<ul style="list-style-type: none"> What is the applicant's access to diagnostic and laboratory services, and what is the applicant's plan for responding to the increased needs of convalescent care residents for these services?
Part C: Environment (20%)	
<ul style="list-style-type: none"> Physical environment 	<ul style="list-style-type: none"> Does the physical environment described support the program description? Is there a clear and defensible rationale for the number and configuration of beds proposed? Does this number take into account critical mass for both programming and efficiencies? Do space allocations (e.g., for therapy) support the program description? Is the environment conducive to recovery, and are there opportunities for convalescent care residents to learn self-care and practice using the skills they will need and the services that will be available in the community?
<ul style="list-style-type: none"> Adequacy of supplies and equipment 	<ul style="list-style-type: none"> Has the applicant considered the needs of convalescent care residents for more (although not necessarily different) supplies and equipment than traditional LTC residents? Is there a realistic plan to address these needs?
<ul style="list-style-type: none"> Information systems 	<ul style="list-style-type: none"> Do the information systems support recording and sharing of applicant/resident information among LTCHs, hospitals, and CCACs as appropriate and with applicant/resident consent? Have program staff been sufficiently trained in using the information systems?

Criterion	Considerations
Part D: Readiness to Implement the New Convalescent Care Program (20%)	
<ul style="list-style-type: none"> Human resources 	<ul style="list-style-type: none"> Has the applicant provided an overview of the staff who will support the program? Will the applicant be ready to implement the program within the stipulated timeframe, and is the plan for securing any additional staff comprehensive and feasible?
<ul style="list-style-type: none"> Environmental components 	<ul style="list-style-type: none"> What modifications to the physical plant are required? Will the applicant be ready to implement the program within the stipulated timeframe, and is the plan for any necessary modifications comprehensive and feasible?
<ul style="list-style-type: none"> Previous experience 	<ul style="list-style-type: none"> Does the applicant have previous experience in designing and implementing special programs or services or in using innovative staffing arrangements?
Part E: Finances (15%)	
<ul style="list-style-type: none"> Proposed budget 	<ul style="list-style-type: none"> Does the budget indicate appropriate use of the per diem convalescent care funding? Is the budget realistic to support the program described, and are costs reasonable in light of current and projected wages and necessary infrastructure modifications?

After each applicant has been assigned a score on each of these 12 criteria, a final weighted score will be calculated.

Stage 3: Interview and Site Visit

After having reviewed the applications, the selection committee may request a visit to and/or interviews with all or some of the LTCHs under consideration; these visits are not mandatory, but are left to the committee's discretion. The committee may also request written clarifications and responses to questions about the application.

Stage 4: Making the Recommendations

The selection committee will then reach consensus on its recommendations. At this time, other factors will also be considered (for example, geographic distribution of beds within a community, ability of LTCHs to provide specialized care and/or specific linguistic/cultural services). In consultation, MOHLTC regional and corporate offices will determine the number of beds to be re-designated in each recommended LTCH.

Stage 5: Issuing Letters

The regional office will issue a re-designation letter to each successful applicant. Applicants who have not been selected will be notified by letter with contact information should they wish further clarification from the regional office.

Stage 6: Signing Off Amended Service Agreement

Upon notifying successful applicants and re-designating long stay beds as new convalescent care beds, the regional office will oversee the signing of an amending agreement to the service agreement incorporating the attached terms and conditions (set out in Appendix C) and any commitments made in the application.

4.3 General Information

This application is subject to the *Freedom of Information and Protection of Privacy Act* (the "Act"). Please review Appendix C for some information about the Act and how it applies to the application to re-designate beds to the New Convalescent Care Program.

The MOHLTC may decide not to approve any application submitted to it, or it may cancel the application process at any time. The MOHLTC may disqualify any applicant whose application contains misrepresentations or any misleading information. The MOHLTC may disqualify any applicant who does not submit an application in accordance with this application package.

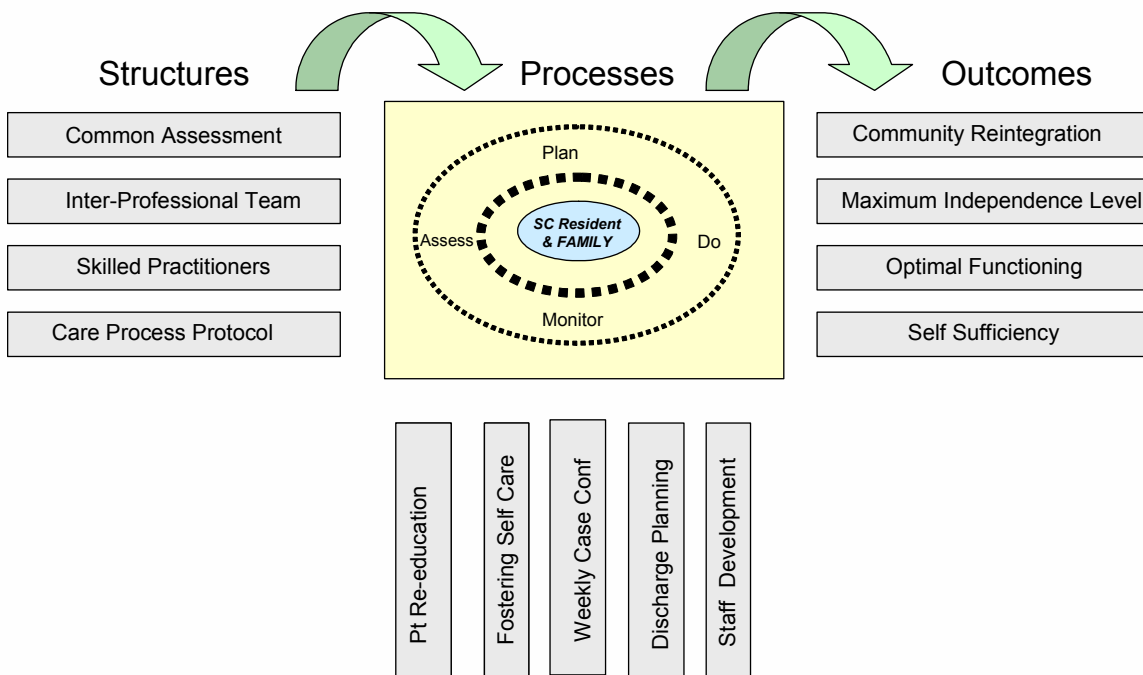
The MOHLTC does not guarantee the number of beds that may be designated in this application process as part of the New Convalescent Care Program. The MOHLTC may change the number of beds that may be designated in this process at any time.

APPENDIX A: CARE MODEL

This addendum focuses on the care model for the New Convalescent Care Program and contains more detailed descriptions about some of the key features of the program design.

Its purpose is to inform and support LTCH applicants to respond to the call for applications effectively.

KEY FEATURES OF THE CONVALESCENT CARE MODEL

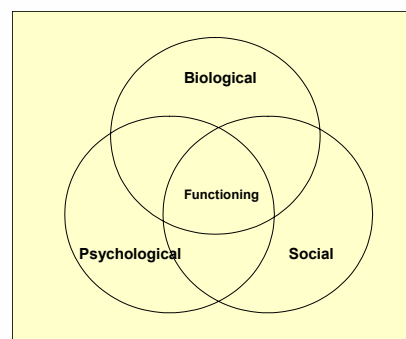


The Care Model Addendum contains the following information:

- A-1 Population Characteristics and Needs
- A-2 Care Philosophy
- A-3 Core and Extended Interdisciplinary Teams
- A-4 Delivery Model
- A-5 Supplies and Equipment
- A-6 Process Protocols

A-1 POPULATION CHARACTERISTICS AND NEEDS

The New Convalescent Care Program recognizes that all convalescent care residents will benefit from improved functioning; the degree of emphasis on one or more spheres (social, biological, and psychological) depends on the convalescent care resident's unique needs. For example:



Some convalescent care residents have compromised health status and need additional recuperative care and support to maximize function and improve health. They may need time for general healing, to learn more about their condition, to build strength and endurance, and/or to enhance their confidence before they return home. This group could include someone recovering from surgery, or someone with cancer who is weak and depressed, but able and willing to return home with additional recovery time, nursing care, therapy, education, and support.

Example: 68 year old woman, living with her 78 year old husband in a condominium, underwent major colon surgery leading to a colostomy, suffered a mild heart attack while in hospital, and was left severely weakened. She needs time to recuperate, learn how to care confidently for her colostomy and cardiac condition, and build general physical strength.

Other convalescent care residents have an impairment, disability, or handicap, and a need to improve their physical functional status before returning home. This group could include, for example, people who cannot yet bear weight after hip or knee replacement surgery, or those who have had a mild stroke with resulting functional limitations. Low intensity therapies will assist in improving strength and endurance. Applicants who are waiting for admission to a rehabilitation facility may be admitted to the New Convalescent Care Program as well provided that their anticipated length of stay in convalescent care is no more than 90 days¹¹

Example: 83 year old woman, living alone with relatives close-by, fractures hip and undergoes a hip replacement. She is unable to bear weight, requires muscle strengthening and is in need of therapy 2-3 times per week for several weeks. Her home requires modifications.

Others may have non-acute clinical conditions and need short-term, 24-hour professional attention (for example, intensive wound care) before they can return home.

¹¹ Sections 9(2)(b) of the Homes for the Aged and Rest Homes Act, R.R.O. 1990, Regulation 637.

¹¹ Sections 131(2)(b) of the Nursing Homes Act, R.R.O. 1990, Regulation 832.

¹¹ Section 62(2)(b) of the Charitable Institutions Act, R.R.O. 1990, Reg. 69.

The LTCH can therefore expect to provide a range of services and activities to convalescent care residents, although it is anticipated that there will be a greater emphasis on particular services such as physical therapy, occupational therapy, nutrition, social work / psychological services, and complex nursing. Examples of services / activities could include but would not be limited to:

<ul style="list-style-type: none"> • Rehabilitative activities <ul style="list-style-type: none"> - Scheduled toileting program or bladder retraining program - Passive or active range of motion - Splint or brace assistance and instruction - Bed mobility or walking training - Transfer training including two-person transfers for a period of time - Dressing or grooming training - Eating or swallowing training - Amputation or prosthesis care and instruction - Communication training • Therapies <ul style="list-style-type: none"> - Low intensity therapies (e.g., 1-2 hours of therapy a week (occupational therapy/ physiotherapy/ speech-language pathology) 	<ul style="list-style-type: none"> • Special treatments <ul style="list-style-type: none"> - Surgical wound care, ulcer care, or open lesion care - Tube feedings - Tracheostomy care - Oxygen therapy - Ostomy care - Intravenous medications and intermittent intravenous therapy - Injections - Blood monitoring • Education or training <ul style="list-style-type: none"> - Health promotion and wellness - Disease or condition-specific information • Psycho/social support <ul style="list-style-type: none"> - Social work and/or psychological interventions
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There may be some convalescent care applicants who have care requirements that are beyond (or are different from) what can be appropriately provided in the New Convalescent Care Program. A suitable convalescent care applicant *is not* an individual who requires:

- acute care
- complex continuing care
- intensive rehabilitation care
- palliative care
- LTCH long stay placement

A-2 CARE PHILOSOPHY

The Convalescent Care Philosophy embraces four thematic care concepts, based on research evidence for effective rehabilitative practice:

Promote self care and self-sufficiency

- Encourage the strength and resourcefulness within each person/family
- Help the person do things for himself/herself in a convalescent environment
- Prepare for community reintegration and re-entry
- Give education and training to equip the person with knowledge and skill to maximize self-care

Emphasize adaptation and abilities

- Individuals may not return to a previous state but can learn to make lifestyle adjustments to cope with illness, impairment, or injury changes
- Make the most of the person's abilities and remaining strengths - Rebuild confidence in their ability to live at home safely - Give constant feedback and encouragement

Treat the whole person

- Each person's goals are unique and based on the individual person's knowledge, skills, insight, capabilities, and personal desires
- Recognize that an illness, impairment, or disability can result in multiple changes in a person's life, and successful adaptation can mean more than biological or clinical stability
- Acknowledge the impact on the family and include and support them accordingly

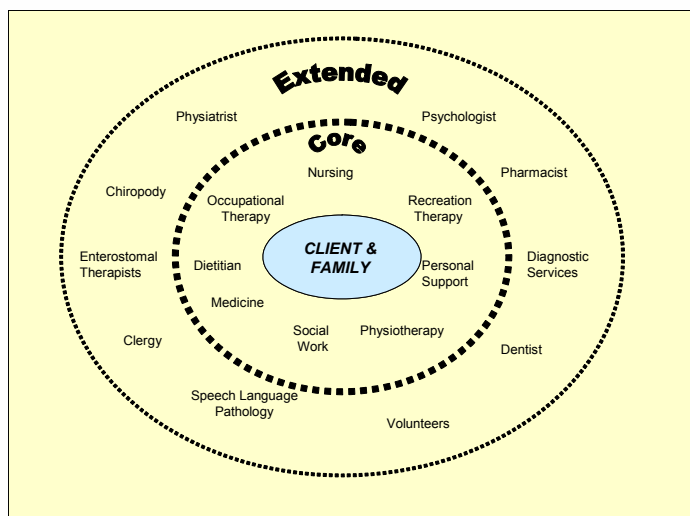
Begin care and service on 'Day One'

- Promote wellness and provide preventive health education (e.g., ensuring adequate nutrition; promoting skin integrity, mobility, and functional independence; establishing bowel and bladder patterns)
- Prevent secondary complications (e.g., the ill effects of immobilization – contractures, skin breakdown, decreased range of motion)

A-3 CORE AND EXTENDED INTERDISCIPLINARY TEAMS

Supporting the resident/family to achieve self-care and community re-entry are two interdisciplinary/interprofessional teams of care providers – the core team and the extended team. At the center is the convalescent care resident.

The **CORE** interdisciplinary team is comprised of personal support or unregulated care providers and seven different professions. Each LTCH will be required to have this care team in place to respond to the individualized care needs of convalescent care residents; the members of this team may be employed or contracted by the LTCH. This team approach has been identified as a ‘best-practice’ in rehabilitative and geriatric care and has been embraced as a critical element of the convalescent care program. It is this interdisciplinary CORE team that will assess, plan, coordinate, and monitor the care of each convalescent care resident.



The **EXTENDED** team of professionals includes additional resources that the LTCH accesses for individual convalescent care residents on an as-needed basis. The services depicted are *examples* of services that may be required. It is expected that the LTCH will have mechanisms in place to arrange such services promptly when needed.

A-4 DELIVERY MODEL

The LTCH is not required to adopt a specific delivery model. The care delivery model can take several forms, for example:

- **The consultative model.** The LTCH contracts with expert practitioners to assess the convalescent care resident’s needs, participate in care planning and monitoring, and teach front-line staff to deliver care and interventions within profession-specific guidelines. Nursing staff consult with or call upon experts as needed. Benefits of this model include the use of expertise at critical stages, embodiment of teaching and consultation as fundamental elements of care, enhancement of front-line staff knowledge and skill, and recognition of shortages in health human resources.

- **The direct delivery model.** The LTCH employs or contracts with practitioners to assess convalescent care resident needs, develop interprofessional care plans, and provide the services required. This is a more traditional delivery model, which may be simpler to administer, communicate, and understand; it uses experts to provide all elements of care, and therefore minimizes staff training time.
- **The combined model.** The LTCH draws on both the consultative and direct delivery models and decides where it will follow a consultative approach and where it will use employees or contracted practitioners to provide services. This model acknowledges that not all skills are teachable or transferable and also provides administrative and care flexibility.

A-5 SUPPLIES AND EQUIPMENT

LTCHs are already in the business of providing supplies and equipment for an aged population as outlined in the *MOHLTC Long-Term Care Program Manual*. The difference with convalescent care is that more equipment is needed so that all convalescent care residents have access to it. This is particularly true for residents who need more physical and occupational therapy. There is also a recognition, however, that these residents are not in need of high intensity therapies and therefore not in need of extensive therapy equipment, although training stairs and parallel bars may be necessary.

EXISTING LTCH SUPPLIES/EQUIPMENT*	
<ul style="list-style-type: none"> • Supplies <ul style="list-style-type: none"> - Prevention/care of skin disorders - Continence care - Colostomy/ileostomy devices - Dressings - Suctioning - Oxygen 	<ul style="list-style-type: none"> • Equipment <ul style="list-style-type: none"> - Wheelchairs - Geriatric chairs - Canes/walkers - Toilet aids • - Self-help aids
* From LTC Program Manual	

Within these categories, specific equipment for convalescent care residents could include:

<ul style="list-style-type: none"> Wheelchairs – 16-24" <ul style="list-style-type: none"> ○ Reclining, full/hemi heights ○ Elevating leg rests ○ Adjustable/removable arms Walkers <ul style="list-style-type: none"> ○ Folding/attachments ○ With/without wheels 	<ul style="list-style-type: none"> ADL aids <ul style="list-style-type: none"> ○ Wheeled/stationary commodes ○ Raised toilet seats ○ Transfer boards ○ Bath seat ○ Bed helper Other <ul style="list-style-type: none"> ○ Passive motion machine
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A-6 PROCESS PROTOCOLS

While LTCHs are familiar with assessing, planning, and monitoring activities, a key emphasis in convalescent care is the expectation that the LTCH maintain a CORE interdisciplinary team to assess, plan, monitor, and coordinate care activities. This ‘best practice’ care approach has been proven to be effective in geriatric rehabilitative settings and has been interwoven throughout the convalescent care program design. It includes:

- Interdisciplinary assessment and plan focusing on convalescent care rehabilitative principles.
- Interdisciplinary team conferences on a weekly basis to check on the status of individual convalescent care residents and adjust care activities as needed.
- Interdisciplinary team case review as close to day 14 as possible for the purposes of formally revisiting goals, activities, and the convalescent care resident’s discharge date. The underlying premise is that by day 14 a pattern of improvement is discernible and if a positive pattern is not evident, the plan of care must be adjusted accordingly.

Further, performance expectations have been articulated with respect to select critical care activities via a care process protocol which outlines the timing of key care activities.

Care Process Protocol

	Admission (24 hrs.) Assess Status and Establish Plan	Daily/Weekly Implement Care	Day 14 Formal Case Review	Prior to Discharge Home Care Needs	At Discharge
Assessment	<ul style="list-style-type: none"> • Clinical status • Functional status • Psychological status • Dietary needs • Etc. 	<ul style="list-style-type: none"> • Reassess when needed 	<ul style="list-style-type: none"> • Formal review of status 	<ul style="list-style-type: none"> • Complete home assessment 	<ul style="list-style-type: none"> • InterRAI HC assessment scheduled
Goal Setting	<ul style="list-style-type: none"> • Personal goals • Clinical goals 	<ul style="list-style-type: none"> • Revise goals when needed 	<ul style="list-style-type: none"> • Revise goals if needed 	<ul style="list-style-type: none"> • Identify home care goals 	<ul style="list-style-type: none"> • Convalescent care goals achieved
Care Planning	<ul style="list-style-type: none"> • Interdisciplinary care plan including <ul style="list-style-type: none"> - Use of applicable care pathways/ protocols - Services and frequencies - Supplies and equipment - Medication administration - Discharge plan - Etc. 	<ul style="list-style-type: none"> • Revise plan when needed 	<ul style="list-style-type: none"> • Revisit care plan 	<ul style="list-style-type: none"> • Develop initial service plan 	<ul style="list-style-type: none"> • Home care service plan finalized
Resident/Family Education	<ul style="list-style-type: none"> • Determine education needs • Condition-specific • Signs and symptoms complications • Health promotion/ safety • Self-care strategies • Etc. 	<ul style="list-style-type: none"> • Provide education as needed 	<ul style="list-style-type: none"> • Revisit education plan 		<ul style="list-style-type: none"> • Education completed
Interventions	<ul style="list-style-type: none"> • Begin planned interventions 	<ul style="list-style-type: none"> • Carry out planned interventions consistent with interdisciplinary plan of care and rights 	<ul style="list-style-type: none"> • Revise as needed 		<ul style="list-style-type: none"> • Interventions completed
Care Monitoring	<ul style="list-style-type: none"> • Establish frequency and method of monitoring 	<ul style="list-style-type: none"> • Conduct weekly interdisciplinary care conference (~60 minutes for 10-15 residents) • Confirm interdisciplinary care plan 	<ul style="list-style-type: none"> • Identify date of next review 		
Discharge Plans	<ul style="list-style-type: none"> • Identify expected date of discharge • Establish discharge criteria • Develop initial plan 	<ul style="list-style-type: none"> • Revise discharge date/criteria/plan as needed 	<ul style="list-style-type: none"> • Revise discharge date and plan if needed 	<ul style="list-style-type: none"> • Order services/ supplies/ equipment 	<ul style="list-style-type: none"> • Discharge criteria met • Discharge summary done within 7 days

APPENDIX B: APPLICATION FORM

New Convalescent Care Program Application Form

Please complete the following application to provide New Convalescent Care Program beds and send three signed hard copies and a diskette containing your application to your MOHLTC regional office by [date]. Applications submitted by electronic mail must be followed by the diskette and signed paper copies. Applications must not be submitted by facsimile.

Each section includes instructions and guidance for completion. If you have any questions or concerns, consult with your New Convalescent Care Program contact within your region.

DATE (mm/dd/yy): _____

1.0 OPERATOR INFORMATION:

Provide the required information about the operator of this LTCH and the key contact who will be available to answer any queries from the ministry.

Operator Name/Business Name (Registered name of business if incorporated)	
Contact (for this application)	
Name:	
Title:	
Mailing Address:	
City:	
Postal Code:	
Contact Phone #:	
Fax #:	
E-mail Address:	

2.0 LTCH INFORMATION:

Provide the required information about the LTCH where the convalescent care beds will be located. A separate application is required for each LTCH site proposing to participate in the New Convalescent Care Program.

LTCH ID: (4-Digit Master Number)	
Name of LTCH: (Registered Name)	
Street Address: (Physical Location)	
City:	
Name of Administrator:	
Administrator E-mail Address:	
Administrator Phone #:	
Name of Current Compliance Advisor	

3.0 CURRENT BED INFORMATION:

Please indicate the classification of the LTCH and the number of all beds (not rooms) by type in the form below. If the LTCH has different classifications (multi-class homes), please provide, in the space given, the bed number breakdowns for each separately classified section of the LTCH. Other beds, including interim beds, beds in abeyance, existing short stay beds, and ELDCAP beds, should be identified separately in the space provided. They should not be reflected in the total number of long stay beds.

Section 1: LTCH Classification	A: <input type="checkbox"/>	B: <input type="checkbox"/>	C: <input type="checkbox"/>	D: <input type="checkbox"/>
Number of Beds	Occupied	Vacant	Total	
# Private beds:				
# Semi-private beds:				
#Basic beds:				
Subtotal # of Beds for Section 1*	0	0	0	
# of Resident Home Areas (RHAs) or Resident Care Units (RCUs):				

Section 2: LTCH Classification		A: <input type="checkbox"/>	B: <input type="checkbox"/>	C: <input type="checkbox"/>	D: <input type="checkbox"/>
Number of Beds	Occupied	Vacant	Total		
# Private beds:					
# Semi-private beds:					
#Basic beds:					
Subtotal # of Beds for Section 2*	0	0	0		
# of RHAs or RCUs:					
Section 3 LTCH Classification:		A: <input type="checkbox"/>	B: <input type="checkbox"/>	C: <input type="checkbox"/>	D: <input type="checkbox"/>
Number of Beds	Occupied	Vacant	Total		
# Private beds:					
# Semi-private beds:					
#Basic beds:					
Subtotal # of Beds for Section 3*	0	0	0		
# of RHAs or RCUs:					
Total Number of Long Stay Beds:*	0	0	0		

*Note: Excluding interim beds, beds in abeyance, short stay beds, and ELDCAP beds

Other Beds: Please indicate the number of existing other beds within the LTCH.	
# Interim Beds:	# Beds in Abeyance:
# Short Stay Beds: Respite beds Supportive care beds	#ELDCAP Beds:

4.0 NEW CONVALESCENT CARE PROGRAM PROPOSAL:

Please outline your proposal to provide convalescent care services under the New Convalescent Care Program by completing the following sections of this application.

4.1 Care Delivery

4.1.1. Program Description

Provide an overview of your proposed convalescent care program, with descriptions of the major components. This description should address, with examples wherever possible, the following questions:

- **How will your program meet the New Convalescent Care Program’s goals of providing appropriate, quality care to individuals who are preparing to return home and of alleviating hospital pressures?**
- **How will your program meet the needs of the individuals you propose to serve? What will the program look like, and how will it be different from traditional LTC?**
- **How do your LTCH’s care and services support the New Convalescent Care Program philosophy of care (as one example, an LTCH’s philosophy of self-care could be evidenced by its medication self-care program and collection of self-help videotapes)?**
- **How will your LTCH will work in partnership with other stakeholders? What is your previous or current experience with collaborative relationships?**

Description (please limit to this page and the following page)

Empty text area for providing the program description.

4.1.1 Program Description (continued)

Empty content area for program description.

4.1.2 Determining Convalescent Care Residents' Needs

Describe how you will determine the needs of your program's convalescent care residents, name any tools used or procedures followed, and list internal and external stakeholders who will participate in this determination.

Process	Tools	People

4.1.3 Determining Appropriate Staff Mix and Levels

Describe how you will determine your convalescent care program's staff mix and levels, name any tools used or procedures followed, and list internal and external stakeholders who will participate in this determination.

Process	Tools	People

4.1.4 Meeting Needs for Diagnostic and Laboratory Services

How do you plan to meet the needs of convalescent care residents for more, and more frequent, diagnostic and laboratory services than traditional LTC residents? What services does your LTCH currently have, and how do you plan to obtain any additional ones required?

4.2 Environment

4.2.1 Physical Environment

Describe the proposed configuration of convalescent care beds including number of beds and your reason(s) for identifying this number, location of beds within the home, type and number of private and semi-private rooms, and bathroom arrangements. Of the beds you have identified, how many are currently vacant and how many are currently occupied? If a transition plan is required, please give a brief outline of this plan.

What space do you plan to allocate for activities related to convalescent care (e.g., therapy)? How will using this space affect the activities of the LTCH's long stay residents?

Description (please limit your response to this page and the following page)

4.2.1 Physical Environment (continued)

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The LTCH environment needs to foster self-sufficiency in the home and community to which the convalescent care resident will return. Please list features and activities in your LTCH that will help prepare the convalescent care resident for this return. Examples could include areas for reading and viewing educational material as well as opportunities to practice skills, become comfortable with community services, and engage in social and recreational activities.

Feature	Description and Comments

4.2.2 Supplies and Equipment

List the supplies and equipment required to meet the needs of convalescent care residents (see the care model addendum to this application) and indicate with check marks those you currently have and those you plan to secure.*

Item	Currently have	Plan to secure

**** The LTCH is responsible for providing all necessary supplies and equipment. These expenditures are not eligible for funding from the High Intensity Needs Fund.***

4.2.3 Information Systems

Can your LTCH's information systems support: 1) recording of and access to information by all stakeholders (with the consent of the convalescent care applicant/resident); and 2) ongoing monitoring of residents and the program as a whole? Are the convalescent care program staff comfortable using these systems? If not, how do you plan to upgrade systems and provide training?

4.3 Readiness to Implement the New Convalescent Care Program

4.3.1 Human Resources

Each LTCH offering convalescent care must have a core interdisciplinary team (medicine, nursing, physiotherapy, occupational therapy, social work, dietetics, recreation therapy, personal support). Using your program design as a basis, please provide an overview in the following chart of the current and proposed staff who will support the program.

CORE CONVALESCENT CARE STAFF ¹²	FTE ¹³ Required	Status		Plan for Securing if Not in Place	Length of Time to Secure
		In place	Will secure		
Physician(s)					
Nurse(s) (RN and RPN)					
Physical Therapist(s)					
Occupational Therapist(s)					
Social Worker(s)					
Dietitian(s)					
Recreation Therapist(s)					
Unregulated Care Worker(s)					
Other(s) (e.g., nurse practitioner, kinesiologist)					
TOTAL FTE					

¹² It is expected that all New Convalescent Care Programs will employ or contract with these professionals in order to provide core services.

¹³ Identify the projected FTE (or its equivalent for contract staff) for each of the identified core staff, assuming that 1 FTE = 1,950 hours.

4.3.2 Environmental Components

Using your proposed program design as a basis, please list all required environmental components (e.g., bed reconfiguration, therapy space), your home’s ability to provide each component, and your plans and timelines for providing components currently not in place.

Environmental Component	LTCH’s Current Capability	Plan for Securing if Not in Place	Length of Time to Secure

4.3.3 Experience

Indicate your experience in designing and delivering special programs or services or using innovative staffing arrangements. When applicable, please provide a short description of your experience.	
Program, Service, or Arrangement	Description and Comments

4.4 Finances

4.4.1 Proposed Budget

LTCHs offering the New Convalescent Care Program will be eligible to receive per diem funding of up to \$186.14 per resident. Please use this page and the following page to describe how your LTCH plans to use this funding to provide convalescent care. This budget must support the program description including the care delivery model and associated staffing, infrastructure modifications, equipment purchases or leases, and any other expected costs. *Please note that, at the discretion of the MOHLTC, applicants may be required to provide additional budget information.*

Proposed Budget (continued)

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5.0 APPLICANT'S DECLARATION:

On behalf of and with the authority of the Applicant, I/we:

1. Apply for the designation under the New Convalescent Care Program of certain beds at the long-term care home named in the Application, in accordance with the Application Package and the Application.
2. Certify that the information that the Applicant has supplied in support of its application is true, correct, and complete in every respect.
3. Agree that, if this Application is selected for a designation of convalescent care beds, the Applicant will agree to amend its Service Agreement for the Home to incorporate the provisions set out in Appendix C of the Application Package and any other terms of this Application Package and the Application.

Name of Applicant: _____

Signature of Authorized Officer: _____

Name of Authorized Officer: _____

Title of Authorized Officer: _____

Date: _____

APPENDIX C: TERMS AND CONDITIONS

New Convalescent Care Program Application, 2005

The New Convalescent Care Program is a new short stay supportive care program. All Convalescent Care Beds awarded by the Ministry are short stay supportive care beds governed by the Applicable Law. The general terms and conditions governing Convalescent Care Beds designated under the **New Convalescent Care Program** are contained in this Application. By signing the Application the Operator agrees to be bound by the general terms and conditions.

In addition to these terms and conditions the Ministry may specify some other terms and conditions which will be contained in subsequent correspondence from the Ministry. To continue to be eligible for the New Convalescent Care Program, the Operator will be required to agree to those terms and conditions by signing and returning that correspondence to the Ministry. Once the Operator signs that correspondence, the contents of the correspondence will form part of the terms and conditions governing the Grant.

All applications submitted to the Ministry are subject to the *Freedom of Information and Protection of Privacy Act* (the "Act"). The Act provides every person with a right of access to information in the custody or under the control of the Ministry, subject to a limited set of exemptions. One such exemption is set out in section 17 of the Act which relates to information that reveals a trade secret or scientific, technical, commercial, financial or labour relations information supplied in confidence, where the disclosure could reasonably be expected to result in certain harms ("Third Party Information").

If an Operator believes that any of the information contained in its Application or submitted to the Ministry in connection with the New Convalescent Care Program reveals Third Party Information, and the Operator (or another party to whom the information relates) wishes to protect the confidentiality of such information, this Third Party Information should be clearly marked as confidential. Before the Ministry grants a request for access to a record that it has reason to believe might contain such information, the Ministry will notify the Operator so that it may, if it so chooses, make representations concerning the disclosure.

The Operator is advised that the names and addresses of facilities participating in the New Convalescent Care Program, the amount of funding provided, and the purpose for which the funding is provided is information that will be made available by the Ministry to the public.

Copies of the *Freedom of Information and Protection of Privacy Act* are available from Publications Ontario at 880 Bay Street, Toronto, ON M7A 1N8, telephone (416) 326-5300 or 1-800-338-9938 or at E-laws at www.e-laws.gov.on.ca.

Amendment to Service Agreement

If the Minister determines to designate beds under the New Convalescent Care Program to an Operator, the Operator and the Ministry will enter into an agreement to amend the Service Agreement. In general, the amendments will provide as follows:

1. The following section will be added to Article 2: The Operator shall operate the Beds designated under the New Convalescent Care Program at the Facility in accordance with this Agreement and a Schedule entitled "New Convalescent Care Program".
2. The following section will be added to the section entitled "Inconsistencies between Contract Documents":

Despite this Article (Inconsistencies between Contract Documents), with respect to the Convalescent Care Beds, the terms and conditions of the Schedule entitled "New Convalescent Care Program" shall prevail over any other provision of this Agreement.

**Schedule to the Service Agreement
New Convalescent Care Program**

**NEW CONVALESCENT CARE PROGRAM
AMENDED TERMS AND CONDITIONS ***

* **Amended to incorporate changes from Amending Agreement of September, 2005**

1.0 Definitions

1.1 In this Schedule, the following terms shall have the following meanings unless the context requires otherwise:

- (a) **“Applicable Law”** means any statute, regulation, order, rule, judgment, guideline, policy, manual or principle of law that applies to the Home or the Operator, regardless of whether the foregoing is legally binding, including, as applicable, the *Charitable Institutions Act*, the *Homes for the Aged and Rest Homes Act*, or the *Nursing Homes Act*.
- (b) **“Application”** means the Application made by the Operator for the designation of long-stay beds at the Home under the New Convalescent Care Program, consisting of a completed and executed Application Form, the Terms and Conditions of the New Convalescent Care Program Application and any instrument amending this Application;
- (c) **“CCAC”** means a Community Care Access Centre as defined in the *Community Care Access Corporations Act, 2001*, which is the placement co-ordinator designated for the Home under Applicable Law;
- (d) **“Convalescent Care Applicant”** means an individual who is determined by the CCAC to be eligible for the New Convalescent Care Program and is approved for admission to a Home;
- (e) **“Convalescent Care Beds”** means the short stay supportive care beds in the New Convalescent Care Program that are designated for use for the New Convalescent Care Program at the Home;
- (f) **“Convalescent Care Resident”** means an individual who is admitted and resides in a Convalescent Care Bed at the Home;
- (g) **“Core Interdisciplinary Team”** means a core team of practitioners including :
 - a. Medicine;
 - b. Nursing;
 - c. Occupational Therapy;
 - d. Dietetics;
 - e. Recreational Therapy;
 - f. Social Work;
 - g. Physiotherapy; and
 - h. Personal support/unregulated care providers.
- (h) **“Director”** means the Director appointed under Applicable Law;
- (i) **“Extended Interdisciplinary Team”** means the practitioner(s) the Home is able to access for individual Convalescent Care Residents on an as-needed basis.
- (j) **“Home”** means the long-term care home of the Operator which is operated under the Applicable Law and which is named in the Application Form;

- (k) **“New Convalescent Care Program”** means the new short stay supportive care program governed under the *Nursing Homes Act*, *Charitable Institutions Act* and *Homes for the Aged and Rest Homes Act*;
- (l) **“Occupancy Rate”** means the number of days residents are actually occupying Convalescent Care Beds divided by the maximum resident days. For the purposes of this definition, **“maximum resident days”** means the number of Convalescent Care Beds multiplied by the number of days in the year in which the New Convalescent Care Program was offered in that Home.
- (m) **“Orientation Period”** means the first ninety (90) days that the Operator operates the Program, commencing on the date the first Bed designated under the New Convalescent Care Program in the Home becomes available to be occupied.
- (n) **“Reconciliation”** means the end of year reconciliation process set out in a Service Agreement;
- (o) **“Waiting List”** means a waiting list for short stay beds kept by the CCAC for the Home pursuant to Applicable Law.

1.2 Unless the context requires otherwise, a word or phrase that is used in this Schedule shall have the same meaning as the word or phrase is defined or used in the Service Agreement or the *Charitable Institutions Act*, the *Homes for the Aged and Rest Homes Act* or the *Nursing Homes Act* and related regulations.

2.0 Re-designation of beds

2.1 Of the number of Beds set out in the Service Agreement that the Operator is approved or licensed to operate at the Home, **X** Beds at the Home are designated as Convalescent Care Beds.

3.0 Terms and Conditions

3.1 To continue to be designated under the New Convalescent Care Program:

- (a) The Home must have a satisfactory compliance record, and its annual compliance review must show either no unmet standards or only some minor unmet standards and a strategy in place to address them to the satisfaction of the compliance advisor;
- (b) Convalescent Care Resident rooms must be private or semi-private (one or two beds), with a bathroom shared with no more than one other person;
- (c) Rooms to be used by Convalescent Care Residents must be wheelchair accessible, and bathrooms must be able to accommodate a resident in a wheelchair and a staff person at the same time;
- (d) The proposed budget to operate the Convalescent Care Beds must not exceed the allocated funding as set out in section 4.0.

3.2 An Operator shall comply with the Applicable Law in respect of the Home, including the following requirements:

- 1.1.1. the Operator shall notify the CCAC of available accommodation in the Convalescent Care Beds no later than 24 hours after the accommodation becomes available,
- 1.1.2. the Operator shall approve a Convalescent Care Applicant's admission into a Convalescent Care Bed unless,
 - (i) the Home lacks the physical facilities necessary to meet the person's care requirements; or

- (ii) the staff of the Home lack the expertise necessary to meet the person's care requirements;
and
 - (a) if the Operator withholds or withdraws approval of the admission of a Convalescent Care Applicant to a Convalescent Care Bed, the Operator shall give written notice to the applicant, the Director and the CCAC setting out the ground or grounds on which the approval is being withheld or withdrawn and a detailed explanation of the supporting facts.
- 3.3 The Operator shall provide or withhold verbal approval to the CCAC of a Convalescent Care Applicant within 2 hours after receiving the referral from the CCAC.
- 3.4 The Operator shall follow up with written notice no later than 24 hours after receiving the request to approve the admission of the Convalescent Care Applicant to the Home.
- 3.5 The Operator shall ensure that the Home is available to approve the admission of Convalescent Care Applicants to the Home every day, including Saturdays, Sundays, and holidays, and for no less than 8 continuous hours during the day-time.
- 3.6 The Operator shall ensure that it maintains a Core Interdisciplinary Team and Extended Interdisciplinary Team for the care of Convalescent Care Residents. The Core Interdisciplinary Team shall use the services of the Extended Interdisciplinary Team as needed.
- 3.7 The Operator shall ensure that the Core Interdisciplinary Team conducts an assessment and develops a plan of care for each Convalescent Care Resident. The Operator shall use its best efforts to ensure that the assessment and plan of care are developed within 24 hours after the Convalescent Care Resident's admission to the Home and, in any event, that they are developed within 48 hours after the Convalescent Care Resident's admission to the Home.
- 3.8 The plan of care shall:
 - (a) be in writing,
 - (b) reflect the Convalescent Care Resident's preferences and goals,
 - (c) describe clearly the activities that will promote and enhance a Convalescent Care Resident's,
 - (i) rehabilitative progress, self-care and self-sufficiency,
 - (ii) community re-integration and re-entry, and
 - (iii) wellness and health promotion, and
 - (d) be easily accessible to the persons participating in the Convalescent Care Resident's care.
- 3.9 The Operator shall review each Convalescent Care Resident's plan of care at least weekly during a case conference held by the Core Interdisciplinary Team, and adjust the plan of care accordingly, if required.
- 3.10 The Operator shall hold a full case review of each Convalescent Care Resident no later than 16 days, and as close to day 14 as possible, after the Convalescent Care Resident is admitted to the Home.
- 3.11 The Operator shall upon discharge of the Convalescent Care Resident:

- (a) complete, within 7 days of the Convalescent Care Resident's discharge from the Home, an interdisciplinary discharge summary outlining the care that the Convalescent Care Resident received during his/her stay; and
- (b) forward a copy of the discharge summary to the Convalescent Care Resident's family physician and to the CCAC.

3.12 The Operator shall operate the Convalescent Care Beds in accordance with the Application Package and its Application, including: **[insert any specific obligations the Applicant proposed in its Application]**.

4.0 Subsidy Payment

4.1 The Ministry shall provide the subsidy to the Operator for the Services provided under the New Convalescent Care Program at the Home as part of the Estimated Provincial Subsidy in the Subsidy Calculation Worksheet, for the period specified in the Subsidy Calculation Worksheet.

4.2 The subsidy for each Convalescent Care Bed will be calculated at a base rate equal to the Base Level of Care Per Diem equal to the Provincial Average Case Mix Index (CMI) of 100.00 plus an additional subsidy based on actual occupancy - resident days (the "Additional Subsidy").

4.3 The Base Level of Care subsidy shall be provided for each Convalescent Care Bed regardless of the Occupancy Rate.

4.4 The Base Level of Care subsidy shall be allocated to the envelopes based on the Level of Care funding model in effect for long stay residents from time to time.

4.5 The following rules apply to the Additional Subsidy:

- (a) The rate is \$61.59 per Convalescent Care Bed per day.
- (b) The Additional Subsidy will be flowed monthly assuming an Occupancy Rate of 100%.
- (c) The allocation of the Additional Subsidy to the Envelopes shall be:
 - (ii) Program and Support Services, \$16.98;
 - (iii) Nursing and Personal Care, \$39.61; and
 - (iv) Other Accommodation (excluding Raw Food), \$5.00.
- (d) During the Orientation Period, the Additional Subsidy will be provided for each Convalescent Care Bed regardless of the Occupancy Rate.
- (e) With the exception of the Orientation Period, if the Occupancy Rate is 80% or higher, the Additional Subsidy will be provided for each Convalescent Care Bed regardless of the Occupancy Rate. If the Occupancy Rate is 50% or more but less than 80%, the Additional Subsidy shall be reconciled to the actual Occupancy Rate.

4.6 With the exception of the Orientation Period, if the Home is unable to achieve an Occupancy Rate of at least 50%, the Ministry may reduce the number of Convalescent Care Beds at the Home and the amount of the subsidy payments.

- 4.7 The nursing and personal care, program and support services, and raw food envelopes relating to the Base Level of Care subsidy and Additional Subsidy shall be reconciled annually to the actual expenses, with any amount unspent to be recovered by the Ministry.
- 4.8 The Base Level of Care subsidy and the Additional Subsidy provided for the Convalescent Care Beds shall be reconciled annually at the end of each calendar year for the Home. The reconciliation process shall be separate and apart from the normal payment and reconciliation process that occurs at the end of each calendar year for the Home relating to beds other than Convalescent Care Beds.
- 4.9 The number of Convalescent Care Beds may be increased, at the discretion of the Ministry, if the Home has achieved and maintained the Occupancy Rate, there is demonstrated need for the program expansion in the specific region, the Home is able to manage an increase in the number of Convalescent Care Beds and the Operator is in compliance with the Service Agreement.
- 4.10 The Operator shall not collect any co-payment from Convalescent Care Residents despite Applicable Law. For greater clarity, and subject to Section 4.13, nothing herein limits the Operator's right to collect any co-payment from a long-stay resident in a Bed designated under the New Convalescent Care Program during the Orientation Period until such time as the long-stay resident is replaced with a Convalescent Care Resident.
- 4.11 The Operator shall not charge Convalescent Care Residents any amount for preferred accommodation. For greater clarity, and subject to Section 4.13, nothing herein limits the Operator's right to charge a long-stay resident in a Bed designated under the New Convalescent Care Program during the Orientation Period until such time as the long-stay resident is replaced with a Convalescent Care Resident.
- 4.12 The Operator shall comply with the reporting and reconciliation process as set out in Applicable Law.
- 4.13 Notwithstanding Section 4.10 and 4.11 above, the Operator and MOHLTC hereby acknowledge and agree that:
- (a) in some circumstances, Operators will have to phase in Convalescent Care Beds during the Orientation Period (the "**Phase In**") since not all Convalescent Care Beds will be open for filling at the outset;
 - (b) during the Phase In, some long-stay residents will, as of the commencement of the Orientation Period, continue to occupy beds that have been redesignated and will be funded as Convalescent Care Beds;
 - (c) long-stay residents in Convalescent Care Beds shall be treated as Convalescent Care Residents by the MOHLTC in respect of funding the Operator receives;
 - (d) during the Orientation Period only, the Operator may: (i) continue to collect the co-payment from long-stay residents in beds that have been designated as Convalescent Care Beds; and (ii) charge long-stay residents in Convalescent Care Beds amounts for preferred accommodations;
 - (e) the co-payment and preferred accommodation amounts collected and/or charged by Operators from long-stay residents in Convalescent Care Beds as provided for in (d) above shall be considered by the MOHLTC as basic accommodation revenue during reconciliation; and
 - (f) From and after the commencement of the Orientation Period, the Operator agrees to use best efforts to transfer any long-stay residents situated in a bed redesignated as a Convalescent

Care Bed in the Home to any available Bed in the Home, as they arise, provided that the long-stay resident agrees to such a transfer.

5.0 Operator Warranties and Representations

5.1 The Operator warrants and represents that:

- (a) the Operator has full power and authority to submit the Application and to observe, perform, and comply with the terms and conditions of this Application, and all necessary acts and procedures have been taken in order to authorize this Application;
- (b) if the Operator is a corporation, it is duly organized, registered, and validly existing under the laws of Ontario or Canada, and is qualified to do business whenever necessary to carry out the terms and conditions of this Application, and has not been dissolved; and
- (c) if the Operator is a partnership, all appropriate registrations have been made and will be maintained, and that the partnership is qualified to do business wherever necessary to carry out the terms and conditions of this Application.

6.0 Further Conditions and Changes to the Application Terms and Conditions

6.1 The Ministry may impose such additional terms or conditions or change the terms and conditions to obtain the additional funding, which it considers appropriate upon thirty (30) days' prior notice to the Operator, and the Operator shall agree to such terms and conditions in order to continue to be eligible under the New Convalescent Care Program.

6.2 The Operator shall participate in the program evaluation and performance monitoring portion of the New Convalescent Care Program as determined by the Ministry.

7.0 Term of Designation of Convalescent Care Beds

7.1 Except as provided in sections 8, 9 and 10, the Operator shall be admitted into the New Convalescent Care Program on the date the Amending Agreement is last signed by the parties and the term of the designation of Convalescent Care Beds shall commence on the date the Orientation Period begins and it shall end on March 31, 2007.

7.2 The Ministry may extend the New Convalescent Care Program beyond March 31, 2007 at the sole discretion of the Ministry, and the Ministry may require the Operator to reapply to continue to be part of the New Convalescent Care Program.

8.0 Termination of Convalescent Care Designation by the Operator

8.1 The Operator may at any time terminate the designation of the Convalescent Care Beds and revert them back to Long-Stay beds by giving thirty (30) calendar days' prior written notice of termination to the Ministry.

9.0 Termination by the Ministry for Convenience

9.1 The Ministry may terminate the designation of the Convalescent Care Beds at any time, upon giving at least sixty (60) calendar days' written notice to the Operator.

10.0 Termination of Convalescent Care Designation by the Ministry

10.1 The Ministry may terminate immediately the designation of Convalescent Care Beds upon giving written notice to the Operator, if, in the opinion of the Ministry:

- (a) the Operator has provided false or misleading information regarding its Application for designation of the Convalescent Care Beds or in any other communication with the Ministry; or
- (b) the Operator breaches any term or condition of this Schedule; or
- (c) the Operator breaches any term or condition of the Service Agreement; or
- (d) the Operator or the Home ceases to carry on business.

10.2 If the Ministry, in its sole discretion, considers the nature of the breach to be such that it can be remedied and that it is appropriate to allow the Operator the opportunity to remedy the breach, the Ministry may give the Operator an opportunity to remedy the breach by giving the Operator written notice:

- (a) of the particulars of the breach;
- (b) of the period of time within which the Operator is required to remedy the breach; and
- (c) that the Ministry shall terminate the designation of the Convalescent Care Beds:
 - (i) at the end of the notice period provided for in the notice if the Operator fails to remedy the breach within the time specified in the notice; or
 - (ii) prior to the end of the notice period provided for in the notice if it becomes apparent to the Ministry that the Operator cannot completely remedy the breach within that time or such further period of time as the Ministry considers reasonable, or the Operator is not proceeding to remedy the breach in a way that is satisfactory to the Ministry.

10.3 If the Ministry has provided the Operator with an opportunity to remedy the breach, and

- (a) the Operator does not remedy the breach within the time period specified in the notice;
- (b) it becomes apparent to the Ministry that the Operator cannot completely remedy the breach within the time specified in the notice or such further period of time as the Ministry considers reasonable; or
- (c) the Operator is not proceeding to remedy the breach in a way that is satisfactory to the Ministry,

the Ministry may immediately terminate the designation of the Convalescent Care Beds by giving written notice of termination to the Operator.

10.4 If the Convalescent Care designation is terminated pursuant to this section, the effective date of termination shall be the last day of the notice period, the last day of any subsequent notice period or immediately, whichever applies.

11.0 Subsidy Upon Termination or Determination of Non-Eligibility

11.1 If the Convalescent Care Bed designation is terminated before the end of the term, or if it is found that the Operator was not eligible for a Subsidy after the Subsidy has been paid to the Operator or set off against any amount payable upon Reconciliation, the Ministry shall:

1.1.3. cancel all further Subsidy payments to the Operator; and

1.1.4. demand the repayment of any Subsidy or any part of the Subsidy that has been paid to the Operator or set-off as reasonably determined by the Ministry in the circumstances.

11.2 If the Ministry demands the repayment of any part of the Subsidy, the amount demanded shall be deemed to be a debt due and owing to the Ministry and the Operator shall pay the amount to the Ministry immediately unless the Ministry directs otherwise.

11.3 The Ministry may demand interest on any amount owing by the Operator at the then current rate charged by the Province of Ontario on accounts receivable.

11.4 The Operator shall repay the amount demanded by cheque payable to the "Minister of Finance" and mailed to the Ministry, or the Ministry may set-off that amount against any amounts owing by the Ministry to the Operator, including any amounts under any service agreement with the Operator.

12.0 Assignment of Convalescent Care Beds Designation

12.1 The Operator shall not assign the Convalescent Care Designation or its associated subsidy or any part thereof without the prior written consent of the Ministry.

13.0 Survival

The provisions in Section 11 shall survive the expiry or termination of the designation of Convalescent Care Beds at a Home, or the termination of the New Convalescent Care Program.

- END OF PAGE -

APPENDIX D: APPLICATION CHECKLIST

The following checklist is identical to the one that your MOHLTC regional office will use to determine whether your application is complete. You may wish to refer to it when you are ready to submit your application.

1.0 Operator Information	
	LTCH name and application contact information
2.0 LTCH Information	
	LTCH ID number, name, address, administrator name, and administrator contact information
3.0 Current Bed Information	
	LTCH classification, number of beds by type, number of occupied and vacant beds, number of resident home areas (RHAs) or resident care units (RCUs), number of other beds (interim beds, beds in abeyance, short stay beds, ELDCAP beds)
4.0 New Convalescent Care Program Proposal	
	4.1 Care delivery
	4.1.1 Program description
	4.1.2 Determining convalescent care residents' needs
	4.1.3 Determining appropriate staff mix and levels
	4.1.4 Meeting needs for diagnostic and laboratory services
	4.2 Environment
	4.2.1 Physical environment
	4.2.2 Supplies and equipment
	4.2.3 Information systems
	4.3 Readiness to implement the New Convalescent Care Program
	4.3.1 Human resources
	4.3.2 Environmental components
	4.3.3 Experience
	4.4 Finances
	4.4.1 Proposed budget
5.0 Applicant's Declaration	
	5.1 Signed applicant's declaration form

POLICIES

REPORTING OF UNUSUAL OCCURRENCES

**UNUSUAL
OCCURRENCES:
INTRODUCTION**

Most resident-related occurrences or incidents of accident or injury within a facility are not considered "unusual occurrences", and are documented and managed through the facility's internal program to monitor, evaluate and improve quality. This program includes the development of protocols, which demonstrate that the facility is taking corrective action to support the safety and security of the residents, staff and visitors.

In addition to being examined by the facility as part of the internal program, unusual occurrences shall be reported to the Residential Services Branch Regional Office. The Regional Office will in turn communicate the information to the LTC Area Office.

This policy defines the process for facilities with regard to the reporting and management of unusual occurrences.

DEFINITION

An occurrence which poses a potential or actual risk to the safety, security, welfare and/or health of a resident or staff member, or to the safety and security of the facility, which requires action by staff.

**PURPOSE OF REPORTING
UNUSUAL
OCCURRENCES**

To advise the LTC Division of issues that have a major impact on resident safety.

ACTIONS TO BE TAKEN

When unusual occurrences occur, the administrator (or designate) shall take necessary action to provide the required care and comfort to residents and/or others.

POLICIES

REPORTING OF UNUSUAL OCCURRENCES

When unusual occurrences occur, the administrator (or designate) shall ensure that the occurrence is reported to the Residential Services Branch Regional Office, according to reporting requirements set out below. In addition, the administrator is encouraged to telephone the Residential Services Branch Regional Office staff to discuss any concerns he/she may have about any unusual occurrence.

For all unusual occurrences, the administrator shall ensure that a copy of the written Unusual Occurrence Report Form is sent to the Residential Services Branch Regional Office within **10 working days** of the occurrence or sooner in response to requests by the RSB Regional Office.

TYPES OF UNUSUAL OCCURRENCES AND ACTIONS TO BE TAKEN

The following is a list of occurrences, which are considered by the Ministry to be unusual occurrences.

They are grouped according to Ministry reporting requirements:

A. UNUSUAL OCCURRENCES TO BE REPORTED IMMEDIATELY BY TELEPHONE AND FOLLOWED BY A WRITTEN REPORT

1. Occurrences which pose an immediate risk to resident(s) and which involve intervention by an outside agency or agencies such as police, fire department, or medical officer of health.

Agency Contacted:

a) Police for occurrences of:

- abuse and/or assault involving a resident, including willful direct infliction of physical pain or injury, as well as sexual assault

POLICIES**REPORTING OF UNUSUAL OCCURRENCES****a) Police (cont.)**

- alleged fraud, theft
- bomb threats, evacuations
- missing person, according to the facility's own disaster/search plan definition of when a person is "missing"
- unusual/accidental death including suicide
- missing/misappropriated drugs

b) Fire Department for occurrences of:

- fire emergency within the facility requiring partial evacuation of an area or disruption of service.

c) Medical Officer of Health for occurrences of:

- infectious disease at the outbreak level
- communicable diseases as per *Health Protection and Promotion Act*
- problems with drinking water supply (i.e. contamination)

POLICIES

REPORTING OF UNUSUAL OCCURRENCES

- B. UNUSUAL OCCURRENCES TO BE REPORTED THE NEXT WORKING DAY BY TELEPHONE AND FOLLOWED BY A WRITTEN REPORT**
1. Events requiring the intervention of one or more outside agencies, such as those listed in Section A, but which do not pose an immediate risk to residents.
 2. The implementation of any part of the facility's emergency plan including the evacuation of residents for any reason (with the exception of false alarms or fire drills).
 3. Major equipment or system breakdown, which places residents at risk.
- C. UNUSUAL OCCURRENCES TO BE REPORTED IN WRITING WITHIN 10 WORKING DAYS**
1. Injury, medication error or treatment error resulting in transfer of a resident to hospital for treatment and/or admission, including but not limited to:
 - obvious or suspected head injuries
 - medication errors having serious effects.

WHERE TO CALL

DURING OFFICE HOURS CALL THE RESIDENTIAL SERVICES BRANCH, REGIONAL OFFICE.

AFTER HOURS CALL QUEEN'S PARK AT

1-416-325-1090.

CROSS REFERENCE

The management of **all other occurrences** is discussed in the "Monitoring, Evaluating and Improving Quality" section, located in the Facility Organization and Administration Standards.



Ministry of Health
Ministère de la Santé
Ministry of Community and Social Services
Ministère des Services sociaux et communautaires

Residential Services Branch
Direction des services en établissement

15 Overlea Blvd., 5th Floor
Toronto, Ontario
M4H 1A9

Tel: (416) 327-7357
Fax: (416) 327-7364

January 13, 1994

MEMORANDUM TO: Nursing Home Licensees
Nursing Home Administrators
Nursing Home Directors of Care

FROM: Sandy Knipfel
Acting Director

RE: REPORTING OF UNUSUAL OCCURRENCES

For the past several years, nursing homes have been required by legislation to submit incident report forms to the Residential Services Branch describing every occurrence of fire, assault, injury, communicable disease or death resulting from accident or undetermined cause. This requirement remains in effect within the revised Nursing Home Regulation 832 proclaimed July 1, 1993 under Bill 101.

The Residential Services Branch recognizes that this process has at times, proven to be somewhat cumbersome in administration from both the facility and Branch perspectives. In order to reduce administrative time and simplify the process, a new unusual occurrence reporting form was developed in the context of the new "Long-Term Care Facility Program Manual". A copy of this form is attached, and as well, is contained in the draft manual which was distributed to all long-term care facilities in June and July of this year.

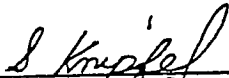
Please be advised that although nursing homes continue to be required to document all unusual occurrences as defined by regulation, our expectation is that the new form within the Manual be implemented. This will hopefully be of assistance to homes in reducing current facility staff hours which must be committed to completing existing forms.

The new unusual occurrence forms are to be submitted to the Residential Services Branch Regional Offices. The Regional Office will in turn communicate pertinent information, as appropriate, to the Long-Term Care Area Office.

Incidents which do not meet the definition for reporting as set out under the attached new form but are included in regulation, are to be documented and maintained on record at the nursing homes. These records will be reviewed by Compliance Advisors, and where appropriate, staff from the Enforcement Unit, on visits to the nursing homes.

Supplies of the new forms are available in the Residential Services Branch Regional Offices. You may either make copies of the attached form when needed or contact your respective Regional Office for whatever additional numbers that you consider are required for your facility.

Should you have any questions or need further information with respect to the above, please contact the Compliance Advisor assigned to your nursing home or the Managers of the Regional Offices.



Sandy Knipfel

Enclosure

cc: Geoffrey Quirt
RSB Managers
LTC Area Office Managers

AP/jl/5688



Unusual Occurrence Report

Rapport d'événement inusité

Confidential when completed / Confidenciel une fois rempli

Regional office/Bureau régional	Name of facility/Nom de l'établissement
Address of facility/Adresse de l'établissement	

I The unusual occurrence/Description de l'événement inusité

Time/Heure	Date	Location/Lieu
------------	------	---------------

Type of unusual occurrence: (check off appropriate items)/Type d'événement inusité (cocher les mentions appropriées)

<input type="checkbox"/> injury resulting in transfer to hospital blessure entraînant un transfert à l'hôpital	<input type="checkbox"/> missing person personne disparue	<input type="checkbox"/> missing/misappropriated drugs médicaments disparus – détournés
<input type="checkbox"/> injury resulting in hospital admission blessure entraînant l'admission à l'hôpital	<input type="checkbox"/> alleged/actual abuse/assault abus/agression présumé – réel	<input type="checkbox"/> disease outbreak flambée de maladies
<input type="checkbox"/> unusual or accidental death mort inhabituelle ou accidentelle	<input type="checkbox"/> bomb threat alerte à la bombe	<input type="checkbox"/> implementation of evacuation plan mise en oeuvre d'un plan d'évacuation
<input type="checkbox"/> medication/treatment error resulting in hospital admission erreur de médication/traitement entraînant l'admission à l'hôpital	<input type="checkbox"/> fire incendie	<input type="checkbox"/> major equipment/system breakdown panne du matériel/système principal
<input type="checkbox"/> alleged/actual fraud/theft fraude/voit présumé – réel	<input type="checkbox"/> evacuation évacuation	<input type="checkbox"/> other (describe) autres (décrire)

Description of the occurrence, including events leading up to the occurrence./Description de l'événement, y compris qui a précédé.

II Identifying information/Renseignements identificatoires

Name of resident Nom du (de la) pensionnaire	Name of other person(s) involved in occurrence Nom de l'autre ou des autres personnes visées par l'événement
Category of person(s) involved in occurrence/Catégorie(s) de personnes visées par l'événement	
<input type="checkbox"/> resident/pensionnaire	<input type="checkbox"/> visitor/visiteur
<input type="checkbox"/> staff/personnel	<input type="checkbox"/> other/autres
Date of birth of resident/ Date de naissance du (de la) pensionnaire	Date of admission Date d'admission
Name and category of person who discovered occurrence Nom et catégorie de la personne qui a découvert l'événement	Name and category of person who observed occurrence Nom et catégorie de la personne qui a observé l'événement

III Actions taken/Mesures prises

What care was given or action taken as a result of the occurrence? By whom?
Quels soins ont été prodigués ou quelles mesures ont été prises à la suite de l'événement? Par qui?

Was physician called?/A-t-on appelé le médecin?	date	time/heure	Name of physician/Nom du médecin
<input type="checkbox"/> no/non <input type="checkbox"/> yes/oui			

Physician action/Mesures prises par le médecin

For resident-related occurrences:/Pour les événements liés aux pensionnaires

Were relatives/friends of resident notified?/A-t-on averti les parents/amis du (de la) pensionnaire?	date	time/heure
<input type="checkbox"/> no/non <input type="checkbox"/> yes/oui		

Name of relative(s) friend(s) notified/Nom des parents/amis avertis

If not, why not?/Si non, pourquoi?

IV Analysis and follow-up/Analyse et suivi

What is the outcome/current status of the individual(s) who was involved in this occurrence?
Quel est l'état actuel ou la situation actuelle des personnes qui ont participé à cet événement?

What immediate actions have been taken to prevent recurrence?
Quelles mesures immédiates ont été prises pour en prévenir la répétition?

What long term actions are planned to correct this situation and prevent recurrence?
Quelles mesures à long terme prévoit-on pour corriger cette situation et en prévenir la répétition?

Name and category of person initiating report/Nom et catégorie de la personne qui a rédigé le rapport	Date of report/Date du rapport
---	--------------------------------

Regional office notified/Bureau régional avisé	By whom/Par qui?	Date	Signature of Administrator or designate Signature de l'administrateur ou de l'administratrice ou de son représentant
--	------------------	------	---

For office use only/Réservé au bureau	
Date Area Office notified/Date de l'avis au bureau régional	Date forwarded to Area office/Date d'envoi au bureau de secteur

POLICIES

LEVELS OF CARE CLASSIFICATION OF RESIDENTS

BACKGROUND

The provincial government introduced the Levels of Care Classification System to Ontario in the summer of 1992.

The RESIDENT CLASSIFICATION SYSTEM FOR LONG-TERM CARE FACILITIES provides data used in determining funding for nursing and personal care requirements in nursing homes and homes for the aged.

FUNDING FOR NURSING AND PERSONAL CARE

Funding for nursing and personal care in homes for the aged and nursing homes is based on the care requirements of residents. To determine how much money a facility should receive, residents' nursing and personal care requirements are measured and classified into a level of care.

This "levels of care" funding provides incentives for facilities to admit heavy-care applicants, and to provide the care the residents require.

It recognizes the cost differences among facilities based on the nursing and personal care requirements of residents.

For residents, this will result in fewer transfers between facilities and increased nursing and personal care as their service requirements change.

THE CLASSIFICATION SYSTEM

The levels of care classification system was developed in Alberta to provide information on the nursing and personal care requirements of residents of long-term care facilities.

The classification system places persons with similar needs into categories. It measures differences between the nursing and personal care requirements of groups or categories of long-term care residents, and provides a basis for equitable funding.

POLICIES

LEVELS OF CARE CLASSIFICATION OF RESIDENTS

Facilities with a higher proportion of heavy care residents receive relatively higher levels of funding to provide the care required by these individuals, than do facilities with a higher percentage of light-care residents.

Residents are classified once a year by registered nurses trained in the use of the Classification Tool.

PROVINCIAL RESIDENT CLASSIFICATION FORM

The Provincial Resident Classification Form contains nine pages of information. The nurse classifier fills out one of these forms for each resident in the facility, based on the various forms of documentation provided by the facility.

The Resident Classification Form collects information on care requirements for activities of daily living, behaviours of daily living, and continuing care requirements, therapeutic interventions, family involvement in resident care and demographic information on each resident.

There are over 60 items of information about the resident on the Provincial Resident Classification Form. Many of the items provide information to assist the government with monitoring trends in patient characteristics and long-term care, including trends in demographics, diagnoses, family participation in care, medications and treatments.

CLASSIFICATION INDICATORS

Eight of these items were found to predict differences in nursing care requirements, and it is these eight indicators which are used to determine an individual's classification or level of care category.

The eight classification indicators are organized into three "domains of care". The care requirement domains and their associated indicators are:

POLICIES

LEVELS OF CARE CLASSIFICATION OF RESIDENTS

Activities of Daily Living (ADL)

- Eating
- Toilet aid
- Transferring
- Dressing

Behaviours of Daily Living (BDL)

- Potential for injury to self or others
- Ineffective coping

Continuing Care Level (CCL)

- Urinary Continence
- Bowel Continence

**CLASSIFICATION
CATEGORY**

Based on the level of dependence noted for each of these eight indicators, residents are placed into a level of care in each of the three care domains: Activities of Daily Living, Behaviours of Daily Living and Continuing Care Levels.

The combination of levels of care in each domain determines the classification category for each resident. Based on the combination of levels of care, residents are classified into one of seven categories A through G. Categories A and B represent light care; C, D, and E represent medium care; and F and G represent heavy care.

Nurse classifiers do not determine residents' classification categories. This is done by computer at Queen's Park, based on the information submitted by the classifiers.

**DOCUMENTATION
REQUIREMENTS**

The success of annual levels of care classifications depends on how well the facility RNs and RNAs document nursing and personal care requirements on resident records.

Nurses in long-term care facilities are required to provide appropriate documentation to demonstrate the requirements of their residents.

POLICIES

LEVELS OF CARE CLASSIFICATION OF RESIDENTS

Facilities need to review their documentation. This will reduce the possibility that nursing and personal care requirements are not accurately reflected.

Facilities need **not** change the forms they are using for resident records and resident care plans. Staff should try to be as effective as possible within their own charting systems by detailing each resident's care.

Facility staff should keep in mind the information that the classifiers will need to classify residents properly.

The nurse classifiers will obtain the data from the facility's records and use it in completing the Provincial Resident Classification Form for each resident. This will take 20 to 30 minutes for each resident. The resident will not be seen or interviewed.

The classification process includes the following:

- review of resident chart
- review of resident care plan
- review of other relevant documentation, for example, quarterly summary, progress notes, treatment sheets, flow sheets, and medication profiles
- verification interview with RN where required

Written documentation of a problem, condition (and intervention) is necessary in order to be acknowledged by the classifier as being present.

It is to the advantage of the facility in terms of the provincial classification system to have interdisciplinary progress notes so that the nurse classifier can review current nursing, physiotherapy, occupational therapy, dietary, physician, and other records.

POLICIES

LEVELS OF CARE CLASSIFICATION OF RESIDENTS

Contradictory or incomplete information will be verified by the classifier with the staff RN, or with the physiotherapist or occupational therapist if one is employed by the facility.

The classification should reflect the current status of the resident during the most recent 24-hour period. The facility's documentation must be up-to-date and complete. When resident care needs change, the documentation must be changed.

The nurse classifier will go through the most recent documentation, which in most cases will be the last month's records. If necessary, classifiers will go back as far as the last three months.

The classifier has to fill in all 66 categories of the Provincial Resident Classification Form, although only eight will be used for classification and funding purposes.

Ideally, the resident care documentation should accomplish the following:

- identify the care required by the resident
- identify the problems or issues
- outline the interventions and reasons for them
- record the frequency and staff time taken by interventions for behaviours
- record the outcome of the plan of care
- be a current reflection of the resident's status

Facility staff may need to enhance the documentation on Activities of Daily Living (ADL) and Continuing Care Level (CCL) categories. All resident behaviours that require staff intervention or time should be identified and documented in the Behaviours of Daily Living (BDL) section.

POLICIES

LEVELS OF CARE CLASSIFICATION OF RESIDENTS

ACTIVITIES OF DAILY LIVING

Four of the eight indicators that are used to determine a resident's classification fall under the Activities of Daily Living domain.

The need for assistance with activities of daily living form a large part of the care required by long-term care facility residents.

The part of the Provincial Resident Classification Form which contains the four ADL indicators (Eating, Toilet aid, Transferring, Dressing) follows.

EATING

Eating refers to the process of getting food into the stomach, excluding tube feeding and parenteral feeding. The relevant information for eating is usually in the plan of care and/or progress notes.

The levels of intervention for eating include: **assistance**, **encouragement** and **complete feeding**. It is important that these terms appear in the documentation of a resident's care. The facility should include the interventions when describing the type of assistance required.

Plan of Care example:

- Encourage intermittently, open cartons, cut meat.
- Total feed, guide process of eating, feed slowly.

Progress Note example:

- Resident requires assistance opening cartons, cutting meat because of loss of fine motor skill. She is a slow eater but eats unassisted with intermittent encouragement.

POLICIES

LEVELS OF CARE CLASSIFICATION OF RESIDENTS

- Resident is now unable to eat independently. She chokes frequently and must be fed slowly and repositioned often. Constant encouragement is required to maintain interest in eating.

TOILET AID

Toilet aid refers to the process of getting to and from a toilet or commode (or use of other toilet aid equipment), transferring on and off toilet, cleansing self after elimination and adjusting clothes.

The levels of intervention for toilet aid include: **assistance, intermittent supervision, constant supervision**, and requires **two people** to provide assistance. The relevant information for toilet aid is usually on the plan of care.

Documentation should focus on the degree of intervention required for toilet aid, rather than on the degree of continence or incontinence. It is important to note the degree of supervision and assistance required to complete the total task of toilet aid.

For example:

- Requires two persons for toilet aid, do not leave alone, total assistance with all aspects of toilet aid.
- Requires assistance with clothing, supervise in getting on and off toilet for safety.

TRANSFERRING

Transferring is the process of moving between positions (e.g. to/from bed, chair, standing) excluding transfers in/out of bath and on/off toilet.

The levels of intervention for transferring include: **needs another person to position, intermittent supervision, constant guidance**, and requires **two or more people**. The relevant information is usually on the plan of care.

POLICIES

LEVELS OF CARE CLASSIFICATION OF RESIDENTS

The amount of physical assistance required is well documented in general. However, the degree of supervision or guidance required is often missing. When a two person or mechanical lift is indicated, the reason for the lift should be written.

For example:

- Requires two person total transfer for safety, resident unable to weight bear.
- Requires assistance of one person for all transfers.

DRESSING

Dressing is the process of getting street clothes on.

The levels of intervention for dressing include: **help assembling, supervision** and **assistance**. The relevant information is usually on the plan of care. The level of intervention that may not be clear on many plans of care is the level of supervision that is required by the resident.

For example:

- Leave out clothing, help with buttons and zippers.
- Requires constant supervision and coaching to complete dressing.
- Requires total assistance to put on clothing.

BEHAVIOURS OF DAILY LIVING

The behaviours of daily living classification indicators, potential for injury to self or others and ineffective coping, are intended to reflect the amount of care the resident requires to manage the behaviour.

An intervention is described as any physical, nursing, medical or pharmacological intervention aimed at limiting, controlling or eliminating behavioural problems.

POLICIES

LEVELS OF CARE CLASSIFICATION OF RESIDENTS

Interventions can include redirection, behaviour modification or retraining, social interventions, or restraint (physical or chemical).

There must be documentation in the progress notes indicating that the behaviour is currently an assessed need, what intervention controls the behaviour, the frequency with which the intervention occurs, and the time required by the intervention.

Record the need for intervention during the 24-hour period, whether or not the behaviour occurs. If intervention is actually preventing the behaviour and continues to be necessary to prevent the behaviour, it should be recorded.

Staff should identify and record behaviours that require staff time. This section is the most difficult to document successfully. For example, staff in long-term care facilities often do not view chronic behaviour patterns as time demanding. All behaviours should be recorded, even what might be considered "normal" behaviour.

The relevant information for behaviours of daily living is usually on the resident's plan of care and the progress notes. The plan of care should identify the behaviours and interventions. The progress notes should record the frequency of the behaviour, the interventions, the time involved and the result of the interventions.

There are 15 BDL indicators on the Provincial Resident Classification Form. These indicators include examples of behaviours that require care. They are:

- Wandering
- Hoarding, Rummaging
- Aggressive/angry behaviour
- Agitated behaviour

POLICIES

LEVELS OF CARE CLASSIFICATION OF RESIDENTS

- Suspicious behaviour
- Indiscriminate ingestion of foreign substances
- Inappropriate sexual behaviour
- Inappropriate smoking
- Alcohol and/or drug abuse
- Resident resists treatment or refuses care
- Resident acts sad or depressed
- Resident demands attention
- Suicidal behaviour
- Anxious behaviour
- Other behaviour requiring care

These behaviours, which usually require staff intervention, are used as a guide to complete the behavioural classification indicators: Potential for Injury to Self or Others, and Ineffective Coping. Facility staff must document planned behavioural interventions with time and frequency.

The part of the Provincial Resident Classification Form which contains the two BDL indicators (Potential for Injury to Self or Others, and Ineffective Coping) follows.

POTENTIAL FOR INJURY TO SELF OR OTHERS

Potential for injury to self or others refers to all types of behaviour or physical conditions that might put a resident or others at risk. For example:

- memory and orientation problems that place the resident at risk
- judgement and decision-making abilities that are extremely poor or non-existent
- any of the previously reviewed behaviours that will potentially place the resident or others at risk
- risk of seizures requiring monitoring and/or accompaniment off the unit
- choking
- unsteady gait

POLICIES

LEVELS OF CARE CLASSIFICATION OF RESIDENTS

Intervention may require a regular routine schedule of observation and intervention, for example, hourly checks.

For example:

"Resident grabs."

Because no planned interventions are outlined with time and frequency, the resident does not qualify for points under Ineffective Coping and/or Potential for Injury.

The following example addresses time and frequency:

"Mr. X continues to grab at persons who pass close to him. Mr. X was removed from his usual seating place on _____, 1992. After the move, Mr. X did not eat well and pinched staff. At the care conference, Mr. X's behaviour was discussed and the plan of care was updated. Staff are now involving Mr. X in activity programs, talking to him for 15 minutes twice daily and a volunteer is scheduled to visit him three times weekly. This has been discussed with his family and they are visiting him in the late afternoon when Mr. X demands more attention. This program has been in effect for one week and Mr. X is now eating better and shows some interest in the activity groups, and is less aggressive towards staff."

The plan of care should be updated to include a description of the behaviour to reflect the nursing diagnoses of potential for social isolation or ineffective coping, and potential for injury to others, and the interventions that are planned. Time and frequency of interventions must be included.

Another item to document under the safety section of your plan of care is potential for injury related to side rail use. When two bed rails are raised as a safety order, frequent checking is required.

POLICIES

LEVELS OF CARE CLASSIFICATION OF RESIDENTS

For example:

- Bed rails up x 2 for safety, check hourly when in bed.

INEFFECTIVE COPING

Ineffective coping reflects the resident's lack of ability to deal with individuals or with routine/daily living situations. Ineffective coping may reflect the resident's identified psychosocial strengths and weaknesses. The behaviours mentioned on the Provincial Resident Classification Form are by no means an exhaustive list.

Interventions are aimed at changing behaviours to improve coping ability, but may not be successful. Intervention for ineffective coping tends to be unpredictable, rather than on a routine schedule. Interventions are cumulative over a 24 hour period.

For example:

"Mrs. Y is sad."

Because no interventions are outlined with time and frequency, the resident does not qualify for points under ineffective coping.

The following example addresses time and frequency of interventions:

"Mrs. Y remains sad relating to the loss of a friend. Staff encourage Mrs. Y to verbalize her feelings and spend at least 20 minutes with her on evening and night shifts. Mrs. Y's family are very supportive and are willing to bring family members, friends or even the family pet to visit."

The plan of care identifies that Mrs. Y's sad behaviour is being addressed with outlined staff interventions. The progress notes refer to the interventions. Mrs. Y's needs will now be reflected under ineffective coping.

POLICIES

LEVELS OF CARE CLASSIFICATION OF RESIDENTS

CONTINUING CARE LEVEL

The last two indicators for classification are under the Continuing Care Level domain.

The Continuing Care Level section looks at Urinary Continence/Catheter Care - any inappropriate voiding causing hygienic or health risk; and Bowel Continence/Ostomy Care - any inappropriate bowel elimination causing hygienic or health risk. This area is usually well documented.

Management procedures refer to regular toilet aid or use of incontinence products.

Retraining refers to the teaching and supervision of a program to restore a normal pattern of continence. The resident must be mentally alert to cooperate in the retraining.

OTHER AREAS CLASSIFIERS LOOK AT

A number of other indicators are assessed by the classifier. The purpose of these indicators is to assist in the development of a total care profile of long-term care facility residents and to study trends. It would be helpful if this information is easy to find and current. The following indicators are assessed:

- Memory and Orientation
- Medications
- Communication
- Therapeutic Interventions
- External Demand Level (family involvement)
- Language
- Marital Status
- Current Medical Diagnoses
- Rehabilitation (OT and PT involvement)

MEMORY AND ORIENTATION

This section of the resident classification form is the most difficult to identify within the documentation.

POLICIES

LEVELS OF CARE CLASSIFICATION OF RESIDENTS

COMMUNICATION - VERBAL OR NON- VERBAL

This section generally has to be verified with the facility personnel. There is usually documentation that gives some indication as to the patient's status but often it is vague.

CHECKLIST OF ITEMS TO BE INCLUDED IN DOCUMENTATION

Here is a sample checklist for monthly documentation that you should have identified in your care plan. Be sure to consider that behaviours are different in evening, night and day shifts.

Eating

- no assistance
- open containers
- intermittent/constant guidance
- intermittent/constant help
- full feed

Toileting

- independent
- remind/assist to bathroom
- intermittent/constant guidance
- intermittent/constant help
- 2 persons

Transferring

- independent
- position equipment
- intermittent/constant guidance
- intermittent/constant help
- 2 person/mechanical lift

Dressing/Undressing

- independent
- help assemble clothes
- intermittent/constant guidance
- total help

POLICIES

LEVELS OF CARE CLASSIFICATION OF RESIDENTS

Bladder

- continent
- incontinent
- 2 hour toilet aid
- diapers
- remind to go to toilet
- take to toilet
- catheter

Bowel

- continent
- incontinent
- regular toilet aid
- diapers
- remind to go to toilet
- take to toilet

Behaviours

- wanders
- hoards
- aggressive
- angry
- agitated
- suspicious
- eats foreign substance
- inappropriate sexual behaviour
- smokes
- alcohol abuse
- drug abuse
- resists prescribed medications
- refuses care
- acts sad/depressed
- inappropriate requests for attention
- suicidal behaviour
- anxious
- grieving

POLICIES**LEVELS OF CARE CLASSIFICATION OF RESIDENTS**

- inappropriate dresser
- repetitive actions
- screams
- sleeplessness
- wants to go home
- unsteady gait
- choking
- falls
- hits at staff/residents
- manipulative
- inappropriate requests for attention by family
- family supportive

Time spent with resident

- to check for safety, or prevention
- to help resident cope

SUMMARY

The facility is not expected to totally change its documentation system. However, the documentation on Behaviours and possibly a few of the Activities of Daily Living indicators should be enhanced.

The Provincial Resident Classification System identifies the resident's needs in eating, toilet aid, dressing, transferring, potential for injury, ineffective coping, bladder and bowel care.

These are the eight indicators that are used for determining funding for nursing and personal care in long-term care facilities.

It is very important for facilities to have appropriate documentation, so that the annual levels of care classification will accurately reflect the nursing and personal care requirements of residents.

POLICIES

LEVELS OF CARE CLASSIFICATION OF RESIDENTS

Please do not "over document". Strive for clarity in documentation not quantity. Also remember that any attempt at self-classification of residents by the facility cannot be accepted by the classifier. The classifier must substantiate the resident's care requirements through the documentation.

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MAR 07 2002

MEMORANDUM TO: Long-Term Care Facility Administrators
Long-Term Care Facility Medical Directors/Advisory Physicians

FROM: Paul Tuttle, Director Long-Term Care Facilities

RE: Policy on Cardio-Pulmonary Resuscitation (CPR) and Do Not Resuscitate (DNR) Orders in Ontario Long-Term Care (LTC) Facilities

The attached policy directive is being distributed to long-term care facility administrators and medical advisors/directors in response to questions and concerns that have arisen on CPR and DNR orders in LTC facilities.

Facilities with well-developed resuscitation policies are commended. For facilities that need to develop or revise policies, the attached directive will provide the guidance for this task. We encourage you to access the many other resources available in professional standards, journal publications and on the Internet, for assistance in the process.

The development of appropriate resuscitation policies is a process that takes time as it involves discussions, education and often a culture shift for staff, residents and substitute decision makers. Ministry compliance staff will take this into consideration as they conduct reviews in LTC facilities. We expect LTC facilities that do not yet have appropriate resuscitation policies to continue working towards establishing them.

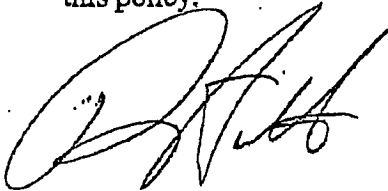
We are releasing this policy directive in coordination with the Advance Directives on Care Choices initiative of *Ontario's Strategy for Alzheimer Disease and Related Dementias*. Advance care planning is a key educational component of the *Advance Directives on Care Choices* initiative which aims to help seniors, persons with dementia, and health practitioners to become more aware of the process of advance care planning.

Early this year two educational and training products will be released in connection with the Advance Directives on Care Choices initiative led by the Ontario Seniors' Secretariat: *A Guide to Advance Care Planning* and an *Advance Care Planning Resource Manual*. The guide is designed for the general public and explains step-by-step what an individual needs to do to begin a process of advance care planning and provides answers to frequently asked questions. The resource manual is specifically designed for health practitioners that may be involved in discussing advance care planning with people in health care settings or as a result of contact with the person through health and community services.

.../2

The Ontario Long-Term Care Association and the Ontario Association of Non-Profit Homes and Services for Seniors as well as other experts in the field of advance care planning helped to develop these products. Comments from the Long-Term Care Facilities Operations and Programs Standards Committee have been incorporated into the policy directive. The MOHLTC policy on DNR/CPR is intended to complement the advance care planning material.

We appreciate your cooperation in ensuring that your resuscitation policies are developed or updated, in order to achieve consistency with current professional and clinical standards. Please contact your regional office if you require any clarification or assistance in implementing this policy.



Paul Tuttle
Director, Long-Term Care Facilities

Attachment

c.c. Ontario Association of Non-Profit Homes and Services for Seniors
Ontario Long-Term Care Association
Ontario Long-Term Care Physicians
Regional Directors
LTC Program Managers
Community Care Access Centres
Mary Kardos-Burton, Executive Director, Health Care Programs
Mindy Ginsler, Director, Operational Support Branch
Sharon Marsden, Manager (A), LTC Operational Support Unit
David Harvey, Manager, Planning Accountability and Evaluation Unit
Elizabeth Esteves, Manager Policy Initiatives, Ontario Seniors' Secretariat, Ministry of
Citizenship

Policy on Cardio-Pulmonary Resuscitation (CPR) and Do Not Resuscitate (DNR) Orders in Ontario Long-Term Care Facilities

1. CPR should not be initiated in anticipated deaths.

Cardio-pulmonary resuscitation (CPR) is used for sudden, unexpected cardio-pulmonary arrests, which are potentially reversible aberrations in cardiac activity that result in the cessation of cardiac output¹. Many deaths in long-term care facilities are a result of either terminal illness or chronic, multi-system medical problems. The initiation of CPR in these cases has little if any benefit and may in fact increase pain and suffering and prolong the dying process².

2. LTC facilities must develop resuscitation policies to guide staff in making appropriate decisions on whether or not to initiate CPR. A "blanket DNR" policy does not meet acceptable standards of care.

There are situations where resuscitation is the appropriate response to the cessation of cardiac output. LTC facilities must develop protocols and guidelines to assist staff in making the determination whether or not to initiate CPR where a resident has a cessation of cardiac function.

3. Physicians in LTC facilities are encouraged to identify expected outcomes of CPR for residents under their care.

The attending physician has a key role in the decision-making process for resuscitation. S/he can contribute by providing an assessment on the efficacy of resuscitation for residents under his or her care. Generally, there are four categories of outcomes expected from resuscitation³:

- people who are likely to benefit from CPR;
- people for whom benefit is uncertain;
- people for whom benefit is unlikely; and
- people who almost certainly will not benefit.

Physicians are encouraged to document assessments on the expected outcomes of resuscitation to inform staff, residents and substitute decision-makers. Physicians should discuss assessments with residents or the residents' substitute decision-makers if the residents are not capable in respect to treatment.

4. A Resident should be invited to express his/her wishes for life-sustaining treatment, after being provided with the information on the physician's assessment and the expected outcomes of CPR. If wishes are expressed, then these should be documented. If a resident is not mentally capable for treatment, the resident's appropriate substitute decision-maker for consent/refusal of consent to treatment should be

provided with this information and this issue addressed and documented in the plan of treatment.

Where an individual resident is a potential candidate for CPR, the LTC facility should identify and document the resident's wishes, if known, with respect to CPR. Residents may state their wishes orally, in a written form, or communicate these wishes by any other means (Health Care Consent Act s. 5(1), (2)). The LTC facility cannot require a resident to use a particular form of written advance directive but may facilitate discussions with residents on the options of expressing wishes now about future treatment, including life-sustaining or end-of-life treatment, in the event that they become incapable of providing consent/refusal of consent to treatment. (see *Advance Care Planning Resource Manual* and *A Guide to Advance Care Planning* to be released in 2002 as part of the Advance Directives on Care Choices Initiative under Ontario's Strategy for Alzheimer Disease and Related Dementias). Residents cannot be refused admission or continued residence to or in a LTC facility because they or their substitute decision-makers refuse to sign a facility form concerning CPR or end-of-life care.

Where a resident is not capable of giving or refusing consent to treatment, as determined in accordance with the Health Care Consent Act (HCCA), and after the alleged incapable resident has been provided with the appropriate rights information and opportunity to challenge the finding of incapacity before the Consent and Capacity Board, these discussions should take place with the resident's substitute decision-maker (as defined by the HCCA). Substitute decision-makers are entitled to receive the same information about the risks and benefits of treatment, as the resident would have if capable in giving or refusing an informed consent.

Substitute decision-makers cannot do advance care planning for incapable residents, and cannot execute advance care directive documents on behalf of an incapable resident but can provide consent or refusal of consent to treatments, including CPR and end-of-life treatments, in a "plan of treatment" in the context of the incapable resident's *present health condition*.

A "plan of treatment" means a plan that:

- (a) is developed by one or more health practitioners,
- (b) deals with one or more of the health problems that a person has and may, in addition deal with one or more of the health problems that the person is likely to have in the future given the person's *present health condition*, and,
- (c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's *present health condition*. (HCCA s.2)

It is acknowledged that the admission period is a stressful time for residents and their families. The timing of this discussion will therefore vary with the individual situation.

5. Where residents are potential candidates for resuscitation, they (or where incapable, their substitute decision-makers) must be given the information necessary for them to make informed decisions about CPR.

Residents or their substitute decision-makers must be free to make their own decisions. It is important that residents or their substitute decision-makers be encouraged to participate in full and informed decisions concerning treatment options. The consequences of different treatment choices should be clearly explained to the resident or his/her substitute decision-maker.

This should include the benefits and risks involved in such treatment and the probabilities of a successful outcome. Regular reviews of the resident's resuscitation decisions are required and should be documented when a resident's condition changes, with any revisions communicated to other members of the care team.

6. CPR is initiated for an actual cardiac arrest in the absence of a DNR order or an expressed wish not to be resuscitated.

If there is no DNR order or the resuscitation wishes of the resident are unknown, LTC facility staff should proceed with CPR only for an actual cardiac arrest. The following principles, should guide health care professionals in determining the appropriateness of initiating CPR⁴:

- The arrest should have been witnessed by a reliable observer or have occurred within minutes of when the patient was last seen functioning normally.*
- The event should have been unexpected, given the clinical situation. Anticipated deaths should not be treated as cardiac arrests.
- The patient should not be suffering from a complex, multi-system medical problem that has been shown not to benefit from CPR (e.g. overwhelming sepsis, end-stage cardiorespiratory dysfunction, severe metabolic abnormality or a recent catastrophic cerebrovascular event).[†]
- The patient clearly does not have an illness for which death would be the expected outcome. (e.g. an untreatable malignancy or end stage neurological disorder).

7. CPR should not be initiated if there is a DNR order or where facility staff knows that the resident does not wish to be resuscitated.

* Health professionals must use their expert clinical judgement to determine whether to proceed with CPR, taking into account signs such as absence of vital signs, skin discolourization, lividity, fixed stare, corneal opacification or rigour mortis.

[†] Conditions such as "overwhelming sepsis" and "severe metabolic abnormalities" are conditions regarded by physicians as end stage disorders, similar to "end stage cardiorespiratory dysfunction" and "catastrophic cerebrovascular event". It should be noted that such patients have been treated for their sepsis and metabolic abnormalities, but have not responded and have deteriorated to a point where further treatment would be futile in reversing or stemming the process.

In the event of a cardiac arrest, CPR is not initiated if the resident's wish for no resuscitation is known to the facility staff through any form of advance care plan or plan of treatment. This would include wishes about no resuscitation expressed orally, in a written document (power of attorney for personal care or other advance directive/living will) or by any alternative means of communication (i.e. Bliss Board etc). The resident's wish for no resuscitation is to be followed even in the absence of a physician's DNR order⁵.

- 8. LTC facility staff should initiate CPR at the Basic Cardiac Life-Support (BCLS) level until emergency/ambulance personnel arrive to initiate Advanced Cardiac Life-Support (ACLS). It is important that LTC facility staff not wait for emergency/ambulance staff to initiate CPR.**

Where CPR is determined to be the appropriate action, LTC facility staff should initiate BCLS as soon as they have determined that an actual cardiac arrest has occurred. Survival is dependant on the rapidity of emergency response services, with improved outcomes when CPR is initiated within four minutes of the onset of cardiac arrest.

BCLS involves the application of artificial ventilation (mouth-to-mouth resuscitation or bagging) and chest compressions. Where CPR is the appropriate response, facility staff must initiate BCLS within four minutes of the cardiac arrest and continue until the arrival of emergency/ambulance personnel. It is important that facility staff not wait for emergency/ambulance personnel to start CPR as the chance of survival is enhanced with a quick response.

ACLS activities include intubation and defibrillation. Long-term care facilities are not expected to provide ACLS in the event of a cardio-pulmonary arrest. Once emergency personnel arrive, they can initiate ACLS.

- 9. Registered Nurses and Registered Practical Nurses are expected to be able to perform CPR at the BCLS level.**

The College of Nurses of Ontario (CNO) has determined that the ability to perform CPR at a Basic Cardiac Life-Support level is a competency expected of both registered nurses and registered practical nurses, relevant to their practice. As CNO registrants are expected to perform CPR in LTC facilities, each registrant practising in this setting has a responsibility to maintain competency in performing CPR. Competency may be acquired through activities such as formal certificate programs, workplace inservices, and practical experience. Annual registration with CNO does not require proof of a formal credential in CPR. However, employers may have specific requirements relating to competence in CPR⁶.

- 10. LTC facilities should develop policies to address conflicts between or among care providers, residents, families or substitute decision-makers with respect to end-of-life issues.**

The needs, values and preferences of residents should be a primary focus in determining a plan of care. However, conflict may arise where views differ on the right thing to do in the face of threats to life, health or well being. For example, professional assessment on efficacy of treatment may clash with cultural, religious or ethnic values with respect to resuscitation decisions. Conflicts may arise between or among care providers, residents, families or substitute decision-makers. As well as policies to avert potential conflicts, it is important for facilities to have a process in place for conflict resolution⁷.

LTC facilities should develop a conflict resolution process with multi-disciplinary input. In order to support and promote an open process, the process should be accessible to all residents and families/substitute decision-makers.

Conclusion

In summary, a blanket DNR policy does not conform with generally accepted standards of care, as it potentially denies appropriate care and choice to residents. As well, where CPR is the appropriate action, LTC staff must initiate CPR at the BCLS level until the arrival of emergency/ambulance personnel. It is expected that all LTC facilities will have policies and processes in place to guide decisions on CPR and resolve conflicts as they arise.

The decisions relating to CPR and DNR are complicated but the process should respect the residents' attitudes and beliefs balanced with the professional assessments and advice of the health care team.

¹ Gordon, M, Cheung M; DNR policy and CPR practice in geriatric long-term institutional care [editorial], *Can Med Assoc J* 1991; 145(3):209-212

² Canadian Nurses Association (1995). Policy Statement: Joint Statement on Resuscitative Interventions. In conjunction with the Catholic Health Association of Canada, the Canadian Healthcare Association, the Canadian Medical Association and with the co-operation of the Canadian Bar Association. Ottawa: Author. Also available at www.cna-nurses.ca

³ Ibid p.3

⁴ Gordon, M, Cheung M; DNR policy and CPR practice in geriatric long-term institutional care [editorial], *Can Med Assoc J* 1991; 145(3): 209-212

⁵ College of Nurses of Ontario (1999) Resuscitation Standard for Nurses in Ontario (revised 1999) for Registered Nurses and Registered Practical Nurses in Ontario. Toronto: Author, p.8

⁶ College of Nurses of Ontario (1999) Resuscitation Standard for Nurses in Ontario (revised 1999) for Registered Nurses and Registered Practical Nurses in Ontario. Toronto: Author, p. 4.

⁷ Canadian Nurses Association and others. (1999) Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving care, Ottawa, Author. Also available at www.cna-nurses.ca.

Additional references:

Canadian Healthcare Association, Canadian Medical Association, Canadian Nurses Association, Catholic Health Association of Canada ; Making Decisions About CPR

Also available at http://206.191.29.104/pages/resources/making_decisions_about_cpr.htm

Canadian Nurses Association (1994) Policy Statement: Joint Statement on Advance Directives

Also available at www.cna-nurses.ca

Canadian Nurses Association (1996) Policy Statement: Joint Statement on Resuscitative Interventions

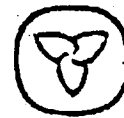
Also available at www.cna-nurses.ca

Canadian Nurses Association (1997) Code of Ethics for Registered Nurses

Ersek, M, Miller Kraybill, B, & Handsberry, J; Assessing the Educational Needs and Concerns of Nursing Home Staff Regarding End-of Life-Care. *Journal of Gerontological Nursing* October 2000: 16-25

Moorehouse, A; When CPR is not an option, *Canadian Nurse* 97 (1), January 2001

Rempusheski, V.F, Hurley, A.C; Advance Directives and Dementia. *Journal of Gerontological Nursing* October 2000: 28-34



Assistant Deputy Minister
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Sous-ministre adjoint
Programmes des soins de santé
Édifice Hepburn, 9^e étage
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January 31, 2000

Memorandum To: Long-Term Care Facility Administrators
Donna Rubin, Executive Director
Ontario Association of Non-Profit
Homes and Service for Seniors
Vida Viatonis, Executive Director
Ontario Nursing Home Association

From: John King, Assistant Deputy Minister
Health Care Programs

Re: Laboratory Services in Long-Term Care Facilities

The Ontario Association of Medical Laboratories (OAML) has indicated that private medical laboratories will no longer be providing phlebotomy services and unscheduled pick-up of specimens at no charge to long-term care facilities effective February 1, 2000.

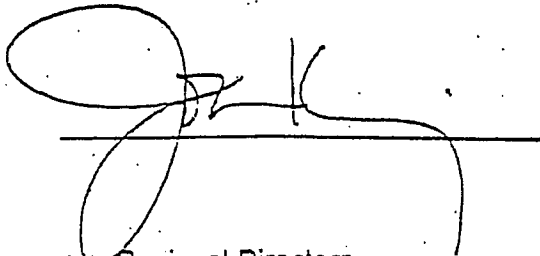
The Ministry of Health and Long-Term Care funds private medical laboratories, on a fee-for-service basis, to carry out laboratory procedures, including patient documentation and specimen handling for people in the community. In addition, the Ministry funds private medical laboratories to pick up specimens and test specimens from residents of Long-Term Care facilities.

In the past, many private medical laboratories also provided phlebotomy services and unscheduled specimen pick-ups free of charge to nursing homes and homes for the aged, although these services were not funded by the Ministry of Health and Long-Term Care. Private laboratories have indicated that they can no longer provide this service free of charge.

In the short-term, until the end of the fiscal year 1999/2000 we are using the High Cost/ Equipment/Supplies Program to assist long-term care facilities in defraying the costs of these laboratory services not funded through the existing payment system for private medical labs. We will convene a working group immediately composed of Ministry staff and representatives for the Ontario Association of Non-Profit Homes and Services for Seniors and the Ontario Nursing Home Association to identify utilization patterns in long-term care facilities and to develop a process for the processing of claims and any clinical protocols that may be involved.

Utilization of this fund is an interim solution until the working group has examined other options that may be more appropriate to ensure availability or access to these services.

We ask all long-term care facilities, in the meantime, to take advantage of scheduled pick-ups whenever possible. We look forward to working with you and your associations to identify a long-term solution to this issue.

A handwritten signature in black ink, consisting of a large, stylized 'J' followed by 'K' and a long horizontal line extending to the right.

c.c. Regional Directors

Ministry of Health
and Long-Term Care

Assistant Deputy Minister
Health Care Programs

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Ministère de la Santé
et des Soins de longue durée

Sous-ministre adjoint
Programmes de soins de santé

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JUN 15 2000

MEMORANDUM TO: Long-Term Care Facility Administrators

FROM: John King
Assistant Deputy Minister
Health Care Programs

RE: Payment for Phlebotomy Services for Long-Term Care
Facility Residents - April 1, 2000

As indicated in my January 31, 2000, memorandum to Long-Term Care facilities, the Ontario Association of Medical Laboratories has announced that private medical laboratories will no longer provide phlebotomy services and unscheduled collection of specimens at no charge to facilities effective February 1, 2000.

Until the Ministry has a longer term solution in place to address this service need, the Ministry will reimburse facilities for the cost of phlebotomy services and urgent specimen collection until March 31, 2001.

Facilities should make every effort to provide these services in the most cost-effective manner available, and ensure that services are provided on a scheduled basis whenever possible. The Ministry will be working with the representatives of the Ontario Association on Non-Profit Homes and Services for Seniors and the Ontario Long-Term Care Association to develop clinical protocols for the laboratory services most frequently required by facility residents.

Long-term care facilities may submit one claim form for reimbursement to Regional offices for costs incurred for the period February 1 to March 31. Payment for the February 1 to March 31 period will be made as a special payment.

For the fiscal year 2000/2001, facilities should submit one claim form for each quarter. Payment for each quarter will be made in the next scheduled payment to the facility.

...12.

Claims for reimbursement should be submitted to the Regional Office according to the following schedule:

<u>Period</u>	<u>Due to Region</u>
February 1 to March 31, 2000	June 30, 2000
April 1 to June 30, 2000	July 15, 2000
July 1 to September 30, 2000	October 15, 2000
October 1 to December 31, 2000	January 15, 2001
January 1 to March 31, 2001	April 7, 2001*

* Note: it may be necessary to project costs for this period, which can be reconciled to actual costs when all invoices are available.

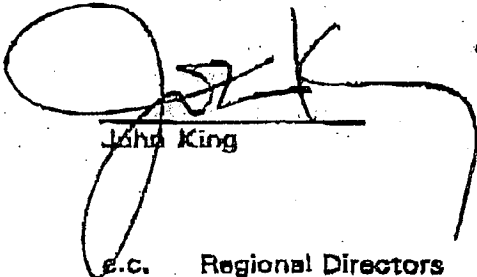
Please ensure that all invoices are attached to your claim forms.

Reimbursement will be paid based on the actual cost of the service, regardless of whether the service was provided by a private medical laboratory, purchased from another provider or provided by staff hired by the facility to provide phlebotomy services. Charges for phlebotomy services and specimen collection should not exceed the tariff proposed by the Ontario Association of Medical Laboratories, specifically:

- Phlebotomy services provided at a prescheduled time - fee of \$50 per visit plus \$5 for the second and each additional resident.
- Phlebotomy services provided at times other than regularly scheduled visits - fee of \$75 per visit plus \$5 for the second and each additional resident, and
- Courier services to pick up specimens at times other than regularly scheduled pick up times - fee of \$25.

The claim form and instructions for its use are attached. Also attached for your information, is a questions and answers document to assist you in addressing service access and quality concerns, and in negotiating contracts with laboratory service providers.

We are continuing to seek a long-term funding solution to this issue, and will provide you with further information in the near future. Please call Irv Kirstein at (416) 327-7366 if you need further assistance.



John King

s.c. Regional Directors
 Jenny Rejaballey, Director, Operational Support Branch
 Dawn Ogram, Director, Laboratories Branch

MINISTRY OF HEALTH AND LONG-TERM CARE**Laboratory Services in Long-Term Care Facilities****Reimbursement Process for Phlebotomy Services and
Urgent/Stat Specimen Collection****Overview**

An interim reimbursement system is being implemented to assist Long-Term Care Facilities in defraying the costs of phlebotomy services and urgent/STAT specimen collection, which are not funded through the existing payment system for private medical laboratories.

Eligible Expenditures

Facilities will be reimbursed for the cost of phlebotomy services and urgent/STAT (i.e., non-routine) specimen collection incurred on or after February 1, 2000, until March 31, 2001. Charges incurred prior to February 1, 2000 will not be reimbursed.

Reimbursement Process

The facility completes the Reimbursement Form and attaches a copy of each invoice for which the claim applies. The invoice should detail the date(s) of service, the services provided on that date, the number of residents who required the service on that date and the cost of service.

Reimbursement will be based on the actual cost of service, whether the service was provided by a private medical laboratory, purchased from another provider or provided by staff hired by the facility to provide phlebotomy services.

Facilities that incurred costs for phlebotomy and urgent specimen pick up in February and March should submit one reimbursement form for the period ending March 31, 2000. The claim for reimbursement should be forwarded to the Regional Office.

Payment for February and March billings will be issued as a special payment.

Facilities should submit one claim form for each quarter in 2000/2001 to the Regional Office. Payment will be made in the next scheduled payment to the facility.

Claims for reimbursement should be submitted to the Regional Office according to the following schedule:

<u>Period</u>	<u>Due to Region</u>
February 1 to March 31, 2000	June 30, 2000
April 1 to June 30, 2000	July 15, 2000
July 1 to September 30, 2000	October 15, 2000
October 1 to December 31, 2000	January 15, 2000
January 1 to March 31, 2001	April 7, 2001*

* Note: it may be necessary to project costs for this period, which can be reconciled to actual costs when all invoices are available.

Ministry of Health and Long-Term Care

Laboratory Services In Long-Term Care Facilities

Reimbursement Form for

Phlebotomy Services and Urgent/STAT Specimen Collection

Name of LTC Facility: _____

Number of Beds: _____

LTC Region: _____

Billing Period From: _____ To: _____

IMPORTANT: Please attach all invoices and include the following summary information:

Number of residents requiring phlebotomy services during this period: _____

Number of visits by the phlebotomist during this period: _____

Number of urgent or stat specimen collections required during this period (i.e., specimen pick-ups required outside of regular scheduled collection times as a result of resident needs): _____

# of Invoices Attached	Total Cost

Signature of Facility Official

Date

Approved for payment:

Regional Office

Date

**LABORATORY SERVICES
Questions and Answers**

- **What laboratory services should LTC facilities expect from their community laboratories?**

Routine services: laboratory testing for tests in the Schedule of Benefits, laboratory supplies and scheduled pick ups of samples from Monday to Friday.

These services will continue to be provided free of charge to LTC facilities.

- **What is included in supplies?**

- Vacutainer Tubes
- Blood sampler
- 24 hr. urine container
- Alcohol swabs
- Blood culture kits
- Chlamydia media
- Cotton balls
- Culture swabs with media -charcoal
- Cytology pap kits
- Cytology requisitions
- Fungal kits
- Histology kits
- Micropore tape
- Multi sample needles
- Needle holders
- Pediatric urine collector
- Sharp disposal containers
- Sterile urine/sputum containers
- Tourniquets, reclosable bags

The laboratory performing the testing for the LTC facility will provide these supplies.

- **How can LTC facilities access OHIP requisitions directly?**

OHIP requisitions are available at no cost from:

**DATA BUSINESS FORMS
2 SHAFTSBURY LANE
BRAMPTON ONT
L6T 3X7
(905) 791-3480 ext. 482.**

OHIP requisitions for testing must be signed by the physician who orders the laboratory tests for the resident.

- **How can LTC facilities access the *Schedule of Benefits for Laboratory Services*?**

The schedule of benefits is available on the Ministry of Health and Long-Term Care website at www.gov.on.ca/health.

- **Why are the community laboratories charging LTC facilities for phlebotomy and pick-up?**

The Ontario Association of Medical Laboratories (OAML), which represents community laboratories, has indicated that their members can no longer provide phlebotomy services free of charge to long-term care facilities. In the past, laboratories provided these services to long-term care facilities at no cost to attract business from the facilities. With the introduction of a provincial cap on funding for laboratory services and corporate caps on the individual laboratories, the laboratories are not prepared to offer this service free of charge.

- **What are the services for which LTC facilities will be charged?**

The OAML tariff includes a fee guide for the provision of this and other non-routine, "uninsured" services in long-term care facilities, including:

- Phlebotomy services provided at a prescheduled time (fee of \$50 per visit plus \$5 for the second and each additional resident)
- Phlebotomy services provided at times other than regularly scheduled visits (fee of \$75 per visit plus \$5 for the second and each additional resident)
- Courier services to pick up specimens at times other than regularly scheduled pick up times (fee \$25 per visit)

Consultation services, including consultation on infection control, audits, accreditation, in-service education (fee \$50 per visit).

- **What are the options for a LTC facility to obtain phlebotomy services?**

The range of options available to long-term care facilities include:

- Hiring or training staff to provide phlebotomy services and contracting analysis and pick up services from hospitals or private medical labs. Facilities that choose this option should ensure that they have appropriately qualified and trained staff and there are provisions to ensure continuing competency in phlebotomy and back-up for vacation or illness.

- Purchasing phlebotomy services from private medical laboratories or hospitals, either individually or in collaboration with other facilities or agencies (e.g., CCACs)
- Sharing staff amongst a group of facilities

- **What is the role of the OAML and what is the working relationship between the Ministry and the OAML?**

The OAML is the association that represents 98% of all community laboratories and negotiates laboratory funding for community laboratories with the Ministry of Health and Long-Term Care. As part of the negotiated contract, standing committees have been formed to review laboratory issues relating to tests in the Schedule of Benefits and use of laboratory services. The Ministry discusses any problems that have been identified in the delivery of community laboratory services with the OAML.

- **What is the process for Long-Term Care facilities to report access or quality concerns relating to laboratory services to the Ministry?**

Any concerns relating to lack of access to laboratory services or quality issues should be brought to the Ministry's attention, in writing. Depending on the issue the Ministry will work with stakeholders to resolve the issue.

Contact:

Laboratory Licensing and Inspection Service
 Box 9000, Terminal "A"
 Toronto ON M5W 1R4

Phone: 416-235-6054

Fax: 416-235-6282

- **What are the options for a LTC facility if it cannot find a community laboratory to provide laboratory services to their facility?**

Any LTC facility finding itself in this position should contact the Compliance Advisor at the appropriate Regional Ministry of Health and Long-Term Care Office, who will liaise with other parts of the Ministry to resolve the issue.

- **What should long-term care facilities consider in negotiating contracts with laboratory service providers?**

LTC facilities should be discussing the details of the laboratory services, including supplies, specimen pick-up and testing with the private laboratory provider.

There should be a written contract between the long-term care facility and the provider(s) of laboratory and phlebotomy services. In negotiating contracts with laboratory services providers, long-term care facilities should consider the following:

- the quality management expectations for laboratory services, including but not limited to provision of laboratory supplies, frequency of pick up of specimens, instructions on collection, storage and transportation of specimens and documentation to track utilization of laboratory services.
- providing reports for each resident within a mutually agreed upon time, in accordance with resident needs and accepted laboratory practices.

For the following services, the details that should be discussed with laboratory service providers, and should be agreed upon are:

1. Phlebotomy services and stat pick-up of specimens (can be contracted from a variety of providers):

- routine phlebotomy
- stat phlebotomy
- stat pick-up of specimens
- costs for each service
- contacts for resolution of issues and timeliness of responses

2. Laboratory testing:

- supplies to be provided at no cost by the laboratory performing the testing
- frequency of routine pick-up of specimens and flexibility of pick-ups depending on the type of specimens to be picked up, e.g.: fasting blood glucose and INR
- method of reporting for stat, abnormal and routine results, e.g.: phoned, faxed to ordering physician
- turnaround times for test results, both stat and routine to ordering physician
- consultation and interpretation of test results
- instructions on patient preparation and collection of specimens
- summary report on organisms identified in the facility for infection control
- contacts for resolution of issues within an agreeable timeframe

March 30, 2000

Ministry of Health
and Long-Term Care
5th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 1R3

Ministère de la Santé
et des Soins de longue durée
Édifice Hepburn, 5 ième stage
80 rue Grosvenor
Toronto ON M7A 1R3



MAY 06 2002

MEMORANDUM TO: Long-Term Care Facility Administrators

FROM: Paul Tuttle
Program Director, Long-Term Care

RE: **Payment for Phlebotomy Services for Long-Term Care Facility Residents**

I am writing to provide an update of the June 15, 2000, memorandum to Long-Term Care Facility Administrators, where Assistant Deputy Minister, John King indicated that the Ontario Association of Medical Laboratories (OAML) announced that private medical laboratories would no longer provide free phlebotomy services and unscheduled collection of specimens to facilities and that the Ministry of Health and Long-Term Care (MOHLTC) would fund these services. Until a resolution has been developed, the MOHLTC will continue to fund phlebotomy services and unscheduled collection of specimens beyond the original specified date of March 31, 2001, until further notice.

The Ministry is still in the process of developing and implementing a methodology to best address this funding issue. The Ministry continues to work with representatives of the Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) and the Ontario Long-Term Care Association (OLTCA) to develop clinical protocols for laboratory services most frequently used by facility residents.

Facilities should continue to make every effort to provide these services in the most cost-effective manner available, and on a scheduled basis whenever possible. For the fiscal year 2002/2003, Long-Term Care facilities should continue to submit one claim for each quarter. Payment for each quarter will be processed as part of the next scheduled payment to the facilities.

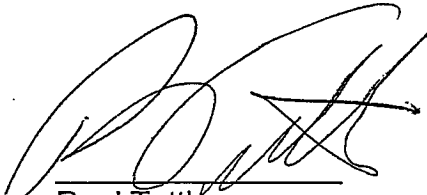
Charges for phlebotomy services and specimen collection should not exceed the tariff proposed by the OAML. Reimbursement is paid based on the actual cost of the service, to a maximum amount prescribed by the OAML tariff, regardless of whether the service was obtained by a private medical laboratory, purchased from another provider scheduled by the facility specifically for phlebotomy services.

.../2

Specifically, charges should not exceed:

- Phlebotomy services provided at a prescheduled time – fee of \$50 per visit plus \$5 for the second and each additional resident,
- Phlebotomy services provided at times other than regularly scheduled visits – fee of \$75 per visit plus \$5 for the second and each additional resident, and
- Courier services to pick up specimens at times other than regularly scheduled pick-up times – fee of \$25.

We are working to reach a long term funding solution to this issue and will provide you with further information in the near future.



Paul Tuttle

c: Regional Directors

Mary Kardos Burton
Executive Director, HCP

John McKinley,
Director, Finance and Information Management Branch

Dawn Ogram,
Director, Laboratories Branch

Gail Paech,
ADM & CEO, LTC Redevelopment Project

HIGH INTENSITY NEEDS FUND MANUAL FOR LONG-TERM CARE HOMES

Ministry of Health and Long-Term Care
Revised November 2007



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WHAT'S NEW IN THE HINF MANUAL

Section	New/Revised	Details
2.2 Eligibility Criteria	NEW	A list of eligibility criteria has been added to ensure consistent application and approval of the HINF.
3.3 Enteral Nutrition Support	NEW	Effective July 1, 2007, the Ministry will provide full reimbursement for both enteral nutrition and raw food until the resident returns to raw food only, for residents who require both. Assessment by a Registered Dietitian with the appropriate recommendation is required.
3.9 Treatment Equipment/Supplies and Transferring Equipment	REVISED	The policy on transferring equipment has been clarified to ensure consistency across all homes. The term 'morbidly obese' has been defined for the purposes of the Fund.
3.10 Transportation for Dialysis Treatment	REVISED	Changes to the transportation policy have been made to provide clarity. The Ministry will continue to provide funding to LTC homes to cover the costs of transportation for dialysis treatment, subject to the requirements outlined in the Manual.
3.11 Preferred Accommodation	REVISED	The preferred accommodation policy has been clarified to ensure consistency across all homes.
3.12 Supplementary staffing	REVISED (November 2007)	The supplementary staffing policy has been clarified to ensure consistency across all homes.
4.4 Reimbursement Process	REVISED	Effective July 1, 2007 all NHCSR forms must be signed by a Compliance Advisor before a claim is submitted.
5.0 Reporting Requirements	NEW	Effective July 1, 2007, the Ministry will implement a quarterly performance reporting process for all LTC homes. Homes will be required to submit information related to their utilization of the HINF.
6.0 Record Keeping Requirements	NEW	This section has been added to the Manual, however, record keeping requirements are unchanged.
Appendix 1: HINF Equipment and Supply List	NEW	An updated list of equipment eligible for funding through the HINF has been added to the Manual to serve as an easy reference guide.
Appendix 2: High Intensity Needs Claim Form	NEW	The claim form is unchanged, but has been added to the Manual to serve as a reference.
Appendix 3: Notification of High Cost Service Requirement Form	REVISED	This form has been revised; instructions for completion have been added.

1.0 PURPOSE

The High Intensity Needs Fund (HINF) is primarily designed to prevent unnecessary admissions to hospitals and to enable the discharge of patients from hospitals to long-term care (LTC) homes.

The HINF program aims to meet the care requirements of high needs residents in LTC homes in an effective, sustainable, accountable and integrated manner. It supports LTC homes to fund the extraordinary treatment costs of residents with acute or intensive service needs.

2.0 HINF PROGRAM OVERVIEW

2.1 PROGRAM REQUIREMENTS

In addition to the specific conditions detailed throughout this Manual, LTC homes are expected to meet the following general guidelines before accessing the HINF:

1. Examine all other resources and sources of funding. For example:
 - Suppliers/vendors may incorporate consultation, instruction and education in the cost of supplies or equipment;
 - Hospitals may provide some supplies on a short-term basis when the resident is discharged, or alternatively may provide some supplies or equipment as a result of volume purchasing;
 - Professional staff contracted through the Community Care Access Centre (CCAC) may be available to teach staff of LTC homes to perform treatment procedures or clinical interventions of particular acuity/intensity; and
 - Professional staff such as physiotherapists and occupational therapists may be contracted through the CCAC or other service providers to undertake some types of procedures or clinical interventions.
2. Obtain a professional assessment by a clinician who has current knowledge and appropriate expertise in the procedure. Most assessments can be completed without additional cost to the home by CCAC staff, physicians or LTC home staff, depending on the expertise required and available for a particular condition. For more detailed information on assessments, see section 3.1.
3. Obtain, where required, a written treatment order from a physician.
4. Ensure that the supplies, equipment and/or services used provide the most clinically appropriate product in the most cost-effective way. The Ministry suggests that homes acquire quotes from a variety of suppliers when high cost items are being considered for use. Experts who are independent of commercial suppliers are often the best source of objective advice on appropriate equipment/supplies.
5. Be prepared to provide the appropriate support and follow through with the treatment plans outlined.
6. Obtain **pre-approval** from a Compliance Advisor and document this on the Notification of High Cost Service Requirements for the following items (see Section 4.3 for further details):
 - i. Equipment purchases over \$2,000; and
 - ii. Regardless of cost, the following items:
 - Therapeutic surfaces for Stage II ulcers (refer to section 3.5);

- Transfer equipment for the morbidly obese (refer to section 3.9);
 - Transportation of residents to and from treatment sites for dialysis treatment (refer to section 3.10);
 - Preferred accommodation fee for residents who may require a private room for treatment purposes (refer to section 3.11);
 - Supplementary staffing (refer to section 3.12); and
 - Training for LTC home staff in specific procedures (refer to section 3.13).
7. Obtain written verification that the treatment is clinically necessary and, without the HINF, the resident would require transfer to hospital, would be unable to be discharged from hospital, or is at risk of causing or contributing to significant harm to self or others.
8. Ensure that all resources available at the LTC home are exhausted prior to accessing the HINF. The HINF can only be used to acquire supplies, equipment and/or services that the LTC home currently does not have access to.

Additional Funding Details:

The frequency of order placement for equipment/supplies will vary by home. In order to avoid waste and the need for storage, the purchase of large amounts of supplies in advance is not recommended.

- A. Supplies, equipment and/or services that are not covered may be considered for funding if:
- They are medically essential; and,
 - The resident will remain in hospital or will require admission to the hospital if the item(s) are not provided in the LTC home.
- B. Funding is provided on a case by case basis to meet the needs of individual residents who require specific, identified clinical interventions. The HINF is to be used for no other purpose.
- C. LTC homes are expected to use their Levels of Care per diem whenever possible.
- D. The frequency of order placement for equipment/supplies will vary by home. In order to avoid waste and the need for storage, the purchase of large amounts of supplies in advance is not recommended.

2.2 ELIGIBILITY CRITERIA

NEW▶ Effective July 1st, 2007, residents must meet criteria 1, 2, 3 **AND** one of 4a, 4b **OR** 4c to be eligible for support from the High Intensity Needs Fund.

1. Resident is in a long-term care home. This excludes convalescent care residents.

AND

2. Resident requires support from one of the following high needs categories as defined in the High Intensity Needs Funds Manual:

- Assessments (section 3.1)
- Complete nutritional supplement support (section 3.2)
- Enteral Nutrition Support (section 3.3)
- Total Parenteral Nutrition (TPN) (section 3.4)

- Wound care (section 3.5)
- Extraordinary costs for ostomy supplies (section 3.6)
- Extraordinary costs for oxygen (section 3.7)
- Vital processes and pain management (section 3.8)
- Treatment equipment/supplies and transferring equipment (section 3.9)
- Transportation for dialysis treatment (section 3.10)
- Preferred accommodation (section 3.11)
- Supplementary staffing (section 3.12)
- Training for LTC home staff in specific procedures (section 3.13)

AND

3. Resident has identified risk factors for significant functional decline. Identified areas of risk may include but are not limited to: behaviours, nutrition, renal, bladder, pain, respiratory, bowel and wounds.

AND

- 4a. Resident would require transfer to hospital without this support
- OR**
- 4b. Resident would be unable to be discharged from hospitals without this support
- OR**
- 4c. Resident is at risk of causing or contributing to significant harm to self or others.

2.3 WHAT IS FUNDED BY THE HINF?

The HINF is available to LTC homes to acquire specific types of high cost supplies, equipment and/or services to support interventions that are not traditionally provided or available in LTC homes, and are necessary to support essential treatment or to prevent hospitalization. Funding is provided until:

- Staff in the LTC home can be taught to independently carry out a specific treatment intervention;
- Resident needs have been addressed and there is no further need for treatment; or,
- Frequency of treatment intervention has been reduced to a level that can be adequately managed by the home within its existing Levels of Care per diem.

Subject to the requirements of this Manual, the following items are eligible for funding by the HINF:

- Complete Nutritional Supplement Support
- Enteral Nutrition Support
- TPN Supplies & Equipment
- Wound Care Products/Supplies
- Equipment & Supplies to support vital processes for pain management
- Treatment/Transfer Equipment and Supplies
- Transportation for Dialysis
- Preferred Accommodation
- Training
- Supplementary Staffing
- Ostomy Supplies
- Oxygen Supplies and Equipment
- Assessments

2.4 WHAT IS NOT FUNDED BY THE HINF?

Funding is not provided for supplies, equipment and/or services that are:

- Normally covered by the home's Levels of Care per diem;
- Eligible for funding through other Ministry programs, e.g. Home Oxygen Program (HOP), Assistive Devices Program (ADP), Ontario Drug Benefit Program (ODBP) (residents will continue to be responsible for any co-payments under these programs); or,
- Supporting a treatment that a resident may wish, but which is not essential to prevent significant harm to self or others, or hospitalization.

Funding is also not provided for expenses that exceed normal reasonable costs for the supplies, equipment and/or services. Whether any given expenditure meets the requirements and criteria of this Manual will be determined in the sole discretion of the Ministry, so it is important, in the event of any uncertainty, to check with the Ministry in advance.

3.0 SUPPLIES, EQUIPMENT AND/OR SERVICES COVERED

The following describes the clinical indicators, costs covered, conditions and duration of funding for each category of supplies, equipment and/or services eligible for funding.

3.1 ASSESSMENT

In order for supplies, equipment and/or services to be provided through the HINF, a resident must have a clinical assessment to support the treatment plan of these supplies, equipment and/or services. Assessments may be conducted by any person who has the clinical expertise to determine the need for a specific treatment or service option.

Most assessments can be completed without additional cost to the LTC home by CCAC staff when available, physicians, or LTC home staff, depending on the expertise required and available for a particular condition.

Where the usual sources of assessments are not available without unreasonably long delays, the HINF may be used to fund assessments by other providers.

Requirements

- Any condition for which the HINF is used and which requires a clinical assessment;
- There is no one within the LTC home with the expertise to make an assessment to determine an appropriate treatment plan; and,
- Assessment through the CCAC is not available or not available without an unreasonably long delay.

Eligible Costs

- Cost of initial clinical assessment or reassessments for the purpose of determining treatment plan related to supplies, equipment and/or services eligible for funding under the HINF.

3.2 COMPLETE NUTRITIONAL SUPPLEMENT SUPPORT (PREVIOUSLY CALLED ORAL FEEDS)

Complete nutritional supplement support refers to products that can provide individuals with complete nutrition, including all the required energy/protein/vitamins/minerals, and may address specific dietary needs (e.g., energy dense, high protein, semi-elemental, low electrolyte), which cannot be provided by “home made” blenderized products. Natural foods for liquid oral diet should be considered first and foremost over nutritional supplements.

Requirements

The cost of complete nutritional supplement support may be covered if it is required as a total nourishment product for the resident; and,

- Without the provision of the product, enteral nutritional support or total parenteral nutrition would be necessary because the resident is severely malnourished or has a functionally compromised GI tract; and,
- The resident can only ingest a liquid diet; and,
- The resident’s condition has been assessed, and the appropriate intervention determined by a Registered Dietitian who is skilled in the interpretation and planning of therapeutic diets and supplemental feeds.

Eligible Costs

- Complete nutritional supplement products (e.g., Peptamen) to the extent that the costs exceed the daily raw food per diem.

Note: Many of these products do not exceed the cost of the daily raw food per diem.

Duration of Funding

- Complete nutritional supplement support may be funded on a short-term basis or a long-term basis, as determined by the assessment of the resident’s need.

3.3 ENTERAL NUTRITION SUPPORT (PREVIOUSLY CALLED ENTERAL FEEDS)

Enteral nutrition is appropriate when a resident is unable to orally consume his/her nutritional requirements, or when the resident’s GI tract is compromised, secondary to malabsorption or indigestion. Enteral nutrition maintains proper nutrition by providing nourishment through a tube into the digestive tract. The formula for enteral nutrition usually consists of commercially prepared products that provide total nourishment or act as a meal replacement. Methods to infuse nourishment may include gravity or the use of a pump.

The ADP and the ODBP do not fund enteral nutrition in LTC homes.

Requirements

- Enteral nutrition is used when the resident is unable to orally consume all his/her nutritional requirements (energy, protein, vitamins and minerals) or when the resident’s GI tract is compromised, secondary to malabsorption or indigestion;
- The resident’s condition has been assessed and the appropriate intervention determined by a Registered Dietitian skilled in the interpretation and planning of therapeutic diets and supplemental feeds; and,
- Staff in the LTC home will be taught to carry out the intervention whenever necessary.

Eligible Costs

- Supplies, equipment and/or services to support enteral nutrition; and,
- Formulae, to the extent that the cost exceeds the daily raw food per diem.

NEW>Changes for Residents Requiring both Enteral Nutrition Support and Raw Food

As of July 1st, 2007, when the resident is using a combination of enteral nutrition and raw food, the Ministry will provide full reimbursement for both enteral nutrition and raw food until the resident returns to raw food only. Assessment by a Registered Dietitian with the appropriate recommendation is required.

Duration of Funding

Enteral nutrition may be funded on a short-term or a long-term basis, as determined by the assessment of the resident's needs.

3.4 TOTAL PARENTERAL NUTRITION

Total parenteral nutrition (TPN) is nutrition provided intravenously. A pharmaceutically prepared solution of nutrients, vitamins, minerals and water is infused through a special intravenous line and site.

It is anticipated that few people will require TPN in LTC home settings. However, there may be isolated cases where a resident could be discharged from the hospital to a LTC home, or where a resident has been living at home with the support of TPN and now requires treatment in a LTC home. In these situations, the hospital, CCAC, and LTC home must work closely together as a team to ensure that training and backup is in place in the LTC home.

Requirements

TPN is used for the treatment of residents who have a compromised capacity for intestinal digestion, which is likely to result in a state of severe malnourishment and/or death due to starvation. Essential indicators are as follows:

- The resident has been assessed by a multi-disciplinary team of clinicians prior to the implementation of TPN;
- Adequate medical, dietary and other appropriate professional supports are available to home staff; and,
- Staff in the LTC home will be taught to carry out the intervention whenever necessary.

This situation can arise as a result of:

- The inability to eat or drink due to a hole or blockage in the digestive system;
- The inability to absorb food that is taken by mouth or obtain nourishment by other means (e.g., enteral nutritional support); or
- Prolonged high-energy requirements for healing.

Some examples of residents who may need TPN are:

- Starving residents who cannot be fed enterally;
- Residents who are malnourished, unable to be fed enterally and unlikely to start eating within one week;
- Residents whose inability to absorb nutrients is expected to exceed one week;
- Residents with massive bowel obstruction or resection, enteric disease, radiation enteritis, end-jejunosomy feeding or inadequate oral feeding, where enteral nutritional support is inappropriate and the condition will result in uncontrolled fluid and electrolyte imbalance;

- Residents whose bowel requires a rest due to illness or surgery and the most likely outcome of taking nothing by mouth for a period of time will result in malnourishment; or,
- Residents with a non-functioning GI tract due to ileus, vomiting, diarrhea, ascites or peritonitis.

Eligible Costs

- Solutions and nutritive additives; and
- Only those costs above the daily per diem for raw food will be reimbursed.

Total Parental Nutrition (TPN) products are generally eligible for reimbursement under the Ontario Drug Benefit (ODB) program as “extemporaneous preparations”, as permitted under section 17 of the Ontario Drug Benefit Act (ODBA).

TPN additives such as multivitamins and vitamin K may be funded under Section 16 of the ODBA through the Individual Clinical Review (ICR) program. To obtain approval for funding under the ICR program, a physician must apply in advance to the Individual Eligibility Review Branch of the ministry. ICR approvals are not retroactive for costs already incurred. It is important that applications for ICR approvals be made in advance of discharge from the hospital whenever possible.

Duration of Funding

- TPN supplies and equipment may be funded on a short-term or a long-term basis, as determined by the assessment of the resident’s needs.

The Role of the Hospital in the Provision of TPN in Community Based Setting

If TPN is provided in the LTC home sector it is the responsibility of the LTC home to ensure that a local hospital is prepared to provide the following:

Staff who:

- Are capable of inserting and managing the complications of a central venous catheter;
- Undertake assessments;
- Undertake teaching of TPN to the person, his/her caregiver, and service provider if necessary; and,
- Provide the necessary backup/medical support, should complications arise.
 - Note:** At a minimum this requires:
 - A physician or nurse who is skilled in vascular access, insertion and management of central venous catheters;
 - A dietitian who is skilled in monitoring, reviewing and adjusting the nutritional plan; and,
 - A pharmacist to prepare solutions.
- A minimum practicum of one person at any given time to maintain clinical competency in TPN;
- Ongoing advice/assistance to community based service providers/discharged persons on any problems that may arise, for example, infection control and complications;
- Training to service providers; and
- Education in the administration of TPN

Persons who require TPN on a long-term basis (longer than three months) must have the medical back-up/support of a hospital centre that is recognized as a specialty treatment centre in the procedure.

Persons who require TPN on a short-term basis (less than three months) must have the medical back-up/support of the hospital that performed the procedure and meets the criteria identified above.

Note: This means that community hospitals should undertake TPN only for persons who are anticipated to be on the program for a short period of time (less than three months).

3.5 WOUND CARE

Access to appropriate wound care supplies, equipment and/or services in the LTC home may facilitate earlier hospital discharge, or prevent a LTC home resident with an advanced-stage wound from entering a hospital, and result in better care outcomes.

Supplies and equipment required for wound treatment may include specialized dressings and treatments, irrigation equipment, and therapeutic surfaces. Many products such as bandages, cleansers, dressing trays, and topical medications, should be purchased using the Levels of Care per diem.

Therapeutic surfaces are surfaces that promote active healing, and are used on a short-term basis until more conventional methods of treatment are made available. The use of a specified therapeutic surface facilitates early discharge from the hospital and can prevent further hospitalization.

Funding of supplies and equipment that are necessary to support the healing process, where costs exceed what homes are expected to provide, is contingent upon an accurate assessment of the type of wound (e.g. vascular ulcer, pressure ulcer), predisposing causes (the resident's health status) and determination of the most appropriate and effective treatment.

Wounds can be classified according to a variety of characteristics that describe location, etiology, size, exudate and base. Following assessment of the wound, an appropriate treatment plan can be developed. It is essential that the wound be properly diagnosed.

Requirements

- Except as otherwise specifically specified, funding will be provided for supplies and equipment for Stage III or Stage IV wounds or ulcers or severe dermatological diseases comparable to a Stage III or IV wound:
 - Where supplies/equipment are required for the healing of a severe wound complicated by secondary medical factors;
 - Where contributing medical causal factors have been identified and eliminated but where there have been no effective impacts on healing with conventional and routinely used methods of treatment; and,
 - Where there is a high risk of medical harm or infection that could necessitate hospitalization.
- A person with knowledge of wound care strategies who can correctly diagnose the problem and develop a service plan must assess the resident.

Note: This person could be a health care professional, such as an enterostomal therapist or a nurse, physician or therapist who has received training beyond the level of a generalist. This person must make a proper assessment of a wound and recommend an appropriate treatment intervention. Specialist training may include but is not confined to additional training in:

- Wound etiologies;
 - The use of clinical assessment and data collection instruments;
 - A variety of intervention strategies;
 - Advanced practical application of a variety of treatment interventions; and,
 - Interpretation of clinical trial data.
- It is important that expenditures for specialized supplies and equipment be justified by comprehensive assessment, continued monitoring and regular reassessment by a person with the appropriate skill base;
 - LTC home staff will be educated wherever necessary and are responsible for following and implementing the plan;
 - Pre-approval must be obtained for purchase or rental of wound care supplies/equipment for ulcers in Stage II; and
 - Specialized equipment and supplies used must be consistent with best practices.

Eligible Costs

- Specialized equipment, medical supplies and dressings may be reimbursed through the HINF for extraordinary treatment interventions required;
- Specialized equipment, medical supplies and dressings for ulcers in Stage II may be reimbursed under specific circumstances, such as a high risk of ulcer progressing with serious consequences, or where numerous skin lesions are present, when pre-approved by a Compliance Advisor;
- Wound care equipment may be funded for the purpose of providing extraordinary wound treatments to support the management of the resident's condition; and,

- Specialized medical supplies and dressings may be required for specific and extraordinary treatment of wounds. These include products designed specifically for the treatment of certain categories or types of wounds.

Note: An appropriately skilled person may also make recommendations regarding ongoing preventive measures. These may include consultation with dietitians, or recommendations for optimal positioning techniques for nursing staff. These preventive measures are to be paid for by the Levels of Care per diem funding.

Duration of Funding

- Wounds can require short-term or long-term treatment. A skilled and objective resource person may recommend a combination of interventions to be used at various stages of the healing process; and,
- Supplies and equipment will be provided for a maximum of three months, provided active healing or recovery is occurring.

Note: Extensions of up to three months may be obtained as long as the wound is actively healing but additional time is required, or if at the outset of the intervention it is anticipated that the healing process will take longer than three months. An extension may not be approved if the intervention is not working.

Exclusion

- The HINF will not provide funding for surfaces primarily intended to prevent skin breakdown or facilitate mobility. The Levels of Care per diem should be used to purchase such items and can be used for residents who have stable chronic conditions.

3.6 EXTRAORDINARY COSTS FOR OSTOMY SUPPLIES

Ostomy refers to a surgically created opening connecting an internal organ to the surface of the body. Different kinds of ostomies are named for the organ involved. The most common types of ostomies in intestinal surgery are ileostomies (which connect the small intestine to the skin) and colostomies (which connect the large intestine to the skin).

Requirements

- Resident requires daily or more frequent changes of ostomy due to complications such as prolapsed stoma, skin breakdown around stoma, excessive discharge or other complications;
- The LTC home will be able to produce documentation on monies received and dispersed for ostomy supplies for the individual resident.

Eligible Costs

- HINF will only cover costs that exceed \$1,000 per resident in any year. Typically ADP will cover the first \$800 in the year, and the home is expected to cover the next \$200.

Note: The year will be determined by the 12 month period that ADP uses to fund ostomy supplies for the resident. This is based on the date that ostomy funding is first provided by ADP for the resident.

Duration of Funding

- Funding for extraordinary costs of ostomy supplies may be long-term.

3.7 EXTRAORDINARY COST FOR OXYGEN

Funding for oxygen therapy is available through the Ministry's Home Oxygen Program (HOP). Costs not covered through the HOP may be covered by the HINF.

Requirements

- Funding is provided only in connection with severe, short-term reversible conditions such as pneumonia, or other illnesses where need is demonstrated by oximetry testing (where oxygen saturation level is less than 88%).

Eligible Costs

- Costs of a basic oxygen system for residents receiving treatment for severe short-term, reversible conditions. These costs include disposable supplies such as masks, nasal cannules, and bubble humidifiers;
- Equipment and supply costs for oxygen are funded on a short-term basis only when HOP funding is not available.

Duration of Funding

- Funding is short-term.

Exclusions

- Residents who meet the following criteria can, subject to program changes, receive 100% funding through the HOP:
 - Chronic hypoxemia on room air at rest, requiring long-term (six months or longer) oxygen therapy;
 - Blood gas test must be done to confirm that oxygen therapy is necessary;
 - Ninety days and fifteen months after the oxygen program has started, oximetry reassessments must be performed; and,
 - HOP provides funding for palliative residents who do not otherwise meet the medical criteria for HOP funding. For these residents, a maximum of 90 days of oxygen therapy will be provided. This funding can only be accessed once, with no extensions.
- Residents funded by the HOP are not eligible for funding through the HINF.

3.8 VITAL PROCESSES AND PAIN MANAGEMENT

This type of equipment is essential to support one or more body systems or processes, to prevent the breakdown of one or more body systems, and to prevent pain and fight infection.

Requirements

Funding is provided to ensure that residents receive equipment and supplies necessary to support the treatment, when as a result of their health condition, they are:

- At a risk of dying or suffering the breakdown of essential bodily functions. This is to ensure the initiation or continuation of measures to support essential physical needs and/or begin therapeutic interventions for conditions that would quickly compromise essential bodily functions if not addressed e.g. administration of intravenous and subcutaneous medications;
- Require the service to control severe symptoms. For example, comfort care such as that provided in oncology regimes and palliative care situations;
- The provision of the equipment is essential to care for the resident. This means there is an absolute need for the equipment that is consistent with the purpose of the treatment to be

administered. The consequences of not having the equipment would be a real and significant threat of danger or medical harm, unmanaged pain, or certain death; and,

- The resident must be assessed by a clinician with expertise on the intervention. LTC home staff are responsible for supporting and assisting with the plan of care that has been implemented and must be provided with any necessary training.

Eligible Costs

- All supplies necessary to support the treatment and all equipment as recommended by a clinician with expertise in the provision of the intervention; and,
- Equipment in this category includes, but is not confined to standard compressors, heavy duty compressors, apnea monitors, intravenous pumps, pain pumps, tubing and IV poles, and hydration fluids/supplements.

Duration of Funding

- No time limit is specified.

Exclusions

- Funding for equipment/supply costs associated with peritoneal dialysis is not provided. LTC homes may, on a client by client basis, feel that with appropriate equipment and education of their staff, dialysis may be performed in their LTC homes. The costs of equipment, training and supplies may be defrayed through the Chronic Kidney Disease (CKD) Regional Program of the Ministry, and other Ministry dialysis programs, where eligible; and
- Where the equipment is made available or funded through the ADP program, it must be obtained through the ADP.

3.9 TREATMENT EQUIPMENT/SUPPLIES AND TRANSFERRING EQUIPMENT

A. Treatment equipment/supplies

Treatment equipment/supplies in this category include equipment required to support medical treatments which promote healing and prevent deterioration of an acute condition, or exacerbation of a chronic condition.

Note: This does not include wound care supplies or equipment, as these are addressed in Section 3.5.

The provision of the equipment/supplies must be consistent with the treatment being administered. When available, funding must be acquired through the ADP rather than the HINF.

Requirements

ALL of the following indicators must be present:

- The resident requires the equipment/supplies to support a medical treatment, and to promote healing or prevent deterioration of an acute condition or exacerbation of a chronic condition;
- The treatment to be administered is dependent upon the equipment/supplies;
- The equipment and supplies are consistent with the purpose of the treatment being administered;
- The consequence of not having the equipment/supplies would be a real and significant threat of danger, medical harm, or severe exacerbation of an illness or condition;
- LTC home staff are required to support and assist with the plan that has been implemented; and
- LTC home staff must be provided with any necessary training.

Eligible Costs

- These include but are not confined to, ultrasound therapy, transcutaneous electrical nerve stimulation (TENS), continuous passive motion (CPM) machines, extremity pumps and sleeves, and nebulizers.

B. Protective Supplies

Routine practices help to prevent the transmission of unknown pathogens from one person to another.

The use of supplies such as gloves, goggles and masks are required in some situations to provide a barrier to transmission. For example gowns and goggles are used where there is danger of spattered blood or body fluids.

Supplies required for routine practices to prevent transmission remain the responsibility of LTC homes.

Some organisms are transmitted by means which render the use of routine practices inadequate. When dealing with these organisms, additional precautions are necessary.

Requirements

- Additional precautions to prevent the transmission of known organisms may require stringent isolation strategies and techniques. There is significant cost involved in the implementation of these additional precautions in some situations. For example, it may be necessary for the resident to be isolated in a private room (see section 3.11) and require any person entering the room to wear gloves and gown.

Eligible Costs

- Supplies required to implement additional precautions, over and above basic routine practices, to limit or prevent the transmission of known organisms, will be funded. Refer to the Provincial Infectious Diseases Advisory Committee's report "Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Health Care" for a discussion of conditions for which additional precautions may be necessary in LTC homes.

C. Transferring equipment

Transferring equipment may be purchased or leased for residents who are morbidly obese. For the purposes of the HINF, morbidly obese refers to a resident whose weight cannot be supported by conventional transfer equipment.

Requirements

- The resident is morbidly obese and if the equipment was not provided, the resident could not be accommodated in the LTC home; and,
- Pre-approval of the Compliance Advisor is required prior to implementing this arrangement.

Eligible Costs

- Shower chairs for the morbidly obese; and,
- Bariatric lifts for the morbidly obese.

Duration of Funding

- Supplies/equipment may be provided on either a short or long-term basis.

Exclusion

- The cost of beds or mattresses for bariatric residents is not funded through the HINF.

3.10 TRANSPORTATION FOR DIALYSIS TREATMENT

REVISED➤ Changes for Residents Requiring Transportation for Dialysis Treatment

Changes to the transportation policy have been made to establish guidelines and to provide clarity, simplicity and uniformity across all homes. The Ministry will continue to provide funding to LTC homes to cover the costs of transportation for dialysis treatment, subject to the requirements below.

The HINF may only be used to provide transportation to and from treatment sites for dialysis, and does not cover the cost of other routine transportation to hospitals and/or medical appointments, nor does it cover costs of attendants to accompany the resident. Routine transportation costs may be funded through community support services. LTC homes are expected to assist with arrangements as necessary, to ensure that residents have access to required treatment.

Requirements

- Resident requires planned, frequent transportation to and from dialysis treatment, either at a hospital or a clinic;
- All other sources of assistance have been explored without success;
- Volunteers are used as much as possible;
- Pre-approval from a Compliance Advisor is required prior to the implementation of this arrangement; and
- When determining the appropriate form of transportation, LTC homes must use the most cost effective option.

Eligible Costs

- Taxi, mileage, bus, handicapped transit; and
- Ambulance fees.

Exclusions

- Costs of attendant(s) to accompany the resident; and
- The HINF will not cover the cost of air transportation.

Duration of Funding

Transportation assistance is normally provided on a long-term basis.

3.11 PREFERRED ACCOMMODATION

REVISION➤

The preferred accommodation policy has been clarified to ensure consistency across all homes.

The Ministry will provide coverage for preferred accommodation for residents with severe behavioural response issues who may be at risk of harming themselves or others. Preferred accommodation is also available for residents with extensive equipment needs and a need for isolation related to infectious diseases.

Requirements

- Preferred accommodation may be used, with pre-approval from the Compliance Advisor, only for:
 - Current residents with ongoing or emerging behavioural issues;
 - Residents requiring segregation due to severe behavioural problems that pose a risk to themselves, other residents and staff in the LTC home;
 - Residents newly transferred from hospital or other facilities back to a LTC home with ongoing or emerging behavioural issues;
 - Residents returning from a psychiatric leave of absence or Form 1 referral with ongoing behavioural issues, who require it as part of their reintegration back into the home.
 - Residents requiring extensive therapeutic supplies and equipment that cannot be provided in a multi-bed room or without significant disruption to the previous quality of life and safety of other residents;
 - Residents requiring isolation related to infectious disease, where additional precautions, other than routine practices, is indicated (refer to the Provincial Infectious Diseases Advisory Committee’s report “Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Health Care”) and where no infirmary room is available;
 - Residents currently in ward or semi-private accommodation;
- A comprehensive care plan must be developed and implemented to address the needs of the resident, which includes a psychological and behavioural assessment and any identified supplemental training requirements;
- The resident’s care plan must be amended to address the needs of the resident;
- If there is no progress in managing the resident’s behaviours and/or it is determined by the home in consultation with a specialized geriatric mental health outreach team or psychiatrist that the home does not have the capacity to effectively care for the resident, alternative placement options must be explored;
- Pre-approval from a Compliance Advisor is required prior to the implementation of this arrangement; and
- Compliance Advisors must receive weekly reports, which can be in the form of a telephone call, regarding the status of the resident if this intervention is required beyond a period of two weeks.

Eligible Costs

- The difference between a resident’s regular bed type and a preferred accommodation costs up to 30 days (unless an extension is approved by a Compliance Advisor).

Duration of Funding

- A maximum 30-day period which can only be extended in exceptional circumstances, with approval and review of the home’s plan to manage the behaviours by the Compliance Advisor; and,
- This funding may be used in conjunction with supplementary staffing.

Exclusions

- Residents already paying for private rooms are not eligible for subsidy;
- Residents already paying basic/semi-private rates are eligible for the difference between basic/semi-private and private. If appropriate, single bed rooms sharing a bathroom may be used; and
- Residents that are not assessed as eligible for placement in a LTC home.

NEW➤

Transfer back:

- The determination that a resident no longer requires preferred accommodation should be made by the person who initially signed as the “assessor” on the Notification of High Cost Service Requirements form in conjunction with the resident’s care team and with communication to the Compliance Advisor;
- Once a resident is transferred from their current bed to preferred accommodation, their bed may be given up for the next appropriate resident on the CCAC wait list;
- Once the resident placed in preferred accommodation has been determined to no longer require preferred accommodation, they will be transferred back to the next appropriate bed available; and
- If the resident’s regular bed type is not available, the Ministry will pay for the difference of their regular bed type and preferred accommodation for up to a maximum of 30 days or until the bed type becomes available, whichever period is shorter.

3.12 SUPPLEMENTARY STAFFING

REVISION➤

The supplementary staffing policy has been clarified to ensure consistency across all homes.

The Levels of Care per diem is provided to cover all staffing costs based on the level of care identified for each LTC home through the current classification process. However, under exceptional circumstances, where a resident who may be at risk of harming themselves or others requires short-term one-to-one (1:1) care and supervision as a result of mental health and/or severe behavioural response issues, funding may be provided, subject to the following requirements.

Requirements

- Supplementary staffing may be used, with pre-approval from the Compliance Advisor, for:
 - Current residents with ongoing or emerging behavioural issues;
 - Newly admitted residents with ongoing, emerging, or the potential for behavioural issues who could harm themselves or others;
 - Residents newly transferred from hospital or other facilities back to a LTC home with ongoing, emerging or potential behavioural issues; and
 - Residents returning from a psychiatric leave of absence or Form 1 referral with ongoing behavioural issues who require support as part of their reintegration back into the home.
- Upon approval, an external assessment/consultation with a specialized geriatric mental health outreach team, physician or psychiatrist must be obtained to develop/amend the resident’s care plan in consultation with the LTC home health care team and PIECES trained staff (if available);
- The resident’s care plan must be amended to address the needs of the resident;

- Homes can draw down up to 72-hours of staff-time for 1:1 staffing which can be extended with Compliance Advisor approval for additional 72 hour periods if another episode occurs or the current episode has not been managed;
- Compliance Advisors must receive weekly reports, which can be in the form of a logged phone call, on the status of the resident if this intervention is required beyond a period of two weeks;
- This funding may be used in conjunction with preferred accommodation; and,
- If there is no progress in managing the resident's behaviour and/or it is determined by the home in consultation with a specialized geriatric mental health outreach team that the LTC home does not have the capacity to effectively manage the resident, alternative placement options must be explored.

Eligible Costs

- Only regular salary costs will be reimbursed. This includes the employer contribution of benefits for the hours that staff provide one-to-one care and supervision.
- Claims submitted for supplementary staffing should indicate the number of hours worked, the wage rate of the employee and the prorated benefit cost.

Exclusions

- Overtime costs are not funded by HINF.

Use of 72-hour staffing:

- LTC homes may use each 72 hour increment of 1:1 staff time on an as needed basis over various days and shifts and can also use registered and unregistered staff interchangeably as needed, such as RNs, RPNs, PSWs and HCAs;
- LTC homes will determine the appropriate staffing mix and utilization of the 72 hours available for supplementary staffing.

3.13 TRAINING FOR LTC HOME STAFF IN SPECIFIC PROCEDURES

Where possible, LTC homes will use internal resources and available external resources such as CCAC staff, hospitals and vendors as sources of staff training in acute care and complex procedures not normally performed in LTC homes.

Under specified circumstances staff training in complex procedures not traditionally provided in the homes may be funded by the HINF, in order to facilitate a discharge from hospital or prevent admission to hospital. It is expected that knowledge transfer will occur among staff to ensure continuity of care.

The HINF does not fund training for staff on procedures that are within the normal scope of service to be provided in LTC homes.

Requirements

- Resident requires treatment or procedure for which LTC home staff is not trained and without which the resident would remain in hospital or require transfer to hospital;
- Training must be relevant to health issues associated with high needs or high risk residents;
- Training is not otherwise available, or is available but cannot be arranged in enough time through CCAC, hospital or vendors (where appropriate);
- Training must be specific to assessment or management related to complex clinical needs of a population of residents in their home or to individual residents assessed as high needs;
- Attempts must first be made to tap into other training sources normally available such as CCAC, hospitals, external sources of funding and vendors; and

- Pre-approval from a Compliance Advisor is required prior to the implementation of this arrangement.

Eligible Costs

- Costs of external trainer and any supplies specifically related to HINF training e.g., videotapes, or the purchase of training manuals to provide in house training for LTC clinical staff.

Duration of Funding

- Funding is provided on a short term basis in order to provide specific training for LTC home staff.

4.0 ACCESS, AUTHORIZATION AND REIMBURSEMENT PROCESS

4.1 WHO MAY ACCESS THE HIGH INTENSITY NEEDS FUND?

LTC homes may directly access the HINF. On occasion CCACs, in consultation with LTC homes, may authorize the purchase or rental of supplies, equipment and/or services, in keeping with the established funding criteria. Certain expenditures will require pre-approval as indicated below.

LTC Homes

Where the LTC home provides supplies, equipment and/or services in accordance with this Manual, the home will be reimbursed by the Ministry for the associated eligible costs. In this case, the LTC home pays for the supplies, equipment, services, assessments or training as the case may be, and the Ministry adjusts the LTC cash flow as needed to provide the appropriate reimbursement.

Community Care Access Centers (CCAC)

There may be circumstances where the LTC home may require assistance from CCACs to access equipment and supplies necessary for the required treatment.

If the CCAC is providing the equipment and supplies, the CCAC invoices the LTC home. Following reconciliation, the LTC home reimburses the CCAC and follows the process for reimbursement through the Ministry. The Ministry will adjust the LTC home cash flow.

4.2 AUTHORIZATION PROCESS

General

LTC homes may authorize the provision of supplies, equipment and/or services without pre-approval from the Ministry using established funding criteria, except for purchases of equipment over \$2,000, or where pre-approval is required by the Compliance Advisor. If the criteria set out in this Manual are met, the Ministry will reimburse the LTC home for the costs incurred. If these criteria are not met, no reimbursement will be made.

Whether any given expenditure meets the requirements and criteria of this Manual is determined in the sole discretion of the Ministry, so if there is a doubt as to whether a particular item is covered, it should be verified with the Ministry prior to proceeding.

4.3 APPROVAL REQUIREMENTS

Pre-Approval Required For

Pre-approval is required for purchases over \$2,000. While pre-approval is not required where the rental costs are expected to amount to over \$2,000 over the course of the treatment, it may be advisable to discuss the situation with a Compliance Advisor. Depending on the circumstances, such as projected length of need or anticipated usage of equipment for other residents in the same circumstance, it may be advisable to purchase equipment or negotiate for rental costs to be applied to purchase.

Other Procedures Requiring Pre-Approval

Regardless of price, pre-approval from a Compliance Advisor is required prior to the implementation of the following arrangements:

- Therapeutic surfaces for Stage II ulcers;
- Transfer equipment for the morbidly obese;
- Transportation of residents to and from treatment sites for dialysis treatment;
- Preferred accommodation fee for residents who may require a private room for treatment purposes;
- Supplementary staffing; and,
- Specific training for LTC home staff.

All requests for approval must be resident-specific and identify the specified needs of the resident.

Requests for equipment approvals must:

- Be consistent with the skills possessed by the LTC home staff who are available to use the equipment or who are being taught to use the equipment;
- Support efficient and effective treatment/care; and,
- Be justified by a cost benefit analysis. (Estimated savings and how long it will take for the equipment to pay for itself. There may be a need for the equipment by more than one resident with similar conditions/needs to justify the cost-effectiveness of the purchase.)

Equipment Rental

An alternate approach to outright purchase is a “rent to own” arrangement. If the rent required for a piece of equipment is expected to exceed the purchase price, the LTC home can arrange with the vendor for rental costs to contribute toward the total cost of the equipment. The purchased equipment then becomes the responsibility of the LTC home to service and maintain.

Notification of High Cost Service Requirements (NHCSR Form)

LTC homes must complete a “Notification of High Cost Service Requirements” (NHCSR) to authorize use of the HINF (see Appendix 3). The NHCSR form is available online from <http://www.forms.ssb.gov.on.ca/>.

For equipment purchases over \$2,000 and for services/equipment/supplies requiring pre-approval from the Compliance Advisor, the NHCSR form must be submitted to the Ministry and approved prior to implementation of arrangements for these services.

NEW> NHCSR Form Verification

For all other services, equipment and/or supplies, the NHCSR form must be signed by a Compliance Advisor before a claim is submitted to the Ministry.

LTC homes must maintain a separate file containing copies of all NHCSR forms, claim forms and invoices for HINF services, equipment and/or supplies. This file must be available for audit by the Compliance Advisor or other Ministry staff.

Claim forms for equipment purchases of \$2,000 and over must be accompanied by invoices. It is not necessary to submit invoices for items/services under \$2,000 to the Ministry, but they must be maintained and available in the LTC home for audit by Ministry staff.

The NHCSR form will enable the Ministry to document the resident's need for service and to identify where funds are being spent. This process will assist with data collection for monitoring and evaluation purposes.

The NHCSR form provides:

- Demographic data, including the resident's name, the LTC home name, address, telephone and fax numbers, Compliance Advisor and a description of the resident's need for specified equipment/supplies/services;
- Category of equipment /supplies/services being accessed;
- Anticipated duration of the resident's need for the specified equipment/supplies/services;
- The name of the person who conducted the clinical needs assessment;
- Name and signature of the staff person (LTC home or CCAC) completing the form;
- Date the report was completed;
- Confirmation that the equipment/supplies/services obtained are over and above those that the LTC home is expected to provide; and
- Information on resident re-assessments if applicable.

4.4 REIMBURSEMENT PROCESS

High Intensity Needs Claim Form

The purpose of the High Intensity Needs Claim Form is to provide detailed cost information regarding supplies/equipment/services for all residents receiving HINF funding on one form (see Appendix 2). The Claim form is available online from <http://www.forms.ssb.gov.on.ca/>.

The Claim Form provides:

- Claim period
- Home's information
- Resident names
- Invoice number
- Treatment categories
- Cost of supplies/equipment/services for each resident and for each category
- Home official's signature
- Date of submission of claim form.

Receiving Reimbursement from the HINF

The following outlines the guidelines that homes must follow when submitting documentation to receive reimbursement:

- A Notification of High Cost Service Requirement (NHCSR) form must be completed for each individual resident being supported by the HINF;
- Pre-approval from a Compliance Advisor must be obtained where required, and must be reflected on the NHCSR form (see above for pre-approval requirements);

NEW► Effective July 1, 2007 all NHCSR forms must be signed and verified by a Compliance Advisor before a claim is submitted.

- A High Intensity Needs Claim Form listing all HINF claims for the month (homes may choose to submit quarterly, depending on volume and cash flow) must be submitted to the Ministry along with a NHCSR form verified by a Compliance Advisor for each individual resident receiving HINF support;
- Invoices for all purchases over \$2,000 must be submitted to the Ministry;
- A second NHCSR form regarding the same resident must be completed only when a resident's condition has changed or the resident requires a different type of equipment or supply or service. This second NHCSR form must be accompanied by the initial NHCSR form;
- When a final claim form is being submitted for reimbursement of funds, the final notification date is inserted on the NHCSR form. This provides notification that funds for an individual resident and condition will no longer be required.

Obtaining Equipment and Supplies from the CCAC:

- On occasion the CCAC may assist LTC homes in obtaining from a contracted vendor supplies/equipment/services that are not easily accessible and routinely available in the LTC homes for the resident.
- In the event that this occurs, the LTC home is responsible for completing the NHCSR form and obtaining any approval necessary before purchase of supplies/equipment.
- The CCAC may assist in facilitating the completion of the NHCSR form if necessary.
- If the CCAC is providing the equipment and supplies, the CCAC invoices the LTC home. Following reconciliation, the LTC home reimburses the CCAC and follows the process for reimbursement through the Ministry. The Ministry will adjust the LTC home cash flow.

Obtaining Supplies, Equipment or Services Directly From a Vendor

- The home staff obtains the appropriate supplies, equipment and/or services from the vendor.
- The vendor sends the invoice to the LTC home for equipment and supplies purchased or rented on behalf of the resident.
- The LTC home reconciles equipment, supplies, and services received with the invoice. The invoice includes the resident's name and an itemized list of equipment/supplies/services rented or purchased. Any discrepancies between equipment/supplies/services received by the LTC home and those listed on the invoice are clarified and resolved with the vendors.
- Upon verification of equipment/supplies/services received and those listed on the invoice, the LTC home provides payment to the vendor.

- The LTC home enters the details of the invoice on the High Intensity Needs Claim Form, attaches invoices for items costing \$2,000 and above, and a NHCSR form for each resident receiving supplies, equipment or services through the HINF and submits to the Ministry.
- Upon review and verification the Ministry adjusts quarterly cash flow to the LTC home to reflect eligible expenditures for high cost equipment/supplies/services in accordance with this Manual.

5.0 REPORTING REQUIREMENTS

NEW➤ Performance Reports

Effective July 1, 2007, the Ministry will implement a quarterly performance reporting process for all LTC homes.

Purpose

The HINF Performance Report enables the Ministry to support continuous program improvement to meet the high needs of residents. The Performance Report supports the standardization of program components and Ministry expectations regarding measurable program outcomes and utilization.

Submission Process

The Ministry will provide the Performance Report form along with technical guidelines and timeframes for completion.

Frequency

The Performance Report measures quarterly information and therefore must be submitted on a quarterly basis accordingly:

- First Quarter (Q1): January 1 to March 31
- Second Quarter (Q2): April 1 to June 30
- Third Quarter (Q3): July 1 to September 30
- Fourth Quarter (Q4): October 1 to December 31

Submission Requirements

The Director of Care and the Signing Officer for the Approved Operator of the LTC home must sign the Performance Report.

The Ministry may require that a LTC home provide receipts, invoices, assessment forms and if required, additional documentation to substantiate the Performance Report.

6.0 RECORD KEEPING REQUIREMENTS

NEW➤

Effective July 1, 2007, LTC homes must meet the record keeping requirements.

The LTC home must keep documentation that demonstrates compliance with all the applicable criteria and requirements. These records should be kept for six years and must be made available for audit by the Compliance Advisor or other Ministry staff upon request. Without limiting the generality of the foregoing, homes shall keep the following records for the Ministry inspection:

- NHCSR forms;
- High Intensity Need Claim forms;

- Invoices;
- Receipts;
- Records that identify and detail application of eligibility criteria to the applicable resident; and,
- Date of Compliance Advisor approval where required, and the name of the Compliance Advisor, or copy of written approval.

APPENDICES

APPENDIX 1: HINF EQUIPMENT AND SUPPLY LIST

The HINF is available to LTC homes to acquire specific types of high cost supplies, equipment and/or services to support interventions that are not traditionally provided or available in LTC homes, and are necessary to support essential treatment or to prevent hospitalization. Funding is provided until:

Equipment funded by the HINF may include:

- Apnea Monitor
- Bladder Irrigation Equipment
- Bariatric Transferring Equipment
- Nebulizers
- Negative Pressure Wound Therapy
- Pumps (for Feeds, Pain, or Intravenous)
- Suction Catheters
- TENS
- Therapeutic Surfaces

Supplies funded by the HINF may include:

- Enteral Nutrition Support
- Hydration Fluids (IV / Hypodermoclysis)
- Total Parenteral Nutrition supplies
- Complete Nutritional Supplement Support (liquid)
- Tracheostomy Supplies
- Wound Dressings

* The Nursing and Personal Care Envelope should be used to pay for the maintenance of equipment & supplies. For further information, please refer to the LTC Homes Program Manual.

Instructions for Completing the High Intensity Needs Fund (HINF) Claim Form

General

- ❖ Use this form to submit all claims for High Intensity Needs (HIN).
- ❖ You must use the same claim form for all residents for whom claims are being made for any given claim period.
- ❖ Claims for **each** resident must be supported by Compliance approved Notice of High Cost Service Requirements Form for **that** resident.
- ❖ For **all** of the residents claimed on the form **each** resident's name and the associated cost per category for that resident should appear **only once** on the claim form.
- ❖ All information provided must be related to the period of the claim
- ❖ Invoices for purchases of \$2,000 or more **must** be attached.
- ❖ All expenditures claimed must be supported by matching invoices, filed by resident, in the Home's files.

Part 1: Claim Period

- Indicate the period using **either** a **full calendar month**, (i.e. Jan. 1– 31, Feb. 1-28, Mar. 1-31, etc.) or a **full quarter** (i.e. Jan. 1 - Mar. 31, Apr. 1 - Jun. 30, July 1 - Sep. 30, Oct. 1 - Dec. 31)
- The claim must reflect the first and last day of the month or quarter even if the supplies/equipment/services were not used for the full month or quarter claimed.
- Claims **must not** overlap calendar years.

Part 2: Home Information

- Provide the name and complete address of the LTC Home.
- Provide the contact person's name, telephone number and fax number.
- Provide the names of the LHIN, Compliance Advisor and Service Area Office.

Part 3: Claim Details

- Include the name of each resident for whom supplies, equipment or services were acquired.

Invoices Numbers

- Invoices must be provided and invoice numbers must be included on the form for purchases of \$2,000 or more.

HIN Category

Show the total cost for each HIN category as per legend.

For Enteral Nutrition Support Columns with HIN Category legend A, B or C:

- The total cost of Enteral Nutrition Support will be reimbursed only as follows.
 - I. Where the Enteral Nutrition Support expenditures exceed the raw food cost (raw food per diem X total number of days) only the additional cost above the raw food cost will be reimbursed
 - II. Where the resident receives a combination of raw food and enteral nutrition full reimbursement will continue until the resident returns to raw food nutrition only
 - III. If daily Enteral Nutrition Supplement is less than the daily raw food per diem insert "N/A" in the column labeled "Less Raw Food Costs". **Do not** include the Nutrition supplement amount in Columns A, B or C as applicable.
- The number of days for daily raw food costs should be counted from and including the day started, within the period of the claim, to the earlier of the last day of support or the end of the period claimed.
- If all costs of supplements have been claimed in one claim period and supplement use continues over additional claim periods raw food costs must be deducted for the claim periods in which supplement use continues.

For Wound Care Column Category D:

- Costs of therapeutic surface for the claim period, and related supplies and equipment must be totaled and placed in column D of the Claim form.
- When sending the claim along with the supporting copies of the approved residents' Notification of High Cost Service Request (NHCSR) forms to the ministry show the actual cost for each item purchased on the supporting copy of the NHCSR beside the corresponding supplies and equipment listed.

Category Amounts

- Provide the **total costs** incurred for the month/quarter for each HIN category used.

Claim Status

- Use the legend to identify whether the claim is an Initial Change (I), No change (N), Change (C), or Final (F) claim by entering the corresponding letter.

Total cost per resident

- Add up the resident's expenses for all categories being claimed, subtracting raw food costs if applicable, and insert the total in the far right hand column.

Part 4: Verification/ Approval information

Signature of the Home Official

- The LTC Home Official must print his or her name & title *and* date and sign **all** pages of the claim. The claim will be **returned** if this is missing.

•

Page Total and Grand Total

- If using more than one page, each page should be totaled separately.
- Total all pages and enter the Grand Total on the top copy.
- LTC Home official **must** sign and date **all** pages.

Mail completed claims along with **all** required supporting documentation to:

Long Term Care Homes – Claims

Ministry of Health and Long-Term Care
Financial Management Branch
5700 Yonge Street, 12th Floor
Toronto, ON M2M 4K5



High Intensity Needs Fund Claim Form

Part 1 Claim Period

Month(s) Covering: Jan 01 - Mar 31 Yr: 2007

↑ The first day of the first month of the quarter to the last day of the last month of the quarter

Part 2 Home Information

Home Name: Green Acres Nursing Home
Address: 121 Hollywood Blvd
Phone: 416-555-1666
Fax: 416-555-1667
LHIN: Hamilton Niagara Haldimand Brant
Compl. Advisor Service Area: Angelina Jolie Hamilton

High Intensity Needs Category Legend:		
A	Oral Nutrition Support	H Preferred Accommodation
B	Enteral Nutrition Support	I Training
C	TPN Supplies & Equipment	J Supplementary Staffing
D	Wound Care Products/Supplies	K Ostomy Supplies
E	Equipment & supplies to support Vital Processes for Pain Mgmt	L Oxygen Supplies & Equipment
F	Treatment/Transfer Equipment & Supplies	M Assessments
G	Transportation for Dialysis	

Status Legend:	
Initial	I
No change	N
Change	C
Final	F

Pre-approval by Compliance Advisor Required:
Therapeutic Surfaces for Stage II Ulcers (D)
Transfer Equipment (F)
Preferred Accommodation (H)
Training (I)
Transportation (G)
Supplementary Staffing (J)
Items \$2000+ (attach invoices)

Part 3 Claim Details

*Submit individual Compliance Approved NHCERS form for each Resident on the claim

Resident Name	Invoice Number	A	s	B	s	C	s	Less Raw Food Costs (\$)	Total Raw Food Days	D	s	E	s	F	s	G	s	H	s	I	s	J	s	K	s	L	s	M	s	TOTAL
		\$	s	\$	s	\$	s			\$	s	\$	s	\$	s	\$	s	\$	s	\$	s	\$	s	\$	s	\$	s	\$	\$	
Jane Doe				1002.00	N			502.32	92	12940.00	N																	68.00	14604.32	
Will Smith																600.00														
Shania Twain										6000.00																		68.00	6068.00	
Brad Pitt				1600.00				191.10	35			1000.00																		2826.10
Column Totals				2602.00				693.42	127	18940.00		1000.00				600.00												136.00	23498.42	

Part 4 Verification/Approval Information

Signature of LTC Home Official: _____ Name of LTC Home Official: _____
 Date: _____ Title of LTC Home Official: _____

Complete Page and Grand Total	Page Total:	23,498.42
	Grand total:	23,498.42
MOH Use Only	Less Amt Denied:	
	Total Paid by MOH:	



Notification of High Cost Service
Requirements

I. Long-Term Care Home Information

Name of Home		
Address - number, street name	City or Town	Postal Code
Contact Name - first name, last name	Telephone number () -	Fax number () -
Compliance Advisor- first name, last name	Service Area Office	LHIN

II. Resident Information

Resident Name - first name, last name	Initial Assessment Date (yyyy/mm/dd)	Final Notification Date (yyyy/mm/dd)
<input type="checkbox"/> Initial Assessment OR <input type="checkbox"/> Change in Assessment (attach Initial Assessment form)		Change in Need Date (yyyy/mm/dd)

III. High Intensity Needs Category

<input type="checkbox"/> A. Complete Nutritional Supplement Support	<input type="checkbox"/> E. Equipment & Supplies to support vital processes for pain management	<input type="checkbox"/> I. Training
<input type="checkbox"/> B. Enteral Nutrition Support	<input type="checkbox"/> F. Treatment/Transfer Equipment & Supplies	<input type="checkbox"/> J. Supplementary Staffing
<input type="checkbox"/> C. TPN Supplies & Equipment	<input type="checkbox"/> G. Transportation for Dialysis	<input type="checkbox"/> K. Ostomy Supplies
<input type="checkbox"/> D. Wound Care Products/Supplies	<input type="checkbox"/> H. Preferred Accommodation	<input type="checkbox"/> L. Oxygen Supplies & Equipment
		<input type="checkbox"/> M. Assessment

IV. Initial Assessment / Re-Assessment

Description of diagnosis – resident care needs and frequency of administration. Please see instructions on reverse for additional requirements.

V. Equipment and Supplies Required (check all that are required)

Equipment	Supplies
<input type="checkbox"/> Apnea Monitor <input type="checkbox"/> Bariatric Transferring Equipment <input type="checkbox"/> Bladder Irrigation Equipment <input type="checkbox"/> Nebulizers <input type="checkbox"/> Negative Pressure Wound Therapy <input type="checkbox"/> Pumps (for Feeds, Pain, or Intravenous) <input type="checkbox"/> Suction Catheters	<input type="checkbox"/> Enteral Nutrition Support <input type="checkbox"/> Hydration Fluids (IV/hypodermoclysis) <input type="checkbox"/> Total Parenteral Nutrition <input type="checkbox"/> Complete Nutritional Supplement Support (liquid) <input type="checkbox"/> Tracheostomy Supplies <input type="checkbox"/> Wound Dressings (specify in Part IV) <input type="checkbox"/> Other (specify):
<input type="checkbox"/> TENS <input type="checkbox"/> Therapeutic Surfaces <input type="checkbox"/> Other (specify):	

Specify any equipment purchases that exceed \$2,000: (include product name and cost)

VI. Estimated Duration of Need

Less than 1 month
 1-3 months
 3-6 months
 6 months-1 year
 One-Time Expenditure
 Indefinite (specify reason): _____

VII. Assessor Information

Assessment conducted by - first name, last name	Title	Date (yyyy/mm/dd)
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VIII. Confirmation

I confirm that the information provided on this form is accurate and to the best of my knowledge is sufficient to indicate that the equipment, services and/or supplies are entitled to funding and are being provided for a resident who is defined as eligible for the equipment, services and/or supplies in accordance with the High Intensity Needs Fund Manual.

Signature	Name - first name, last name	Title	Date (yyyy/mm/dd)
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This information is collected under the authority of section 36 of the Personal Health Information Protection Act, 2004, S.O. 2004, c. 3, Sched. A, for the purpose of administering the High Intensity Needs Funding program. It may be used and disclosed in accordance with the Personal Health Information Protection Act, 2004, as set out in the Ministry of Health and Long-Term Care "Statement of Information Practices", which may be accessed at www.health.gov.on.ca. If you have any questions concerning the collection of this information, please contact: Manager, Access and Privacy Office, Ministry of Health and Long-Term Care, 5700 Yonge St., 5th Floor, Toronto, Ontario, M2M 4K5

IX. Approvals (complete only if verbal approval has been acquired from the Compliance Advisor)

Check if verbal pre-approval has been acquired from the Compliance Advisor.

Name of Compliance Advisor - first name, last name	Date of Approval (yyyy/mm/dd)	Time (HH : MM)
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Notes

Ministry Use Only

Approved by - first name, last name	Date (yyyy/mm/dd)
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Notes

Notification of High Cost Service Requirements - Instructions for Completion

Eligibility Criteria

Residents must meet criteria 1, 2 **AND** 3 **AND** 4a) **OR** 4b) **OR** 4c) to be eligible for support from the High Intensity Needs Fund.

1. Resident is in a long-term care home (excludes convalescent care residents).

AND

2. Resident requires support from one of the following high needs categories as defined in the High Intensity Needs Fund Manual:

- Complete nutritional supplement support
- Enteral nutrition support
- Total parenteral nutrition
- Wound care products/supplies
- Equipment/supplies to support vital process or pain management
- Treatment/transfer equipment and supplies
- Transportation for dialysis
- Preferred accommodation
- Training
- Supplementary staffing
- Ostomy supplies
- Oxygen supplies and equipment
- Assessments

AND

3. Resident has identified risk factors for significant functional decline. Identified areas of risk may include but are not limited to: behaviours, nutrition, renal, bladder, pain, respiratory, bowel and wounds.

AND

- 4a. Resident would require transfer to hospital without this support.

OR

- 4b. Resident would be unable to be discharged from hospital without this support.

OR

- 4c. Resident is at risk for causing or contributing to significant harm to self or others.

General Instructions

Pre-approval from your Compliance Advisor is required for any of the following items and where the resident meets the criteria listed above:

- The acquisition of any one item over \$2,000 (excluding surface rental);
- Therapeutic surfaces for Stage II wounds;
- Transfer equipment for the morbidly obese;
- Preferred accommodation;
- Training for long-term care home staff;
- Transportation to and from treatment sites for dialysis; and,
- Supplementary staffing

Completing the Form

I. Home Information

- Provide the name and address of the LTC home including the name, phone number and fax number of the contact person.
- Provide the LHIN, Service Area Office and name of the Compliance Advisor.

II. Resident Information

- Provide the name of the resident, the initial assessment date and the final notification date.
- Indicate whether the assessment is the initial or a re-assessment due to a change in need.
- Re-assessments due to change in need must be accompanied by the original approved Notice of High Cost Service Requirements.

The following situations will require re-approval from a Compliance Advisor:

- Approval needs to be extended beyond the initial duration identified during the original assessment.
- A change in a resident's condition that modifies initial care requirements indicated in Section IV.
- Wound care treatment required beyond the initial 90 day duration.
- Changes in transportation requirements.
- Preferred accommodation required beyond 30 days.
- Supplementary staffing/1:1 staffing required beyond 72 hours.

III. High Intensity Needs Category

- Check off the appropriate High Needs category(s).
- For Wound Care, check off 'D' only.

IV. Initial Assessment/ Re-Assessment

- Provide a description of the care requirements and goal.
- List the frequency of administration.

- Specify wound stage, sites, size and all supplies required.
- If the wound is Stage II, please explain the specific circumstances.
- List interventions for one-to-one staffing.
- If palliative, specify the analgesic order and effect.
- If additional space is required, please attach a separate page.

V. Equipment and Supplies Required

- Check off the applicable equipment and/or supplies required.
- For wound care, detail all supplies required in Section IV.
- Any individual equipment purchases that exceed \$2,000 should be detailed including the cost and type of equipment.

VI. Estimated Duration of Need

- Check the applicable duration of need.
- Provide a reason when the duration identified is 'Indefinite'.
- Please refer to the High Intensity Needs Fund Manual for timeframe restrictions on specific categories.

VII. Assessor Information

- Assessments are to be conducted by any healthcare professional who has the clinical expertise to develop an appropriate treatment plan for the resident. For example, a Registered Dietitian would assess a resident for Enteral Nutrition Support.
- The name and title of the professional performing the assessment is required.

VIII. Confirmation of Need

- The signature of a LTC home staff member who has clinical knowledge of the resident is required. Staff could include Director of Care, Charge Nurse, Physician, etc.
- This section must not be completed by the same individual who has completed Section VII.

IX. Approvals

- In certain circumstances, the Compliance Advisor may provide verbal approval to expedite the delivery of care to residents.
- Where verbal approval has been acquired, the name of the Compliance Advisor, date and time of approval should be provided.

Returning the Completed Form

Your completed form should be faxed to your Service Area Office to the attention of your Compliance Advisor.

To ensure efficient processing of the form, please review that the form is complete and includes all required signatures.

**Ministry of Health
And Long-Term Care**

Community Health Division
Long-Term Care Homes Branch
56 Wellesley St. West, 9th Floor
Toronto ON M7A 2J9

**Ministère de la Santé
Et des Soins de longue durée**

Division de la santé communautaire
Direction des foyers de soins de longue durée
56, rue Wellesley Ouest, 9^e étage
Toronto ON M7A 2J9



FEB 13 2006

MEMORANDUM TO: Long-Term Care Home Administrators

FROM: Tim Burns
Director, Long-Term Care Homes Branch

RE: **Submission of Claims: High Intensity Needs Fund and Lab Costs**

This memorandum is to confirm the timelines for the submission of claims for lab costs and goods and services purchased for residents as part of the High Intensity Needs Fund initiative for 2005 and ongoing calendar years.

Your continued cooperation in meeting these timeframes is appreciated. By establishing timelines, the Ministry is able to manage the claims process more effectively, and identify when homes should expect reimbursement for the appropriate time period.

Timelines for 2005 Claims:

All outstanding claims for the calendar year 2005 must be submitted for reimbursement no later than **March 31, 2006**.

The Ministry will not reimburse LTC homes for any claims made in 2005 if they are not properly documented and received by March 31, 2006.

Timelines for 2006 and Ongoing Claims:

Claims Period	Submission Deadline	Payment Notice
January - March 31	May 31	July
April - June 30	August 31	October
July - September 30	November 30	January
October - December 31	March 31	May

LTC homes submitting a large volume of claims should consider monthly submissions. LTC homes submitting a smaller volume of claims may consider quarterly submissions.

The Ministry will make every effort to ensure that LTC homes are paid within the timeframes indicated.

Should you have any questions, please contact your Regional Office.

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Burns". The signature is written in a cursive style with a large initial "T" and "B".

Tim Burns
Director, Long-Term Care Homes Branch

- c. Donna Rubin, CEO, Ontario Association of Non-Profit Homes and Services for Seniors
Karen Sullivan, Executive Director, Ontario Long-Term Care Association
Senior Financial Analysts
Regional Program Managers

Operator's Guide to the Process for Alterations, Renovations or Additions to Existing Long-Term Care Facilities

Purpose

Any or all alterations, renovations or additions to an existing long-term care facility must be approved by the Ministry of Health and Long-Term Care.

The purpose of this Guide is to provide Operators with a summary of the process for alterations, renovations or additions to existing long-term care facilities.

This document identifies the minimum structural requirements, the submission requirements, timelines and responsibilities, and the review and approval process.

1.0 Structural Requirements

The review of plans for alterations, renovations or additions to existing long-term care facilities will use, as a minimum, the structural requirements as captured in the regulations applicable to the facility proposing the project work, with an eye towards ensuring that the work being undertaken serves to improve the operations of the facility and the living conditions of the resident. However, if an Operator indicates that the purpose of the project work is to bring the facility closer to, or in line with, the "A" structural classification, the Ministry will then reference the Long-Term Care Facility Design Manual (1998) in the plans review process.

2.0 Submission of Project Summary, Operational Plan and Drawings

Prior to commencing any type of alteration, renovation or addition to an existing long-term care facility, the Operator must submit 3 copies of the Project Summary, Operational Plan and Drawings (described on next page) to the following address:

Ministry of Health and Long-Term Care
Long-Term Care Redevelopment Project
101 Bloor Street West, 11th Floor
Toronto, Ontario
M5S 2Z7
Attention: Planning Team Lead

At the same time, 1 copy of the Project Summary and the Drawings must be sent to the Ontario Fire Marshall (OFM) for review and approval* at the following address:

Office of the Fire Marshall
5775 Yonge Street, 7th Floor
Toronto, Ontario
M2M 4J1
Attention: LTC Plans Approval

* The Ministry will require the Ontario Fire Marshall to copy the Long-Term Care Redevelopment Project Planning Team Lead on the response back to the Operator.

2.1 Project Summary

The information in the Project Summary is intended to support the timely completion of the plans review process by providing the Ministry with basic information about the proposed project.

The Project Summary must provide written information outlining how the proposed work will support the effective delivery of care, programs and services to residents residing in the facility. The Project Summary must also include information about the existing facility, the project concept, and the project schedule. For a detailed outline of the content requirements for the Project Summary, please refer to [Appendix A](#).

2.2 Operational Plan

The purpose of the Operational Plan is to provide a detailed account of how resident health, safety and general well-being will be assured over the construction period. For a detailed outline of the content requirements for the Operational Plan, please refer to [Appendix B](#).

2.3 Drawings

The Drawings must show the planned project work, as well as any areas adjoining the area(s) where project work is taking place and any other affected systems or spaces within the facility. Depending on the proposed scope of work, mechanical, electrical or other detailed plans may also be required.

3.0 Approval/Non-Approval of Project Summary, Operational Plan and Drawings

The Ministry will respond to the Operator's submission of the Project Summary, Operational Plan and Drawings with an approval, or non-approval, letter within 20 business days of receipt.

If the submission documents are approved, the Ministry will send the Operator comments on the proposed scope of work along with an approval to start construction letter.

Note: If the Ontario Fire Marshall has not responded to the Operator on the Project Summary and Drawings, the Ministry's approval letter will include a statement notifying the Operator that prior to commencing the project work, the Operator will be required to obtain Ontario Fire Marshall approval of the project plans or a statement from the Ontario Fire Marshall that their approval is not required.

If the submission documents are not approved, the Ministry will send the Operator comments on the proposed scope of work that identifies the areas of concern along with a non-approval letter. The non-approval letter may require the Operator to respond to identified issues in writing, or in some cases to resubmit any or all of the documents.

If the written response or resubmitted Plans or Drawings are approved, the Ministry will send the comments (if required) and approval letter to the Operator within 10 business days of receipt of the response or resubmission.

4.0 Monitoring During Construction

While the project work is in progress, the Regional Office will monitor the facility for any operational health and safety concerns and to ensure compliance with the approved Operational Plan.

The frequency of the monitoring during construction will be determined by the Regional Office based on the scope of the project work.

5.0 Completion Statement

Upon completion of the project work, the Regional Office is responsible for inspecting the facility to confirm that the project work was done in accordance with the Ministry approved plans. In order to confirm that the work is ready for inspection, the Operator must provide a statement confirming that the project work has been completed and that all necessary permits required by applicable law have been acquired and will be available on site at the completion review.

The Completion Statement must be received by the Regional Office Program Manager and Compliance Advisor before a date for the Completion Review will be set.

Following receipt of the Completion Statement, the Regional Office Compliance Advisor will schedule a Completion Review with the Operator within 20 business days.

6.0 Completion Review

As indicated above, the purpose of the Completion Review is to confirm that the construction work in the long-term care facility was done in accordance with the Ministry approved plans and is ready for resident and staff use.

At the end of the Completion Review, unmet criteria may be issued as part of a Summary Report. In such cases, the Operator will be required to submit a compliance plan to the Regional Office that addresses the outstanding items. The timelines for the submission of a compliance plan and the corrective action dates will be determined at the Completion Review. Compliance plans for prior to occupancy issues must be submitted within 48 hours. Compliance plans for post-occupancy issues must be submitted within 7 business days.

Note: Areas in which construction work occurred cannot be used or occupied until the Completion Review has been conducted and written notification of Completion Approval issued.

7.0 Completion Approval

Within seven business days of the Completion Review, the Operator will be notified in writing, whether the Ministry:

- a) Approves the project work; or
- b) Does not approve the project work, together with the reasons for non-approval.

The Ministry is entitled to impose on the Operator conditions to the Completion Approval requiring the Operator to repair, improve and/or modify any aspect of the Facility that does not comply with the approved scope of work and/or the appropriate legislative requirement. The Ministry's Completion Approval with respect to the Facility will be conditional on completion of the repairs, improvements and/or modifications to the satisfaction of the Ministry. In such cases, the Ministry will arrange and conduct one or more subsequent Completion Reviews.

If at the subsequent Completion Review all of the conditions have been met and the review is successful, the Ministry will send a Completion Approval letter (as described above).

APPENDIX A: PROJECT SUMMARY REQUIREMENTS

OVERVIEW AND PURPOSE

The purpose of the **Project Summary** is to provide written information outlining how the proposed work will support the effective delivery of care, programs and services to residents residing in the long-term care facility. This information is intended to support the timely completion of the plans review process by providing the Ministry with basic information about the proposed project work.

Three (3) copies of the proposed **Project Summary** must be submitted.

CONTENT OF THE PROJECT SUMMARY

The proposed **Project Summary** must include the following information under the following general headings:

1. Existing Facility

Briefly describe the existing facility – include the following:

- Size of Facility
- Number of storeys and beds per floor
- If a mixed classification facility (i.e. mixed “A” Class and “C” Class), indicate the total number of beds and the number of beds per classification

2. Project Concept

The project concept should describe the desired “end state” of the facility after completion of the project work, for example:

- Upon completion of the project work, the facility will comprise (as applicable):
 - Number of beds (private, semi-private, etc.)
 - Shower and bathroom ratios
 - Common areas (dining rooms, lounges, activity areas, etc.)
 - Support facilities (laundry, kitchen, etc.)

APPENDIX B: OPERATIONAL PLAN REQUIREMENTS

OVERVIEW AND PURPOSE

The purpose of the Operational Plan is to provide a detailed account of how resident health, welfare, safety and general well being will be assured over the construction period. The order in which phases of construction will occur and the time frames that each phase will take place, must be included in the plan. The Project Summary will not be approved unless it contains an Operational Plan acceptable to the Minister.

FORMAT AND CONTENT

The Operational Plan must include the following information under the following general headings:

A. Overview of the Project

This section provides a brief description of the project including:

- what is being built, for example, a new addition or renovations to existing areas;
- the anticipated dates when construction is expected to begin and when construction is expected to be completed; and
- if the project is to be done in phases or stages, the anticipated time frames for the different phases/stages of construction.

B. Administration

This section must briefly describe how the project administration issues will be addressed including:

- the name and position title of the on-site supervisor of the construction project; and
- communication protocols between the foreman and Administrator of the long-term care facility, for example, daily meetings to be conducted.

C. Communications

This section must briefly describe the process for notification and communication to all affected parties about the project, safety protocols and other matters related to the construction project including:

- All staff - staff must be familiar with and been given the opportunity to participate in the development of the operational plan.
- Families - families must be notified of overall plan and be notified of changes that will directly affect their family member.

- Fire Marshal's Office/Local Fire Department- the Fire Marshal's Office/Local Fire Department must be notified of overall plan.
- Public Health Unit- the Public Health Unit must be notified if there is to be any change/disruption in the kitchen design and/or food service.

D. General Safety Measures

This section must indicate how general safety measures will be addressed including but not limited to:

- the name and position title of the person assigned to monitor safety.
- the separation(s) or types of barriers to be provided between all construction sites from resident care and living areas.
- safety measures which will be implemented to protect confused/wandering residents.
- staff in-service regarding safety measures including temporary barriers, temporary alarms (doors, call pulls, fire panels) - staff and construction crew must be aware of the need to keep construction areas and equipment inaccessible to residents
- openings (doors, windows and walls) into the construction site must be secure:
 - Are openings used for entering and exiting alarmed?
 - Are all alarms (permanently and temporarily placed) checked frequently?
 - Will any door alarms be temporarily disconnected?
- Measures to be implemented in the event of temporary disconnection of electricity for the following:
 - residents care (i.e., oxygen concentrators)
 - monitoring of doors on alarm
 - fire safety issues
 - emergency call bells
 - additional staffing resources
 - transportation of residents, for example, when elevators not available
 - food preparation contingency plans
 - dishwashing
 - housekeeping
 - maintenance
 - laundry
- Measures to be implemented in the event of a temporary shut off of water for the following:
 - residents personal care
 - fire safety issues
 - food preparation

- dishwashing and general kitchen sanitation
- housekeeping
- maintenance
- laundry
- Protocols to be implemented to minimize dust and dirt for the construction area.
 - What additional housekeeping hours will be provided when necessary?
 - What protection will be provided for residents who may be more affected by increased dust levels (i.e., allergies)?
- Protocols for advising the construction crew of the safety needs specific to the resident population.

E. Resident Areas

This section must briefly describe how resident areas affected by construction will be secured.

Questions to address:

- If during construction, there are approved temporary bedrooms, or overbedding of existing rooms, have all safety and comfort features been provided such as the call system, over bed lighting, privacy curtains?
- If during construction, there are approved temporary washrooms or tubrooms, or renovations are occurring in parts of these areas, have all safety and comfort features been provided, such as the call system, grab bars, lighting, privacy curtains, ventilation?
- If during construction, there are approved temporary common areas - lounge, dining, activity, have all safety and comfort features been provided such as lighting, natural lighting as a preference, call system?
- If during construction, resident outside areas are affected, has a temporary enclosed area been established?

F. Food Service

This section should briefly describe how changes to the food/meal service will be managed.

Questions to address:

- What is the impact on the food service?
- How long will the kitchen be closed?
- When will construction work be scheduled (i.e., nights only)?
- What measures are to be taken to provide safe meals to the residents, e.g., food handling, food transporting and food temperature requirements are met)

- Are nutritious meals that include sufficient menu variety, special diets and snack requirements met?
- Has the local Public Health Unit been informed and given approval to implement temporary measures?

G. Noise Factors

This section must briefly describe how noise factors will be managed.

Questions to address:

- What will the time periods be when construction noises should cease, i.e., meal times, early mornings and nights?
- Will residents have to be re-located to another section of the facility, or out on a day trip during times when construction noise is a serious concern?

H. Laundry Service

This section must briefly describe how, if applicable, laundry services will be affected and managed.

Questions to address:

- What is the contingency plan if laundry service is to be interrupted for period of time, for example, temporary location for laundry processing?

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TAB 09 STANDARDS: RESIDENT CARE

SECTION	SUBJECT		DATE OF AMENDMENT
0901	INTRODUCTION TO RESIDENT SAFEGUARDS, CARE AND SERVICES		
	01	Introduction	20 December 1993
0902	A. RESIDENT SAFEGUARDS		
	01	Standards and Criteria	July 1998
	02	Guidelines	20 December 1993
0903	B. RESIDENT CARE AND SERVICES		
NEW➤	01	Standards and Criteria	April 2006 (<i>replaces previous version</i>)

STANDARDS: RESIDENT CARE**INTRODUCTION TO RESIDENT SAFEGUARDS, CARE, AND SERVICES****INTRODUCTION**

The Resident Safeguards, and Resident Care and Services standards promote and support residents' autonomy and involvement in decision-making regarding their own care and services.

Facility staff are expected to provide residents with the opportunity, assistance, support and encouragement to assist them to meet his/her individual goals. It is understood that some residents may not choose or be able to use all of the available supports and services.

Efforts must be made to promote as much decision-making and control as possible on the part of residents. For those who have diminished capacity to make some decisions, the standards make provision for a "representative" to assist residents in expressing their wishes and understanding their rights. These representatives include family members or friends designated by the individual resident. Where applicable, it will include the person who is lawfully authorized to make decisions on behalf of the resident.

The Resident Safeguards section includes standards and criteria designed to respect, support and promote residents' rights. There is emphasis on resident/representative participation in the planning and evaluation of facility programs and services, as well as the planning and evaluation of the individual resident's own care. These standards also list key information, which the facility must provide to all residents/representatives.

The Resident Care and Services section includes the performance or achievement expectations for the provision of care, support and services to residents. Standards are made observable/understandable/measurable through the use of criteria. Criteria identify elements, which contribute to the achievement of standards. Along with standards, criteria are also requirements, which are monitored as part of the provincial accountability management program.

STANDARDS: RESIDENT CARE

INTRODUCTION TO RESIDENT SAFEGUARDS, CARE, AND SERVICES

**INTRODUCTION
(cont.)**

The standards and criteria are written from a holistic, interdisciplinary perspective in order to support a team approach to meeting residents' needs. All staff of the facility interact with residents and contribute to their quality of life. Therefore, these standards and criteria are not department specific.

It is expected that care and services will be provided in a manner which fully promotes residents' rights and respects their dignity and privacy. Care and services must also be provided in accordance with professional standards of practice; therefore, the standards do not detail professional knowledge of how the standards can be met. The means of achieving the standards are not prescribed. Rather, the facility is encouraged to develop creative approaches to organizing and providing care and services.

In addition to Resident Care and Services standards, separate standards for facility programs and services have been developed. They identify the resources and support, which the facility organizes to achieve the Resident Care and Services standards.

STANDARDS: RESIDENT CARE

A. RESIDENT SAFEGUARDS

STANDARDS AND CRITERIA

**STANDARD 1:
RESIDENT SAFEGUARDS**

A1. THERE SHALL BE MECHANISMS IN PLACE TO PROMOTE AND SUPPORT RESIDENTS' RIGHTS, AUTONOMY, AND DECISION-MAKING.

ADVOCACY

Criteria:

- A1.1 Residents/representatives shall be encouraged and supported to participate in the planning and evaluation of programs and services.
 - A1.2 Residents/representatives shall be informed of opportunities to participate in their own interdisciplinary care conferences.
 - A1.3 Residents and/or their representatives shall be encouraged to participate in the assessment, planning, provision and evaluation of the resident's care.
 - A1.4 Residents shall have access to and an explanation of their plan of care and shall receive assistance, where necessary, to read and understand the record.
 - A1.5 With the consent of the resident, the resident's representative shall have access to, and an explanation of the resident's plan of care and shall receive assistance to read and understand the record.
- Note: For those residents who are unable to give consent, the person who is lawfully authorized to make decisions regarding personal care shall have access to the resident's plan of care.*
- A1.6 Residents shall be informed of advocacy/support agencies, available to them, which can assist them in promoting their rights.
 - A1.7 Residents shall be assisted in accessing advocacy/support agencies according to their requests.

STANDARDS: RESIDENT CARE**A. RESIDENT SAFEGUARDS****STANDARDS AND CRITERIA****RESIDENTS' RIGHTS**

- A1.8 The residents' Bill of Rights shall be posted in large print in both English and French, in locations in the facility easily accessible to residents/representatives.
- A1.9 Residents and their representatives shall receive a copy of the Bill of Rights on admission. French-speaking residents shall receive a copy in the French language if they request it.
- A1.10 The facility shall have policies for the following:
- promotion of residents' rights;
 - what constitutes resident abuse;
 - how to prevent abuse;
 - actions to be taken in all instances of alleged abuse, including notification of the family/representative, police and Ministry staff;
 - for those instances where abuse has been confirmed, resources available to assist the abused resident and the person responsible for the abuse.
- A1.11 Residents' rights which shall be fully respected and promoted include, but are not limited to the following rights contained in the *Long-Term Care Statute Law Amendment Act, 1993* (Bill 101):
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's dignity and individuality and to be free from mental and physical abuse.
 2. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
 3. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.

STANDARDS: RESIDENT CARE**A. RESIDENT SAFEGUARDS****STANDARDS AND CRITERIA****RESIDENTS' RIGHTS
(CONT'D)**

4. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
5. Every resident has the right to keep in his or her room and display personal possessions, pictures and furnishings in keeping with safety requirements and other residents' rights.
6. Every resident has the right,
 - i. to be informed of his or her medical condition, treatment and proposed course of treatment;
 - ii. to give or refuse consent to treatment, including medication, in accordance with the law and to be informed of the consequences of giving or refusing consent;
 - iii. to have the opportunity to participate fully in making any decision and obtaining an independent medical opinion concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a home; and
 - iv. to have his or her medical records kept confidential in accordance with the law.
7. Every resident has the right to receive reactivation and assistance towards independence consistent with his or her requirements.

STANDARDS: RESIDENT CARE

A. RESIDENT SAFEGUARDS

STANDARDS AND CRITERIA

**RESIDENTS' RIGHTS
(CONT'D)**

8. Every resident who is being considered for restraints has the right to be fully informed about the procedures and the consequences of receiving or refusing them.
9. Every resident has the right to communicate in confidence, to receive visitors of his or her choice and to consult in private with any person without interference.
10. Every resident whose death is likely to be imminent has the right to have members of the resident's family present twenty-four hours per day.
11. Every resident has the right to designate a person to receive information concerning any transfer or emergency hospitalization of the resident and where a person is so designated to have that person so informed forthwith.
12. Every resident has the right to exercise the rights of a citizen and to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the residents' council, home staff, government officials or any other person inside or outside the home, without fear of restraint, interference, coercion, discrimination or reprisal.
13. Every resident has the right to form friendships, to enjoy relationships and to participate in the residents' council.

STANDARDS: RESIDENT CARE**A. RESIDENT SAFEGUARDS****STANDARDS AND CRITERIA****RESIDENTS' RIGHTS
(CONT'D)**

14. Every resident has the right to meet privately with his or her spouse in a room that assures privacy and where both spouses are residents in the same home, they have a right to share a room according to their wishes, if an appropriate room is available.
15. Every resident has a right to pursue social, cultural, religious and other interests, to develop his or her potential and to be given reasonable provisions by the home to accommodate these pursuits.
16. Every resident has the right to be informed in writing of any law, rule or policy affecting the operation of the home and of the procedures for initiating complaints.
17. Every resident has the right to manage his or her own financial affairs where the resident is able to do so, and where the resident's financial affairs are managed by the home, to receive a quarterly accounting of any transactions undertaken on his or her behalf and to be assured that the resident's property is managed solely on the resident's behalf.
18. Every resident has the right to live in a safe and clean environment.
19. Every resident has the right to be given access to protected areas outside the home in order to enjoy outdoor activity, unless the physical setting makes this impossible.

STANDARDS: RESIDENT CARE**A. RESIDENT SAFEGUARDS****STANDARDS AND CRITERIA****USE OF PHYSICAL
RESTRAINTS**

Note: See Glossary for a definition of restraints

Criteria

- A1.12 A resident shall not be restrained unless there is an identified risk of injury to him/herself or others, and other alternatives have been considered and have been found to be ineffective.
- A1.13 The decision to continue the use of a restraint as well as the type of restraint shall be re-evaluated prior to each application on an ongoing basis.
- A1.14 A physical restraint may be applied to a resident on the direction of a registered nurse where there is an immediate risk of injury to him/herself or others. The rationale for the use of the restraint shall be documented. A physician's verbal order shall be obtained within 12 hours of the restraint application and documented, and the resident's care plan shall be revised.
- A1.15 The use of a physical restraint may be continued only on the written order of a physician who is attending the resident. The type of restraint, and orders for application shall be documented on the resident's record and reviewed at least quarterly following the interdisciplinary team conference.
- A1.16 Where it is considered necessary to restrain a resident, the least restrictive measures shall always be used.
- A1.17 A restraint in use shall be applied to a resident according to manufacturers' specifications and facility policy.
- A1.18 Restraint use shall be documented for the period it is in use. At a minimum, there shall be a record of the time of application and removal as well as the resident's response.

STANDARDS: RESIDENT CARE

A. RESIDENT SAFEGUARDS

STANDARDS AND CRITERIA

**USE OF PHYSICAL
RESTRAINTS
(CONT'D)**

A1.19 Minimum interventions for physically restrained residents shall include but not be limited to, hourly checks to monitor the resident’s safety, comfort and position of the restraint and the release of the restraint and repositioning every two hours when the resident is awake. (See B3.40, B3.41, B3.44).

A1.20 When a restrained resident is sleeping, minimum interventions shall include but not be limited to hourly checks to monitor the resident's safety, comfort, and the position of the restraint. (See B3.40, B3.41, B3.44).

RESIDENTS' COUNCIL

A1.21 Residents shall be given the opportunity and support to establish and maintain an organized residents' council.

A1.22 Family members or other individuals from the community may attend residents' council meetings by invitation of the residents' council.

A1.23 Suggestions and complaints from the residents' council shall be documented, investigated and responded to in writing by the administrator of the facility within 21 days.

A1.24 Residents shall be informed of the results of residents' council meetings along with feedback from the administrator, (e.g., by posting of the minutes in a location easily accessible to residents and their representatives, with residents' council consent).

A1.25 Where residents do not choose to have or are unable to participate in such a council, the facility shall call an annual general meeting for residents and their representatives, to which members of the community are invited to attend. The purpose of the meeting is to provide an opportunity for residents/families/representatives to express suggestions or concerns and for the facility to report to the residents regarding the status

STANDARDS: RESIDENT CARE**A. RESIDENT SAFEGUARDS****STANDARDS AND CRITERIA**

of services in the facility.

**PROCESSES FOR
OBTAINING
INFORMATION, RAISING
CONCERNS, LODGING
COMPLAINTS OR
RECOMMENDING
CHANGES**

A1.26 On admission, each resident/representative shall be informed in writing of the processes for obtaining information, raising concerns, lodging complaints or recommending changes regarding the facility and its services. The processes shall include, but are not limited to, any of the following:

- Discussing the issue with a staff member.
- Discussing the issue with a nurse manager.
- Discussing the issue with the residents' council of the facility.
- Discussing the issue with a member of the facility administration, licensee or board (name and addresses must be posted).
- Contacting the Provincial Government:
 - local Long-Term Care Division Regional Office (address, phone number and name of director must be posted);
 - Long-Term Care Division Corporate Office;
 - the Minister of Health.
- Contacting local and/or provincial consumer groups.

A1.27 These processes, as well as the offices and numbers to contact shall also be permanently posted in a location easily accessible to residents, families and representatives.

STANDARDS: RESIDENT CARE

A. RESIDENT SAFEGUARDS

STANDARDS AND CRITERIA

**RESPONDING TO
RESIDENT/
REPRESENTATIVE
COMPLAINTS**

- A1.28 There shall be formal mechanisms for receiving, investigating, and responding to residents'/representatives' suggestions, requests and complaints. Information shall be provided in writing to residents/representatives on admission, during orientation to the facility.
- A1.29 There shall be written policies and procedures for dealing with resident/representative complaints.
- A1.30 The administrator shall respond within 10 days to all residents'/representatives' requests, suggestions and complaints, indicating possible plans of action.
- A1.31 All concerns and complaints received shall be documented, including a list of the issues, date expressed, date and follow up action taken, final resolution if any, and date feedback was provided to the complainant.
- A1.32 The Long-Term Care Division shall receive a copy of all written complaints received by the facility, including a description of the follow-up actions taken.

**STANDARD 2:
ADMISSION AGREEMENT**

A2. THERE SHALL BE A FACILITY-SPECIFIC WRITTEN ADMISSION AGREEMENT IN PLACE TO DELINEATE THE ACCOMMODATION, CARE, SERVICES, PROGRAMS, AND GOODS THAT WILL BE PROVIDED TO THE RESIDENT AND, THE OBLIGATIONS OF THE RESIDENT WITH RESPECT TO THEIR RESPONSIBILITIES AND PAYMENT FOR SERVICE

Criteria

- A2.1 The facility shall develop a process to ensure input and support of residents and families with respect to the development of the facility-specific admission agreement.

STANDARDS: RESIDENT CARE**A. RESIDENT SAFEGUARDS****STANDARDS AND CRITERIA****STANDARD 2:
ADMISSION AGREEMENT
(CONT'D)**

Note: The Resident's Council for the facility as well as any Family Advisory organizations are of primary importance in this process.

- A2.2 The admission agreement (or attached schedules) shall include the Resident Bill of Rights as contained in legislation.
- A2.3 The admission agreement shall include but not be limited to:
- i. the term of the agreement and a cancellation clause;
 - ii. the definitions of the terms contained in the agreement;
 - iii. the type and rate of accommodation that will be provided to the resident;
 - iv. the type and cost of other services that the facility may agree to provide with the approval of the resident and the process for notification of any rate change;
 - v. the accommodation, care, services, programs, and goods that the facility is required to provide in accordance with legislation, standards and criteria, and the policy and directives of the Ministry of Health;
 - vi. the obligations of the resident with respect to their responsibilities and payment for services.

Note: An admission agreement shall not require a resident to agree to pay a penalty in lieu of a specific notice period prior to discharge.

STANDARDS: RESIDENT CARE

A. RESIDENT SAFEGUARDS

STANDARDS AND CRITERIA

**STANDARD 2:
ADMISSION AGREEMENT
(CONT'D)**

- A2.4 Prior to admission or as soon as possible following admission, the resident shall be informed of the contents of the admission agreement and the meaning of each section.
- A2.5 The admission agreement shall be signed by the resident/lawfully authorized substitute and witnessed on admission to the facility, retained in the resident's records, and a copy provided to the resident.
- A2.6 The admission agreement shall be reviewed by the facility and resident/family council at least every three years and where necessary, amendments shall be made.
- A2.7 The facility shall provide the resident/lawfully authorized substitute with the opportunity to review the admission agreement annually or upon the request of the resident/lawfully authorized substitute.

**INFORMATION TO
BE PROVIDED TO
RESIDENTS ON
ADMISSION**

- A2.8 Facilities shall provide in writing to residents/representatives on admission, information and explanation about the following:
 - the facility organizational structure and internal accountability mechanisms;
 - residents' rights;
 - residents' council;
 - residents' responsibilities when living in the facility;
 - how to obtain information, raise concerns, lodge complaints, or recommend changes in the facility;

STANDARDS: RESIDENT CARE

A. RESIDENT SAFEGUARDS

STANDARDS AND CRITERIA

INFORMATION TO BE PROVIDED TO RESIDENTS ON ADMISSION (CONT'D)

- the process for resident/representative participation in assessment, planning, and evaluation of the individual resident's care and the facility programs and services;
- any advocacy process and resources available to residents;
- care, programs and services provided at no additional cost to the resident;
- other available services and associated costs to the residents;
- health care services available in the facility, or which may be arranged for by the facility, including any associated costs to the residents;
- the choice of attending physician that is available to the resident, including the resident's own physician;

Note: The expectations that will be made of any physician who provides care to residents of the facility will also be explained.

- costs of accommodation;
- other financial information such as availability of trust accounts;
- orientation information for residents/representatives to the facility;
- the facility environment, including safety and security.

STANDARDS: RESIDENT CARE**A. RESIDENT SAFEGUARDS****STANDARDS AND CRITERIA****INFORMATION TO
BE PROVIDED TO
RESIDENTS ON
ADMISSION (CONT'D)**

A2.9 The resident shall be informed in writing of the following basic care, programs and services which the facility shall provide to residents at no additional cost:

- Nursing and personal care on a 24-hour basis, including care given by or under the supervision of a registered nurse or a registered nursing assistant, the administration of medication and assistance with activities of daily living.
- Medical care that is available in the facility.

Note: Residents may continue to have their personal physician provide care to them in the facility. These physicians will be expected to meet the standards and criteria for attending physicians. (Refer to Medical Services.)

- Medical supplies and nursing equipment necessary for the care of residents, including the prevention or care of skin disorders, continence care, infection control, and sterile procedures.
- Medical devices, such as catheters and colostomy and ileostomy devices.
- Supplies and equipment for personal hygiene and grooming, including skin care lotions and powders, shampoos, soap, deodorant, toothpaste, toothbrushes, denture cups and cleansers, toilet tissue, facial tissue, hair brushes, combs, razors/shavers, shaving cream, feminine hygiene products.

STANDARDS: RESIDENT CARE**A. RESIDENT SAFEGUARDS****STANDARDS AND CRITERIA****INFORMATION TO
BE PROVIDED TO
RESIDENTS ON
ADMISSION (CONT'D)**

- Equipment for the general use of residents, including wheelchairs, geriatric chairs, canes, walkers, toilet aids and other self-help aids for the activities of daily living.
- Meal service and meals, including three meals daily, snacks between meals and at bedtime, special and therapeutic diets, dietary supplements and devices enabling residents to feed themselves.
- Social, recreational and physical activities and programs, including the related supplies and equipment.
- Laundry, including labelling, machine washing, and drying of personal clothing.
- Bedding and linen including firm, comfortable mattresses with waterproof covers, pillows, bed linen, wash cloths and towels.
- Bedroom furnishings such as beds, adjustable bed rails, bedside tables, comfortable easy chairs, and where a resident is confined to bed, a bed with an adjustable head and foot.
- Standard ward accommodation.
- The cleaning and upkeep of accommodations.
- Suitable accommodation and seating for meetings of the residents'/family councils.
- Use of an infirmary room, if available.
- Maintaining personal funds entrusted to the facility.

STANDARDS: RESIDENT CARE**A. RESIDENT SAFEGUARDS****STANDARDS AND CRITERIA****INFORMATION TO
BE PROVIDED TO
RESIDENTS ON
ADMISSION (CONT'D)**

It is not permissible to charge for:

- Prescription pharmaceutical preparations listed in the Drug Benefit Formulary.
- Special preparations or medical devices which may be obtained from the Ontario Drug Benefit Program as interim non-formulary benefits.
- Insured devices, equipment, supplies and services available to residents through other programs such as the Home Care Program and Assistive Devices Program.
- Non-prescription drugs, medication and treatment products, and supplies obtained through Ontario Government Pharmaceutical and Medical Supply Services upon requisition.

(See the Financial Administration Section 0606-03 for further details on the various supplies and equipment that may be provided by LTC facilities.)

OTHER SERVICES

A2.10 Residents/representatives shall be informed in writing about other services that may be available to them in the facility, as well as the associated costs to the residents if they agree to receive such services. These services may include, but not be limited to:

- preferred accommodation;
- hairdressing and barber services;
- telephone connections and monthly fees;
- cable television connections and monthly fees;
- newspaper delivery;

STANDARDS: RESIDENT CARE**A. RESIDENT SAFEGUARDS****STANDARDS AND CRITERIA****OTHER SERVICES
(CONT'D)**

- tuck shop;
- dry cleaning;
- mending and ironing;
- non-prescription drugs, medication and treatment products, and supplies not available through Ontario Government Pharmaceutical and Medical Supplies.

HEALTH CARE SERVICES

A2.11 Residents/representatives shall be informed in writing about the health care services that may be available in the facility or which may be arranged for by the facility, including any associated costs to the residents if they agree to receive such services, e.g., foot care, dental care.

**COSTS OF
ACCOMMODATION**

A2.12 Residents/representatives shall be informed in writing about the cost of accommodation provided to residents in the facility, including applicable resident charges for standard ward, semi-private and private accommodation.

**OTHER FINANCIAL
INFORMATION**

A2.13 Residents/representatives shall be informed in writing of other financial information including:

- Comfort allowance guaranteed to residents receiving OAS/GIS/GAINS.
- Government financial assistance programs available to citizens aged 60 years and over.
- Availability of trust accounts for residents.

**ORIENTATION TO THE
FACILITY
ENVIRONMENT,
PROGRAMS AND
SERVICES**

A2.14 Residents shall be provided written information to orient residents/families/representatives to the facility including but not limited to:

- The programs available in the facility.
- Location of fire exits.

STANDARDS: RESIDENT CARE

A. RESIDENT SAFEGUARDS

STANDARDS AND CRITERIA

ORIENTATION TO THE FACILITY ENVIRONMENT, PROGRAMS AND SERVICES (CONT'D)

- Facility and municipal smoking regulations.
- Resident identification procedure (e.g., name bands if applicable).
- Personal appliance purchase authorization or approval to operate such items in a facility.
- Location and operation of call bells.
- Exit alarm system.
- Safety devices and signs in use in the facility.
- Fire and disaster procedures and drills.
- Records and procedure for notification of next-of-kin/representative for resident injury or changes in resident status.
- Storage and responsibility for residents' valuables.
- Facility routines including visiting hours, meal hours, special diets.
- Leaves of absence procedures including casual, vacation, medical and psychiatric leaves, and the bed-holding process.

STANDARDS: RESIDENT CARE**A. RESIDENT SAFEGUARDS****GUIDELINES*****EXAMPLES: DIGNITY AND RESPECT***

Examples of activities which demonstrate respect for residents and which promote residents' dignity include but are not limited to:

- *Each resident is addressed courteously in a manner that demonstrates respect and using a name of the resident's choice. (e.g., "Mr. James, may I take you back to your room now?")*
- *Staff listen carefully and focus on the resident when he/she is talking.*
- *Each resident's dressing and grooming promotes a dignified appearance, according to the resident's preference.*
- *Each resident is supported in being as independent as possible.*
- *Each resident's belongings and personal space are respected consistently (e.g., clothing, closets and drawers, telephone, valuables).*
- *Each resident's preferences are considered at all times.*
- *Each resident's environment is kept safe and clean at all times.*
- *Each resident's response to life events is recognized and appropriate supports are arranged for as needed (e.g., relocation, family crisis, bereavement).*
- *Each resident is assisted to maintain his/her desired involvement in hobbies, community groups and religious affiliations.*

STANDARDS: RESIDENT CARE**A. RESIDENT SAFEGUARDS****GUIDELINES*****EXAMPLES: PRIVACY/
CONFIDENTIALITY***

Examples of activities which demonstrate that residents' privacy is respected and confidentiality is maintained include but are not limited to:

- *Each resident receives personal care in privacy at all times (e.g., bathing, toilet aid, continence care, dressing changes, medical examination).*
- *Privacy in residents' rooms is respected through recognizing closed doors as a desire for privacy, respecting "do not disturb" signs, and knocking prior to entering.*
- *Each resident is provided with private time and space to be with a spouse/partner, family, friends or others on request.*
- *Each resident determines the information he wishes shared with family members or others.*
- *Health team members discuss issues related to residents in a setting where confidentiality can be maintained.*
- *Each resident's medical records are kept in a secure place; they are seen only by people responsible for the resident's care.*

***EXAMPLES:
AUTONOMY/RIGHT TO BE
INFORMED***

Examples of activities which enable residents to freely make decisions from available options about their life and care and enable them to act on these decisions include, but are not limited to:

- *Each resident is involved in any decision about admission, discharge or transfer to or from a long-term care facility.*

STANDARDS: RESIDENT CARE**A. RESIDENT SAFEGUARDS****GUIDELINES**

- *Each resident is involved in the process of assessment, goal setting and planning for all aspects of his/her care.*
- *Each resident is provided with choices about his/her daily routine (e.g., bath or shower, time of activity, food preferences, amount of food, clothing, involvement in programs).*
- *Each resident is informed of the process of making complaints within the facility and outside the facility.*
- *Each resident is encouraged to be involved in the residents' council.*
- *Each resident manages his/her own financial affairs if he/she is able to do so and if that is the resident's preference.*
- *Each resident is provided information about his/her medical condition, treatment and recommended plan for treatment.*
- *Each resident is provided the opportunity to give or refuse consent for medical treatment, medications, and the use of restraints; the consequences of his/her decision to give or refuse consent are discussed with the resident by the doctor or another qualified person.*
- *Each resident is offered a second opinion about care or treatment as requested.*
- *Each resident is provided with opportunities to be involved in programs and activities which promote independence (e.g., assistance with self-dressing, walking programs, exercises, adaptations to promote independence in eating).*

STANDARDS: RESIDENT CARE**A. RESIDENT SAFEGUARDS****GUIDELINES****EXAMPLES:
FREEDOM FROM
ABUSE/NEGLECT**

Examples of what constitutes resident abuse include the following:

Physical Abuse includes but is not limited to:

- *wilful direct infliction of physical pain or injury from slapping, pushing, pinching, beating, twisting, shaking, burning, forced feeding, rough handling*
- *sexual assault or molestation*
- *forced confinement in a room, bed or chair*

Emotional Abuse includes but is not limited to:

- *verbal assault, humiliating, threatening, intimidating, insulting*
- *isolating, ignoring, denying participation in discussions with respect to his or her own life*
- *treating a resident like a child.*

Financial Abuse includes but is not limited to:

- *forcing a person to sell property*
- *stealing a resident's money, pension cheques or possessions*
- *fraud, forgery and extortion*
- *wrongful use of Power of Attorney*

Neglect includes but is not limited to:

- *withholding food and/or health services*
- *deliberately failing to meet a dependent resident's needs.*

STANDARDS: RESIDENT CARE
B. RESIDENT CARE AND SERVICES
STANDARDS AND CRITERIA

This consolidation of the B, J and K standards is effective April 1, 2006 and replaces all previous versions of:

- Document 0903-01, Standards and Criteria B1, B2, B3, B4 and B5
- Document 1008-01, Standard and Criteria J1, Dental Services
- Document 1009-01, Standard and Criteria K1, Foot Care Services
- Document 1009-02, Foot Care Services *Guidelines*
- Document 0903-02, Standard S and Criteria, dated September 2005

INTRODUCTION

The Resident Care and Services standards are organized under five broad categories:

1. Assessment of each resident's needs for care and services
2. Planning of each resident's care and services
3. Implementation: provision of care and services to each resident consistent with his/her plan of care
4. Monitoring and evaluating each resident's care, services and outcomes of care
5. Documentation of each resident's care and services

ASSESSMENT AND PLANNING

Assessment is the systematic collection and review of resident-specific information gathered from all available sources.

Whenever possible, the primary source of any information is the resident. In discussion with the resident, staff comes to better understand the resident's values, needs, wishes, strengths, social and personal resources, culture, interests, health status, extent of independent functioning, type and amount of supports required.

Assessment is a continuous process. Assessments done on admission to the LTC home should build on information provided by the resident/representative prior to admission. Reassessment then occurs at least quarterly and whenever there is a change in the resident's health status, abilities or needs.

STANDARDS:
**B. RESIDENT CARE
 RESIDENT CARE AND SERVICES
 STANDARDS AND CRITERIA**

**ASSESSMENT AND
 PLANNING (CONT'D)**

During the assessment, every effort should be made to minimize duplication and prevent repetition for the resident or others providing information.

The resident's plan of care gives direction for the care, support and services to be provided. The plan of care is the result of a systematic communication and assessment process with the resident/representative and members of the interdisciplinary care team, with the collaboration of other professionals on a referral basis. Goals may include, for example, prevention of disease or further limitations, maintenance or improvement of current abilities.

The resident's involvement in care planning should be sensitive to the wishes of the resident. This means that some residents may not wish to attend a team conference, but would prefer to discuss their needs on a one-to-one basis.

**PROVISION OF CARE
 AND SERVICES**

Care and services are provided according to each resident's assessed needs and mutually determined goals identified in his/her individual plan of care.

**MONITORING AND
 EVALUATION**

Each resident's care and services are monitored and evaluated to determine the extent to which actions have been successful in achieving desired goals. The process of monitoring and evaluation results in reassessing, reordering priorities, setting new goals, and revising the plan of care.

DOCUMENTATION

All significant information about each resident is documented in his/her record. Documentation in each resident's record includes identification of the residents' needs, the plan of care to address the identified needs, the care and services provided to respond to his/her needs, and an evaluation of care and services and the resident's care outcomes.

STANDARDS: **RESIDENT CARE**
B. **RESIDENT CARE AND SERVICES**
STANDARDS AND CRITERIA

STANDARD 1:
ASSESSMENT

B1. EACH RESIDENT'S NEEDS FOR CARE AND SERVICES SHALL BE DETERMINED WITH THE RESIDENT/REPRESENTATIVE THROUGH AN INTERDISCIPLINARY ASSESSMENT PROCESS.

Criteria

- B1.1 Each resident/representative shall be encouraged and supported to participate in the resident's assessment process.
- B1.2 The assessment process shall include determining the resident's preferences, strengths, social and personal resources, interests, health status, needs, extent of independent functioning, type and amount of support required, and decisions regarding the type of care and/or interventions, including advance directives or substitute decisions.
- B1.3 Building on previous information, medical and nursing assessments shall be completed within 7 days of admission.

Note: For short-stay residents, the goal is to safely support/continue the plan of care and services that has been implemented in the community or hospital prior to admission. Repetition of assessments and care planning are unnecessary. The care plan can be built on previous assessments, information obtained during the pre-admission assessment and initial assessment once admitted. If a resident has used a short-stay program before, the previous care plan may be reactivated and updated. Records from other LTC homes may also be used.

STANDARDS:
B. RESIDENT CARE
RESIDENT CARE AND SERVICES
STANDARDS AND CRITERIA

STANDARD 1:
ASSESSMENT (CONT'D)

B1.4 Assessments by the other members of the LTC home's interdisciplinary care team shall be completed within 21 days of each resident's admission.

Note: For short-stay residents, assessments by other care team members are completed only if required to meet the realistic goals which have been negotiated with the resident/representative.

B1.5 The interdisciplinary team shall assess each resident's need for referral to physicians with specialist knowledge or other external consultants.

B1.6 Each resident's care and service needs shall be reassessed at least quarterly and whenever there is a change in the resident's health status, needs or abilities. (See B2.6).

NEW ➤
 Assessing Residents' Bowel and Bladder Functioning and Level of Continence

B1.7 Each resident's bowel and bladder functioning, including individual routines and the resident's level of continence, shall be:

- Assessed within 7 days of admission, as part of the interdisciplinary assessment
- Reassessed at least quarterly; and
- Reassessed when there is any change in the resident's health status that affects continence.

NEW ➤
 Continence Care Protocols To Meet Residents' Individual Needs

B1.8 The Long-Term Care (LTC) Home Operator shall develop and implement continence care protocols/procedures that address residents' individual needs with respect to continence of the bowel and bladder. The continence care protocols shall address:

- Residents who are continent
- Residents who are not currently, but have the potential to be, continent
- Residents who are incontinent.

NEW ➤

B1.9 Each individualized program of bladder continence care shall be reassessed quarterly, and when indicated by a change in the resident's condition that affects continence.

STANDARDS:
**B. RESIDENT CARE
 RESIDENT CARE AND SERVICES
 STANDARDS AND CRITERIA**

**STANDARD 1:
 ASSESSMENT (CONT'D)**

NEW ➤

B1.10 This individualized program of bowel continence care shall be reassessed quarterly, and when indicated by a change in the resident's condition that affects continence.

NEW ➤

Identifying a Resident's Level of
 Continence

B1.11 The LTC Home Operator's policies and procedures for bowel and bladder function shall include the identification of a resident's level of continence and shall assess the following and identify the contributing factors to incontinence:

- Frequency and individual patterns of toileting
- Fluid intake
- Method(s) of toileting/environmental barriers
- Functional abilities (e.g., mobility)
- Safety
- Medications
- Cognitive ability and awareness of the urge to void or defecate
- Presence of any infection
- Potential for continence promotion (e.g., with prompted voiding)
- Overall health status
- Resident's preferences

STANDARDS:
**B. RESIDENT CARE
RESIDENT CARE AND SERVICES
STANDARDS AND CRITERIA**

**STANDARD 1:
ASSESSMENT (CONT'D)**

NEW ➤
Continence Care – Bowel

B1.12 The LTC Home Operator shall develop and implement policies and procedures to identify residents who are prone to constipation and provide the bowel management assistance that those residents require. These policies and procedures shall take into consideration the following factors:

- Bowel pattern (frequency and character of stool, usual time of bowel movement)
- Episodes of constipation and/or fecal incontinence or soiling
- Usual fluid and food intake (type of fluids, amounts and time)
- Method of toileting, functional abilities
- Intake of fibre
- Relevant medical history
- Medications
- Activity level
- Measures resident has previously taken to have a bowel movement
- Ability to sense urge to defecate
- When to make a referral to a physician
- Risk factors related to constipation, obstipation and diarrhea.

STANDARDS:
**B. RESIDENT CARE
 RESIDENT CARE AND SERVICES
 STANDARDS AND CRITERIA**

**STANDARD 1:
 ASSESSMENT (CONT'D)**

NEW ➤

**SKIN CARE
 AND WOUND
 MANAGEMENT**

- B1.13 Each LTC Home Operator shall develop and follow policies on the management of skin care (including care of the skin, nails, feet and mouth). These policies shall include, but not be limited to, the following:
- Care providers' roles and responsibilities in the maintenance of each resident's skin integrity
 - The role and membership of the Interdisciplinary Skin Care Management Team
 - Assessments (type, frequency, clinical tools used, wound staging)
 - Referrals, interdisciplinary communication and consultation
 - Education plan for nursing staff
 - Bathing and personal hygiene care as related to skin care
 - Nutrition care as related to skin integrity and wound healing
 - The process for obtaining the resident's consent for treatment and personal care (personal assistance services), or consent of the resident's substitute decision-maker (SDM) with legal authority to make treatment or personal care (personal assistance services) decisions if the resident is mentally incapable of making treatment decisions
 - The treatment intervention process, including a list of basic skin care supplies and positioning devices
 - Safe and effective techniques for positioning and transferring residents
 - Safe and effective use of equipment for positioning and transferring residents
 - If an optional service is being considered, the resident's authorization for payment, or authorization for payment from the resident's SDM with legal authority to make property or financial decisions.

STANDARDS:
B. RESIDENT CARE
RESIDENT CARE AND SERVICES
STANDARDS AND CRITERIA

STANDARD 1:
ASSESSMENT (CONT'D)

NEW ➤
Interdisciplinary Team and
Skin Care Coordinator

B1.14 An interdisciplinary team shall coordinate the LTC Home Operator's program of skin care and wound management. This interdisciplinary team shall include a Skin Care Coordinator, who is a regulated health-care professional, and who will coordinate and bring together the required expertise in order to educate and support staff on skin care and wound management and knowledge of current "best practices". The team shall meet quarterly, at minimum.

NEW ➤
 Complete Skin Assessments

B1.15 Each resident shall have his or her skin-related risk assessed by a member of the registered nursing staff, under the following circumstances:

- Upon admission, as part of the development of a plan of care
- Quarterly and whenever there is a change in the resident's health status that affects skin integrity
- During the six-week post-admission review – when the resident has been identified as being at risk for altered skin integrity.
- For residents who are at risk for altered skin integrity, a complete skin assessment shall be required within 24 hrs upon return from hospital for an absence greater than 24 hours, and upon return from leave(s) of absence greater than 24 hours.

NEW ➤

B1.16 This skin-related risk assessment shall include documented interventions aimed at maintaining the resident's skin integrity, and shall be conducted at the convenience of the resident.

NEW ➤
 Residents With Altered Skin
 Integrity: Assessment and
 Referrals

B1.17 Each resident who exhibits skin breakdown and/or wounds shall be assessed each week or more frequently, if needed, by a member of the registered nursing staff.

NEW ➤

B1.18 The registered dietitian shall assess each resident who exhibits skin breakdown and / or wounds.

STANDARDS:
B. RESIDENT CARE
RESIDENT CARE AND SERVICES
STANDARDS AND CRITERIA

STANDARD 1:
ASSESSMENT (CONT'D)
NEW ➤

Co-ordination of
 Dental Care Services
 -Treatment

NEW ➤

B1.19 Referrals shall be made to one or more regulated health care professional(s) with expertise in skin care, as necessary.

B1.20 When a resident requires dental treatment or other services not provided by the LTC home, the Home Operator shall make every effort to secure an appointment with a dentist or other dental professional of the resident's choice.

If referral for dental services is being considered, the resident's authorization for payment, or authorization for payment from the residents' SDM with legal authority to make property or financial decisions is required.

Co-ordination of
 Dental Care Services
 -Assessment and Preventative

NEW ➤

B1.21 A dental assessment and preventive services (scaling and cleaning, and an assessment to ensure that dentures are properly fitted) performed by qualified dental professionals shall be offered to residents annually.

If dental assessment and preventative services are being considered, the resident's authorization for payment, or authorization for payment from the residents' SDM with legal authority to make property or financial decisions is required.

Co-ordination of
 Dental Care Services
 -Emergency

NEW ➤

B1.22 The LTC Home Operator shall arrange to provide emergency dental services for residents, as required.

In areas where emergency dental services are limited, the Operator shall make every effort to secure emergency services for each resident who requires them. In situations where emergency dental services are unable to be accessed, a referral to the physician is appropriate.

If referral for emergency dental services is being considered, the resident's authorization for payment, or authorization for payment from the residents' SDM with legal authority to make property or financial decisions is required.

STANDARDS:
B. RESIDENT CARE
RESIDENT CARE AND SERVICES
STANDARDS AND CRITERIA

STANDARD 1:
ASSESSMENT (CONT'D)

- Co-ordination of
Foot Care Services
- NEW ➤**
- B1.23 When a resident requires a referral to a foot care provider, such as a podiatrist, chiropodist, or registered nursing staff with advanced skills in foot care, the Home Operator shall assist the resident to arrange treatment, if the resident wishes assistance.
- If referral for a foot care specialist is being considered, the resident's authorization for payment, or authorization for payment from the residents' SDM with legal authority to make property or financial decisions is required.

STANDARDS: **RESIDENT CARE**
B. **RESIDENT CARE AND SERVICES**
STANDARDS AND CRITERIA

STANDARD 2:
PLANNING

B2. EACH RESIDENT'S CARE AND SERVICES SHALL BE PLANNED WITH THE RESIDENT/REPRESENTATIVE THROUGH AN INTERDISCIPLINARY PLANNING PROCESS.

Criteria

B2.1 A written plan of care shall be initiated for each new resident within 24 hours of admission.

B2.2 The initial plan of care shall provide sufficient information to assist staff to give safe care, including but not limited to:

- safety/security risks
- the extent of independence in activities of daily living and type of assistance needed
- medication, treatment and diet orders

B2.3 An organized, documented interdisciplinary team conference shall be held with the resident/representative, if they are able and wish to attend, within six weeks following admission, to review and further develop the written plan of care.

Note: For short-stay residents, a team conference is not required for the purposes of reviewing and revising the plan of care. The plan of care and the frequency of reassessments may be modified in order to reflect the resident's needs during his/her limited stay. However, reassessment will be necessary if the resident's condition changes; this will be very important if the assessment requires a change in the plan of care or medication/diet orders.

B2.4 Each resident's plan of care shall reflect his/her current strengths, abilities, preferences, needs, goals, safety/security risks, and decisions including advance directives provided by the resident or any substitute decisions provided by the lawfully authorized person. The plan of care shall give clear directions to staff providing care.

**STANDARDS:
B. RESIDENT CARE
RESIDENT CARE AND SERVICES
STANDARDS AND CRITERIA**

**STANDARD 2:
PLANNING (CONT'D)**

- B2.5 Each resident's plan of care shall be accessible to the members of the health care team who provide care and services to residents. Pertinent information, including changes in the resident's condition, shall be communicated to staff providing care.
- B2.6 Each resident's plan of care shall be reviewed and where necessary revised, at least quarterly, by the physician, nursing staff, the dietitian or food service supervisor, and other care team members as appropriate.
- B2.7 An organized, documented interdisciplinary care team conference shall be held annually with the resident/representative, if they are able and wish to attend, to reassess the resident's care and service needs, and to review and revise the plan of care.

CONTINENCE CARE

NEW ➤

- B2.8 The findings of each continence care assessment and reassessment shall be documented in the resident's plan of care.

NEW ➤

Residents Who Have Been Identified As Incontinent

- B2.9 Each resident who has been identified as bladder incontinent shall have an individualized program of continence care to promote comfort, maintenance of skin integrity, and prevention of infections. This program shall be documented in the resident's plan of care.

NEW ➤

Residents Who Have Been Identified As Bowel Incontinent

- B2.10 Each resident who has been identified as bowel incontinent shall have an individualized program of continence care to promote comfort, maintenance of skin integrity and to prevent infections. This program shall be documented in the resident's plan of care.

NEW ➤

Residents Who Are Continent or Have the Potential for Continence

- B2.11 For residents who are continent, or who have been assessed as having the potential for continence, an individualized plan of care shall be developed to maintain or promote continence. This plan shall take into consideration the specific contributing factors as determined on assessment conducted under section B1, "Identifying a Resident's Level of Continence".

STANDARDS:
B. RESIDENT CARE
RESIDENT CARE AND SERVICES
STANDARDS AND CRITERIA

STANDARD 2:
PLANNING (CONT'D)

- NEW** ➤ Residents With Altered Skin Integrity: Plans of Care
- B2.12** The skin care treatment plan for each resident with altered skin integrity shall be developed in consultation with, at minimum, the:
- Resident or SDM
 - Registered nursing staff
 - Attending physician or RNEC [Registered Nurse Extended Class (Nurse Practitioner)] or Enterostomal Therapist
 - Skin Care Coordinator and/or infection control practitioner
 - Registered Dietitian
 - Designated front-line staff.
- NEW** ➤ **B2.13** Each resident who is assessed as being at risk for altered skin integrity, or whose skin integrity has been compromised, shall have that risk or condition documented in the resident's plan of care.
- This plan shall outline the skin care measures to be provided to the resident. These measures shall include but not be limited to:
- Promotion of healing
 - Optimizing nutrient intake
 - Minimizing pain and discomfort
 - Efforts to prevent deterioration and infection.
- NEW** ➤ **B2.14** The frequency and method of bathing, as well as the alternatives in exceptional circumstances (e.g. when the resident has altered skin integrity), shall be presented to the resident and identified in each resident's plan of care.

STANDARDS:
**B. RESIDENT CARE
 RESIDENT CARE AND SERVICES
 STANDARDS AND CRITERIA**

STANDARD 3: NEW ➤ B3. EACH RESIDENT SHALL RECEIVE CARE AND PROVISION OF SERVICES CONSISTENT WITH HIS/HER PLAN OF CARE AND WITH RESIDENTS' RIGHTS OUTLINED IN THE BILL OF RIGHTS, AND THE HEALTH CARE CONSENT ACT AND THE SUBSTITUTE DECISIONS ACT.

Criteria		
EMOTIONAL, SOCIAL AND CULTURAL	B3.1	Each resident shall be encouraged to have his/her room reflect his/her personal style, cultural context and preferences with pictures, possessions and furnishings (in keeping with safety requirements and other residents' rights).
	B3.2	Each resident's responses to situations and life events shall be recognized and community resources contacted as required.
	B3.3	Each resident shall be assisted in arranging for available counseling and bereavement support, according to his/her needs and preferences.
	<i>Note:</i>	<i>For one-to-one counseling which may not be provided by the LTC home, payment of any costs incurred shall be authorized by the resident/representative..</i>
	B3.4	Each resident shall be supported and assisted in maintaining his/her desired involvement with family, friends and others in the community
	B3.5	Each resident shall be supported in maintaining his/her desired cultural observances, practices and affiliations and in maintaining desired links with his/her cultural community.
	<i>Note:</i>	<i>For opportunities, which are not part of the LTC home's programs, payment of any costs incurred shall be authorized by the resident/representative).</i>

STANDARDS:
B. RESIDENT CARE
RESIDENT CARE AND SERVICES
STANDARDS AND CRITERIA

STANDARD 3:
RESIDENT CARE, CON'T
LANGUAGE

B3.6 Available resources shall be accessed, if required, to assist non-English-speaking residents to communicate with others and to assist staff to communicate with these residents.

Note: In areas designated under the French Language Services Act, the assessment, team conference, and care plan shall be available in French, if desired by French-speaking residents.

LTC homes should contact their Compliance Advisor for further clarification and for information about assistance in implementing French language services expectations.

RECREATION AND LEISURE

B3.7 Opportunities shall be provided for each resident to plan, initiate, facilitate and participate in his/her own leisure, entertainment, recreational and educational opportunities, as desired by the resident.

B3.8 Support/assistance shall be provided as needed to assist each resident to prepare for and attend recreation and leisure activities of his/her choice.

SPIRITUAL AND RELIGIOUS

B3.9 Each resident shall be supported and assisted in maintaining his/her preferred spiritual and religious observances, practices and affiliations.

B3.10 Each resident shall have access to/be assisted in arranging for available spiritual and religious resources, according to his/her needs and preferences.

B3.11 Support/assistance shall be provided as needed to assist each resident to prepare for and attend spiritual and religious activities of his/her choice.

COGNITIVE AND INTELLECTUAL

B3.12 Each resident's physical environment and care programming shall promote his/her orientation to time, place, person and event.

STANDARDS:
B. RESIDENT CARE
RESIDENT CARE AND SERVICES
STANDARDS AND CRITERIA

STANDARD 3:
RESIDENT CARE, CON'T

B3.13 Each resident shall have opportunities and assistance to participate in programs which are appropriate to his/her cognitive status, interests and preferences, both within the LTC home and in the community.

Note: For opportunities, which are not part of the LTC home's programs, payment of any costs incurred shall be authorized by the resident/representative).

B3.14 Opportunities shall be provided for each resident to access resources such as newspapers, books, radios, and television.

B3.15 Information and assistance shall be provided to assist each resident to participate in learning opportunities of their choice, both within the LTC home and in the community.

SAFETY AND SECURITY

B3.16 Each resident's environment shall be maintained to minimize safety and security risks. Action shall be taken to protect each resident from identified potentially hazardous substances, conditions and equipment.

B3.17 Risks to each resident's health and safety shall be identified and addressed in ways that consider his/her choice, freedom of movement, dignity and respect, in keeping with other residents' rights.

Note: Standards and Criteria relating to use of restraints are now found in Section A: Residents' Safeguards, A.1.12-A1.20.

SENSORY FUNCTION AND COMMUNICATION

B3.18 Each resident shall be offered support and assistance to enable him/her to communicate and to be as independent as possible.

B3.19 Referrals shall be made as required for assessments of each resident's sensory function and communication, as authorized by the resident/representative.

STANDARDS:
B. RESIDENT CARE
RESIDENT CARE AND SERVICES
STANDARDS AND CRITERIA

STANDARD 3:
RESIDENT CARE, CON'T

- B3.20 Arrangements shall be made for acquiring mechanical aids to enhance sensory function and communication, when the resident/ representative authorizes payment.
- B3.21 Each resident's sensory and communication aids, e.g. eye glasses and hearing aids, shall be cared for, cleaned, and accessible to him/her.
- B3.22 Arrangements shall be made for repair of sensory and communication aids when payment is authorized by the resident/representative.
- B3.23 Each resident shall receive nutritional care according to his/her assessed needs and measures shall be taken to identify and address problems related to nutrition
- B3.24 Each resident's height shall be recorded on admission and his/her weight shall be measured and recorded on admission and subsequently at least monthly. Changes in weight shall be evaluated and action shall be taken as required
- B3.25 The food and fluid intake of each resident who is identified at nutritional risk shall be monitored and steps shall be taken to address problems.
- B3.26 Each resident with needs for assistance shall be professionally assessed and shall be provided with special utensils/assistive devices as required.
- B3.27 Each resident shall be offered desired portions of safe, palatable, nutritious, appealing food and fluids in sufficient quantity to meet his/her nutritional needs.
- B3.28 Each resident shall have opportunities to select his/her choice of food at meals from available menus.
- B3.29 Each resident shall be provided sufficient fluids to maintain proper hydration.

NUTRITION

STANDARDS:
B. RESIDENT CARE
RESIDENT CARE AND SERVICES
STANDARDS AND CRITERIA

STANDARD 3:
RESIDENT CARE, CON'T

- | | | | |
|-----------------------------|------------------|-------|--|
| | | B3.30 | Food and beverages shall be given to each resident at a temperature and in a manner that promotes comfort and safety. |
| | | B3.31 | Sufficient time shall be given to allow each resident to eat at his/her own pace. |
| | | B3.32 | Each resident shall receive encouragement, supervision and assistance with food and fluid intake to promote his/her safety, comfort and independence in eating. |
| | | B3.33 | Each resident who requires assistance or supervision with meals shall be positioned to allow appropriate socialization and proper feeding techniques. |
| | | B3.34 | Texture-modified foods served shall not be stirred together, unless requested by the resident. |
| ORAL AND DENTAL CARE | AMENDED ➤ | B3.35 | Residents shall have clean teeth and mouths, and steps shall be taken to maintain the integrity of residents' oral tissue. |
| | AMENDED ➤ | B3.36 | Deleted. |
| | AMENDED ➤ | B3.37 | Each resident who wears dentures shall have clean, labeled dentures that he or she can locate and use. Staff shall assist residents with their dentures, as required. |
| SKIN AND NAIL CARE | AMENDED ➤ | B3.38 | Each resident's fingernails and toenails shall be cleaned and trimmed in accordance with his or her stated preferences and documented on the resident's plan of care. |
| BATHING REQUIREMENTS | AMENDED ➤ | B3.39 | Each resident shall be bathed at least twice a week – if the resident so desires – by the method of his or her choice (i.e. tub bath, sponge bath, shower) and more frequently as determined by the hygiene requirements of the resident. Bathing by a method other than that which the resident has chosen may be required, due to the resident's exceptional circumstances, including hygiene-related or other needs, such as altered skin |

STANDARDS:
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integrity.

**STANDARD 3:
 RESIDENT CARE, CON'T**

SKIN CARE AND WOUND MANAGEMENT	AMENDED ➤	B3.40	Each resident shall receive skin care according to his or her individually assessed needs. This individualized skin care shall: <ul style="list-style-type: none"> ▪ Reduce or relieve pressure ▪ Promote and maintain skin integrity ▪ Promote the resident's comfort and mobility ▪ Promote the prevention of infection ▪ Promote good nutritional care as it relates to skin integrity and wound healing.
	AMENDED ➤	B3.41	Each resident who requires assistance in repositioning shall be turned or repositioned at least every two hours , while he or she is awake.
	AMENDED ➤	B3.42	Basic skin care products shall be available and accessible for use.
	AMENDED ➤	B3.43	Each resident's treatment plan shall be carried out.
COMFORT, REST AND SLEEP	AMENDED ➤	B3.44	Each resident's physical environment, positioning, health treatment and care routines shall promote his or her comfort, rest and sleep.
	AMENDED ➤		Disruptions to a resident's sleep shall be minimized. Residents who are at high risk for skin integrity issues shall be turned and provided skin care at minimum two (2) times on the night shift. Changes to turning and skin care frequency will be assessed on an individual basis and documented on the resident's plan of care.
		B3.45	Each resident who experiences pain/discomfort shall receive care to manage the pain/discomfort.
		B3.46	Each resident's individual desired bedtime routines shall be encouraged and promoted, in keeping with other residents' rights.

STANDARDS:
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STANDARD 3:
RESIDENT CARE, CON'T

AMENDED ➤ B3.47 Positioning aids used to relieve pressure and to promote each resident's comfort and healing, as required, shall be available within the LTC home and accessible to staff.

ELIMINATION

AMENDED ➤ B3.48 Each resident shall be clean and dry with every effort made to maintain dignity, comfort and independence.

Residents Who Are Unable to
Toilet Independently

AMENDED ➤ B3.49 Individual toileting schedules shall be established for each resident who is unable to toilet independently and who has been assessed as having the potential to benefit from a toileting schedule.

AMENDED ➤ B3.50 Each resident who is unable to toilet independently shall be provided with assistance in accordance with the plan of care and the resident's request.

AMENDED ➤ B3.51 The LTC Operator shall provide comfortable continence care products that meet residents' care needs and promote their dignity and independence. These continence care products shall be provided at no charge to the residents who require them.

HYGIENE AND GROOMING

B3.52 Each resident's hygiene and grooming care shall meet his/her needs and shall consider his/her preferences whenever possible.

**ACTIVITIES OF DAILY
LIVING**

B3.53 Each resident shall receive supervision/assistance and services which promote independence, maintain or improve function in activities of daily living, according to his/her assessed abilities, wishes and preferences.

B3.54 Each resident shall receive supervision/assistance and services which promote mobility (i.e. transfers, ambulation, endurance), according to his/her assessed abilities, wishes and preferences.

B3.55 Each resident's environment shall promote independence in activities of daily living.

STANDARDS:
**B. RESIDENT CARE
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**STANDARD 3:
 RESIDENT CARE, CON'T**

		B3.56	Each resident shall be instructed in the use of his/her assistive devices, and shall be supported in using them.
ELIMINATION			
	NEW ➤	B3.57	For each resident who has been identified as being at risk for constipation, measures shall be taken to remedy and to prevent the occurrence of constipation, including the use of natural stimulants. These measures shall be determined by the interdisciplinary team, and consented to by the resident or, if the resident is incapable of providing consent, by his or her substitute decision-maker (SDM) and documented on the resident's plan of care.
Preventative Measures for Residents at Risk of Constipation			
	NEW ➤	B3.58	The frequency of changing a resident's continence care product shall be based on the resident's individual needs.
SKIN CARE AND WOUND MANAGEMENT	NEW ➤	B3.59	Each resident's nutritional plan of care as it relates to skin integrity or the promotion of wound healing shall be carried out.
Repositioning Residents and Relieving Pressure	NEW ➤	B3.60	When a resident requires assistance in repositioning, the LTC Home Operator will refer the resident to the attending physician to evaluate for further referral to a physiotherapist, and/or to refer the resident to an occupational therapist.
Transferring and Positioning Residents Safely	NEW ➤	B3.61	When transferring or positioning a resident, staff shall use safe transferring and positioning techniques and equipment.
Resident's Hygiene Needs	NEW ➤	B3.62	Each resident shall receive assistance as needed with her or his personal hygiene needs, every morning and evening, and more often as necessary.

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STANDARD 3:
RESIDENT CARE, CON'T

Provision of Advanced Foot Care

NEW ➤

B3.63

Advanced foot care shall be provided to residents only by persons governed by the *Regulated Health Professions Act* who are qualified with advanced skills in foot care

Skin Care
And Wound
Management Program

NEW ➤

B3.64

The Long-Term Care (LTC) Home Operator shall develop and follow an organized program of skin care (including care of the skin, nails, feet and mouth) and wound management with the objective of promoting and achieving the skin integrity of residents.

STANDARDS:
**B. RESIDENT CARE
 RESIDENT CARE AND SERVICES
 STANDARDS AND CRITERIA**

**MONITORING AND
 EVALUATION**

**B4. THERE SHALL BE ONGOING MONITORING
 AND EVALUATION OF EACH RESIDENT'S
 CARE, SERVICES, AND CARE OUTCOMES.**

Criteria

B4.1 Changes in each resident's condition, as well as any other significant information, shall be promptly reported to the staff member in charge of the resident's care.

B4.2 Each resident/representative shall be encouraged and supported to participate in the evaluation of the resident's plan of care and outcomes of care and services.

B4.3 Each resident's care and services shall be modified in response to the resident's changing needs, wishes and preferences.

Continence Care Products

NEW ➤

B4.4 The LTC Home Operator's quality management program shall include an annual evaluation of the continence care products to determine residents' satisfaction, and shall be based on feedback from residents, family members, residents' substitute decision-makers, and staff. Evaluation information will inform the Operator's purchasing decision when vendor contracts are negotiated.

NEW ➤

B4.5 When an evaluation of the residents' satisfaction with the continence care products provided at no charge has been carried out, the LTC Home Operator shall take action (e.g. select specific products for the residents to try out) to address the results of the evaluation.

NEW ➤

Skin Care and Wound Management

B4.6 The LTC Home Operator shall monitor and evaluate the effectiveness of the home's skin care and wound management program. This report shall be documented quarterly.

STANDARDS:
B. RESIDENT CARE
RESIDENT CARE AND SERVICES
STANDARDS AND CRITERIA

STANDARD 5:
DOCUMENTATION

B5. ALL SIGNIFICANT INFORMATION ABOUT EACH RESIDENT SHALL BE DOCUMENTED IN HIS/HER RECORD.

Criteria

B5.1 Documentation in each resident's health record shall include the identification of his/her needs and wishes for care and services and the plan of care to address the identified needs.

Note: For short-stay residents, the goal is to safely support/continue the plan of care and services that has been implemented in the community or hospital prior to admission. Repetition of assessments and care planning are unnecessary.

The care plan can be built on previous assessments, information obtained during the pre-admission assessment and initial assessment once admitted. If a resident has used a short-stay program before, the previous care plan may be reactivated and updated. Records from other LTC homes may also be used.

B5.2 The care and services provided to each resident shall be documented in the resident's record according to LTC home policies and procedures.

B5.3 The evaluation of care and services and care outcomes shall be documented in each resident's health record.

B5.4 All documentation in the resident's health record shall be:

- current
- complete
- accurate
- legible
- written by the person who made the observation or who provided or supervised the care or treatment
- written as close to the time of the event as possible
- written in chronological order
- permanently recorded
- identified by the date, time, signature and status of the person documenting the entry.

STANDARDS: RESIDENT CARE
B. RESIDENT CARE AND SERVICES
STANDARDS AND CRITERIA

STANDARD 5:
DOCUMENTATION (CONT'D)

<p>NEW> Residents' Purchase of Continence Care Products</p>	B5.5	<p>When a resident wishes to purchase her or his own continence care products, the reasons for doing so shall be documented. These reasons shall include an explanation as to why the resident, SDM or family member deems the products offered by the LTC Home Operator to be inadequate to meeting the resident's needs.</p>
<p>NEW> Bathing Requirements</p>	B5.6	<p>Any changes that require a revision to the plan of care, including any changes to the resident's bathing routine and preferences, shall be documented.</p>
<p>PALLIATIVE CARE AMENDED></p>	<i>Note:</i>	<p><i>For content relating to residents with palliative care needs, see B1.2, B2.5, B3.3, B3.10, B3.44 and B3.45.</i></p>

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	02 Guidelines	30 November 1995
1002	D. STAFF EDUCATION	
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1003	E. RECREATION AND LEISURE SERVICES	
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1014	P. DIETARY SERVICES	
NEW➤	01 Standards and Criteria	January 2007
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STANDARDS: PROGRAMS AND SERVICES

C. NURSING SERVICES

STANDARDS AND CRITERIA

INTRODUCTION

This section outlines the nursing services that are required to support the provision of nursing and personal care to all residents of the facility. For a description of the care and services which the facility is expected to provide to each resident, refer to the Resident Safeguards and Resident Care and Services sections of the manual.

STANDARD 1: SERVICE PROVISION

C1. THERE SHALL BE AN ORGANIZED PROGRAM OF NURSING SERVICES TO MEET RESIDENTS' NURSING AND PERSONAL CARE NEEDS, CONSISTENT WITH THE PROFESSIONAL STANDARDS OF PRACTICE OF THE COLLEGE OF NURSES OF ONTARIO.

Criteria

NURSING STAFF

C1.1 There shall be a director of nursing responsible for managing nursing services.

C1.2 Qualifications of **new directors of nursing** shall include:

- A General Registered Nurse with a current certificate of competence with the College of Nurses of Ontario, **and**
- Post-R.N. education in gerontology or 3 years relevant experience in working with persons in long-term care, (including diploma or certificate courses such as those offered at community colleges), **and**
- Post-R.N. education in management or a minimum of 3 years relevant experience in management.

STANDARDS: PROGRAMS AND SERVICES**C. NURSING SERVICES****STANDARDS AND CRITERIA****NURSING STAFF
(CONT'D)****Criteria**

C1.3 All Registered Nurses and Registered Practical Nurses who provide care to residents in the facility shall have a current certificate of competence with the College of Nurses of Ontario.

**ADMINISTRATION OF
MEDICATIONS BY
REGISTERED
PRACTICAL NURSES**

C1.4 Registered Practical Nurses who are on staff and are currently responsible for the administration of medications to residents, and who have previously been approved by the Ministry (applies to Homes for the Aged), or who have had administrative approval by the facility (applies to Nursing Homes only) may continue to administer medications.

All new Registered Practical Nursing staff who will be administering medications to residents shall have completed the following:

A Registered Nursing Assistant/Registered Practical Nurse program which contains a Medication Administration course as part of the core program. (Note: This is available in community colleges in Ontario); or

A Registered Nursing Assistant/Registered Practical Nurse Medication Administration Certificate program provided in Ontario since 1985; or

STANDARDS: PROGRAMS AND SERVICES

C. NURSING SERVICES

STANDARDS AND CRITERIA

**ADMINISTRATION OF
MEDICATIONS BY
REGISTERED
PRACTICAL NURSES
(CONT'D)**

A Medication Administration Certificate course provided out of province and which has been evaluated by the facility's Director of Nursing to determine if the content is equivalent to the course content offered in the Ontario Community College Registered Nursing Assistant/Registered Practical Nurse Medication Administration Certificate program.

Note: A copy of the record of the completion of the required Medication Administration course shall be kept in the staff member's personnel record.

NURSING STAFF

C1.5 The director of nursing shall work the required number of hours per week in the capacity of director of nursing. Required minimum director of nursing hours dedicated to the direction of nursing services are:

Fewer than 20 beds:	4 on-site hours/week
20-29 beds:	8 on-site hours/week
30-39 beds:	16 on-site hours/week
40-65 beds:	24 on-site hours/week
66-80 beds:	32 on-site hours/week
More than 80 beds:	40 hours or the facility maximum full-time hours.

Note: Replacement of director of nursing hours for vacation and extended sick time shall be required.

C1.6 There shall be a registered nurse on duty at all times in addition to the director of nursing.

C1.7 Where a registered nurse is not on duty, there shall be a registered nurse on call at all times, who is a regular member of the nursing staff.

STANDARDS: PROGRAMS AND SERVICES

C. NURSING SERVICES

STANDARDS AND CRITERIA

NURSING STAFF CONT'D)

C1.8 The allocated funding shall be used to provide numbers and levels of nursing staff to provide the treatments and personal care required by the residents.

Note: Refer to the financial section for discussion of what may be included in the nursing and personal care section of the funding model.

Any positions and time funded in this section must be dedicated to the delivery of nursing and personal care only, e.g. Nursing and personal care does not include students' hours, nursing staff being orientated or time spent on housekeeping or laundry service.

The numbers and levels of staff in the nursing and personal care envelope and the proposed 24-hour staffing pattern shall be reviewed and approved by the compliance advisor and program supervisor during the annual negotiation of the service agreement. The proposed staffing pattern shall provide sufficient registered staff hours to provide the treatments and personal care required by the residents and to provide for the education and supervision of direct care staff. If the proposed nursing staffing pattern is not considered adequate, the pattern will not be approved.

This staffing will be monitored and evaluated during facility reviews.

Time spent coordinating, planning, and providing inservice education shall not be included in the expenditures for nursing and personal care.

STANDARDS: PROGRAMS AND SERVICES

C. NURSING SERVICES

STANDARDS AND CRITERIA

**NURSING STAFF
(CONT'D)**

Criteria

- C1.9 The 24-hour staffing pattern on each unit shall be consistent with the care and safety needs of residents, with adjustments made as required.
- C1.10 Staff assignments for resident care shall be in place and regularly reviewed.
- C1.11 Time schedules shall be maintained which indicate the names of nursing staff and hours worked each day.

UNIT CLERKS

***Note:** A facility may choose to use funding from the nursing and personal care section of the funding model for the provision of clerical services for the resident care units only. This funding may not be used for clerical services to other services in the facility.*

- C1.12 Assignment of unit clerks shall be dedicated to nursing services, with specified hours on resident care units for unit-related duties.

Criteria

**SUPPLIES AND
EQUIPMENT**

***Note:** Refer to the financial section for discussion of the supplies and equipment that may be funded from the nursing personal care section of the funding model.*

STANDARDS: PROGRAMS AND SERVICES**C. NURSING SERVICES****STANDARDS AND CRITERIA****MEDICATION
ADMINISTRATION**

- C1.13 Self-administration of medications by residents shall be permitted when specifically ordered by the physician in consultation with the care team.
- C1.14 Medications, prescription and approved non-prescription drugs and biologicals may be administered to residents only by physicians, dentists, registered nurses and registered practical nurses (who meet the requirements of C1.5), according to their respective standards of practice.
- C1.15 Medications shall be administered only from properly labelled containers.
- C1.16 Residents shall be correctly identified prior to receiving medications and treatments.
- C1.17 Each resident shall receive medication and treatment as ordered by the physician, unless the resident refuses.
- C1.18 For every medication administered, there shall be a record which includes date, time, dose and route where applicable, signed by the person who gave the medication.
- C1.19 Each resident's response to medications and treatments shall be monitored and evaluated and changes shall be made as required.
- C1.20 Each resident's response to PRN medications and treatments shall be monitored, evaluated and documented.

**Ministry of Health
and Long-Term Care**

Community Health Division
Long-Term Care Homes Program
Compliance Inspection &
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**Ministère de la Santé
Et des Soins de longue durée**

Division de la santé communautaire
Direction des foyers de soins de longue durée
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Toronto ON M7A 1R3



January 9, 2006

MEMORANDUM TO: Long-Term Care Home Administrators

FROM: Vahe Kehyayan, Director
Compliance Inspections and Enforcement
LTC Homes Programs

CC: John McKinley, Assistant Deputy Minister
Community Health Division

RE: 24/7 RN Requirement in LTC Homes

I am writing to report on the outcome of the Ministry's LTC Home staffing survey, which was conducted in November 2005. I am pleased to report that five hundred and fifty (550) homes or 93% self-reported full compliance with the 24/7 RN requirement. While 40 homes self-reported non-compliance, most reported about their due diligent efforts to achieve full compliance with this requirement. Over the next several months Compliance Advisors will be verifying these self-reports and homes' due diligence efforts.

The regulations under the *Nursing Homes Act*, the *Homes for the Aged and Rest Homes Act*, and the *Charitable Institutions Act* require that each LTC home

“ ... shall ensure that at least one registered nurse who is a member of the regular nursing staff of the home is on duty and present in the home at all times”.

There are three distinct criteria for achieving compliance with this requirement: (1) at least one registered nurse on duty; (2) registered nurse must be a member of regular nursing staff; and (3) registered nurse must be present in the home at all times. I am appreciative that at times due to staff turnover or unexpected absenteeism, it is a challenge to achieve full and continued compliance with this requirement. In view of these challenges, as an interim measure effective this date Compliance Advisors will exercise discretion in issuing non-compliances, on a case-by-case basis in the following situations:

- 1) Homes that co-locate with acute care hospitals and the hospital RN is readily available and accessible to respond to the needs of the home;
- 2) Homes (other than those referred to in #1) that demonstrate due diligence (see **Appendix "A"**) to recruit RNs and deploy alternative measures to cover "vacant" shifts according to Ministry guidelines, including the deployment of on-call RNs; homes will as well have to make a commitment to reach full compliance over a time frame that has been approved by the Ministry; and
- 3) Homes to deploy agency RNs to cover short-term or unexpected absenteeism such as sickness.

While we are adopting this interim measure, it is in no way to be interpreted that LTC Homes are exempt from this requirement. As we all recognize the importance of regular staffing in the provision of quality care to residents, I encourage you to continue your efforts in remaining in or achieving full and continued compliance with the regulatory requirement of 24/7 RN coverage.

Thank you.



Vahe Kehyayan, Director

- cc. John McKinley, Assistant Deputy Minister
Tim Burns, Director, LTC Homes Branch
Program Managers
Compliance Advisors
Kathy O'Reilly, Manager, Enforcement
Donna A. Rubin, Chief Executive Officer, OANHSS
Karen Sullivan, Executive Director, OLTC

DUE DILIGENCE

LTC Homes must provide tangible evidence to the Ministry of their diligent efforts to achieve compliance with the regulation. Acceptable evidence of what may be considered as being demonstrable "due diligence" in terms of efforts made may include but is not limited to the following:

Recruitment:

- 1) Evidence of ads placed in print media to recruit registered nurses must be provided for review by compliance staff. That evidence must further prove that recruitment efforts to date have not been successful and that all efforts continue and the process of recruitment remains ongoing;
- 2) Other modes of advertisement designed to support recruitment - such as radio ads, TV or other electronic media – will be deemed to be acceptable as evidence of recruitment efforts;
- 3) Evidence/proof that interviews have been conducted with no success;
- 4) Evidence that the home has contacted provincial nursing organizations to validate that their particular situation is a direct result of a nursing shortage in the community;
- 5) Evidence that local Human Resource Development Canada offices have been contacted;
- 6) Contact with Nursing Education Programs in the province have been undertaken and evidence to indicate same documented and recorded;
- 7) Participation in job fairs; and
- 8) Assignment of a "dedicated recruiter" within the LTC Home or corporate office that is dedicated to recruitment of registered nursing staff;

Interim Measures:

- 1) Deployment of DOC and RPNs on day shift so that RN staff are available for evening and night shifts;
- 2) Maximum deployment of all available Registered Nurses to have 24/7 coverage (e.g., overtime);
- 3) Provision of RPN coverage on those shifts that the DOC is in the building with deployment of RN staff to those times where no Registered Nurse is present in the building – *NOTE* – additional RPN staff would need to be scheduled to assist the DOC with appropriately delegated duties that are within the scope of the RPN during this time frame. It is not the intent of the Ministry that DOC time as protected in the regulations be compromised; and

- 4) Limited and temporary utilization of contracted/agency Registered Nurses – although not a preferred option in terms of facilitating consistency of nursing care, this could be considered as an acceptable short-term plan until such time that permanent Registered Nurse staff is secured. Temporary utilization of agency staff would be approved under the following conditions:
- a) A formal agreement with a provider that facilitates the provision of consistent staff to support 24/7 RN coverage. In other words, the same RN's assigned so as to promote the consistency and enhanced safety with respect to the delivery of care and services to residents;
 - b) Provision of a mandatory comprehensive orientation program for temporary agency staff. This program must be available for review by Compliance Advisors and must include at a minimum orientation to residents' profile (care needs), care planning, care provision, medication administration and documentation systems, clinical/care issues, and home safety/security plans.

Ministry of Health
and Long-Term Care

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Ministère de la Santé
et des Soins de longue durée

Division des Programmes des Soins de Santé
Édifice Hepburn, 5^{ème} étage
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Toronto ON M7A 1R3



MAY 09 2001

MEMORANDUM TO: Long-Term Care Facilities

FROM: Jenny Rajaballey
Director
Operational Support Branch

RE: Pronouncement of Expected Death by Nurses in LTC Facilities

In April 1996, the College of Nurses of Ontario (CNO) issued a *Standard on the Nurse's Role in Pronouncing Death When Death is Expected*. This standard specified that RNs and RPNs could pronounce death where death is expected.

The Ministry supports the role of the nurses (RNs and RPNs) in pronouncing expected death. This means that RNs and RPNs in Ontario long-term care facilities may pronounce expected death as allowed by the College of Nurses of Ontario's scope of practice.

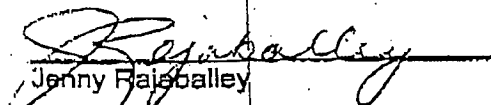
Please refer to the College of Nurses of Ontario's standard for information related to the specific criteria and requirements that must be met in order for RNs and RPNs to assume this role.

In instances of unexpected death, the physician will continue to be required to pronounce death, determine the cause of death and sign the death certificate.

As you are aware, nurses (RN's and RPN's) do not have the legal authority under the Vital Statistics Act to sign death certificates. However, this issue is being reviewed by the Ministry.

If you have any questions regarding this direction, please contact Joan Kennedy at (613) 241-4263 Ext. 239.

Attached please find the CNO Standard.


Jenny Rajaballey

cc: Regional Directors
Donna Rubln, Ontario Association of Non-Profit Homes & Services for Seniors
Vida Vaitonis, Ontario Long-Term Care Association

Attachment

NURSING PRACTICE STANDARDS OF PRACTICE

STANDARDS OF PRACTICE QUALITY ASSURANCE

Standard on the Nurse's Role in Pronouncing Death When Death is Expected

This document sets out CNO standards of practice for registered nurses (RNs) and registered practical nurses (RPNs) registered in Ontario. As an RN or RPN, you are professionally accountable to practise in accordance with these standards.

Introduction

Over the past few years, nurses (RNs and RPNs) have contacted the College of Nurses of Ontario (CNO) to clarify issues related to pronouncing and certifying the death of clients whose death was expected. A delay of the physician's arrival to pronounce death and complete the death certificate can lead to increased stress for families and uncertainty for nurses. CNO staff discussed this issue with a number of service providers and developed this standard to clarify the nurse's role in situations where death is expected.

Assumptions

Nurses have the knowledge and skill to assess the presence or absence of vital signs. When clients are expected to die and their care plans do not include resuscitation, nurses have the authority to pronounce death. In instances of unexpected death, other members of the health team need to be included in the decision to pronounce death.

Definitions

For the purpose of this standard, death is expected when, in the opinion of the health team, the client is irreversibly and irreparably terminally ill, that is, there is no available treatment to restore health.

Expected death is considered to have occurred when:

- vital signs have ceased (pulseless at the apex and absent respirations) and the pupils are dilated and fixed;
- the death of the client is anticipated by the client, the family and the health team; and
- the death has been planned for in a written plan.

"Pronouncing death," for the purpose of this standard, means declaring that death has occurred. There is no legal definition of pronouncing death and no legal requirement for a physician to pronounce death.

"Certifying death," for the purpose of this standard, means determining the cause of death and signing the death certificate. There is a legal requirement for a physician to certify death.

Nurses may pronounce death, when the death of a client is expected, in both the community and a health care facility.

When a client's death is expected, it is important that the nurse, as a member of the health team (which includes the client, family or substitute decision maker):

- Identifies the client's and family's cultural and religious beliefs and values about death and treatment of the body after death;
- Identifies whether the family wants to see the body after death (if the death occurs in a health care facility);
- Identifies the family member to notify when the client dies (if the death occurs in a health care facility);
- Identifies the most appropriate category of health care provider to notify the family;
- Decides, if necessary, which category of health care provider will pronounce the death;
- Identifies, if necessary, the physician responsible for determining the cause of death and for signing the death certificate;
- Determines a timeframe to carry out these activities; and
- Records the above information in a written plan of care.

In certain situations, even though the death was expected, the coroner will need to be notified. Nurses need to be aware of policies which outline the situations in which a coroner needs to be notified and need to advocate for such policies if none exist.

Unexpected Death

In situations where death is unexpected, the physician needs to be notified to pronounce death, to determine the cause and sign the certificate. The body cannot be moved. The most appropriate person will notify the family.

April 1996, #41023

STANDARDS: PROGRAMS AND SERVICES

C. NURSING SERVICES

GUIDELINES

RESPONSIBILITIES OF THE DIRECTOR OF NURSING SERVICES

The responsibilities of the director of the nursing department/director of resident care may include but not be limited to:

- *development of the philosophy of nursing, the statement of purpose for nursing services and the description of nursing functions.*
- *setting goals and objectives for nursing services*
- *setting standards of resident care, involving residents wherever possible*
- *development and implementation of nursing services policies and procedures*
- *preparation and management of the nursing services budget according to the facility's policies and procedures*
- *development of a human resources plan for the service with consideration of the appropriate mix of professional and support staff to meet the needs of the resident population served*
- *selection, placement, promotion, transfer or termination of nursing staff according to the facility's policies and procedures*
- *ensuring that all nursing staff receive regular written performance appraisals*
- *review and approval of position descriptions*
- *conducting or guiding the program to monitor, evaluate and improve the quality of nursing services*
- *ensuring the competency of staff by a process of identification, current certification and/or re-certification for the performance of specific nursing skills*
- *support and promotion of the orientation, staff development and continuing education of nursing staff*
- *provision of formal liaison with other clinical services, support services and with external agencies*
- *ensuring representation of staff on committees which affect the service*

STANDARDS: PROGRAMS AND SERVICES

C. NURSING SERVICES

GUIDELINES

RESPONSIBILITIES OF THE DIRECTOR OF NURSING SERVICES (CONT'D)

- *delegation of clinical and managerial responsibilities to appropriately qualified staff, according to the applicable legislation and standards of the College of Nurses of Ontario*
- *coordination of nursing services with other facility services*
- *participation in decision making at the senior management level*
- *participation as a member of the research committee*
- *providing support for education and research activities*
- *promoting liaison, cooperation and coordination of services/programs with community agencies and other health care providers*
- *ensuring that information obtained by nursing staff is available to relevant members of the health care team, resident and family in a professional manner, consistent with facility policies and procedures for maintaining confidentiality of information.*

QUALIFICATIONS OF NEW DIRECTORS OF NURSING

Examples of relevant experience in working with people in long-term care include but are not limited to:

- *provision of care to persons in chronic care hospitals/units and continuing care units*
- *provision of care to persons requiring long-term care in community-based services, medical units in acute care hospitals, and psychiatric units/hospitals*
- *provision of services within a psycho-geriatric team/service and/or geriatric assessment teams or services*

STANDARDS: PROGRAMS AND SERVICES

C. NURSING SERVICES

GUIDELINES

QUALIFICATIONS OF NEW NURSING DIRECTORS OF NURSING

Examples of relevant experience in management include but are not limited to:

- *holding a position as team leader in a hospital setting*
- *holding a position of unit coordinator/administrator*
- *head nurse positions*
- *previous management of community-based services*
- *previous experience in a supervisory or management position in health services such as Director of Nurses position.*

RESPONSIBILITIES OF THE REGISTERED NURSE MANAGING EACH UNIT

The responsibilities of the registered nurse accountable for managing each unit on a 24-hour basis may include but not be limited to:

- *development of the unit statement of purpose and a description of the functions of the unit*
- *setting of standards of resident care for the unit*
- *setting of goals and annual objectives for the unit*
- *development and implementation of policies and procedures for the unit*
- *preparation and administration of the unit's budget according to the facility's policies and procedures*
- *selection, assignment, promotion and transfer or termination of unit staff according to the facility's policies and procedures*
- *ensuring that all unit staff receive regular written performance appraisals*
- *development and revision of position descriptions for each classification of staff on the unit*
- *conducting or guiding the program to monitor, evaluate and improve the quality of nursing services provided by the unit*
- *ensuring that the credentials of staff are verified, where applicable*
- *support and promotion of the orientation, staff development and continuing education of unit staff*

STANDARDS: PROGRAMS AND SERVICES**C. NURSING SERVICES****GUIDELINES**

- *monitoring and evaluation of unit staff compliance with facility and service policies and procedures*
- *ensuring representation of unit staff on committees which affect the service*
- *coordination of unit nursing services with other services in the facility*
- *liaising with other services in the facility*
- *providing formal liaison with medical services, other professional services, support services and external agencies*
- *delegation of clinical and administrative responsibilities to appropriately qualified staff of the unit*
- *supporting the facility's policies and procedures for the research program*
- *providing opportunities for placement of students for education and research, according to facility policies.*

COMMUNICATION

The statement of purpose, the goals and the objectives may be communicated to all nursing services staff and to other relevant services with mechanisms such as:

- *quality management*
- *nursing orientation and in service training*
- *committees*
- *manuals*
- *memoranda*
- *staff meetings*

STANDARDS: PROGRAMS AND SERVICES

C. NURSING SERVICES

GUIDELINES

PARTICIPATION OF NURSING STAFF

There should be systems to ensure that nursing services staff participate in the planning, decision-making and formulation of policies for the nursing department. Systems may include memberships on, or input into committees, task forces, reports and presentations.

FUNCTIONS OF NURSING SERVICES

Principal functions of nursing services should include but not be limited to:

- *data collection and nursing assessment, planning of resident care, implementing and evaluating nursing interventions*
- *documentation of the nursing process*
- *coordination of the interdisciplinary approach to resident care*
- *emotional support for and counselling of residents and their families*
- *education of residents*
- *supervision of nursing staff providing resident care*
- *maintenance of residents' independence in activities of daily living and life decisions*
- *provision for restorative services*
- *discharge planning*
- *supporting resident choices*
- *health promotion and disease prevention*

POLICIES AND PROCEDURES

Policies and/or procedures for organization and management of the service should include but not be limited to:

- *nursing service committees*
- *nursing education*
- *approval process for transfer of functions and delegated acts*

Policies and/or procedures for clinical activities should include but not be limited to:

- *communication with other interdisciplinary and committee members*
- *orientation of the resident and family to the service and to*

STANDARDS: PROGRAMS AND SERVICES

C. NURSING SERVICES

GUIDELINES

- *relevant policies and procedures*
- *standards of resident care*
- *application of the nursing process*
- *development of care plans with residents/representatives*
- *nursing interventions including treatments and medication administration*
- *methods of care delivery*
- *transferred functions and specialized nursing skills*
- *response to resident crises*
- *residents' faith group specific care needs*
- *management of specific conditions and medical emergencies*
- *staff orientation and inservice training*
- *documentation to support the implementation and evaluation of all clinical activities*

Policies and/or procedures for ethical issues should include but not be limited to:

- *nursing's response to ethical issues within the facility*
- *residents' rights to make decisions concerning their life, care and death*
- *informed consent*
- *use of restraints - chemical, physical and environmental*
- *dying with dignity*
- *organ donation*
- *specific practices of the faith groups regarding death, burial and organ donation*

Policies and/or procedures for safety should include but not be limited to:

- *first aid measures*
- *fire plan*
- *aid to choking victims*
- *cardiopulmonary resuscitation*
- *resident safety issues*
- *internal and external disaster planning*

STANDARDS: PROGRAMS AND SERVICES

C. NURSING SERVICES

GUIDELINES

- *Workplace Hazardous Materials Information System (WHMIS)*
- *infection control (aseptic technique and isolation)*
- *dispensing and storage of medications*
- *incident and medication error reporting*
- *medication reviews*
- *use of restraints*
- *use of ambient air concentrators and low flow oxygen (and liquid oxygen in low pressure tanks in nursing homes)*
- *catheter care*
- *back care, techniques for lifting and transferring residents*
- *equipment maintenance*
- *implementation of Guidelines for Prevention and Management of Hot Weather-Related Illness*

Policies and/or procedures for documentation on residents' health record should include but not be limited to:

- *nursing history and assessments*
- *social history*
- *care plan - indicating residents' goals based on strengths, needs and wishes*
- *plan for spiritual and religious care*
- *nursing interventions and residents' responses or outcomes*
- *progress notes*
- *flow charts, if applicable*
- *evidence of health education provided to resident and/or family*
- *residents' decisions regarding treatment and death*
- *physician's orders*
- *diagnostic reports, e.g. laboratory and x-ray*
- *medications and treatments.*

STANDARDS: PROGRAMS AND SERVICES

D. STAFF EDUCATION

STANDARDS AND CRITERIA

**STANDARD 1:
ORIENTATION**

**D1. THERE SHALL BE AN ORGANIZED
ORIENTATION PROGRAM THAT RESPONDS TO
THE LEARNING NEEDS OF NEW STAFF.**

Criteria:

- D1.1 All new staff, including part-time staff, shall attend an organized, facility-wide general orientation program that responds to the learning needs of new staff.
- D1.2 All new staff, including part-time staff, shall attend a department-specific orientation program, which addresses the responsibilities of their position.
- D1.3 Agency staff shall receive task-specific orientation in order to provide safe care to the residents.
- D1.4 Staff shall have opportunities to evaluate the content and process of the orientation program.
- D1.5 Orientation programs shall be reviewed and revised annually or more frequently in order to reflect the changing needs of the resident population and the learning needs of new staff.

DOCUMENTATION

- D1.6 There shall be a system in place for those providing general orientation and department-specific orientation to document the information they have provided to each new employee. Each new employee shall acknowledge by signature the information they have received.
- D1.7 There shall be a system in place to document the attendance of staff at all inservice programs.

STANDARDS: PROGRAMS AND SERVICES

D. STAFF EDUCATION

STANDARDS AND CRITERIA

**STANDARD 2:
INSERVICE EDUCATION**

**D2. THERE SHALL BE AN ORGANIZED INSERVICE
EDUCATION PROGRAM THAT RESPONDS TO
THE ASSESSED LEARNING NEEDS OF STAFF**

Criteria

- D2.1 The inservice education program shall take into account those factors which the residents indicate are important to their quality of life and which affect their care.
- D2.2 All inservice education programs shall be planned, designed and the evaluation method determined by the staff member coordinating staff development, in collaboration with department managers.
- D2.3 Staff on all shifts shall have access to inservice education opportunities.
- D2.4 Staff shall have opportunities to evaluate the content, delivery and effectiveness of inservice sessions, which they attend.
- D2.5 The inservice education program shall be evaluated annually to determine if learning objectives are met and staff develop skills and increase knowledge to meet residents' needs.

STANDARDS: PROGRAMS AND SERVICES

D. STAFF EDUCATION

STANDARDS AND CRITERIA

**REQUIRED
EDUCATIONAL
PROGRAMS**

Criteria

- D2.6 There shall be a minimum of ten inservice education programs delivered annually which are based on the assessed learning needs of staff.

- D2.7 In addition to other legislated requirements, inservice education programs designed to improve the quality of care and services shall be provided for all staff annually, including but not limited to:
 - Quality of life issues for residents
 - Infection control practices
 - Understanding residents with cognitive impairment and responding to disruptive behaviour
 - Facility and resident emergency procedures

- D2.8 There shall be a staff member responsible for coordinating orientation and ongoing inservice education for facility staff.

- D2.9 The person responsible for coordinating staff orientation and inservice education shall be qualified by education and experience for the responsibilities of the position.

Note: Time spent coordinating, planning, and providing inservice education shall not be included in the expenditures for nursing and personal care.

STANDARDS: PROGRAMS AND SERVICES

D. STAFF EDUCATION

GUIDELINES

QUALIFICATIONS

Suggested qualifications of the staff member responsible for coordinating staff development programs include:

- *completion of EITHER an undergraduate degree in a health or social science discipline*

OR

- *a registered nurse with a current certificate of competence with the College of Nurses of Ontario*

AND

- *completion of course work in adult education at the community college or university level*

AND

- *experience in long-term care.*

***ROLE OF THE PERSON
COORDINATING***

The staff member responsible for coordinating staff education should act as an educational resource to managers and committees and assist them in identifying and responding to the learning needs of staff.

Educational programs should be planned, designed and evaluated with the manager requesting the educational program.

The staff member coordinating the staff development program should play a role in the strategic planning process and identify the training/education that is required to support identified organizational change.

The staff member should design and deliver educational programs using the principles of adult learning.

STANDARDS: PROGRAMS AND SERVICES

D. STAFF EDUCATION

GUIDELINES

PHILOSOPHY OF EDUCATION

The statement of purpose for staff education should reflect the philosophy of education which respects the learning needs and styles of adult learners.

EDUCATIONAL PROGRAM DEVELOPMENT

Components of an educational program should include the following:

A) NEEDS ASSESSMENT

The education needs assessment should include:

- an annual written needs assessment*
- informal assessment of staff knowledge/skills*
- analysis of organizational needs, residents' needs and input from the program designed to manage quality and risk*
- analysis of changes in the field of long term care, standards and legislation*

Each request for education should be assessed with managers and staff to determine if the issue is the result of staff lacking knowledge/skills or if it is related to supervision or resources.

B) DESIGN OF EDUCATIONAL PROGRAMS

Educational programs should be designed and delivered in collaboration with management staff.

Educational programs should be designed using adult learning theory.

C) EVALUATION OF EDUCATIONAL PROGRAMS

Educational programs should be evaluated to determine if programs have addressed the learning needs of staff and have resulted in performance improvement.

STANDARDS: PROGRAMS AND SERVICES

D. STAFF EDUCATION

GUIDELINES

STAFF EDUCATION COMMITTEE

The staff member responsible for coordinating staff education may work with an interdisciplinary committee to identify the learning needs of staff and evaluate education programs.

GENERAL ORIENTATION

Suggested areas of learning for new staff include but are not limited to:

The Organization

- *Mission and philosophy of the facility*
- *Organization of the facility*
- *Staff participation in programs designed to manage quality and risk*
- *Standards of conduct*
- *Tour of the facility (including non-service areas)*
- *Job description*

The Resident

- *Residents' rights*
- *Dispelling the myths of ageing and disability*
- *Communicating with residents who have difficulty with communication*
- *Understanding the special needs of residents with cognitive impairment*
- *Understanding and responding to residents with difficult or disruptive behaviours*
- *Role of the family*
- *Role of residents' council*
- *Legal issues*
- *Death and dying (including advance directives)*
- *Consent to treatment*

STANDARDS: PROGRAMS AND SERVICES

D. STAFF EDUCATION

GUIDELINES

GENERAL ORIENTATION (cont.)

The Interdisciplinary Team

- *Understanding the interdisciplinary approach*
- *Developing and implementing the interdisciplinary plan of care*

Health and Safety

- *Back care/body mechanics for staff*
- *Fire safety*
- *Resident emergency procedures*
- *Facility emergency procedures*
- *Infection control*
- *WHMIS (general overview)*
- *Choking*
- *Accident prevention*
- *Low flow oxygen, if applicable*

Policies and Procedures

- *Personnel policies*
- *Procedure manuals*
- *Performance reviews*

INSERVICE EDUCATION

The inservice education program should respond to the educational issues identified through the facility-wide programs designed to manage quality and risk.

The inservice education program should be based on a formalized annual written needs assessment, to determine the learning needs of staff.

STANDARDS: PROGRAMS AND SERVICES

D. STAFF EDUCATION

GUIDELINES

CORE PROGRAMS

Suggested issues which the inservice education program may address include:

- *The ageing process*
- *Communication with and support to residents and families*
- *Feeding skills and adaptations for residents with swallowing disorders*
- *Stress management*
- *Continence care*
- *Oral care and its effectiveness in preventing pneumonia and other health problems*
- *Skin care*
- *Foot care*
- *Positioning and measures to promote mobility*
- *Measures to promote resident comfort*
- *Resident care planning process*
- *Palliative care*
- *Advance directives*
- *Medications and interactions*
- *Alternatives to restraint*
- *Therapeutic principles and applications*
- *Ethical issues*
- *Assessment skills for registered nurses*
- *Safety issues*
- *Back care/body dynamics*
- *Team dynamics*
- *Supervisory skills*
- *Dealing with conflict*
- *Trends in long-term care*
- *Levels of care funding charting requirements*
- *Aboriginal peoples*
- *Francophones*
- *Ethno-cultural groups*

STANDARDS: PROGRAMS AND SERVICES

D. STAFF EDUCATION

GUIDELINES

LIBRARY RESOURCES

There should be gerontology and health-related books and journals available for staff and volunteers. All shifts of staff should have opportunities to use various media and library resources.

STANDARDS: PROGRAMS AND SERVICES

E. RECREATION AND LEISURE SERVICES

STANDARDS AND CRITERIA

**STANDARD 1:
SERVICE PROVISION**

E1. THERE SHALL BE RECREATION AND LEISURE SERVICES ORGANIZED TO PROVIDE AGE-APPROPRIATE RECREATION, LEISURE, AND EDUCATION OPPORTUNITIES BASED ON AND RESPONSIVE TO THE ABILITIES, STRENGTHS, NEEDS, INTERESTS AND FORMER LIFESTYLE OF THE RESIDENTS.

Criteria

- E1.1 The variety and scope of recreational programming shall be planned with residents/representatives.
- E1.2 Each recreation and leisure program shall be clearly defined by a program description, which outlines the purpose, goals and objectives of the program.
- E1.3 Information about recreation programs and services shall be readily available to residents, their representatives and others who are interested.
- E1.4 Assistance or adaptations shall be provided to facilitate residents' participation in activities they wish to attend.
- E1.5 Small group programs and individualized activities shall be provided for those residents who are not interested or are not able to participate in larger groups.
- E1.6 Residents shall be provided opportunities and assistance to participate in social and community programs, which are compatible with their interests and abilities, both within the facility and in the community.

STANDARDS: PROGRAMS AND SERVICES

E. RECREATION AND LEISURE SERVICES

STANDARDS AND CRITERIA

Criteria

E1.7 Activities shall be offered during evenings and weekends.

E1.8 Activities and trips shall be provided outside the facility.

**MANAGEMENT OF
RECREATION AND
LEISURE SERVICES**

E1.9 There shall be a staff member responsible for managing recreation and leisure services.

E1.10 The person responsible for managing recreation and leisure services shall be qualified by education and experience for the responsibilities of the position.

**RECREATION SERVICES
STAFF**

E1.11 The staff who provide recreation and leisure programs shall be qualified by education and/or experience for the responsibilities of their position.

E1.12 Staffing requirements to provide activities for recreation/restorative care programs shall be: a minimum of 40 hours (or the facility maximum full-time hours) for each 60 residents.

Note: Staff hours may be applied to both Recreation and Leisure Services and restorative care provided in Therapy Services. (Refer to the Therapy Services section.)

STANDARDS: PROGRAMS AND SERVICES

E. RECREATION AND LEISURE SERVICES

GUIDELINES

RECREATION AND LEISURE OPPORTUNITIES

A variety of leisure and recreation opportunities should be provided for residents to:

- *have fun and enjoyment*
- *improve self-esteem*
- *participate with others of various ages*
- *socialize and enjoy companionship*
- *maintain their desired involvement with the community*
- *participate in learning opportunities*
- *retain former lifestyle and interests*
- *maintain leisure skills and learn new ones*
- *be creative*
- *be involved in therapeutic and diversional activities*
- *maintain contact with news and current events*

POLICIES AND PROCEDURES

Written policies and procedures for recreation and leisure services may include but are not limited to:

- *program planning*
- *assessment*
- *community integration and involvement*
- *documentation*
- *professional accountability*
- *quality management*
- *risk management*

QUALIFICATIONS

Qualifications of the staff member responsible for managing recreation and leisure services should include:

- *a diploma in recreation/leisure studies from a recognized community college or university*
- *courses in gerontology*
- *demonstrated leadership and organizational skills*
- *knowledge of programs and techniques in recreation*
- *excellent communication skills*

STANDARDS: PROGRAMS AND SERVICES

E. RECREATION AND LEISURE SERVICES

GUIDELINES

- *3 to 5 years experience in long-term care*
- *knowledge of community resources*
- *knowledge of program development*

RESPONSIBILITIES

Responsibilities of the staff member responsible for managing recreation and leisure services may include but are not limited to:

- *developing goals and objectives*
- *developing and implementing policies and procedures*
- *planning, developing, implementing and monitoring or recreation and leisure service delivery*
- *managing resources (human, fiscal and equipment/supplies)*
- *implementing activities to monitor, evaluate and improve quality*
- *ensuring the orientation of new recreation staff*
- *supporting and promoting staff development and ongoing education of recreation staff members*
- *coordinating recreation services with other internal and external services and/or community agencies.*
- *liaising with the interdisciplinary team and family members*
- *facilitating and maintaining community integration and involvement*
- *supervising student placements and volunteers*
- *facilitating and implementing quality management and risk management activities for the department*
- *ensuring accurate documentation of recreation and leisure services to residents*
- *supporting and facilitating the residents' council if requested by the residents*

STANDARDS: PROGRAMS AND SERVICES

E. RECREATION AND LEISURE SERVICES

GUIDELINES

RESIDENT ASSESSMENT

The following sources may be used to assess the resident's recreational and social needs:

- *pre-admission assessment*
- *resident interview*
- *family/volunteer interview*
- *resident interest questionnaires*

PROGRAM PLANNING

Resident recreational planning may include but is not limited to:

- *written recreation goals for the resident*
- *description of staff and space requirements*
- *communication with the resident, family and representative*
- *activities implemented*
- *evaluation process identified*
- *documentation of progress toward written goals*

EVALUATION OF ACTIVITIES

Recreation activities may be evaluated based on:

- *feedback questionnaires*
- *interviews with residents, families and volunteers*
- *review of residents' attendance*

STANDARDS: PROGRAMS AND SERVICES

F. SOCIAL WORK SERVICES

STANDARDS AND CRITERIA

**STANDARD 1:
SERVICE PROVISION**

F1. THERE SHALL BE AN ORGANIZED PROGRAM OF SOCIAL WORK SERVICES, OR ARRANGEMENTS ARE MADE TO ACCESS AVAILABLE SOCIAL WORK SERVICES TO MEET RESIDENTS' PSYCHOSOCIAL NEEDS.

Criteria

**COORDINATION OF
SOCIAL WORK SERVICES**

F1.1 There shall be a staff member responsible for coordinating social work services.

STANDARDS: PROGRAMS AND SERVICES

F. SOCIAL WORK SERVICES

GUIDELINES

POLICIES AND PROCEDURES

Policies and procedures should include but not be limited to:

- *organization and management of the service*
- *confidentiality of information and records*
- *code of ethics*
- *guidelines for documentation*
- *case referral*
- *interdisciplinary meetings*
- *psychosocial assessments*
- *advocacy*

QUALIFICATIONS OF SOCIAL WORK STAFF

Social workers providing social work services should possess a degree in social work and/or be eligible for membership in the Ontario Association of Professional Social Workers (OAPSW).

Social work staff should possess specialized knowledge in gerontology and should have experience in a long-term care setting.

STANDARDS: PROGRAMS AND SERVICES

F. SOCIAL WORK SERVICES

GUIDELINES

RESPONSIBILITIES OF STAFF

Responsibilities of social work services staff may include but are not limited to:

- *new admission assessments*
- *participation in interdisciplinary care planning*
- *psychosocial assessment*
- *adjustment counselling (resident and/or family)*
- *short stay programs (post-admission coordination of respite, supportive, emergency)*
- *counselling (individual, group work)*
- *facilitating the advocacy process*
- *discharge planning (community referral, follow-up).*

ASSESSMENT

The need for social work services may be identified through:

- *self-referral*
- *staff observation*
- *interdisciplinary team conferences*
- *family request*
- *group meetings*

INTERVENTION

Social work intervention may consist of:

- *counselling (resident/family)*
- *psychosocial assessment*
- *facilitating the advocacy process*
- *group work (resident/family)*
- *community referral*
- *education*
- *discharge planning*
- *internal referral/transfer*

STANDARDS: PROGRAMS AND SERVICES

G. SPIRITUAL AND RELIGIOUS PROGRAM

STANDARDS AND CRITERIA

**STANDARD 1:
SERVICE PROVISION**

G1. THERE SHALL BE AN ORGANIZED SPIRITUAL AND RELIGIOUS CARE PROGRAM TO RESPOND TO THE SPIRITUAL AND RELIGIOUS NEEDS AND INTERESTS OF THE RESIDENTS.

Criteria

G1.1 Residents' preferred spiritual and/or religious observances, practices, and affiliations shall be supported, while respecting the rights of others.

G1.2 Arrangements shall be made to provide for regular worship services.

G1.3 Efforts shall be made to arrange for spiritual counselling and one-to-one visitation, according to the resident's wishes.

G1.4 Mechanisms shall be in place to support and facilitate residents' participation in the facility's spiritual and/or religious programs.

G1.5 Arrangements shall be made to facilitate spiritual and religious care for the hearing and visually impaired, where resources are available.

**COORDINATION OF
SPIRITUAL AND
RELIGIOUS CARE
PROGRAM**

G1.6 There shall be a staff member responsible for coordinating the spiritual and religious care program.

Note: Long-term care facilities are encouraged to use the services of the Ontario Multifaith Council for Spiritual and Religious Care. Services available to facilities include assistance in developing and evaluating spiritual and religious care programs.

STANDARDS: PROGRAMS AND SERVICES

G. SPIRITUAL AND RELIGIOUS PROGRAM

GUIDELINES

SPIRITUAL AND RELIGIOUS PROGRAM

The spiritual and religious care program should be endorsed by the local faith groups to respond to the spiritual and religious needs and interests of the residents.

ADVISORY COMMITTEE

A Spiritual and Religious Care Advisory Committee should be established and maintained to provide guidance to and support for the spiritual and religious care program.

COORDINATOR

If a qualified spiritual and religious care coordinator is retained by the facility, suggested qualifications include:

- *endorsement by the Ontario Multifaith Council for Spiritual and Religious Care*
- *post-graduate education relevant to spiritual and religious care*
- *endorsement by the coordinator's faith group*
- *training and/or experience in gerontology*
- *training and/or experience in multifaith programming*

ROLE

The role of a qualified spiritual and religious care coordinator should include but not be limited to:

- *facilitating contact with the residents' former community/faith groups*
- *providing support to staff members in spiritual and religious care issues (e.g. dietary needs, death and burial practices, palliative care)*
- *providing grief and bereavement support to staff, residents and families of residents*
- *providing input for dealing with ethical issues for residents, staff and families*
- *providing crisis intervention in experiences such as grief, illness, and death*
- *coordinating and directing faith groups' programs of support to residents*

STANDARDS: PROGRAMS AND SERVICES

G. SPIRITUAL AND RELIGIOUS PROGRAM

GUIDELINES

ROLE (cont.)

Note: If the staff member responsible for coordinating spiritual and religious services is not qualified, his/her role should involve accessing the resources to provide the above services for residents.

A member of the spiritual and religious care program may participate in the team planning to communicate the resident's wishes and special needs. Members of the spiritual and religious care program may contribute notes in the residents' records, when appropriate.

PLAN FOR SPIRITUAL AND RELIGIOUS CARE

There should be a written plan for provision of spiritual and religious care from the faith groups which includes but is not limited to:

- *Role of faith group leaders (e.g. minister, rabbi, imam) in support of individual and group worship and religious care*
- *Facility support of spiritual and religious care by community leaders.*

A written plan for the provision of spiritual and religious care by volunteers should include but not be limited to:

- *Identification of volunteers' interests and abilities in relation to spiritual and religious care*
- *Interviewing of spiritual and religious volunteers and assessing their ability and suitability to work with older persons*
- *Orientation of volunteers*
- *Assignment of volunteers*
- *Defining roles of volunteers and their relationships to the staff*
- *Supervision of volunteers*
- *Documentation of activities*
- *Recognition of volunteers for their services.*

STANDARDS: PROGRAMS AND SERVICES

G. SPIRITUAL AND RELIGIOUS PROGRAM

GUIDELINES

ASSESSMENT

The assessment should identify:

- *the resident's faith group affiliation and preferred activities*
- *the resident's desire to sustain a relationship with any former faith group in the community*
- *the names of any specific advisors whom the resident wishes to have contacted*
- *the resident's preferred frequency of attendance at worship services*
- *the resident's level of independence/need for assistance in order to attend worship services*

PHYSICAL RESOURCES

The space used for worship should be conducive to the worship experience and shall be free from interruptions during services.

There should be dedicated symbols of worship present, which can be enclosed when not in use.

STANDARDS: PROGRAMS AND SERVICES

H. THERAPY SERVICES

STANDARDS AND CRITERIA

INTRODUCTION

This section refers to a program of therapy services. Basic nursing and personal care and services expectations to be provided to each resident are included in Resident Care and Services standards under "Activities of Daily Living".

STANDARD 1: SERVICE PROVISION

H1. THERE SHALL BE AN ORGANIZED PROGRAM OF THERAPY SERVICES OR ARRANGEMENTS SHALL BE MADE TO ACCESS AVAILABLE THERAPY SERVICES TO MEET RESIDENTS' IDENTIFIED THERAPY NEEDS.

(Services may be provided by qualified therapists employed by the facility or by therapy services accessed through contractual arrangements.)

Criteria

- H1.1 There shall be provisions for individualized therapy services.
- H1.2 If group programming is provided, it shall be based on the assessed needs of the residents participating.
- H1.3 There shall be a process in place to coordinate and integrate therapy services interventions with residents' nursing and personal care activities.

AIDS AND EQUIPMENT

- H1.4 Aids and equipment shall be arranged for through relevant assistive devices programs to meet the residents' needs, when payment is authorized by the resident/representative.
- H1.5 Staff shall be instructed in the safe and correct use of therapeutic equipment and adaptive aids.
- H1.6 Residents and representatives shall receive instruction about the use of equipment and adaptive aids.

STANDARDS: PROGRAMS AND SERVICES**H. THERAPY SERVICES****STANDARDS AND CRITERIA****Criteria****COORDINATION OF
THERAPY SERVICES**

H1.7 There shall be a staff member responsible for coordinating therapy services.

**FACILITY STAFF
PROVIDING THERAPY
SERVICES**

H1.8 Facility staff members who assist in the provision of therapy services to individual residents shall be instructed and receive direction from licensed therapists.

H1.9 The relationship between the therapist and staff who assist in the provision of therapy services shall be clearly defined.

Note: The hours provided to meet the staffing requirements for Recreation and Leisure Services (a minimum of the equivalent of one full-time position for each 60 residents) may include staff hours used to provide restorative care, which is included in this Therapy Services section. (Refer to the Recreation and Leisure Services.)

STANDARDS: PROGRAMS AND SERVICES

H. THERAPY SERVICES

GUIDELINES

STAFFING (cont.)

The relationship between the therapist and those assisting in the provision of therapy services should be consistent with the positions of the Ontario Society of Occupational Therapists, the Ontario Physiotherapy Association and the Ontario Association of Speech Language Pathologists and Audiologists on the role and use of support staff.

Qualifications of staff members who assist in the provision of therapy services should include:

- *completion of a recognized post-secondary diploma at the community college level. (It is recommended that the course be in a health-related field resulting in an understanding of medical conditions, human behaviour and medical terminology.)*

or

- *completion of an in-house "Rehabilitation Assistant" training course designed and supervised by a qualified therapist.*

POLICIES AND PROCEDURES

Policies and procedures should include but not be limited to:

- *Roles and responsibilities of therapy staff, nursing staff and other appropriate members of the inter-disciplinary team concerning the implementation of the therapeutic plan of care (e.g. treatments such as hot/cold packs, passive range of motion exercises or use of functional ADL activities to support the current therapeutic treatment interventions)*
- *A system in place to ensure that the therapist communicates and teaches other staff the ongoing therapeutic plan of care*
- *Arrangements for referrals*
- *Documentation of all therapy services received, including the use of residents' care plans*

STANDARDS: PROGRAMS AND SERVICES

H. THERAPY SERVICES

GUIDELINES

STAFFING

Qualifications of staff members and agency personnel providing therapy services should be:

Qualified/licensed professionals from the disciplines of Occupational Therapy, Physical Therapy and/or Speech-Language Pathology.

Registered members, in good standing in their respective College. (New Colleges to be in place with proclamation of Regulated Health Professions Act).

Professional qualifications currently recognized by employers:

Occupational Therapist:

Eligibility for membership in Canadian Association of Occupational Therapists (CAOT).

Eligibility requirements: baccalaureate degree from a university with an occupational therapy program approved by the Canadian Association of Occupational Therapists, or from another school of occupational therapy approved by the World Federation of Occupational Therapists.

Physiotherapist:

Current licensure with Ontario Board of Directors of Physiotherapy.

Speech-Language Pathologist:

Eligibility for membership in The Ontario Association of Speech-Language Pathologists and Audiologists.

Eligibility requirements: Master's Degree in speech-language (or equivalent) from a university with recognized standing.

STANDARDS: PROGRAMS AND SERVICES

H. THERAPY SERVICES

GUIDELINES

SERVICE PROVISION

Service provision should include but not be limited to:

- *screening*
- *assessment with data collection and analysis*
- *treatment*
- *teaching/counselling*
- *discharge planning*
- *follow-up*
- *evaluation*

STANDARDS: PROGRAMS AND SERVICES

I. VOLUNTEER SERVICES

STANDARDS AND CRITERIA

**STANDARD 1:
SERVICE PROVISION**

**II. THERE SHALL BE AN ORGANIZED PROGRAM
OF VOLUNTEER SERVICES.**

Criteria

- I1.1 There shall be a current written description of each volunteer function to provide clear direction about the scope of volunteers' functions and responsibilities.
- I1.2 Volunteer services shall respond to residents' interests and shall be consistent with the residents' strengths, needs and preferences.
- I1.3 Residents shall be involved in planning and evaluating services of volunteers.
- I1.4 All new volunteers shall receive an orientation to the facility and emergency procedures.
- I1.5 There shall be a staff member responsible for coordinating and integrating volunteer services into programs and services of the facility.

**COORDINATION OF
VOLUNTEER SERVICES**

STANDARDS: PROGRAMS AND SERVICES

I. VOLUNTEER SERVICES

GUIDELINES

SERVICE PROVISION

Volunteer services should enrich the lifestyles of residents and respond to residents' interests and cultural and language needs.

Volunteer services may include but are not limited to:

- *gift/tuck shop*
- *hairdressing*
- *bingos*
- *bars*
- *special events*
- *publicity*
- *visiting with residents*
- *one-to-one relationships with residents*
- *friendship (e.g. sending birthday cards, Christmas cards, etc.)*
- *organizing special occasion/birthday parties*
- *library services*
- *chapel liaison*
- *spiritual care*
- *palliative care*
- *escort*
- *transportation*
- *crafts*
- *welcoming new residents*
- *seniors' day centre*

QUALIFICATIONS

Suggested qualifications of the staff member responsible for coordinating volunteer services include:

- *completion of courses in volunteer services at a community college or university, and*
- *3 to 5 years volunteer experience with seniors*

The staff member responsible for volunteer services should achieve certification with the Ontario Association of Directors of Health Volunteer Services (OADHVS).

STANDARDS: PROGRAMS AND SERVICES**I. VOLUNTEER SERVICES****GUIDELINES*****RESPONSIBILITIES***

Responsibilities of the staff member coordinating volunteer services may include but are not limited to:

- *conducting a needs analysis for volunteers in conjunction with all user departments, which identifies areas where volunteers can be used to advantage*
- *planning and organizing a volunteer program to respond to the resident's identified strengths, needs, and wishes*
- *recruiting and selecting volunteers, determining their suitability in relation to the facility's needs, in cooperation with the management of the requesting departments*
- *showing potential volunteers through the facility, providing information regarding the philosophy of the facility and volunteer program*
- *providing orientation for new volunteers; coordinating and maintaining educational and training programs for facility volunteers in cooperation with staff education*
- *developing and maintaining organized documentation for all aspects of the volunteer program*
- *coordinating and monitoring the activities of the facility volunteers on an ongoing basis*
- *regularly evaluating the work performed by volunteers*
- *liaising with the auxiliary of the facility, if one exists*
- *liaising with community volunteer organizations regarding volunteerism; engaging in joint planning and educational programming as appropriate to the facility mandate*
- *organizing publicity and recognition events for the volunteer program*
- *providing regular reports on the volunteer program and initiatives to the facility administrator.*

STANDARDS: PROGRAMS AND SERVICES

I. VOLUNTEER SERVICES

GUIDELINES

Volunteers should be encouraged to acquire new skills and expand their knowledge in pertinent areas by attending appropriate workshops, seminars and conferences, etc. in the community as well as relevant facility staff education programs.

PLAN FOR VOLUNTEER SERVICES

A written plan for the volunteer program may include but is not limited to:

- *Defining volunteers' roles and responsibilities*
- *Identifying volunteers' interests and abilities*
- *Interviewing volunteers and assessing them for their ability and suitability to work with seniors*
- *Assignment of volunteers*
- *Pledge of confidentiality of volunteers*
- *Orientation of volunteers*
- *Supervision by designated staff members*
- *Documentation of volunteers' activities*
- *Recognition of volunteers for their services*

ORIENTATION OF VOLUNTEERS

Orientation for new volunteers may include but is not limited to:

Introduction:

- *facility philosophy*
- *organizational structure*
- *volunteer mission*
- *scope of volunteer opportunities*
- *tour of the facility*

Emergency Procedures:

- *fire safety*
- *bomb threat*
- *disaster*
- *missing persons*

STANDARDS: PROGRAMS AND SERVICES**I. VOLUNTEER SERVICES****GUIDELINES*****Administration:***

- *confidentiality*
- *volunteer manual*
- *definition of volunteers' roles and responsibilities*
- *sign in/out procedure*
- *attendance protocol*
- *incident/accident reporting*
- *meeting schedule*

Safety:

- *smoking*
- *wheelchairs*
- *hazards*
- *body mechanics*
- *infectious disease precautions*
- *diet restrictions, e.g. diabetic diets*

Communication:

- *residents' rights and responsibilities*
- *interdisciplinary team*
- *resident interaction*
- *hearing loss*
- *vision loss*
- *cognitive impairment*
- *responses to disruptive behaviour*

STANDARDS: PROGRAMS AND SERVICES
J. DENTAL SERVICES
STANDARDS AND CRITERIA

STANDARD 1.
SERVICE PROVISION

J1. *DELETED*

Criteria

J1.1 ***DELETED***

J1.2 ***DELETED.***

J1.3 ***DELETED***

J1.4 ***DELETED.***

STANDARDS: PROGRAMS AND SERVICES
K. FOOT CARE SERVICES
STANDARDS AND CRITERIA

INTRODUCTION *DELETED*

STANDARD 1: *DELETED*
SERVICE PROVISION

Criteria

K1.1 *DELETED*

K1.2 *DELETED*

K1.3 *DELETED*

K1.4 *DELETED*

**STANDARDS: PROGRAMS AND SERVICES
K. FOOT CARE SERVICES
GUIDELINES**

***FOOT CARE SERVICES
PROVIDED BY
REGISTERED NURSING
STAFF*** ***DELETED***

***BASIC NURSING SKILLS
IN FOOT CARE*** ***DELETED***

***ADVANCED NURSING
SKILLS IN FOOT CARE*** ***DELETED***

***POLICIES AND
PROCEDURES*** ***DELETED***

STANDARDS: PROGRAMS AND SERVICES

L. OTHER APPROVED PROGRAMS

STANDARDS AND CRITERIA

**STANDARD 1.
SERVICE PROVISION**

**L1. OTHER PROGRAMS/SERVICES PROVIDED
BY THE FACILITY SHALL BE ORGANIZED
TO PROVIDE SERVICES TO RESPOND TO
RESIDENTS' IDENTIFIED NEEDS/
PREFERENCES.**

Criteria

- L1.1 Each program shall be developed based on residents' identified needs or preferences.
- L1.2 Residents/representatives shall be encouraged and supported to participate in determining the types of other programs and services provided by the facility.
- L1.3 Residents/representatives shall be encouraged to participate in the planning and evaluation of all other programs and services provided by the facility.

STANDARDS: PROGRAMS AND SERVICES**M. FACILITY ORGANIZATION AND ADMINISTRATION****STANDARDS AND CRITERIA****STANDARD 1:
ORGANIZATION AND
ADMINISTRATION****M1. THE PROGRAMS AND RESOURCES OF THE FACILITY SHALL BE ORGANIZED TO EFFECTIVELY MANAGE THE FACILITY AND EACH OF ITS PROGRAMS AND SERVICES, IN KEEPING WITH MINISTRY ACTS, REGULATIONS, POLICIES AND DIRECTIVES.****Criteria**

- M1.1 There shall be a statement of mission and a resident-focused service philosophy, which guides the operation of the facility.
- M1.2 An organizational chart shall be developed to represent the structure of the organization and the reporting relationships. The organizational chart shall be updated as changes occur.
- M1.3 Long-term goals and short-term objectives shall be developed to support the facility's mission statement.
- M1.4 The facility's goals and objectives shall be developed with staff, resident and family input, and approved by the board/owner/governing body.
- M1.5 There shall be written goals and objectives for each program and service area which are consistent with the facility's goals and objectives and which support the mission of the facility.
- M1.6 Current policies and procedures, consistent with Ministry policies and directives, shall be in place to guide the management and service delivery of each program and service.

STANDARDS: PROGRAMS AND SERVICES**M. FACILITY ORGANIZATION AND ADMINISTRATION****STANDARDS AND CRITERIA****Criteria****ORGANIZATION AND
ADMINISTRATION
(CONT'D)**

M1.7 Policies and procedures shall be kept current and available to all staff.

M1.8 Opportunities for interdisciplinary and interdepartmental communication and coordination shall be in place and regularly evaluated.

**FINANCIAL
MANAGEMENT**

M1.9 The board/owner/governing body shall be responsible for the appropriate expenditure of financial resources and for meeting all the provincial financial requirements as outlined in the service agreement.

CONTRACTED SERVICES

M1.10 When services are contracted, there shall be written agreements between the facility and the contracted services, detailing the service expectations to meet the standards and criteria.

ADMINISTRATOR

M1.11 There shall be a designated administrator, accountable to the board/owner/governing body with overall responsibility and authority for the day-to-day operation of the facility.

M1.12 Required minimum on-site hours of administrator time are:

Fewer than 65 beds:	16 on-site hours/week
66 to 99 beds:	24 on-site hours/week
100 or more beds:	40 hours or the facility maximum full-time hours.

STANDARDS: PROGRAMS AND SERVICES

M. FACILITY ORGANIZATION AND ADMINISTRATION

STANDARDS AND CRITERIA

Criteria

ADMINISTRATOR
(CONT'D)

M1.13 Qualifications of a **new administrator** shall include:

- Education in management and/or 3 years relevant experience in management, **and**
- Education in health or social services or 3 years relevant experience in long-term care.

Note: Administrators hired prior to January 1, 1996, shall be deemed to have to met the requirements.

In the future, a certification program that may be developed by ONHA and OANHSS may be considered in determining the qualifications of new administrators.

HUMAN RESOURCES

M1.14 Staffing needs for the facility shall be evaluated according to program and service requirements.

M1.15 Staffing shall be provided according to the approved staffing plan in the service agreement.

M1.16 Staff shall be allocated according to residents' care needs, facility design and resources.

M1.17 Written job descriptions detailing responsibilities and scope of function shall be available for all staff positions.

M1.18 The facility's policies, procedures, and work routines shall be followed in the provision of care and services. Staff shall be re-instructed when required.

STANDARDS: PROGRAMS AND SERVICES**M. FACILITY ORGANIZATION AND ADMINISTRATION****STANDARDS AND CRITERIA****Criteria****SUPPLIES AND
EQUIPMENT**

M1.19 Supplies and equipment shall be provided and shall be readily available for use to support safe and effective care and services to residents, including but not limited to:

- Privacy screens which provide complete privacy, according to applicable legislation
- Bedroom furnishings such as beds with adjustable bed rails and firm, comfortable mattresses with waterproof covers; bedside tables, comfortable easy chairs, and where a resident is confined to bed, a bed with an adjustable head and foot
- Supplies and equipment for social, recreation and physical activities
- Medical supplies and nursing equipment for the care of residents, including the prevention or care of skin disorders, continence care, infection control and sterile procedures
- Medical devices, such as catheters and colostomy and ileostomy devices
- Assistive devices for enabling residents to feed themselves

STANDARDS: PROGRAMS AND SERVICES**M. FACILITY ORGANIZATION AND ADMINISTRATION****STANDARDS AND CRITERIA****SUPPLIES AND
EQUIPMENT (CONT'D)**

- Supplies and equipment for personal hygiene and grooming, such as skin care lotions and powders, shampoos, soap, deodorant, toothpaste, toothbrushes, denture cups and cleansers, toilet tissue, facial tissue, hair brushes, combs, razors/shavers, shaving cream, feminine hygiene products, and self-help devices

M1.20 Supplies and equipment shall be maintained in good condition.

**STANDARD 2:
MONITORING,
EVALUATING AND
IMPROVING QUALITY****M2. THERE SHALL BE A COMPREHENSIVE,
COORDINATED, FACILITY-WIDE PROGRAM
FOR MONITORING, EVALUATING AND
IMPROVING THE QUALITY OF
ACCOMMODATION, CARE, SERVICES,
PROGRAMS AND GOODS PROVIDED BY THE
FACILITY.**

Note: There are many programs designed to monitor, evaluate and improve quality. The facility may choose to put into place any program or combination of programs which best focus on responding to the needs and expectations of the residents and their families.

Criteria

M2.1 There shall be regular formal and informal mechanisms to monitor resident and family satisfaction with the quality of accommodation, care, services, programs and goods provided by the facility.

STANDARDS: PROGRAMS AND SERVICES**M. FACILITY ORGANIZATION AND ADMINISTRATION****STANDARDS AND CRITERIA****Criteria****MONITORING,
EVALUATING AND
IMPROVING QUALITY
(CONT'D)**

- M2.2 Each program and service within the facility shall be included in the program for monitoring, evaluating and improving quality.
- M2.3 Staff from all programs and services shall be involved in activities associated with monitoring, evaluating and improving quality.
- M2.4 There shall be clearly assigned responsibilities for activities to monitor, evaluate and improve quality.
- M2.5 All activities and components of the program to monitor, evaluate and improve quality shall be documented.
- M2.6 A regular report of activities to monitor, evaluate and improve quality shall be provided to the board/owner/governing body.
- M2.7 The board/owner/governing body shall provide feedback and respond to the issues raised by the activities to monitor, evaluate and improve quality.

STANDARDS: PROGRAMS AND SERVICES**M. FACILITY ORGANIZATION AND ADMINISTRATION****STANDARDS AND CRITERIA****Criteria****STANDARD 3:
RISK MANAGEMENT**

M3. THERE SHALL BE COORDINATED RISK MANAGEMENT ACTIVITIES DESIGNED TO REDUCE AND CONTROL ACTUAL OR POTENTIAL RISKS TO THE SAFETY, SECURITY, WELFARE AND HEALTH OF INDIVIDUALS OR TO THE SAFETY AND SECURITY OF THE FACILITY.

Criteria**HEALTH AND SAFETY**

- M3.1 There shall be an identified staff member designated to be in charge of the facility at all times.
- M3.2 Staff shall be informed of whom to notify in case of an emergency in the facility. Names and telephone numbers for emergency services shall be readily available to staff.
- M3.3 Safety systems shall be in place and policies, procedures and practices shall be implemented to identify and minimize hazards to residents, staff and visitors.
- M3.4 The resident call system and door alarms (as required by applicable legislation) shall be maintained in working order.
- M3.5 Records shall be maintained for resident safety and security, employee occupational health and safety, and facility safety.
- M3.6 Staff shall be instructed in the safe use of all equipment used in their job responsibilities.

STANDARDS: PROGRAMS AND SERVICES**M. FACILITY ORGANIZATION AND ADMINISTRATION****STANDARDS AND CRITERIA****Criteria****UNUSUAL
OCCURRENCES**

M3.7 Unusual occurrences shall be reported according to Ministry policy.

INTERNAL DISASTERS

M3.8 A designated senior staff member shall be in charge of evacuation procedures.

M3.9 There shall be a system to readily identify each resident in the facility (e.g. photo identification, identification bracelets).

M3.10 There shall be written contingency plans for handling internal disasters (including missing residents, bomb threats, fires, loss of essential services, service disruption).

M3.11 Written contingency plans shall be developed in consultation with local and municipal emergency planning groups.

M3.12 Contingency plans for handling internal disasters shall be rehearsed on a regular basis and at a minimum, every three years.

M3.13 The fire plan shall be reviewed annually.

M3.14 Monthly fire drills shall be held on all shifts and staff attendance documented.

M3.15 All facility staff shall receive instruction in fire safety procedures annually.

M3.16 All volunteers and residents shall be provided opportunities to receive instruction about fire safety procedures.

STANDARDS: PROGRAMS AND SERVICES

M. FACILITY ORGANIZATION AND ADMINISTRATION

STANDARDS AND CRITERIA

Criteria

EXTERNAL DISASTERS

M3.17 There shall be written contingency plans for the operation of the facility under the conditions of external disaster (including weather-related, community, and environmental disasters).

M3.18 Emergency plans shall be developed in consultation with local and municipal emergency planning groups.

INFECTION CONTROL

M3.19 There shall be an organized program of infection control, coordinated by a multidisciplinary committee which meets regularly and which is chaired by a designated health care professional with expertise/interest in infection control.

M3.20 A designated infection control practitioner on staff shall be a member of the infection control committee and shall be responsible for the surveillance and outbreak management activities of the infection control program.

Note: The infection control practitioner should possess expertise or demonstrate willingness to acquire expertise in infection control. The designated individual must be a registered nurse or a registered medical laboratory technologist.

M3.21 The infection control program shall include sanitation practices, surveillance and outbreak management protocols, facility policies and procedures, other legislated requirements, and education and consultation to support the policies and procedures.

STANDARDS: PROGRAMS AND SERVICES

M. FACILITY ORGANIZATION AND ADMINISTRATION

STANDARDS AND CRITERIA

INFECTION CONTROL
(CONT'D)

M3.22 There shall be an ongoing program of surveillance to determine the presence of infections.

Each resident admitted to a LTC facility shall be screened for tuberculosis within 14 days of admission.

NEW ➤

Note: For short-stay residents, screening is not required for TB prior to admission. If the person will be in the facility for more than 14 days, the TB test will be carried out within the facility, if there are no previous results available. TB testing should not be repeated within a one-year period. (See 0805-01).

M3.23 All staff shall participate in the facility-wide infection control program and shall be made aware of and practise measures to prevent or minimize the spread of infection.

M3.24 A contingency plan and policies and procedures shall be developed and implemented in the event of a suspected or confirmed outbreak.

M3.25 There shall be a process to facilitate early communication of an outbreak, within the facility and to external agencies.

M3.26 Specific policies relating to infection control and outbreak control shall be developed for each department and all personnel shall be instructed and supervised in implementing the policies.

STANDARDS: PROGRAMS AND SERVICES**M. FACILITY ORGANIZATION AND ADMINISTRATION****STANDARDS AND CRITERIA****STANDARD 4:
RECORDS
MANAGEMENT****M4. THERE SHALL BE AN ORGANIZED SYSTEM OF RECORDS MANAGEMENT WHICH INCLUDES THE COMPONENTS OF COLLECTION, ACCESS, STORAGE, RETENTION AND DESTRUCTION OF RECORDS.****Criteria**

- M4.1 There shall be written policies and procedures for all aspects of:
- Collection of information
 - Completeness of the record
 - Maintaining records
 - Confidentiality of information including any applicable FIPPA requirements
 - Access by the interdisciplinary care team
 - Access by residents to their own records
- M4.2 Members of the interdisciplinary care team shall have access to residents' records as needed in providing care.
- M 4.3 When residents are transferred to hospital, any relevant information required for their continuing safe care shall be transferred at the same time, unless prohibited by other legislative requirements.

Community Health Division
Long-Term Care Facilities Branch
80 Grosvenor Street
5th Floor, Hepburn Block
Queen's Park
Toronto ON M7A 1R3

Division de la santé communautaire
Direction des établissements de soins de longue durée
80, rue Grosvenor
Édifice Hepburn, 5e étage
Queen's Park
Toronto ON M7A 1R3

February 9, 2004

MEMORANDUM TO: Administrators

FROM: Tim Burns
Director (A), Long-Term Care Facilities Branch

RE: N95 masks and mask fit testing

There have been several inquiries regarding the use of N95 masks in long-term care facilities and the associated mask fit testing. The appropriate level of precaution should be driven by the procedure being undertaken and the resident's presenting symptoms. Infection control programs should reinforce the importance of droplet precautions, including hand washing, gloving, eye protection, surgical masks and, in certain situations gowning.

Based on the knowledge now available about the spread of respiratory infections, Health Canada recommends that droplet precautions are the appropriate response during significant resident contact in *non-outbreak* conditions. This means that surgical/procedure masks and eye protection will provide an appropriate barrier.

If your organization is unsure as to what routine practices and procedures require the use of an N95 mask, please discuss this with your Public Health Infection Control Committee member. Please ensure that your infection control policies are updated accordingly.

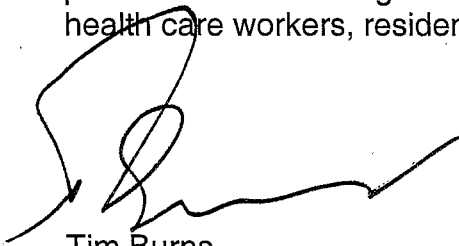
It is recommended that all LTC facilities develop active, hands-on education programs for all staff to ensure they have the knowledge and skills to maintain infection control standards. Education programs should emphasize:

- hand washing
- appropriate use of gloves and gowns
- appropriate cleaning of equipment and rooms, including proper use of disinfectants and required contact times.
- when it is appropriate to use eye protection and N95 masks, and how to use them properly.

All non-acute care health care providers in facilities should comply with existing and updated recommendations for infection control as identified in the Health Canada's "Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Health Care" (<http://www.hc-sc.gc.ca/pphb-dgsp/psp/publicat/ccdr-rmtc/99vol25/25s4/index.html>). Pages 52 – 62 of these Guidelines outline "Recommendations for Long Term Care Facilities".

As per the Occupational Health and Safety Act, 1990, every employer shall ensure that protective devices as prescribed are provided and that the protective devices provided by the employer are used as prescribed. The employer is required to provide information, instruction and supervision to a worker to protect the health or safety of the worker, and take every precaution reasonable in the circumstances for the protection of a worker (25(1) (2)). Supervisors must provide instruction and ensure that workers wear the protective devices or clothing that is required (27(1) (2)). The workers must wear the equipment, protective devices or clothing that the worker's employer requires to be used or worn (28(1)).

Wearing the right protective equipment is necessary to protect health care workers from infection transmission. Any health care worker who is required to wear an N95 mask should be mask fit tested to ensure maximum protection. (Refer to the *SARS Questions and Answers*, December 7, 2003, page 4, Answer 4, for potential companies that provide mask fit testing services.) It is important to improve the safety of our valuable health care workers, residents, and the public in general.



Tim Burns
Director (A), Long-Term Care Facilities Branch

Attachment

cc: Mary Kardos Burton
Regional Directors, Program Managers, Compliance Staff, Regional Office
OANHSS
OLTCA
Concerned Friends

Infectious Diseases Branch
8th Floor, 5700 Yonge Street
Toronto ON M2M 4K5

Direction de la lutte contre les maladies infectieuses
5700, rue Yonge, 8e étage
Toronto ON M2M 4K5

November 18, 2005

Note: Roche Canada is solely responsible for the supply and delivery of Tamiflu®. The Ministry of Health and Long-Term Care is not responsible for any lack of supply of Tamiflu® or lack of timeliness in supply of Tamiflu®. Please contact Roche Canada directly at: (905) 542-5500 or 1(800) 268-0440 regarding any questions respecting Tamiflu® supply

Dear Long-Term Care Home Operator¹, Long-Term Care Home Administrator, and Medical Officer of Health:

This document was prepared by the Ministry of Health and Long-Term Care (MOHLTC) Infectious Diseases Branch, Long Term Care Homes Branch, and Drug Programs Branch to ensure common understanding of the process outlined by Roche Canada (attached) to be followed to obtain Tamiflu® (oseltamivir phosphate) in the event of an institutional influenza outbreak.

Long-Term Care Home Operators are asked to ensure that Medical Directors and attending physicians of residents are provided with a copy of this letter.

As you may know, recent media reports on avian influenza have resulted in an increased awareness regarding a potential pandemic influenza outbreak. As a result, public demand for Tamiflu®, the primary antiviral medication recommended by the World Health Organization in preparation for an influenza pandemic, has dramatically increased in the absence of seasonal influenza.

On Monday October 24, 2005, Roche Canada, the sole supplier of Tamiflu®, released a statement indicating that the company will immediately stop shipment of Tamiflu® until the emergence of seasonal influenza. Once seasonal influenza activity is identified, Roche has announced that deliveries of Tamiflu® to long-term care homes and institutions will be prioritized.

MOHLTC recommendations about antiviral use for institutional influenza outbreak management are unchanged; please refer to the Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes, October 2004, for further details. The Guide can be found at: http://www.health.gov.on.ca/english/providers/pub/pubhealth/ltc_respoutbreak/ltc_respoutbreak.pdf

¹ Long-Term Care Home Operator refers to:

- A licensee of a nursing home under the *Nursing Homes Act*
- A municipality, municipalities or board of management maintaining and operating a home or joint home under the *Homes for the Aged and Rest Homes Act*, or
- An approved corporation maintaining and operating an approved charitable home for the aged under the *Charitable Institutions Act*

During laboratory-confirmed influenza outbreaks in long-term care homes (LTCH), Tamiflu® is at this point the antiviral of choice for both prophylaxis and treatment for an influenza outbreak. Antiviral medication for prevention should continue to be offered to all residents, whether vaccinated or unvaccinated. Unvaccinated staff members should receive antiviral prophylaxis according to the policies and procedures of the LTCH operator and directives from the local Medical Officer of Health.

In the absence of laboratory confirmation of influenza virus in a LTCH respiratory infection outbreak, the medical officer of health has the authority to declare an influenza outbreak, and to initiate the antiviral request process, based on local influenza activity in the area.

Antiviral prophylaxis should not replace annual influenza vaccination. Vaccination remains the primary tool for the prevention of influenza infection and illness. Promotion of influenza vaccination through the Universal Influenza Immunization Program (UIIP) or through facility-based clinics can increase vaccination rates, especially among staff, and may reduce the need for antivirals in this group.

Procedure for obtaining Tamiflu® during an influenza outbreak in a LTCH

As set out in the attached letter of November 7, 2005, Roche Canada has developed an ordering process for Tamiflu® for institutions experiencing an influenza outbreak. LTCHs that do not have dispensing capabilities (i.e. there is no onsite pharmacy) can obtain Tamiflu® for their residents through the usual drug procurement and distribution process.

To place an order for Tamiflu®, contact Roche Canada at (905) 542-5500 or 1(800) 268-0440.

The Ontario Drug Benefit reimbursement procedure for Tamiflu® for LTCH residents is unchanged. Once confirmation of an outbreak is received and an attending physician decides to prescribe Tamiflu, the prescribing physician must complete a limited use (LU) prescription by filling in the appropriate Reason for Use code, date, CPSO number, and by signing the prescription. The name of the home should be written in under "Patient's name". The completed LU prescription must then be attached to a list of affected patients and forwarded to the dispensing pharmacy. One LU prescription should be used for patients requiring treatment (up to 5 days therapy) and a separate LU prescription must be completed for patients requiring prophylactic therapy (up to 6 weeks therapy) during the influenza outbreak. The standard LU prescription process (i.e., one completed prescription for each patient) is also acceptable.

Procedure for obtaining Tamiflu® during an influenza outbreak in a retirement home

Once the influenza outbreak has been confirmed by the local medical officer of health, the retirement home may contact Roche Canada at (905) 542-5500 or 1(800)268-0440 in order to obtain Tamiflu for outbreak management. If a retirement home wishes to employ the foregoing streamlined LU prescription process for its ODB-eligible residents, the home may do so by obtaining a group prescription from a physician and by selecting a single pharmacy outlet in accordance with the procedure established for LTCHs. The standard LU prescription process (i.e. one prescription for each patient) may also be followed.

Procedure for obtaining Tamiflu® during an influenza outbreak in a hospital

As outlined in the attached letter from Roche, hospital pharmacies should contact Roche Canada directly in order to obtain outbreak-related supplies of Tamiflu®.

Special considerations

In the event that an institutional outbreak occurs in a geographically isolated institution, or in an institution for which timely access to Tamiflu® may be problematic, medical officers of health may choose to notify Roche Canada of confirmed influenza activity in their region to expedite the process of procuring a supply of Tamiflu® for affiliated pharmacies. Institutions, other than those identified above, may be eligible to obtain Tamiflu® on a priority basis as deemed appropriate by the local medical officer of health following processes similar to those outlined in this letter.

If you have any questions about the procurement process, please do not hesitate to contact Roche Canada at (905) 542-5500 or 1 (800) 268-0440.

Sincerely,

Original signed by

Dr. David C. Williams
Associate Chief Medical Officer of Health and
Director, Infectious Diseases Branch

Original signed by

Mr. Tim Burns
Director, Long-Term Care Homes Branch

Original signed by

Ms. Susan Paetkau
Director, Drug Programs Branch

- c: Dr. Sheela Basrur, Chief Medical Officer of Health and Assistant Deputy Minister, Public Health Division
Dr. Ted Boadway, Ontario Medical Association
Ms. Deb Saltmarshe, Ontario Pharmacists' Association
Dr. Myrella Roy, Executive Director, Canadian Society of Hospital Pharmacists
Ms. Sudha Kutty, Director, Patient Safety and Clinical Best Practice, Ontario Hospital Association
Mr. Geoff Quirt, Associate Deputy Minister, Senior's Secretariat
Mr. Gord White, Ontario Retirement Communities Association
Ms. Margaret Ringland, Director of Member Relations and Professional Services, Ontario Association of Non-Profit Homes and Services for Seniors
Ms. Karen Sullivan, Executive Director, Ontario Long-Term Care Association
Ms. Ilona Torontali, Roche Canada

**Ministry of Health
and Long-Term Care**

Emergency Management Unit
415 Yonge St., Suite 801
Toronto, ON M5B 2E7

**Ministère de la Santé
et des Soins de longue durée**

Unité de gestion des situations d'urgence
415, rue Yonge, bureau 801
Toronto ON M5B 2E7



November 26, 2004

MEMORANDUM TO: Chief Executive Officers
Private and Public Hospitals

Administrators
Long-Term Care Homes

FROM: Allison J. Stuart, Director
Emergency Management Unit

RE: Use of generators

The power outage of August 2003 was an effective reminder of our collective vulnerability in this area. Organizations have heightened their focus on contingency measures as a result, including the efficacy of existing generators.

Many of you are testing your generators more frequently and/or upgrading and even replacing generators. The ministry supports these pro-active initiatives and encourages organizations to ensure appropriate contingency measures are in place when relying on generator power. These measures should include, but need not be limited to, advising the regional director and the relevant Central Ambulance Communications Centre in your area of any *planned* switch to generator power, other than regular testing of the switch-over function itself. The advice should include when the event will occur, approximate duration, and any internal measures taken to accommodate the planned use of auxiliary power.

Many thanks for your anticipated cooperation.

Original signed

Allison J. Stuart

STANDARDS: PROGRAMS AND SERVICES**M. FACILITY ORGANIZATION AND ADMINISTRATION****GUIDELINES*****ADMINISTRATION***

The mission statement should be developed and approved by the board/owner/governing body and reviewed, at a minimum, every three years.

Objectives should be evaluated annually to determine the level of achievement.

Goals should be reviewed every three years.

Administrative, direct service and professional staff should be represented in planning, decision making, and the formulation of goals, objectives, policies, and procedures related to programs and services.

Policies should include but not be limited to:

- *administration*
- *resident admission, transfer and discharge*
- *programs and services*
- *resident care*
- *human resource management*
- *ethics issues*
- *confidentiality*
- *records management*
- *financial management*
- *contractual arrangements*
- *programs designed to monitor, evaluate and improve quality and to manage risk*
- *infection control*
- *fire and disaster planning*

Mechanisms should be in place to communicate changes in policies and procedures to all staff.

STANDARDS: PROGRAMS AND SERVICES

M. FACILITY ORGANIZATION AND ADMINISTRATION GUIDELINES

COMMITTEES

Committees should address the following:

- *Admissions*
- *Quality*
- *Senior management*
- *Professional advisory*
- *Nursing practice*
- *Pharmacy and therapeutics*
- *Infection control*
- *Resident health records*
- *Health and safety*
- *Community linkages*

Coordinators of programs and services and direct care staff should be included in the facility's committees.

All committees should have clearly stated terms of reference, and should be accountable to the administrator.

The activities of all committees should include agendas and minutes.

Decisions made by committees should be communicated to staff and residents of the facility, where appropriate.

Committees should be evaluated to determine the effectiveness of their problem identification and problem resolution.

FACILITY-WIDE ACTIVITIES

Staff from all programs and services should have opportunities to participate in the following areas:

- *Strategic planning*
- *Service planning*
- *Human resources planning*

STANDARDS: PROGRAMS AND SERVICES

**M. FACILITY ORGANIZATION AND ADMINISTRATION
GUIDELINES**

***FACILITY-WIDE
ACTIVITIES (cont.)***

- *Facility design*
- *Budgeting (operating and capital)*
- *Work planning*
- *Product selection and evaluation*
- *Health and Safety*
- *Staff education*
- *Fire and disaster planning*
- *Research (where applicable)*
- *Programs designed to monitor, evaluate and improve quality*
- *Programs to manage risk*

PERFORMANCE REVIEWS

There should be a policy and procedure requiring written performance reviews for all employees prior to completion of their probation period and on an annual basis.

***CONTINGENCY PLANS:
INTERNAL DISASTERS***

Written contingency plans for internal disasters should have protocols for:

- *Assignment of personnel to specific tasks and responsibilities*
- *Specifications of evacuation routes and procedures, taking into account contingencies such as inclement weather*
- *Arrangements/agreements for alternative shelter in the event of evacuation*
- *Arrangements for transporting records, medications, nursing equipment and supplies*
- *A system to supervise evacuated residents.*

STANDARDS: PROGRAMS AND SERVICES

M. FACILITY ORGANIZATION AND ADMINISTRATION

GUIDELINES

CONTINGENCY PLANS: EXTERNAL DISASTERS

The contingency plans for external disasters should include protocols for:

- *Alternative sources of basic supplies*
- *Emergency disaster supplies*
- *Discharge to another facility*
- *Communication plan*
- *Assignment of staff to specific tasks and responsibilities.*

INFECTION CONTROL PROGRAM

A designated health care professional with expertise/interest in infection control should be responsible for the development, implementation and supervision of the infection control program, in consultation with the local Medical Officer of Health or designate.

There should be defined criteria developed in consultation with the Public Health Unit, which are used to determine the presence of an outbreak.

RISK MANAGEMENT

All risk management activities should be documented, with reports presented to the board/owner/governing body for review and feedback.

Coordinated risk management activities should include the following four components or steps:

STANDARDS: PROGRAMS AND SERVICES**M. FACILITY ORGANIZATION AND ADMINISTRATION
GUIDELINES*****RISK MANAGEMENT
(cont.)*****1. RISK IDENTIFICATION**

The sources of information used for risk identification may include but are not limited to:

Resident Services:

- *resident satisfaction questionnaires*
- *unusual occurrence reporting (refer to requirements related to unusual occurrences)*
- *infections*
- *falls*
- *fires*
- *evacuation*
- *deaths*
- *health care records*
- *resident complaints*
- *service utilization reviews*
- *resident consents*

Management and Operations:

- *policies and procedures*
- *staff qualifications*
- *performance reviews*
- *contracted services*
- *legal action*

Environment and Property:

- *security reports*
- *fire drill reports*
- *mock disaster reports*
- *insurance claims*

STANDARDS: PROGRAMS AND SERVICES

M. FACILITY ORGANIZATION AND ADMINISTRATION

GUIDELINES

RISK MANAGEMENT
(cont.)

Occupational Health and Safety:

- *Workers' Compensation forms*
- *health and safety reports*

2. *RISK ASSESSMENT*

Risks may be assessed using the following criteria:

- *possible cause of risk*
- *the frequency of the occurrence*
- *severity of the occurrence*
- *severity of financial loss*
- *potential for repetition*
- *loss of reputation*

3. *RISK ACTION PLAN*

The system for taking action on identified risk management issues may include:

- *policy and procedure change*
- *modification of a specific practice*
- *alteration in equipment and supplies*
- *staff selection procedures*
- *orientation for new staff*
- *specific inservice training*
- *notification of appropriate management staff and others*

STANDARDS: PROGRAMS AND SERVICES

**M. FACILITY ORGANIZATION AND ADMINISTRATION
GUIDELINES**

***RISK MANAGEMENT
(cont.)***

4. RISK EVALUATION

There should be a system in place to evaluate all action plans.

Evaluation may use such tools as:

- *statistical analysis*
- *trending reports*

STANDARDS: PROGRAMS AND SERVICES**N. MEDICAL SERVICES****STANDARDS AND CRITERIA****STANDARD 1:
SERVICE PROVISION**

N1. MEDICAL SERVICES SHALL BE ORGANIZED TO MEET RESIDENTS' MEDICAL NEEDS, INCLUDING ASSESSMENT, PLANNING AND PROVISION OF RESIDENTS' INDIVIDUALIZED MEDICAL CARE, CONSISTENT WITH PROFESSIONAL STANDARDS OF PRACTICE.

Criteria**MEDICAL DIRECTOR**

- N1.1 Medical services shall be provided through the appointment of a medical director, licensed by the College of Physicians and Surgeons of Ontario.
- N1.2 The medical director shall be appointed by the board/owner/governing body on the recommendation of the administrator.
- N1.3 There shall be a contract/written agreement between the facility and the medical director, which specifies the term of the appointment and addresses the position responsibilities.
- N1.4 Prior to reappointment of the medical director, the administrator shall conduct a review to determine that he/she is meeting the terms of the agreement.
- N1.5 The medical director shall be accountable to the administrator and responsible for the development, implementation, and evaluation of medical services.
- N1.6 The medical director shall provide advice when requested, to the board/owner/governing body on matters pertaining to medical care and services.

STANDARDS: PROGRAMS AND SERVICES**N. MEDICAL SERVICES****STANDARDS AND CRITERIA****Criteria****MEDICAL DIRECTOR
(cont.)**

- N1.7 The medical director shall provide advice to the administrator in the areas of developing, implementing, and evaluating services and policies.
- N1.8 The medical director shall have the responsibility, accountability and authority to monitor and evaluate the medical care and services provided by physicians and to take action when standards are not met.

ATTENDING PHYSICIANS

- N1.9 All attending physicians who are given privileges to provide medical care to residents in the facility shall be licensed by the College of Physicians and Surgeons of Ontario.
- N1.10 All attending physicians shall be appointed by the administrator, on the advice of the medical director.
- N1.11 Attending physicians shall be accountable to the medical director for meeting the facility policies and standards of medical care.
- N1.12 The contract/written agreement between the facility and each attending physician shall identify the term of the appointment and the responsibilities of the position.
- N1.13 Prior to reappointment of the attending physicians, the administrator, in consultation with the medical director, shall conduct a review to determine that they are meeting the terms of the agreement.
- N1.14 Attending physicians shall assess, plan, implement and evaluate their residents' medical care and participate in the interdisciplinary approach to care.

STANDARDS: PROGRAMS AND SERVICES

N. MEDICAL SERVICES

STANDARDS AND CRITERIA

Criteria

**ATTENDING PHYSICIANS
(cont.)**

- N1.15 Attending physicians shall document on the resident health record on each visit, to maintain continuity and ongoing evaluation.
- N1.16 Attending physicians shall arrange for 24-hour medical coverage for residents for whom they provide medical care. These arrangements shall be communicated to facility staff.
- N1.17 All medical care and services provided by physicians in Long-Term Care facilities, shall be subject to peer assessment by the College of Physicians and Surgeons of Ontario, on a random basis, according to College procedures.

STANDARDS: PROGRAMS AND SERVICES

N. MEDICAL SERVICES

GUIDELINES

PRINCIPAL FUNCTIONS

The principal functions should include but are not limited to:

- *clinical care delivery*
- *continuing education of medical staff and other professionals*
- *utilization review*
- *health promotion and illness prevention*

MEDICAL DIRECTOR

Advice provided by the medical director to the board/owner/governing body on matters pertaining to medical care and services should include but is not limited to:

- *Organization of medical services*
- *Credentiailling of physicians*
- *Physician membership in appropriate associations*
- *Continuing medical education*
- *Annual report*
- *Facility budget*
- *Community outreach programs*
- *Arranging medical care for residents without attending physicians.*

Advice provided by the medical director to the administrator in areas of developing, implementing and evaluating services and policies should include but is not limited to:

- *Ethical dilemmas*
- *Safety*
- *Disaster planning*
- *Resident care programs, with special consideration of the resident population language, culture and care needs*
- *Diagnostic services*
- *Pharmacy and therapeutics*
- *Drug profiles*
- *Emergency and on-call provision of care*

STANDARDS: PROGRAMS AND SERVICES

N. MEDICAL SERVICES

GUIDELINES

MEDICAL DIRECTOR (cont.)

- *Admission of residents*
- *Transferring and discharge of residents*
- *Restraints*
- *Preventive health care*
- *Immunization programs*
- *Contagious diseases*
- *Incident reports*
- *Relationships with hospitals and other agencies*

MEDICAL DIRECTOR'S CONTRACT

The medical director's contract should include but not be limited to:

- *The requirements of a medical director according to applicable statutes and regulations.*
- *The pertinent requirements of a medical director included in the standards for medical services of the Long-Term Care Facility Manual.*
- *Accountability relationship between the medical director and the administrator of the facility.*
- *Responsibility of the medical director for developing, implementing and evaluating medical services.*
- *Providing advice to the owner, board, government body on matters pertaining to medical care and services.*
- *Reference to the responsibility, accountability and authority of the medical director.*
- *Reference to the responsibility of the medical director to monitor and evaluate attending physicians' compliance with the facility's policies, and other long-term care standards, including accreditation.*

STANDARDS: PROGRAMS AND SERVICES

N. MEDICAL SERVICES

GUIDELINES

MEDICAL DIRECTOR'S CONTRACT (contd.)

- *Reference to the responsibility of the medical director to monitor, evaluate, and where necessary take corrective action for attending physicians who do not meet regulatory requirements.*
- *Reference to maintaining current knowledge and practice in geriatric medicine and gerontology.*
- *Remuneration.*
- *The length of the agreement and the terms for cancellation.*
- *The facility's requirements of the medical director for staff education.*

ATTENDING PHYSICIANS

Responsibilities of the attending physicians should include but are not limited to:

- *Regularity of attending residents*
- *Arrangements for 24-hour coverage*
- *Performing admission and annual reassessments*
- *Performing assessments following readmission from an acute care facility*
- *Infectious disease surveillance*
- *Writing medical orders*
- *Quarterly medication and diet reviews*
- *Medical charting and documentation*
- *Discussion and communication with residents/representatives*
- *Interdisciplinary communication and plan of care*
- *Referrals to physicians with specialist knowledge*
- *Communicating with the public health department*
- *Referrals to other paramedical services.*

STANDARDS: PROGRAMS AND SERVICES**N. MEDICAL SERVICES****GUIDELINES*****ATTENDING PHYSICIANS
(contd.)***

Participation of attending physicians in the interdisciplinary approach to care should include but is not limited to:

- *Collecting and analyzing data pertaining to the resident*
- *Making a diagnosis*
- *Planning, implementing and evaluating the interventions*
- *Attending team conferences*
- *Attending resident/staff/family conferences*
- *Providing interdisciplinary staff education*
- *Providing medical input into pre-admission assessments*
- *Contributing to the ongoing improvement of the quality of medical services available to the residents*

***RESIDENTS' MEDICAL
CARE***

Resident care should include but is not limited to:

- *Admission and annual assessment*
- *TB surveillance*
- *Writing medical orders*
- *Medication reviews*
- *Medical charting and documentation*
- *Resuscitative interventions, and/or DNAR orders*
- *Providing/arranging for 24-hour medical coverage to their residents*
- *Discussion and communication with residents/representatives*
- *Interdisciplinary communication and plan of care*
- *Communication with the public health department*
- *Arranging consultative services for residents as required*
- *Clinical care including maintenance of skin integrity, management of falls, incontinence (bowel and bladder) nutrition and dysphagia management, behaviour management of aggressive, agitated residents, etc.*

STANDARDS: PROGRAMS AND SERVICES

N. MEDICAL SERVICES

GUIDELINES

DOCUMENTATION

Documentation should include but is not limited to:

- *History, including details of present illness, functional inquiry, past history, and social history*
- *Physical examination, admitting diagnosis*
- *Orders for diagnostic tests and therapeutic procedures*
- *Confirmation of telephone orders*
- *Significant clinical, laboratory or other diagnostic procedures*
- *Clinical diagnosis to support medications and diagnostic interventions*
- *Progress notes, reports and consultations*
- *Discussions with residents, families and staff at care conferences*
- *Discharge or death summary*

STANDARDS: PROGRAMS AND SERVICES

O. ENVIRONMENTAL SERVICES

STANDARDS AND CRITERIA

**STANDARD 1:
ENVIRONMENTAL
SERVICES**

O1. ENVIRONMENTAL SERVICES SHALL BE ORGANIZED TO PROVIDE A SAFE, COMFORTABLE, CLEAN, WELL-MAINTAINED ENVIRONMENT FOR RESIDENTS, STAFF AND VISITORS.

Criteria

**MANAGEMENT OF
ENVIRONMENTAL
SERVICES**

O1.1 There shall be a staff member responsible for managing maintenance services.

O1.2 There shall be a staff member responsible for managing housekeeping services.

O1.3 There shall be a staff member responsible for managing laundry services.

Note: Depending on facility size or other factors, the responsibility for supervision of maintenance, housekeeping and laundry services may be combined into one position, (e.g. a manager/supervisor of environmental services) or two positions.

WASTE MANAGEMENT

O1.4 There shall be an organized program for waste management.

O1.5 Disposal of dry and wet garbage, including sharps and biological waste, shall be done in a recognized, approved manner.

O1.6 Every waste storage station located within or adjacent to the long-term care facility shall be constructed to keep out insects, rodents, birds and other animals, and shall be in a location which is easily accessible for any waste collection vehicles.

STANDARDS: PROGRAMS AND SERVICES**O. ENVIRONMENTAL SERVICES****STANDARDS AND CRITERIA****Criteria****WASTE MANAGEMENT
(CONT'D)**

O1.7 Every waste storage station shall be emptied and cleaned at least weekly, or more often as required.

O1.8 Where there is a private sewage and waste disposal system, measures shall be taken to maintain the system.

PEST CONTROL

O1.9 Measures are implemented to control pests.

O1.10 There shall be an organized program of pest control, which is under the direction of a licensed pest control operator.

O1.11 A record of visits and action taken is kept on file at the facility.

WATER SUPPLY

O1.12 A supply of potable water at sufficient pressure shall be provided to serve all areas of the building.

O1.13 The water supply serving the facility shall be free of offensive odours and free of minerals which can damage the plumbing system or stain fixtures and equipment.

O1.14 Where there is a private water supply that is chemically treated (e.g. chlorinator or other such treatment system), the chemical residual shall be checked on a daily basis and a record shall be kept on file at the facility.

O1.15 Where there is a private water supply, drinking water samples shall be analyzed at least four times each year (on a seasonal basis), to ensure safe drinking water.

O1.16 Where hoses have been attached to water lines, a back-flow prevention device shall be installed.

STANDARDS: PROGRAMS AND SERVICES

O. ENVIRONMENTAL SERVICES

STANDARDS AND CRITERIA

Criteria

WATER TEMPERATURE

O1.17 The temperature of the water serving all bathtubs, showers, and hand basins used by residents shall not exceed 49 degrees Celsius, and shall be controlled by a device, inaccessible to residents, that regulates the temperature.

O1.18 Hot water temperature shall be monitored daily at the source and once per shift in random locations where residents have access to hot water.

O1.19 Immediate action shall be taken where water temperatures exceed 49 degrees Celsius.

O1.20 The temperature of the hot water serving all bathtubs and showers used by residents shall be maintained at a temperature not below 40 degrees Celsius.

AIR TEMPERATURE AND QUALITY

O1.21 The facility shall be maintained at a minimum temperature of 22 degrees Celsius.

O1.22 Designated smoking areas shall be enclosed and separated from the rest of the facility and provided with an exhaust vent to the exterior. Minimum ventilation rates shall be according to the *Tobacco Control Act, 1994*.

O1.23 At least once a year the heating equipment shall be serviced by qualified personnel and the chimneys shall be inspected and cleaned if necessary.

O1.24 At least once a year air conditioning and air exchange systems shall be serviced by qualified personnel.

STANDARDS: PROGRAMS AND SERVICES**O. ENVIRONMENTAL SERVICES****STANDARDS AND CRITERIA****STANDARD 2:
MAINTENANCE
SERVICES****O2. THE FACILITY INCLUDING FURNISHINGS AND
EQUIPMENT SHALL BE MAINTAINED.****Criteria****PREVENTIVE
MAINTENANCE**

O2.1 The maintenance program shall provide for routine, preventive, and remedial maintenance.

O2.2 Maintenance services shall provide 24-hour emergency coverage.

O2.3 An established schedule of preventive maintenance procedures shall be followed and completion of work shall be documented.

O2.4 Plant and environmental control systems shall be maintained in good operating order.

O2.5 All electrical appliances shall be Canadian Standards Association approved.

**FACILITY GROUNDS,
EXTERIOR**

O2.6 The exterior of the building, walkways and outside areas shall be kept in good repair and free of debris.

O2.7 All entrances, exits, exterior stairwells and walkways shall be kept clear and unobstructed.

O2.8 Outside furniture shall be maintained in good repair, safe for resident use.

STANDARDS: PROGRAMS AND SERVICES**O. ENVIRONMENTAL SERVICES****STANDARDS AND CRITERIA**

	Criteria
FACILITY INTERIOR	<p>O2.09 Flooring shall be composed of a smooth, tight, impervious, non-slippery material that is maintained free of cracks, breaks and open seams.</p> <p>O2.10 Carpets shall be maintained in good repair, free of open seams, tears and buckling.</p> <p>O2.11 Walls, ceilings and doors shall be maintained in good repair.</p> <p>O2.12 All furnishings and equipment shall be maintained in good repair and safe for use.</p> <p>O2.13 The surface of toilet and bathing fixtures shall be maintained smooth and free of cracks.</p> <p>O2.14 All grab bars shall be securely fastened.</p> <p>O2.15 All faucets installed for resident use shall be clearly identified and easy to use.</p> <p>O2.16 Protective guards shall be placed around and over all radiators and heating devices.</p>
STANDARD 3: HOUSEKEEPING SERVICES	<p>O3. THE FACILITY, INCLUDING FURNISHINGS AND EQUIPMENT, SHALL BE KEPT CLEAN.</p> <p style="text-align: center;">Criteria</p> <p>O3.1 The housekeeping program shall provide for routine, preventive and remedial housekeeping.</p> <p>O3.2 Work routines that include cleaning frequencies and schedules of cleaning shall be established and followed.</p>

STANDARDS: PROGRAMS AND SERVICES**O. ENVIRONMENTAL SERVICES****STANDARDS AND CRITERIA****Criteria****HOUSEKEEPING
SERVICES (CONT'D)**

O3.3 The cleaning of the facility shall include but not be limited to:

- Resident bedrooms, including floors, furnishings, wall areas, contact surfaces such as door knobs and grab bars.
- Resident personal furnishings and mementos.
- Resident common areas (lounges, dining room and activity areas) including floors, furnishings, wall areas.
- Resident washrooms and bathing facilities, including floors, toilets, sinks, tubs, showers and whirlpools, and contact surfaces such as grab bars, handrails, door knobs, etc.
- Hydrotherapy unit (whirlpools) cleaning shall include the disinfecting of the recirculation lines, jets and turbines on a daily basis or more frequently as indicated by policy or type of resident condition (i.e. skin breakdown) since these units can be sources of nosocomial infections.
- Hydrotherapy units, tubs, shower chairs and lift chairs shall be cleaned with a germicidal cleaner between resident use.

STANDARDS: PROGRAMS AND SERVICES**O. ENVIRONMENTAL SERVICES****STANDARDS AND CRITERIA****Criteria****HOUSEKEEPING
(CONT'D)**

O3.3 (cont'd)

- The following service areas shall be included in the list of areas to be cleaned:
 - laundry areas
 - utility rooms, storage rooms
 - kitchen areas
 - kitchenettes
 - corridors/entrances/stairways
 - elevators
 - garbage rooms
 - staff lounges, dining rooms, locker rooms
 - offices
 - maintenance rooms

O3.4 Action shall be taken promptly to identify and address incidents of offensive odour.

**SUPPLIES AND
EQUIPMENT**

O3.5 Each housekeeping cart shall be designed and constructed to allow it to be easily cleaned and maintained.

O3.6 Each housekeeping cart shall be equipped with a locked compartment for storage of hazardous substances and each cart is locked at all times when not attended.

O3.7 The janitor's closet door shall be equipped with a locking device and shall be locked at all times when unattended.

O3.8 All chemicals shall be stored in labelled containers, which are kept inaccessible to residents.

O3.9 All chemicals shall be decanted in a protected area using the required safety equipment.

STANDARDS: PROGRAMS AND SERVICES**O. ENVIRONMENTAL SERVICES****STANDARDS AND CRITERIA****STANDARD 4:
LAUNDRY SERVICES****O4. LAUNDRY SERVICES SHALL BE ORGANIZED
TO MEET THE LINEN AND PERSONAL
CLOTHING NEEDS OF RESIDENTS.****Criteria****RESIDENTS' PERSONAL
CLOTHING**

- O4.1 Policies and procedures, work routines, schedules, and frequencies shall be followed for collection, transporting, sorting, processing, and delivery of linen and residents' personal clothing.
- O4.2 The facility shall provide labels as well as a service that labels all resident clothing, without additional cost to the resident.
- O4.3 Clothing shall be clearly labelled in a manner that respects residents' dignity.
- O4.4 The facility shall provide a service for mending and ironing of residents' clothing, on a fee-for-service basis when payment is authorized by the resident/representative.
- O4.5 Dry cleaning services shall be available to residents on a fee-for-service basis when payment is authorized by the resident/representative.
- O4.6 There shall be a system to communicate to residents/representatives, resident needs for clothing purchase or repair, as applicable.
- O4.7 There shall be a system in place to sort clothing for machine washing and dry cleaning.

STANDARDS: PROGRAMS AND SERVICES**O. ENVIRONMENTAL SERVICES****STANDARDS AND CRITERIA**

	Criteria
RESIDENTS' PERSONAL CLOTHING (CONT'D)	<p>O4.8 There shall be an effective system in place to collect soiled personal clothing and return clean clothing to residents' rooms within forty-eight hours of pick-up.</p> <p>O4.9 There shall be a system in place to notify staff when families assume the responsibility for laundering residents' personal clothing.</p> <p>O4.10 There shall be a system to regularly check for misplaced or unlabelled articles.</p> <p>O4.11 There shall be a system in place to follow up and take action on all reports of lost clothing.</p> <p>O4.12 Space for storage of personal clothing is provided and available to residents in their rooms.</p>
LINEN	<p>O4.13 There shall be supply of clean linen (including sheets, pillow cases, blankets, towels, bibs, and continence care supplies), sufficient to meet the residents' needs, readily available for use.</p> <p>O4.14 Linen shall be maintained in a good state of repair and free of stains.</p> <p>O4.15 Residents' bed linen shall be clean and free of odours. Bed linen shall be changed at least weekly and more frequently as required.</p> <p>O4.16 There shall be clean towels and face cloths, sufficient to meet residents' needs, provided to each resident at least daily.</p>

STANDARDS: PROGRAMS AND SERVICES**O. ENVIRONMENTAL SERVICES****STANDARDS AND CRITERIA**

	Criteria
LINEN (CONT'D)	O4.17 Clean linen shall be stored on resident care units, readily available to staff.
	O4.18 A supply of linen shall always be available for emergencies.
	O4.19 A system shall be in place to inspect and discard worn linen and to detect linen requiring repair.
	O4.20 Clean and soiled linen shall be kept separate at all times.
	O4.21 Separate laundry carts shall be used for pick up of soiled linen, and the distribution of clean linen.
	O4.22 Soiled linen shall be placed into laundry bags or carts at the point of service.
	O4.23 There shall be regular collection of soiled linen from the units in a manner that limits the possibility of infection, controls odours and maintains aesthetic conditions.
	O4.24 Soiled linen shall be taken to the soiled storage or laundry area in covered bins or closed bags.
	O4.25 All soiled linen shall be bagged before entering a laundry chute.
	O4.26 Contenance care supplies shall be laundered separately from other laundry.

STANDARDS: PROGRAMS AND SERVICES

O. ENVIRONMENTAL SERVICES

STANDARDS AND CRITERIA

Criteria

LINEN (CONT'D)

O4.27 There are procedures for clearly identifying, handling and washing linen used by residents who have communicable diseases or infections requiring precautions.

**SERVICE AREA
AND EQUIPMENT**

O4.28 The laundry area shall be locked when not in use.

O4.29 Where laundry services are conducted in-house, equipment shall be provided and maintained to meet the linen and personal clothing needs, and to support safe laundry handling.

O4.30 Where the laundry service is provided in-house, industrial washers and dryers shall be provided to meet the laundry services needs.

Note: Facilities shall be expected to meet this requirement by January 1997.

O4.31 The clean and soiled work areas of the laundry room shall be separate and clearly defined in a manner that minimizes microbial contamination.

O4.32 The laundry room shall have a hand wash basin equipped with hot and cold running water, single-service towels and dispensed liquid soap.

O4.33 All carts/bins used for laundry services shall be in good repair, of a material that is easily cleaned, and clearly labelled "clean" or "soiled".

STANDARDS: PROGRAMS AND SERVICES

O. ENVIRONMENTAL SERVICES

GUIDELINES

SUPERVISOR OF ENVIRONMENTAL SERVICES

Qualifications should include:

- *grade 12 with post-secondary course and/or at least 1 year experience in a supervisory position, or*
- *be enrolled in a post-secondary course related to environmental services*

If there is a supervisor for each service, qualifications for each supervisor should include:

SUPERVISOR OF MAINTENANCE SERVICES

Qualifications should include:

- *experience in general maintenance and repair buildings*

SUPERVISOR OF HOUSEKEEPING SERVICES

Qualifications should include:

- *experience in a health care facility housekeeping service and*
- *training in housekeeping techniques*

SUPERVISOR OF LAUNDRY SERVICES

Qualifications should include:

- *experience in a health care facility laundry service and*
- *training in laundry techniques*

STANDARDS: PROGRAMS AND SERVICES**O. ENVIRONMENTAL SERVICES****GUIDELINES*****STAFFING:
HOUSEKEEPING***

A number of factors influence the number of housekeeping staff required in each facility:

- design of the facility*
- age of the facility*
- type of finishing, carpeting, vinyl flooring, etc.*
- furnishings*
- variances of assigned duties*

Staffing should cover day and evening shifts, 7 days per week.

***STAFFING:
LAUNDRY***

A number of factors influence the staffing requirements for a facility's laundry services. Examples are:

- type of equipment*
- out-of-laundry duties, e.g. pick up and delivery of laundry from/to nursing units*
- type of continence care products*
- mending, repairing and ironing*
- valet services*
- housekeeping duties of the laundry area, etc.*

Staffing should cover 7 days per week.

STANDARDS: PROGRAMS AND SERVICES

O. ENVIRONMENTAL SERVICES

GUIDELINES

***PREVENTIVE
MAINTENANCE PROGRAM***

Equipment and systems which should be included in the preventive maintenance program include but are not limited to:

- *door exit alarms and resident call bells (where required by legislation)*
- *boilers/burners, circulating pumps*
- *hot water storage tanks*
- *water temperature monitoring*
- *water softeners*
- *grease traps*
- *compactor bins*
- *air compressors*
- *electrical appliances*
- *clocks*
- *outside lighting*
- *floor drains*
- *filters and hoods, and grease trays*
- *kitchen electrical equipment*
- *serveries*
- *resident lifts*
- *heating and ventilating supply units*
- *return air fans*
- *main exhaust fans*
- *filter replacement*
- *mechanical areas*
- *grills and diffusers*
- *room thermostats*
- *dryers*
- *washing machines*
- *sump pumps*
- *plumbing*
- *dishwashers and dishwasher boosters*
- *coolers and freezers*
- *suction machines*
- *small appliances*

STANDARDS: PROGRAMS AND SERVICES

O. ENVIRONMENTAL SERVICES

GUIDELINES

***PREVENTIVE
MAINTENANCE PROGRAM
(cont.)***

- *hot water radiators*
- *electric baseboard heaters*
- *doors and hardware*
- *portable fans*
- *carts - nursing, housekeeping*
- *beds, overbed tables*
- *privacy curtains, screens*
- *residents' equipment*
- *approval of small appliances*
- *wheelchairs*

Waste receptacles used in the facility should be leakproof, durable, non-absorbent and free from sharp edges.

Where a facility cannot be maintained below a temperature of 27 degrees Celsius, accepted measures under the guidelines for Prevention and Management of Hot Weather-related Illness in Long Term Care Facilities should be implemented.

HOUSEKEEPING

Floors should have a non-glare surface.

Used disposable incontinence products should be discarded immediately and placed in covered waste containers that are located in the soiled utility room and shall be emptied at least twice daily or more often as required.

Cleaning solutions with germicidal properties should be diluted in accordance with manufacturer's specifications and shall be dispensed from an automatically fed, pre-measured dispenser, to ensure proper dilutions and to avoid potentially dangerous mixtures.

Chemical "contact times" indicated by the manufacturer should be implemented.

STANDARDS: PROGRAMS AND SERVICES

O. ENVIRONMENTAL SERVICES

GUIDELINES

HOUSEKEEPING (cont.)

Floor machines, i.e. floor strippers, polishers, etc., should be operated in accordance with the manufacturer's specification, including chemical dilutions and operating techniques. All floor machines shall be of such a design that the apparatus can be easily cleaned and well maintained.

Food items that are kept in resident care and staff areas should be stored in containers which have tight fitting lids and which are leakproof and readily cleanable.

STANDARDS: PROGRAMS AND SERVICES

P. DIETARY SERVICES

STANDARDS AND CRITERIA

Criteria

**STANDARD 1:
SERVICE PROVISION**

P1. THERE SHALL BE AN ORGANIZED PROGRAM OF DIETARY SERVICES TO RESPOND TO RESIDENTS' NUTRITIONAL CARE NEEDS AND TO PROVIDE SAFE, PERSONALLY ACCEPTABLE, NUTRITIOUS FOOD TO RESIDENTS.

MENU PLANNING

P1.1 Menus shall be developed in consultation with residents.

P1.2 Menus shall be planned to meet dietetic practice guidelines and shall be reviewed by the dietitian.

P1.3 There shall be an established menu cycle for both regular and therapeutic diets, including texture modifications and snacks.

P1.4 Each day each resident shall be provided with a variety of foods, including at least the following:

Grain Products: five servings of whole grain or enriched bread and cereals

Vegetables and Fruits: five 125 ml servings of vegetables, fruits and/or fruit juices

Milk products: adults - 500 ml

Meat and Alternatives: Two servings weighing 50 to 100 grams cooked weight of meat containing 7 grams of protein for each 30 gram serving, or the equivalent grams of protein in alternatives.

STANDARDS: PROGRAMS AND SERVICES**P. DIETARY SERVICES****STANDARDS AND CRITERIA****Criteria****MENU PLANNING
(CONT'D)**

- P1.5 The menu plan shall provide nutrients, calories and fluids based on recommended dietary allowances that provide for daily amounts to meet current Recommended Nutrient Intake (RNI) as determined by Health and Welfare Canada and adjusted for the facility residents' age, sex, weight, physical activity, physiological function and therapeutic needs.
- P1.6 All menus, including alternative choices, for the whole of the current week shall be dated and posted in advance of the current week for reference by persons serving food.
- P1.7 Menus shall be communicated to the residents.
- P1.8 The planned alternative menu choices for entrées, vegetables, and desserts shall be provided, prepared and served at the same time as the first choice.
- P1.9 Menu substitutions shall be of comparable nutritional value.
- P1.10 Any change to a meal shall be marked on the production menu before the preparation of the meal is commenced.

FOOD PRODUCTION

- P1.11 Facility staff involved in food preparation or service shall participate in a food safety awareness program, offered by the board of health.
- P1.12 Food shall be obtained from regulated and approved sources, with any exceptions approved by the registered dietitian.

STANDARDS: PROGRAMS AND SERVICES

P. DIETARY SERVICES

STANDARDS AND CRITERIA

Criteria

**FOOD PRODUCTION
(CONT'D)**

- P1.13 All food shall be stored and maintained in a manner that:
- prevents contamination or spoilage,
 - prevents food-borne illness,
 - retains maximum nutritive value and food quality, and
 - enhances effective food production.
- P1.14 Food shall be prepared and served following standardized food service practices in a manner that:
- preserves nutritive value, flavour, colour, texture, appearance and palatability,
 - prevents contamination or spoilage,
 - prevents food-borne illness,
 - retains maximum nutritive value, and
 - enhances effective food production.

MEAL SERVICE

- P1.15 Residents shall be involved in planning times of meal service, in keeping with the following requirements (unless a survey of all residents demonstrates the majority currently seek alternative meal times):
- A full breakfast shall be available to residents up to at least 0830 hours.
 - The evening meal shall not be served before 1700 hours.
- P1.16 A minimum of three meals shall be offered to each resident daily.

STANDARDS: PROGRAMS AND SERVICES**P. DIETARY SERVICES****STANDARDS AND CRITERIA****Criteria****MEAL SERVICE (CONT'D)**

- P1.17 Beverages shall be offered to all residents at meals, between meals and at bedtime, unless contraindicated in individual residents' plans of care.
- P1.18 Snacks shall be offered to all residents at mid-afternoon and at bedtime, unless contraindicated in individual residents' plans of care.
- P1.19 All residents shall be provided supervision during meals.
- P1.20 Residents shall be served meals in the dining room unless their needs are better met in another location, according to the residents' plans of care.
- P1.21 Meals shall be served one course at a time, unless individual residents request otherwise.
- P1.22 The portion size for menu items shall be posted for serving staff and followed unless otherwise specified by the residents' requirements.
- P1.23 Hot foods shall be served to residents at a minimum of 60°C and cold foods shall be served at a maximum of 5°C, excluding tube feedings.
- P1.24 To provide a pleasurable dining experience, meals shall be served in an unhurried manner, in comfortable dining areas equipped to meet the meal service requirements of residents.
- P1.25 Delivery of a meal to residents requiring assistance in eating shall occur no more than five minutes in advance of assistance being provided.
- P1.26 Minced and puréed items shall be provided after there has been a nutritional assessment.

STANDARDS: PROGRAMS AND SERVICES

P. DIETARY SERVICES

STANDARDS AND CRITERIA

Criteria

NUTRITIONAL CARE

- P1.27 Dietary services shall be organized to provide nutritional care according to residents' needs, consistent with their plans of care.
- P1.28 Nutritional care shall be provided consistent with the current Dietitians of Canada (formerly Ontario Dietetic Association)/Ontario Hospital Association Nutritional Care Manual and dietetic professional standards.
- P1.29 The nutritional care program shall include:
- Screening to identify nutritional risk;
 - Nutritional assessments and identification of interventions on residents' plans of care;
 - Reassessment of care plans based on residents' changing needs; and
 - Interpreting and individualizing of residents' regular, modified and therapeutic diets and supplemental feedings, as well as other aspects of the care plan that impact dietary services.
- P1.30 The current manual approved by the Dietitians of Canada (formerly Ontario Dietetic Association) shall be readily available in the facility.

STANDARDS: PROGRAMS AND SERVICES

P. DIETARY SERVICES

STANDARDS AND CRITERIA

Criteria

NUTRITIONAL CARE (CONT'D)

- P1.31 When enteral feedings are provided, a comprehensive program shall be in place which includes but is not limited to:
- Assessment and interdisciplinary care team review to determine the resident's clinical condition and expressed wishes demonstrate the use of enteral feedings is reasonable,
 - Provision of care in a manner that minimizes risk,
 - Efforts to restore normal feeding function if possible, and
 - Training of staff in enteral feeding.

REGISTERED DIETITIAN

- P1.32 There shall be a registered dietitian employed to be on duty in the facility on a regularly scheduled basis.
- P1.33 Staffing requirements for the registered dietitian shall be: a minimum of 15 minutes per resident per month.
- P1.34 The dietitian shall be registered with the College of Dietitians of Ontario.

NUTRITION MANAGER (FOOD SERVICE SUPERVISOR)

- P1.35 There shall be a food service supervisor on staff, employed to be on duty in the facility on a regularly scheduled basis.

AMENDED ➤

- P1.36 Staffing requirements for qualified food service supervisors shall be a minimum of 8 hours per week per 30 meal days.

Note: If a registered dietitian is employed as the food service supervisor, the requirement for hours for the food service supervisor shall be provided in addition to the required dietitian hours.

STANDARDS: PROGRAMS AND SERVICES

P. DIETARY SERVICES

STANDARDS AND CRITERIA

Criteria

- | | |
|--|--|
| <p>FOOD HANDLERS HOURS</p> <p style="text-align: center;">AMENDED ➤</p> | <p>P1.37 The food service supervisor shall be eligible for membership in the Ontario Society of Nutrition Management (formally known as the Ontario Food Service Supervisors Association) (OFSSA).</p> <p>P1.38 Staffing requirements for food handlers shall be: a minimum of 0.42 hours per day per meal day.</p> |
| <p>FOOD SERVICE WORKER TRAINING</p> <p style="text-align: center;">NEW ➤</p> | <p>P1.39 100% of new hires for the position of Food Service Worker to be employed by the Nutrition and Food Services/Dietary Department will be required to have completed the Food Service Worker training program, or be enrolled in a Food Service Worker training program offered by an established college as listed in the <i>Ontario Colleges of Applied Arts and Technology Act, 2002</i> or a registered private career college in Ontario. If this is not possible, then a written alternative plan must be developed and in place with evidence of ongoing recruitment.</p> <p><i>Note: This requirement does not include students or seasonal workers hired on a part time/casual basis, or cooks/chefs who have a diploma from an established college as listed in the Ontario Colleges of Applied Arts and Technology Act, 2002 or a registered private career college in Ontario or cooks that have attained Interprovincial Standards Red Seal Program status.</i></p> |

Memorandum To: Administrators of Long-Term Care Facilities

From: <name of regional director>
Regional Director
<name of region>

Date: June 26, 2003

RE: July 1, 2003 Increase in the Per Diem Rates for Nursing and
Personal Care, Program and Support Services, Raw Food, and
Other Accommodation

This is to advise you of per diem funding increases to the Nursing and Personal Care, Program and Support Services, Raw Food and Other Accommodation funding envelopes effective July 1, 2003:

- The per diem rate for the Nursing and Personal Care funding envelope will be increased by \$1.75 for a facility with a Case Mix Index (CMI) of 100;
- The per diem rate for the Program and Support Services funding envelope will be increased by \$0.45;
- The per diem rate for the Raw Food funding envelope will be increased by \$0.75; and
- The per diem rate for the Other Accommodation funding envelope will be increased by \$0.92. \$0.47 of this \$0.92 increase is allocated for an increase in the staffing requirements for food handlers.

Please note that the Ministry is increasing the minimum requirement for food handlers from 0.4 hours per meal day to 0.42 hours. This new minimum requirement replaces the current standard in both the Long-Term Care Facility Program Manual and the long-term care facility regulations.

The new funding per diem rates for long-term care facilities are:

Funding Envelope	Current Per Diem	Increase in Per Diem Effective July 1, 2003	New Per Diem Effective July 1, 2003
Nursing and personal care (based on CMI 100)	\$61.20*	\$1.75	\$62.95*
Program and support services	\$5.47	\$0.45	\$5.92
Raw food	\$4.49	\$0.75	\$5.24
Other accommodation:			
Additional increase - \$0.45 Dietary staffing - \$0.47	\$41.08	\$0.92	\$42.00
2003/04 previously announced increase		\$0.93**	\$0.93**
Total other accommodation	\$41.08	\$1.85	\$42.93
Total	\$112.24	\$4.80	\$117.04

*The current base nursing and personal care per diem includes a per diem of \$1.01 for the Nursing Enhancement Fund.

**Administrators have already received a memorandum regarding the per diem rate increase of \$0.93 for the Other Accommodation funding envelope.

Funding for your facility will be adjusted in your July 2003 provincial monthly payment notice to reflect the per diem increases to the funding envelopes.

Should you require any further information or clarification, our Regional Finance Manager <name of regional finance manager>, would be pleased to assist you.

The Ministry of Health and Long-Term Care recognizes the importance of funding equalization for the long-term care facility sector. As you may know, the Ministry continues to work with sector representatives to achieve resolution on outstanding equalization issues.

<name of regional director>
<title>

c: <name of regional finance manager>

Ministry Ministère
of de
Health la Santé

Long-Term Care Division
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Division des soins de longue durée
Édifice Hepburn, 5^e étage
Queen's Park
Toronto, ON M7A 1R3
Fax: (416) 327-8375

February 26, 1998

MEMORANDUM TO: Long-Term Care Facility Administrators

RE: Provision of Registered Dietitian Hours in Long Term Care Facilities

As you are aware, a third and final base rate adjustment for Long-Term Care facilities took effect on January 1, 1998 under the plan for redistribution of \$144.6 million in existing funding. This redistribution is the result of the full implementation of the resident needs based funding system. The January 1, 1998 adjustment increased the Nursing and Personal Care Envelope by 31 cents and the Program Envelope by 56 cents.

The Long-Term Care Division has implemented a review of the standards for facilities in an effort to introduce a more outcome-focused approach in setting expectations and monitoring achievement. To support this process, a pilot on the use of outcome-focused standards for dietary care and services was conducted last year in a small number of facilities. The intent is to review and revise the current standards in the Long-Term Care Facility Program Manual, in order to focus on the outcomes that should be achieved in the provision of care, programs, and services to residents.

It is expected that the review will be conducted in consultation with the Ontario Nursing Home Association and the Ontario Association of Non-Profit Homes and Services for Seniors and will occur over the next months. However, in the interim, in order to provide residents in each Long Term Care Facility with access to the services of a registered dietitian, the Long-Term Care Division is requiring specified Dietitian time for all long-term care facilities.

The following conditions will apply to the requirement for dietitian time:

1. As of June 1, 1998, all homes will be required to provide 15 minutes/resident/month of dietitian time (as currently set out in the LTC Facility Program Manual).
2. The time spent by the dietitian shall be dedicated to the provision of clinical and therapeutic nutritional care of residents of LTC facilities, including but not limited to;
 - assessment of the nutritional needs of all residents on admission (eg. special diets, swallowing disorders and tube feeds);

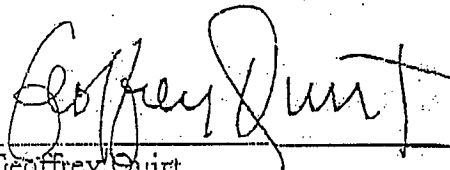
addressing the nutritional needs of residents identified at risk of malnutrition/poor nutrition on admission and during reassessment; and

on-going assessment and intervention (participation in care-planning and menu development) for the nutritional needs of this frail population; and

3. Funds from either the Program and Support Services Envelope or the Accommodation envelope may be used for payment for the 15 minutes of required clinical and therapeutic time. This time may not be used for the management of the dietary department. For example, if the food services supervisor is a dietitian, funding for the time spent managing the dietary staff (8 hours per week, per 30 meal days) shall remain in the Accommodation Envelope.

Transfer of the costs of dietitian services to the Program Envelope may be done retroactive to January 1, 1998, providing the criteria for payment out of that envelope have been met. The timing of this change, is tied to the January 1, 1998 increase in the Program and Support Services Envelope in order to maintain continuity in existing programs, i.e., there would be no reduction in current service levels.

If there are any questions in relation to this requirement, please contact your Long-Term Care Regional Office.



Geoffrey Quirt
Executive Director

cc: Astrida Florins
Long-Term Care Regional Directors
Kathy O'Reilly
Patrick Laverty

LTCH Program Reform

Standards Renewal

Two new standards will be effective January 1, 2006:

- Skin Care and Wound Management standards
- Contenance Care standards

This past summer a Joint Implementation Team was formed with representation from the long-term care (LTC) home sector and other key stakeholders to complete work on the six draft standards and policies that were introduced to LTC homes in the summer and fall of 2004 through province-wide training sessions.

Important progress has been made. In consultation with the Joint Implementation Team, the first two standards - Skin Care and Wound Management and Contenance Care will be incorporated into the LTC Homes Program Manual effective January 1, 2006. As a result, ministry compliance advisors will inspect for these two standards as of January 1, 2006.

The two standards will be substantially the same as the draft versions introduced to LTC homes last year.

In the work completed for these standards, the Implementation Team considered “Lessons Learned” from LTC homes that have already implemented the new standards as part of their best practices and feedback from last year’s province-wide training sessions.

These lessons will improve standards development and implementation processes in the

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future and will promote consistent application and inspection.

Look for additional updates prior to the January 1, 2006 effective date.

“Lessons Learned” will be available shortly on our website at <https://www.ltchomes.net> under “News and Information.”

Bathing Regulation-- Interpretation

The ministry has received a number of queries regarding the bathing regulation introduced early in 2005.

- ✓ **What the regulation requires:** The ministry requires that every LTC home resident receive at least two baths or showers per week, unless medically contraindicated. The regulation setting this as the minimum standard took effect January 1, 2005. The regulation also requires nursing staff to ensure that proper and sufficient care of each resident's body be provided daily to safeguard the resident's health and to maintain personal hygiene.
- ✓ **"Bath"** in the regulation means a tub bath or sponge bath.
- ✓ **Consent required:** Informed consent to the provision of care is required. Where a resident has been determined to be incapable of making the decision, the *Health Care Consent Act, 1996* provides that the resident's authorized substitute decision-maker may consent to a personal assistance service (or other treatment) on behalf of the resident. (Personal assistance services include assistance with or supervision of hygiene and washing).

The new skin care and wound management standards to become effective January 1, 2006 support implementation of the bathing and other related regulations.

A more detailed interpretation will soon be available at <https://www.ltchomes.net> - under the "News and Information" section of the website.

Public Reporting

More enhancements to the ministry's public reporting website were implemented. Here is how the website has changed:

1. **Improved Search Function:** End-users can enter any postal code in Ontario and find homes located within close proximity of the postal code selected.

2. Modification to Complaints information:

For all homes, only verified concerns resulting from a complaint investigation where an "unmet" was issued are identified on the public reporting website. Originating complaints are listed under "verified concerns" and, the resulting unmet are found under "Inspection Findings."

3. **Improved Refresh Process:** The ministry is moving toward a quarterly refresh cycle to ensure that data reported on the site is as current as possible. Stay tuned for the next refresh scheduled for early 2006.

Long-Term Care Common Assessment Project

This project supports the introduction of the Resident Assessment Instrument Minimum Data Set (RAI MDS 2.0). In June 2005, the ministry launched an early adoption phase lead by 20 homes. The early adoption phase includes:

- ✓ A broad and representative group of homes from the sector
- ✓ Project educators providing training on six RAI MDS 2.0 modules
- ✓ Project evaluation of education, support and training models

The lessons learned from these 20 early-adopter homes will be used to develop a detailed province-wide implementation plan.

New Program Developments

High Intensity Needs Fund

Program changes to the High Intensity Needs Fund (HINF) are being made to better support harder to serve residents - particularly those residents presenting behavioral challenges.

Effective October 1, 2005, use of the fund will be extended to provide coverage for preferred accommodation charges as well as supplemental staffing for residents with significant behavioural

problems. Under certain conditions, support may now be available for up to 72 hours or longer for *each episode* of severe mental health and/or behavioral problems.

As they do currently, homes will need to receive approval in advance from their Regional Office. Look for a detailed program update on the HINF in October.

Dietitian Time

Since October 1, 2004 the amount provided for programming and support services (PSS) was increased by \$0.60 per resident day. This increase was intended to support, among other goals, improved nutritional outcomes for residents. Since 1998, homes have been required to provide a minimum of 15 minutes per resident per month of therapeutic Dietitian time and have been allowed to charge these costs to the PSS envelope.

Retroactive to January 1, 2005, homes will now be permitted to claim up to a *maximum* of 30 minutes per resident per month of Dietitian time in the PSS envelope, provided the time spent is dedicated to the provision of clinical and therapeutic nutritional care. This excludes time spent by Registered Dietitians performing administrative duties. The 15-minute *minimum* remains in effect.

Look for a program update in October containing administrative details.

OMA Agreement – Funding for Physicians On-Call

As of October 1, 2005, LTC homes will be eligible to receive \$100 per bed (with a minimum of \$10,000 per home and a maximum of \$30,000 per home) to support physician on-call coverage.

This funding is dedicated for on-call coverage by a physician claiming the service between 17:00 hours and 07:00 hours Monday to Friday and 24-hour coverage on weekends and holidays, including:

- ✓ Responding to all telephone calls from the LTC home in respect of the medical care of the resident; and
- ✓ Making telephone calls to the family, power of attorney or substitute decision-maker in respect of the medical care of the resident.

The ministry is working with the OMA and sector representatives to finalize implementation details.

Also, a monthly management fee for physicians, an all-inclusive fee for providing services to residents in LTC homes, has been introduced. The W-Fee Code Monthly Management Fee of \$85.70 will be effective April 1, 2006.

More details will be provided to homes this fall.

Expansion of OHIP-Funded Physiotherapy Services

Activities to improve access to OHIP funded physiotherapy services for LTC home residents continue. To date, funding arrangements have been made for homes with no previous access to external physiotherapy services. These homes are now introducing on-site physiotherapy services for their residents.

The current focus is to expand OHIP-funded physiotherapy services where limited access now exists. These homes will be notified within the next few days and requested to submit information for the application and funding process.

More information on physiotherapy services for LTC homes residents can be obtained by contacting the Provider Services Branch in the Ministry of Health and Long-Term Care by Telephone: 613-536-3067 or by e-mail at ooandproviderprograms@moh.gov.on.ca

Lifts

The lift equipment strategy is an integral component of the government's broader Nursing Strategy. To date, the LTC home sector has been the largest single recipient of this funding.

Last month, the ministry completed the 2005 application process for homes.

The ministry is now streamlining the purchasing process. A Request for Proposals will be issued shortly to establish a centralized process for the purchasing of lift equipment. More information about this initiative will be shared as soon as possible.

Operations: New and Topical

In-Year Recovery / Revenue Occupancy Report

Starting this year, information reported in the Revenue/Occupancy Report will be used to determine recoveries based on occupancy rates, where applicable.

The objective of this new process is to improve the use of program funds by recovering surplus funding over the course of the year rather than upon the completion of the annual reconciliation report. The Revenue Occupancy Report is due from all home operators by October 14, 2005 and will cover the period of January 1- September 30, 2005. In-year recoveries will start in November 2005.

Outbreak Funding Policy

The LTC Homes Program contains a funding adjustment to support continuity of operations throughout an outbreak period.

The ministry provides two types of resident day credits in the calculation of a home's subsidy:

- A) Credits for vacancies that occur within the period of closure, from the date of each vacancy to the end of the closure period. Credit is not given for vacancies in homes at the start of the outbreak period.
- B) Homes may also receive additional credit for potential new residents who could have been placed (based on the applicant's first choice of placement) but who had to be placed

elsewhere or whose placement needed to be deferred.

The ministry is guided by public health units in determining whether the outbreak affects part or all of the home. Outbreak funding support is provided accordingly. In the event that a partial closure has a broader impact on a home's admission processes, homes should contact their Regional Office regarding applicable resident day credits.

To be eligible for any of these credits, homes must report the outbreak using the Schedule of Vacancies (available online at <https://www.ltchomes.net> or from your Regional Office) along with the required documentation from the local public health unit and CCAC.

Look for a program update providing further clarification of this policy in the near future.

Staffing Report

Phase 3 of the Staffing Report was launched September 23, 2005. Staffing information collected during this phase is for the period January 1, 2005 to June 30, 2005. This version of the report has been streamlined and features a number of technical improvements. Homes have until October 14th to submit their information.

Homes are strongly encouraged to meet this deadline as this will enable early and more comprehensive reporting on LTC home workforce changes, a matter of great interest to all of us in the LTC home community. If you have questions or require technical support, call: 416-326-9753 or email at commentsLTCF@moh.gov.on.ca.

Staffing information reported by homes is being reviewed by the ministry and will be released later this fall.

2005 Levels of Care Classification

The annual, province-wide Resident Classification is underway. This year approximately 69,000 residents will have their care needs coded by

classifiers. Results are expected to be available for release in December 2005.

Some Recent Announcements: A Recap

Over recent months, the LTC sector has benefited from a number of key investments. Some of these include:

- ✓ **Residents:** The co-payment freeze has been extended until July 31, 2006. Homes received a \$0.76 per resident day increase to the Other Accommodation/Raw Food envelopes to maintain service levels during the freeze period.
- ✓ **Funding for care, food and accommodation:** Total average per diem increase since September 2004 is \$8.18.

<i>Envelope</i>	<i>Sept/2004</i>	<i>Oct/2005</i>	<i>Increase</i>
NPC	\$63.84	\$68.19	\$4.35
PSS	6.00	6.60	0.60
RF	5.24	5.34	0.10
OA	42.93	44.42	1.49
EQ (average)	-	1.64	1.64
Total*	\$118.01	\$126.19	\$8.18

* Total level of care per diem including average equalization adjustment.

- ✓ **Knowledge Transfer:** The Seniors' Health Research Transfer Network has been granted \$1.9 million to support some very important research initiatives and improve the capacity of the system to translate this research into practice.
- ✓ **Best Practice Guidelines Coordinators:** Eight nursing leaders have been recruited to coordinate the adoption of RNAO nursing best practice guidelines.

Looking forward

ltcfacilities.net is getting a fresh look!

As of October 2005, www.ltcfacilities.net is changing to <https://www.ltchomes.net>. This new URL better reflects the resident-centred focus of program renewal. Go ahead and bookmark the

new URL. The old URL will continue to work during the transition period.

Update of Contact Info for LTC Homes

To support our on-going efforts to improve communications, help us keep your contact information current. In October 2005, the ministry will be asking homes to review and update where necessary all of their contact information, including e-mail and regular mail addresses. Thanks in advance for supporting this important process.

Program Brief

Program Brief is distributed electronically to long-term care homes and is available online at <https://www.ltchomes.net>.

Printed copies are available upon request from the ministry's regional offices.

Your feedback is welcome. If you have a question or a comment, e-mail us at commentsLTCF@moh.gov.on.ca or write to us at our new Corporate Office address:

Ministry of Health and Long-Term Care
Community Health Division
Long-Term Care Homes Branch
56 Wellesley Street West, 9th Floor,
Toronto, ON M7A 2J9

STANDARDS: PROGRAMS AND SERVICES

P. DIETARY SERVICES

GUIDELINES

REGISTERED DIETICIAN RESPONSIBILITIES

Responsibilities of the registered dietician should include but are not limited to:

- *Menu planning, recipe development and food production controls*
- *Developing and monitoring policies and procedures for all aspects of food service and nutritional care*
- *Developing and monitoring standards governing resident nutritional care, food safety, sanitation, cost controls and staff performance*
- *Determining screening/profile requirements to identify residents at nutritional risk*
- *Providing nutritional assessments and nutritional care plans for residents identified at nutritional risk*
- *Interpreting and individualizing residents' regular, modified and therapeutic diets and supplemental feedings*
- *Participating in and making recommendations at interdisciplinary care reviews, by providing verbal or written input or by delegating attendance to the food services supervisor*

COOKS

Suggested preparation for cooks is a minimum certification at the level of Junior Cook (which is considered a Level 1). The requirements for the Certificate of Qualification are contained in the Trades Qualifications Act.

STANDARDS: PROGRAMS AND SERVICES**P. DIETARY SERVICES****GUIDELINES****GOALS OF DIETARY SERVICES**

Goals should include but are not limited to the following areas:

Meal service:

Promoting adequate nutritional intake, improving health and enhancing quality of life by providing meal service as a pleasurable dining experience, including the following:

- *Access to sufficient, nutritious and personally acceptable foods*
- *Focus on eating as a social experience*
- *Special meals to increase pleasure and happy memories*
- *Pleasant meal time ambience*
- *Focus on sound nutrition practices*

Food Production and Service:

Maintaining residents' health and enhancing their quality of life by minimizing the incidence of food-borne illness and increasing the service of nutritious foods and beverages. Measures include the following:

- *Receiving, storing, preparing and serving food in a manner, consistent with public health practices and institutional food production methods.*
- *Service of nutritious, appetizing, palatable food with risk of food-borne illness minimized and nutrient retention maximized.*

STANDARDS: PROGRAMS AND SERVICES

P. DIETARY SERVICES

GUIDELINES

GOALS OF DIETARY SERVICES (cont.)

Menus:

Supporting individuals' right to personally acceptable foods and following dietetic professional practice standards.

Nutritional Care:

Identifying individuals' dietary needs and providing care as indicated in the plans of care, congruent with residents' rights.

MENUS

Regular menus, texture-modified menus and therapeutic menus should be planned to ensure variety.

MEAL SERVICE

Planning of meal seating should consider issues related to residents' compatibility and special needs.

Each resident who cannot be transferred to regular dining chairs should be properly positioned at the table.

Residents should be served by table, with order of table service rotated so that all residents have an opportunity to be served first.

Complete table settings should be used for all residents unless their functional and safety needs indicate otherwise.

Appropriate garnishes and condiments should be readily available.

Second helpings of food and beverages should be offered.

Plate returns should be monitored for unpopular items, and reasons analyzed.

GUEST MEALS

Guest meals may be made available provided space is adequate, sufficient notice is given to the dietary service, and the service to residents is not disrupted.

STANDARDS: PROGRAMS AND SERVICES

Q. DIAGNOSTIC SERVICES

STANDARDS AND CRITERIA

**STANDARD 1:
SERVICE PROVISION**

**Q1. THE FACILITY SHALL MAKE
ARRANGEMENTS FOR DIAGNOSTIC
SERVICES TO MEET RESIDENTS'
NEEDS AS ORDERED BY THE
RESIDENTS' PHYSICIANS.**

Criteria

Q1.1 There shall be a process in place to coordinate diagnostic services provided on-site with resident care activities and routines in order to provide for residents' privacy and convenience.

STANDARDS: PROGRAMS AND SERVICES**Q. DIAGNOSTIC SERVICES****GUIDELINES*****CONTRACTS***

Services may be contracted from a variety of sources, including local hospitals, mobile x-ray services or community laboratories. The contract may include but is not limited to:

- *a list of services to be provided*
- *quality assurance and risk management expectations and corresponding documentation required by the facility*
- *method of communicating results of tests so that appropriate action can be taken.*

REPORTS

Written policies and procedures may include but are not limited to the following areas:

- *Monitoring by facility staff to ensure reports of diagnostic tests are provided promptly, within time periods specified in the agreement.*
- *Clear instructions for nursing staff on the procedure to be followed when test results are received, so that appropriate action is taken for the benefit of the resident.*
- *Documenting of reports telephoned to the physician*
- *Initialling of reports by the nursing staff member receiving the report.*
- *Initialling of reports by the attending physician before they are filed on the residents' records.*
- *Retention of reports on the residents' health records.*

STANDARDS: PROGRAMS AND SERVICES

R. PHARMACY SERVICE

STANDARDS AND CRITERIA

Note: *The Ontario Drug Benefit Program (ODB) covers/funds all drugs listed in the Drug Benefit Formulary/Comparative Drug Index that are prescribed for residents of long-term care facilities, as well as ODB approved non-prescription drugs available through the Ontario Government Pharmaceutical and Medical Supply Service.*

STANDARD 1: ADMINISTRATION

R1. THERE SHALL BE AN ORGANIZED PROGRAM FOR THE PROVISION OF PHARMACY SERVICE TO MEET THE RESIDENTS' IDENTIFIED NEEDS.

Criteria

R1.1 There shall be a pharmacist registered with the Ontario College of Pharmacists to provide clinical pharmacy services to the facility.

R1.2 A pharmacy accredited by the Ontario College of Pharmacists shall be retained to provide the drugs and drug products to the facility. Drugs may also be provided by a non-accredited pharmacy service owned and operated by a municipality or hospital.

Note: The pharmacist providing the drugs may or may not be the same pharmacist providing clinical pharmacy services.

CONTRACT

R1.3 There shall be a written contract(s) between the facility and those responsible for providing pharmacy service. (Exception: a pharmacy service that is owned and operated by a municipality or hospital having financial and legal responsibility for the facility.)

STANDARDS: PROGRAMS AND SERVICES**R. PHARMACY SERVICE****STANDARDS AND CRITERIA****CONTRACT (CONT'D)**

R1.4 The contract shall specify the pharmaceutical service expectations that may include but not be limited to:

- The administrative and clinical relationships of the pharmacist with the facility and in the case of two separate services, then the relationships between both;
- The method of communication established between the facility and the pharmacist;
- Quality management expectations for pharmaceutical service, including but not limited to drug storage, prescribing and distribution systems, and corresponding documentation required by the facility;
- Participation in the interdisciplinary review process for the direction of the facility's pharmacy program and service;
- Providing accurate and safe acquisition and dispensing of medications for each resident within a mutually agreed upon time, in accordance with resident needs, legislation and Ministry policies and procedures;
- Reviewing the residents' profile prior to dispensing prescriptions, communicating and resolving any concerns with the attending physician, and a process for notifying the facility of any change in physician orders.

STANDARDS: PROGRAMS AND SERVICES**R. PHARMACY SERVICE****STANDARDS AND CRITERIA****CONTRACT (CONTD.)****Criteria**

- Providing clinical consultation within a mutually agreed upon time on residents' pharmacotherapy and other drug-related matters, including participating when requested in the development, implementation, and review of residents' individual care plans (either in person or through a written report to the interdisciplinary care team) and in response to identified resident needs.
- Documenting all clinical consultations concerning a specific resident's therapy on the resident's health record;
- Reporting any irregularities or concerns about drug ordering or administration to the administrator, physician, or the director of nursing;
- Preparing and reviewing a record of the drug regimen for the residents' quarterly review;
- Maintaining a complete medication profile for each resident
- Providing a complete medication administration record (MAR) for each resident

STANDARDS: PROGRAMS AND SERVICES**R. PHARMACY SERVICE****STANDARDS AND CRITERIA****CONTRACT(CONT'D)**

- Implementing programs designed to improve residents' pharmacotherapy, such as a drug utilization review, drug compression;
- Providing educational seminars related to pharmacy and therapeutics for medical and nursing staff;
- Providing necessary information and education about the specific medications that are administered, to the professional staff who administer medications and to residents, as required;
- Drug destruction within the facility according to applicable legislation and facility policy.

Note: The list of pharmacy services for which a LTC facility may contract is not limited to the above criteria.

R1.5 Access to pharmacy service shall be available on a 24 hour basis seven days a week.

R1.6 Drug reference materials, the pharmacy's telephone number, the pharmacy policy and procedure manual, antidote information, and the telephone number of the regional poison control centre shall be available at each nursing unit.

STANDARDS: PROGRAMS AND SERVICES

R. PHARMACY SERVICE

STANDARDS AND CRITERIA

**STANDARD 2:
ORGANIZED REVIEW
PROCESS**

**R2. THERE SHALL BE AN ORGANIZED
INTERDISCIPLINARY REVIEW PROCESS FOR
DIRECTING THE FACILITY'S PHARMACY
PROGRAM AND SERVICE.**

Criteria

- R2.1 The pharmacist shall participate in the interdisciplinary review process for the direction of the facility's pharmacy program and service.
- R2.2 The review process shall include but not be limited to:
- Documenting findings of the review and actions on a quarterly basis;
 - Reviewing the Quality and Risk Management program as it relates to pharmacy services with a focus on improving residents' pharmacotherapy.
- R2.3 Current written policies and procedures shall be in place for all aspects of pharmacy service.

**STANDARD 3:
PRESCRIPTION
ORDERING,
TRANSMISSION**

**R3. THE PRESCRIPTION ORDERING AND
TRANSMISSION OF ORDERS SHALL SUPPORT
THE SAFE PROVISION OF DRUGS TO
RESIDENTS.**

Criteria

- R3.1 All prescriptions shall be written and shall be signed by the physician.
- R3.2 Prescriptions shall specify at least the resident's name, date, medication name, strength, form, quantity, frequency and route of administration (application area if topical), and be signed by the physician.

STANDARDS: PROGRAMS AND SERVICES**R. PHARMACY SERVICE****STANDARDS AND CRITERIA****STANDARD 3:
PRESCRIPTION
ORDERING,
TRANSMISSION
(CONT'D)**

- R3.3 There shall be a system in place for safe, accurate and timely transmission of all prescription orders.
- R3.4 All telephone prescription orders shall be given by the prescriber and shall be received and documented in the facility by registered nursing staff or the pharmacist.
- R3.5 The prescriber or the attending physician shall sign the documented telephone order in accordance with established facility policy.
- R3.6 A written copy of all prescriptions or duplicate prescription order sheets signed by the prescriber shall be sent to the pharmacist.
- R3.7 All medication orders telephoned to the pharmacy shall be given only to the pharmacist.
- R3.8 There shall be a quarterly, or more frequent as needed, documented review of each resident's medications, signed by the physician.
- R3.9 Following the quarterly medication review, the quarterly medication review record shall be included in the resident's health record and a copy shall be returned to the pharmacy.

STANDARDS: PROGRAMS AND SERVICES

R. PHARMACY SERVICE

STANDARDS AND CRITERIA

**STANDARD 4:
DRUG DISPENSING**

R4. THE PHARMACY SERVICE SHALL PROVIDE FOR THE ACCURATE, SAFE DISPENSING OF PRESCRIPTION DRUGS AND BIOLOGICALS TO MEET RESIDENTS' IDENTIFIED MEDICATION REQUIREMENTS.

Criteria

R4.1 Dispensing shall be carried out by a pharmacist, physician or dentist in all but exceptional circumstances, where the registered nurse may dispense, according to established policies and procedures. (Refer to Resident Leaves of Absence policy)

R4.2 All drugs and biologicals for individual residents shall be labelled with a prescription number, the resident's name, date, medication's name, strength, form, manufacturer, quantity, directions for use, a valid expiration date (if for PRN use), the prescriber's name, the name, owner, address, and telephone number of the dispensing pharmacy and with appropriate accessory and cautionary instructions.

**STANDARD 5:
RECORDING RECEIPT
AND DISPOSITION OF
DRUGS**

R5. A SYSTEM OF RECORDS FOR RECEIPT AND DISPOSITION OF ALL DRUGS RECEIVED BY THE FACILITY SHALL BE MAINTAINED IN SUFFICIENT DETAIL TO ENABLE ACCURATE TRACKING, RECONCILIATION, AND AUDITING, IN ACCORDANCE WITH APPLICABLE LEGISLATION.

STANDARDS: PROGRAMS AND SERVICES**R. PHARMACY SERVICE****STANDARDS AND CRITERIA****STANDARD 6:
DRUG STORAGE****R6. ALL DRUGS AND BIOLOGICALS SHALL BE STORED UNDER PROPER CONDITIONS OF SANITATION, TEMPERATURE, LIGHT, HUMIDITY AND SECURITY.****Criteria**

- R6.1 All drugs and biologicals shall be stored in conveniently located, locked drug cabinets or storerooms.
- R6.2 Narcotic and controlled drugs shall be stored in a separately locked, permanently affixed compartment within the general drug cabinet or storeroom.
- R6.3 Every drug cabinet or storeroom shall be kept locked at all times and only the registered nursing staff and the pharmacist may have access to the keys.
- R6.4 A medication administration system facilitating monitoring (Monitored Dosage System), such as unit dose/blister pack shall be in use for all medications except liquids or other forms of medication which require dispensing in an alternative suitable system.

**STANDARD 7:
DRUG DISPOSAL,
DESTRUCTION****R7. DISPOSAL OF DRUGS SHALL BE IN ACCORDANCE WITH ESTABLISHED MINISTRY POLICY.****Criteria**

- R7.1 Discontinued, unused, expired, recalled, deteriorated, unlabelled drugs and containers with worn, illegible, damaged, incomplete or missing labels shall be removed from current medication supplies.

STANDARDS: PROGRAMS AND SERVICES

R. PHARMACY SERVICE

STANDARDS AND CRITERIA

STANDARD 7: DRUG DISPOSAL, DESTRUCTION (CONT'D)

R7.2 Drugs shall be destroyed and removed from the facility according to applicable legislation and established Ministry policies and guidelines.

Note: Residents (including short-stay residents) may take with them, on discharge, unused medications which they have paid for.

MEDICATION ADMINISTRATION

Note: For standards and criteria addressing administration of medications, refer to the Nursing Services section.

STANDARD 8: MEDICATION ERRORS/ADVERSE REACTIONS

R8. THERE SHALL BE A SYSTEM FOR IMMEDIATE REPORTING OF EACH MEDICATION ERROR AND ADVERSE DRUG REACTION, WITH SPECIFIC FOLLOW-UP ACTION TO BE TAKEN.

Criteria

R8.1 All medication errors and adverse drug reactions shall be reported promptly to the director of nursing, prescriber, and pharmacist according to established policy and procedure and specific follow-up action shall be taken.

R8.2 The description of a medication error or adverse drug reaction shall be recorded in the resident's clinical record immediately after the report is made.

R8.3 Any adverse drug reaction shall be recorded in the resident's medication profile and reported to the pharmacist who will report to the Canadian Adverse Drug Reaction Monitoring Program.

STANDARDS: PROGRAMS AND SERVICES**R. PHARMACY SERVICES****GUIDELINES*****ADDITIONAL
RESPONSIBILITIES OF
THE PHARMACY AND
THERAPEUTICS
COMMITTEE***

Additional responsibilities of the Pharmacy and Therapeutics Committee should include but are not limited to:

- *Establishing, reviewing, revising, and communicating the goals and objectives of the facility's pharmacy program and evaluating achievement;*
- *Developing, promoting and reviewing the facility's written policies and procedures to address all aspects of pharmacy services, in order to provide consistent direction for staff;*
- *Making recommendations for improvement of pharmacy programs and monitoring their adequacy in achieving safe and effective and cost-effective pharmacotherapy, drug distribution, control and use;*
- *Reviewing all medication error reports and error rates for purposes of identifying causes and developing policies or procedures to prevent similar occurrences in the future;*
- *Reviewing the audit records of the drug storage and distribution system, copies of which are retained by the pharmacist;*
- *Reviewing the drug destruction records to identify and make recommendations about any unnecessary waste;*
- *Approving/recommending reference materials and other information sources about drugs.*

STANDARDS: PROGRAMS AND SERVICES

R. PHARMACY SERVICES

GUIDELINES

REGULAR, EMERGENCY AND AFTER-HOUR PHARMACY SERVICE

The pharmacy service should be provided 24 hours a day, 7 days a week for the following:

- *Pharmacy service (which may include provision for contingency drugs kept in the facility)*
- *Clinical consultation on residents' pharmacotherapy and other drug-related matters*

POLICIES AND PROCEDURES

Written policies and procedures for the pharmacy service and program should include but are not limited to:

- *purpose*
- *policy and procedure authorization*
- *pharmacy/pharmacist service agreement*
- *problem-solving mechanisms re resident pharmacotherapy*
- *formulary, drug substitution and special drug authorization*
- *drug ordering, delivery schedule, and receipt of drugs*
- *emergency medication service and contingency drugs*
- *procedure for drug inventory control which must include narcotic and controlled drugs*
- *procedures for drug utilization review (DUR) or evaluation (DUE)*
- *automatic stop orders*
- *standard times for medication administration and duration of therapy*
- *standard quantities for dispensing (routine, large quantities & trial)*
- *medication labelling/re-labelling*
- *discontinuation/change/modification of medication*
- *system to alert staff when a drug order is modified*
- *disposal, reallocation and recycling of drugs and supplies*
- *leave of absence medication*

STANDARDS: PROGRAMS AND SERVICES

R. PHARMACY SERVICES

GUIDELINES

POLICIES AND PROCEDURES (cont.)

- *categories of personnel authorized to prescribe, administer and dispense medications*
- *resident self-administration of medication*
- *assessment of drug treatment*
- *assessment of drugs brought to the facility on admission*
- *medication errors*
- *resident medication profile record, and medication administration record (MAR)*
- *adverse drug reactions and allergies*
- *reference sources and texts*
- *medication counselling*
- *issues such as anticoagulant therapy, use of medication for behavioral control (chemical restraint), investigational, anticarcinogenic drugs, standing orders*
- *economic accountability, e.g. reallocation, development of an adapted Ontario Drug Benefit Formulary specific to facility needs*

MEDICATION PROFILE

The complete medication profile should include but are not limited to:

- *the current medication regimen, including those drugs and approved non-prescription medications obtained from Ontario Government Pharmacy and Medical Supply Services (OGPMSS);*
- *pertinent laboratory and clinical information;*
- *drug and food allergies;*
- *significant medication history;*
- *any additional data deemed relevant to appropriate pharmacotherapy.*

STANDARDS: PROGRAMS AND SERVICES**R. PHARMACY SERVICES****GUIDELINES*****DOCUMENTATION WHEN
PRESCRIPTIONS ARE
WRITTEN***

When prescriptions are written, documentation by the physician should but not be limited to: the need for pharmacotherapy, drug selection, dosage regimen, route and form of administration, duration of therapy, potential unwanted interactions between drugs, food, or laboratory tests, possible adverse effects.

***SPACE, EQUIPMENT,
SUPPLIES***

Adequate space should be provided on each resident care unit to meet the needs of professional functions of the pharmacy service.

The space, equipment and supplies available to store and administer medications should support safe nursing practice.

STAFF EDUCATION

The pharmacist should provide educational seminars related to pharmacy and therapeutics for medical and nursing staff at least 3 times a year.

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MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES FACILITY REVIEW PROCESS

INTRODUCTION

Monitoring and evaluation involves the comparison of the actual care, programs, and services provided to residents in the facility with established expectations. These expectations are defined by:

- applicable Acts and regulations;
- the terms and conditions of the service agreement between the facility and the Province;
- the standards and criteria contained in the LTC Facility Program Manual; and
- Ministry policies and directives;

MONITORING AND EVALUATION ACTIVITIES

Monitoring and evaluation activities by LTC Division staff include:

- reviewing the facility profile to become familiar with the facility's structure, programming, resident population, issues, developments, and terms and conditions of the service agreement;
- scheduling a visit to the facility and setting specific objectives for the review in consultation with the facility management staff;
- observations of facility operations to determine strengths and positive outcomes as well as the presence of indicators of risk or negative outcomes;
- conducting a resident-focused, outcome-oriented review of resident care, programs and services;

MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES FACILITY REVIEW PROCESS

- interviewing residents, families and staff where possible;
- auditing resident and other facility records;
- providing feedback and addressing concerns and issues using a collaborative approach
- offering interpretation and consultation to facility staff;
- reporting on the results of the review process, areas reviewed, conclusions and if required, time frames for corrective action; and
- ongoing follow-up to determine effectiveness of corrective action plans developed and implemented by the facility.

FREQUENCY OF REVIEWS

During the implementation phase of the new program, a baseline review of each facility's care, programs and the services negotiated in the current service agreement will be carried out. Thereafter, reviews will be conducted at least once in a calendar year. Further reviews will be conducted as necessary, including follow-up visits, complaint investigations and special visits.

PROCEDURES: PREPARATION FOR A REVIEW VISIT

The following is a description of the monitoring tools and the review process:

1. As a general rule, the reviewer notifies the facility of the planned date of the review.
2. The **Profile Of The Long Term Care Facility** form is completed in advance by facility staff and is available on-site for the reviewer. The form provides the reviewer with background data on the overall operation of the facility.

MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES
FACILITY REVIEW PROCESS

3. The reviewer familiarizes him/herself with information about the facility, including previous reviews and other relevant information.
4. The reviewer plans initial review objectives. These objectives include the follow-up of any issues outstanding from previous reviews. The objectives may be modified in response to issues and concerns identified as priorities by the facility's administrator during the entrance conference.

**PROCEDURES:
ENTRANCE
CONFERENCE**

The reviewer meets with facility management staff at an entrance conference in order to:

- provide facility staff with an opportunity to report on or raise any issues, developments and planning since the last review visit;
- receive a copy of the **Profile of the Long Term Care Facility** form and clarify information as needed;
- discuss the objectives of the visit;
- request any necessary information and respond to questions;
- plan jointly with the facility staff the review process that will be followed, including participation of staff;
- explain that residents' privacy will be respected and that every consideration will be given to staff routines and activities;
- explain that open communication and feedback will be provided throughout the review and following completion of the review.

**MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES
FACILITY REVIEW PROCESS**

**PROCEDURES:
INITIAL
WALK-THROUGH**

It may be desirable to have a senior staff member of the facility accompany the reviewer on the initial walk-through to answer questions and to introduce the reviewer to staff, residents and any family members present.

The reviewer carries out an initial walk-through in order to:

- observe resident care;
- speak with residents, family, visitors and volunteers;
- observe interactions between staff and residents, as well as between staff members;
- observe strengths and positive indicators;
- observe the physical environment, including residents' rooms, common areas, kitchen, and laundry facilities; and
- determine the presence of indicators of risk or negative outcomes.

**PROCEDURES:
REVIEW OF RESIDENT
CARE AND SERVICES**

The review of resident care, programs, and services includes the following four activities:

Part A: Programs and Services Review

Part B: Indicator Identification and Analysis, including focused audits

Part C: In-Depth Review of Resident Care

Part D: Review of Staffing

MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES

FACILITY REVIEW PROCESS

During the review process, a number of residents, families and staff members are interviewed. Every effort is made to avoid disruption of resident and staff routines and activities.

The reviewer plans the sequence of the review in consultation with facility management staff. Factors which may influence this decision include:

- issues identified during the initial walk-through;
- reviewer's familiarity with the facility's programs and services;
- availability of staff involved in review of care, programs and services;

PART A: PROGRAMS AND SERVICES REVIEW

A review of the operation of the facility is conducted according to the **Facility Programs and Services Review** form, which reflects established standards and criteria.

PART B: INDICATOR IDENTIFICATION AND ANALYSIS

An indicator identification and analysis process is carried out as part of the monitoring process. This involves the review and evaluation of resident care, programs and services from a risk management perspective, concentrating on significant care concerns. Eighteen specific aspects of care, programs and services have been selected for indicator analysis.

Indicator analysis is a focused approach to monitoring to:

- identify and analyze indicators that are important to residents' quality of life and care
- provide an opportunity to explore outcomes of care and those structures and processes which support positive quality of care and quality of life outcomes; and

MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES

FACILITY REVIEW PROCESS

- allow Ministry and facility staff, through a collaborative approach, to identify key areas which may be problematic and require concentrated attention.

IDENTIFICATION OF INDICATORS

The specific process for reviewing each indicator is set out under the heading "Identify By" on each indicator page.

The reviewer may identify indicators from various sources and at different phases in the review process as follows:

- pre-review planning from available reports in the facility's file;
- information obtained during the entrance conference;
- observations, discussions and interviews during the walk-through phase; and
- completion of focused audits of residents to determine the presence of indicators which are not readily identified by observation.

FOCUSED AUDITS: Focused audits include care reviews of a minimum of **six** residents if applicable, selected from **each** of the following groups:

- those with unplanned weight change
- those with pressure ulcers
- those with pain/discomfort
- those who demonstrate disruptive behaviour
- those who are restrained, or who have an order for a restraint

**MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES
FACILITY REVIEW PROCESS**

**WHEN INDICATORS ARE
NOT IDENTIFIED**

Where possible, residents are sampled from all resident care units. The reviewer may choose to complete more than six resident-focused audits to collect data relevant to the indicator of risk or negative outcome.

If no residents are identified as being at risk for any one of the five specific focused audits, the reviewer makes note of this on the audit form.

If there are no indicators of risk or negative outcome identified during the entrance conference, the walk-through, and the completion of the focused audits, then the indicator analysis process ends.

**ANALYSIS OF
IDENTIFIED INDICATORS**

Where there are indicators of risk or negative outcomes noted, the reviewer then initiates an in-depth analysis of the indicators using the suggested standards associated with each. (These are set out on each indicator page under the heading "Areas to Review").

The reviewer summarizes the reasons for the decision to initiate an in-depth analysis of the indicators in the "Reason for Analysis" space. This could include a summary of the observations, interview results or unmet standards identified through the focused audits, which led to the decision to complete an indicator analysis.

The indicator analysis is completed in collaboration with the facility's management staff, to assist in identifying factors contributing to the presence of the indicator of risk or negative outcome, and to assist in development of a corrective action plan.

MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES

FACILITY REVIEW PROCESS

After the indicator of risk or negative outcome analysis is completed, the reviewer documents in the "Conclusion" space the action taken as a result of the analysis. This may include documentation that immediate correction of an unmet standard was initiated, or that written documentation of an unmet standard or criteria is planned, or that a referral to other resources will be made.

It may not be possible to complete an in-depth analysis of every indicator of risk or negative outcome observed during a review. Follow-up visits can be scheduled to complete the indicator analysis process.

PART C: IN-DEPTH REVIEW OF RESIDENT CARE:

In addition to the residents selected for review for the five focused audits, a minimum of five residents are selected by the reviewer for an in-depth care review.

Where possible, the reviewer selects residents for in-depth review from each unit in the facility. The sample includes residents with a variety of care needs; for example, residents with complex medical/nursing care needs, frequent hospital admissions, new admissions to the facility.

The number of residents selected for an in-depth review will be determined by the reviewer based on:

- the indicators of risk or negative outcomes identified by other parts of the review and
- knowledge of the care, programs and services provided by the facility

The results of the review are documented on the **In-depth Review of Resident Care** form.

MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES FACILITY REVIEW PROCESS

A review of the selected residents' care, outcomes of care and relevant documentation is completed to determine the following:

- the resident's needs/desires have been assessed and identified in the plan of care;
- the resident is receiving care, programs and services consistent with his/her plan of care;
- the extent to which residents have the opportunity to exercise their rights and to have autonomy and choice in their lives.

This component of the monitoring process also provides an opportunity to evaluate the effectiveness of interdisciplinary and interdepartmental communication and coordination in meeting residents' needs.

PART D: REVIEW OF STAFFING

A review of the staffing deployment is completed to assess the allocation of staff in accordance with residents' needs as well as the staffing information submitted with the service agreement.

EVALUATION OF REVIEW RESULTS AND CONCLUSIONS

Throughout the review, the facility's success in providing quality care programs and services is evaluated and decisions are made about the facility's performance.

It may be necessary for the facility staff to address and correct some issues immediately if the situation observed poses an immediate or serious risk to residents' health, safety, welfare or rights. This will be discussed with staff at the time the issue is identified and the reviewer will confirm and document that corrective actions have been taken.

MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES

FACILITY REVIEW PROCESS

Not all care, program and service issues identified during a review are considered examples of unmet standards or criteria. Using a consultative approach, the reviewer discusses with staff any issues that have been identified as well as the possible reasons and contributing factors. Approaches that could be considered to address these issues may be suggested by the reviewer, along with resources that may be helpful.

Some concerns may be identified in writing as "unmet standards or criteria".

Note: A written statement of an unmet standard or criteria is not considered a sanction and should not be confused with a written notice of non-compliance with an Act or regulations. (See Sanctions section)

In concluding that a standard or criteria has not been met, the reviewer considers the following factors:

- conditions have been observed that pose actual or potential risks to a resident's health, safety, welfare or rights (severity); and/or
- conditions have been observed that are not as serious but are prevalent or recurring; and/or
- the facility has not made successful efforts to initiate corrective action; and/or
- conditions have been identified during previous reviews, but have not been corrected within the negotiated time frame for corrective action.

MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES REPORTING

REPORTING: WRITTEN REPORT

At the end of the review, the reviewer prepares a **Statement of Unmet Standards or Criteria** listing the standard or criteria number, content and the specific examples observed which led to the identification of an unmet standard or criteria. (Names of residents are not included but are provided to management staff during the exit interview).

Where there have been no unmet standards or criteria identified, a notation is made on the form indicating this.

The administrator or designate receives a copy of this report during the exit interview. The results of the review and possible corrective actions are discussed. This information is later processed and is attached to the **Interim Summary Report**.

REPORTING: SUBMISSION AND EVALUATION OF FACILITY RESPONSE

The facility is required to prepare a written response outlining the short-term and long-term corrective action plans, where applicable, for any problems resulting from unmet standards or criteria identified during the review. The plan of corrective action is submitted to the reviewer within 14 days of the review.

The reviewer evaluates the submitted plan to determine the effectiveness of the proposed corrective actions in response to the identified problems as well as the proposed time frames.

CORRECTIVE ACTION PLAN

A corrective action plan should include the following:

- immediate action taken during the review to correct identified risks to the residents' health, welfare, safety or rights;
- short-term and long-term corrective action plan, where applicable, for identified problems;

MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES REPORTING

- identification of the title of the person responsible for ensuring the plan is implemented and monitored; and
- the time frames for corrective actions.

Some corrective actions may be instituted over a longer term if the issues identified do not pose risks to residents or affect their quality of life.

If the submitted corrective action plan is not acceptable, the reviewer will ask for the plan to be revised and resubmitted or minor changes may be negotiated with the administrator or designate by telephone.

REPORTING: INTERIM SUMMARY REPORT

On completion of the review, an **Interim Summary Report** is prepared by the reviewer summarizing the review. The report includes but is not limited to:

- the purpose of the review;
- the facility's strengths in relation to delivery of care, programs, and services to residents; organizational structure; facility design and facility operations;
- updates on any new care, programs and services being provided by the facility;
- the status of the current care, programs and services provided by the facility, including reference to any problems or issues identified; and
- The **Report of Unmet Standards or Criteria** is included as an attachment, along with the facility's submitted corrective action.

MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES REPORTING

A letter to the administrator, signed by the Regional Manager, will accompany the **Interim Summary Report** when:

- serious issues posing a risk to the health, safety, welfare or rights of residents have been identified during the review and the corrective action plan is not acceptable, or
- conditions identified during previous reviews had not been corrected within the negotiated time frame and were found to be outstanding at the time of the current review.

***Note:** This letter is not a sanction. It is a warning letter of further steps, which could be taken by the Ministry, including application of sanctions, if corrective action is not undertaken. This letter is attached to the **Interim Summary Report** and is not posted as part of the final public document.*

The **Interim Summary Report** will then be sent to the facility. The administrator may submit, within 14 days, additional comments on any sections of the reviewer's report and/or further corrective action statements to be included in the report.

REPORTING: FINAL SUMMARY REPORT

Upon receipt of any comments from the facility, the **Interim Summary Report** is revised or amended as necessary. Should the facility choose not to respond, the report is processed and the **Final Summary Report** is prepared as originally written.

The **Final Summary Report** is sent to the administrator of the facility.

MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES REPORTING

REPORTING: POSTING OF FINAL SUMMARY REPORT

The final review report is required to be posted or placed in the facility in a location that is easily accessible to residents, staff, families and visitors.

A copy of the Final Summary Report is also placed in the provincial libraries, and is available to the public on request.

FOLLOW-UP: PURPOSE

Follow-up on any care, programs and services review is scheduled according to:

- the strengths of the facility and areas in need of improvement as identified by the reviewer;
- the nature and degree of seriousness of any unmet standards or criteria; and
- the proposed plan of corrective action.

FOLLOW-UP: PROCEDURE

Follow-up may take various approaches, at the reviewer's discretion, including for example,

- another visit to the home, which may include indicator analysis, in-depth resident care reviews, review of staffing; or
- a telephone call or a letter requesting the status of corrective measures.

FOLLOW-UP: PROVIDING FEEDBACK AND CONSULTATION

As during a complete review, feedback and consultation on areas reviewed are provided by the reviewer.

A brief report of any unmet standards or criteria which are outstanding from previous reviews, or are observed during the follow-up visit, will be left with the Administrator or designate.

MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES REPORTING

REPORTING: SUBMISSION AND EVALUATION OF FACILITY RESPONSE

As during a complete review, the facility prepares a corrective action plan for any unmet standards or criteria identified as a result of the follow-up review. The corrective action plan should include the short-term and long-term corrective action plan (where applicable), the identification of the person responsible for ensuring the plan is implemented and monitored, and the time frames for corrective actions.

As during a complete review, the reviewer evaluates the plan to determine the effectiveness of the corrective actions.

If the submitted corrective action plan is not acceptable, the reviewer may ask for the plan to be revised and resubmitted or minor changes may be negotiated with the administrator or designate by telephone.

REPORTING: INTERIM SUMMARY REPORT

As during a complete review, an **Interim Summary Report** is prepared by the reviewer summarizing the review, including but not limited to:

- the purpose of the review;
- the facility's strengths in relation to delivery of care, programs and services to residents, organizational structure, facility design and facility operations;
- updates on any new care, programs and services being provided by the facility;
- the status of the current care, programs and services provided by the facility, including reference to any problems or issues identified; and
- The **Report of Unmet Standards or Criteria** is included as an attachment, along with the facility's submitted corrective action plan.

MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES REPORTING

As during a complete review, a letter signed by the Regional Manager may accompany the final summary report outlining the possible sanctions to be taken if corrective action plans are not successfully implemented. The **Interim Summary Report** is sent to the facility in order to provide an opportunity for the administrator to submit, within 14 days, comments on any sections of the reviewer's report and/or to request inclusion of further comments.

REPORTING: FINAL SUMMARY REPORT

Upon receipt of comments from the facility, the **Interim Summary Report** is revised or amended as necessary. Should the facility choose not to respond, the report is processed and the **Final Summary Report** is prepared as originally written.

The **Final Summary Report** is sent to the administrator of the facility.

POSTING OF FINAL SUMMARY REPORT

The final review report is required to be posted or placed in the facility in a location that is easily accessible to residents, staff, families and visitors.

A copy of the Final Summary Report is also placed in the Ministry libraries, and is available to the public, from the facility, on request.

NOV 16 2004

MEMORANDUM TO: Long-Term Care Home Administrators

FROM: Tim Burns,
Director, Long-Term Care Homes Branch

RE: **Launch of Public Reporting on Long-Term Care
Homes in Ontario**

Today marks the official launch of the web site on Public Reporting on Long-Term Care Homes in Ontario. You can view the public version of the web site at www.health.gov.on.ca.

I want to take this opportunity to thank you for working with the Ministry of Health and Long-Term Care to ensure the smooth launch of this initiative. The verification of the information on your home for this phase, and in the future, is a significant part of this endeavor.

We will continue to work with your provincial associations and consumer groups on ideas that have been identified to improve and enhance both the data management and the public presentation of this information. I look forward to your continued input and support as we move forward.

Public reporting is an important step toward providing consumers with more of the information they need to make informed decisions about long-term care.

If you have any questions, please do not hesitate to contact Janet Robinson of the Long-Term Care Homes Branch at (416) 314-1310.

Sincerely,



Tim Burns
Director, Long-Term Care Homes Branch

COMMITTEES

List Internal Committees:

Committee	Chairperson/Person Accountable	Frequency of Meetings

	Resident Involvement	Family Involvement
Orientation Tours		
Admission		
Interdisciplinary Team Conference		
Residents' Council		
Family Council		
Annual Interdisciplinary Team Conference		
Family Nights		
Annual Contract Renewal		
Other		

**PROFILE OF LTC FACILITY
STRUCTURAL INFORMATION**

1102-01

Separate Infirmary _____ **Room No.** _____

Type of Security System (describe)

Year of Construction _____

Opening date _____

Year(s) of renovation (if applicable) _____

Number of Floors _____

Number of units and beds:

Unit	Number of Beds	Manager

Type of rooms: (this refers to structural layout rather than what is charged as preferred accommodation)

1 bedrooms _____

2 bedrooms _____

3 bedrooms _____

4 bedrooms _____

Other _____

ADDITIONAL SERVICES PROVIDED TO RESIDENTS

	Service provided		Contract for Service		Explanation if Applicable
	Yes	No	Yes	No	
Emergency Medical Coverage					
Pharmacy					
Laboratory					
Radiology					
Physiotherapy					
Occupational Therapy					
Foot Care					
Ophthalmology/Optomety					
Audiology					
Dental					
Denturist					
Respiratory Technology					
Mental Health Services i.e. Psycho-geriatrics					
Transportation					
Other					

**PROFILE OF LTC FACILITY
COMMUNITY LINKAGES**

1102-01

Community Linkages	Service provided		Comments
	Yes	No	
Volunteer Program			
Service Groups			
Language Interpreters			
Cultural Interpreters			
Advisory Council			
Community Board			
Faith Communities			

SERVICES PROVIDED TO THE COMMUNITY
(e.g. Meals on Wheels, Day Care Programs, Short Stay Programs)

SHARED SERVICES (if applicable)

Do staff provide services such as laundry, housekeeping, dietary, maintenance to other than long term care residents? If so, how many?

MONITORING TOOL FOR REVIEW OF RESIDENT CARE AND SERVICES**INDICATOR ANALYSIS (REFERENCE)****CHECK LIST: INDICATORS OF RISK OR NEGATIVE OUTCOME**

Instruction: Indicate any of the following, negative outcomes observed/identified:

1. Inappropriate staff/resident interactions
2. Serious or unexplained injuries
3. Medication errors
4. Infections
5. Resident inactivity
6. Poor positioning
7. Disorganized meal service
8. Food and/or fluids not consumed
9. Odours
10. Unclean and/or inadequate equipment, linen and supplies
11. Poor maintenance and housekeeping
12. Environmental safety hazards
13. Unplanned weight change
14. Pressure ulcers
15. Pain and discomfort
16. Disruptive behaviour
17. Restraint use
18. Poor grooming

Reasons for carrying out analysis:

INAPPROPRIATE STAFF-RESIDENT INTERACTIONS

Definition of risk or negative outcome: Direct observation of care or interaction which indicates residents' rights to dignity, privacy, respect, individuality, and freedom from mental and physical abuse are not met.

Identify by: Interviewing residents, families and visitors

- Residents and/or families report situations where individual rights are not respected

Observation of interactions between staff and residents

- Staff address residents in a condescending manner or in a way which does not demonstrate respect
- Residents' grooming or clothing are not age-appropriate
- Staff handle residents roughly or are verbally abusive
- Residents' preferences or requests are ignored
- Residents' privacy is not respected through use of privacy screening, closed doors; e.g. during personal care such as bathing, toilet aid, continence care, treatments
- Staff interact with each other, ignoring residents who are present

Reasons for carrying out analysis, and observations made:

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
A1.8	The residents' Bill of Rights is posted in both English and French, in locations in the facility easily accessible to residents/representatives.	
A1.9	Residents and their representatives receive a copy of the Bill of Rights on admission.	
A1.17	On admission, residents/representatives are informed in writing of the processes for obtaining information, raising concerns, lodging complaints or recommending changes regarding the facility and its services.	
A1.20	There are written policies and procedures for dealing with resident/representative complaints.	

INAPPROPRIATE STAFF-RESIDENT INTERACTIONS (cont.)

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
A1.10	The facility has policies for the following: <ul style="list-style-type: none">• promotion of residents' rights• what constitutes resident abuse• how to prevent abuse• actions to be taken in all instances of alleged abuse, including notification of the family/representative, police and Ministry staff• resources available to assist the abused resident and the person responsible for the abuse	
M1.18	The facility's policies and procedures, including ways of communicating with residents/representatives and responding to their concerns and complaints, are followed in the provision of care and services. Staff are re-instructed when required.	

Conclusion and action taken:

SERIOUS OR UNEXPLAINED INJURIES

Definition of risk or negative outcome: Injuries related to hazardous situations and requiring nursing/medical intervention.

- Identify by:**
- Reviewing incident reports
 - Reviewing residents' records
 - Interviewing staff and residents
 - Interviewing physicians as required
 - Checking condition and use of equipment
 - Observing for hazardous situations
 - Checking water temperature

Reasons for carrying out analysis, and observations made:

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
M3.	There are coordinated risk management activities designed to reduce and control actual or potential risks to the safety, security, welfare and health of individuals or to the safety and security of the facility.	
M3.3	Safety systems are in place and policies, procedures and practices are implemented to identify and minimize hazards to residents, staff and visitors.	
M1.19	Supplies and equipment are provided and are readily available for use to support safe and effective care and services to residents.	
M1.20	Supplies and equipment are maintained in good condition.	
M1.16	Staff are allocated according to residents' care needs, facility design and resources.	

SERIOUS OR UNEXPLAINED INJURIES (cont.)

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
M3.6	Staff are instructed in the safe use of all equipment used in their job responsibilities.	
M1.18	The facility's policies, procedures and work routines are followed in the provision of care and services. Staff are re-instructed when required.	
B3.14	Each resident's environment is maintained to minimize safety and security risks. Action is taken to protect each resident from identified potentially hazardous substances, conditions and equipment.	
B2.4	Each resident's plan of care reflects his/her current strengths, abilities, preferences, needs, goals and safety/security risks, and gives clear directions to staff providing care.	
B3.15	Risks to each resident's health and safety are identified and addressed in ways that consider his/her choice, freedom of movement, dignity and respect, in keeping with other residents' rights.	

Conclusion and action taken:

MEDICATION ERRORS

Definition of risk or negative outcome: Any errors in administration of medications requiring medical intervention and/or a pattern of errors.

- Identify by:**
- Analyzing reports of medication errors
 - Reviewing policies and procedures for all aspects of drug administration
 - Reviewing residents' records
 - Interviewing residents, nursing staff, physicians and pharmacist.

Reasons for carrying out analysis, and observations made:

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
R2.3	Current written policies and procedures are in place for all aspects of pharmacy services, to provide consistent direction for all staff. Policies and procedures are consistent with Ministry policies, professional standards, and generally accepted practices for each discipline.	
M1.18	The facility's policies, procedures and work routines are followed in the provision of care and services. Staff are re-instructed when required.	
M1.8	Opportunities for interdisciplinary and interdepartmental communication and coordination are in place and are regularly evaluated.	
M3.9	There is a system to readily identify each resident in the facility.	
D1.2	All new registered staff, including part-time and agency staff, attend a department-specific orientation program which addresses the responsibilities of their positions, including a review of all policies and procedures related to medication administration.	
D1.3	Agency staff receive a task-specific orientation in order to provide safe care to residents.	

MEDICATION ERRORS (cont.)

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
R1.3	The pharmacy service provides the professional staff who administer medications and residents, as required, necessary information and education about the medications that are administered.	
R8.	There is a system for immediate reporting of each medication error and adverse drug reaction, with specific follow-up action to be taken.	
R1.4	Drug reference materials, the pharmacist's telephone number, the pharmacy policy and procedure manual, antidote information, and the telephone number of the regional poison control centre are available at each nursing unit.	
R1.3	There is a contract between the facility and those responsible for providing pharmacy services which specifies the terms of the agreement and includes the method of communication established between the facility and the pharmacist, quality management expectations and corresponding documentation required by the facility, and a list of contracted pharmacy services to be provided.	
R4.	The pharmacy service provides for the accurate, safe dispensing of prescription drugs and biologicals to meet residents' identified medication requirements.	
C1.19	Each resident's response to medications and treatments is monitored and evaluated and changes are made as required.	
B5.2	The care and services provided to each resident are documented in the resident's record, according to the facility policies and procedures.	

Conclusion and action taken:

INFECTIONS

Definition of risk or negative outcome: Incidents of respiratory, enteric, urinary tract or skin infections above the base line incidence identified for the facility.

- Identify by:**
- Reviewing Ministry reports of the facility's outbreaks
 - Observing staff and residents during the walk-through
 - Reviewing the infection control program
 - Reviewing minutes of the infection control committee
 - Reviewing surveillance reports
 - Reviewing shift report books
 - Reviewing medication administration records
 - Interviewing the person responsible for coordinating infection control, as well as other registered staff.

Reasons for carrying out analysis, and observations made:

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
M3.19	There is an organized program of infection control, coordinated by a multidisciplinary committee which meets regularly.	
M3.21	The infection control program includes sanitation practices, surveillance and outbreak management protocols, facility policies and procedures, other legislated requirements, and education and consultation to support the policies and procedures.	
M3.20	A designated infection control practitioner on staff is responsible for the surveillance and outbreak management activities of the infection control program.	
M3.22	There is an ongoing program of surveillance to determine the presence of nosocomial infections.	

INFECTIONS (cont.)

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
M3.23	All staff participate in the facility-wide infection control program and are made aware of and practise measures to prevent or minimize the spread of infection.	
M3.24	A contingency plan and policies and procedures have been developed and are implemented in the event of a suspected outbreak.	
M3.25	There is a process in place to facilitate early communication of an outbreak, within the facility and to external agencies.	
M3.26	Specific policies relating to infection control and outbreak control have been developed for each department and all personnel are instructed and supervised in implementing the policies.	
M1.18	The facility's policies, procedures and work routines are followed in the provision of care and services. Staff are re-instructed when required.	

Conclusion and action taken:

RESIDENT INACTIVITY

Definition of risk or negative outcome: A pattern of residents uninvolved in activities offered by the facility.

- Identify by:**
- Interviewing residents, families
 - Interviewing recreation and leisure services staff
 - Reviewing appropriate documentation to determine participation
 - Reviewing program schedules, descriptions
 - Observation of residents sitting for long periods of time
 - Observation of residents involved in activities not appropriate for their age
 - Reviewing programs offered in relation to assessments of residents' needs

Reasons for carrying out analysis, and observations made:

Status Code: 1 = met; 2 = not met; 3 =not applicable

No.	Standards/Criteria to Review:	Status
M2.1	There are regular formal and informal mechanisms to monitor resident and family satisfaction with recreation and leisure programs.	
B3.7	Support/assistance is provided as needed to assist each resident to prepare for and attend recreation and leisure activities of his/her choice.	
E1.3	Information about recreation programs and services is readily available to residents, their representatives and others who are interested.	
E1.5	Small group programs and individualized activities are provided for those residents who are not interested or are not able to participate in larger groups.	
E1.1	The variety and scope of recreational programming is planned with residents/representatives.	
E1.7	Activities are offered during evenings and weekends.	
M1.8	Opportunities for interdisciplinary and interdepartmental communication and coordination are in place and regularly evaluated.	

Conclusion and action taken:

POOR POSITIONING

Definition of risk or negative outcome: Observation of residents poorly positioned; no supports for dependent limbs; residents sliding out of chairs.

- Identify by:**
- Observing residents
 - Discussion with residents, family, staff

Reasons for carrying out analysis, and observations made:

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
M1.6	Current policies and procedures, consistent with Ministry policies and directives, are in place to guide the management and service delivery of each program and service.	
M1.18	The facility's policies and procedures are followed in the provision of care and services. Staff are re-instructed when required.	
B3.54	An adequate supply of positioning aids is readily available for use to meet the comfort needs of residents.	
H1.	There is an organized program of therapy services, or arrangements are made to access available therapy services to meet residents' identified therapy needs.	
B1.1	Each resident/representative is encouraged and supported to participate in the resident's assessment process.	
B2.4	Each resident's plan of care reflects his/her current strengths, abilities, preferences, needs, goals and safety/security risks, and gives clear directions to staff providing care.	
B2.5	Each resident's plan of care is accessible to the members of the care team who provide care and services to residents. Pertinent information, including changes in the resident's condition, are communicated to staff providing care.	
B3.51	Each resident's physical environment, positioning, health treatment and care routines promote his/her comfort, rest and sleep. Disruptions to each resident's sleep are minimized.	

Conclusion and action taken:

DISORGANIZED MEAL SERVICE

Definition of risk or negative outcome: Observation of delays in meal service; noisy environment in dining area; careless service; crowded dining room; inappropriate feeding practices.

- Identify by:**
- Observing meal times
 - Interviewing residents
 - Reviewing residents' council minutes, with permission
 - Interviewing staff

Reasons for carrying out analysis, and observations made:

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
M2.2	Meal service is included in the program for monitoring, evaluating and improving quality.	
M2.1	There are regular mechanisms to monitor resident satisfaction with meal service.	
P1.20	Residents are served meals in the dining room unless their needs are better met in another location, according to the residents' plans of care.	
M1.6	Current policies and procedures, consistent with Ministry policies and directives, are in place to guide the management and service delivery of all programs and services, including meal services.	
M1.16	Staff are allocated according to residents' care needs, facility design and resources.	
B3.39	Each resident receives encouragement, supervision and assistance with food and fluid intake to promote his/her safety, comfort and independence in eating.	
M1.8	Opportunities for interdisciplinary and interdepartmental communication and coordination are in place and are regularly evaluated.	

DISORGANIZED MEAL SERVICE (cont.)

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
M1.19	Supplies and equipment are provided and are readily available for use to support safe and effective care and services to residents.	
M1.20	Supplies and equipment are maintained in good condition.	
M1.18	The facility's policies, procedures and work routines are followed in the provision of care and services. Staff are re-instructed when required.	

Conclusion and action taken:

FOOD AND/OR FLUIDS NOT CONSUMED

Definition of risk or negative outcome: A pattern of residents not eating a specific meal or a specific resident not eating more than one meal. Fluids not consumed after being served.

- Identify by:**
- Observing food left on plates after meals
 - Observing snacks and fluids left at the bedside or in lounge area
 - Interviewing staff
 - Discussion with residents
 - Reviewing minutes from residents' council meetings or food committee meetings, with permission

Reasons for carrying out analysis, and observations made:

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
M1.18	The facility's policies, procedures and work routines are followed in the provision of care and services. Staff are re-instructed when required.	
M1.16	Staff are allocated according to residents' care needs, facility design and resources.	
P1.1	Menus are developed in consultation with residents.	
B3.32	The food and fluid intake of each resident who is identified at nutritional risk is monitored and steps are taken to address problems.	
B3.37	Food and beverages are given to each resident at a temperature and in a manner that promotes comfort and safety.	
B3.35	Each resident has opportunities to select his/her choice of food at meals from available menus.	
P1.8	The planned alternative menu choices for entrées, vegetables, and desserts are provided, prepared and served at the same time as the first choice.	

FOOD AND/OR FLUIDS NOT CONSUMED (cont.)

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
P1.25	Delivery of a meal to residents requiring assistance in eating occurs no more than five minutes in advance of assistance being provided.	
B3.38	Sufficient time is given to allow each resident to eat at his/her own pace.	
B2.5	Each resident's plan of care is accessible to the members of the health care team who provide care and services to residents. Pertinent information, including changes in the resident's condition, are communicated to staff providing care.	

Conclusion and action taken:

ODOURS

Definition of risk or negative outcome: Persistent, lingering, and offensive odours in one or more areas of the facility.

- Identify by:**
- Detecting odours during the walk-through
 - Discussion with staff, residents and family members.

Reasons for carrying out analysis, and observations made:

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
M2.2	Control of odours is included in the program for monitoring, evaluating and improving quality.	
M1.6	Current policies and procedures, consistent with Ministry policies and directives, are in place to guide the management and service delivery of each program and service.	
M1.8	Opportunities for interdisciplinary and interdepartmental communication and coordination are in place and are regularly evaluated.	
O3.1	The housekeeping program provides for routine, preventive and remedial housekeeping.	
O3.4	Action is taken promptly to identify and address incidents of offensive odour.	
M1.19	Supplies and equipment are provided and are readily available for use to support safe and effective care and services to residents.	
O4.13	A supply of clean linen, sufficient to meet the residents' needs, is readily available for use.	
O4.22	Soiled linen is placed into laundry bags or carts at the point of service.	

ODOURS (cont.)

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
O4.23	There is regular collection of soiled linen from the units in a manner that limits the possibility of infection, controls odours, and maintains aesthetic conditions.	
B3.59	Each resident's hygiene and grooming care meets his/her needs and considers his/her preferences whenever possible.	
B3.57	Each resident who is incontinent has an individualized program of continence care.	
B3.58	Continence care products are available to each resident requiring them.	
B3.36	Each resident is provided sufficient fluids to maintain proper hydration.	

Conclusion and action taken:

UNCLEAN AND/OR INADEQUATE EQUIPMENT, LINEN AND SUPPLIES

Definition of risk or negative outcome: Equipment, linen and/or supplies not available, not clean, or not in good repair.

- Identify by:**
- Reviewing incident reports
 - Observation during walk-through
 - Interviewing staff and residents
 - Reviewing maintenance records
 - Reviewing shift reports

Reasons for carrying out analysis, and observations made:

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
M2.2	The availability, cleanliness and repair of equipment, linen and supplies are included in the program for monitoring, evaluating and improving quality.	
M3.3	Safety systems are in place and policies, procedures and practices are implemented to identify and minimize hazards to residents, staff and visitors.	
M1.6	Current policies and procedures, consistent with Ministry policies and directives, are in place to guide the management and service delivery of each program and service.	
M1.18	The facility's policies, procedures and work routines are followed in the provision of care and services. Staff are re-instructed when required.	
M1.19	Supplies and equipment are provided and are readily available for use to support safe and effective care and services to residents.	
M1.20	Supplies and equipment are maintained in good condition.	
O4.13	A supply of clean linen, sufficient to meet the residents' needs, is readily available for use.	

UNCLEAN AND/OR INADEQUATE EQUIPMENT, LINEN AND SUPPLIES (cont.)

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
O2.	The maintenance program provides for routine, preventive and remedial maintenance.	
O2.3	An established schedule of preventive maintenance procedures is followed and completion of work is documented.	
O3.1	The housekeeping program provides for routine, preventive and remedial housekeeping.	
O3.2	Work routines that include cleaning frequencies and schedules of cleaning are established and followed.	

Conclusion and action taken:

POOR MAINTENANCE AND HOUSEKEEPING

Definition of risk or negative outcome: Building, grounds, furnishings and/or equipment not maintained in a clean, safe, comfortable and/or functional manner.

- Identify by:**
- Observation during walk-through
 - Discussion with staff
 - Discussion with residents/families

Reasons for carrying out analysis, and observations made:

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
M2.2	Environmental services are included in the program to monitor, evaluate and improve quality.	
M1.6	Current policies and procedures, consistent with Ministry policies and directives, are in place to guide the management and service delivery of each program and service.	
M1.18	The facility's policies, procedures and work routines are followed in the provision of care and services. Staff are re-instructed when required.	
O3.2	Work routines that include cleaning frequencies and schedules of cleaning are established and followed.	
D1.2	All new staff, including part-time staff, attend a department-specific orientation program which addresses the responsibilities of the position.	
M1.16	Staff are allocated according to residents' care needs, facility design and resources.	
M1.19	Supplies and equipment are provided and are readily available for use to support safe and effective care and services to residents.	
M1.20	Supplies and equipment are maintained in good condition.	
M1.8	Opportunities for interdepartmental and interdisciplinary communication and coordination are in place and regularly evaluated.	

Conclusion and action taken:

ENVIRONMENTAL SAFETY HAZARDS

Definition of risk or negative outcome: Any object or practice which could cause injury or could contribute to a risk or injury.

- Identify by:**
- Observation during walk-through
 - Reviewing incident reports
 - Reviewing Occupational Health and Safety reports
 - Discussion with staff and residents

Reasons for carrying out analysis, and observations made:

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
M3.	There are coordinated risk management activities designed to reduce and control actual or potential risks to the safety, security, welfare and health of individuals or to the safety and security of the facility.	
O1.5	Disposal of dry and wet garbage, including sharps and biologicals, is done in a recognized, approved manner.	
M3.6	Staff are instructed in the safe use of all equipment used in their job responsibilities.	
M1.6	Current policies and procedures, consistent with Ministry policies and directives, are in place to guide the management and service delivery of each program and service.	
M1.18	The facility's policies, procedures and work routines are followed in the provision of care and services. Staff are re-instructed when required.	
B3.14	Each resident's environment is maintained to minimize safety and security risks. Action is taken to protect each resident from identified potentially hazardous substances, conditions and equipment.	
B3.15	Risks to each resident's health and safety are identified and addressed in ways that consider his/her choice, freedom of movement, dignity and respect, in keeping with other residents' rights.	

Conclusion and action taken:

UNPLANNED WEIGHT CHANGE

Definition of risk or negative outcome: Unplanned weight change of 5% over a one-month period or 10% over a six-month period.

- Identify by:**
- Interviewing the Dietician/Food Service Supervisor
 - Interviewing nursing staff
 - Reviewing residents' weight records
 - Completing focused audits

Reasons for carrying out analysis, and observations made:

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
M2.2	Early recognition of and response to residents' unplanned weight change is included in the program to monitor, evaluate and improve quality.	
M1.6	Current policies and procedures, consistent with Ministry policies and directives, are in place to guide the management and service delivery of each program and service.	
M1.18	The facility's policies, procedures and work routines are followed in the provision of care and services. Staff are re-instructed when required.	
B1.1	Each resident/representative is encouraged and supported to participate in the resident's assessment process.	
B1.2	The assessment process includes determining the resident's needs and preferences and where applicable, the resident's functional status in relation to eating and swallowing.	
B2.4	Each resident's plan of care identifies potential for weight change, if applicable, and gives clear directions to staff providing care.	
B2.5	Each resident's plan of care, including food intake and preferences, is accessible to the members of the health care team who provide care and services to residents. Pertinent information, including changes in the resident's condition, are communicated to staff providing care.	

UNPLANNED WEIGHT CHANGE (cont.)

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
B3.30	Each resident receives nutritional care according to his/her assessed needs, and measures are taken to identify and address problems related to nutrition.	
B3.39	Each resident receives encouragement, supervision and assistance with food and fluid intake to promote safety, comfort and independence in eating.	
B3.31	Each resident's weight is measured and recorded at least monthly. Changes in weight are evaluated and action is taken as required.	
B5.	All significant information about each resident's weight changes and eating patterns is documented.	
B4.	There is ongoing monitoring and evaluation of each resident's care, services, and care outcomes.	
M1.19	Equipment is provided and is readily available for use to monitor residents' weights.	
M1.20	Equipment to monitor residents' weights is maintained in good condition.	

Conclusion and action taken:

UNPLANNED WEIGHT CHANGE - FOCUSED AUDITS

- Sample residents from:**
- Residents identified by staff
 - Weight monitoring records

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Areas to Review	Residents' Names					
B2.6	The resident's care plan of care is reviewed and revised at least quarterly by the physician, nursing staff, the dietician or food service supervisor, and other care team members as appropriate.						
B2.4	The resident's plan of care reflects his/her current strengths, abilities, preferences, needs, goals and safety/security risks, and gives clear directions to staff providing care.						
B3.39	The resident receives encouragement, supervision and assistance with food and fluid intake to promote his/her safety, comfort and independence in eating.						
B3.38	Sufficient time is given to allow the resident to eat at his/her own pace.						
P1.18	Snacks are offered to the resident at mid-afternoon and at bedtime, unless contraindicated in the resident's plan of care.						
B3.31	The resident's weight is measured and recorded at least monthly. Changes in weight are evaluated and action is taken as required.						
B5.	All significant information about the resident's weight changes and eating patterns is documented in his/her record.						

Conclusion and action taken:

PRESSURE ULCERS

Definition of risk or negative outcome: Breakdown in skin integrity related to pressure; includes four stages of ulcer development
 (1) skin red; intact, blanches when touched;
 (2) shallow skin ulcer, may be serous drainage;
 (3) subcutaneous tissues involved, drainage;
 (4) fascia, then muscle and bone involved, drainage.

- Identify by:**
- Reviewing treatment lists
 - Interviewing nursing staff
 - Completing focused audits

Reasons for carrying out analysis, and observations made:

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
M2.2	Evaluation of the effectiveness of preventive measures and treatments for pressure ulcers is included in the program to monitor, evaluate and improve quality.	
M1.6	Current policies and procedures, consistent with Ministry policies and directives, are in place to guide the management and care delivery of each program and service, including skin care.	
M1.18	The facility's policies, procedures and work routines are followed in the implementation of care and services. Staff are re-instructed when required.	
B2.4	Each resident's plan of care identifies potential for skin breakdown and gives clear directions for staff providing care.	
B3.47	Each resident receives skin care to promote and maintain skin integrity and to promote comfort and mobility.	
B3.48	Each resident who has altered skin integrity receives skin care measures to promote healing, minimize discomfort and prevent deterioration.	
B3.50	The treatment protocol/plan is consistently carried out as ordered by the physician/nurse.	

PRESSURE ULCERS (cont.)

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
B4.1	Changes in each resident's condition, as well as any other significant information are promptly reported to the staff member in charge of the resident's care.	
B3.30	Each resident receives nutritional care according to his/her assessed needs and measures are taken to identify and address problems related to nutrition.	
B4.	There is ongoing monitoring of each resident's care, services, and care outcomes.	
B5.	All significant information about each resident's skin condition and treatments is documented in his/her record.	
B3.49	Skin care supplies and devices are available as required to relieve pressure and promote healing.	
O4.13	A supply of clean linen, sufficient to meet the residents' needs, is readily available for use.	

Conclusion and action taken:

PRESSURE ULCERS - FOCUSED AUDITS

- Sample residents from:**
- Residents identified by staff
 - Treatment lists

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review	Residents' Names					
B2.4	The resident's plan of care identifies the potential for skin breakdown and gives clear directions to staff providing care.						
B2.5	The resident's plan of care is accessible to the members of the health care team who provide care and services to residents. Pertinent information, including changes in the resident's condition, are communicated to staff providing care.						
B3.47	The resident receives skin care measures to promote healing, minimize discomfort, and prevent deterioration.						
B3.50	The treatment protocol/plan is consistently carried out as ordered by the physician/nurse.						
B3.30	The resident receives nutritional care according to his/her assessed needs and measures are taken to identify and address problems related to nutrition.						
O4.13	A supply of clean linen, sufficient to meet the residents' needs, is readily available for use.						
B3.49	Skin care supplies and devices are available as required to relieve pressure and promote healing.						
B5.	All significant information about each resident's skin condition and response to treatments is documented in the resident's record. (e.g. site, stage, size, exudate, appearance and odour).						

Conclusion and action taken:

PAIN/DISCOMFORT

Definition of risk or negative outcome: Residents complaining of or exhibiting signs of pain or discomfort.

- Identify by:**
- Observing and/or interviewing residents
 - Interviewing staff
 - Reviewing residents' records - e.g. residents with recent falls, fractures or receiving palliative care
 - Completing focused audits

Reasons for carrying out analysis, and observations made:

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
B1.1	Each resident/representative is encouraged and supported to participate in the resident's assessment process.	
B2.4	Each resident's plan of care reflects his/her current strengths, abilities, preferences, needs, goals and safety/security risks, and gives clear directions to staff providing care.	
B2.5	Each resident's plan of care is accessible to the members of the health care team who provide care and services to residents. Pertinent information, including changes in the resident's condition, are communicated to staff providing care.	
N1.14	The attending physician assesses, plans, implements and evaluates his/her residents' medical care, and participates in the interdisciplinary approach to care.	
B3.51	Each resident's physical environment, positioning, health treatment and care routines promote his/her comfort, rest and sleep. Disruptions to each resident's sleep are minimized.	
B3.52	Each resident who experiences pain/discomfort receives care to manage the pain/discomfort.	
B4.	There is ongoing monitoring and evaluation of each resident's care, services, and care outcomes.	
B3.54	An adequate supply of positioning aids is readily available to meet the comfort needs of residents.	
M1.18	The facility's policies and procedures are followed in the provision of care and services. Staff are re-instructed when required.	

Conclusion and action taken:

PAIN AND DISCOMFORT - FOCUSED AUDITS

- Sample residents from:**
- Residents identified by staff
 - Observation of residents

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Residents' Names					
B1.1	The resident/representative is encouraged and supported to participate in the resident's assessment process to determine the his/her needs, including comfort needs and pain management.						
N1.14	The attending physician assesses, plans, implements and evaluates the resident's medical care, and participates in the interdisciplinary approach to care.						
B2.4	The resident's plan of care reflects his/her current strengths, abilities, preferences, needs, goals and safety/security risks, and gives clear directions to staff providing care.						
B2.5	The resident's plan of care is accessible to the members of the health care team who provide care and services to residents. Pertinent information, including changes in the resident's condition, are communicated to staff providing care.						
B3.52	The resident receives care to manage the pain/discomfort.						
B3.54	An adequate supply of positioning aids is readily available to meet the comfort needs of the resident.						
C1.17	The resident receives medication and treatment as ordered by the physician, unless the resident refuses.						
C1.19	The resident's response to medications and treatments is monitored and evaluated and changes are made as required.						

Conclusion and action taken:

DISRUPTIVE BEHAVIOUR

Definition of risk or negative outcome: Residents' behaviour which results in risk to themselves or others.

- Identify by:**
- Reviewing incident reports
 - Interviewing staff, residents and families
 - Observation of residents

Reasons for carrying out analysis, and observations made:

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
M2.2	Effectiveness of measures to address behaviour management is included in the program to monitor, evaluate and improve quality.	
M1.6	Current policies and procedures, consistent with Ministry policies and directives, are in place for all aspects of behaviour management.	
M1.18	The facility's policies, procedures and work routines are followed in the provision of care and services. Staff are re-instructed when required.	
D2.7	Inservice education programs provided for all staff annually include understanding residents with cognitive impairment and responding to disruptive behaviour.	
M1.16	Staff are allocated according to residents' care needs, facility design and resources.	
M1.8	Opportunities for interdisciplinary and interdepartmental communication and coordination are in place and regularly evaluated.	
B1.1	Each resident/representative is encouraged and supported to participate in the resident's assessment process.	
B2.4	Each resident's plan of care reflects his/her current strengths, abilities, preferences, needs, goals and safety/security risks and gives clear directions to staff providing care. E.g. Factors which trigger disruptive behaviour are included in the plan of care.	

DISRUPTIVE BEHAVIOUR (cont.)

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
B2.5	Each resident's plan of care is accessible to the members of the health care team who provide care and services to residents. Pertinent information, including changes in the resident's condition, are communicated to staff providing care.	
B1.5	The interdisciplinary team assesses each resident's need for referral to physicians with specialist knowledge or other external consultants.	
B3.51	Each resident's physical environment promotes his/her comfort, rest and sleep.	
B5.	All significant information about each resident is documented in his/her record.	

Conclusion and action taken:

DISRUPTIVE BEHAVIOUR - FOCUSED AUDITS

- Sample residents from:**
- Residents identified by staff
 - Incident reports

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Residents' Names					
B2.4	The resident's plan of care reflects his/her current strengths, abilities, preferences, needs, goals and safety/security risks, and gives clear directions to staff providing care. Factors which trigger disruptive behaviour are included in the plan of care.						
B2.6	The resident's behaviour management issues have been reviewed by the physician and nursing staff at least quarterly.						
B1.5	The interdisciplinary care team assesses the resident's need for referral to physicians with specialist knowledge or other external consultants.						
B3.51	The resident's physical environment promotes his/her comfort, rest and sleep.						
E1.5	Small group programs and individualized activities are provided for those residents who are not interested or are not able to participate in larger groups.						
E1.4	Assistance or adaptations are provided to facilitate the resident's participation in activities he/she wishes to attend.						
B4.	There is ongoing monitoring and evaluation of the resident's care, services and care outcomes.						
B5.	All significant information about the resident is documented in his/her record.						

Conclusion and action taken:

RESTRAINT USE

Definition of risk or negative outcome: Residents in restraints or with orders for restraints. For purposes of indicator analysis, a restraint is defined as any physical appliance which inhibits free movement, and which cannot be released easily by the resident (chemical restraints are assessed elsewhere).

- Identify by:**
- Direct observation of residents
 - Interviewing staff, residents, and families
 - Review of documentation
 - Completing focused audits

Reasons for carrying out analysis, and observations made:

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
M2.2	Evaluation of the use of restraints is included in the program to monitor, evaluate and improve quality.	
M1.6	Current policies and procedures, consistent with applicable legislation, Ministry policies and directives, are in place for all aspects of restraint use.	
M1.18	The facility's policies and procedures for restraint use are followed. Staff are re-instructed when required.	
B1.5	The interdisciplinary team assesses each resident's need for referral to physicians with specialist knowledge or other consultants.	
B2.4	Each resident's plan of care reflects his/her current needs, strengths, abilities, preferences, needs, goals and safety/security risks, and gives clear directions to staff providing care.	
B3.16	A resident is not restrained unless there is an identified risk of injury to him/herself or others, and other alternatives have been considered and have been found to be ineffective.	
B3.17	Following the initial use of as restraint, there is an evaluation of the factors leading to the restraint use and the plan of care is revised as required. The rationale for use of the restraint is documented.	

RESTRAINT USE (cont.)

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
B3.18	A physical restraint is applied only on the written order of a physician who has attended the resident and approved the type of restraint.	
B3.20	Where it is considered necessary to restrain a resident, the least restrictive measures are used.	
B3.21	Only restraints that have been designed to be used as a restraint are used.	
B3.22	Restraints are applied according to manufacturers' specifications and cause the least possible discomfort to the resident.	
B3.24	Minimum hourly interventions for physically restrained residents include release of the restraint and repositioning.	
B5.4	All documentation in the resident's health record regarding use of restraints is complete, according to the facility's policies and procedures.	
B3.54	An adequate supply of positioning aids is readily available to meet the comfort needs of residents.	
M1.8	Opportunities for interdisciplinary and interdepartmental communication and coordination are in place and are regularly evaluated.	

Conclusion and action taken:

RESTRAINT USE - FOCUSED AUDITS

- Sample residents from:**
- Restraint documentation forms
 - Direct observation
 - Residents identified by staff

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review	Residents' Names					
B2.	The decision regarding use of a restraint was made through an interdisciplinary planning process, with the resident/representative.						
B5.1	Documentation in the resident's health record includes the identification of his/her needs and the plan of care to address the identified needs.						
B3.16	There is evidence that there is an identified risk of injury to him/herself or others, and other alternatives have been considered and have been found to be ineffective.						
B3.20	Where it is considered necessary to restrain the resident, the least restrictive measures are being used.						
M1.18	The facility's policies and procedures (as well as applicable legislation) for restraint use are followed. Staff are re-instructed when required.						
B3.21	Only restraints that have been designed to be used as a restraint are used.						

RESTRAINT USE - FOCUSED AUDITS (cont.)

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review	Residents' Initials					
B3.22	Restraints are applied according to manufacturers' specifications and cause the least possible discomfort to the resident.						
B3.24	Minimum hourly interventions for physically restrained residents include release of the restraint and repositioning.						
B3.23	The resident's need for a restraint is reassessed every twelve hours and documented.						
M1.18	The facility's policies and procedures are followed in the provision of care and services. Staff are re-instructed when required.						

Conclusion and action taken:

POOR GROOMING

Definition of risk or negative outcome: Observation of poorly groomed residents, e.g., several residents with uncombed or dirty hair, dirty fingernails, poor mouth care, unshaven faces, dirty or wrinkled or ill-fitting clothing.

- Identify by:**
- Observing residents
 - Interviewing residents, families, and staff
 - Checking available supplies

Reasons for carrying out analysis, and observations made:

Status Code: 1 = met; 2 = not met; 3 = not applicable

No.	Standards/Criteria to Review:	Status
M2.2	Evaluation of residents' grooming is included in the program to monitor, evaluate and improve quality.	
M1.6	Current policies and procedures, consistent with Ministry policies, are in place for residents' grooming.	
M1.18	The facility's policies, procedures and work routines are followed in the provision of care and services. Staff are reinstructed when required.	
M1.16	Staff resources are allocated according to residents' care needs.	
M1.19	Supplies and equipment are provided and are readily available for use to meet the residents' grooming needs.	
O4.8	There is an effective system in place to collect soiled personal clothing and return clean personal clothing to residents' rooms within forty-eight hours of pick-up.	
O4.6	There is a system to communicate to residents/representatives, needs for clothing purchase or repair, as applicable.	
O4.4	The facility provides a service for mending and ironing of residents' clothing, on a fee-for-service basis when payment is authorized by the resident/representative.	
B1.	Each resident's needs for care and services are determined with the resident/representative through an interdisciplinary assessment process.	
B2.4	Each resident's plan of care reflects his/her current strengths, abilities, preferences, needs, goals and safety/security risks and gives clear directions to staff providing care.	

Conclusion and action taken:

MONITORING TOOL FOR REVIEW OF RESIDENT CARE AND SERVICES

IN-DEPTH REVIEW OF RESIDENT CARE REFERENCE

"Resident" refers to resident/representative.

Status Code: 1 = met; 2 = not met; 3 = not applicable

Resident Names

	ASSESSMENT AND PLANNING OF CARE AND SERVICES						
No.	Standards/Criteria to Review:	Status					
B1.2	The assessment includes determining the resident's preferences, strengths, social and personal resources, interests, health status, extent of independent functioning, type and amount of support required.						
B1.3	Building on previous information, medical and nursing assessments are completed within 7 days of admission.						
B1.4	Assessments by the other members of the facility's interdisciplinary care team are completed within 21 days of the resident's admission.						
B2.1	A written plan of care is initiated within 24 hours of admission.						
B2.3	Organized, documented interdisciplinary team conferences are held with the resident/ representative, within six weeks following admission, to review and further develop the written plan of care.						
B2.4	The resident's plan of care reflects his/her current strengths, abilities, preferences, needs, goals and safety/security risks, and gives clear directions to staff providing care.						
B2.6	The resident's plan of care is reviewed and, where necessary, revised at least quarterly by the physician, nursing staff, the dietician or food service supervisor, and other care team members as appropriate.						
B2.7	Organized, documented interdisciplinary team conferences are held annually with the resident/ representative, if they are able and wish to attend, to reassess the resident's care and service needs, and to review and revise the plan of care.						

Resident Initials

PROVISION OF CARE AND SERVICES							
No.	Standards/Criteria to Review:	Status					
Emotional, Social and Cultural							
B3.1	The resident is encouraged to have his/her room reflect his/her personal style, cultural context and preferences with pictures, possessions and furnishings (in keeping with safety requirements and other residents' rights).						
B3.3	The resident is supported and assisted in maintaining his/her desired involvement with family, friends and others in the community.						
Recreation and Leisure							
B3.6	Opportunities are provided for the resident to plan, initiate, facilitate, and participate in his/her own leisure, entertainment, recreational and educational opportunities, as desired by the resident.						
B3.7	Support/assistance is provided as needed to assist the resident to prepare for and attend recreation and leisure activities of his/her choice.						
Spiritual and Religious							
B3.8	The resident is supported and assisted in maintaining his/her preferred spiritual and religious observances, practices and affiliations.						
B3.9	Support/assistance is provided as needed to assist the resident to prepare for and attend spiritual and religious activities of his/her choice.						
Cognitive and Intellectual							
B3.11	The resident has opportunities and assistance to participate in programs which are appropriate to his/her cognitive status, interests and preferences, both within the facility and in the community.						
Safety and Security							
B3.14	The resident's environment is maintained to minimize safety and security risks. Action is taken to protect the resident from identified potentially hazardous substances, conditions and equipment.						

Resident Initials

PROVISION OF CARE AND SERVICES (cont.)							
No.	Standards/Criteria to Review:	Status					
Sensory Function and Communication							
B3.25	The resident is offered support and assistance to enable him/her to communicate and to be as independent as possible.						
B3.28	The resident's sensory and communication aids, e.g. eye glasses and hearing aids, are cared for, cleaned, and accessible to him/her.						
Nutrition							
B3.30	The resident receives nutritional care according to his/her assessed needs and measures are taken to identify and address problems related to nutrition.						
B3.31	The resident's height is recorded on admission. His/her weight is measured and recorded on admission and subsequently at least monthly. Changes in weight are evaluated and action is taken as required.						
B3.35	The resident has opportunities to select his/her choice of food at meals from available menus.						
B3.37	Food and beverages are given to the resident at a temperature and in a manner that promotes comfort and safety.						
B3.38	Sufficient time is given to allow the resident to eat at his/her own pace.						
Oral and Dental Care							
B3.43	The resident's mouth, teeth and/or dentures are cleaned daily or more frequently as required, with assistance provided according to the resident's ability to manage his/her own care.						
B3.44	The resident's dentures are labelled, cleaned and accessible to the resident.						

PROVISION OF CARE AND SERVICES (cont.)							
No.	Standards and Criteria to Review:	Status					
Skin and Nail Care							
B3.45	The resident receives nail care to promote and maintain skin integrity and to promote comfort and mobility.						
B3.47	The resident receives skin care to promote and maintain skin integrity and to promote comfort and mobility.						
Comfort, Rest and Sleep							
B3.51	The resident's physical environment, positioning, health treatment and care routines promote his/her comfort, rest and sleep. Disruptions to the resident's sleep are minimized.						
B3.53	The resident's individual desired bedtime routines are encouraged and promoted, while respecting other residents' rights.						
Elimination							
B3.55	Measures are taken to promote each resident's normal bowel and bladder function.						
B3.56	Steps are taken to identify where possible and address factors which may impede the resident's continence.						
B3.57	If the resident is incontinent he/she has an individualized program of continence care.						
B3.58	Continence care products are available to the resident if he/she requires them.						
Hygiene, Grooming							
B3.59	The resident's hygiene and grooming care meets his/her needs and considers his/her preferences whenever possible.						

Resident Initials

PROVISION OF CARE AND SERVICES (cont.)							
No.	Standards/Criteria to Review:	Status					
Activities of Daily Living							
B3.60	The resident receives supervision/assistance and services which promote independence, maintain or improve function in activities of daily living, according to his/her assessed abilities, wishes and preferences.						
Medications and Treatments							
C1.15	Medications are administered only from properly labelled containers.						
C1.17	The resident receives medication and treatment as ordered by the physician, unless the resident refuses.						
C1.18	For every medication administered, the record includes date, time, dose and route where applicable, signed by the person who gave the medication.						
R6.3	Every drug cabinet or storeroom is kept locked at all times and only the registered nursing staff and the pharmacist may have access to the keys.						
Palliative Care							
B3.64	The resident/representative is involved in decisions regarding the type of care and interventions received.						
B3.65	Any decisions regarding the type of care and interventions, including advance directives, are documented.						
B3.66	The resident receives measures to control symptoms and to promote comfort.						
B3.67	The resident is assisted in arranging for available counselling and bereavement support, according to his/her needs and preferences.						
B3.68	The resident has access to/is assisted in arranging for available spiritual and religious resources, according to his/her needs and preferences.						

No.	Standards/Criteria to Review:	Status					
MONITORING AND EVALUATION							
B4.	There is ongoing monitoring of the resident's care, services, and care outcomes.						
DOCUMENTATION							
B5.	All significant information about the resident is documented in his/her record.						
B5.3	The evaluation of care and services and care outcomes are documented in the resident's health record.						

MONITORING TOOL FOR REVIEW OF RESIDENT CARE AND SERVICES

PROGRAMS AND SERVICES REVIEW (REFERENCE)

Status Code: 1 = met 2 = unmet 3 = not applicable **Status**

	Posting of Required Documents:	
Bill 101	<ul style="list-style-type: none"> • Licence 	
	<ul style="list-style-type: none"> • Residents' Bill of Rights 	
	<ul style="list-style-type: none"> • Service Agreement 	
	<ul style="list-style-type: none"> • Financial Reports 	
	<ul style="list-style-type: none"> • Review Reports (Annual and Follow-up) 	
A1.18	<ul style="list-style-type: none"> • The processes for obtaining information, raising concerns, lodging complaints or recommending changes, including telephone numbers and addresses of local Area and Regional Offices, are permanently posted in a location easily accessible to residents, families and representatives. 	

Status

No.	Resident Safeguards	
A1.1	Residents/representatives are encouraged and supported to participate in the planning and evaluation of programs and services.	
A1.12	Residents are given the opportunity and support to establish and maintain an organized residents' council.	
A1.14	Suggestions and complaints from the residents' council are documented, investigated and responded to in writing by the administrator within 21 days.	
A1.15	Residents are informed of the results of residents' council meetings, along with feedback from the administrator.	
A1.19	There are formal mechanisms for receiving, investigating, and responding to residents'/representatives' suggestions, requests and complaints. Information is provided in writing to residents/representatives on admission, during orientation to the facility.	
A1.10	<p>The facility has policies for the following:</p> <ul style="list-style-type: none"> • promotion of residents' rights • what constitutes resident abuse • how to prevent abuse • actions to be taken in all instances of alleged abuse, including notification of the family/representative, police and Ministry staff. • resources available to assist the abused resident and the person responsible for the abuse. 	

No.	Facility Organization and Administration	
M1.19	Supplies and equipment are provided and are readily available for use to support safe and effective care and services to residents. (Refer to list of requirements)	
M2.1	There are regular formal and informal mechanisms to monitor resident and family satisfaction with the quality of accommodation, care, services, programs and goods provided by the facility.	
M2.2.	Each program and service within the facility is included in the program for monitoring, evaluating and improving quality.	
M2.3	Staff from all programs and services are involved in the activities associated with monitoring, evaluating and improving quality.	
M3.	There are coordinated risk management activities designed to reduce and control actual or potential risks to the safety, security, welfare and health of individuals or to the safety and security of the facility.	
M3.3	Safety systems are in place and policies, procedures and practices are implemented to identify and minimize hazards to residents, staff and visitors.	
M3.4	The resident call system and door alarms (as required by applicable legislation) are maintained in working order.	
M3.7	Unusual occurrences are reported according to Ministry policy.	
M3.9	There is a system to readily identify each resident in the facility, e.g. photo identification, identification bracelets.	
M3.10	There are written contingency plans for handling internal disasters (including missing residents, bomb threats, fires, loss of essential services, service disruption).	
M3.17	There are written contingency plans for the operation of the facility under the conditions of external disaster (including weather-related, community and environmental disasters).	

No.	Facility Organization and Administration (cont'd)	
M3.19	There is an organized program of infection control, coordinated by a multidisciplinary committee which meets regularly and which is chaired by a designated health care professional with expertise/interest in infection control.	
M3.20	A designated infection control practitioner on staff is responsible for the surveillance and outbreak management activities of the infection control program.	
M3.22	There is an ongoing program of surveillance to determine the presence of infections.	
M3.24	A contingency plan and policies and procedures are developed and implemented in the event of a suspected or confirmed outbreak.	
M3.25	There is a process to facilitate early communication of an outbreak, within the facility and to external agencies.	

No.	Staff Education:	
D1.1	All new staff, including part-time staff, attend an organized, facility-wide general orientation program that responds to the learning needs of new staff.	
D1.2	All staff, including part-time staff, attend a department-specific orientation program which addresses the responsibilities of the position.	
D1.3	Agency staff receive task-specific orientation in order to provide safe care to residents.	
D2.3	Staff on all shifts have access to inservice education opportunities.	
D2.6	There are a minimum of ten inservice education programs delivered annually which are based on the assessed learning needs of staff.	
D2.7	Required programs provided annually include: <ul style="list-style-type: none"> • Quality of life issues for residents • Infection control practices • Understanding residents with cognitive impairment and responding to disruptive behaviour • Facility and resident emergency procedures 	

Status

No.	Medical Services	
N1.1	There is an appointed medical director.	
N1.3	There is a contract/written agreement between the facility and the medical director which specifies the term of the appointment and addresses the position responsibilities.	
N1.12	The contract/written agreement between the facility and each attending physician identifies the term of the appointment and the responsibilities of the position.	
N1.16	Attending physicians arrange for 24-hour medical coverage for residents for whom they provide medical care. These arrangements are communicated to facility staff.	

No.	Environmental Services	
O1.16	The temperature of water serving all bathtubs, showers and hand basins used by residents does not exceed 49 degrees Celsius and is controlled by a device, inaccessible to residents, that regulates the temperature.	
O1.17	Hot water temperature is monitored daily at the source and once per shift in random locations where residents have access to hot water.	
O1.20	The facility is maintained at a minimum temperature of 22 degrees Celsius.	
O2.7	The exterior of the building, walkways and outside areas are kept in good repair and free of debris.	
O2.8	All entrances, exits, exterior stairwells and walkways are kept clear and unobstructed.	
O2.12	All furnishings and equipment are maintained in good repair and safe for use.	
O3.	The facility, including furnishings and equipment, are kept clean.	
O3.6	Each housekeeping cart is equipped with a locked compartment for storage of hazardous substances and each cart is locked at all times when not attended.	
O3.7	The janitor's closet door is equipped with a locking device and is locked at all times when unattended.	
O4.8	There is an effective system in place to collect soiled personal clothing and return clean clothing to residents' rooms within forty-eight hours of pick-up.	
O4.13	A supply of clean linen, sufficient to meet the residents' needs, is readily available for use.	
O4.16	There are clean towels and face cloths, sufficient to meet residents' needs, provided to each resident at least daily.	
O4.14	Linen is maintained in a good state of repair and free of stains.	
O4.17	Clean linen is stored on resident care units, readily available to staff.	
O4.20	Clean and soiled linen are kept separate at all times.	
O4.27	There are procedures for clearly identifying, handling and washing linen used by residents who have communicable diseases or infections requiring precautions.	
O4.31	The clean and soiled work areas of the laundry room are separate and clearly defined in a manner that minimizes microbial contamination.	

No.	Dietary Services	
P1.3	There is an established menu cycle for both regular and therapeutic diets, including texture modifications and snacks.	
P1.1	Menus are developed in consultation with residents.	
P1.17	Beverages are offered to all residents at meals, between meals, and at bedtime, unless contraindicated in individual residents' plans of care.	
P1.18	Snacks are offered to all residents at mid-afternoon and at bedtime, unless contraindicated in individual residents' plans of care.	
P1.13	<p>All food is stored and maintained in a manner that:</p> <ul style="list-style-type: none"> • prevents contamination or spoilage, • prevents food-borne illness, • retains maximum nutritive value and food quality, and • enhances effective food production. 	
P1.14	Food is prepared and served in a manner that prevents food-borne illness.	

No.	STAFFING	
M1.12	Administrator: The required number of on-site hours of administrator time are provided.	
Service Agreement	Nursing and Personal Care Staffing: The planned deployment pattern provides hours according to the Service Agreement and staffing requirements for:	
C1.5	• Director of Nursing	
C1.6	• Registered nurses	
Service Agreement	Dietary Staffing: The planned deployment pattern provides hours according to the Service Agreement and staffing requirements for:	
P1.33	• Dietician	
P1.36	• Food Service Supervisor	
P1.38	• Food Handlers	
Service Agreement	Program Staffing: Hours are provided according to the Service Agreement.	
	Other:	

MONITORING TOOL FOR REVIEW OF RESIDENT RECORDS
REVIEW OF RESIDENT BUSINESS RECORDS (REFERENCE)

"Resident" refers to resident/representative.

Status Code: 1 = met; 2 = not met; 3 = not applicable

Resident Names

	ADMISSION INFORMATION							
Bill 101	<ul style="list-style-type: none"> Authorization for Admission Form on file of recently admitted residents. 							
	<ul style="list-style-type: none"> An Application for Residents Subsidy Form is on file for those residents receiving subsidy. 							
	ADMISSION AGREEMENT SPECIFIES:							
	<ul style="list-style-type: none"> Type of accommodation resident has requested. 							
	<ul style="list-style-type: none"> Signature of resident/lawful representative agreeing to pay at the rate specified for preferred accommodation. 							
	<ul style="list-style-type: none"> Signature of resident/lawful representative authorizing payment for specified other services. 							
	<ul style="list-style-type: none"> The amount to be billed for accommodation requested and approved and the approved other services. 							
	BILLINGS							
	<ul style="list-style-type: none"> The resident's business record reflects applicable and approved charges. 							

MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES
USE OF SANCTIONS

INTRODUCTION

In collaboration and consultation with facility staff, Long-Term Care Division field staff monitor and evaluate the performance of long-term care facilities. When a facility does not achieve the agreed upon expectations despite these efforts, sanctions may be considered to support the achievement of compliance.

Sanctions will be invoked to protect and support residents' health, safety, welfare, security and rights.

**SANCTIONS
 UNDER LONG-TERM
 CARE FACILITIES
 LEGISLATION**

The following sanctions could be applied to long-term care facilities under applicable Long-Term Care Legislation as amended:

1. Written notice of non-compliance with applicable Acts and Regulations, or the terms and conditions of the service agreement including the Standards and Criteria and Policies included in the Long-Term Care Facilities Program Manual, and requirement of response within 14 days with a corrective action plan. This applies to all facilities.
2. Suspension of admissions applies to all facilities.
3. A licence of a nursing home may be revoked or suspended if the facility is in contravention of the Act or Regulations.
4. The approval of a charitable home for the aged may be revoked or suspended if the facility is in contravention of the Act or Regulations. Municipal homes for the aged are required by statute to establish and operate a home for the aged.

**MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES
USE OF SANCTIONS**

5. The Ministry may also take over the operation of a nursing home under the Health Facilities Special Orders Act.
6. Nursing homes in violation of the Nursing Homes Act and Regulation 832 may be subject to prosecution under Section .

**SANCTION 1:
WRITTEN NOTICE**

**A WRITTEN NOTICE FROM MINISTRY STAFF OF
NON-COMPLIANCE WITH THE ACTS, REGULATIONS
AND CONDITIONS OF THE SERVICE AGREEMENT.**

This action may be taken on its own, or in conjunction with any other sanctions if follow up reviews indicate that the facility has not yet taken corrective action in an identified area, or if something very severe is noted in the context of the monitoring process.

The following criteria will be grounds for this sanction:

**CRITERIA FOR ISSUING
A WRITTEN NOTICE**

- When the facility fails to meet the requirements of the applicable Acts and Regulations or the terms and conditions of the Service Agreement, including the Standards and Criteria and Policies included in the Long-Term Care Facilities Program Manual, despite consultative efforts and previous recommendations of Ministry staff; and
- The conditions observed pose a risk to health, safety, welfare, security, or rights of residents, and corrective action has not been taken; and/or
- The conditions observed are prevalent.

MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES

USE OF SANCTIONS

Examples of conditions which pose a risk to health, safety, welfare, security and rights of residents include, but are not limited to:

- structural defects
- construction or repairs resulting in an unsafe environment
- the presence of noxious substances
- conditions which would prevent quick exit in case of an emergency
- extremes of temperature
- factors preventing appropriate hygiene/sanitary conditions
- insufficient staff to care for residents
- lack of necessary equipment/supplies or food

PROCESS

Ministry staff observe these conditions while:

- monitoring and evaluating facility performance
- investigating a complaint, or

Ministry staff will inform the facility verbally and in writing of the non-compliance, specifying the conditions observed and the applicable Act and Regulations, or the terms and conditions of the service agreement, including the Standards and Criteria and Policies included in the Long-Term Care Facilities Program Manual, that have been breached.

MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES
USE OF SANCTIONS

Note: This written notice should not be confused with a written statement of unmet standards or expectations which is given to the facility following the completion of a review.

**SANCTION 2:
 SUSPENSION OF
 ADMISSIONS**

**SUSPENSION OF ADMISSION OF RESIDENTS TO A
 LTC FACILITY**

**GROUND FOR
 SUSPENSION**

THIS ACTION MAY BE TAKEN FOLLOWING THE WRITTEN NOTICE OF NON-COMPLIANCE IF FOLLOW UP REVIEWS INDICATE THAT THE FACILITY HAS NOT YET TAKEN CORRECTIVE ACTION IN AN IDENTIFIED AREA.

- When the facility fails to meet the expectations of the Acts, Regulations or the terms and conditions of the Service Agreement, including the Standards and Criteria and Policies included in the Long-Term Care Facilities Program Manual, despite consultative efforts and previous recommendations of Ministry staff; and
- The conditions observed pose a risk to health, safety, welfare, security, and rights of residents, and corrective action has not been taken; and
- the conditions observed are prevalent.

Examples of conditions which pose a risk to health, safety, welfare, security, and rights of residents include, but are not limited to:

- structural defects

MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES

USE OF SANCTIONS

- construction or repairs resulting in an unsafe environment
- the presence of noxious substances
- conditions which would prevent quick exit in case of an emergency
- extremes of temperature
- factors preventing appropriate hygiene/sanitary conditions
- insufficient staff to care for residents
- lack of necessary equipment/supplies, e.g. food

***Note:** In some cases, admissions to a facility may be suspended in agreement with the operator. Examples of this could include a facility undergoing renovations or instances of an outbreak. These are measures designed to protect residents and will not be considered a sanction.*

PROCESS

Ministry staff observe these conditions while:

- monitoring and evaluating facility performance
- investigating a complaint

Ministry staff will inform the facility verbally and in writing of the non-compliance, specifying the conditions observed and the applicable Act and Regulations, or the terms and conditions of the service agreement, including the Standards and Criteria and Policies included in the Long-Term Care Facilities Program Manual, that have been breached.

MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES

USE OF SANCTIONS

Note: This written notice should not be confused with a written statement of unmet standards or expectations which is left with the facility following the completion of a review.

The Area/Regional Office Manager notifies the Director of the conditions observed and the recommendation for suspension of admissions. The Director will direct the local Placement Coordination Service to suspend admissions to the facility. A copy of this notice will be sent to the facility.

The Ministry's written notice of suspension of admissions is posted in a prominent place in the facility lobby, to inform residents, their representatives and the community.

Ministry staff will continue to work with the facility to support the achievement of compliance so that admissions can resume.

If corrective action is not initiated promptly, the Ministry's Senior Management staff may review whether other sanctions are warranted.

TERMS

Suspension of admissions to a licensed facility may be a temporary procedure pending appropriate corrective action taken by the facility.

Restoration of admissions may be permanent or temporary, contingent on:

- past record of the operator in taking corrective action
- degree of corrective action completed
- whether the suspension was applied due to negligence or carelessness on the part of the facility.

MONITORING AND EVALUATION OF CARE, PROGRAMS, AND SERVICES
USE OF SANCTIONS

SCOPE OF AUTHORITY

The Placement Coordination Service may suspend admissions of a licensed/approved facility on the direction of the Director for the time period necessary to achieve correction of the identified problems.

The Director may direct the facility to resume admissions after a review has been carried out to determine if the identified problems have been addressed.

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TAB 99 APPENDIX

SECTION		SUBJECT	DATE OF AMENDMENT
9901	01	GLOSSARY	January 2007
9902	01	FORMS	20 December 1993
	02	NEW FORMS	20 December 1993
	03	FORMS CURRENTLY RETAINED	20 December 1993
	04	MCSS FORMS WITH CONTINUED USAGE	20 December 1993
	05	FORMS NO LONGER IN USE	20 December 1993

**APPENDIX
GLOSSARY**

ACTIVITIES OF DAILY LIVING	Activities of daily living is a term which includes all the routines which a resident engages in daily to meet his/her basic needs,(e.g., eating, walking, use of the toilet, bathing, grooming).
ADVOCACY	Advocacy is a system, which is designed to support and assist a resident to express his/her wishes, to understand his/her rights, and to facilitate his/her access to services which are required.
ASSESSMENT	Assessment involves systematically collecting information gathered from all available sources (including the resident and his/her representative) and evaluating the information in order to develop a plan of care.
ASSISTIVE DEVICES	Assistive devices are equipment which assist residents to maintain or increase independence in activities of daily living.
ATTENDING PHYSICIAN	An attending physician is the physician of record with the responsibility to provide care to individual residents within one or more than one facility. The resident should always have a choice of attending physician providing the physician is willing to meet the facility's standards for medical services in place at the time.
BIOLOGICALS	Biologicals are drugs listed in Schedule D of the Food and Drug Act. Examples include: vaccines, insulin, glucagon.
CAREGIVER	Caregivers are family members (including non-traditional partners), friends or volunteers who assume responsibility for all or part of the care and/or supervision of an individual, including assistance with activities of daily living, instrumental activities of daily living, and/or providing health care services.
CRITERIA	Criteria identify elements of care and services which contribute to the achievement of standards. Along with standards, criteria are requirements which are monitored as part of the provincial accountability management program.
DIAGNOSTIC SERVICES	Diagnostic services include laboratory tests or diagnostic x-rays which assist the health care team to establish or monitor health status.
DISASTER: EXTERNAL	An external disaster is a major disaster outside the facility's control with the potential of causing disruption to the operation of the facility. (Examples include severe bad weather, disasters in the community, environmental disasters.)

**APPENDIX
GLOSSARY**

DISASTER: INTERNAL	An internal disaster is a situation within the facility requiring partial or complete evacuation of the facility, or requiring contingency plans to maintain residents' health and safety. (Examples include missing residents, bomb threats, loss of essential services, service disruption.)
EMPOWERMENT	Empowerment is the process of assisting an individual to gain and exercise control over choices affecting all aspects of his/her life.
EVALUATION	Evaluation is the determination of the extent to which actions have been successful in achieving predetermined objectives. It involves measures of adequacy, effectiveness and efficiency.
FOOD HANDLING STAFF	Food handling staff are cooks, dietary aides and other individuals employed in the preparation and cooking of food and in the cleaning of kitchen equipment but does not include time spent by: <ol style="list-style-type: none"> a) persons performing food supervisory duties; b) dietitians in the performance of their duties; c) nursing and personal care staff in assisting residents with meals.
FOOD SAFETY AWARENESS PROGRAM	<p>^{NEW} > The Food Safety Awareness program offered by the Public Health unit is usually 1-2 days in length. The content of this program is specific to food safety. The LTC Homes Program Manual states: "Facility Staff involved in food preparation or service shall participate in a food safety awareness program, offered by the board of health" (P1.11) Those LTC staff that must take this program include:</p> <ul style="list-style-type: none"> • All Nutrition and Food Services/Dietary Department staff • Staff from other departments who assist in plating or garnishing food • Staff from other departments who may be involved in resident programs where food preparation is a component. <p>*Note: This Food Safety Awareness Program does not meet the Ministry expectations with respect to the FSW training programs.</p>

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GLOSSARY

**FOOD SERVICE
WORKER**

NEW > A Food Service Worker is an employee in the Nutrition and Food Services / Dietary Department and is involved in the preparation of and handling of food within a LTC Home.

The term Food Service Worker is synonymous with Food Handler, Dietary Aide and Kitchen Aide.

The FSW is recognized as an integral member of the LTC Home interdisciplinary team, and as such, is expected to be accountable for their responsibilities in terms of delivery of quality nutrition care and food and beverage service to residents of LTC Homes in Ontario.

The FSW is normally expected to participate in some or all of the following activities:

- Preparing and delivering food and beverages according to each resident's assessed needs;
- Plating and garnishing food at the point of service;
- Conducting tasks designed to monitor safety and sanitation of prepared food;
- Conducting tasks related to ensuring the safety and sanitation of equipment used for meal preparation, delivery and service;
- Receiving, storing and managing the inventory of food and food service supplies;
- Communicating with other members of the interdisciplinary care team and LTC Homes residents regarding food service and nutritional care issues/concerns
- Demonstrate an understanding of and ability to follow therapeutic and texture modified menus
- Demonstrate an understanding of and ability to follow residents' care plans including dietary preferences, needs and safety requirements
- Cooking and/or finishing and/or texture-modifying products in accordance with standardized recipes and production guidelines
- Recognizing and understanding the importance of dining for the residents so as to ensure that dining is consistently provided in a quality manner
- Conducting quality audits related to meal service/dining

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FOOD SERVICE WORKER TRAINING PROGRAM

NEW > The Food Service Worker training program is a college level course, usually consisting of 180 hours, and presented in 5-6 modules. This program educates students in the skill sets, and knowledge required by a FSW in a LTC Home. Most students complete the modules over a period of 1-3 years. It is important to note that the Food Safety Awareness program offered by the Public Health units, does NOT meet the Ministry expectations with respect to the FSW training requirements. The Food Safety Awareness program usually 1-2 days in length, and is not equivalent to the FSW training program. The content of Food Safety Awareness program is specific to food safety.

GOALS

Goals are broad statements describing desired outcomes of the care/support and services provided. Goals support the statement of purpose of the facility and they are the means through which the mission of the facility is attained.

GOVERNING BODY

Governing body refers to those with ultimate authority and responsibility for the overall operation of the long-term care facility.

GUIDELINES

Guidelines provide explanatory detail related to standards and/or criteria. They are intended to provide guidance and resource to long-term care facilities as they attempt to operationalize the standards and criteria. Guidelines are not part of the provincial accountability management program.

HEALTH

Health is an optimal state of physical, intellectual, emotional, social and spiritual well-being and not merely the absence of disease and infirmity. "...the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs; and on the other hand, to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living; it is a positive concept emphasizing social and personal resources, as well as physical capacities." (World Health Organization, 1984).

HEALTH PROMOTION

Health promotion is "The process of enabling people to increase control over, and to improve their health." (WHO. "Ottawa Charter for Health Promotion." Canadian Journal of Public Health. 77:6, 1986)

INTERDISCIPLINARY

An interdisciplinary process brings together a group of people

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PROCESS	from various disciplines for the purposes of a group approach to assessment, planning, implementation, monitoring and evaluation of care/support and services. The interdisciplinary team is responsible for developing and reviewing each resident's plan of care.
LAWFULLY AUTHORIZED PERSON	The "lawfully authorized person" refers to the person who under the Long-Term Care Statutes Law Amendment Act, 1993, is lawfully authorized to make decisions on behalf of the resident regarding personal care. This is separate from the Resident/Representative (see Glossary: Resident/Representative).
LONG-TERM CARE FACILITY	A long-term care facility is a facility that provides long-term care on a 24-hour basis to individuals whose needs can no longer be met in the community. Long-term care facilities include all existing nursing homes and homes for the aged.
MEAL DAY	A meal day includes the combined total of resident meal days and non-resident meal days. Non-Resident Meal Day: means the total number of meals that a facility prepares for non-residents' meals and nourishments divided by 3. Resident Meal Day: means the daily food materials that a facility prepares for residents' meals and nourishments. For calculation purposes, one resident meal day is equivalent to one eligible resident day.
MEDICAL DIRECTOR	A medical director is a physician who provides the clinical and administrative direction for the medical services of the facility. The medical director may also be an attending physician.
OBJECTIVE	Objectives are realistic and measurable steps taken to achieve identified goals. Objectives are written for the overall service and for each unit/division within the service.
OPTIMUM	"Optimum" refers to the best possible outcome that can be achieved in given circumstances with available resources.

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PEER ASSESSMENT (MEDICAL)	Medical peer assessment is that process whereby the care provided by physicians is subject to review by a second physician chosen to do this because of the experience this assessor brings to the situation. The process also includes a strong educational component both in the structured review and any remedial endeavour that might result.
PHILOSOPHY	A philosophy is a statement of beliefs that directs individuals in a facility or service in achieving the purpose of the facility.
POLICY	A policy is a written statement, which clearly indicates the position of a facility on an issue.
PROCEDURE	A procedure is a written set of instructions to achieve a given task. A procedure may form a standard against which to evaluate the performance of that task. A principle is a reason, a general truth, a base on which standards are founded or derived.
RED SEAL CERTIFIED COOK	^{NEW} > Red Seal certified cooks are cooks that have attained <i>Interprovincial Standards Red Seal</i> Program status. Through this program, cooks who have completed their training and certified journeypersons, are able to obtain a "Red Seal" endorsement on their Certificates of Qualification and Apprenticeship by successfully completing an Interprovincial Standards Examination
RESIDENT/ REPRESENTATIVE	A representative is a person who assists the resident in expressing his/her wishes and understanding his/her rights; a representative can be a family member or friend designated by the resident. The representative is separate from the "lawfully authorized person" (see Glossary: Lawfully Authorized Person).
RESTORATIVE CARE	Restorative care is defined as an interdisciplinary approach to care provision which is designed to assist the resident to maximize his/her remaining strengths and abilities in order to attain/maintain the maximum level of functioning possible and/or desired by the resident.
STANDARDS	Standards set out performance or achievement expectations in the provision of care, support and services to residents. Standards are made observable/understandable/measurable through the use of criteria.
RESTRAINT:	A pharmaceutical given with the specific purpose of inhibiting or

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CHEMICAL	controlling behaviour or movement. Differentiating between the use of a drug, a therapeutic agent or a restraint is difficult. Often a drug may be used for both purposes. When a drug is used to treat "clear cut" psychiatric symptoms rather than socially disruptive behaviours, it should not be considered a restraint. (<u>The Use of Restraints and Alternatives in Long-Term Care Facilities</u> . Vol. 2: Ontario Association of Non-Profit Homes and Services for Seniors)
RESTRAINT: ENVIRONMENTAL	A barrier to free personal movement which serve to confine residents to specific (geographic) areas. (<u>The Use of Restraints and Alternatives in Long-Term Care Facilities</u> . Vol. 2: Ontario Association of Non-Profit Homes and Services for Seniors)
RESTRAINT: PHYSICAL	An appliance or apparatus that inhibits general movement. Included in this definition are: <ul style="list-style-type: none"> • Jackets and vest restraints; • Geriatric chairs or wheelchairs with tabletops in place; • Roller bars on wheelchairs; and • lap belts if they are applied in such a fashion that the seat belt opening is placed at the back of the chair and the seat belt cannot be undone by the resident. <p>Devices which are not defined as restraints include:</p> <ul style="list-style-type: none"> • devices for positioning or limb support; and • bed rails.
RISK MANAGEMENT	Risk management activities are coordinated, comprehensive strategies designed to reduce and control actual or potential risks to the safety, security, welfare and health of individuals or to the safety and security of the facility.
STUDENTS (WORKING IN NUTRITION AND FOOD SERVICES/DIETARY DEPARTMENT)	^{NEW >} A student is an individual who is attending secondary school, College, or University, who is working part time in the Nutrition and Food Services/ Dietary Department, and anticipates moving to an alternate career path once his/her school program has been completed.
WORKPLACE HAZARDOUS	WHMIS is a national communication system developed by labour, industry and federal/provincial governments to ensure the

APPENDIX

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**MATERIALS
INFORMATION SYSTEM
(WHMIS)**

provision of information on hazardous materials to all employees in the workplace.

APPENDIX

FORMS

INTRODUCTION

As the Homes for the Aged Programs and the Nursing Homes Program developed within the Ministry of Community and Social Services and the Ministry of Health various forms were created both for the use of facilities and for the use of Ministry staff.

There have been a number of changes to forms as new funding models and accountability mechanisms have been introduced into the Long-Term Care Facility Program and this section of the manual lists the new forms that will be used in the program, those that have been replaced or are obsolete as well as those that will be retained for the present and may still be used.

These forms may be obtained from the Area or Regional Office who will order them from the Ministry of Health Stockroom.

In general, forms for capital are generic forms of the Ministry of Community and Social Services and will continue to be used on an interim basis. Area and Regional Office will be able to obtain these forms from the Ministry of Community and Social Services Distribution Centre.

APPENDIX**FORMS****NEW FORMS**

The following forms have been developed for the implementation of new funding models and accountability mechanisms.

Unless otherwise noted, these forms will be used in all long-term care facilities.

TITLE	FORM NUMBER
Resident Classification System for Long-Term Care Facilities	1882-61
Application for Long-Term Care Facility Reduction in Accommodation Fees for Basic Accommodation	2304-69
Demande de réduction des tarifs d'hébergement avec services de base - établissements de soins de longue durée	2856-69
Long-Term Care Staffing Schedule	2605-69
Annexe sur la dotation en personnel pour un établissement de soins de longue durée	2876-69
In-Depth Review of Resident Care	2441-52
Indicator Analysis	2442-52
Focused Audit	2444-52
Programs and Services Review	2443-52
Long-Term Care Facility Service Agreement	2615-69

APPENDIX**FORMS****NEW FORMS**

Entente de service pour les établissements de soins de longue durée	2879-69
Application for Supplementary Accommodation Funding; Demande d'aide supplémentaire pour les établissements	2616-69
Long-Term Care Facility	2380-69
Program Description Description des programmes des établissements de soins de longue durée	2440-69
Profile of Long-Term Care Facility; Profil de l'établissement de soins de longue durée	2308-69
Long-Term Care Facility Quarterly Report Level of Care Funding	2612-69
Rapport trimestriel d'un établissement de soins de longue durée Financement selon le niveau de soins	2877-69
Long-Term Care Facility Quarterly Report Red-Circle Funding	2613-69
Rapport trimestriel d'un établissement de soins de longue durée Financement quotidien bloqué	2878-69
Subsidy Calculation Worksheet Approved Charitable Homes for the Aged	2602-69

APPENDIX**FORMS****NEW FORMS**

Feuille de calcul de subvention pour les établissements de longue durée Document budgétaire pour les foyers de bienfaisance agréés pour personnes âgées	2873-69
Subsidy Calculation Worksheet Municipal Homes for the Aged	2603-69
Feuille de calcul de subvention pour les établissements de longue durée Document budgétaire pour les foyers municipaux pour personnes âgées	2875-69
Subsidy Calculation Worksheet Nursing Homes	2601-69
Feuille de calcul de subvention pour les établissements de longue durée Document budgétaire pour les maisons de soins infirmiers	2872-69
Unusual Occurrence Report; Rapport d'événement insuité	2309-69
Long-Term Care Facility Occupancy Report; Rapport sur le taux d'occupation d'un établissement de soins longue durée	2387-69
Long-Term Care Facility Revenue/Occupancy Report; Rapport sur le taux d'occupation et les revenus d'un établissement de soins longue durée	2388-69
Long-Term Care Facility Accommodation Staffing Report	2880-69

APPENDIX**FORMS****FORMS CURRENTLY RETAINED**

The following forms will be retained for the present time, however it is recognized that many will be changed or replaced and may currently have limited usage by either the facilities or Ministry staff.

These forms are categorized within the originating Program.

HOMES FOR THE AGED PROGRAMS

TITLE	FORM NUMBER
Health Assessment/Appl. to Admit - Form 2; Formule d'évaluation de L'état de santé	2867-69
Consent to Inspect Assets - Form 3; Consentement à la vérification des avoirs	2870-69
Home Physician's Certificate - Form 4; Certificat du médecin du foyer	2871-69
Five Year Medical Record - Form 5	2798-69
Rapport médical quinquennal	2805-69
Report on Inspection of Private Residence - Form 11	2799-69
Request for Approval re-salary; Demande d'approbation de salaire	2801-69
Request for Approval - Operating Expenditure	2802-69
Financial Statement - Revenue/Expenditures	2818-69

APPENDIX**FORMS****FORMS CURRENTLY RETAINED**

Application for Payment of Capital Grant - Form 2	2824-69
Appendix to Application For Final Payment (Municipal Homes)	2854-69
Repairs and Replacement Forecast Schedule	2829-69
Allocated Administration Costs Schedule	2830-69
FIPPA Notice	2848-69
Client Requisition	6859-93
Approved Non-Prescription Drugs Requisition	3060-47
Surplus Prescribed Drug Form	5586-47

NURSING HOME PROGRAM

TITLE	FORM NUMBER
Observations/Discussion (P. 1)	1613-52
Application For License to Establish	1668-52
Nursing Home License; Permis d'exploitation de maison de soins infirmiers	1669-52
Observations/Discussion (P. 2)	1739-52
Compliance Review Findings (P. 1) Resultats de l'inspection de conformité	2088-52

APPENDIX**FORMS****FORMS CURRENTLY RETAINED**

Compliance Review Plan	2112-52
Compliance Review Report; Rapport d'inspection de conformité	2540-52
Compliance Review Findings (P. 2); Resultats de l'inspection de conformité	2560-52
Compliance Plans; Plans de conformité	2611-52
Appointment; Nomination	3986-52
Invoice/Facture (Fee to Establish)	4712-93
Staff Time Summary	6549-52

APPENDIX**FORMS****MCSS FORMS WITH CONTINUED USAGE**

There are a number of forms that are used in the facility program that are generic forms of the Ministry of Community and Social Services and will not be transferred to the Ministry of Health. The use of these forms will continue until they are replaced by the Ministry of Health.

TITLE	FORM NUMBER
Notification - Budget Approval for Other than a Major Building Project	0305
Application For Payment Of Capital Financial Assistance For other than a Major Building Project	0361
Monthly Progress Report - Project Status And Cash Flow Projections	0365
Request For Approval - Major Capital Assistance	0366
Appendix To Application For Final Payment (Charitable Homes)	0367
Annual Budget, Capital Expenditures for other than a Major Building Project	0369
Application for Payment of a Major Capital Grant	0370

APPENDIX**FORMS****FORMS NO LONGER IN USE**

The following forms have been replaced or have become obsolete.

HOMES FOR THE AGED PROGRAMS

TITLE	FORM NUMBER
Application to Admit a Person to a Home Demande d'admission dans un foyer pour personnes âgées	0879 2800-69
Financial Report - Form 7 Rapport Financier	0885 0857
Application for Monthly Payment of Provincial Subsidy - Form 8 (Operating subsidy) Demande de Versement Mensuel	0886 0851
Summary of Statistics	0890
Operating Expenditure Worksheet	0891
Satellite Homes Statistics	0892
Expenditure Approval Referral	0895
Inventory Form	0896
Expenditures Ledger	0897
Revenue Ledger	0898
Operating Revenue Worksheet	0899
Operating Expenditure Analysis	0905

APPENDIX**FORMS****FORMS NO LONGER IN USE**

Confidential Salary Schedule	0907
Certificate - Adjuvant Training	0911
Certificate - Residents Council	0912
Unusual Incident Report; Rapport d'incident inhabituel	0913
Financial Statement - Revenue/Expenditures Etat des recettes et des dépenses	0922
Application for Monthly Payment of Provincial Subsidy - Form 4A - Homes for the Aged - Charitable	0930
Worksheet - Charitable Homes for the Aged	1667
Worksheet - Municipal Homes for the Aged	1668
Subsidy Calculation Worksheet - Charitable; Feuille de travail pour le calcul d'une subvention/Foyers de bienfaisance	1689
Subsidy Calculation Worksheet - Municipal	1690
Accumulative Quarterly Financial Report	1977
Extended Care: Request for Approval for Preferred Accommodation	unnumbered
Environmental Checklist	unnumbered
Extended Care: Request for Approval for Preferred Accommodation	unnumbered

APPENDIX**FORMS****FORMS NO LONGER IN USE****NURSING HOME PROGRAM**

TITLE	FORM NUMBER
Incident Report	2059-52
Quality of Care and Services Review - Annual	2086-52
Resident Care Needs Assessment	2087-52
Nursing Home Profile	2106-52
Resident Risk Profile	2107-52E
Profil des risques pour le pensionnaire	2107-52F
Residents Selected for Quality Care Review	2110-52
Statement of Revenue and Expenditure (Form 7); Etat des recettes et dépenses	2302-52
Resident Census; Recensement des pensionnaires	2465-52
Care and Services Review: Indicator Analysis	3621-52
Check List: Indicators of Risk or Negative Outcome	3660-52
Care & Services Review - Follow-up	3860-52
Leave of Absence Record	3914-52
Resident Classification	3989-52
Equipment and Supplies Checklist	3990-52
Care and Services Review	unnumbered

APPENDIX

FORMS

FORMS NO LONGER IN USE

Recommendations Following Inspection	7619-52
Weekly Staffing Table	unnumbered
Weekly Time Sheet	unnumbered
Staffing - D (Deployment)	unnumbered
Staffing - B (Weekly)	unnumbered
Areas of Non-Compliance; Infractions	7618-52