

- *Small Option Homes* provide support and supervision for three or less seniors in a purchased or rented unit. The home assists the resident in the development of self-care skills. Trained staff are available on site at all times.

3.3 Homes for Special Care

3.3.1 Homes for Special Care are licensed by the Department of Health and Wellness pursuant to the *Homes for Special Care Act* and *Regulations*. Licensed Homes for Special Care fall into one of the following categories:

- *Residential Care Facilities* (RCF) provide supervisory care and/or personal care in a residential setting to four or more persons. Trained staff is available on site at all times.
- *Nursing Homes or Homes for the Aged*, hereinafter referred to as nursing homes, provide personal and/or skilled nursing care in a residential setting to individuals who require the availability of a registered nurse on-site at all times.

4.0 GENERAL ELIGIBILITY

4.1 An application for long term care facility admission may be made by a person who:

- (a) is lawfully entitled to be or to remain in Canada;
- (b) makes the person's home and is ordinarily resident in Nova Scotia;
- (c) meets the eligibility requirement for Nova Scotia's Health Insurance Plan (i.e. the person has been issued a valid Nova Scotia Health Card with an effective date which precedes the date of the individual's Long Term Care Facility Financial Application); and
- (d) is 18 years of age or older.

Persons 18 years of age or younger, or their authorized representative, may apply for admission to specialized long term care facilities for children.

4.2 If a person does not meet the requirements outlined in either section **4.1 (b) or (c)** above, an application may be made to the Minister or designate to have one or both of these requirements waived under the following exceptional circumstances:

- The person is residing in Nova Scotia and has made Nova Scotia their permanent home and does not yet have a valid Nova Scotia Health Card, or
- The person is a resident of another province and, for care reasons, it is not feasible to establish Nova Scotia residency prior to admission, and:
 - the person was a resident of Nova Scotia for a total of thirty (30) or more years and wishes to return to Nova Scotia to be close to family and friends, or
 - the applicant wishes to live close to his/her family supports.

Persons seeking more information on the exception request process may contact the Continuing Care Intake Office at 1-800-225-7225 or 902-424-6090.

4.3 Persons who are granted exceptional status, and who are admitted to a long term care facility under the provisions of Section 4.2, shall be responsible to :

- pay the full “facility per diem rate”, including health and accommodation costs, until the person becomes eligible for Nova Scotia Health Insurance coverage and the Department of Health and Wellness issues a Notice of Authorized Charge;
- ensure adequate financial coverage of all physician, hospital, and prescription drug expenses is in place, until becoming eligible for Nova Scotia Health Insurance and Nova Scotia Pharmacare;
- have sufficient funds to cover items of personal need such as scheduled or emergency local transportation, dental services, eyeglasses, hearing aids and any other required devices or equipment, and
- cover any and all transportation costs related to relocating for admission to the long term care facility

4.4 The person or their representative must apply for long term care services through the Department of Health and Wellness’s Single Entry Access.

4.5 Before being considered for placement in a long term care facility, an applicant must undergo:

- a comprehensive assessment to determine the type and level of care required; and
- a financial application process to determine the applicable accommodation charge for long term care services.

- 4.6 The options for placement in any particular long term care facility are determined in accordance with the level(s) of care the facility is licensed or approved to provide by the Department of Health and Wellness.

5.0 ELIGIBILITY DETERMINATION PROCESS

5.1 Referral/Intake

- 5.1.1 Referral is the initial screening process to gather the information necessary to determine whether the individual's request is appropriate for assessment for home care or for long term care placement.
- 5.1.2 A referral may be accepted from the individual or any person acting on the individual's behalf.
- 5.1.3 Where an individual is competent and refuses to give permission for the referral for intake, the Care Coordinator or the Continuing Care Referral Assistant shall not accept the referral.
- 5.1.4 If a Care Coordinator has information that an individual may be an "adult in need of protection" as defined by the *Adult Protection Act*, the Care Coordinator or the Continuing Care Referral Assistant shall report the situation to Adult Protection Services.

5.2 Functional Assessment

- 5.2.1 The individual must be willing to participate in a functional assessment (*Minimum Data Set – Home Care, MDS-HOME CARE*) prior to consideration of eligibility for the services available under Continuing Care. This process includes assessment of the person's functional, health, and social situation; and the completion of a financial application.
- 5.2.2 The purpose of the functional assessment is to determine unmet needs and to recommend an appropriate program for the individual using the most cost effective and least intrusive service plan.
- 5.2.3 The applicant must obtain and provide a Medical Status Report ninety days prior to admission to a long term care facility.

5.3 Care Level Recommendation

- 5.3.1 If, in the professional judgment of the Care Coordinator, the applicant's needs would be most appropriately met through placement to a long term care facility, the Care Coordinator shall make a recommendation with respect to an appropriate level of care, to the relevant care level determination authority, as defined in Section 3.1 of the *Facility Placement Policy*.

Care Coordinators are to recommend one of the following three options when forwarding an application for care level determination:

1. Deny application
2. RCF/CBO level care
3. Nursing home level care

5.4 Care Level Decisions

- 5.4.1 The care level determination authority shall review and interpret the application and assessment documentation and make one of the following decisions. The decision shall be documented on a *Form C-Care Level Decision For Long Term Care Facility Admissions* form.

- Deferred - Where there is insufficient information to reach a decision, the application will be deferred until additional information is available.
- Denied - If the applicant's care needs are too low or go beyond what a Department of Health and Wellness licensed or approved long term care facility can accommodate, the application is denied.
- RCF - The care needs of the applicant are consistent with the admission criteria for the category of licensed Residential Care Facility or approved Community Based Option. Generally, care is required by a person: who has decreased physical and/or mental abilities and who primarily requires supervision and/or assistance with activities of daily living and provision for meeting psycho-social needs through social and recreational services.
- Nursing Home Level 2 (NH2) - The care needs of the applicant are consistent with the admission criteria for the category of Department of Health and Wellness licensed nursing home. Generally, care is required by a person: with a relatively stabilized (physical or mental) chronic disease or functional disability, whose condition is not likely to change in the near future; and who requires the availability of personal care on a continuing 24 hours basis, with medical and professional nursing supervision and provision for meeting psycho-social needs.

- Nursing Home Level 1 (NH1) – Similar to NH2. The distinction between Level 1 or Level 2 depends on the degree and intensity of care and assistance required by the individual.

5.5 Eligibility Guidelines

The following are written as exclusionary criteria, outlining circumstances under which persons are generally **not eligible** to be admitted to Department of Health and Wellness licensed or approved facilities.

5.5.1 All Department of Health and Wellness Long Term Care Facilities

Individuals are not eligible for admission to Nursing Home, RCF or CBO facilities if they:

- have physical or mental illness that is not stabilized (e.g. daily medication orders, Cheyne-Stokes respirations, etc.);
- are likely to expire in the next 5 to 7 days;
- exhibit serious behavioral problems, and who might be harmful to themselves and/or others and destructive to property;
- are in acute withdrawal from substance abuse or are active substance abusers;
- are persons with communicable diseases/viral infections, which are still infectious. Exceptions to this restriction include applicants with anti-microbial resistant micro-organisms identified within the Department of Health and Wellness's *Partners For Infection Control Committee Guidelines*, (e.g. MRSA, C-Difficile, VRE). In addition, persons diagnosed with HIV or Hepatitis would be considered for admission. Long term care facilities must adhere to applicable guidelines established by Partners For Infection Control.
- have treatment needs that are not covered by Acute Home Care and which fall outside the mandate of the long term care providers (e.g. extensive dressings in which cost and frequency of nursing care are a factor.)
- have great physical difficulty in swallowing and who are at risk of aspiration, with or without food or drink.
- take their nutritional requirements other than by mouth, by gastrostomy or jejunostomy (e.g. Naso-gastric tube, TPN or IV);

- have inadequate nutritional intake. Applicants must have 800-1000cc per 24-hour period. IV should be discontinued for 2 days prior to classification to ensure this intake has stabilized. Special consideration will be given to palliative care applicants.
- have been placed on a new medication or whose medications have been significantly adjusted without sufficient time to monitor effectiveness or to ensure a therapeutic blood level where appropriate (e.g. psychiatric medications, cardiac medications, anti-convulsive medications, pain medications);
- require blood work more than 3 times a week. Exceptions may occur depending on the admission status of the applicant, the reason for and duration of the blood work required and accessibility to service within the community;
- have retention sutures. Following extensive surgery it is recommended that a classification officer or a nursing representative see the long term care applicant before classification;
- require continuous bladder irrigation;
- do not appear to require the service;
- in the opinion of care level determination authority, are not appropriate for admission to a long term care facility.

5.5.2 Residential Care Facilities and Community Based Options

5.5.2.1 Individuals are **not eligible** for admission to RCF or CBO facilities if they:

- require the services of a Registered Nurse (e.g. ongoing professional nursing assessment and care).
- cannot ambulate on their own (with or without the assistance of a cane, wheelchair, or walker).
- do not have the physical or cognitive ability to evacuate independently, in the event of an emergency (may use devices if necessary).
- require more than 1.5 hours of care of one-on-one care for supervision or assistance with activities of daily living.
- are consistently confused or an elopement risk.

- require complete assistance with activities of daily living due to confusion and/or physical impairment.

5.5.2.2 Individuals may be considered for admission to RCF or CBO facilities, in the following circumstances. Applications will be reviewed on an individual basis by the care level determination authority.

- applicants who require an indwelling catheter;
- applicants who are insulin dependent diabetics;
- applicants who require wound management care (dressing).

5.6 Placement

5.6.1 The *Form C- Care Level Decision for Long Term Care Facility Admissions* form is provided to the Placement Coordination Office and the applicant's Care Coordinator. The applicant is informed by the Care Coordinator of the care level decision.

5.6.2 If the care level decision is "NH2" or "NH1", the applicant may be placed to a nursing home that is suitable to meet the applicant's specific care needs. If the care level decision is "RCF", the applicant may be placed to a residential care facility or community based option that is suitable to meet the applicant's specific care needs.

5.6.3 The Care Coordinator informs the Placement Coordination Office of the applicant's specific care needs (e.g. dementia care, etc.) and facility preferences. The Placement Coordination Office arranges admission in accordance with Continuing Care's *Facility Placement Policy*. Placement ensures that care needs are met first and, where possible, facility preferences are accommodated.

6.0 **TEMPORARY ABSENCES**

6.1 A long term care facility may approve the holding of a resident's bed to allow the resident to visit family for a period generally not to exceed 30 days per year.

6.2 At the request of the resident or authorized representative, a long term care facility may approve the holding of a resident's bed when a resident is transferred to a health care facility if, based on the resident's prognosis, the resident is expected to return to the facility within thirty days.

- 6.3 For residents transferred to a health care facility, a resident's long term care bed may be held for longer than thirty days if:
- the facility provides the resident's Care Coordinator a written prognosis explaining the need for an absence beyond 30 days; and
 - the Care Coordinator forwards the written request and supporting documentation to the Supervisor for approval.

6.4 The resident will be responsible for the accommodation charges during their absence from the facility. Beds held in accordance with this policy shall not be used during the resident's absence.

7.0 TRANSFERS

7.1 Movement of a resident from one category of facility or level of care to a different category of facility or level of care is considered a new placement, not a transfer. In such instances, a new application shall be completed.

7.2 Additional information on transfers may be found in Continuing Care's *Facility Placement Policy*.

8.0 CHANGE IN RESIDENT CARE NEEDS

8.1 If a long term care facility operator finds that a resident's care needs can no longer be safely met at the long term care facility, he/she shall work with the resident, the resident's family, Continuing Care staff and the resident's physician to secure appropriate care arrangements at an alternative setting.

8.2 If a long term care facility operator or the Department of Health and Wellness facility inspector suspects that a resident does not meet the Department of Health and Wellness's admission criteria, but believes that the facility can continue to provide safe and appropriate care to the resident, he or she shall report this situation to the Director, Monitoring and Evaluation, Continuing Care Branch, who shall:

- ensure that an assessment of the resident is conducted by the appropriate health professionals;
- determine, in collaboration with the facility operator, the facility's capacity to serve the client; and

- provide direction to the facility operator on the appropriate action to be taken. This may or may not include the relocation of the resident to another long term care facility more appropriate to meet the resident's care needs.