

3.04—Long-Term Care Facilities Activity

BACKGROUND

Long-term-care facilities provide care and services to individuals who are unable to live independently at home and who require the availability of round-the-clock nursing services to meet their daily nursing and personal care needs. These facilities comprise nursing homes and homes for the aged. They operate under the authority of the *Nursing Homes Act*, the *Homes for the Aged and Rest Homes Act*, and the *Charitable Institutions Act*. These acts and their regulations specify the requirements for admission, the care to be provided to residents, the rights of residents, the responsibilities of the facility, and the obligations of the Ministry. Rest and retirement homes, which may provide care, including assistance with daily living activities as well as nursing care, do not receive ministry funding and are not covered by these three acts.

In each act, the stated fundamental principle to be applied is that each long-term-care facility “is primarily the home of its residents and as such it is to be operated in such a way that the physical, psychological, social, cultural, and spiritual needs of each of its residents are adequately met and that its residents are given the opportunity to contribute, in accordance with their ability, to the physical, psychological, social, cultural, and spiritual needs of others.”

Admissions to long-term-care facilities are arranged by placement co-ordinators designated by the Minister. In determining eligibility for admission, a placement co-ordinator takes into account an assessment made by a health practitioner relating to a person’s impairment or capacity and an assessment of information relating to the person’s requirements for medical treatment, health care, or other personal care.

The Ministry’s key responsibility regarding the operations of long-term-care facilities is to ensure that they are delivering services to residents in accordance with their service agreements with the Ministry and in compliance with applicable legislation and ministry policies. Ministry oversight for long-term-care facilities is carried out through the Ministry’s seven regional offices. Funding for the Long-Term Care Facilities Activity is provided through the Ministry’s Integrated Health Care Program.

In 1998, the government announced an eight-year plan to provide 20,000 new long-term-care beds and to renovate structurally non-compliant facilities containing 13,583 long-term-care beds. In March 1999, the government announced that the 20,000 new beds would be completed by 2004. With respect to structurally non-compliant facilities to be renovated by 2006, the number of beds was later revised to 15,835. In early 2000, the Ministry established a Long-Term Care Redevelopment Project office to undertake operational responsibility for the plan.

Funding for long-term-care facilities is provided through four distinct per diems (funding envelopes). The daily rate for each is set by regulation. As at March 31, 2002, the per diem rates for residents of long-term-care facilities who required an average level of care were as outlined in the following table.

**Per Diems for Long-Term-Care Residents
Requiring an Average Level of Care,
as at March 31, 2002**

Funding Envelope	Per Diem (\$)
Nursing and personal care	52.38
Program and support services	5.24
Raw food	4.49
Other accommodation costs*	40.21
Total	102.32

* Facility costs, including administration, housekeeping, building and operational maintenance, and dietary and laundry services.

Source of data: Ministry of Health and Long-Term Care

The per diems are the same for all facilities, except for the nursing and personal care rate, which is based on an assessed level of care for each resident living in a facility.

Residents make co-payments for their accommodation and food. The maximum daily rate paid by the resident for basic accommodation is \$44.51. Residents in basic accommodation who do not have sufficient income to pay the maximum rate can apply for a rate reduction. The amount of the reduction is dependent on the resident's income. Facilities are allowed to reduce the basic accommodation rate to \$30.24 per day without obtaining ministry authorization. Any further reductions require ministry approval.

If a resident pays less than the basic rate, the Ministry makes up the difference, so that the facility receives the full \$44.51. A long-term-care facility can also charge residents an additional \$8 for a semi-private room and \$18 for a private room. Residents in semi-private and private rooms must pay the full basic accommodation rate in addition to the applicable premium.

As of March 2002, there were approximately 60,000 residents in 558 long-term-care facilities. For the 2001/02 fiscal year, long-term-care facilities received approximately \$1.6 billion in funding from the Ministry and approximately \$793 million in accommodation charges from residents.

AUDIT OBJECTIVES AND SCOPE

The objectives of our audit of the Long-Term Care Facilities Activity were to assess whether the Ministry had adequate procedures in place to:

- ensure that resources were managed with due regard for economy and efficiency;
- ensure that facilities providing long-term-care were complying with applicable legislation and ministry policies; and
- measure and report on the Activity's effectiveness.

Our audit was performed in accordance with standards for assurance engagements, encompassing value for money and compliance, established by the Canadian Institute of Chartered Accountants, and accordingly included such tests and other procedures as we considered necessary in the circumstances. Prior to the commencement of our work, we identified the audit criteria that would be used to address our audit objectives. These criteria were reviewed and agreed to by senior management.

The scope of our audit work, which was substantially completed by May 2002, included a review and analysis of information available at the Ministry's head office, three regional offices, and the Redevelopment Project office, as well as discussions with appropriate staff. We visited a number of long-term-care facilities to gain a better understanding of the services being provided and to review certain procedures.

We also met with representatives of the Ontario Long Term Care Association and the Ontario Association of Non-Profit Homes and Services for Seniors, which collectively represent most of the owners/operators of long-term-care facilities in Ontario.

In 2001, the Ministry's Internal Audit Services Branch undertook a review of a long-term-care facility regarding financial complaints and compliance with the *Nursing Homes Act*. However, the results of this review did not affect the extent of our audit work because it primarily addressed specific concerns related to one facility.

OVERALL AUDIT CONCLUSIONS

In certain significant respects, the Ministry did not have all of the necessary procedures in place to ensure that long-term-care resources are managed with due regard for economy and efficiency and that long-term-care facilities are complying with applicable ministry policies. A number of our concerns were also reported in our 1995 Annual Report. In particular, we noted:

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- The Ministry had still not developed either standards to measure the efficiency of facilities in providing quality care or models for staff mixes for providing nursing and personal care and, therefore, did not have a sufficient basis for determining appropriate levels of funding. In addition, the Ministry had not addressed the results of a 2001 consulting report that noted that residents of Ontario's long-term-care facilities "receive less nursing and therapy services than [those in] similar jurisdictions with similar populations."
 - Although the Ministry inspected all long-term care facilities in 2001, it did not have a risk-based approach for prioritizing its facility inspection procedures, such as conducting in-depth inspections of facilities with a history of failing to meet provincial quality-of-care standards.
 - Some regions lacked advisors, such as dieticians, who could provide specialized advice. For instance, in facilities that they inspected, dieticians found higher incidences of unmet dietary criteria—such as unsanitary procedures in the kitchen and lack of appropriate nutrition—than compliance advisors found.
 - The Ministry was not adequately tracking complaints, unusual occurrences, and outbreaks of contagious diseases to identify and resolve systemic problems. In 2001, of seven regions, only two regions recorded unusual occurrences, which totalled 1,900. In the same year, only four regions recorded outbreaks of contagious diseases, which totalled 219 and affected 7,500 residents and staff.
 - Contrary to legislation, none of the nursing homes in Ontario had current ministry-issued licences at the time of our audit. At least 15% of licences had expired more than one-and-a-half years ago. As well, most nursing homes that opened after 1998 had never been issued a licence.
 - Surplus funds were not being recovered from facilities on a timely basis because the Ministry was performing annual reconciliations almost two years after the applicable year-end. The delayed recovery of approximately \$50 million for the 1999 calendar year resulted in approximately \$5 million in interest expenses being passed on to the taxpayers.

Since our previous audit in 1995, the Ministry has established a target for the number of long-term-care beds required and has implemented a strategy to cope with the increasing demand for beds arising from the growing elderly population. However, the Ministry did not have a process in place for periodically reviewing whether its target of 100 beds per 1,000 individuals aged 75 and over was appropriate.

Through the long-term-care redevelopment project, the Ministry allocated funding to build new long-term-care facilities in regions of the province where the need for additional beds was the greatest and was providing financial assistance to facilities that do not meet minimum structural and environmental standards.

Finally, we concluded that the Ministry's procedures for providing adequate accountability to the public and ensuring that long-term-care facilities provide services efficiently and effectively were impaired because:

- Financial information submitted by facilities was not sufficient to allow the Ministry to determine whether funds had been used in accordance with the Ministry's expectations.
- The Ministry had not developed outcome measures that addressed the appropriateness of services provided, including the quality of care received by residents.

DETAILED AUDIT OBSERVATIONS

MONITORING QUALITY OF CARE

The Ministry's primary tool for monitoring the quality of care provided to residents of long-term-care facilities is its Compliance Management Program, whereby the Ministry is to:

- conduct annual inspections of all long-term-care facilities;
- conduct other inspections as required by specialists, such as dietary and environmental advisors; and
- investigate complaints submitted by residents, residents' families, and the general public.

The Compliance Monitoring Program is the responsibility of the regional offices. Each regional office is staffed by a long-term-care manager and compliance advisors who are registered nurses. Some regional offices also have an environmental and/or dietary advisor(s) to handle more specialized reviews. Compliance advisors inspect facilities to ensure that all legislation, regulations, and standards as defined in the Ministry's Long-Term Care Facility Program Manual are being met. Facilities that fail to meet any of these requirements must take appropriate and timely corrective action. If standards continue to be unmet and/or there is a serious threat to the health, safety, or welfare of residents, a facility can be put under enforcement.

In July 2000, the Minister announced that a full evaluation of the Compliance Management Program would be conducted to:

- identify the current strengths and weaknesses of the program;
- analyze long-term-care monitoring mechanisms in other jurisdictions;
- identify opportunities to strengthen linkages with other long-term-care initiatives;
- recommend opportunities for program improvement; and
- recommend areas for more in-depth study.

The review was being done internally in consultation with stakeholder groups. Initially the deadline for the project was December 2001, but has been rescheduled for the end of 2002.

At the time of our audit, the review committee had identified the strengths and weaknesses of the compliance program and developed a draft enforcement policy and a list of triggers to identify when a facility may not be spending funds prudently or for the purposes intended. However, recommendations for compliance program improvement remained to be developed.

Annual Inspections

Under the *Nursing Homes, Homes for the Aged, and Charitable Homes* acts, the Ministry has the right to inspect facilities to ensure compliance with legislation and regulations, service agreements, and/or licences. According to ministry policy, “reviews will be conducted at least once in a calendar year.” The objective of the annual inspection is to monitor and evaluate the quality of resident care and services, the quality of programs, and the overall operation of each facility. The results of the annual inspections are to be posted in each facility.

Between 1997 and 1999, fewer than half of the facilities were inspected annually. In 2000, the then Minister announced that all long-term-care facilities would be inspected on a yearly basis. All of the facilities were inspected in the 2001 calendar year. We reviewed the inspection process and noted that, although senior management tracks the number of inspections completed, they do not routinely review the findings of these inspections in order to identify:

- facilities not in compliance with legislation and ministry policies;
- facilities with infractions that can have a serious negative impact on the quality of resident care;
- facilities that consistently have problems; and
- operators who demonstrate a pattern of non-compliance in their facilities.

We also noted that:

- The Ministry lacked a formalized risk-assessment approach for prioritizing inspection procedures or focusing on facilities with a history of failing to meet provincial quality standards. Currently, the Ministry conducts an in-depth, annual inspection at all facilities, which on average takes four days for each facility. However, a full inspection may not be warranted for facilities that have historically always been in compliance and have received few or no complaints, while facilities with chronic problems may warrant more in-depth inspections.
- Both associations representing facility operators informed us that, according to their member facilities, compliance standards were not being applied consistently among

facilities and across regions. Much depends on how those standards are interpreted and enforced by compliance advisors. For example, some compliance advisors told us that they might give an operator a warning while another advisor might give a citation for the same unmet standard.

- A facility may be notified up to a week in advance of an upcoming annual inspection. Some facilities may use this time to “prepare” for the inspection. As such, the inspection results may not be reflective of the ongoing care provided at the facility. For example, one facility wrote to its corporate office that, “The Nursing Department, with considerable help from Corporate staff and registered staff from other Corporate facilities, had a week to prepare for the [Ministry] annual review. All staff involved are to be commended for their efforts which were reflected in the favourable outcome of the review.”
- Ministry policy states that a compliance advisor can refer issues to advisors who specialize in the areas of environmental health, dietary, financial, and medical services. We were advised that, while there has not been a medical advisor available for the last five years, medical advice is sought when it is needed. However, none of the three regions we visited had an environmental advisor and only one had a dietary advisor. In addition, the compliance advisors lacked guidance as to when a referral was appropriate. We also noted that regions with dietary advisors were more likely to initiate dietary inspections, and facilities inspected by dietitians had higher reports of incidences of unmet dietary criteria. These included unsanitary procedures in the kitchen, lack of disinfectant use, inadequate maintenance of food temperatures, and lack of appropriate nutrition.
- “Focused audits” are part of the annual inspection process and require compliance advisors to select the case files of six residents from each facility to investigate areas considered to be of highest risk to residents, including unplanned weight change, pressure ulcers, pain and discomfort, disruptive behaviour, and use of restraints. The results of these audits are used to reach conclusions on the adequacy of care provided by a facility.

The sampling methodology was left to the discretion of each compliance advisor. Some compliance advisors told us that they based sample sizes on previous facility visits and personal comfort levels, while others indicated they selected samples based on bed capacity. We reviewed a sample of annual review files and noted that in 92% of the cases less than six case files were reviewed. Furthermore, we found no evidence to indicate that management had reviewed and approved the adequacy of the sample sizes used. A similar concern was raised in our 1995 Annual Report.

Recommendation

To help ensure that long-term-care facilities meet the assessed needs of each of their residents, the Ministry should:

- ensure senior management assesses the results of annual facility inspections for possible corrective and preventive action;
- implement a formalized risk-assessment approach for its annual inspections that concentrates on facilities with a history of non-compliance and prioritizes inspection procedures;
- ensure consistency in the application of standards;
- establish acceptable notification periods and conduct surprise inspections of high-risk facilities to reduce the risk that facilities will “prepare” for an inspection; and
- evaluate the experience and skills required to inspect facility operations and ensure the appropriate mix of specialists is available.

Ministry Response

The Ministry’s compliance program is carried out by staff who are fully committed to ensuring the health and quality of life of residents. However, the Ministry strives to improve and is currently undertaking a comprehensive review to determine areas for improvement, including appropriate staff mix. The Ministry continues to recruit for vacant positions to meet the needs of its compliance management program.

The core of this review is the development of a risk-assessment approach. Features may include the addition of risk indicators that will act as triggers for action by compliance staff and/or senior management. These indicators and actions would be in addition to actions that are currently triggered by reports from the compliance management team.

The Ministry currently conducts unannounced visits to long-term-care facilities and expects to incorporate surprise inspections in the future.

Health and Safety of Residents

COMPLAINTS

Ministry policy requires that all complaints made against a long-term-care facility be investigated within 20 days of being received. Currently all complaint investigations are conducted by regional compliance officers. In the past, the Ministry had an enforcement unit, which investigated the more serious complaints, such as alleged resident abuse. However, the enforcement unit was discontinued in June 1999.

The Ministry tracks the response times for and the nature and source of the complaint. We analyzed complaint information recorded in the Facility Monitoring Information System (FMIS) and noted the following items:

- In the last two years, 83% of complaints were investigated within the required 20 days. However, performance varied greatly across regions. While one region almost always

met the 20-day requirement, another region was consistently late in completing one-third of its complaint investigations.

- In the three regions we visited, at least half of the facilities did not receive any complaints in 2001. We noted that most facilities that had received more than 10 complaints each also had significant non-compliance issues identified during the annual inspection process. For example, a facility that received a total of 29 complaints in 2001 and 24 complaints in 2000 also had reoccurring non-compliance issues going back to 1990. However, the Ministry had no procedures for analyzing complaints in order to identify and address facility/system weaknesses.

UNUSUAL OCCURRENCES

The Ministry defines an unusual occurrence as “an occurrence that poses a potential or actual risk to the safety, security, welfare, and/or health of a resident, or to the safety and security of the facility, which requires action by staff.” Facilities are required to report all unusual occurrences to the Ministry’s regional offices. The regional compliance advisors review the details of incidents, and consider what action, if any, is necessary.

At the time of our audit, there was no requirement to record unusual occurrences in FMIS. However, for the two regions that did record unusual occurrences in FMIS, we found a total of 1,600 unusual occurrences for calendar year 2000 and 1,900 for 2001. Injuries requiring transfer of a resident to a hospital for treatment or admission accounted for 70% of all unusual occurrences recorded in FMIS while cases of alleged abuse of residents represented 9% of reported cases.

We reviewed unusual occurrence reports for a sample of long-term-care facilities in the regions we visited and found that facilities that exhibited a higher number of repetitive, serious non-compliance issues and complaints also experienced a higher number of unusual occurrences. For instance, one such facility that had ongoing serious compliance issues for more than 10 years also had very serious occurrences.

OUTBREAKS OF CONTAGIOUS INFECTIONS

Ministry policy requires long-term-care facilities to report all outbreaks of contagious infections to their respective regional offices. This is to help the Ministry:

- identify outbreak prevalence and emerging trends in long-term-care facilities;
- ensure outbreak information is relayed to appropriate personnel; and
- ensure that information relating to outbreaks is complete, including information outlining the duration of the outbreak.

The Ministry relies on local public health departments to assess and respond to outbreak information.

For each reported outbreak, an outbreak document is prepared, reviewed by the regional compliance advisor, and filed in the appropriate facility’s file. Regional offices are required to

maintain an outbreak log, which lists each facility that had an outbreak, the type of outbreak, and the dates of initial and final notification to the Ministry.

At the time of our audit, only four of the seven regional offices were recording outbreaks in FMIS. Those four regions alone reported a total of 219 outbreaks in 2001, affecting over 7,500 residents and staff. We visited two of the regional offices that did not maintain their logbooks on FMIS. The logbook for one region indicated an additional 80 outbreaks in 2001 but contained no indication of how many people were affected. The second region we visited did not maintain a logbook at all.

For the regions that did record outbreaks in FMIS, we noted one region accounted for 62% of all outbreaks in 2001. This trend was consistent with the prior three years. However, it was unclear whether there was a problem with infection control practices in this region or whether facilities in other regions were not accurately reporting all outbreaks to their regional offices. In addition, we found that no effort had been made to correlate the number of outbreaks per facility with the unmet criteria identified in annual inspections, such as poor sanitation, environmental cleanliness, or resident hygiene.

Recommendation

To better protect the health and safety of residents of long-term-care facilities, the Ministry should ensure that all:

- **complaints are investigated and responded to in a timely manner;**
- **unusual occurrences and outbreaks of contagious infections are reported to the Ministry and recorded in its Facility Monitoring Information System on a timely basis; and**
- **complaints, unusual occurrences, and outbreaks of contagious infections are assessed in relationship to annual facility inspection results to identify and resolve systemic problems.**

Ministry Response

The Ministry has a policy of investigating and responding to complaints within 20 days. The Ministry has a good track record of responding to complaints; however, it is continually striving to improve.

Ministry staff follow up on all unusual occurrences. The Ministry, in conjunction with local public health agencies, has strict protocols and procedures to ensure resident safety in outbreak situations (for example, quarantines and specific hygiene measures). Local public health agencies determine when a facility is in outbreak status.

The Ministry is committed to improving its data-entry systems with respect to these issues and will use this data to identify and resolve any systemic problems.

Facility Licences and Service Agreements

Under *The Nursing Homes Act* “no person shall establish, operate, or maintain a nursing home except under the authority of a licence issued by the Director under this Act.” All licences expire and must be renewed annually and may be revoked or their renewal refused if the licensee contravenes the legislation. While there are no licensing requirements for municipal and charitable homes, all long-term-care facility operators are required to have a signed service agreement with the Ministry.

We reviewed the licence status of nursing homes and found that, at the time of our audit, none of the nursing homes operating in the province of Ontario had a valid operating licence. While most of the licences had expired within the last year, at least 15% of licences had expired more than one and a half years ago. In fact, we noted one facility whose licence had expired in 1994, another whose licence had expired in 1997, and two others whose licences had expired in 1998. As well, most nursing homes that opened after 1998 had never been issued a licence to operate.

According to the Management Board of Cabinet Directive on Transfer Payment Accountability, a signed agreement must be in place prior to advancing any provincial funds to transfer-payment recipients, which include long-term-care facility operators. We noted, however, that the Ministry’s normal practice is to finalize and sign service agreements after the funding year has passed. At the time of our audit, none of the service agreements for the 2001 and 2002 calendar years had been signed. While ministry staff indicated to us that the old service agreements remain in effect, the facility operators in one of the regions we visited often disagreed with the Ministry’s position. Service agreements cover a specific year because they indicate the amount of the subsidy only for that year.

We also noted the Ministry did not take into consideration whether or not the facilities were in compliance with ministry standards at the time service agreements were signed.

Recommendation

To help ensure that ministry policies and legislation regarding long-term-care facilities are followed and that long-term-care service providers understand their responsibilities, the Ministry should ensure that all long-term-care facilities have valid service agreements and that each facility’s compliance status is taken into account.

The Ministry should also ensure that all nursing homes have valid licences as required by legislation.

Ministry Response

The Ministry is undertaking a review of the management process supporting service agreements. The 2001 and 2002 service agreements will be distributed

to facility operators by October 31, 2002. The Ministry will distribute the 2003 service agreements to facility operators by December 31, 2002.

The Ministry now has a program in place to ensure all licences are current. As of September 1, 2002, all nursing homes have current licences.

PER DIEM FUNDING

Level-of-care Classifications

Level-of-care requirements for residents are determined through an annual classification assessment of residents at each facility conducted by ministry assessors. The assessors, who are registered nurses with long-term-care experience, conduct the assessments by reviewing resident charts and plans of care. Residents are classified into one of seven nursing and personal care categories based on the level of care they require. Each category is assigned an established weight based on assessed resident needs, taking into account the related resource use. The percentage of residents in each category is multiplied by weighting factors to determine the case-mix measure of that facility. The ratio of the facility's case-mix measure to the average provincial case-mix measure produces a case-mix index, which is multiplied by a set per diem rate to determine the funding a facility will receive per resident for nursing and personal care.

Long-term-care facility funding through the nursing and personal care funding envelope in the 2001/02 fiscal year totalled approximately \$1.1 billion of the \$1.6 billion provided by the Ministry to long-term-care facilities.

LEVEL-OF-CARE AUDITS AND APPEALS

A decrease in a facility's case-mix measure affects the per diem it receives for nursing and personal care. A facility is entitled to appeal its classification if its case-mix measure decreases by more than 7% from the previous year. In 1997, the Ministry introduced annual audits of facilities whereby it verifies the level-of-care classification at a sample of facilities. These audits initially involve the reassessment of a minimum of 20 residents and are based on the residents' documented care and direct observation. If the case-mix measure for those residents exceeds their annual classification by more than 10%, a full audit is conducted on all facility residents who were there when the annual classification was completed.

According to ministry policy, if the full audit verifies that the documented and observed care have changed by more than 10% from the annual classification, the Ministry will consider increasing or decreasing funding. In a December 2001 memo to all regional offices, the Ministry noted that since the audit and appeals process began, the policy to decrease funding had not been applied where warranted.

The Ministry currently offers seminars to help facilities improve their documentation of resident-care needs but does not penalize those facilities that, based on the audits, it knows or strongly suspects are misrepresenting resident needs in an effort to obtain additional funding.

Recommendation

To help ensure fairness in the levels of funding provided to long-term-care facilities, the Ministry should adjust funding where warranted as a result of any level-of-care classification audit in accordance with its policy.

Ministry Response

Currently, some adjustments are made by the Ministry as a result of audits. However, the Ministry will be reviewing the implementation of the policy to adjust funding as a result of the audit and appeals process.

Reasonableness of Per Diem Funding

In our 1995 audit report, we recommended that the Ministry use information on the cost of providing care and accommodation to verify the accuracy of the standard rates paid in each of the funding envelopes. Since that time, the Ministry has made periodic funding adjustments based primarily on the overall increase in the provincial case-mix measure. However, the Ministry has not done a detailed analysis to determine an appropriate amount of funding.

In June 2000, the Ministry established a committee to review how funding is determined, allocated, and distributed and to recommend improvements to the current per-diem-based methodology. The committee, composed of ministry staff and representatives from associations of service-provider groups, recommended increases in the four funding envelopes based on changes in residents' needs, negotiated contract increases with staff, and other inflation-related adjustments but did not discuss the adequacy of the current funding amount.

For the past two years, the Ministry has produced sector per diem reports that list for each facility the actual amount spent per resident per day for each type of expense and for each funding envelope in total. The cost data is accumulated by sector (charitable homes, municipal homes, and nursing homes) within each region. We reviewed the 1999 reports for the three regions we visited and noted large variances among the sectors and among facilities in expenditures for nursing and personal care and in accommodation expenses.

In our 1995 Annual Report, we also recommended that the Ministry develop standards to measure the efficiency of facilities in providing quality care and develop models for staff mixes for providing nursing and personal care to arrive at appropriate funding levels. Prior

to 1996, the Ministry required each long-term-care facility to have a registered nurse on duty and on site at all times, and it guaranteed, as a minimum, sufficient funding to ensure that each nursing-home resident received, on average, a minimum of 2.25 hours of nursing and personal care per day. This funding was to be provided regardless of the overall care needs of residents in each nursing home.

In 2001, the Ministry provided the funding for a consulting firm to review how the level of services provided to residents of Ontario's long-term-care facilities in terms of nursing staff, health care aides, and therapies compared to services provided in other jurisdictions in Canada, the U.S., Europe, and in Ontario's chronic-care facilities. The report considered only the amount of care provided, not the quality of care. According to the consultants, the study's limitations included the facts that data for many of the comparative jurisdictions were gathered from three to five years earlier than the Ontario data and that "several of the jurisdictions were required to submit the data for funding purposes, which may influence data quality." Nevertheless, the published report stated:

The results of this study indicate that residents in Ontario [long-term-care] facilities receive less nursing and therapy services than similar jurisdictions with similar populations. Furthermore, Ontario [long-term-care] residents have some significant differences in terms of their levels of depression, cognitive levels and behavioural problems which indicate higher needs for service levels to meet higher care requirements.

Specifically:

- The proportion of care provided by registered nurses in Ontario's long-term-care facilities to each resident per day was the lowest in comparison with other jurisdictions.
- Only one-third of Ontario residents in long-term-care facilities who had restricted ranges of motion received any range-of-motion exercise.
- Ontario residents in long-term-care facilities had the highest proportion of mental health disturbances and/or problems, of which 65% were handled either with restraints or anti-psychotic medication. Less than 6% had any intervention related to evaluation or "talk therapies."

We found no evidence to indicate that the Ministry had addressed the results of this study.

We also noted that 36 U.S. states have established staffing requirements or standards, such as:

- a minimum number of hours of nursing care per resident per day;
- a minimum caregiver-to-resident ratio; and/or
- a requirement for a registered nurse to be on site 24 hours a day.

Currently, the Ministry does not have any staffing requirements and does not track facility staff-to-resident ratios, the number of registered-nursing hours per resident, or the mix of registered and non-registered nursing staff.

Recommendation

To help ensure that the funding provided to long-term-care facilities is sufficient to provide the level of care required by residents and that the assessed needs of residents are being met, the Ministry should:

- verify the reasonableness of the current standard rates for each funding category and develop standards to measure the efficiency of facilities providing services;
- track staff-to-resident ratios, the number of registered-nursing hours per resident, and the mix of registered to non-registered nursing staff and determine whether the levels of care provided are meeting the assessed needs of residents; and
- develop appropriate staffing standards for long-term-care facilities.

Ministry Response

Effective August 1, 2002, the Ministry increased nursing and personal care funding by \$100 million (\$6.33 per resident per day). The total per diem for a long-term-care facility with average care levels is \$110.73.

Currently, long-term-care facilities receive differential funding based on the care needs of their residents. The Ministry is committed to investigating the feasibility of implementing a new resident-classification instrument and funding methodology that will further enhance its ability to assess resident care and staffing needs.

Annual Reconciliations

The Ministry's Long-Term Care Facility Program Manual states that each facility is required to submit an audited annual report to its regional office so the regional office can compare actual to approved expenditures and determine whether a final funding adjustment is necessary.

We noted that the Ministry had not established any timelines for completing the annual reconciliations and that surpluses were not being recovered promptly. For instance, surpluses for 1998 were recovered in late 2000 and early 2001, and, at the time of our audit, reconciliations for 1999 were still being completed. In each of the last three years, net surpluses owed to the Ministry exceeded \$50 million. Given that the average one-year borrowing rate for the government in 2000 and 2001 was 5.7% and 3.8% respectively, the late recoveries of excess funding for the 1999 calendar year alone have cost taxpayers at least \$5 million in interest expenses.

For the 1999 calendar year, the Ministry did not forward annual report forms to facilities until April 2001. Most facility operators completed and returned the required forms within 90 days of receipt, as required under ministry policy. However, regional office staff did not

begin the reconciliation process until the fall of 2001. The annual report forms for the 2000 calendar year were sent to operators on February 25, 2002, 14 months after that year-end.

Most long-term-care facilities have surpluses because the Ministry regularly underestimates facility revenue from resident payments. For example, the Ministry used actual resident revenue for 1996 to estimate facility resident revenue for 1999, without making adjustments for known increases in the per diem accommodation rates. Resident revenue cannot be easily estimated because some residents are eligible for rate reductions due to financial need. As mentioned earlier, facilities are allowed to reduce the basic resident rate for ward accommodation from \$44.51/day to \$30.24/day for residents in financial need without ministry authorization.

Although financial analysts in the regional offices are now adjusting in-year payments based on more recent estimates of resident revenue, there were inconsistencies in the approaches among regions. Ministry staff advised us that, beginning July 1, 2002, the process for in-year adjustments will be standardized.

RECONCILIATION PROCESS

Funding provided to long-term-care facilities within each envelope is intended to cover eligible expenses as outlined in the Ministry's Long-Term Care Facility Program Manual. Except for funds received for certain accommodation costs, facilities must return all unspent funds to the Ministry.

We reviewed the financial information submitted by facilities to the Ministry's regional offices and found that there was insufficient information to determine whether funds within each envelope were used for their intended purposes. Most of the Ministry's regional financial analysts we surveyed agreed that the information was inadequate.

The majority of expenditures in the nursing and personal care funding envelope are for staff salaries, yet facilities are not required to submit staffing data, such as the number of employees per type (registered nurses, practical nurses, and health care aids) or their respective salaries. Also, facilities do not routinely provide regional offices with a list of equipment and supplies purchased during the year under each funding envelope. Analysts advised us that, in several instances, facilities charged accommodation equipment and supplies as medical items to the nursing and personal care funding envelope, thus minimizing the amount of funding they may be required to return to the Ministry.

In addition, a number of long-term-care facility operators are also operating retirement homes on adjacent premises. Retirement homes do not receive ministry funding but may share some services and staff with their affiliated long-term-care facilities. For three regions alone, the Ministry identified 69 long-term-care facilities with attached retirement homes operating in the same facility. Long-term-care facilities are not required to submit a full set of audited financial statements. Without audited financial statements that contain segregated information, the Ministry does not know whether operators are properly allocating costs.

Recommendation

To help ensure surplus funding to long-term-care facilities is accurately identified and returned to the province on a timely basis, the Ministry should ensure that:

- audited financial information provided by facilities meets ministry needs; and
- reconciliations are completed and surpluses recovered on a timely basis.

Ministry Response

The Ministry will review the form and content of information currently collected from facilities to ensure that it is meeting ministry needs.

The Ministry will commit to sending out the 2001 and 2002 reconciliation reports to long-term-care facilities by December 31, 2002.

The Ministry has developed a consistent revenue/occupancy report. Beginning January 1, 2003, all seven regional offices will monitor and adjust cash flows as required.

THE LONG-TERM CARE REDEVELOPMENT PROJECT

Supply of Long-term-care Beds

In our 1995 Annual Report, we noted that, although it was aware of significant growth projected for the population aged 65 and over, the Ministry did not have a strategy for dealing with the anticipated increase in demand for long-term-care beds. We also noted that it did not have a systematic plan to determine where beds were most needed and to eliminate the wide variations in bed supply to make it equitable throughout the province.

In the fall of 1996, the Ministry established the Long-Term Care Bed Distribution and Needs Study Steering Committee (steering committee), made up of ministry staff and representatives from external associations. The steering committee was to review ways to equitably distribute long-term-care beds throughout the province and to suggest any policy or legislative changes to facilitate such a distribution.

In the introduction to its April 1997 report, the steering committee noted that provincially funded and regulated long-term-care beds had “for many years been inequitably distributed across Ontario both by region and within regions themselves. This distribution has occurred more by ‘accident’ than as a result of needs-based planning.”

The steering committee indicated that “given the time parameters of the study and issues affecting the [long-term-care] facility service system, [it] was not able to establish a bed

planning target.” It recommended that the Ministry undertake further study and research to define a bed-planning target for long-term care. The steering committee also urged that its recommendations be considered in conjunction with recommendations regarding long-term care from the Health Services Restructuring Commission. In 1997, the Health Services Restructuring Commission released a discussion paper stating that by 2003, the province would need an additional 15,404 long-term-care beds. According to the Commission, these additional beds would result in an average bed ratio of 96.4 beds for every 1,000 individuals aged 75 and over.

In April 1998, Management Board of Cabinet approved in principle a plan from the Ministry requesting a total of 20,000 new beds to be built by the end of the 2005/06 fiscal year and the renovation of facilities with 13,583 existing long-term-care beds that did not meet current structural requirements. Ministry staff informed us that although there was no ministry standard for determining the future need for long-term-care beds, they were attempting to reach a target of 100 beds for every 1,000 individuals aged 75 and over. While the Ministry was unable to provide information on how it arrived at this target, it was consistent with the target recommended by the Health Services Restructuring Commission. By way of comparison, a ministry-initiated study indicated that in 2000, Alberta had a ratio of 109 beds per 1,000 individuals aged 75 and over, while Manitoba’s planning guideline was 120 beds per 1,000 individuals aged 75 and over. It is important to note that the future need for long-term-care beds is affected by many factors, including the availability of home-care, chronic-care, and other services.

Based on the allocation of the approximately 20,000 new beds, by 2006 the projected bed ratios across provincial service areas (municipalities, districts, or counties) are expected to range from 88 to 138 beds for every 1,000 individuals aged 75 and older. Without the 20,000 new beds, projected bed ratios would have ranged from 38 to 138 beds for every 1,000 individuals aged 75 and over. Areas of the province most likely to exceed the target were generally above the target before the new beds were allocated and, accordingly, were generally not awarded new beds.

Recommendation

To help ensure that the need for long-term-care beds is met on a timely basis, the Ministry should:

- **conduct research to determine whether its target of 100 beds per 1,000 individuals aged 75 and over is appropriate; and**
- **develop a strategy to address the results of the research.**

Ministry Response

The Ministry is currently conducting policy work on a long-term strategy for long-term care. This strategy will look at the full range of services available to seniors and make recommendations about programmatic responses.

Capital Redevelopment Plan

In March 1999, the government announced that the expansion project for long-term-care beds was being accelerated and that the 20,000 new beds would be completed by 2004, bringing the total number of long-term-care beds to approximately 77,000. The 2006 deadline for renovating existing substandard facilities remained unchanged while the number of beds in substandard facilities was later revised from 13,583 to 15,835.

Contracts for the construction and operation of new facilities for the 20,000 new beds were primarily issued through three competitive selection processes in December 1998, March 1999, and May 2001. The 20,000 new beds included approximately 1,200 beds that had been awarded to operators in the 1980s and had not yet been developed. The regional offices handled the 1998 and 1999 selection processes based on common procedures established by the Ministry's head office. The third was undertaken by the newly established Long-Term Care Redevelopment Project office (Redevelopment Project office).

The Redevelopment Project office was established by the Ministry in May 2000 to oversee the operation of its bed-expansion project, including:

- developing and tracking the awarding of beds (including beds awarded in 1998 and 1999);
- reviewing and ranking the proposals in 2001;
- negotiating development contracts with successful applicants;
- reviewing and approving construction plans for new and replacement beds; and
- advising on and resolving municipal issues related to the construction of the new beds.

CAPITAL FUNDING

The Ministry is funding the construction of facilities for the 20,000 new beds and the renovation of facilities containing 15,835 beds by providing a per diem of up to \$10.35 per bed. These payments are for 20 years and commence the day the bed is available for use and will amount up to approximately \$75,000 for each new or renovated bed. Over 20 years, the capital costs to the Ministry will total up to \$1.5 billion for the new beds and up to \$1.2 billion for the renovated beds.

In addition, in January 2001, the Ministry revised its policy on preferred accommodation revenue. Previously, facilities shared preferred-accommodation revenue (that is, additional amounts charged for private or semi-private accommodation) with the province on an equal basis. All operators, including those with existing facilities that were not being renovated, would now be permitted to keep 100% of their preferred accommodation revenue. According to ministry documentation, "This funding is intended to supplement the \$10.35 provided to facilities to support the cost of construction." Currently, this will provide at least \$50 million of additional annual funding to long-term-care facilities.

We noted that the Ministry had not assigned to either the Redevelopment Project office or the regional offices the responsibility for obtaining actual expenditure reports for facilities that had been operating for more than one year to ensure that per diem construction funding was based on actual costs. In February 2002, the Ministry assigned that responsibility to the regional offices. However, by that time, one facility was more than two years late in submitting its report.

Recommendation

The Ministry should ensure that the per diem paid to long-term-care facilities for capital construction are consistent with the actual construction costs incurred.

Ministry Response

The Ministry's policy for funding construction costs of long-term-care facilities and development agreements require operators to submit audited statements of final capital costs. The Ministry has developed guidelines for consistent review and approval of these statements and will ensure they are appropriately implemented.

ALLOCATION OF NEW BEDS

In its presentation to Management Board of Cabinet, the Ministry stated that “all 20,000 new beds [were to be] awarded through a highest quality RFP process.” At the time of our audit, new beds had been allocated as outlined in the following table.

**Beds Awarded through
Competitive Selection Processes,
1998–2001**

Year of Allocation	# of Beds Awarded	% of Total Beds Awarded
1998	6,157	34
1999	5,347	29
2001	6,682*	37
Total	18,186	100

* includes 1,065 beds returned by successful applicants and subsequently re-allocated to other applicants, and 704 beds allocated through subsequent competitive processes to meet needs in under-serviced areas

Source of data: Ministry of Health and Long-Term Care

In the 1998 process, beds were to be awarded to the applicants who received the highest rankings after taking into account the Ministry's "policy decisions about appropriate geographical distribution of long-term-care facilities in each service area of the province of Ontario." The Ministry could also require as a condition of award that a successful applicant develop beds in a different geographical location than described in the applicant's proposal but within the same service area. We reviewed the 1998 awards and found that, generally, beds were awarded in accordance with the stated selection criteria. However, where there were exceptions, the Ministry was not able to locate the supporting documentation in all cases.

In the 1999 process, in addition to the selection criteria used in 1998, the Ministry reserved the right to decline awards where there would be an unacceptable concentration of ownership of long-term care beds in the province or where applicants who were successful in four or more proposals could not demonstrate the financial and organizational capacity to develop that many sites. Based on our review of available documentation, successful applicants were selected in accordance with the stated selection process. In all cases where the highest scorer was not selected, there were multiple applicants who were perceived not to have the organizational or financial capacity to develop all of the beds that they could be awarded. External consultants hired by the Ministry performed the multiple applicant analyses and provided advice and recommendations to the Ministry.

A new evaluation process was used in 2001 and the Redevelopment Project office hired external consultants to evaluate the proposals. The selection of successful applicants was not based on the highest ranked proposals. Instead, scores were used to group applicants within service areas into three "bands". The first band included the top-ranked applicants. As one would expect, virtually all applicants in the first band received awards. The second band included all other applicants who scored over 65%. The applicants within this band were considered equivalent in terms of the quality and merits of their applications. Preference was given to applicants adding new beds to structurally non-compliant facilities and to applicants who proposed to build in preferred locations within service areas. As was the case in 1999, the Ministry reserved the right to consider the financial and organizational capacity of applicants who were successful in a number of proposals. The third band was made up of applicants who scored less than 65%, and, therefore, were not eligible for selection.

According to the Ministry, approximately 900 new beds were awarded outside the regular processes to:

- comply with recommendations pertaining to hospitals that were made by the Health Services Restructuring Commission; and
- improve the economic viability of successful applicants from earlier RFPs that requested additional beds.

Subsequent to the 2001 process, competitive selection processes were instituted in three service areas to award beds that either had been returned or were not initially awarded

because of insufficient interest in 2001. Unlike the other three processes, where proposals were scored and ranked, the proposals for two of the service areas were evaluated based on a comparison of the positive and negative aspects of the proposals. The process for the other service area was still ongoing when we completed our audit work in this area.

Recommendation

To help demonstrate that awards for new long-term-care beds are based on a fair and open process that is consistently and objectively applied, the Ministry should ensure that the justification for all decisions is properly documented.

Ministry Response

The Ministry will do its best to ensure proper documentation of all decisions.

Structural Compliance

In our 1995 Annual Report, we noted that 68 nursing homes with approximately 7,000 beds were so deficient they required major renovations or complete reconstruction to meet existing minimum structural and environmental standards. The Ministry is addressing the need to upgrade certain facilities through the Long-Term Care Redevelopment Project, which includes funding for the renovation of substandard facilities containing 15,835 beds.

In 1995, we also noted that there were no comparable regulatory standards for homes for the aged and that the Ministry had not assessed the structural and environmental adequacy of these facilities. We recommended that the Ministry establish a plan to replace facilities that cannot meet structural and environmental requirements and that homes for the aged be assessed for structural and environmental deficiencies.

In April 1998, the Ministry introduced new standards that would be applicable to all long-term-care facilities. Ministry staff classified all facilities into one of four categories:

- class A facilities that met 1998 design standards;
- class B and C facilities that did not meet the 1998 standards but did meet the 1972 regulated standards; and
- class D facilities that met neither the 1998 nor the 1972 standards.

These classifications were primarily based on the review of building plans on file with the Ministry and the results of structural compliance assessments of nursing homes completed in 1984/85. However, ministry staff did not have building plans for municipal or charitable homes. Facilities were permitted to appeal their classifications. Ministry staff, using a standardized survey template, reassessed these facilities, which resulted in a change of classification for a number of facilities.

At the request of the Ontario Association of Non-Profit Homes and Services for Seniors, the Ministry hired a consultant to conduct on-site reviews of the approximately 320 facilities that did not appeal their classifications. While the consultant identified 32 facilities that should have had a different classification, the Ministry adjusted the classification of only three facilities. The other 29 included 10 facilities containing 1,515 beds that the consultant stated should be class D rather than class C facilities and, therefore, should be renovated. Such renovations would normally receive financial support from the Ministry.

By the end of 2001, only 42% of class D facility operators had agreed to rebuild their facilities to meet 1998 design standards. These operators would be eligible for a per diem premium of up to \$10.35 per bed for 20 years. In December 2001, the Ministry introduced a new program to encourage more operators of class D facilities to commit to renovation. Class D facility operators now could also:

- retrofit the facility to meet 1998 core design criteria, allowing design flexibility to reduce costs and enable better use of existing sites and structures. Depending on the extent to which the design varied from 1998 standards, operators would be eligible for a per diem premium of between \$7.00 and \$10.35 per bed for 20 years; or
- upgrade the facility to meet all the class C structural classification criteria or spend at least \$3,500 per bed. The operator would then be entitled to the structural compliance premium of \$1.00 per bed per day.

In addition, these operators would be eligible for additional financial support to help with unavoidable costs unique to redevelopment and retrofit projects, such as temporary facility leasing costs, temporary storage and operational costs, and fixed operating costs. Eligibility would be assessed on a case-by-case basis. By the time we completed our audit, the Ministry had received commitments from all of the operators of class D facilities to rebuild, retrofit, or upgrade their facilities.

Class A, B, and C facilities are paid a structural compliance per diem premium, intended as compensation for previously completed structural improvements. Higher amounts are paid to facilities that more closely meet the 1998 design standards and have not received grants from the province to construct their facilities.

Per Diem Structural Compliance Premiums, 2002

Facility Classification	Premium for Nursing Homes (\$)	Premium for Charitable and Municipal Homes (\$)	Premium for Upgraded Class D Facility (\$)
A	5.00	1.50	N/A
B*	2.50	1.25	N/A
C*	1.00	0.50	1.00

* According to ministry policy, class B and class C facilities are not eligible for redevelopment funding and cannot improve their classifications in order to receive a higher premium even if they pay for their own upgrades.

Source of data: Ministry of Health and Long-Term Care

With respect to structural compliance premiums, we noted the following:

- Because the province had funded 50% of the original construction costs of charitable and municipal homes, per diem premiums for these facilities were apparently reduced by 50%; but premiums were not reduced for nursing homes that, prior to 1996, received provincial funding through debt servicing and compliance premiums to partially compensate them for the cost of construction.
- Ministry staff could not explain the apparent inequity whereby class A charitable and municipal homes receive only 30% of the premiums received by nursing homes whereas class B and C facilities receive 50%.
- All class D facilities that upgrade to class C were entitled to the full \$1.00 premium, even though the majority of class D facilities were either charitable or municipal homes and would otherwise only be entitled to a premium of \$.50. The Ministry could not explain the basis for this premium.

Recommendation

To help ensure that funding for structural compliance is fair and to encourage facilities to meet the new design standards, the Ministry should:

- ensure all facilities are properly classified;
- review the structural compliance premiums to ensure that they are equitable and are achieving their intent; and
- consider providing incentives for facilities to upgrade their classifications.

Ministry Response

The Ministry is currently conducting policy work on asset management and facility renewal. This policy work will give consideration to the Provincial Auditor's recommendations.

PERFORMANCE MEASURES

According to the Management Board of Cabinet's minutes for May 17, 2000, "the Ministry needs to establish acceptable outcome measures and suitable commitments to better reflect its major activities/programs and contribution to core business outcomes." For 2000/01, the only performance measure in the Ministry's Business Plan for long-term-care facilities was to increase the number of long-term-care beds.

The 2001/02 Business Plan stated that the goal of the Integrated Health Care Programs Division was to ensure that "the needs of Ontario's changing population are anticipated and appropriate services and technology are available throughout people's lives, close to their homes in their chosen communities" and included the following performance measures:

Residents of long-term-care facilities receiving quality care programs and services in a safe and home-like environment in accordance with provincial legislation, standards, and policies as shown by:

- results of annual compliance reviews—100% of facilities inspected annually; and
- redevelopment of existing [class D facilities] so that they meet or exceed current design standards.

However, the Business Plan indicated no commitments or measures to address the appropriateness of services provided, such as the quality of care received by residents, or to determine whether programs offered by the facilities were meeting the needs of the residents.

Senior ministry officials advised us that they recognize there are deficiencies in their assessment of program efficiency and effectiveness and are considering the implementation of the Resident Assessment Instrument (RAI). The RAI is currently used by all U.S. government-sponsored nursing homes as a uniform, standardized, comprehensive assessment instrument for all long-term-care residents in an effort to address concerns about basic levels of care. The RAI consists of a Minimum Data Set (MDS) and a series of resident assessment protocols describing how to use the MDS data for care planning. Quality indicators can be derived from the RAI to help identify potential problem areas for further review and investigation and may enable users to compare care among facilities. These indicators help identify the prevalence of inappropriate conditions. Ministry staff informed us that its level-of-care classification system currently collects about 60 pieces of data on each resident. Using MDS, over 400 pieces of information could be collected for each resident. Ministry staff believe that MDS would provide information that could be used to develop benchmarks and identify quality improvements.

In October 2000, a review committee established by the Ministry recommended that the Ministry pilot the implementation of RAI at 40 facilities and conduct an evaluation prior to full implementation. The committee also recommended that the Ministry develop a funding methodology based on MDS and explore a partnership with the home-care sector to develop a common assessment tool. However, at the time of our audit, no progress had been made in implementing a pilot project.

Recommendation

To provide better accountability to the public and to help ensure that services of long-term-care facilities are provided efficiently and effectively, the Ministry should:

- **establish program goals, performance measures, and benchmarks and use them to assess performance;**
- **take corrective action where necessary; and**
- **report publicly on performance achieved.**

Ministry Response

Comprehensive annual reports from the long-term-care facilities' compliance reviews are posted at the facilities for the public to see and are available to interested parties.

It is the Ministry's intention to move to a system that:

- **collects data and organizes the information to develop individualized resident care plans (this will reduce nursing time spent documenting and increase time spent providing care);**
- **uses the data to develop risk-weighted quality indicators (quality indicators will enable benchmarks to be set that facilities must meet); and**
- **compares facilities using the benchmark data. The Ministry will take corrective action where necessary.**

When the new system is fully implemented, the Ministry will make available as much information as possible on comparative indicators.