

SCHEDULE "D"

GUIDELINES FOR APPLICATION AND INFORMATION REQUIREMENTS FOR LICENSURE OF ADDITIONAL COMMUNITY CARE BEDS WITHIN EXISTING FACILITIES

This document sets out the requirements that must be followed to obtain a license for new community care beds within existing community care facilities. Pursuant to requirements under the *Community Care Facilities and Nursing Home Act* and the Community Care Facility Regulations, the application to license a community care facility, with applicable fee, is to be submitted to the Community Care Facilities and Nursing Homes Board (herein referred to as the "Board").

Completed applications, together with all other information and the application fee, are to be submitted to the Community Care Facilities and Nursing Homes Board for review.

Ongoing site visits will be required throughout the application process.

DEFINITIONS:

Applicant: The person applying for a license to operate a community care facility

Operator: The person or organization responsible for the management and operation of a community care facility

To be eligible for licensure for additional beds, the application package must include the completed application form and the following:

1. Proof of Insurance coverage as set out in the *Operational Care Service Standards for Community Care Facilities* Standard 2.4.
2. Completed Declaration form signed by the applicant.
3. Floor plans that clearly indicate all current and additional bed locations. Floor plans must provide the exact measurements of all additional resident rooms and dining spaces.
4. Architect and/or engineer stamped plans, if completing a significant expansion or structural renovation to accommodate the additional beds.
5. Updated evacuation plan to include additional beds.
6. Staffing proposal.
7. A business plan completed on a form approved by the Board may be required if the Board deems it necessary.

Inspection information:

Inspection authorities (e.g. fire, electrical etc.) will be informed by the operator and Department of Health and Wellness that additional community care beds have been requested. Each inspection service will determine if a physical inspection of the area is deemed necessary.

- Physical inspection of resident's room(s), which would include, but not limited to:
 - Regulatory requirements for space and equipment
 - Working call bell within washroom facilities and acceptable water temperature
 - Additional spaces as required (access to lounge, dining areas etc.)

- Staffing
 - review of proposed schedule
 - review of personnel files demonstrating vetting of all new staff members prior to employment *per Operational and Care Service Standards for Community Care Facilities* Section 7.2c

Please note that applications will be returned before consideration if they are:

- Incomplete, or
- Any required supporting documents are missing

Application Checklist:

As described above, the following documents **MUST BE INCLUDED** in your application for additional community care beds:

- Application fee, cheque made payable to Minister of Finance
- Completed, signed and dated application form
- Valid insurance certificate
- Signed declaration form
- Floor plans with exact measurements of all potential rooms and dining spaces
- Updated evacuation plan to include any additional nursing beds
- If completing structural renovations, architect and/or engineer stamped plans
- Staffing proposal

INSURANCE REQUIREMENTS

The Facility, without limiting its obligations or liabilities, provides and maintains policies of insurance satisfactory to the Department of Health and Wellness and in accordance with the minimum requirements as determined by the Risk Management and Insurance Section, Department of Provincial Treasury.

Principle:

The Facility has current and adequate insurance coverage relative to the services provided and the property owned and/or operated.

Criteria:

1. The Facility has Commercial General Liability coverage in an amount not less than \$2,000,000.00 inclusive per occurrence against bodily injury and property damage. The Government is added as an additional insured under this policy. Such insurance includes, but is not limited to:
 - a) Blanket Written Contractual Liability;
 - b) Personal Injury Liability;
 - c) Non-owned Automobile Liability; and,
 - d) Cross Liability.
2. Commercial General Liability insurance is endorsed to provide the Government with thirty (30) days advance written notice of cancellation or material damage.
3. In the event that the Facility transports residents as part of the services provided, the Facility carries Automotive liability coverage (Standard Automobile Policy) on all vehicles, owned, leased, operated or licensed in the name of the Facility, in an amount not less than \$1,000,000.00. Attached to and forming part of the Standard Automobile Policy (S.P.F. No. 1) is the Standard Endorsement Form (SEF), 6(a) Permission to Carry Passengers for Compensation Endorsement.
4. The Facility carries a Comprehensive Dishonesty, Disappearance and Destruction Policy in an amount not less than \$5,000.00 to cover the property of residents in the event of dishonest acts committed by the Facility or the Facility's employees.

FORM 1

**DEPARTMENT OF HEALTH AND WELLNESS
COMMUNITY CARE FACILITIES**

**Box 2000,
CHARLOTTETOWN
PRINCE EDWARD ISLAND
C1A 7N8**

PRINCE EDWARD ISLAND

APPLICATION FOR COMMUNITY CARE LICENSE

1. Applicant's Name _____ Phone No. _____
2. Applicant's Address _____ Postal Code _____
3. Operator's Name (If Different than Applicant) _____
4. Operator's Address _____
Postal Code _____ Phone No. _____
5. Operator's Qualifications for Operating Such a Facility:

6. Operator's Experience in Operating Such a Facility:

7. Facility Name _____ Phone No. _____
8. Facility Address _____ Postal Code _____
9. Is Property Owned by Applicant? _____ Yes _____ No
Is Property Leased by Applicant? _____ Yes _____ No

Duration of Lease _____

10. Residents to be
 admitted Personal Care # _____

- Supervisory Care # _____
 Other # _____

Give details for other _____

APPLICATION FOR COMMUNITY CARE LICENSE

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Applicant Name: _____

11. List the services which are available to residents:

12. List the number of each type of proposed staff and their qualifications:

13. Attach a proposed work schedule of staff.

14. Attach a physical description of premises, including type of construction, general condition, site, number and size of rooms, number of storeys and a sketch of the floor plan.

15. Attach a projected operating budget of monthly revenue and expenditures.

16. The following inspections have been completed:

	YES	NO	DATE COMPLETED
Building Construction Standards	<input type="checkbox"/>	<input type="checkbox"/>	_____
Electrical Standards	<input type="checkbox"/>	<input type="checkbox"/>	_____
Elevator Standards (If Applicable)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fire Safety Standards	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hygiene Standards	<input type="checkbox"/>	<input type="checkbox"/>	_____

This is to certify that the information contained herein and in the attachments as required is true and correct to the best of my knowledge and belief.

Signature of Applicant

Date Signed

DECLARATION (OPERATOR/ MANAGER)

To be completed at the request of the CCFNH Board, pursuant to section 6 and 6.1 of the Community Care Facilities and Nursing Homes Board Act Regulations

Full Legal Name: _____ Address: _____
Other Name(s) / Aliases: _____ Phone Number: (H) _____
Date of Birth: _____ (C) _____
SIN: _____ Email Address: _____

I, _____, of _____(city), Province of _____, SOLEMNLY DECLARE (check correct response, provide information where required):

1) I have never been convicted of a criminal offence _____
I have previously been convicted of a criminal offence (provide details below) _____

2) I have never been licensed to operate, or been employed in, a community care facility, nursing home, or similar care facility in another province or country. _____
I have been licensed to operate, or have been employed in, a community care facility, Nursing home, or similar care facility in another jurisdiction AND I have had the following (list if any) conditions applied to my license or employment. _____

(List Jurisdiction(s), and any applicable license conditions in each jurisdiction):

Declared on the ____ day of _____, 20__.

Declarant