Dear Applicant:

Re: Your request for access to information under Part II of the Access to Information and Protection of Privacy Act [Our File #: HCS/114/2019]

On August 12, 2019, the Department of Health and Community Services (the Department) received your request for access to the following records:

“July 2019 briefing materials titled: ??? HCS Meeting Minutes - Ambulance Association Presidents June 27 2019; ??? Decision Note - Central Health: Request to convert an activity room to Long Term Care beds at Fogo Island Health Centre; ??? Information Note - Paramedics Providing Palliative Care Program; ??? Information Note - Review of Person and Family Centered Care in Long Term Care; ??? Information Note - Personal Care Home Program Growth - Central Health.”

I am pleased to inform you that a decision has been made by the Department to provide access to most of the requested information. Access to the remaining information contained within the records has been refused in accordance with the following exceptions to disclosure as specified in the Access to Information and Protection of Privacy Act (the Act):

Policy advice or recommendations
29. (1)(a) The head of a public body may refuse to disclose to an applicant information that would reveal advice, proposals, recommendations, analyses or policy options developed by or for a public body or minister.

Disclosure harmful to the financial or economic interests of a public body
35. (1) The head of a public body may refuse to disclose to an applicant information which could reasonably be expected to disclose:
   (c) plans that relate to the management of personnel of or the administration of a public body and that have not yet been implemented or made public;
   (d) information, the disclosure of which could reasonably be expected to result in the premature disclosure of a proposal or project or in significant loss or gain to a third party;
   (g) information, the disclosure of which could reasonably be expected to prejudice the financial or economic interest of the government of the province or a public body.

Disclosure harmful to business interests of a third party
39. (1)(a)(ii)(b)(c)(i) The head of a public body shall refuse to disclose to an applicant information that would reveal commercial, financial, labour relations, scientific or technical information of a third party; that is supplied, implicitly or explicitly, in confidence; and the disclosure of which could reasonably be expected to harm significantly the competitive position or interfere significantly with the negotiating position of the third party.
Disclosure harmful to personal privacy

40. (1) The head of a public body shall refuse to disclose personal information to an applicant where the disclosure would be an unreasonable invasion of a third party's personal privacy.

Please be advised that page 6 has been withheld in its entirety under s. 29(1)(a) of the Act.

The Act requires us to provide an advisory response within 10 days of receiving the request. As this request has been completed prior to day 10, this letter also serves as our Advisory Response.

Please be advised that you may ask the Information and Privacy Commissioner to review the processing of your access request, as set out in section 42 of the Access to Information and Protection of Privacy Act (the Act). A request to the Commissioner must be made in writing within 15 business days of the date of this letter or within a longer period that may be allowed by the Commissioner.

The address and contact information of the Information and Privacy Commissioner is as follows:

Office of the Information and Privacy Commissioner
2 Canada Drive
P. O. Box 13004, Stn. A
St. John’s, NL. A1B 3V8
Telephone: (709) 729-6309
Toll-Free: 1-877-729-6309
Facsimile: (709) 729-6500

You may also appeal directly to the Supreme Court Trial Division within 15 business days after you receive the decision of the public body, pursuant to section 52 of the Act.

Please be advised that responsive records will be published following a 72 hour period after the response is sent electronically to you or five business days in the case where records are mailed to you. It is the goal to have the responsive records posted to the Completed Access to Information Requests website within one business day following the applicable period of time. Please note that requests for personal information will not be posted online.

If you have any further questions, please contact the undersigned by telephone at 709-729-7010 or by email at MichaelCook@gov.nl.ca.

Sincerely,

Michael Cook
ATIPP Coordinator
/Enclosures
Access or correction complaint

42. (1) A person who makes a request under this Act for access to a record or for correction of personal information may file a complaint with the commissioner respecting a decision, act or failure to act of the head of the public body that relates to the request.

(2) A complaint under subsection (1) shall be filed in writing not later than 15 business days

(a) after the applicant is notified of the decision of the head of the public body, or the date of the act or failure to act; or

(b) after the date the head of the public body is considered to have refused the request under subsection 16 (2).

(3) A third party informed under section 19 of a decision of the head of a public body to grant access to a record or part of a record in response to a request may file a complaint with the commissioner respecting that decision.

(4) A complaint under subsection (3) shall be filed in writing not later than 15 business days after the third party is informed of the decision of the head of the public body.

(5) The commissioner may allow a longer time period for the filing of a complaint under this section.

(6) A person or third party who has appealed directly to the Trial Division under subsection 52 (1) or 53 (1) shall not file a complaint with the commissioner.

(7) The commissioner shall refuse to investigate a complaint where an appeal has been commenced in the Trial Division.

(8) A complaint shall not be filed under this section with respect to

(a) a request that is disregarded under section 21;

(b) a decision respecting an extension of time under section 23;

(c) a variation of a procedure under section 24; or

(d) an estimate of costs or a decision not to waive a cost under section 26.

(9) The commissioner shall provide a copy of the complaint to the head of the public body concerned.
Direct appeal to Trial Division by an applicant

52. (1) Where an applicant has made a request to a public body for access to a record or correction of personal information and has not filed a complaint with the commissioner under section 42, the applicant may appeal the decision, act or failure to act of the head of the public body that relates to the request directly to the Trial Division.

(2) An appeal shall be commenced under subsection (1) not later than 15 business days

(a) after the applicant is notified of the decision of the head of the public body, or the date of the act or failure to act; or

(b) after the date the head of the public body is considered to have refused the request under subsection 16 (2).

(3) Where an applicant has filed a complaint with the commissioner under section 42 and the commissioner has refused to investigate the complaint, the applicant may commence an appeal in the Trial Division of the decision, act or failure to act of the head of the public body that relates to the request for access to a record or for correction of personal information.

(4) An appeal shall be commenced under subsection (3) not later than 15 business days after the applicant is notified of the commissioner’s refusal under subsection 45 (2).
Meeting Minutes  
Department of Health and Community Services  
Ambulance Association Presidents  
June 27, 2019 11:00 AM  
Executive Boardroom

Attendees:
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- Karen Stone, Deputy Minister, Health and Community Services (HCS)  
- Heather Hanrahan, Assistant Deputy Minister, HCS  
- Wayne Young, Ambulance Programs, HCS

Agenda item #1 - Service Agreement Extension until March 31, 2022
- Karen Stone reminded everyone of government’s desire to sign Service Agreement extensions with the private and community ambulance operators until March 31, 2022. The extensions will coincide with government’s current direction for public procurement of ambulance services by April 1, 2022.

- In response to request from associations for increased compensation the associations were told they could make a request in writing.  

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- It was agreed that the presidents would discuss the financial proposal(s) content and format among themselves and with their executives then return to government within a reasonable timeframe.

Agenda item #2 - Public Procurement of Ambulance Services
- Karen Stone explained that the Public Procurement Act requires government to publically procure contracted ambulance services.
• Wayne Young was asked to follow up with the association presidents on July 11, 2019 to set a date for further discussions on public procurement options.

Agenda item #3 - Regulations Consultation
• Karen Stone explained that HCS is preparing the regulations necessary for the proclamation of the *Emergency Health Services and Paramedicine Act*.

• Karen offered to provide the association presidents with the opportunity to review the draft regulations.

• September 17, 2019 is tentatively scheduled for the review meeting.

Agenda item #5 – Off load delays at St. John's Metro Hospitals
• Eastern NL operators are experiencing off load delays at the emergency departments at St. Clare’s and Health Science Complex. The delay can be as long as 4.5 hours.

• The ambulances tied up in St. John’s reduce emergency response capacity in the operator’s region.

• Karen assured the association president’s that Eastern Health’s management are investigating potential solutions.

Agenda item #6 – Advance Care Paramedics (ACPs) in Private and Community Services
• There are a growing number of ACPs working as Primary Care Paramedics in private ambulance services.
Decision Note
Department of Health and Community Services

Title: Central Health: Request to convert an activity room to Long Term Care beds at Fogo Island Health Centre

Decision/Direction Required:
- [Redacted]

Background and Current Status:
- There are approximately 2,400 residents on Fogo Island who access health services at the Fogo Island Health Centre (FIHC). Two physicians are based in the FIHC and the facility currently is operating with five acute and nine LTC beds.

- Initially, the plan for FIHC identified nine acute beds and 11 LTC beds. This plan changed prior to opening, and since opening, the bed composition has changed several times. The following table summarizes the changes in beds at the FIHC.

<table>
<thead>
<tr>
<th></th>
<th>Number of Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Acute</td>
</tr>
<tr>
<td>Proposed Bed Numbers (Summer 2019)</td>
<td>5</td>
</tr>
<tr>
<td>Current (Since 2015)</td>
<td>5</td>
</tr>
<tr>
<td>Beds increased in 2006</td>
<td>5</td>
</tr>
<tr>
<td>At time of FIHC opening in 2004</td>
<td>5</td>
</tr>
<tr>
<td>Initial Plan</td>
<td>9</td>
</tr>
</tbody>
</table>

- The residents of Fogo have identified that one of their primary concerns regarding access to health services is the insufficient number of LTC beds. Recently, there have been several residents who had to leave Fogo to access LTC beds.

- In addition to the FIHC, there is a privately operated personal care home (PCH), Riverhead Manor, operating in Fogo. This 17 bed home is licensed to provide care for clients assessed with Level I and II care needs. This PCH has historically operated with varying levels of vacancies, and at July 9, 2019, had only seven residents.

- **Currently 9 individuals are awaiting LTC placement in FIHC, and 2 individuals are awaiting a transfer from another LTC facility. During 2018, there was an average of 1 individual waiting for placement, and another 10 individuals waiting for a transfer to the FIHC.**

- There is no waitlist for placement at the PCH, and should an appropriate client present, placement in Riverhead Manor would be quickly facilitated.

- CH has identified several options for renovating the FIHC to address the need for additional LTC beds, however only one of these options is considered viable.
• A room which had originally been intended to be used as a double LTC room, is currently being used as an activity room. CH is proposing to renovate this space and convert the activity room into a two bed LTC room, as was originally designed.

• In order to facilitate this proposal, several rooms will be repurposed and services relocated within the facility. The most noteworthy of these changes will be the space allocated to the Home Dialysis Unit. The current Home Dialysis Unit can accommodate three units being used at the same time for education/training purposes; however, the new proposed space will have space for only one unit. CH advises the room has not been used in recent history for this purpose and currently there are no units on site.

• CH advises there is capacity within current staffing levels to absorb the work associated with two additional LTC residents.

• The proposed renovations can be achieved with minimal expense ($11,000 for renovations and $24,400) for furnishings/minor equipment.

Analysis:
• The option to renovate the activity room into a double LTC room is feasible and will assist in addressing the LTC capacity issues being experienced.

• The renovation can be quickly achieved, at a reasonable cost and with limited interruption to current services at FIHC.

• CH has sufficient deferred revenue to offset the anticipated $34,400 in expenses related to renovating and furnishing the new room.

• Staffing levels at FIHC are such that no additional staffing expenses will be incurred with the addition of two LTC residents. All on-going operational costs can be absorbed within existing budget allocations.

• The LTC residents currently at FIHC were admitted with the understanding that they would not be sharing their room. As a result, CH will offer the double LTC room option only to new residents. This proposed practice will ensure that current residents remain in their single room as committed upon admission.

• New LTC residents may not like the option of sharing a room, and may decide to wait for a single room to become available. Should this happen, CH will continue to experience a waitlist for services at FIHC.

• The Home Dialysis Unit has not been used in recent history, and has never been used for multiple units at a time. If the proposed changes are approved, CH will monitor the usage of the Home Dialysis Unit and identify an alternate delivery site if capacity becomes an issue.

• CH will have to ensure that a communication plan is developed to alleviate any concerns with the repurposing of space.
Information Note
Department of Health and Community Services

Title: Paramedics Providing Palliative Care Program

Issue: To provide an overview of the Paramedics Providing Palliative Care Program and outline the requirements to expand the program to other regional health authorities (RHAs).

Background and Current Status:
- Palliative care is specialized medical care for people living with a life limiting illness, focusing on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for the patient and their family. This care is appropriate at any age and at any stage in a palliative illness.

- Eastern Health (EH) received a $545,000 grant from the Canadian Partnership Against Cancer and the Canadian Foundation for Health Improvement over a four year term to establish a Paramedics Providing Palliative Care Program (the program) in St. John’s.

- The program provides clinical support from paramedics to patients with palliative conditions, permitting them to remain in their home, potentially avoiding unnecessary transport and subsequent admission to hospital.

- The program is intended to work as a complementary service to the care provided by palliative care and community health programs. Paramedicine can bridge service gaps as it is available 24/7, 365 days of the year and partners with all palliative patient care providers.

- The program was developed by officials with the Provincial Medical Oversight (PMO) in collaboration with co-sponsors from the Palliative Care Program at EH.

- The program has a number of objectives:
  o standardized approach to palliative care provided by paramedics;
  o reduction in ambulance transports and patient admissions to hospital;
  o improved patient experience during palliation, including the ability to remain at home with pain and symptom management provided by paramedics during palliative crisis;
  o enhanced and expanded palliative care education;
  o increased paramedic comfort and confidence in providing palliative care; and
  o improved interdisciplinary collaboration.

- To meet the program’s objectives, the project team had to achieve the following:
  o expansion of paramedic scope of practice;
  o creation of a palliative care clinical practice guideline;
  o paramedics educated in LEAP-Paramedic program offered through Pallium Canada;
  o creation of a palliative care project patient database;
  o integration of the patient database with the Medical Communications Center through iNet Computer Aided Dispatch (CAD) and mobile-CAD (tablets in the ambulances);
  o enhanced partnerships between community health, palliative care, long term care and cancer care, among others; and
  o development of data metrics and program evaluation tools.

- The program registers palliative patients with a unique identifier number, which is given to dispatch when a paramedic response is needed. The iNet system informs dispatch that the call is palliative in nature and transmits pre-arrival instructions to paramedics. Paramedics
document their visit and leave a copy of the Patient Care Record in the patient's home chart to ensure all members of the multi-disciplinary care team are aware of the care provided.

- Program delivery began in April 2019. As of early July 2019, 250 patients are registered. Paramedics have responded to 70 calls and receive one to two palliative calls per 24-hour period.

**Analysis:**
- EH received expressions of interest from all other RHAs to consider expanding the program province-wide. While provincial expansion is outside the project's scope, EH is able to share the program's materials, evaluation tools, etc.\[s. 29(1)(a)\]

**Action Being Taken:**
- EH's intends to offer the program materials, evaluation tools, etc. to the other RHAs.\[s. 29(1)(a)\]

**Prepared/Approved by:** W. Young/T. Power/A. Bridgeman

**Ministerial Approval:** Received from Hon. John Haggie, MD

July 24, 2019
Information Note
Department of Health and Community Services

Title: Review of Person and Family Centered Care in Long Term Care.

Background and Current Status:

- Person and family centered care (PFCC) is a philosophy of care that centers on the needs of the individual and their family and is contingent upon knowing the person through an interpersonal relationship.

- Resident and family councils are a mechanism established in residential care facilities to incorporate a PFCC approach to the provision of services to residents and their families.

- PFCC focuses on creating and nurturing partnerships among the organization's team members, and the residents and families they serve. Providing PFCC means working collaboratively with residents and their families to provide care that is respectful, compassionate, culturally safe, and competent, while being responsive to their needs, values, cultural backgrounds and beliefs, and preferences.

- The Provincial Long Term Care Operational Standards support the philosophy of PFCC including:
  - the requirement for residents in long term care (LTC) to have an integrated care plan developed in collaboration with the resident, family and relevant service providers; and
  - a standard promoting the formation of resident and family councils to formalize opportunities to exchange ideas and opinions and to discuss issues and concerns with the administration and board.

- The Provincial Long Term Care Operational Standards promote the formation of resident and family councils and include the following performance measures:
  - written policies and procedures governing the organization's recognition of and support for resident and family councils;
  - resident and family councils have autonomy over their own affairs;
  - establishment of clear reporting mechanisms and lines of communication to the facility's administration and to the board of directors; and
  - the facility's support for resident and family councils is monitored and evaluated by the continuous quality improvement plan.

- LTC homes in the province are required to be accredited through Accreditation Canada. Accreditation Canada's sector and service based standards help organizations assess quality at the point of service delivery and embed a culture of quality, safety and PFCC into all aspects of service delivery.

- A recent survey of the LTC programs in each of the four regional health authorities (RHAs) demonstrates that a PFCC approach to service delivery in LTC is currently the philosophy of care throughout the province.

- All four RHAs have active resident and family councils in their respective regions.
Analysis:

- Currently, most LTC homes in the province have demonstrated they have PFCC established in their service delivery model including the establishment of resident and family councils.

- Central Health (CH) and Labrador-Grenfell Health (LGH) advise that all LTC homes in their respective regions have active resident and family councils. Western Health (WH) advises that four out of six LTC homes in the region have an active resident and family council. Eastern Health (EH) advises that all LTC homes except one have an active resident and family council.

- The frequency of resident and family council meetings vary but typically occur either quarterly or bi-annually.

- Minutes of family and resident council meetings are available to all residents and/or family members of the respective LTC home. The councils report to the manager and/or directors of the respective LTC homes.

- The RHAs have reported that resident and family councils play a valuable role in service delivery in LTC. These councils are involved in addressing quality of food issues, menu planning, laundry issues, and development of resident recreational programs.

- The RHAs have identified that low attendance at resident and family council meetings has been a concern, particularly in rural areas. In an effort to enhance engagement, RHAs are having residents and/or family chair the meetings rather than a RHA representative.

- A recent survey of all RHAs conducted by HCS to identify initiatives in support of PFCC in LTC identified several common measures:
  - interdisciplinary team meetings are organized within four to six weeks of admission and annually thereafter, to discuss a resident’s care needs. Both residents and/ or family members attend the meetings;
  - “Getting to know You” surveys are completed at admission with residents and/or families; and
  - annual summer family celebrations are held at each LTC site and families are involved in planning of activities.

- The following initiatives were identified by individual RHAs:
  - Western Health
    - establishment of a Newsletter Committee to organize the development of a newsletter to provide a local LTC home perspective. Each committee has a resident or family member representative; and
    - the establishment of Regional Dementia Support Group in collaboration with the Alzheimer’s Society of Newfoundland and Labrador to support residents and family members in navigating a diagnosis of dementia.
Central Health
  o involvement of a regional resident and family council in the design of new LTC homes; and
  o administration of resident and family experience surveys every two years.

Eastern Health
  o providing staff with Gentle Persuasive Approach training to optimize resident care and support resident choice;
  o family and resident engagement in the development of the Appropriate Use of Antipsychotics initiative; and
  o implementation of a regional Resident and Family Advisory Committee to advise on policy and program development.

Labrador-Grenfell Health
  o encouraging increased involvement of residents and families to lead resident and family council meetings including the revision of terms of reference for the councils to reflect opportunities for increased family and resident involvement.

Action Being taken:
- The LTC operational standards are under review. The RHAs have requested that review include the development of a mandatory policy on resident and family councils. In current standards, it is promoted but not required.
- RHAs continue to comply with accreditation service based standards.
- HCS continues to work closely with RHAs to provide quality care to all patients and supports RHAs in efforts to ensure PFCC philosophy is integrated in service delivery models in LTC.

Prepared/Approved By: M. Davis/ A. Bridgeman/ T. Power
Ministerial Approval: Received from Hon. John Haggie, MD

July 19, 2019
Information Note

Department of Health and Community Services

Title: Personal Care Home Program Growth - Central Health

Issue: Potential impact of growth in the personal care home sector in Central Health.

Background and Current Status:
- Personal care homes (PCHs) are licensed, privately owned businesses governed by the Personal Care Home Regulations established under the authority of the Health and Community Services Act, and the Provincial PCH Operational Standards (2007) established under the authority of the Minister of HCS.

- According to the Regulations, personal care home means “a premises, place or private residence in which personal care is provided, for remuneration, to five or more adults”. Further, the Regulations define personal care as “care and assistance provided to assist a person with his or her activities of daily living” which includes “bathing, dressing, feeding, elimination and ambulation”. The current levels of care framework for residential placement defines persons with these needs as Level I, II or Enhanced Care.

- As of March 2019, provincially there were:
  o 84 PCHs;
  o 4,155 beds available (as determined by owner);
  o 3,326 occupied beds (20 per cent vacancy rate); and
  o 2,789 residents receiving a financial subsidy (84 per cent).

- Provincially, as of May 2019, the RHAs have advised that construction of 26 new homes and expansion to 13 existing homes is planned with a possible 2,415 new PCH beds in various stages of planning. If all are constructed this will equate to a potential 60 per cent increase in PCH bed capacity provincially.

- Central Health (CH) is experiencing the impact of this increased growth. Of the total 764 potential new PCH beds planned in the CH region, 268 beds will open by August 2019, with an additional 100 beds anticipated to open in October 2019. A complete list of the planned/potential new PCH infrastructure in CH is included as Appendix 1.

Analysis:
- Some PCH operators have expressed concern about the process for assessment and placement of clients in PCHs in the CH region.

- CH advises that a standard process is followed to determine eligibility for PCH placement:
  o Inquiries for Community Support Services are received through a single intake number.
  o Professional staff of the RHA (nurse or social worker) complete a clinical assessment using a standardized clinical assessment tool. This typically occurs within three weeks of initial inquiry to the RHA.
All assessments for residential placement are processed through the single entry system and are reviewed by a team of clinical staff including a manager responsible for the PCH program.

- Clients who meet clinical eligibility may apply for a financial subsidy and undergo a financial assessment.
- Clients who meet clinical eligibility requirements are provided a list of PCHs, RHA staff do not promote select PCHs.
- The client selects their home of choice. Clients have the right to choose which home they want to reside in and have the ability to transfer homes after placement, provided the home can meet their clinically assessed needs.
- If financially eligible for a subsidy, the subsidy is assigned upon placement (subsidies are not assigned and held in anticipation of a new PCH opening).

- CH advises that clients assessed as requiring Level I care may wait for a subsidy. As of July 18, 2019, 16 people with Level I care needs were waiting for a subsidy. The typical wait time is two to three months. There is no wait time for clients assessed as requiring Level II or Enhanced Care.

- CH advises that where a client is requesting entry into a new (unopened) PCH, a clinical assessment is completed within the three months prior to the anticipated opening of the new PCH. Clients are prioritized for assessment based on presenting risk and complexity of referral (e.g., APA referrals, Home First referrals, placement breakdowns).

- CH advises that new home openings are having an impact on existing homes as some residents are leaving current homes to go to the newer homes. Transfers from existing PCHs:

1. **New Home - White Bay PCH (Baie Verte, opened June 2019) – Capacity: 68 beds**
   - There have been transfers from the following PCHs to White Bay PCH

2. **New home – Kingsway Living GFW (opened July 18, 2019) – Capacity: 100 beds**
   - Transfers pending from the following PCHs to Kingsway GFW
3. New home - Kingsway Living Lewisporte (anticipated opening August 4, 2019) -
   Capacity: 100 beds
   Owners:
   - There are potential transfers from the following PCHs to Kingsway Living Lewisporte

   - As additional homes open, it is anticipated that existing residents may continue to choose to transfer to new homes that may offer more amenities than existing homes.

   **Action Being Taken:**
   - s. 29(1)(a)
   - HCS will complete an analysis and make recommendations regarding a standardized waitlist policy for the PCH sector.
   - HCS will complete an analysis of potential impact of the proposed growth in the PCH sector on the RHAs and Service NL human resources that will be required to meet the monitoring requirements of the PCH program.
   - A decision note outlining new opportunities in PCHs including a potential model of care for adult day programming, reablement and dementia care is under development. Once approved a request for proposals will be issued.

   **Prepared/Approved by:**  M.Davis/D.Waddleton/A. Bridgeman/K. Stone
   **Ministerial Approval:**  Received from Hon. John Haggie, MD

   **July 22, 2019**
### Appendix 1: List of Approved and Potential New PCH beds by Location

<table>
<thead>
<tr>
<th>Location</th>
<th>Owner/Operator</th>
<th>Number of beds</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingsway Living</td>
<td></td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Grand Falls- Windsor</td>
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<td></td>
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<tr>
<td>Lanes Retirement Living</td>
<td></td>
<td>100</td>
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<tr>
<td>Gander</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Whitebay Retirement Living</td>
<td></td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>Baie Verte</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kingsway Living - Lewisporte</td>
<td></td>
<td>100</td>
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<tr>
<td>Hollett Park Retirement Living (Phase 2 - Grand Falls- Windsor, Shaun has an existing Holletts also in GFW)</td>
<td></td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Oram’s Bethesda Manor Gander</td>
<td></td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Golden Years Estates Gander</td>
<td></td>
<td></td>
<td>Increase from 76 to 100 beds</td>
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<tr>
<td>Harbour Breton</td>
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<tr>
<td>Pleasantview Estates Lewisporte</td>
<td></td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Grand Falls- Windsor</td>
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