Submission to the Ministry of Health and Long-Term Care:

Proposed Initial Draft Regulation made under the *Long Term Care Homes Act, 2007*

June 5, 2009

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INTRODUCTION

The Advocacy Centre for the Elderly (ACE) is a community legal clinic, funded by Legal Aid Ontario, to provide legal services to low income seniors on elder law issues. ACE has been in operation since 1984. A primary area of practice of ACE has been advocacy and representation of residents in the long-term care system. One of the lawyers at ACE is a full-time Institutional Advocate, who provides advice to seniors living in various forms of facilities in the health system, as well as people considering moving into such places and families of seniors who may become or are residents in long-term care homes, hospitals, and other group living environments. ACE not only represents and advises individual clients, but also engages in public legal education and law reform activities on long-term care and health institution issues. ACE has also produced a text in excess of 600 pages that is now in its third edition entitled *Long Term Care Facilities in Ontario: The Advocate's Manual*.

We would like to thank the Ministry of Health and Long-Term Care for allowing us to participate in the process under which the draft regulations were initially created. We believe that the consultations which have taken place over the past year with various stakeholders have proven invaluable in the creation of these regulations. Of critical importance was the Ministry's outreach to residents, family councils and staff working in the homes, whose input was critical. We would like to specifically commend Colleen Sonnenberg and her team for their hard work, listening to stakeholders and endeavouring to draft regulations which meet the needs of residents of long-term care homes.

GENERAL COMMENTS

The Ministry of Health and Long-Term Care has given the public one month to comment on Part I of the draft regulations. One of the difficulties with this process is that the contents of Part II are unknown. One can hazard a guess as to the contents of the second set of regulations; however, until they are actually published, the actual regulations are unknown. We therefore request that the following provision be added:

> ***Part I of the draft regulations will be open to further amendments upon receipt of Part II of the draft regulations to ensure completeness and permit the public an opportunity to respond to the draft regulations in its entirety.***

We would also like to note that throughout most of our submission, we have provided suggestions as to what the amendments to the regulations should look like. In other instances, while we have indicated that a regulation is required, the contents and drafting are left to the Ministry to determine. These areas have been shaded in grey.

PART I – INTERPRETATION

Sections 1 and 3 – Definitions

Section 1 of the draft regulations sets out a definition for both "private accommodation" and "semi-private accommodation" while section 3 defines "accommodation", "basic accommodation" and "preferred accommodation".

It is ACE's opinion that the definitions of the different types of accommodation in the regulation are not comprehensive. The regulations must define what is actually meant by each type of accommodation.

For example, the current regulations to the *Nursing Homes Act* define each type of accommodation as follows:

"private room" means,

(a) in the case of a nursing home to which the design manual or the part of the retrofit manual concerning resident bedrooms and headed "Option A" applies, a room with one bed that has a private ensuite washroom, other than a room that is designated by a licensee as a standard room,

(b) in the case of a nursing home to which the part of the retrofit manual concerning resident bedrooms and headed "Option B" applies, a room with one bed that has an ensuite washroom, other than a room that is designated by a licensee as a standard room, or

(c) in the case of all other nursing homes, a room with one bed, other than a room that is designated by a licensee as a standard room;

"semi-private room" means,

(a) in the case of a nursing home to which the design manual or the part of the retrofit manual concerning resident bedrooms and headed "Option A" applies, a room with one bed that has an ensuite washroom, other than a room that is designated as a standard room by a licensee,

(b) in the case of a nursing home to which the part of the retrofit manual concerning resident bedrooms and headed "Option B" applies, a room with two beds that affords privacy to each resident, and that has an ensuite washroom, other than a room that is designated as a standard room by a licensee, or

(c) in the case of all other nursing homes, a room with two beds, other than a room that is designated as a standard room by a licensee;

"standard room" means,

(a) in the case of a nursing home to which the design manual or the retrofit manual applies, a room with one or two beds that affords privacy to each resident, that has an ensuite washroom, and that is designated as a standard room by a licensee, or

(b) in the case of all other nursing homes,

(i) a room with three or more beds, or

(ii) a room with less than three beds that is designated by a licensee as a standard room;[1]

The problem with the current definitions is that they do not properly define what a "private", "semi-private" or "standard" accommodation bed is in homes which may have built or retrofitted prior to the design/retrofit manuals being introduced. These homes, which approximate the standards in those manuals, fall into a grey area. This has led to numerous disputes about the definition of rooms in the home.

Take the example of a home rebuilt prior to any of the new design standards being introduced. This home has three types of rooms: a single bed with its own washroom; a single bed with a shared washroom; and a double bed with its own washroom. It would appear that these configurations approximate the standards of the new design and that, for example, all rooms with a double bed and an ensuite washroom would be considered to be basic accommodation. According to the above-noted definitions, however, this can also be considered a semi-private room under the old standards.

Homes have used this to their advantage by designating some of these beds as semi-private and some as standard, thereby keeping the number of standard beds to as close the minimum required as possible. If the home had been designed under the new standards, these rooms would only be able to be offered at the standard rate.

The draft regulations are even less detailed, thereby opening them to even more potential abuses. We therefore recommend the following definitions:

"private accommodation" means,

(a) in the case of long-term care home to which the design manual or the part of the retrofit manual concerning

[1] R.R.O. 1990, Reg. 832, s. 1.

resident bedrooms and headed "Option A" applies, a room with one bed that has a private ensuite washroom, other than a room that is designated by a licensee as basic accommodation,

(b) in the case of a long-term care home to which the part of the retrofit manual concerning resident bedrooms and headed "Option B" applies, a room with one bed that has an ensuite washroom, other than a room that is designated by a licensee as basic accommodation, or

(c) in the case of all other long-term care homes, as designated by the Director, other than a room that is designated by a licensee as basic accommodation;

"semi-private accommodation" means,

(a) in the case of a long-term care home to which the design manual or the part of the retrofit manual concerning resident bedrooms and headed "Option A" applies, a room with one bed that has an ensuite washroom, other than a room that is designated as basic accommodation by a licensee,

(b) in the case of a long-term care home to which the part of the retrofit manual concerning resident bedrooms and headed "Option B" applies, a room with two beds that affords privacy to each resident, and that has an ensuite washroom, other than a room that is designated as basic accommodation by a licensee, or

(c) in the case of all other long-term care homes, as designated by the Director, other than a room that is designated as basic accommodation by a licensee;

"basic accommodation" means,

(a) in the case of a long-term care home to which the design manual or the retrofit manual applies, a room with one or two beds that affords privacy to each resident, that has an ensuite washroom, and that is designated as basic accommodation by a licensee, or

(b) in the case of all other long-term care homes,

(i) a room that is designated by the Director as basic accommodation or

(ii) a room that is designated by a licensee as basic accommodation.

PART II – RESIDENTS: RIGHTS, CARE AND SERVICES

Residents' Bill of Rights

The Residents' Bill of Rights is an integral part of the legislation. Subsection 3(4) of the legislation allows for regulations governing how these rights are to be respected and promoted by the licensee. The draft regulations say nothing about the Residents' Bill of Rights.

We recommend that, at minimum, the following regulations be included:

> ***Every licensee shall actively promote the Residents' Bill of Rights as follows:***
>
> ***(1) Provide a copy of the Residents' Bill of Rights to each resident and their family/substitute decision-maker upon admission;***
>
> ***(2) Review the Residents' Bill of Rights with the resident and/or their substitute-decision-maker at the comprehensive care conference; and***
>
> ***(3) Conduct annual seminars on Residents' Bill of Rights for***
>
> ***(a) the residents; and***
>
> ***(b) Family and substitute decision-makers.***
>
> ***Every licensee shall actively respect the Residents' Bill of Rights as follows:***
>
> ***(1) All policies must comply with the Residents' Bill of Rights; and***
>
> ***(2) All policies must be reviewed annually to ensure continued compliance with the Residents' Bill of Rights.***

Section 6 – Initial Plans of Care

The plans of care set out in section 6 of the draft regulations do not indicate that there must be consent to each pursuant to the *Health Care Consent Act*. Unfortunately, failure to obtain informed consent for treatment continues to be an issue in long-term care, despite the fact that legislation specifically dealing with consent has been enacted in Ontario since 1995.[2]

[2] The *Consent to Treatment Act, 1992*, S.O. 1992, c. 31 was enacted on April 3, 1995. It was repealed and replaced by the *Health Care Consent Act, 1996*, S.O. 1996, c.2, Sched. A on March 29, 1996.

We therefore recommend that section 6 be amended as follows:

> ***(1) Every licensee of a long-term care home shall ensure that an initial plan of care for each resident is developed, consented to in accordance with the Health Care Consent Act, and communicated to direct care staff within 24 hours of the resident's admission to the home.***
>
> ***(2) An initial plan of care must identify the resident and must include, as a minimum, the following information with respect to the resident:***
>
> ***8. Whether the resident is capable of consenting to the plan of care.***
>
> ***9. Where the resident is capable, confirmation that informed consent was obtained.***
>
> ***10. Where the resident is not capable of consenting to the plan of care, the name of the substitute decision-maker, and confirmation that informed consent was obtained.***

Section 7 – Comprehensive Plan of Care

As set out above, consent is also specifically required for the comprehensive plan of care.

This legislation omits a requirement for a care conference. Care conferences are important as they are often the only time that the resident and/or their substitute decision-maker are provided with information about the resident's care and given an opportunity to ask questions. Without a regulation requiring that a care conference be held, many homes will not do it, given the logistical difficulties in holding them. This is not in the interest of the resident, and homes must be required to hold them at the time that the initial plan is developed and at least annually thereafter.

We recommend amendments to section 7(2) as follows:

> ***(2) A comprehensive plan of care, …***
>
> ***(c) must be consented to in accordance with the Health Care Consent Act***
>
> ***(d) must document whether the resident is capable of consenting to the plan of care; and***

(i) where the resident is capable, confirmation that informed consent was obtained; or

(ii) where the resident is not capable of consenting to the plan of care, the name of the substitute decision-maker, and confirmation that informed consent was obtained.

. . . .

(4) ***A licensee of a long-term care home shall ensure that,***

(a) a conference of the inter-disciplinary team providing the resident's care is held, within six weeks following the resident's admission to the home and at least annually after that, to review the resident's plan of care;

(b) the resident, the substitute decision-maker, where applicable, and such other person as they may direct are given an opportunity to participate fully in the conferences held under clause (a); and

***(c) with respect to each conference held under clause (a), a record is kept of the date of the conference, the participants in the conference and the results of the conference*.**

Transfer to Hospital

When a resident is transferred to hospital, there must be a requirement for information to be sent with the person to the hospital about their condition. As part of their care plan, this information should be ready to be sent to the hospital, should the person become ill. It is ACE's experience that residents are too frequently transferred to hospital without this information and as a result, precious time at the hospital is needlessly spent discerning the resident's medical history or contraindicated medication is administered.

We recommend that the following section be added:

When a resident requires a transfer to hospital for treatment, the following information shall be documented and sent to the hospital with the patient or as soon thereafter as possible:

1. List of specific information, such as diagnosis, medication and allergies. (The Ministry to add additional items to list as appropriate to drafting)

Section 15 – Altercations

Resident altercations can be of a major or minor nature. It is often difficult for the home to deal with these issues, sometimes resulting in complaints by residents and families, as well as Ministry and police involvement.

Resident altercations are different from "abuse". "Abuse" must include an imbalance of power where the person being abused is in a subordinate position to that of the abuser. In long-term care, abuse generally results from the actions of staff, although it could be by family or other third parties.

Where the issue is a resident upon resident altercation, this does not constitute abuse, although it can be just as serious. Resident altercations can be a simple verbal discussion, up to and including assaults resulting in death.

Residents have the right to live in an environment that is safe for them. This safety includes safety from other residents. This is a two-fold responsibility between the home and the Ministry of Health and Long-Term Care to ensure that all residents are both safe and receive any special care that they require.
We recommend that, apart from this legislation, the Ministry of Health and Long-Term Care develop criteria with respect to the admission to both complex continuing care units and mental health facilities where some resident may need to reside instead of in long-term care. While long-term care has the ability to deal with many resident needs, there are some which cannot be met in this setting. Unfortunately, there is no clear admission criterion for complex continuing care or mental health facilities, resulting in people being admitted to long-term care where their needs really cannot be met.

We therefore recommend that section 15 be amended as follows:

> ***Every long-term care resident is entitled reside in a safe environment.***
>
> ***(1) Every licensee of a long-term care home shall ensure that the risk of altercations between residents is reduced by,***
>
> ***(a) identifying factors, based on information provided to the licensee or staff or through observation, that could potentially trigger such altercations;***
>
> ***(b) identifying and implementation interventions;***
>
> ***(c) where interventions are not able to resolve the situation, to contact the Ministry of Health and Long-Term Care for assistance in resolving the***

situation, which may include the provision of increased funds for the care of that resident.[3]

(3) Every licensee of a long-term care home shall contact the Ministry of Health and Long-Term Care where a resident altercation results in:

(a) police intervention;

(b) hospitalization;

(c) a pattern of escalation of altercations involving one more residents.

Section 16 – Policy to Promote Zero Tolerance

Subsection 20(2) of the legislation requires each home to have a policy to promote zero tolerance of abuse and neglect of residents. Paragraph 20(2)(c) states that the policy "shall provide for a program, that complies with the regulations, for preventing abuse and neglect". The draft regulations have not provided any regulations regarding such a program. We recommend the following be added:

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, in addition to complying with clauses 20(2)(a) to (f) of the Act,

(d) identifies the home's prevention of abuse and neglect policy;

(e) identifies the staff member(s) in charge of the prevention of abuse and neglect in the home; and

(f) identifies situations which may lead to abuse and neglect and how to avoid such situations.

Section 20 – Restraining of Residents - Duty on Licensee re Written Policy

We are concerned with subsection 20(2)(c) which refers to the "common law duty of restraint". As it is unlikely that the home's restraint policies will be written by lawyers or in consultation with lawyers, this section is both meaningless and could cause further harm to residents. It will likely be interpreted as a "duty TO restrain" when in fact we understand that it is the intent of the Ministry to flag the fact that a common law duty CONCERNING restraint exists.

[3] This is a reference to the High Intensity Needs Fund, and could be specified as such under the regulations.

We recommend that this section be rewritten to include, at a minimum, a definition similar to that found in the *Health Care Consent Act,* as follows:

> ***Without restricting the generality of subsection (1), the licensee shall ensure that the written policy deals with,***
>
> ***(c) restraining under the common law in emergencies when immediate action is necessary to prevent serious bodily harm to the person or to others.***

We also recommend that clarification be made in this section regarding the use of chemicals (pharmaceuticals) for restraint. The legislation states that chemical restraints can only be used under the "common law". Based on the feedback we have been receiving on the draft regulations, this phrase is misunderstood. We therefore recommend that the following be added to section 20(2):

> ***Without restricting the generality of subsection (1), the licensee shall ensure that the written policy deals with,***
>
> ***(h) use of a drug pursuant to the common law in emergencies for the purpose of restraint.***

Section 21 – Requirements Relating to Restraining by Physical Devices

We believe that not only do staff require initial training in the use of physical devices, but that they also require ongoing training.

We therefore recommend that section 21(1) be amended as follows:

> ***Every licensee of a long-term care home shall ensure that the following requirements are met with respect to restraining by physical devices:***
>
> ***6. Staff who apply physical devices or who monitor residents restrained by physical devices are:***
>
> **(i)** ***trained in the application, use and potential dangers of these devices prior to using or monitoring any physical restraints; and***
>
> ***(ii) receive ongoing training in the application, use and potential dangers of these devices.***

The regulation regarding the use of physical restraints pursuant to the common law requires further changes. As presently written, it appears to allow the home to indefinitely restrain a resident pursuant to the common law. It must be made clear that restraint under the common law is only administered on an emergency

basis and that restraint must only be continued with the consent of the resident or their substitute decision-maker.

We recommend that the following be added to section 21(3):

> ***Where a resident is being restrained pursuant to the common law duty described in section 36 of the Act, the licensee shall ensure that,***
>
> ***(c) that within 24 hours of the initial administration of the physical restraint, that consent be obtained from the resident or their substitute decision-maker and that all other regulations regarding physical restraint be complied with in that regard.***

Requirements relating to Documentation when Restraining by the Administration of Drugs Pursuant to the Common Law Duty

Section 36(4) of the legislation permits regulations to be made requiring the licensee to ensure that the administration of a drug pursuant to the common law duty is done in accordance with the requirements of the regulations. However, the regulations contain no requirements respecting the documentation that must be kept if drugs are used as chemical restraints. We recognize that the intent of the legislation is that chemicals cannot be used as restraint except in emergencies when there is an immediate risk of harm to an individual or others, following the common law principle. We submit that without specific requirements in the regulations concerning their use, chemicals will be used as continuing restraints, rather than just on a temporary basis as intended.

Thus, we recommend the following be added to the regulations following section 21:

> ***Every licensee shall ensure that every administration of a drug to restrain a resident is documented in the resident's record, and without limiting the generality of this requirement, the licensee shall ensure that the following are documented:***
>
> ***1. Circumstances precipitating the application of the drug.***
>
> ***2. What alternatives were considered and why those alternatives were inappropriate.***
>
> ***3. Who made the order, what drug was ordered, the dosage, and by what means it was delivered.***
>
> ***4. The resident's response to the drug.***
>
> ***5. Who gave the drug and the time of administration.***
>
> ***6. All assessments, reassessments and monitoring.***

7. ***Discussion(s) with the resident or the substitute decision-maker, where the resident is incapable, following the intervention, to explain the reasons for the temporary use of a chemical restraint*.**

Section 22 – Requirements Relating to the Use of PASDs

Clause 34.2 of the legislation requires the home to keep records regarding the application of PASDs in accordance with the regulations. The draft regulations do not specify any requirements which we view as an important omission.

Thus, we recommend that section 22(2) be amended as follows:

Every licensee shall ensure that,

(c) Staff that apply PASDs or who monitor residents with PASDs are:

(i) trained in the application, use and potential dangers of the PASDs to using or monitoring PASDs; and

(ii) receive ongoing training in the application, use and potential dangers of these devices.

Moreover, we would like to see ongoing training of staff, similar to those we set out for restraints.

We recommend that the following requirement be added to section 22:

(4) Every licensee shall ensure that every use of a PASD is documented in the resident's record, and without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

1. Circumstances precipitating the application of the PASD.

2. What alternatives were considered, and tried where appropriate, and the reasons why those alternatives were not effective in assisting the resident with the routine activities of living.

3. Who approved the PASD.

4. Consent.

5. All assessments, reassessments and monitoring, as required.

6. Release of the device and repositioning, as required.

Section 26 – Absences

Where a resident is on an absence and is unable to be readmitted due to an issue with the home, such as an outbreak, they should not be discharged from the home.

We recommend that the following be added to section 26:

(6) Where a resident is ready to return to the home, but is prevented from doing so due to an outbreak or other issue at the home, the absence shall be continued until such time as their return is allowed.

Off-Site Visits and Outings

ACE gets numerous complaints from both residents and families and friends regarding the prevention of residents from leaving the home to visit people or go on outings. We believe it should be made clear that residents generally have the ability to come and go from a home and that they should not be prevented from doing so.

There are several common scenarios. Firstly, many homes have a blanket "policy" that residents are not allowed to leave unless a third party has agreed to be "responsible for them. Not only is this often illegal, it certainly does not respect the resident's right of autonomy. Long-term care homes are not prisons and do not have "detention" authority. Homes need to understand that many residents are able to come and go on their own if they wish.

Secondly, overprotective families and substitute decision-makers or others may direct the home to place restrictions as to whom the resident may visit. Very often, this stems from issues of family dynamics or bad blood with a friend of the resident rather than any actual risk to the resident. We submit that unless there are credible allegations that the resident will be harmed or in danger if they leave, residents are entitled to leave the home within the restriction of the "absences" provisions.

We therefore recommend the following:

(1) A resident is presumed to be capable of making a decision to leave the home for an outing.

(2) Where the resident is found to be incapable of making a decision to leave the home on outing, they shall not be restricted in doing so with a third party unless there is credible evidence that they may be harmed, injured or otherwise in danger in so doing.

PART III – ADMISSION OF RESIDENTS

Section 27 – Definition

This section requires clarification that a substitute decision-maker may act on behalf of the incapable person and has the same rights.

We recommend that the following definition be added:

"substitute decision-maker" means a person making placement decisions for the applicant who has been found incapable of making admission decisions pursuant to the Health Care Consent Act and who may make applications on behalf of the applicant.

Responsible Placement Co-ordinator

When a person's application to long-term care involves different Community Care Access Centres, it is often not clear, for example, which Community Care Access Centre has the responsibility to make the finding or to provide information.

We therefore recommend that a section be added between sections 28 and 29 that will define which Placement Co-ordinator has responsibility for which parts of the application process, as the Ministry of Health and Long-Term Care determines is appropriate:

Where an applicant is making an application in the area managed by one Community Care Access Centre but who is applying for placement in a long-term care home managed by another Community Care Access Centre, the responsibilities are as follows:

1. List of responsibilities of the placement co-ordinator in the area where the person is making the application.

2. List of responsibilities of the placement co-ordinator in the area where the person is applying.

Section 28 – Ineligibility to be Placement Co-ordinator.

We would like this section amended to ensure clarity. We have found that in many cases, hospital employees are doing almost all of the work of the placement co-ordinator. This is a conflict of interest, as the hospital employee has demands made of them by the hospital which should not affect the placement process. The reason for having Community Care Access Centres is to provide a non-partisan and client-centred individual to assist in the placement process.

We therefore recommend the following addition:

> ***(1) Every person or entity that is not a community care access corporation within the meaning of the Community Care Access Corporations Act, 2001, is ineligible for designation as a placement co-ordinator.***
>
> **(2) *No hospital or hospital employee is eligible for designation as a placement co-ordinator*.**

Section 29 – Information to be Provided by Placement Co-ordinator

This section of the draft regulation stipulates that the person is to be given information about many things but it fails to include a requirement that the person receive information about the homes where they actually want to reside.

We therefore recommend the following be added between what are presently subsections (2) and 3:

> ***(3) When a person is determined eligible for admission, the placement co-ordinator shall provide the person with information about any long-term care home for which he or she requests information.***

Further, there is no requirement that persons seeking admission to long-term care be given information about their rights or assistance in exercising their rights, as set out in section 55(2)(d) of the Act.

We therefore recommend the following be added to section 29 as the new subsection (5):

> ***(5) The placement co-ordinator shall provide the person with information about their rights and in exercising their rights, which shall include, but not be limited to:***

(i) information about any laws or policies which affect their admission to a long-term care home;

(ii) information about priorities and wait lists for long-term care homes to which the person wishes to apply;

(iii) information about transferring between long-term care homes;

(iv) information about admission to a long-term care home from hospital, where applicable;

(v) information about any temporary program for which the person may be eligible;

(vi) information about their right to apply to the Consent and Capacity Board to review a finding with respect to his or her incapacity to make a decision regarding admission to a care facility pursuant to the Health Care Consent Act;

(vii) information about their right to apply to the Consent and Capacity Board for the appointment of a representative to make a decision regarding admission to a care facility on their behalf pursuant to the Health Care Consent Act;

(viii) Depending on the second set of draft regulations, in may be appropriate to include a section here on rights advice for admission to a secure unit.

Duty of the Placement Co-ordinator

ACE has been encountering refusals by placement co-ordinators to take applications and determine eligibility. We believe that it is important for the regulations to explicitly state that placement co-ordinators must take an application and determine eligibility when requested by the person or their substitute decision-maker.

We recommend that the following section be added after the present section 29:

> ***A placement co-ordinator shall complete an application to determine eligibility when a request is made and consented to by the person requesting admission or their substitute decision-maker.***

Section 30 – Criteria for Eligibility, Long-stay

Section 30(1)(e) of the draft regulation states that an applicant can only be found eligible for admission if their care requirements can be met in a long-term care home. However, there is no definition or explanation as to what this means in the draft regulations or the legislation. The lack of clarity causes difficulties, as applicants whose needs are too complex or who require additional care are often either admitted to homes when they should not be, or they are made eligible and are subsequently unable to find a home which will admit them.

In such situations, we believe the Ministry of Health and Long-Term Care must make a decision based upon the Ministry providing additional funding and resources, in addition to the applicant's individual circumstances.

We therefore recommend that section 30(1)(e) be amended as follows:

> ***An applicant shall be determined to be eligible for admission to a long-term care home as a long-stay resident only if,***
>
> ***(e) the applicant's care requirements can be met in a long term care home, and specifically:***
>
> ***(i) details to be determined by the Ministry of Health and Long-Term Care***

Section 30(3) states that an applicant is not eligible for placement if caregiving, support, or companionship arrangements, other than that which is publicly funded is available, will meet the applicant's requirements. This section can be interpreted as requiring family members and others to provide care although they may not want or be able to do so. The person requiring placement should not be required to be taken care of by someone who does not wish or is not able to do so.

We therefore recommend that section 30(3) be amended as follows:

> **1.** ***None of the publicly-funded community based services available to the applicant while the applicant lives in his or her residence are sufficient to meet the applicant's requirements.***
>
> ***2. None of the publicly funded community based services available to the applicant in the area to which the applicant plans to move are sufficient to meet the applicant's requirements.***

Section 34 – Application for Determination of Eligibility

This section allows for assessments to be completed by an "agent" of the placement co-ordinator. We have encountered many situations where these forms are not completed properly because the agents do not understand the documents, a lack of proper training, or they have their own agenda which are contrary to the interests of the applicant. We believe it is only appropriate for the documents to be completed by the placement co-ordinator, not an agent.

We therefore recommend that clause 34(1)(d) be amended as follows:

> ***An up-to-date assessment of the applicant's functional capacity, requirements for personal care, current behaviour, and behaviour during the year preceding the assessment signed by the placement co-ordinator.***

Section 42 – Removal from Waiting List

The present regulations require that persons be removed from the waiting list if they refuse to consent to admission to the long-term care home. This has been interpreted as including the situation where the person arrives at the home and turns down the room due to problems with the room. ACE has had many cases where a person is justified in refusing consent to admission. For example, an anxiety ridden senior arrived at a home to discover that her roommate was a very demented woman who continuously screamed. She refused to have this roommate and was taken off of the list. In another case, a client refused to stay at a home after learning that the previous resident had repeatedly urinated on the floor and despite attempts to clean the room, it still smelled of urine. Finally, offers have been turned down because persons were misinformed about the homes or their choices. We know of people who are told to put a home on their list and then go to see it later. Admission is offered almost immediately, before the person is able to visit, and when they see the home they are unhappy and refuse to go.

As demonstrated above, there are many extenuating circumstances which should be considered as exceptions to this presently rigid rule.

We recommend that the following section 42(1)(b)(i) be amended as follows:

> ***The appropriate placement co-ordinator shall remove an applicant from every waiting list the placement co-ordinator keeps for admission to a long-term care home as a long-stay resident, and make a record of the removal,***

(d) if the placement co-ordinator offers to authorize the applicant's admission to a long-term care home as a long-stay resident, and the applicant,

(i) refuses to consent to admission, unless the refusal is approved by the Director.

Section 43 – Removal from Waiting List, Short Stay

We recommend that section 43(1)(a) be amended, as per above:

An applicant may be removed from the waiting list for a long-term care home to which the applicant is awaiting admission as a short-stay resident if the appropriate placement co-ordinator offers to authorize the applicant's admission to the home and the applicant,

(a) refuses to consent to admission, unless the refusal is approved by the Director

Section 46 – Crisis Category

ACE submits that when a person is in crisis, they need a bed regardless of their ability to pay. We therefore recommend that persons who become crisis be admitted to the first bed in a home of their choice, regardless of whether it is preferred or basic accommodation. Once the person is admitted, they should be allowed to stay in that room until such time as an internal transfer was available, if they so wished. This will require new regulations in the fee sections, which are not presently available.

We therefore recommend section 46 be amended as follows:

(1) An applicant shall be placed in category 1 on the waiting list for any bed in a long-term care home to be charged at the basic accommodation rate if the applicant requires immediate admission as a result of a crisis arising from the applicant's condition or circumstances.

(2) An applicant shall be placed in category 1 on the waiting list for any bed in a long-term care home to be charged at the basic accommodation rate if….

Section 48 – Religious, Ethnic or Linguistic Origin

At present, there are no criteria as to when a home or unit can be designated as serving the interest of particular religions, ethnic origins or linguistic origins.

We recommend that the regulations be amended to add a section to define the following, as the Ministry of Health and Long-Term Care determines is appropriate:

1. ***What criteria are used to designate a home or unit as serving a particular group.***
2. ***Who authorizes the designation.***
3. ***The definition of "religion", "ethnic origin" and "linguistic origin".***
4. ***That a list must be available with information as to the designation of particular homes and units pursuant to this section.***

Sections 48 and 49 – Placement into Categories on Waiting List

Both subsections 48(2)(a) and 49(2)(a) refer to the placement of applicants into particular categories on waiting lists for long-term care homes if they are not residents of a long-term care home but they require or receive high service levels under the *Home Care and Community Services Act, 1994*. However, there is no definition of "high service levels" in the draft regulation or the *Home Care and Community Services Act, 1994* (which is currently known as the *Long-Term Care Act, 1994*). Thus, it is difficult for us to comment on these sections without knowing or understanding its context. Having said that, with reference to subsection 49(2)(a) and category 4A on the waiting list, we believe it should include those applicants who are participating in the "Wait at Home Program" or similar initiatives.

Section 59 – Authorization of Admission

The regulations have never been clear as to how long a person has to make their decision regarding accepting an offer of admission and how long they have to move in to the home before being charged.

We recommend that the following be added to section 59:

> ***When a bed is offered to an applicant, the applicant has 24 hours to accept or reject the offer.***

(1)(g) The applicant has 24 hours from the time they accept the offer to move into the home before payment is required.

Section 64 – Transfer List

In order for the transfer list to be transparent and to ensure fairness for both those requesting intra-home transfers and those applying for admission from the community, the placement co-ordinator must be provided with the transfer list.

We recommend that the following be added to section 64:

(5) The licensee shall provide the placement co-ordinator with a copy of the transfer list monthly.

Section 67 – Infection Prevention and Control Program

We often receive complaints and requests for information regarding visitors from being denied admission to long-term care homes because of infection control or outbreak situations. There does not appear to be a clear rule regarding these situations, which causes distress for residents and their visitors.

For example, an ACE staff member was recently advised that we could not visit a long-term care home due to the H1N1 Influenza outbreak. The home did not have any cases, nor were the staff who wished to visit specifically targeted. Instead, the home had stated that no visitors except immediate family were allowed to visit the home. While this would appear to be contrary to the Residents' Bill of Rights, it is not clear at what point a home has the right to restrict visitors.

We recommend that a section be added at the end of section 67, specifying the rules regarding the restriction of visitors, as determined appropriate by the Ministry of Health and Long-Term Care, as follows:

Restrictions on visitation

1. Ministry of Health and Long-Term Care requirements

2. Policy requirements