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INTRODUCTION

The *Long-Term Care Homes Act, 2007 (LTCHA or the Act)* is coming into force in Ontario on July 1, 2010. This legislation replaces the three current pieces of legislation which presently govern long-term care homes: the *Charitable Homes Act*, the *Homes for the Aged and Rest Homes Act* and the *Nursing Homes Act*. Not only will there only be one piece of legislation, but there will also be a fundamental shift in the way that long-term care is regulated. This special edition insert will provide a brief guide to the legislation for residents, families and friends to acquaint them with the upcoming changes. Future newsletter articles will explore specific areas of the legislation in more detail.

People need to be aware that there are two separate parts to legislation: the statute and the regulations. The statute is the framework that sets out the general areas of the law. The regulations are the “meat” that flesh out the rules and they must be read in conjunction with the statute. Regulations are subsidiary pieces of legislation which can be easily changed by the Lieutenant Governor in Council, while statutes

are harder to change as they must be passed by elected members of government. The new regulations are lengthier and more robust than what previously existed. One of the reasons is because the regulations replace many of the standards previously contained in the *Long-Term Care Homes Program Manual* (which will no longer exist once the legislation is proclaimed).

In addition to the Act and its regulations, long-term care homes have to comply with many other pieces of legislation. Examples include the:

- *Health Care Consent Act*;
- *Substitute Decisions Act*;
- *Personal Health Information and Protection Act*;
- *Fire Code*; and
- *Occupational Health and Safety Act*.

All legislation can be found online at www.e-laws.gov.on.ca.

Hopefully, the new system of regulation will be more transparent and more consistent than in the past. As well, the new compliance system provides the Ministry of Health and Long-Term Care with more tools to enforce the legislation which should result in better care for residents.



FUNDAMENTAL PRINCIPLE

The fundamental principle of the legislation is stated in section 2:

The fundamental principle to be applied in the interpretation of this Act and anything required or permitted under this Act is that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met.

This principle is to be considered when applying any part of the legislation or its regulations.

LICENSEE

The legislation refers throughout to the “licensee”. The licensee is defined as the holder of a licence issued under the Act, and includes the municipality or municipalities or board of management that maintains a municipal home, joint home or approved First Nations home.¹

RESIDENTS: RIGHTS, CARE AND SERVICES

Residents’ Bill of Rights

The *LTCHA* contains 27 residents’ rights,² expanded from 19 in the previous legislation.

¹ *LTCHA*, s. 2(1).

² *LTCHA*, s. 3(1).

In general, the “new” rights are simply a clarification and expansion of the previous legislation with only a few changes. Rights which are new or amended include the rights:

- Not to be neglected by the licensee or staff;
- To have their personal health information kept confidential and to have access to their personal health information;
- To receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible;
- Not to be restrained except in limited circumstances and in accordance with the Act;
- When very ill or dying to have friends or family present 24 hours a day;
- To have their lifestyle and choices respected;
- To meet privately with their spouse or another person;
- To share a room with another resident according to their mutual wishes, if appropriate accommodation is available; and
- To have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home.

Residents' rights can be enforced by the Ministry of Health and Long-Term Care's inspectors, either during the annual inspection process, or as a response to a report or a complaint. However, the legislation has also enshrined the ability of residents to enforce their rights. The Act states that these rights can be enforced as if a contract had been entered into between the resident and the licensee.³ This means that the resident can sue the home for damages if he/she believes that his/her rights have not been respected.

Mission Statement

Each home must develop a mission statement which sets out the principles, purpose and philosophy of care of the home and ensure that they are put into practice in the day-to-day operation of the home. The home must also ensure that the mission statement is consistent with the fundamental principle of the Act and the Residents' Bill of Rights.⁴ Every licensee must also ensure that the home is a safe and secure environment for its residents.⁵ The regulations set out specific requirements about the following aspects of safety in the home:

- Doors;
- Elevators;
- Floor space;
- Furnishings;
- Privacy curtains;
- Grab bars;
- Bed rails;
- Windows;
- Communication and response systems;
- Lighting;
- Generators;
- Cooling requirements;
- Air temperature;

³ LTCHA, s. 3(3).

⁴ LTCHA, s. 4.

⁵ LTCHA, s. 5.

- Plumbing; and
- Compliance with manufacturer's instructions.⁶

Specific Services

Long-term care homes are required to provide the following services:

- Nursing and personal support services;⁷
- Restorative care, including for those residents with cognitive impairments or who are unable to leave their rooms;⁸
- Recreational and social activities, including for those residents with cognitive impairments or who are unable to leave their rooms;⁹
- Dietary services and hydration;¹⁰
- Medical services;¹¹
- Organized programs to ensure a reasonable opportunity for residents to pursue their religious and spiritual practices;¹²
- Accommodation services, including housekeeping, laundry and maintenance;¹³ and
- Volunteer programs.¹⁴

In general, each program must comply with the following requirements:

- Include a written description of the program, including goals, objectives and relevant policies, procedures and protocols providing methods to reduce risk and monitor outcomes, including protocols regarding referrals of residents to specialized resources where required;

⁶ O. Reg. 79/10, ss. 9-23.

⁷ O. Reg. 79/10, ss. 31-47.

⁸ O. Reg. 79/10, ss. 56-64.

⁹ O. Reg. 79/10, ss. 65-67.

¹⁰ O. Reg. 79/10, ss. 68-78.

¹¹ O. Reg. 79/10, ss. 79-84.

¹² O. Reg. 79/10, s. 85.

¹³ O. Reg. 79/10, ss. 86-92.

¹⁴ O. Reg. 79/10, ss. 94-95.

- Where the staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to the resident, they must be appropriate for the resident based on the resident's condition;
- Be evaluated and updated at least annually in accordance with either evidence based practice or, if there are none, prevailing practices; and
- Keep a written record of these evaluations.¹⁵

While there are no minimum staffing ratios for registered nurses and personal support workers, homes are expected to be able to provide the care and services spelled out in the legislation.¹⁶ However, each home must have at least one registered nurse on duty at all times, except where excluded by the regulations.¹⁷

These programs are regulated in detail in the regulations. The regulation concerning nursing and personal care, for example, includes detailed requirements regarding:

- Personal care;
- Bathing;
- Oral care;
- Foot and nail care;
- Transferring and positioning techniques;
- Personal items and personal aids;
- Notification about personal belongings;
- Mobility devices;
- Dress;
- Bedtime and rest routines;
- End-of-life care;
- Communication methods;
- Availability of supplies; and
- 24-hour nursing care.¹⁸

¹⁵ O. Reg. 79/10, s. 30(1).

¹⁶ *LTCHA*, s. 17(1).

¹⁷ O. Reg. 79/10, s. 45.

¹⁸ O. Reg. 79/10, ss. 31-45.

¹⁹ O. Reg. 79/10, s. 48(1).

Homes must develop and implement interdisciplinary programs in the following areas:

- Falls prevention and management to reduce the incidence of falls and risks of injury;
- Skin and wound care to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions;
- Continence and bowel program to promote continence and to ensure that residents are clean, dry and comfortable; and
- Pain and wound management to identify and manage pain in residents.¹⁹

The minimum requirements for each of these programs are also set out in detail in the regulations.²⁰ It is intended that each home satisfy the same minimum standards, while at the same time allowing them to create a policy that meets their own unique needs.

Screening and Training of Staff and Volunteers

All staff and volunteers in a long-term care home must be screened, which includes the completion of a criminal reference check (unless the person is less than 18 years of age).²¹

The majority of staff, including agency staff, must receive orientation training before starting work (a maximum of one week delay is allowed only in emergencies or in exceptional and unforeseen circumstances).²²

Some people are exempted from this requirement to receive training, although they must be provided with the information in writing before providing services. Persons who are exempt are those who:

- Work in the home pursuant to a contract or agreement with the licensee;

²⁰ O. Reg. 79/10, ss. 49-52.

²¹ *LTCHA*, s. 75.

²² *LTCHA*, s. 76(3).

- Work in the home pursuant to a contract or agreement between the licensee and an employment agency or other third party;
- Will only provide occasional maintenance or repair services to the home; and
- Will not provide direct care to residents.²³

The orientation, as well as re-training, must include the following topics:

- The Residents' Bill of Rights;
- The mission statement of the long-term care home;
- The home's policy to promote zero tolerance of abuse and neglect of residents;
- The duty under section 24 to make mandatory reports about suspected abuse, neglect or misuse of money;
- The protections afforded by the whistle-blowing provisions in section 26;
- The policy of the home to minimize the restraint of residents;
- Fire prevention and safety;
- Emergency and evacuation procedures;
- Infection prevention and control;
- All acts, regulations and policies of the Ministry, as well as similar documents, (including policies of the licensee) that are relevant to the person's responsibilities; and
- Any other areas provided for in the regulations (there are none at present).²⁴

Staff providing direct care to residents must also receive training and re-training in the following areas:

- Abuse recognition and prevention;
- Mental health issues, including care for persons with dementia;
- Behaviour management;

- The minimization of restraint, where necessary, and the application of restraint in accordance with the legislation;
- Palliative care;
- Any other areas provided for in the regulations. Presently, the following areas are listed:

- Fall prevention and management;
- Skin and wound care;
- Contenance care and bowel management;
- Pain management, including recognition of specific and non-specific signs of pain;
- Training in the application, use and potential dangers of physical devices for staff who apply or monitor residents restrained by physical devices; and
- Training in the application, use and potential dangers of personal assistance service devices for staff that apply or monitor residents with personal assistance services devices.²⁵

Medical Directors, physicians and nurses in the extended class retained or appointed to provide care to residents are exempted from the direct care training requirements.²⁶

Volunteers must also undergo orientation which must include information on:

- The Residents' Bill of Rights;
- The mission statement of the long-term care home;
- The policy of the home to promote zero tolerance of abuse and neglect of residents;
- The duty under section 24 to make mandatory reports;

²³ O. Reg. 79/10, s. 222(1).

²⁴ *LTCHA*, s. 76(2) & (4).

²⁵ *LTCHA*, s. 76(7); O. Reg. 79/10, s. 221(1).

²⁶ O. Reg. 79/10, s. 222(2).

- Fire safety and universal infection control practices;
- Any other areas provided for in the regulations. Currently, this is only required for those who start volunteering after the Act comes into force and includes:
 - Resident safety, including information on wheelchair safety and reporting incidents, accidents and missing residents;
 - Emergency evacuation procedures;
 - Escorting residents;
 - Mealtime assistance, if the volunteer is to provide such assistance;
 - Communication techniques to meet the needs of the residents;
 - Techniques and approaches to respond appropriately to the needs of residents with responsive behaviours; and
- The whistle-blowing protections afforded by section 26.²⁷

Prior to being hired, personal support workers, although not regulated, must complete a personal support worker training program which meets the criteria set out in the regulations. However, a grandfathering clause allows those who have three years full-time experience or part-time equivalent and who have worked during the first year of the legislation's operation as a personal support worker, to continue to work without completing the training.²⁸

Plan of Care

The statute and regulations contain detailed requirements regarding plans of care. Within 24 hours of the resident's admission, a care plan must be prepared and communicated to staff. The regulations set out the minimum amount of information which must be included in this 24-hour admission plan of care.²⁹

Within 14 days of being admitted to the home, assessments must be completed in order to prepare the initial care plan, which must be developed within 21 days of admission.³⁰ Each resident must have a written plan of care setting out his/her planned care, proposed goals and clear directions to staff and others who will be providing the care to the resident. The preparation of the plan of care requires the involvement of the resident, their substitute decision maker, if any, and any other person that the resident or substitute decision-maker wishes to assist them. Care must be based on an assessment of the resident and his/her needs and preferences.

The plan of care must be assessed for effectiveness, and revised when required, or at least every six months.³¹

The regulations set out that a minimum of 23 different assessments must be completed and included in the preparation of the plan of care.³² Examples of the types of assessments include:

- Mood and behaviour patterns (including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day);
- Physical functioning and the type and level of assistance that is required relating to activities of daily living (including hygiene and grooming);
- Contenance (including bladder and bowel elimination);
- Nutritional status (including height, weight and any risks relating to nutrition care); and
- Cultural, spiritual and religious preferences and age-related needs and preferences.

²⁹ O. Reg. 79/10, s. 24.

³⁰ O. Reg. 70/10, s. 25.

³¹ *LTCHA*, s. 6.

³² O. Reg. 79/10, s. 26(3).

²⁷ *LTCHA*, s. 77; O.Reg. 79/10, s. 223(2)-(3).

²⁸ O. Reg. 79/10, s. 47.

Prevention of Abuse and Neglect

All homes are required to protect residents from abuse by anyone and neglect by staff.³³ Abuse includes emotional, financial, physical, sexual and verbal abuse.³⁴ Licensees must promote zero tolerance of abuse and neglect, ensure compliance with their abuse and neglect policy and communicate their policy to both residents and their substitute decision-makers.³⁵

The regulations require a home's written policy to deal with the following elements:

- The lack of tolerance for abuse and neglect;
- Explaining what constitutes abuse and neglect;
- Providing for a program of prevention of abuse;
- Explaining the duty to make mandatory reports;
- Assistance and support to the victim or alleged victim;
- How to deal with the perpetrator or alleged perpetrator;
- The consequences for those who abuse or neglect residents;
- Investigation of allegations of abuse and neglect; and
- Training and re-training of staff.³⁶

When an alleged incident occurs, the home must notify the resident's substitute decision-maker, if any, or other person specified by the resident³⁷ and perform an investigation. Upon completion of the investigation, the home must immediately notify the resident, their substitute decision-maker or other person of the results of the investigation.



A welcome new requirement is that the home must also notify the police where there is any alleged, suspected or witnessed incident of abuse or neglect which may constitute a criminal offence.³⁸ Failure by the home to do so has been a common complaint in the past, with homes either ignoring such offences or dealing with them "internally". Finally, there must be an analysis of each incident and evaluation of policy on at least an annual basis.³⁹

Responsive Behaviours

A new concept introduced in the legislation is that of "responsive behaviours". Responsive behaviours are defined as behaviours which often indicate:

- An unmet need in a person, whether cognitive, physical, emotional, environmental or other; or
- A response to circumstances within the social or physical environment that may be frustrating, frightening or confusing to a person.⁴⁰

³³ *LTCHA*, s. 19(1).

³⁴ O. Reg. 79/10, s. 2(1).

³⁵ *LTCHA*, s. 20.

³⁶ *LTCHA*, s. 20(2); O.Reg. 79/10, s. 96.

³⁷ O. Reg. 79/10, s. 97(1).

³⁸ O. Reg. 79/10, s. 98.

³⁹ O. Reg. 79/10, s. 99.

⁴⁰ O. Reg. 79/10, s. 1.

Homes must ensure that the needs of residents with responsive behaviours are met by developing:

- Written approaches (including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other);
- Written strategies (including techniques and interventions, to prevent, minimize or respond to the responsive behaviours);
- Resident monitoring and internal reporting protocols; and
- Protocols for referral of residents to specialized resources where necessary.⁴¹

Licensees must ensure that all of these matters are integrated into the care provided to residents (based on the assessed needs of those with these behaviours) and coordinated and implemented on an interdisciplinary basis into all programs and services.⁴² The licensee shall also ensure that for those demonstrating responsive behaviours, triggers for these behaviours are identified, strategies are developed and implemented to respond to the behaviours (where possible) and actions are taken to respond to the needs of those residents.⁴³

BEHAVIOURS, ALTERCATIONS AND OTHER INTERACTIONS

There is now a duty on the home to take steps to minimize the risk of and prevent altercations between residents, as well as to assist both residents and staff. The home must also develop procedures to minimize the risk of potentially harmful interactions due to residents' behaviours (including responsive behaviours).⁴⁴

⁴¹ O. Reg. 79/10, s. 53(1).

⁴² O. Reg. 79/10, s. 53(2).

⁴³ O. Reg. 79/10, s. 53(4).

⁴⁴ O. Reg. 79/10, ss. 54-55.

⁴⁵ *LTCHA*, s. 21; O. Reg. 79/10, s. 100(1).

⁴⁶ *LTCHA*, s. 22; O. Reg. 79/10, s. 103.

REPORTING AND COMPLAINTS

Homes must have written procedures about initiating complaints and how the licensee will deal with those complaints.⁴⁵ When a written complaint is made, licensees must forward them to the Ministry of Health and Long-Term Care.⁴⁶

Reporting of Abuse and Neglect

Licensees must ensure that every alleged, suspected or witnessed incident of abuse by anyone, as well as neglect by a staff member, be immediately investigated. The results of the investigation and any action(s) taken by licensees must be provided to the Ministry within 10 days of the licensee becoming aware of the incident.⁴⁷ If this is not possible, a preliminary report must be provided within the same timeframe, with a final report to be provided by a date specified by the Ministry.⁴⁸

There is also mandatory reporting to the Ministry by **any person** (except a resident) where the following resulted in either harm or a risk of harm to a resident:

- Improper or incompetent treatment or care;
- Abuse of a resident by anyone or neglect of a resident by a staff or licensee;
- Unlawful conduct;
- Misuse or misappropriation of a resident's money; and
- Misuse or misappropriation of funding.⁴⁹

These sections apply even if the report is based on information made to certain health care professionals that would otherwise be confidential and privileged. In other words, physicians and other members of a College under the *Regulated Health Professions Act*, persons registered under the *Drugless Practitioners Act* and members of the Ontario College of Social Workers and Social Service Workers all have a statutory duty to report.⁵⁰

⁴⁷ *LTCHA*, s. 23; O. Reg. 79/10, s. 104(1).

⁴⁸ O. Reg. 79/10, s. 104(2)-(3)

⁴⁹ *LTCHA*, s. 24(1).

⁵⁰ *LTCHA*, s. 24(4).

The legislation also sets out timelines for the completion of investigations by the Ministry of Health and Long-Term Care, depending upon the nature of the allegations.⁵¹

Provincial Offence

It is an offence to report false allegations,⁵² fail to report⁵³ and to suppress reports.⁵⁴

Whistle-Blowing Protections

Whistle-blowing protections have been included in the legislation to protect anyone from retaliation as a result of disclosing information to an inspector, making a report to the Ministry or providing evidence in a legal proceeding.⁵⁵ The definition of retaliation includes, but is not limited to, the following actions:

- Dismissing a staff member;
- Disciplining or suspending a staff member;
- Imposing a penalty upon any person; and
- Intimidating, coercing or harassing any person.⁵⁶

Hopefully, this will prevent homes from taking action against residents, substitute decision-makers, family members and friends of residents who may make complaints. In the past, we have seen family members who have made complaints about care threatened with or actually barred from attending at the home because they complained. These new sections go further to protect residents and others who may raise issues in the home.

Critical Incidents

Homes are also required to report critical incidents to the Ministry. Incidents which must be reported immediately are:

- Emergencies (such as the loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding);
- An unexpected or sudden death (including death resulting from an accident or suicide);
- A resident who is missing for three hours or more;

- Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing;
- An outbreak of a reportable or communicable disease as defined in the *Health Protection and Promotion Act*; and
- Contamination of the drinking water supply.⁵⁷

Other Reportable Incidents

Other incidents must be reported to the Ministry within one business day after the occurrence of the incident. These include:

- A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition;
- An environmental hazard (including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period of more than six hours);
- A missing or unaccounted for controlled substance;
- An injury which requires a person to be taken to hospital; and
- A medication incident or adverse drug reaction where a resident is taken to hospital.⁵⁸

Also, the resident's substitute decision-maker, if any, as well as any other designated person, must be promptly notified of any serious illness or injury.⁵⁹

⁵¹ *LTCHA*, s. 25.

⁵² *LTCHA*, s. 24(2)-(4).

⁵³ *LTCHA*, s. 24(5).

⁵⁴ *LTCHA*, s. 24(6).

⁵⁵ *LTCHA*, s. 26(1).

⁵⁶ *LTCHA*, s. 26 (2)-(8).

⁵⁷ O. Reg. 79/10, s. 107(1).

⁵⁸ O. Reg. 79/10, s. 107(3).

⁵⁹ O. Reg. 79/10, s. 107(5).

MINIMIZING RESTRAINTS

The legislation deals with a number of different types of “restraints”, each in a different way; however, there must be a written policy dealing with the minimization of all types of restraints. The minimum requirements of the policies are set out in the regulations.⁶⁰ The home is required to comply with both the law and its own policy regarding restraints.⁶¹

A home must ensure that no resident is restrained:

- For the convenience of the licensee or staff;
- As a disciplinary measure;
- By the use of a physical device except as allowed by section 31 or under the common law duty described in section 36;
- By the administration of a drug to control the resident, except under the common law duty described in section 36; and
- By the use of barriers, locks or other devices or controls, from leaving a room or any part of a home (including the grounds of the home) or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36.⁶²

The legislation also states that some things are not restraints:

- Devices that can be released by the resident;
- Personal assistance services devices;
- Use of drugs as a form of treatment;
- Use of barriers, locks or other devices or controls at entrances and exits to the home or the grounds unless the resident is prevented from leaving; and
- Use of barriers, locks or other devices or controls at stairways as a safety measure.⁶³

The regulations also set out a number of devices that cannot be used either as a restraint or a personal assistance services device.⁶⁴

Physical Devices

Physical devices can only be used as restraints if they are included in a care plan and the following specific requirements are met:

- There is a significant risk to the resident or another person of serious bodily harm if the resident is not restrained;
- Alternatives to restraint have been considered and tried, where appropriate, and would not or have not been effective;
- The method of restraint is reasonable given the person’s mental and physical condition and personal history, in addition to being the least restrictive effective method;
- A physician or registered nurse in the extended class has ordered or approved the restraint;
- Consent has been obtained from the resident or, if incapable, their substitute decision-maker; and
- The plan of care provides for the requirements of section 31(3) which deals with restraint by physical devices.⁶⁵

The regulations also contain requirements for restraint, such as:⁶⁶

- The resident must be monitored;
- The resident must be released and repositioned from time to time;
- The resident must be reassessed and the effectiveness of the restraint re-evaluated;

⁶⁰ O. Reg. 79/10, s. 109.

⁶¹ *LTCHA*, s. 29. ⁶² *LTCHA*, s. 30(1).

⁶² *LTCHA*, s. 30(1).

⁶³ *LTCHA*, s. 30(2)-(6).

⁶⁴ O. Reg. 79/10, s. 112.

⁶⁵ *LTCHA*, s. 31(2).

⁶⁶ O. Reg. 79/10, s. 110.

- The resident must only be restrained for as long as necessary to address the risk; and
- The method of restraint must be discontinued if, after reassessment, one of the following is identified that would address the risk:
 - An alternative to restraint; or
 - A less restrictive method of restraint is reasonable in light of the resident's physical and mental condition and personal history.⁶⁷

The home must also complete an evaluation of all physical devices used to restrain in accordance with the regulations.⁶⁸

Barriers/Secure Units

Section 32 of the Act dealing with barriers and secure units has not been enacted; therefore, there is no legal authority to detain residents in the long-term care home, except under the common law. This may pose a problem for long-term care homes as they already detain residents on locked units or prevent them from leaving the home.

Under Canadian law, a person cannot be detained except in accordance with the common law or legislation and, even then, only in accordance with the strictest requirements. Until the *LTCHA*, there has been no authority for homes to detain residents. Yet, homes have historically done so, despite the complete absence of due process for the residents being detained.

Homes will have to seek their own legal advice on how to deal with this issue. However, it is recommended, at a minimum, that the home determine whether the resident meets the requirements necessary to detain under the *LTCHA*. For instance, ACE is aware that many homes have blanket policies that do not allow residents to leave the home without escorts: this clearly is not legal.

⁶⁷ *LTCHA*, s. 31(3).

⁶⁸ O. Reg. 79/10, s. 113.

⁶⁹ *LTCHA*, s. 33(2).

⁷⁰ *LTCHA*, s. 33(4).

Homes must ensure that their present practices do not prevent residents who are competent from coming and going as they wish. Even incapable persons who are able to go out safely cannot be prevented from leaving. Homes must ensure that residents' rights are not infringed by over-broad policies.

Finally, it is not clear whether, even once these sections are enacted, homes will have authority to detain residents. This remains to be seen and, perhaps, determined by the courts.

Personal Assistance Service Devices

Personal assistance service devices (PASDs) are new to the *LTCHA*. They are defined as "a device used to assist a person with a routine activity of living".⁶⁹ A PASD limits or inhibits a resident's freedom of movement as the resident is unable to release themselves from the PASD; however, it is not defined as a restraint. One example of a PASD is a lap belt which prevents residents from sliding out of their wheelchair if they lack the muscle control to stay sitting.

If PASDs are to be used, they must be included in the person's plan of care and only if the following requirements are satisfied:

- Alternatives have been considered and tried where appropriate but would not or have not been effective;
- Their use is reasonable in light of the resident's physical and mental condition and personal history, and are the least restrictive PASD that would be effective; and
- Their use is approved by a:
 - Physician;
 - Registered nurse;
 - Registered practical nurse;
 - Member of the College of Occupational Therapists of Ontario; or
 - Member of the College of Physiotherapists of Ontario.⁷⁰



Records must be kept about the usage of PASDs.⁷¹ If a PASD is being used to restrain, then the restraint provisions of the legislation will also apply.⁷² There are many physical restraints that could be considered either a restraint or PASD, depending upon their usage.

The regulations set out when the use of PASDs should be discontinued,⁷³ as well as other specifications for their use.⁷⁴

Common Law Duty to Restrain

Nothing in the legislation affects the common law duty to restrain or detain when immediate action is necessary to prevent serious bodily harm to the person or others.⁷⁵ Where physical restraints are used pursuant to the common law duty, there are specific requirements for their use as set out in the regulations.⁷⁶

Currently, as the sections pertaining to detention and secure units are not yet in force, a person can only be detained in accordance with the common law.

Chemical restraints, or the use of medication to restrain, can only be utilized pursuant to the common law. That means that they can only be used where immediate action is necessary and they must be prescribed by a physician.⁷⁷ Prolonged use of chemical restraints is not allowed. If a medication is used for the long-term, it must be a treatment and meet the legal requirements for that type of use.

⁷¹ LTCHA, s. 34.

⁷² LTCHA, s. 33(6).

⁷³ O. Reg. 79/10, s. 111(1).

⁷⁴ O. Reg. 79/10, s. 111(2).

⁷⁵ LTCHA, s. 36(1).

OFFICE OF THE LONG-TERM CARE HOMES RESIDENT AND FAMILY ADVISER

While this section is enacted, there has been no indication that such an office has been or will be created in the near future.

ADMISSION OF RESIDENTS

The admission of residents continues in a fashion similar to what existed in the past. The following sections will discuss some of the main changes to the application process.

Placement Coordinator

The role of the placement coordinator is more specifically defined and there is a clarification of the role of the placement coordinator where multiple Community Care Access Centres are involved. The legislation is intended to require more steps in the admission process to be performed by the placement coordinator. This will not change the practice for those applying from the community, but will for those who are applying from hospital.

Eligibility

While the regulations for the eligibility of persons who can be admitted to long-term care have been changed, there will likely be little effect on those actually being admitted. The changes reflect what have been current practices and are intended to ensure that those who truly need the services are admitted into long-term care.⁷⁸

⁷⁶ LTCHA, s. 36(2).

⁷⁷ LTCHA, s. 36(3).

⁷⁸ O. Reg. 79/10, s. 155(1).

Consent to Admission

Consent is still required throughout the process, including choice of homes. Section 46 sets out the elements of informed consent for placement. This is similar to the elements for informed consent in the *Health Care Consent Act* regarding treatment.

When a person is advised of the availability of accommodation in a home to which they have requested admission, they have 24 hours to consent to the admission.⁷⁹ The old legislation does not specify a timeframe.

Withholding Approval for Admission

The legislation prescribes additional requirements for licensees if they want to withhold approval for admission. The home must approve the application unless:

- The home lacks the physical facilities necessary to meet the applicant's care requirements; and
- The staff of the home lack the nursing expertise necessary to meet the applicant's care requirements.⁸⁰

The home must approve or deny the application within five days of receiving the required documentation.⁸¹ However, the legislation does allow for the licensee to request additional information relevant to making a decision.⁸²

If a home is going to withhold approval for admission or withdraws approval, it must give the applicant, the Director⁸³ and the appropriate placement coordinator, a written notice setting out:

- The ground(s) on which approval is being withheld;
- A detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care;
- An explanation of how the supporting facts justify the decision to withhold the approval; and
- Contact information for the Director.⁸⁴

⁷⁹ O. Reg. 79/10, s. 185(e).

⁸⁰ *LTCHA*, s. 44(7).

Waiting Lists

An important change is the number of maximum homes to which a person can be placed on the waiting list. This number has increased from three to five.⁸⁵ The maximum is lifted when the person is on the crisis list. At that point, the person can have as many choices as they want on their list.⁸⁶

There has been no change with respect to the number of choices or the types of choices for those applying to long-term care from hospital. The legislation does not allow short list requirements, first available bed policies, bed matching or any other such requirements.

The management of the waiting lists has been modified. The changes of importance are as follows:

- The crisis category is expanded to include applicants in hospitals who are facing significant demands on capacity. The criteria to satisfy this new sub-category require: the applicant to be occupying a bed in a hospital under the *Public Hospitals Act*; the applicant to be requiring an alternate level of care and immediate admission to a long-term care home; the hospital to be experiencing severe capacity pressures; and the Local Health Integration Network (LHIN) for the area in which the hospital is located to verify these pressures and set out a time period for which the crisis category will apply;⁸⁷
- Spouses or partners will only be added to the spousal reunification category once one of the spouses or partners have already been placed into long-term care;⁸⁸

⁸¹ O. Reg. 79/10, s. 162(3).

⁸² O. Reg. 79/10, s. 162(4) & (5).

⁸³ The Director is a person or persons designated by the Minister for the purposes of the Act: *LTCHA*, s. 2(1) & 175(1).

⁸⁴ *LTCHA*, s. 44(9); O. Reg. 79/10, s. 184.

⁸⁵ O. Reg. 79/10, s. 164(2)

⁸⁶ O. Reg. 79/10, s. 164(4).

⁸⁷ O. Reg. 79/10, s. 171(4).

⁸⁸ O. Reg. 79/10, s. 172.

- Category 3 (religious, ethnic or linguistic origin) and Category 4 (other) applicants are split into A and B lists:
- The applicant will be put into the A stream if they:
 - o Meet the other criteria for the category;
 - o Are not a resident of a long-term care home and require or are receiving high level services⁸⁹ under the *Home Care Community Services Act, 1994*;
 - o Occupy a bed in a hospital under the *Public Hospitals Act* and require an alternative level of care;
 - o Are a long-stay resident of a long-term care home seeking transfer to their home of first choice; or
 - o Are a short-stay resident of a long-term care home seeking transfer to the home as a long-stay resident.
- All others who meet the category criteria are in stream B.⁹⁰
- A new “re-admission” category has been created to allow persons who were discharged from a long-term care home due to a medical or psychiatric leave longer than the permitted time to be readmitted;⁹¹ and
- Except for special categories, such as related temporary, re-opened, replacement, veteran and exchange, the person in the re-admission category will be placed before those in all other categories.⁹²

Specialized Units

The LHIN may now recommend that the Ministry of Health and Long-Term Care designate special units within homes. Examples of possible units are behavioural

units, young persons units or units for persons with specific illnesses, such as Huntington’s Disease. Waiting lists for these units will be specific to those units and there are special rules regarding discharge back to the regular units in the home.⁹³

ABSENCES

There have been a number of changes to the absences section in the regulations. Medical absences will be changed to a maximum of 30 days, while psychiatric absences will be a maximum of 60 days.⁹⁴ There is to be no more “resetting the clock” by returning residents to the home from hospital for one day in order to keep the bed. Instead, the resident will be discharged once the maximum number of days is met. However, as there is a new “re-admission” category (discussed above), residents will be able to return to their home once they are medically able to do so. It is hoped that this will also prevent residents from being discharged from hospital prematurely for the sole purpose of not losing their bed.

DISCHARGE

There have also been some changes to the law governing the home’s ability to discharge residents due to care requirements. Licensees are permitted to discharge residents if they are informed that the resident’s requirements for care have changed and, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or of the persons who come into contact with the resident. Licensees may only discharge if the information is provided by:

- The Director of Nursing and Personal Care, the resident’s attending physician or registered nurse in the extended class, after consultation with the team providing the resident’s care where the resident is at the home; or
- The resident’s attending physician or registered nurse in the extended class where the resident is absent from the home.⁹⁵

⁸⁹ No definition is included in the legislation for “high service levels”.

⁹⁰ O. Reg. 79/10, ss. 173-174.

⁹¹ O. Reg. 79/10, s. 177.

⁹² O. Reg. 79/10, s. 181.

⁹³ O. Reg. 79/10, ss. 198-206.

⁹⁴ O. Reg. 79/10, s. 138(2)(a)-(b).

⁹⁵ O. Reg. 79/10, s. 145(1)-(2).

Where the discharge is for this reason, licensee is required to ensure that a notice of discharge is given to the person, his/her substitute decision-maker (if any), or any other person as directed by the resident or substitute decision-maker. The notice must be provided as far in advance as possible or, where not possible, as soon as possible after the discharge.⁹⁶ Prior to discharge, licensees must also:

- Ensure that alternatives to discharge have been considered and, where appropriate, tried;
- In collaboration with the appropriate placement co-ordinator and other health service organizations, make alternate arrangements for the accommodation, care and secure environment required by the resident;
- Ensure the resident and his/her substitute decision-maker (if any), and any other person as directed, is kept informed and given an opportunity to participate in the discharge planning and that his/her wishes are taken into consideration; and
- Provide a written notice to the resident and his/her substitute decision-maker, if any, and any other person as directed, setting out a detailed explanation of the supporting facts, as they relate both to the home and the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.⁹⁷

RESIDENTS' AND FAMILY COUNCILS

Residents' Councils will now be mandatory in all long-term care homes.⁹⁸ The other significant change is that only residents may be members.⁹⁹ Previously, Residents' Councils only had to be formed after a request was made by the residents, and substitute decision-makers of incapable residents could be members.

A welcome addition to the legislation is that homes must now allow Family Councils to be organized in the home.¹⁰⁰ Further, Family Councils are to be autonomous and those individuals involved in ownership or administration of the home, or who are staff of the home may not be members.¹⁰¹ The powers of the Family Council are similar to those of the Residents' Council.¹⁰² While the legislation gives the Family Councils certain rights, this does not limit them from doing things which are not included in the legislation. It will be up to each Family Council to decide what its mandate will be.

A very important requirement is that while licensees must co-operate with the Residents' or Family Council, they may not interfere with the Council.¹⁰³ We have already received a number of calls from Family Councils where the home's administration is attempting to restrict membership in the Family Council¹⁰⁴ or dictate terms and conditions of the council where these are not specifically set out in the legislation. Under no circumstances do administrators or licensees have any authority in the decisions of Residents' Councils and Family Councils.

⁹⁶ O. Reg. 79/10, s. 148(1).

⁹⁷ O. Reg. 79/10, s. 148(2).

⁹⁸ *LTCHA*, s. 56(1).

⁹⁹ *LTCHA*, s. 56(2).

¹⁰⁰ *LTCHA*, s. 59 (1)-(5).

¹⁰¹ *LTCHA*, s. 59(6).

¹⁰² *LTCHA*, s. 60.

¹⁰³ *LTCHA*, ss. 62 & 65.

¹⁰⁴ The *LTCHA* states that family members or "persons of importance to a resident" are entitled to be members of the Family Council. Licensees have no authority to determine who meets these criteria.

RESIDENT INFORMATION AND AGREEMENTS

Licensees must ensure that residents and their substitute decision-makers, if any, are provided with specified documents upon admission.¹⁰⁵ There is also information which must be posted in the home and communicated to those who cannot read.¹⁰⁶

Regulated Documents

The legislation introduces “regulated documents”. A regulated document is one which is “required by the regulations to meet certain requirements” and is “described as a regulated document in the regulations”.¹⁰⁷ Licensees are prohibited from presenting such a document to prospective residents, residents or their substitute decision-makers unless it complies with all the legislative requirements and has been “certified” by a lawyer. Unfortunately, it is not clear in legal terms what is meant by “certification”, which will undoubtedly cause confusion.

At present, there are two types of regulated documents. They are:

- Any agreement between the licensee and a resident or a person authorized to enter into such an agreement on the resident’s behalf for allowable resident charges; or
- Any document containing a consent or directive with respect to “treatment” as defined in the *Heath Care Consent Act*, including a document containing a consent or directive with respect to a “course of treatment” or a “plan of treatment” under that Act.¹⁰⁸

Both types of regulated documents will be discussed in greater detail in the following sections of this article.

A welcome addition to the legislation is the provision prohibiting homes from coercing residents into signing documents or agreements. No person shall be told or led to believe that prospective residents can be discharged from the home for:

- Not signing a document;
- Voiding an agreement; or
- Giving, not giving, withdrawing or revoking a consent or directive with respect to treatment or care.¹⁰⁹

However, this section about coercion does not apply to admission to a long-term care home or transfer to a secure unit where admission cannot take place without consent.¹¹⁰

It is very clear that residents cannot be prevented from being admitted to a home for refusing to sign documents such as admission agreements or level of care forms.

Agreements for Allowable Charges

The first type of regulated document pertains to agreements between licensees and residents or an authorized person regarding resident fees, such as accommodation charges and unfunded services. However, while unfunded services (such as preferred accommodation, cable and telephone) must still be agreed to in writing,¹¹¹ there is no requirement that a resident or his/her substitute sign a general “admission agreement”.¹¹²

An agreement (if any) regarding basic or preferred accommodation must be separate from any other agreement and may only include particular provisions. Specifically, there is no allowance for a guarantor, as the regulation explicitly states that it is only the *resident’s* obligation to pay that may be included. This precludes homes from requiring guarantors or third parties from signing admission agreements.¹¹³

¹⁰⁵ *LTCHA*, s. 78; O. Reg. 79/10, s. 224.

¹⁰⁶ *LTCHA*, s. 79; O. Reg. 79/10, s. 225.

¹⁰⁷ *LTCHA*, s. 80.

¹⁰⁸ O. Reg. 79/10, s. 227(1).

¹⁰⁹ *LTCHA*, s. 83(1).

¹¹⁰ *LTCHA*, s. 83(2).

¹¹¹ *LTCHA*, s. 91(2).

¹¹² *LTCHA*, s. 91(3).

¹¹³ O. Reg. 79/10, s. 227(3).



Every person who signs a regulated document is entitled to receive a copy of the document.¹¹⁴ Any agreement is voidable for 10 days after it is made,¹¹⁵ except for preferred accommodation agreements.¹¹⁶ However, the agreement for preferred accommodation may include a clause for the termination of preferred accommodation.¹¹⁷ We would recommend that anyone signing such an agreement ensure that this type of clause is included in their agreement. Finally, even where the agreement is voided, the person is not relieved of liability for charges that were incurred prior to the agreement being voided.¹¹⁸

Consent or Treatment Documents

Any document that contains a consent or directive with respect to treatment (such as plans of care, level of care forms and advance care plans), must meet the requirements of the *Health Care Consent Act*, including the requirement for informed consent. These documents may not include any reference to monetary charges or other financial issues and must make clear that consent may be withdrawn or revoked at any time. In fact, the legislation specifically states that there can be no prohibition on withdrawing or revoking consent.¹¹⁹ As well, the text of section 83 prohibiting coercion must be included in any document dealing with treatment, plan of treatment or course of treatment.¹²⁰

¹¹⁴ O. Reg. 79/10, s. 227(2).

¹¹⁵ *LTCHA*, s. 81(1).

¹¹⁶ *LTCHA*, s. 81(3).

¹¹⁷ O. Reg. 79/10, s. 227(4).

¹¹⁸ *LTCHA*, s. 81 (2).

RESIDENT CHARGES¹²¹

Allowable resident charges are similar to those under the *Nursing Homes Act*. There is still a requirement for written agreements for preferred accommodation and unfunded services.¹²² Residents are still responsible for basic accommodation fees even if they decline to sign a written agreement.¹²³ New is the requirement that licensees provide itemized statements within 30 days of the end of the month to the resident, his/her attorney for property, statutory guardian or guardian of property.¹²⁴

There are, however, some major changes in how reductions to basic accommodation fees are calculated.

The regulation has clarified the definition of annual net income.¹²⁵ An application for a reduction in basic accommodation fees will require that the most recent Notice of Assessment under the *Income Tax Act* be provided annually, along with any other supporting documentation required by the Ministry of Health and Long-Term Care.¹²⁶ While this was sometimes a problem in the past if residents had not completed their income tax returns, the Ministry now has the ability to retroactively apply the reduction, which will hopefully resolve this problem.¹²⁷

¹¹⁹ *LTCHA*, s. 82.

¹²⁰ O. Reg. 79/10, s. 227(6).

¹²¹ See addendum at the end of the article.

¹²² *LTCHA*, s. 91(2).

¹²³ *LTCHA*, s. 91(3).

¹²⁴ *LTCHA*, s. 91(5); O.Reg. 79/10, s. 261.

¹²⁵ O. Reg. 79/10, ss. 249-250.

¹²⁶ O. Reg. 79/10, s. 253(2).

¹²⁷ O. Reg. 79/10, s. 253(15).

Licensees now have an obligation to assist the resident to apply for a rate reduction when requested.¹²⁸ If licensees fail to provide all the information required by the regulations, they are liable for the difference.¹²⁹ This puts the burden on licensees to understand the rules and ensure that the resident applies for all appropriate reductions. In the past, we have seen the failure of licensees to properly assist residents resulting in residents being billed thousands of dollars unnecessarily, often ending in a stalemate between the home, who wants to get paid and the resident and their family, who cannot afford to pay.

Another substantial change to the legislation is the addition of a reduction scheme for residents who may be supporting dependents in the community.¹³⁰ Unfortunately, this is not as generous as the chronic care co-payment scheme under the regulations to the *Health Insurance Act*.¹³¹ It remains to be seen whether this will meet the needs of residents and their families.

Also of importance is the change to the definition of income for those who are under a sponsorship agreement pursuant to the *Immigration and Refugee Protection Act*. When determining annual income for the purpose of applying for a rate reduction, the regulations require that the financial support required to support the resident under the sponsorship undertaking be included.¹³² As part of the sponsorship agreement, the sponsor has agreed to provide the person's basic requirements (such as food, shelter and health not provided by public health) and that the person will not be required to apply for social assistance benefits. It remains to be seen what the Ministry of Health and Long-Term Care will determine to be required as financial support and under what circumstances.¹³³

The Ministry may also deny or retroactively adjust the reduction where it was based upon false information.¹³⁴

New to this legislation is the ability of licensees to charge interest for missed, incomplete or late payments.¹³⁵ However, no interest may be charged where payments are not made pending the determination the rate reduction for basic accommodation by the Ministry.¹³⁶

There are no longer any bed-holding fees to increase the time a resident is allowed to stay in hospital on a medical or psychiatric leave.¹³⁷ Fees to keep a bed open prior to actually moving into the home are the amounts that would be required under sections 91(1) and (3) of the regulations, whether or not the person actually moves into the home.

Trust Accounts

Every home must maintain at least one trust account at a bank or trust company where the balance is insured.¹³⁸ Homes are prohibited from holding more than \$5,000.00 in trust from any one resident at one time and can no longer charge any transactional fees for using the trust account.¹³⁹

There are very specific regulations with regards to having written policies for trust accounts¹⁴⁰ and the requirements for dealing with the money held in the account.¹⁴¹ Of note, the home must have specific authorization to take money out of the trust account to pay accommodation fees.¹⁴² Finally, the home must provide a statement of the trust account quarterly, including all deposits, withdrawals and the balance, during that period.¹⁴³

¹³⁴ O. Reg. 79/10, s. 253(17)-(18).

¹³⁵ O. Reg. 79/10, s. 227(3)4.

¹³⁶ O. Reg. 79/10, s. 254.

¹³⁷ O. Reg. 79/10, s. 151(2)-(3).

¹³⁸ O. Reg. 79/10, s. 241(1)-(2).

¹³⁹ O. Reg. 79/10, s. 241(4).

¹⁴⁰ O. Reg. 79/10, s. 241(5)-(6).

¹⁴¹ O. Reg. 79/10, s. 241(7).

¹⁴² O. Reg. 79/10, s. 241(8).

¹⁴³ *LTCHA*, s. 91(5); O. Reg. 79/10, s. 241(7)(f).

¹²⁸ O. Reg. 79/10, s. 253(3).

¹²⁹ O. Reg. 79/10, s. 253(6).

¹³⁰ O. Reg. 79/10, s. 253(7).

¹³¹ R.R.O. 1990, Reg. 552, s. 10.

¹³² O. Reg. 79/10, s. 249(2)4.

¹³³ In late 2010, the Supreme Court of Canada will be considering the case of *Mavi v. Canada (Attorney General)* 2009 ONCA 794 which considers whether the government must exercise discretion on a case-by-case basis and comply with procedural fairness when enforcing sponsorship undertakings.

COMPLIANCE AND ENFORCEMENT

Perhaps one of the most welcome changes contained in this legislation are those to the compliance and enforcement system. An entirely new system is being developed based on the Quality Indicator Survey (QIS) developed at the University of Denver to ensure that long-term care homes are providing quality care to their residents.

Inspections

Each home will continue to be inspected annually by Ministry of Health and Long-Term Care inspectors.¹⁴⁴ Inspections will be unannounced except for beds or homes that are not yet open, to ensure compliance with a closure plan or where the home has requested the inspection.¹⁴⁵ Inspectors continue to have broad powers of entry and access.¹⁴⁶

Once an inspection report is prepared, the Ministry must give either a copy of the report or a summary of the report to the Residents' and Family Councils. This includes both annual inspections and those prepared following complaints.¹⁴⁷

Enforcement

The inspector also has much broader authority to enforce their findings than they have had previously. When an area of non-compliance is found, inspectors shall do at least one of the following:

- Issue a written notification to the licensee;
- Issue a written request to the licensee to prepare a written plan of correction for achieving compliance, to be implemented voluntarily;
- Make either a compliance order or work or activity order ordering the licensee to:
 - Do anything or refrain from doing anything to achieve compliance with a requirement of the Act; or
 - Prepare, submit and implement a plan for achieving compliance with a requirement of the Act; or

- Allow employees of the Ministry, or agents or contractors acting under the authority of the Ministry, to perform any work or activity at the long-term care home that is necessary, in the opinion of the person making the order, to achieve compliance with a requirement under this Act; and
- Pay the reasonable costs of the work or activity; or
- Issue a written notification to the licensee and refer the matter to the Director for further action by the Director.¹⁴⁸

The Ministry may recover costs of any work or activity by withholding funding or by ordering the LHIN to withhold funding.¹⁴⁹ The Ministry may also require that funding be returned or withheld for non-compliance in an amount not to exceed \$50 per bed per day.¹⁵⁰

Finally, the Ministry may order the home to retain, at its own expense, a management company to manage or assist in managing the home,¹⁵¹ or revoke the home's license.¹⁵²

The regulations require that when deciding which action to take or order to make, the inspector or Director must take into account all of, but only these, factors:

- The severity of the non-compliance and, in cases where there has been harm or the risk of harm to one or more residents arising from the non-compliance, the severity of the harm or risk of harm;

¹⁴⁴ *LTCHA*, s. 143.

¹⁴⁵ O.Reg. 79/10, s. 298.

¹⁴⁶ *LTCHA*, ss. 146-148.

¹⁴⁷ *LTCHA*, s. 149.

¹⁴⁸ *LTCHA*, ss. 152-154.

¹⁴⁹ *LTCHA*, s. 154(4).

¹⁵⁰ *LTCHA*, s. 155.

¹⁵¹ *LTCHA*, s. 156.

¹⁵² *LTCHA*, s. 157.



- The scope of the non-compliance and, in cases where there has been harm or risk of harm arising from the non-compliance, the scope of the harm or risk of harm; and
- The licensee's history of compliance, in any home, with requirements under the Act and with requirements under the previous legislation, the regulations under those Acts and any service agreement required by any of those Acts.¹⁵³

When deciding whether to revoke a licence, in addition to these factors, the Director may consider any other factors he or she believes to be relevant.¹⁵⁴

Homes may request that orders made by inspectors be reviewed by the Director. The Director may rescind, confirm or alter the decision, and shall provide written reasons if the order is confirmed or altered. There is no stay of the order pending the review unless the Director so orders.¹⁵⁵

An appeal of an order or decision of the Director under sections 153 through 157 and 163 can be made to the Health Services Appeal and Review Board. In general, there are no stays to order unless the Board orders otherwise, except for revocation of licenses.¹⁵⁶ Decisions of the Board can be made to court.¹⁵⁷

CONCLUSION

New legislation to govern long-term care homes is long overdue. It will take time before we know whether the goals of the legislation – to provide higher quality of care to residents of long-term care homes in Ontario – will be reached.

ADDENDUM

As this insert went to press, O.Reg. 249/10 to the *Long-Term Care Homes Act*, 2007 was released. It also comes into force on July 1, 2010. The new regulation adds section 246.1 to the regulations which have been previously published. This section states that until January 1, 2011, the Director may determine the maximum amount to be charged for basic accommodation either under sections 247 to 254 of the new regulations under the *LTCHA*, or in accordance with the old regulations under the *Charitable Institutions Act*, *Home for the Aged and Rest Homes Act* and *Nursing Homes Act* (as modified to reflect changes in the maximum rates as of July 1, 2010).

Most residents will not be affected by this change. However, residents with unusual income situations, such as sponsored immigrants, young residents or residents with dependents who are seeking a rate reduction may be affected. A person falling into one of these groups should obtain legal advice if they are experiencing difficulties obtaining a rate reduction.

¹⁵³ O. Reg. 79/10, s. 299(1).

¹⁵⁴ O. Reg. 79/10, s. 299(2)

¹⁵⁵ *LTCHA*, s. 163.

¹⁵⁶ *LTCHA*, ss. 164-169.

¹⁵⁷ *LTCHA*, ss. 170-171.