JUDITH WAHL RETIRING AS THE EXECUTIVE DIRECTOR OF ACE

Judith Wahl has been the Executive Director of the Advocacy Centre for the Elderly (ACE) since it was established in 1984. After more than 32 years of service, she has decided to retire from this position to pursue other opportunities in the area of elder law.

Graham Webb, Staff Litigation Lawyer

…continues on page 2
It would be difficult to overstate Judith’s contribution to ACE, which opened in 1984 as a four-person legal-aid specialty clinic with no history or credentials. Since then, it has grown to a ten-person clinic with an established provincial, national and international reputation for expertise in elder law. Much of the reputation of ACE can be directly attributed to the untiring efforts and leadership of Judith Wahl.

Judith was called to the bar of Ontario in 1979, having previously obtained an LL. B. from Osgoode Hall Law School, York University in 1977, and a B.A. (Honours) in English from St. Michael’s College at the University of Toronto in 1974. She began her legal career by working as an associate lawyer with the Toronto law firm Borins, Birenbaum, Steinberg, O’Sullivan in civil litigation, family law, wills and estates, and immigration law. In 1984 she was hired as the founding Executive Director of ACE, and has served in that position continuously to this date.

Judith immediately established her credentials in the area of consent, capacity and substitute decision-making as a member of the Attorney General’s Committee on Substitute Decision-Making for Incapable Persons (the “Fram Committee”, chaired by Ontario government lawyer Steven Fram). The work of the Fram Committee led to the development of substitute decision-making legislation in Ontario, including the 1992 Substitute Decisions Act, and the Consent to Treatment Act (which was later repealed and replaced by the Health Care Consent Act, 1996). Through the Fram Committee, Judith became involved with consent, capacity and substitute decision-making legislation in Ontario from its early development.

Around the same time, Judith was also a member of the Attorney General’s Review of Advocacy for Vulnerable Adults (the “O’Sullivan Commission”, chaired by the late Rev. Sean
O’Sullivan, MPP) which led to the 1992 enactment of the now repealed Advocacy Act and the brief creation of the Ontario Advocacy Commission.

Following the 1992 enactment of the Substitute Decisions Act, the Attorney General of Ontario appointed Judith as the chair of the Interim Advisory Committee for the Implementation of the Substitute Decisions Act. This was a three-year appointment from 1992 to 1995 that involved intensive work with the Office of the Public Guardian and Trustee to prepare for the implementation of the Substitute Decisions Act in May 1995, following a three-year latency period. This experience undoubtedly gave Judith an unparalleled depth of knowledge in respect of the new Ontario substitute decision-making law.

In the years that followed, Judith’s contribution to public policy in the area of elder law in Ontario and throughout Canada has steadily increased. Her policy development involvements are too numerous to mention. They include her memberships on the Guardianship Advisory Committee of the Office of the Public Guardian and Trustee from 1996 to date; on the Compliance Management Working Group and Standards Review Committee for the Ministry of Health and Long-Term Care from 2004 to 2006; on the City of Toronto Seniors Roundtable from 2004 to 2006; on the Ministry of Citizenship and Ministry of Health and Long-Term Care Alzheimer Roundtable from 2004 to 2007; on the HRSDC Fact-Finding Working Group on Prevention and Awareness of Older Adults with Disabilities from 2009 to 2010; on the Ontario Seniors Secretariat Retirement Home Expert Roundtable in 2010; on the Law Commission of Ontario Law and Aging Project Advisory Committee from 2011 to date; and on the Retirement Homes Regulatory Authority Stakeholder Advisory Council from 2012 to date. Judith’s participation on these committees has brought the rights of older adults to the fore in myriad areas, such as health care decision-making, retirement home and long-term care regulation, elder abuse prevention and privacy of health information.

In addition to her constant management of ACE, and her public policy work in the area of elder law, Judith has also written innumerable articles and other publications on elder law issues and has given countless educational presentations on elder law topics to older adults, their caregivers and loved ones; health practitioners; police; service providers; and other lawyers. She is a former chair of the Canadian Bar Association, National Elder Law Section. She has had a continual presence in the media on elder law issues, and has taught for extended periods of time on elder law at the University of Toronto, Faculty of Social Work, in the Gerontology program at the Faculty of Social Sciences at McMaster University, and at Osgoode Professional Development. For many years, Judith has been particularly instrumental in development of policy and the education of health-care providers on health care consent and advance care planning, capacity and substitute decision-making.

Judith has received many awards and distinctions for her work with ACE and in the area of elder law. For example, she received the Osgoode Hall Law School Gold Key Award for Public service in 2006, the Ontario Bar Association Award for Distinguished Service in 2008 and the Queen Elizabeth II Diamond Jubilee Medal in 2013. She is a Distinguished Fellow of the Canadian Centre for Elder Law Studies.

Judith’s contributions to ACE and to the development of elder law in Canada are incomparable. Although ACE will soon appoint a new Executive Director, Judith Wahl will truly be impossible to replace.
When deciding whether a retirement home is right for you, it’s important to know what it’s going to cost now – and down the road.

Retirement homes are privately owned, usually for-profit businesses that rent units to older adults who pay rent and can purchase care services. Unlike long-term care homes (also known as nursing homes), retirement homes do not receive government funding from sources such as the Ministry of Health and Long-Term Care.

The cost of retirement home living can vary widely, from around $1,500.00 per month up to $10,000.00 per month. According to research by the Canada Mortgage and Housing Corporation in 2015, the average monthly rate for a retirement home in Toronto was $3,134.00.¹


The variation in cost is in part attributable to the diversity of retirement homes, which can house as few as six older adults to as many as hundreds of residents. As well, the available amenities, location of the home and size of the unit can impact the starting rent.

Retirement homes are governed mainly by two pieces of legislation: the Residential Tenancies Act, 2006 (“RTA”) and the Retirement Homes Act, 2010. Pursuant to these Acts, retirement home landlords are required to provide tenants with a written tenancy agreement, which must set out the amount of rent, and the cost of meals and each care service, if any, that the tenant is paying for.

Retirement home tenants have the right to consult with a third party before signing a tenancy agreement and may cancel the agreement by giving written notice to the landlord within five days of signing the agreement.

Before entering into a tenancy agreement, the retirement home landlord must provide you with a care home information package, or “CHIP”. The CHIP must include an itemized list of the different types of accommodation and care services provided in the retirement home and their prices, as well as a statement that a resident may purchase or apply for care services, other services, programs or goods from external care providers (such as the local Community Care Access Centre, for example).
Rent Increases

The rules relating to rent increases in a retirement home are the same as for other types of rental housing. These rules are set out in the *RTA*.

Retirement home landlords must provide tenants with at least 90 days' written notice of a rent increase before it can take effect.

In general, retirement home landlords can raise rent once every 12 months by an amount set yearly by the government; this increase is referred to as the annual guideline increase (for 2016, the annual guideline increase is 2%). You can call the Landlord Tenant Board at 1-888-332-3234 to find out current or past annual guideline increases.

If a retirement home landlord wants to raise rent by more than the guideline amount or more than once annually, the landlord must make an application to the Landlord and Tenant Board and receive a decision allowing them to do so.

Some retirement homes are exempt from guideline increases; for example, certain non-profit housing and newer units (i.e. if no one lived in the building before November 1, 1991 or if the unit was not occupied for any purpose before June 17, 1998). Landlords in these cases must still provide 90 days' notice of a rent increase and can only raise the rent once annually.

Care Services Increases

“Care services” in the *RTA* means health care services, rehabilitative or therapeutic services or services that provide assistance with daily living. This includes, for example, nursing care, bathing assistance, and assistance with dressing and personal hygiene. Recreational or social activities, housekeeping, laundry, and assistance with transportation are considered care services only if they are provided along with another care service.

Retirement home residents have the right to apply for publicly funded care services and to be informed about how to apply for those care services by the retirement home. Residents can also purchase services from private agencies of their choice.

Retirement homes are restricted in what they can classify as care services. It is important to review your tenancy agreement carefully to ensure that certain fees or services are not misclassified. ACE has encountered cases where landlords have inappropriately included items, such as maintenance fees and telephone bills, as care services.

Unlike rent, increases to care services can be made more than once annually, as long as the tenant receives at least 90 days' written notice and the tenant has previously received a written tenancy agreement and CHIP, which meet the requirements under the legislation.

More troubling, however, is the fact that the *RTA* does not explicitly limit the amount by which a landlord can raise care services. This means that if a landlord increases care services by an amount that is unaffordable, older adults who rent from retirement homes may be at risk of “economic eviction”, that is, being forced to move because they can no longer afford to stay in their home.

ACE believes this is an unacceptable gap in the legislation and will be making submissions to the Minister of Municipal Affairs and Housing for legislative change. If you are also concerned with this issue, we suggest you contact your MPP to demand change.

Until the law is remedied, it is important to know that care services purchased from a retirement home may be increased more than once annually and by any amount.

Retirement home residents have rights. If you believe that your landlord has inappropriately included items such as care services in your tenancy agreement or unlawfully increased your rent or care services, seek legal advice at ACE or your local community legal clinic.
Lorsque vous devez prendre une décision sur la maison de retraite qui sera convenable pour vous, il est important d’en connaître les coûts dans l’immédiat et pour l’avenir.

Les maisons de retraite sont des entreprises du secteur privé qui louent des logements à des adultes plus âgés en mesure de payer le loyer et d’acheter des services de soins. Contrairement aux foyers de soins de longue durée (aussi connus sous le nom de maison avec soins infirmiers), les maisons de retraite ne reçoivent pas de financement gouvernemental de sources telles que le ministère de la Santé et des Soins de longue durée.

Les coûts d’habitation liés à une maison de retraite peut varier beaucoup allant de 1 500 $ par mois à 10 000 $ par mois. Selon une recherche entreprise par la Société canadienne d’hypothèques et du logement en 2015, le taux moyen mensuel pour une maison de retraite à Toronto était de 3 134 $.

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La variation dans les coûts est en partie attribuable à la diversité des maisons de retraite qui peuvent accueillir un nombre minimal de six adultes à d’autres pouvant loger plusieurs centaines de résidents. Également, les commodités disponibles, lieu où la maison est située et la dimension du logis peuvent influencer le loyer.

Les maisons de retraite sont régies principalement par deux lois: la Loi de 2006 sur la location à usage d’habitation (« LLUH ») et la Loi de 2010 sur les maisons de retraite. En vertu de ces lois, les propriétaires des maisons de retraite sont tenus de fournir aux locataires une convention de location par écrit laquelle doit préciser le montant de loyer et le coût des repas et de chaque service de soins le cas échéant que le locataire doit payer.

Les locataires de maisons de retraite ont le droit de consulter une tierce partie avant de signer une convention de location et peuvent annuler l’entente par un avis écrit au propriétaire dans un délai de cinq jours après avoir signé l’entente.

Avant de conclure une convention de location, le propriétaire de la maison de retraite doit fournir une trousse d’information sur la maison de soins. Cette trousse doit comprendre une liste des types de logement offerts, les services de soins et leurs prix respectifs ainsi qu’un énoncé relatif au droit de chaque résident d’acheter des services ou de faire une demande se services de soins ou d’autres services, des programmes ou des bien d’un fournisseur de soins extérieur (tel que le Centre d’accès aux services communautaires).

Augmentations de loyer

Les règles relatives aux augmentations de loyer dans une maison de retraite sont les mêmes que pour les autres types de logements locatifs. Ces règles sont énoncées dans le LLUH.

Les propriétaires de maisons de retraite doivent donner aux locataires un préavis de 90 jours avant qu’une augmentation de loyer puisse entrer en vigueur.

En règle générale, les propriétaires d’une maison de retraite peuvent augmenter le loyer qu’une fois tous les 12 mois et seulement pour un montant que le gouvernement établit chaque année; ce montant s’appelle le taux légal (En 2016, ce montant est de 2 %). Vous pouvez téléphoner à la Commission de la location immobilière au 1-888-332-3234 pour connaître le taux légal actuel ou celui des années passées.

Si un propriétaire de maison de retraite veut augmenter le loyer pour un montant plus élevé que le taux légal ou plus qu’une fois par année, le propriétaire doit présenter une demande à la Commission de la location immobilière pour obtenir une ordonnance dans ce sens.

Certaines maisons de retraite ne sont pas assujetties aux règles d’augmentations de loyer comme par exemple certains logements subventionnés et des logements plus récent (ex.: si personne n’a habité l’édifice avant le 1er novembre 1991 ou si le logement n’avait pas été habité avant le 17 juin 1998). Les propriétaires dans ces cas doivent tout de même donner un préavis de 90 jours de l’augmentation de loyer et peuvent seulement augmenter le loyer qu’une fois par année.

Augmentations des services en matière de soins

« Services en matière de soins » dans la LLUH s’entend de services de santé, de services de réadaptation, de services thérapeutiques ou des services d’aide à l’accomplissement des activités de la vie quotidienne. Ceci comprend par exemple les soins infirmiers, l’aide pour le bain, pour l’habillement et l’hygiène personnel. Les activités récréatives ou sociales, l’entretien, le lavage et le transport sont des services en matière de soins seulement s’ils sont fournis avec un autre service en matière de soins.
Les résidents de maisons de retraite ont le droit de demander des services de soins subventionnés et d’être informés sur comment présenter ces demandes par la maison de retraite. Les résidents peuvent également acheter des services des agences de service de leur choix.

Les maisons de retraite sont restreintes sur ce qu’elles peuvent facturer. Il est important de réviser votre convention de location attentivement pour vous assurer que certains coûts ou services ne sont pas catégorisés par erreur comme services de soins. ACE a vu des situations où les propriétaires ont inclus de façon non appropriée des frais d’entretien et de téléphone comme des soins de service.

Contrairement au loyer, les augmentations des services de soins peuvent être imposées plus qu’une fois par année, pourvu que le locataire reçoive au moins un préavis de 90 jours et que le locataire a déjà reçu une convention de location et une trousse d’information qui respectent les exigences en vertu de la Loi.

Ce qui est plus inquiétant encore, c’est que le LLUH ne restreint pas de façon explicite le montant par lequel le propriétaire peut augmenter le montant des services de soins. Ceci signifie que si un propriétaire augmente les soins de services à un taux qui n’est pas abordable, les aînés qui louent une maison de retraite peuvent être à risque d’être évincés pour des motifs économiques puisqu’ils se verrait obligés de quitter leur foyer par manque de moyens financiers.

ACE croit qu’il s’agit d’un manque unacceptable dans la Loi et présentera des observations au ministre des Affaires municipales et du Logement dans le but d’obtenir des changements législatifs. Si vous êtes préoccupé par cette question, nous vous recommandons de communiquer avec votre député pour demander des changements.

Avant que la loi ne soit modifiée, il est important de savoir que les services de soin qui sont achetés d’une maison de retraite peuvent être augmentés plus qu’une fois par année et par un montant irrégulier.

Les résidents de maisons de retraite ont des droits. Si vous croyez que votre propriétaire a de façon inappropriée inclus des services en tant que services de soins dans votre convention de location ou a augmenté votre loyer ou vos services de soins de façon injustifiée, obtenez des conseils juridiques auprès d’ACE ou de votre clinique juridiques communautaire.
Living in a long-term care home can be a lonely and isolating experience, cut off from the outside world. One of the most important ways that a resident’s day can be brightened up is by having a visitor. Unfortunately, residents may encounter issues in having visitors, and visitors may encounter problems when attempting to visit residents.

RESTRICTION BY HOME

The Long-Term Care Homes Act (LTCHA) has as its fundamental principle that a long-term care home is, “primarily the home of its residents”. As such, residents do not lose any rights that they might otherwise have in living on their own, including the right to have visitors of their choosing.

The Residents’ Bill of Rights enshrines this right, providing that:

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

If residents want to have visitors, they may do so. Homes are not entitled to interfere with a resident’s visitors, including preventing them from visiting, restricting hours, or restricting place of visits. While the home may not interfere, the resident and their visitor should also be cognizant of other residents, so if visiting late at night, other sleeping residents should not be disturbed.

On occasion, the staff at a home may become unhappy with visitors. This often occurs when a visitor complains about care issues, is loud, visits at unusual times, or is otherwise seen as “difficult”. Even in these situations, the law is on the resident’s side: the home cannot interfere.

Trespass to Property Act

One way that homes will deal with these issues is by issuing a “Trespass Notice” to visitors, indicating that if the visitor returns, police will be called. It is our opinion that the home has no authority to issue such a notice. The Trespass to Property Act (TPA) says that it can only be used if the person is not “acting under a right or authority conferred by law”. As visitors are acting under a right conferred by law, that being the LTCHA, the home has no authority to use the TPA to prevent visitors from attending. Further, challenging these notices is problematic. In order to do so, the person must: breach the notice; be given a ticket by police; and then request a trial, which can take many months to be heard. In the interim, visits may be difficult, if not impossible, which causes further stress and is unfair to the resident and their visitor.

Criminal Code

If the home believes that the visitor is acting in an illegal manner, police can be called. It would then be up to the police and the Crown to determine whether the person can be charged, and for the courts to determine guilt and possibly restrict the person’s access to the home within that context. In most cases,

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1 Long-Term Care Homes Act, 2007, S.O. 2007, c. 8, s. 1
2 Ibid., s. 3
3 Trespass to Property Act, R.S.O. 1990, c. T.21, s. 2(1) A finding of guilt brings a maximum fine of $2,000.
however, the type of complaints that the home staff has about visitors, such as being interfering, loud, or swearing, are not criminal in nature and would not warrant any type of police involvement.

Restrictions on Visits

Homes are also not entitled to restrict visiting hours or dictate where visits will take place. Visitors cannot be restricted to lobbies or “supervised” areas as this is also interference. Visits to rooms, for example, can be very important when the person is the resident’s substitute decision-maker. It is important for substitute decision-makers to have access to residents in all areas, as they are the voice of the resident and instruct care when necessary. In other cases, the resident may want the visitor to come to their room as it is more comfortable for them, or it is difficult for them to visit in other areas.

Restrictions on Outings/Leaves of Absence

As discussed in our previous article, “Detention in Long-Term Care” homes also do not have authority to prevent residents from leaving the home for a visit, either for a few hours or longer.

ACE had a recent case in which a resident who wished to visit her daughter over the Christmas holidays was barred from leaving by the long-term care home as they did not believe it to be in her “best interest”. (There was no issue of capacity.) ACE quickly intervened and with the assistance of the Ministry of Health and Long-Term Care, the resident was able to spend Christmas with her family. The home owes residents a duty of care, which may be used in some circumstances where there is a serious safety issue related to an incapable resident. Nevertheless, for the most part, the home has no legal authority to prevent such outings.

Restriction by Family, Attorney for Personal Care or Substitute Decision-Maker

At times, a family member, attorney for personal care or substitute decision-maker may attempt to restrict a resident’s visitors or ability to go on outings with certain people. It is not uncommon for family members to tell the home that they should not allow another family member to visit, or that a friend should not be allowed to take Mom out to lunch.

In most cases, the person who purports to be giving instructions will not actually have any authority to do so. First, capacity to consent to a visitor is a very low capacity: if someone wants another person to visit, they may only need to know that they like the person and want them to visit. Second, even if the person is “incapable”, it does not necessarily authorize a third party, such as an attorney for personal care, to give or refuse consent on their behalf.  

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5 Court appointed guardians of the person may have wider areas of authority depending upon what is ordered by the court. However, given the rarity of these
Attorneys for personal care only have such authority as is granted by law. “Personal care” decisions are defined under the Substitute Decisions Act, 1992, as decisions relating to “health care, nutrition, shelter, clothing, hygiene or safety”, and it is only in these areas that an attorney for personal care will have authority. “Visitors” or “outings” are not specified areas, and decisions can only be made by attorneys if the issue relates to one of the specified areas, which is generally “safety”. If it can be shown that visitors or outings are unsafe, then they may have authority to make decisions on the person’s behalf.

In cases where there are no attorneys or guardians of the person, there is no one with authority to make even these decisions on behalf of the resident. A substitute decision-maker under the Health Care Consent Act, 1996, for example, could not make decisions regarding visitors. Homes would therefore have to rely on other legal authority to deal with visitors where the safety of the resident was involved. They would have to go before a justice of the peace and lay an information under s. 810 of the Criminal Code to obtain a peace bond. Homes would need to seek legal advice before doing so.

An example of a case where a long-term care home was found to be non-compliant with the LTCHA by taking instructions from a substitute decision-maker was highlighted in an inspection report in May 2015. The resident’s spouse, who was initially referred to as the “POA”, instructed the administration that the resident’s children, from whom she had been estranged, were not to be advised of her whereabouts, could not take her on a leave of absence, and that the POA was to be notified if anyone came to visit. Staff were notified of same. There was no evidence that any discussion had ever been held with the resident or if she agreed with the visitor restrictions. A Compliance Order was issued stating as follows:

The licensee shall ensure that the right of the residents, including resident #500 to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference are fully respected and promoted.

The home shall review with resident #500 the visitor restrictions put in place by their SDM to determine whether or not these restrictions are acceptable to them.

It is clear that the Ministry of Health and Long-Term Care took this matter seriously by issuing a compliance order once the inspection found this breach.

In our opinion, it would have likely have made little difference whether the spouse was acting as an attorney for personal care or as the substitute decision-maker. As there was no evidence that the resident was incapable of making the decision to have visitors, they would not have had any authority to make this decision on the resident’s behalf.

CONCLUSION

In general, residents are entitled to visitors or to go on outings without interference by the long-term care home or their families or substitute decision-makers. Only in very limited circumstances where there are either criminal or serious safety issues involved can these parties interfere. Even then, the parties are limited in their legal ability to prevent same, and should seek legal advice when they believe that such restrictions are warranted.

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6 Substitute Decisions Act, 1992, S.O. 1992,s. 45
7 It was discovered later that the spouse was not the attorney for personal care and would only be the substitute decision-maker for treatment decisions if the resident was incapable.

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CASE COMMENT: R. V. HOYER

Christine Morano, ACE Volunteer

*R v Hooyer*, 2016 ONCA 44, is a decision that provides guidance as to how the abuse of a power of attorney will be treated under the *Criminal Code*.1

The Trial

Mr. Carroll entered a long-term care facility in 2004. His wife held power of attorney over his property. The appellant, Mr. Hooyer, was named as the alternate attorney for property. He was also the residual beneficiary in both Mr. and Mrs. Carroll’s wills. In September 2004, Mr. Carroll’s wife died, and the appellant assumed control over Mr. Carroll’s property. From 2004 to 2011, the appellant lived at Mr. Carroll’s home and depleted all of his income and assets.

Mr. Hooyer did not pay any of Mr. Carroll’s bills at the long-term care facility although he submitted the bills for reimbursement by Veterans Affairs Canada. Mr. Hooyer then deposited the reimbursement cheques and used the money for his own benefit.

At trial, Mr. Hooyer was convicted of one count of theft by person holding a power of attorney, contrary to section 331 of the *Criminal Code*, and one count of fraud.

The Appeal

Mr. Hooyer appealed only the theft charge. Counsel argued that in order to prove theft, the Crown had to show that Mr. Hooyer knew he was not entitled to use Mr. Carroll’s property for his own purposes and without regard for Mr. Carroll’s needs. At trial, Mr. Hooyer testified that prior to her death, Mrs. Carroll had told him he could use the money as if it were his own.

On appeal, Justice Doherty rejected this argument because Mr. Hooyer acknowledged at trial that he understood from his conversation with Mrs. Carroll that he could use the money as if it were his own, but that he also had an obligation to take care of Mr. Carroll’s needs. He also admitted that he knew the money belonged to Mr. Carroll.

The appeal of the theft conviction was dismissed.

Sentencing

On the charge of theft, the trial judge imposed a sentence of two years less a day and a restitution order in favour of the estate of Mr. Carroll in the amount of $378,552.67.

On the fraud charge, Mr. Hooyer was sentenced to six months concurrent and made a restitution order in favour of Veterans Affairs Canada in the amount of $2,224.89.

Justice Doherty found that the sentence imposed by the trial judge was fit. He stated, “[T]his was an egregious breach of trust committed against a very vulnerable victim over several years.”2

Counsel for Mr. Hooyer challenged the restitution order in favour of Mr. Carroll’s estate, since it was Mr. Hooyer himself who would ultimately benefit from the restitution order as the residual beneficiary under the Will. Justice Doherty refused to interfere with the restitution order and stated that, “the appellant’s status as the residual beneficiary under the Will shall not preclude the making of a restitution order in favour of the estate.”

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1 R.S.C. 1985, c. C-45

Important Points to Take Away

- A power of attorney incorporates the provisions of the Substitute Decisions Act,\(^3\) which puts the attorney in a fiduciary relationship with the grantor. An attorney is legally required to act in the best interests of the grantor.

- Even if an attorney is told to use the money and assets as if they were his or her own, there is still an obligation under the power of attorney to act in the best interests of the grantor.

- The assets of the grantor do not belong to the attorney, even if he or she is a beneficiary under the Will.

- Theft and fraud by an attorney for property are acts punishable under the Criminal Code. They are not merely matters to be addressed in civil courts. If the attorney is convicted of these crimes, jail time is a real possibility.

Of the estimated two million seniors residing in Ontario, it is expected that between two and ten percent will experience abuse. This translates to between 40,000 and 200,000 people over the age of 65 in Ontario who have been, or will be, abused.\(^1\) Given the magnitude of this problem, ACE has always welcomed new measures that seek to address elder abuse. However, ACE recently made written submissions to the Standing Committee on Social Policy, indicating that the mandatory reporting system as envisioned by Bill 148, Protection of Vulnerable Seniors in the Community Act, 2015\(^2\) would not provide an effective response to the problem of elder abuse.

Bill 148 proposes there be mandatory reporting by regulated health professionals of any suspected abuse of “seniors” (defined as all persons 65 years of age and older). Mandatory reporting of suspected elder abuse removes the choice from the older adult of whether to report abuse, but does not address the underlying reasons as to why they may prefer not to.

The following is a summary of the existing law and ACE’s position on Bill 148.

**Existing Mechanisms to Protect Older Adults in Cases of Abuse or Neglect**

Anyone may report cases of suspected abuse or neglect to the police.

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\(^1\) *What is Elder Abuse?* online: <www.elderabuseontario.com>


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**In Congregate Settings**

**Long-Term Care Homes**

Anyone who reasonably suspects the abuse or neglect of a resident of a long-term care home (LTCH) has a duty to report it to the Director at the Ministry of Health and Long-Term Care.\(^3\) The only exceptions to this provision are for other residents of the LTCH, who may report suspected abuse, but are not required to do so, and where the matter is subject to solicitor-client privilege.\(^4\)

It is also mandatory for the home’s licensee to report any such allegations to the Director and investigate any allegations of abuse or neglect, as well as report on the results of its investigation to the Director. Having received this information, the Director is then required to have an inspector conduct an inspection and/or investigation.\(^5\)

If the resident who has been abused is incapable, the licensee of their LTCH is required to notify their substitute decision-maker of the incident, unless the substitute decision-maker is the alleged abuser. They are also required to advise the resident and their substitute decision-maker of the results of the investigation into the incident.\(^6\) Furthermore, licensees must notify police if the suspected abuse or neglect may constitute a criminal offence.\(^7\)
Retirement Homes

Similarly, other than residents of the retirement home, anyone who reasonably suspects the abuse or neglect of a resident of a retirement home has a duty to report it.\(^8\)

Reports must be made to the Registrar of the Retirement Homes Regulatory Authority.\(^9\) Having received a report of suspected abuse or neglect, the Registrar is required to have an inspector visit the retirement home immediately.\(^10\) One may complain as well to the licensee of the retirement home, who must investigate the allegations.\(^11\)

**Mandatory reporting makes sense in congregate settings.** Both retirement homes and LTCHs are settings in which the homes’ operators have an unusually high level of control over residents’/tenants’ day-to-day activities. The mandates of these homes touch on most aspects of their residents’ lives, including care provision, medical assistance, food and nutrition, financial dealings and social activities. Dependence on the operators of these homes for assistance with the activities of daily living, as well as the insular nature of these homes, make residents more vulnerable to abuse or neglect. In this context, mandatory reporting of abuse to the prescribed regulatory authority is an appropriate protection.

In the Community

Reporting Suspected Abuse of an Incapable Person. When an incapable adult living in the community is at risk of suffering serious financial or personal effects as a result of abuse or neglect, anyone may make a report to the Office of the Public Guardian and Trustee (OPGT). Under the *Substitute Decisions Act*, the OPGT has a duty to investigate reports of this kind.\(^12\)

The police may also conduct an investigation where the alleged abuse constitutes an offence under the *Criminal Code*. Reporting of these offences is not mandatory.

**Reporting Suspected Abuse of a Capable Person.** Where a capable adult living in the community may be experiencing abuse or neglect, the OPGT cannot investigate, as it only has authority to deal with incapable adults. Bill 148 does not propose to change the mandate of the OPGT.

Even if an adult is capable, the police may conduct an investigation where the alleged abuse constitutes an offence under the *Criminal Code*. Reporting of these offences is not mandatory.

**Why Mandatory Reporting in the Community is Inappropriate**

It reverses the presumption of capacity. In Ontario, an adult is presumed to have the capacity to make decisions unless there are reasonable grounds to believe they are unable to do so.\(^13\) In establishing a mandatory reporting regime only for those 65 years and older, Bill 148 reverses this presumption, and reflects a long-held prejudicial belief that to be old is to be incapable of caring for oneself. Mandatory reporting of suspected abuse of capable adults would deny them autonomy, and undermine a fundamental tenet of our society — that capable people make their own decisions, even if we disagree with those decisions. Among those decisions would be the right to make a decision about whether to tolerate abusive behaviour.

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\(^8\) *Retirement Homes Act*, S.O. 2010, c. 11 s. 75(1)
\(^9\) Ibid., s. 75(1)
\(^10\) Ibid., s. 75(5)
\(^11\) Ibid., s. 74(1)
\(^12\) *Substitute Decisions Act*, 1992, S.O. 1992, c. 30 s. 27

\(^13\) For example, see Laura Cardiff (ed). *Whaley Estate Litigation on Guardianship*, (Whaley Estate Litigation, 2015), p.23, see *Health Care Consent Act*, 1996, S.O. 1996, c. 2., Sched. A, s.. 4(2) for treatment, admission to a care facility and personal assistance services; see also *Substitute Decisions Act*, supra, note 12, s.2(2) for personal care decisions and s.2(1) for contracts: See also *Knox v. Burton*, 2004 CanLII 35099 (ON SC), online: <http://canlii.ca/t/1gsck>
It is discriminatory. Bill 148 will apply to everyone 65 years of age or older, regardless of capacity.14

It gives no role to the older adult. The proposed reporting regime does not require consultation with the subject senior and does not give them opportunity to refuse to report, or plan a safe exit from the allegedly abusive situation.

It will affect seniors’ relationships with their health practitioners. If seniors fear that frank discussion could lead to a police or OPGT investigation, those who might otherwise disclose abuse may choose not to. This has the paradoxical effect of making help inaccessible that would otherwise be available to the senior. The laws that currently exist permit health practitioners to use their discretion, allowing them to weigh the relative risks and benefits of reporting abuse.15

It provides no new remedy. Mandatory reporting regimes give the impression that a remedy to the reported abuse is available. In ACE’s experience, reporting is not a guarantee that abuse will be confirmed, resolved or stopped.

Conclusion

ACE remains extremely concerned about elder abuse in Ontario. Elder abuse can take many forms and it can be difficult to detect. It is a complex problem requiring varied solutions: one possible solution may lie in offering more services to capable older adults seeking to leave abusive situations; another may lie in changing the implementation of existing laws. ACE does not believe, however, that Bill 148’s mandatory reporting requirement for health care professionals offers the solution to the problem it seeks to resolve and risks harming capable seniors in the process.

14 Bill 148, supra, note 2, s. 1
15 Incidents in which a health care professional has reason to believe that another health care professional has sexually abused a patient are subject to mandatory reporting. Regulated Health Professions Act, S.O. 1991, c. 18, Schedule II, s.85.1 (1)
CONSENT TO TREATMENT IN LONG-TERM CARE HOMES: THE CASE OF RE SW

Jane E. Meadus, Barrister & Solicitor, Institutional Advocate

The use of antipsychotics in long-term care homes has recently been a matter of much concern in the media. Studies in Ontario have shown a high rate of use of these medications in long-term care residents, even though these medications are not approved for treatment of dementia-related behaviours. Increased mortality rates, as well as increased risks for sedation, falls, cardiovascular events and renal injury make the use of these medications controversial in older adults.¹

One contributing factor to overuse of antipsychotics in long-term care is that health practitioners regularly fail to obtain valid informed consent for their use. This leads to their overuse as residents or, where the resident is incapable, their substitute decision-makers are not afforded the opportunity to decide for themselves whether or not these medications are appropriate.

In Canada, medical treatment cannot take place without the health practitioner first obtaining “informed consent.” This means that a treatment cannot begin until the patient or their substitute decision-maker is provided with information about the treatment and they decide to go ahead with the treatment.²

In Ontario, these rules are codified in the Health Care Consent Act, 1996 (HCCA), which provides the roadmap for how consent is to be obtained. Except in an emergency, prior to the start of any medical treatment a health practitioner must obtain an informed consent to the treatment.³ In order for consent to be valid it must:

1. relate to the treatment;  
2. be informed;  
3. be given voluntarily; and  
4. not be obtained through misrepresentation or fraud.⁴

In order for consent to be “informed”, the patient must be told:

1. the nature of the treatment;  
2. the expected benefits of the treatment;  
3. the material risks of the treatment;  
4. the material side effects of the treatment;  
5. alternative courses of action;  
6. the likely consequences of not having the treatment; and,  
7. they must be given responses to requests for any additional information about these matters.⁵

Consent must be obtained from a capable person, which means that the person must have both the ability to understand the information relevant to making the decision and the ability to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.⁶

If the health practitioner proposing the treatment believes that the person is not capable of making such a decision, they must

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³ HCCA, S.O. 1996, c. 2, Sched. A, s. 10  
⁴ Ibid., s. 11(1)  
⁵ Ibid., s. 11(2) & (3)  
⁶ Ibid., s. 4
advise the allegedly incapable person of their finding and of their right to challenge the finding at the Consent and Capacity Board (CCB).\(^7\)

If the person does not challenge the finding, or after any challenges are resolved and the person remains incapable, the health practitioner must then turn to the incapable person’s substitute decision-maker for consent. The requirements for, and list of, the hierarchy of substitute decision-makers is set out in section 20 of the HCCA.

These requirements are in place to ensure the autonomy of the patient. This is important, as different people have different views on treatments (for example, some treatments may be contrary to religious beliefs); the person may have sensitivities or allergies which would otherwise be unknown to the health practitioner; and different people have different risk tolerances. This last is very important, as individuals weigh risks and benefits of treatments very differently. Some people are willing to take greater risks than others. This is a very personal decision, and not one that a health practitioner is entitled to determine.

When it comes to treatment with antipsychotics, especially in the elderly, the issue of risks and benefits is extremely important, given the risks related to the use of these medications outlined above, and the lack of evidence as to their efficacy in the elderly with dementia.

In ACE’s experience, even though consent to treatment is legally required, health practitioners in long-term care homes often do not comply with the law. This is in part due to a lack of understanding of the law by the health professionals, and in part due to a lack of enforcement by the various oversight bodies in enforcing the rules.

The recent case of Re SW\(^8\) is a prime example of the failure to obtain valid consent to treatment in a long-term care home.

SW was a resident of a long-term care home. She was being treated with medication and no consent had been sought from her. SW commenced an application before the CCB to review a finding of incapacity. At the hearing, SW’s counsel, Mark Handelman brought a preliminary motion that SW’s capacity had never been determined and, therefore, the physician could not rely on the consent of a substitute decision-maker.

The evidence showed that SW’s medical chart contained no indication that there had ever been a finding of incapacity. The evidence of the physician who prescribed the medication was that while she had concerns about SW’s capacity, she had never formally assessed it. Neither had she ever had any discussion with SW about her capacity. She had not discussed the finding of incapacity, or informed SW that she had a right to challenge any finding of incapacity.

\(^{7}\) Ibid., s. 17, and see individual policies of each regulated health professions.

\(^{8}\) In the Matter of SW, Consent and Capacity Board, Order/Endorsement of Paul DeVilliers, Presiding Member, April 29, 2016, 15-5454-01; 15-545-02, unreported
At the hearing, the prescribing physician gave the following evidence in cross-examination:

Q. Okay, so she is answering your questions responsively, did you tell her about any of the medications you were prescribing to her?
A. No.
Q. So I guess that means you didn’t tell her about the risks and benefits of them either?
A. No.
Q. So you can’t speak specifically to whether she was able to understand information about the risks or benefits of those medications?
A. No.
Q. And you can’t speak specifically whether or not she was able to appreciate the consequences of giving or refusing consent herself to any of those medications. Is that fair?
A. That’s correct.
Q. And you just assumed that it would be the attorney for personal care that would be giving consent to treatment without actually assessing my client’s capacity yourself, or finding a prior specific capacity assessment addressing her specific capacity to make treatment decisions? Is that fair?
A. That’s correct because that is the way it happens in nursing homes.

Based on this evidence, the CCB held that there had been no relevant determination of capacity. Under Ontario law, in the absence of a finding of incapacity a person is presumed to be capable of making treatment decisions.

This case is an example of a common misconception in long-term care homes: that residents are incapable, and that the health practitioner can simply go to a substitute decision-maker to obtain consent for treatments without determining capacity or obtaining informed consent from a resident.

Residents often tell us that they must take medications because “the doctor ordered it”. Nursing staff will administer medication to residents over their objection, or the objection of the substitute decision-maker, because it is contained in a doctor’s order. Long-term care home staff often believe that because a person is admitted to a long-term care home, or because they were found incapable of making an admission decision by the Community Care Access Centre, that the person is incapable of making treatment decisions. All of these issues demonstrate a lack of understanding of the consent process.

The failure of health practitioners to comply with the HCCA is an ongoing problem in long-term care homes. Without the correct information, residents or substitute decision-makers are not able to determine whether a proposed treatment is appropriate to their circumstances. Given the vulnerability of residents in long-term care, they feel they cannot speak up when given medication they have not consented to. Failing to obtain valid consent is not only contrary to the HCCA, it is also misconduct under the various health profession conduct codes, contrary to the Long-Term Care Homes Act, and opens the health professional up to legal action for negligence and/or battery.

Health professionals and long-term care homes have a legal obligation to educate themselves in the law related to consent to treatment and should be vigilant in ensuring compliance. Residents, their families, and substitute decision-makers should also educate themselves to ensure that treatment only provided after informed consent is given by a legally authorized person.

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9 Evidence of evidence, In the Matter of S.W. (Consent and Capacity Board, April 29, 2016)
10 HCCA, supra, note 3, s. 4(2)
11 For example, see O. Reg. 856/93: Professional Misconduct under the Medicine Act, s. 19
12 Long Term Care Homes Act, 2007, S.O. 2007, c. 8, s. 3(1)11
ESTABLISHING RESIDENCE AND MAXIMIZING RETROACTIVITY OF OLD AGE SECURITY BENEFITS

Rita Chrolavicius, Staff Lawyer

Retroactivity of Benefits

It is important that individuals apply for pension benefits in a timely manner in order to ensure that they receive all Old Age Security (OAS) pension benefits to which they are entitled. An application for pension benefits should be submitted approximately three months before the eligibility date, even if the applicant does not have all of the supporting evidence or documentation to establish entitlement to the pension.

The maximum retroactivity for pension benefits under the Old Age Security Act, R.S.C., 1985, c. 0–9 is the month that the application was received by Service Canada and the previous eleven months. This applies to the OAS pension benefit, the spousal allowance, and the Guaranteed Income Supplement (GIS).

A greater retroactivity of OAS benefits may be allowed if an application is made on behalf of a person who was incapable of forming or expressing an intention to make an application on their own behalf at the time that the pension became eligible. Evidence must be provided to satisfy the Minister of Employment and Social Development of the person’s incapability.

Evidence of Legal Status

Persons applying for benefits under the Old Age Security Act must demonstrate when they became legally resident in Canada. Persons born in Canada must produce their birth certificates. Persons born outside of Canada must also provide their landed immigrant documentation.

If applicants have lost their landed immigrant documents, they can complete an Application for a Verification of Status (VOS) or Replacement of an Immigration Document (IMM 5454) and mail the form to:

Verification of Status (VOS) or Replacement of an Immigration Document Operations Support Centre (OSC) Immigration, Refugees and Citizenship Canada Ottawa, Ontario K1A 1L1

Copies of certain identification documents must be submitted. The fee can be waived if the applicant is on social assistance and provides a letter from the social assistance office confirming that they are receiving benefits.

An alternative is for applicants to sign a Consent to Exchange Information with Citizenship and Immigration Canada (Form SC ISP-3210) so that Service Canada can request this information themselves.

Evidence of Residence in Canada

Section 21 of the Old Age Security Act regulations define residency as follows:

(a) a person resides in Canada if he makes his home and ordinarily lives in any part of Canada; and,

(b) a person is present in Canada when he is physically present in any part of Canada.
Although Service Canada provides you with a list of documents to prove residency, here are some others you can use.

**Passports, Travel Documents**

It is a good idea to keep a written history of all travel into, and out of, Canada. Keep all passports, airplane, bus or train tickets, boarding passes or other travel documents.

**Travel History Reports**

Individuals can write to the Canada Border Services Agency to request their travel history report. The report documents entries into Canada from August 1, 2000. The request can be submitted online. Written requests may be sent to:

Canada Border Services Agency  
Access to Information and Privacy Coordinator  
333 North River Road  
14th Floor, Tower A  
Vanier, Ontario  K1A 0L8

**OHIP Records**

Individuals make a request that the Ontario Health Insurance Plan (OHIP) provide a personal claim history report for the past seven years. Use of OHIP insured services on a particular date is good evidence that the person was in Canada on that date. Requests can be sent to:

Ministry of Health and Long Term Care  
Personal Health Information Office  
49 Place d’Armes, 4th Floor  
Kingston, Ontario K7L 5J3

**Credit Card Statements and Bank Records**

Individuals who use credit cards frequently can produce credit card statements that prove that a particular credit card was used in a particular location on a certain date.

Similarly, bank records may show that withdrawals were made at ATM machines in a particular location on a certain date.
Witnesses

Service Canada may ask for the name of two individuals, unrelated by blood or marriage, who can provide information about an applicant’s residence and physical presence in Canada. Where appropriate, more witnesses’ names can be provided.

Tax Records

It is advisable to file income tax returns each year for persons resident in Canada, even if there is no income tax payable. First, persons may be entitled to certain benefits. Second, it establishes a good historical record for OAS purposes. Tax records may be obtained by making a Privacy Act, R.S.C. 1985, c. P-21, request to the Canada Revenue Agency.

Census Search

A census search may reveal information about a person’s stated age during the time that the census was completed, as well as confirmation of the person’s address. Form 8-9600-21 is accessible online. Inquiries can be directed to the Census Pension Searches program at (613) 951-9483.

Other Evidence

Leases, utility bills, driver’s licenses, insurance policies, cable and internet contracts, memberships to clubs or organizations are types of documentary evidence that may be useful as evidence confirming that an individual was physically present in, and resided in, Canada.

Waiving Entitlement

If, for example, an individual claims legal residence in Canada of 15 years, but can only prove residency in Canada for 11 years, the individual is free to accept an OAS benefit based on 11 years’ residency, and waive any further OAS benefit. This may be especially useful for individuals who plan to continue living in Canada, as the Guaranteed Income Supplement may make up, to some extent, for the loss of entitlement of some additional OAS benefits.

Difficult Cases

There have been cases where it may take years for individuals to establish eligibility for OAS benefits. Generally, low-income seniors can apply for social assistance in the interim. Individuals will have to sign a document agreeing that the social assistance benefits received will be reimbursed from the retroactive OAS benefits eventually received by the applicant. It is important to continue to correspond with the Service Canada offices, to answer any questions they have, and to notify them of any difficulties the applicant is having in establishing entitlement to OAS benefits. In worst case scenarios, individuals may need to re-establish their entitlement to benefits by waiting for 10 years. During the 10 years, they can build up a solid evidentiary base to prove their continued legal residency in Canada.

Requests for Reconsideration and Appeals

If a benefit is denied, Service Canada usually advises the applicant, in writing, that the applicant can request a reconsideration within 90 days of the date of the denial letter. The applicant is further advised of how they can appeal to the Social Security Tribunal of Canada. Any additional documentation or evidence obtained during this time can be submitted both to Service Canada and the appeal tribunal.

Like our Newsletter?

Know anyone who is great at layout or design who would be able to volunteer their time to assist ACE in putting together future Newsletters?

Please contact the Newsletter editor at maheandb@lao.on.ca
If you are not already a member of ACE, please consider joining. Benefits of membership include the ACE Newsletter (published twice a year) and voting privileges at the Annual General Meeting.

MEMBERSHIP APPLICATION
ADVOCACY CENTRE FOR THE ELDERLY*

2 Carlton Street, Suite 701, Toronto, Ontario, M5B 1J3 | www.acelaw.ca | Phone: 416-598-2656

Name: ____________________________
(Individual or Representative of Corporation/ Partnership/ Organization)

Corporate Contact (if applicable) ____________________________________________ Apt. __________

Address: ____________________________________________ Apt. __________

City: ____________________________________________ Postal Code: __________

Telephone: (Home) ________________ (Business) ________________

Email Address: ________________
(complete email address if you would like your newsletter via email instead of regular mail)

Membership Fee (check one)
- Individual $10.00 enclosed
- Corporate, partnership, or other non-individual member $25.00 enclosed

In addition to my membership fee, a donation of $_____ is enclosed**

* Holly Street Advocacy Centre for the Elderly Inc.
** A tax receipt will be issued for donations over $10.00.

Your membership is important. If the fee presents financial difficulties, please feel free to join anyway at no cost.

Committee Membership: I am interested in seniors' issues and would consider membership on an ACE Committee. Yes [] No []

Membership Expiry Date: Annual General Meeting, Fall 2016

Please feel free to photocopy or cut out this page and the next page and send it to ACE to become a member!
Conflict of Interest Declaration

I confirm that neither I nor my spouse, if I have a spouse, nor the Corporation/Partnership/Organization I represent (if Corporate, Partnership or other non individual member applicant) have an interest in a proposed or current contract, piece of litigation, client case, law reform, or any other activity or transaction of ACE that would place me in conflict with ACE. I also agree to abide by the conflict of interest guidelines in the ACE bylaw during the period of time I am a member of ACE.

________________________________________
Signature

ACE Bylaw - Conflict of Interest Guidelines - Summary
(Full text of the conflict of interest sections will be provided on request made to 416-598-2656)

Every Member who is, or may be, in any way directly or indirectly or who has a spouse who is, or may be, directly or indirectly or who is, or whose spouse is, an employee, officer or Director of an organization which directly or indirectly has, or may have, an interest in a proposed or current contract, piece of litigation, client case, law reform, or any other activity or transaction of the Centre shall make a full and fair disclosure of the nature and extent of the interest to the Board of Directors of ACE at the earliest opportunity after learning of the potential or actual conflict.

After making such declaration of such an actual or potential conflict, that member shall not take part in any discussion on the issue nor vote on such contract, piece of litigation, client case, law reform or any other activity or transaction nor shall he or she be counted in the quorum in respect to such contract, piece of litigation, client case, law reform or any other activity or transaction.

If a Member or Representative of a Corporate Member fails to make a declaration of his or her interest or the corporate interest in a contract, piece of litigation, client case, law reform or any other activity or transaction in compliance with this clause, he or she shall account to and reimburse the Centre for all profit realized by him or her and, upon resolution approved by a majority of the Board of Directors, shall submit his or her resignation as a Member.

Where any member feels that another member may be in a conflict of interest, the former may raise the issue at a Board meeting or at a meeting of the membership and the Chairperson shall discontinue discussion of the business at hand until the issue of conflict of interest has been dealt with.

Where a member fails or refuses to declare conflict of interest, the issue of whether or not such conflict exists may be determined by the Board by resolution moved, seconded and passed by a simple vote.

When it is so found, as set above, that a member is in a conflict of interest, he or she shall not take any further part in discussion on the issue and shall not vote on the issue.

No owner or management official of a long term care facility or employee of any organization representing long term care facilities or retirement homes shall be eligible to be elected to the Board of Directors of the Advocacy Centre for the Elderly.

COMMENTS FOR THE EDITOR
Comments about this newsletter may be sent to the editor, Bernadette Maheandiran, via regular mail or email at maheandb@lao.on.ca.

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To receive a copy of this and future newsletters electronically, please send an email to Terri Stein at steint@lao.on.ca