Assisted Living Consultation Response: Health and Safety

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1. Background and Introduction

In November, 2002, the B.C. legislature heralded a new era in the delivery of health and housing services to frail and vulnerable older adults in the province with the passage of Bill 73, the *Community Care and Assisted Living Act* ("the Act", not yet proclaimed). The *Act* represents a significant expansion of the assisted living model of housing for the province, assuring that private and public assisted living will become a growth industry in British Columbia. The province will see approximately 3800 assisted living units added by 2005, [1] more than doubling the 200 publicly funded and the 2000-3000 private assisted living units which the government estimated to exist at the time the legislation was passed. [2] These will either be "new builts" or conversion/ renovations of care facilities or other housing space.

The cost of the building and conversion of assisted living units will be borne, in part, through the affordable housing funding allocated to British Columbia under the Canada-British Columbia Affordable Housing Agreement. [3] The personal care services provided in assisted living will come from regional health authority budgets, without any increase in the regions' budgets. To accommodate the shift to this new model, health regions will be closing long term care beds and setting a higher "bar" of "complex care" for community care facility placement. The percentage of beds being reduced will range among the regions from 8.2% for Vancouver Coastal Health Authority to 18.5% in the Vancouver Island Health Authority by 2004/5.[4]

Why the Change in British Columbia?

An April, 2002 government press release characterized the change in the delivery of care and services from long term care to an assisted living model as one that would offer frail older adults and people with disabilities more "choice":

> "Seniors have told us they want to remain independent as long as possible. They want a choice in the type of care they receive and where they receive it… "They are looking for a broader range of options than is currently available-options that will promote independence, choice and quality of life." [5]

The government discussions and accounts in the legislative record identify other considerations that have been at work in the development of the specific type of assisted living model being adopted. These include operator expediency, housing pressure for deregulation, and an industry preference for self-regulation.[6] Other rationales being suggested for the shift are support for privatization, cost savings to government, cost

shifting to the individual, and a "me too" factor of following Alberta and American examples in attempting to substitute assisted living for long term care.

Cost savings for government are an important feature of the new assisted living model, [7] in that assisted living may utilize less staff, as well as staff with less training than those working in long term care facilities. The estimated cost per resident in assisted living is $50-75 a day, approximately one half of the daily cost of long term care.[8] Assisted living not only represents cost shifting making individuals responsible for some of the costs currently borne by the long term care facility, it also creates greater opportunities for "unbundling" services so that the consumer pays an increasing amount of the service cost.[9]

2. Consultation on the New Framework

In the fall of 2003, the B.C. provincial government circulated three "discussion papers" for public consultation in preparation for finalizing standards and processes. These documents outlined:

a) the framework for assisted living;
b) some of the issues related to protecting the health and safety of people residing in assisted living; and
c) the complaint resolution process.

Each of these components, as they have developed to date, has been based largely on ministry and consultant discussions with operators or potential operators of assisted living. The active involvement of stakeholders representing the people who would live in assisted living is noticeably absent.

The new model has several different components and represents a complex mix of housing, health care and other services which regional health authorities are interpreting and providing in different ways, potentially leading to a patchwork approach. The new scheme is an odd marriage, in that it needs two distinct models and service delivery approaches (health and housing) to work in tandem and in partnership, a new process for both ministries.

This creates a very complicated process for the assisted living consumer, who typically will be an elderly person (aged 85+) with multiple functional limitations, few supports, and lower level of functional literacy, but who is somehow expected to negotiate "a fair deal" and to be able to effectively self advocate if problems develop. Consumers are not alone when it comes to feeling confused about this new model: service providers and the public trying to understand the new direction being taken in British Columbia finds this is complicated by the inconsistent and changing use of language in this area by government ministries. [10]

Did You Know?

According to Statistics Canada, and the International Adult Literacy Survey:

- Approximately 25% of seniors in the province have grade 9 or less education (compared to <5% for people aged 25 to 65)?
- 8 out 10 seniors in the province operate at the two lowest levels of functional literacy. That means they can have difficulty understanding written documents.
- Many people with the lowest level of functional literacy are unaware that they have misunderstood something they have read.

The health and safety features of assisted living facilities are the responsibility of the Ministry of Health Services, while tenure and service protection needs for assisted living occupants and operators are being conducted by the Housing Policy Branch of the Ministry of Community, Aboriginal and Women's Services. This necessitates two mandates for the respective housing and health care components, with two different funding streams and the two processes developing somewhat in isolation. It also creates greater opportunity for

a) inconsistent decisionmaking between the two ministries, and
b) the concerns of residents or others advocating for them being shuttled back and forth between the two ministries ("it's not our responsibility").

Recommendation: It is recommended that the responsibility for oversight of all aspects of assisted living (health, safety and tenant/ consumer protection) in British Columbia be amalgamated under one Ministry.

3. Response to the Consultation Documents

A. What Is Meant by Assisted Living?

In the gerontological literature, the term "assisted living" tends to be characterized as communities that place special emphasis on

a) *providing an atmosphere of respect and friendship* and

b) *where residents can get the help they want, when they need it*.

Supportive services can include assistance with daily personal care, reminders to take medications, housekeeping, and a friendly, helpful staff available 24 hours a day. Through assisted living, the residents should be able to enjoy privacy, independence, and peace of mind knowing supportive help is available.

Under the new B.C. model, assisted living is a form of housing combined with prescribed care services and “hospitality services”. Hospitality services is an unfortunate catch phrase drawn from high end American assisted living services, that creates the impression of the basic supportive services being frill or luxury in nature. In reality, these services actually represent core needs - meals, housekeeping, laundry, opportunities to socialize through recreational activities, and a 24 hour emergency response system.

The personalized assistance and support offered by assisted living operators will fall into two levels. It will either be supportive in nature ("routine", such as help with dressing, medication reminders, group programs to encourage and maintain socialization), or "intensive", such as administering medications or mobility assistance on a regular and continuous basis. The latter, higher level of care services are referred to in the legislation as the "prescribed services". Facilities will be permitted to offer one or two of the prescribed service areas at this more intensive level; operators decide which prescribed services they will specialize in and offer to the public. The one or two prescribed services pertain to the residence as a whole and are selected by the operator when the operator registers the residence. [11] In most cases, this higher level of prescribed services will relate to activities of daily living and/or medications. To this extent and recognizing the higher bar people must meet in order to be eligible for publicly funded "complex care" (discussed below), the "choice" in assisted living is somewhat illusory.

Affordability will be an important issue for older adults in need of assisted living, particularly for older women as they live longer on average than men do, and tend to have more functional disabilities as they age. They are more likely to be widowed and tend to have significantly less income than older men. For example, over 46% of unattached British Columbia older women over the age of 65 live below the poverty line, and the percentage increases significantly with increasing age.[12] Under "Independent

Living BC", the province will fund rent supplements for 1,000 for seniors and people with disabilities who have low to moderate incomes and who are in either private supportive housing or assisted living apartments. This represents only a proportion of the current or future affordability needs of the vast majority of assisted living residents in this area.

B. Who is Assisted Living Suited For?

The target audience for assisted living in British Columbia has yet to be clearly identified in any of the policy documents. In very general terms, it is someone who needs more support and assistance than home care services can provide and yet does not meet the higher bar that has been set for institutional care of requiring 24 hour care and nursing services. That "bar" has been raised significantly in the last year: only those individuals who will require "complex care" in the near future (within the three months) will be eligible for a community care facility that receives public funding. That means that assisted living operators will be housing and providing services to people who may have multiple and complex needs that fall "just short of complex care".

A Vulnerable Group

Many people in need of assisted living will have low income. They will also be physically disabled or with some psychological or cognitive impairment, and will tend to isolated. The majority will be women.

In recent presentations to the public, Myrna Hall, consultant for the government's Assisted Living Registry Project, clearly notes this new model "will not be aging in place." Instead, assisted living will be treated as a one step in a care continuum in which older adults whose care needs exceed what the particular operator offers are expected to move to another facility that can meet those needs or on to long term care. See Figure 1.

What is Aging In Place?

The principle of aging in place means that seniors should be able to stay in their preferred living environments for as long as possible. This principle must be kept in mind when a senior is considering a move to supportive housing and what to do if their health fails while they are living there. Adjusting services to changing needs would be more helpful than requiring a person to move to new settings (i.e. care facilities), where the services are provided centrally. Moving to a new location demands changes in lifestyle and disturbs links with the larger community. These changes can seriously affect how individuals feel about themselves and reduce their sense of well-being.

Supportive Housing in Supportive Communities, 1999.

Figure 1 The Housing- Care Continuum as framed in public consultations, Assisted Living Registry Project

Independent Living	Supportive Housing	Assisted Living	Community Care
- Housing only	- Housing - Support	- Housing - Support - Personal assistance - * May purchase nursing	- Housing - Support - Personal Assistance - Nursing

C. Who is Eligible for Assisted Living in BC?

All persons must be assessed by the health authority as having the requisite level of care needs in order to be eligible for any assisted living supported by public funding. Their specific types of care needs are also identified. It is unclear as to whether private operators who work without this publicly funded health support (in other words, the high end private operators) will or will not have a similar assessment process in place.

Exclusionary Criteria: The new BC model specifically excludes people "who are unable to make decisions on their own behalf" from private and public assisted living, unless they will reside with a spouse who is able to make those decisions for them.[13] This section of the law can be vulnerable to misuse.

The objective of s. 26 (3) of the *Act* is to rule out people with dementia from this assisted living model. However with dementia, decisionmaking difficulties exist on a continuum, and can range from mild impairments to severe ones, and with impairment in some areas, but not others. To help reduce the likelihood of excluding people who have some diminished capacity, operators are expected to start from a legal presumption that the person is capable of decisionmaking on his or her own behalf.

The decisionmaking capacity in residents can change over time. Also, for older adults with some degree of diminished cognitive capacity, the ability to make decisions is often dependent on the supports and assistance available to them. In other cases, those most vulnerable in the community (e.g. those with an acute illness affecting their cognition, or those with substance use or mental health problems) may not initially be capable of making their own decisions, but in a supportive environment they are able to stabilize to the point where they are able to make those decisions. It is not clear whether these

individuals (who would benefit greatly from the kinds of supports that assisted living can offer) would be eligible if operators decided to interpret this section of the *Act* in a narrow manner.

Being Excluded by an Operator: There is nothing in the *Act* at present to challenge the decision of an operator who does not want to accept a particular person to his or her assisted living residence or to review the decision of an operator who decides that the person no longer has the required level of decisionmaking capacity.

Recommendation: It is recommended that there be an affordable and effective legal review mechanism by which residents are protected from arbitrarily being "discharged" from a particular assisted living residence. This would cover key issues such as "inability to make decisions on their own behalf" and the operator's ability to provide care.

It is also recommended that prospective residents have an affordable and effective review mechanism by which to challenge operators who systematically exclude specific groups of prospective residents.

D. What is the New Delivery Model?

The actual delivery model of delivering the services and the mix of services will vary according with the assisted living facility (non profit, for profit, Independent Living BC), and the particular health region. The health authorities may also differ in their interpretation of key elements, such as the legislative requirement to provide 24 hour emergency response system. For example, the Vancouver Island Health Authority (VIHA) is providing its health services directly, in contrast to these being developed and delivered by the assisted living operator. Perhaps as a result, VIHA has decided that providing an emergency response within 15 minutes (as opposed to having staff on site 24 hours) will be sufficient to meet the spirit of the *Act*.

Throughout the province, where the health authority is paying for the personal care services, the person is assessed by the health authority case managers for his or her general eligibility for assisted living and to identify specific kinds of care needs. The actual selection among prospective tenants remains with the operator and will depend on the operator's internal criteria (which may include the existing resident mix, staffing level and staff skills). This may lead to a preference to selecting those prospective residents with the less complex needs ("cherry picking") or a trend to "ghettoize" those with higher needs.

Perhaps one of the most glaring omissions from "health and safety" is that it would appear that no minimum staffing levels have been set under the assisted living legislation, irrespective of whether the facility houses 6, 60, or 300 persons. However, a representative from the Health Employees Union notes that government discussions indicate a minimum of one licensed practical nurse for 50 assisted living residents will be required. There is no evidence being offered to suggest that this is in any way sufficient to meet the needs of residents in assisted living.

Apparently, there has been some discussion by government representatives with assisted living operators about the requisite type of training that staff who provide personal care will have. It is important to recognize many older people eligible for assisted living are likely to have some degree of cognitive impairment (short of "inability to make decisions about their care"), and may have significant physical or psychological impairments. As a result, it is essential that all staff working in assisted living (not just personal care providers) and the operators be properly trained to understand and respond appropriately to the care and other needs of the types of the people who are living there. There is a need to set standards for expected training so that the staff understands behaviours and changes that are more common as people age. In many cases, the quality of day to day living and "eviction issues" in assisted living have less to do with the resident's care needs or behaviours, than they do with the staff's training and the operator's level of knowledge.

E. What Regulations Govern the New Model?

As assisted living is defined as “housing” and not facility care, it is neither licensed nor regulated in the same way as long-term care facilities are. The new legislation anticipates that regulations *could be* developed vis à vis health and safety standards for assisted living. The regional health authorities and the provincial government have been engaged in developing “standards of care”. However, they are equally clear that these standards will not translate into regulations, nor will they be enforced through a provincial/ regional monitoring (i.e. inspection) process. Critics point out that it is unclear how standards, without an enforcement mechanism, can provide frail older adults in assisted living with the protection that they require.[14]

Under the new regimen, all assisted living residences must be registered with the newly established registrar’s office. The registrar has the responsibility to work with operators to establish basic health and safety standards; to develop a process to monitor complaints; and to establish a process to take action if standards are not being met.[15] While the health and safety standards do not carry force of law vis à vis responsibilities to residents, the standards set by health authorities in their contracts with assisted living providers will become part of the operator's contractual obligations, where these exist. However, residents are not a party to the health authority- operator operating contract, so it is not

clear how residents might be able to force either party to live up to their contractual obligations that are intended to be for the benefit of residents.

The registrar is also responsible for resolving concerns related to health and safety standards, such as complaints of abuse. However, those powers are very limited compared to the types of those accorded to Director for community care facilities under Part 2 of the *Act*, which enable the Director to investigate or order an investigation. According to Part 3 of the *Act*, if the assisted living registrar has reason to believe that the health or safety of a resident is at risk, the registrar *may*

- enter and inspect any premises relating to the operation of the assisted living residence, or
- inspect and make a copy of documents.

Although the government website offers reassurances to the public that "the registrar will have the authority to conduct independent investigations of both public and private sector assisted living residences,"[16] an assisted living operator could reasonably argue that nothing in Part 3 or Part 4 of the *Act* specifically gives the registrar this authority. [17] In other words, a right to enter and inspect is not the same as a right to investigate (e.g. interview staff, residents etc). Because investigations are specifically identified under Part 2, that would suggest they are not included in Part 3 because investigations are not mentioned in Part 3.

Recommendation: It is recommended that Part 3 be clarified, and amended to expressly give the registrar the authority to investigate and the power to enforce needed changes.

Who Oversees the Registrar? It has been suggested that issues of fairness of the registrar's process and decisionmaking could be referred to the Office of the Ombudsman. However, the Office of the Ombudsman has made it clear, it does not have sufficient budget to carry out even part of its current mandate, let alone look into issues affecting the Assisted Living Registrar.

Monitoring, Training, Standards: The provincial government has been in discussion with private and non profit operators to discuss the need for monitoring, training and standards. [18] Possible approaches under discussion have included

- establishing a consortium which would become a self-regulatory body, endorsed and resourced by government; and
- creating a "Centre of Excellence" with the health authority providing seed funding. With the Centre for Excellence, best practices would be identified

> and a mechanism for assisted living facilities to become "accredited" would be developed.

These are important steps. However, in the United States, speaking of the American experience with assisted living, the American Bar Association notes:

> "While accreditation is fine as an industry tool for quality improvement, it becomes problematic when states substitute what is essentially self-evaluation, for compliance with regulatory standards and state oversight." [19]

We have seen from other jurisdictions dealing with assisted living that only a small proportion of operators belong to self regulatory associations, particularly those doing accreditation. Similar trends have been noted in British Columbia: B.C. Non Profit Housing Association, which has a long track record of working to improve the knowledge and capacity of non profit housing societies, their boards and staff, for example, still only reaches 10% of all non profit housing societies in the province.

Recommendation: It is recommended that protections for residents are not limited to assisted living operators self regulating. Instead, residents' rights and operators' responsibilities must be identified and enforced *via* regulation.

F. What Happens if Problems Develop?

According to "Consultation Document 3: Discussion Paper on the Complaint Resolution Process", individuals are encouraged to first address the concern with the assisted living operator, and if the issue remains unresolved, the person may contact the assisted living registrar. Thus, problem identification and resolution in assisted living functions through a passive, complaint driven system. This is clearly insufficient, as it fails to recognize the dependency of those in assisted living on those who provide the services 24 hours a day, 365 days a year.

The assisted living registrar will be able to address three types of complaints:

- health and safety concerns;
- violations of health and safety standards; and
- unregistered residences.

Health and safety does not appear to be defined. Arguably, "health and safety" include all aspects that promote the residents' physical, emotional, social and financial wellbeing. However, it is clear from the discussions in the public consultation that the government is interpreting health and safety much more narrowly.

The assisted living registrar does not deal with complaints related to tenure (the tenancy/rental agreement with the residence) or hospitality services (which include would include meals services and the 24 hour response system). [20] The Ministry of Community, Aboriginal and Women's Services is currently considering possible appropriate approaches to addressing tenancy and other consumer protection issues. This arbitrary division of authority and responsibility works against developing a well thought out, holistic approach to assisted living in the province.

The assisted living registrar also does not deal with complaints related to the conduct of staff, unless these relate directly to resident's health and safety such as allegations of abuse or neglect. Fortunately, the resident does not have to have to become an assisted living specialist to decide what is the appropriate body or forum to raise his or her concerns. The registrar can receive complaints and will forward them on to the appropriate body. The registrar has very limited powers to change an operator's course of action. Even where violations occur in the areas under the assisted living registrar's jurisdiction, the only "stick" available to the registrar is deregistering the facility, a move which a) will not benefit the residents, and b) as we have seen in the context of long term care facilities is highly unlikely to happen in all but the most egregious situations.

Thus, there is no real enforcement mechanism.

Bill 73 covers community care facilities and assisted living in separate parts of the *Act* and under Part 2, the law provides protection for residents in long term care who report abuse. The operator or staff cannot threaten to alter, interrupt or discontinue service. Staff is also protected if they report abuse in the facility. These are very important protections considering the fact that the people living there are very dependent on others to provide care. *Unfortunately, the legislation does not have any similar protection for an assisted living resident or staff, even though the degree of vulnerability may be quite similar.* [21]

Recommendation: It is recommended that the legislation be amended to expressly provide protection to assisted living residents, family and staff who report abuse or other violations of health and safety by operators. The operator or staff should be prohibited from threatening to alter, interrupt or discontinue service to a resident who has reported or otherwise voiced a concern. Staff should also be protected if they report abuse in the facility.

All operators should have a responsibility to report to the registrar any incident that negatively affects or jeopardizes the wellbeing of a resident or residents.

To date, consumer input and influence has been noticeably absent from the development of the assisted living model. Perhaps not surprisingly, the resulting health, safety and tenancy safeguards for residents in assisted living have been minimal and those that do exist seldom represent a consumer perspective. For example, one of the guiding principles given in the assisted living model is that the "operation of a residence will not jeopardize the health and safety of occupants", in contrast to a consumer directed approach which would focus on promoting wellbeing, a very important distinction in assisted living. [22] From a consumer perspective, the regimen for assisted living is far more complex than residential tenancy or community care facilities in terms what the consumer is expected to do to assure his or her rights are protected, and yet the approach has far fewer external controls.

Recommendation: It is recommended that plain language documents be created for the public (and for prospective residents in particular) on assisted living -- what it is, what it is not, the processes, and people's rights.

It is further recommended that different types of public advocacy be made available and financially supported by the provincial government to help residents deal with problems or concerns and to assure that the rights of assisted living residents are respected.

Security of Tenancy Issues: The fact that residents in assisted living need protections to accord them security in tenure and affordability is well recognized, however the mechanism by which that will occur is not clear at present. Assisted living is expressly excluded from the protections of the new *Residential Tenancy Act* (RTA) Bill 70 (not yet proclaimed),[23] unlike Ontario where assisted living is covered in a special section of the *Tenant Protection Act* specifically for "Care Homes".[24] [See "What does the Ontario legislation cover?" below] Critics argue that older adults and people with disabilities may be relinquishing considerable by way of consumer protection and basic rights simply to receive assistance and supports in assisted living. This should not be the case.

British Columbia's assisted living residents need automatic protections vis à vis key tenancy issues including security of tenancy; frequency and amount of rent increases; privacy issues; repairs; suite upgrades for disabilities; who bears the cost of making a new suite available for "in house" move; liability for damage beyond reasonable wear and tear; and an arbitration mechanism resolution of tenancy disputes. The BC Housing program guidelines for facilities operating with funding from them, for example, notes that "Except for payment of the Shelter Subsidy, the full normal relationship of landlord and tenant exists between the [non profit] Society and Tenant." [25] A reasonable degree of security in tenancy is fundamental to maintaining the wellbeing of the assisted living residents. Without strong tenancy protections, residents can easily be subjected to

arbitrary house rules, unfair application of exit (discharge) plans, and intimidation or exploitation by operators.

What Does the Ontario Law Cover?

In Ontario, the Tenant Protection Act, 1997 [26] which covers the Ontario's equivalent of assisted living, specifically requires:

- written tenancy agreements
- the agreement must set out what has been agreed to with respect to care services and meals and the charges for them.
- the tenant has the right to consult a third party with respect to the agreement and to cancel the agreement within five days
- operators may enter a rental unit at regular intervals to check the condition of a tenant if that is part of the agreement, but the resident alo has the right to unilaterally revoke that provision
- a resident has the right to terminate a tenancy at any time by giving at least 30 days notice
- cases can go to a tribunal if the operator wants to evict the resident if the resident requires a level of care that the operator feels he or she is not able to provide.
- mandatory mediation of disputes
- at least 90 days notice for any increase a charge for providing a care.

4. Policy Implications

There are major challenges in developing assisted living policy in the province. For one thing, it would appear the policy is being adopted without having an evidence based planning process in place at the outset that would meet the needs of the recipients of the services. Decisions to date (such as the reduction in the number of long term care beds, the costing for direct care in assisted living, the allocation of assisted living units to the regions) have been made without first assessing the actual care needs of residents or waitlisted seniors. Moreover, there has been no effort to pilot test the assisted living model first to determine the full care and support needs and costs for different populations. [27]

5. Conclusion

In 1999, after conducting the first survey with a nationally representative sample of assisted living facilities, the United States Department of Health and Human Services concluded that:

1. Assisted living is a very positive model for seniors with limited care needs.

2. Assisted living is not an effective substitute for residential long-term care because the staffing levels and staffing mix are not adequate for the care requirements of most residents currently in long-term care.
3. Assisted living is largely unaffordable for moderate and low-income seniors.[28]

This likely holds true for British Columbia too. The current approach being taken in British Columbia represents a significant departure from past decades and represents a bold experiment. However, British Columbia still has a long way to go to make assisted living a viable and affordable process capable of meeting the needs of older adults as they become more frail and need more support and assistance. The issue for British Columbians is how the assisted living will be organized and operationalized, and the extent to which it will remove choice from seniors rather than supporting them. As always, "The devil is in the details."

Appendix

Assisted Living Residents' Rights: Health & Safety

People in assisted living retain all their rights and do not relinquish those rights in order to received the support/care they may need to remain independent as possible as long as possible. Those rights include but are not limited to:

- be treated with respect, dignity and consideration
- be assumed to be capable of making their own decisions
- reasonable expectation of privacy and quiet enjoyment of their unit (there should not be an automatic right of entry for the assisted living provider)
- take personal risks in their lifestyle and environment
- refuse or accept a particular type of care/ support option
- come and go as they please from the building
- as little or as much involvement of family and others important to them in their lives
- confidentiality of personal information and clinical records
- plan or decline to plan for incapacity (that is, decide whether or not they want to prepare future planning instruments such as power of attorney, representation agreement, an advance directive)
- freedom from physical, emotional, and other forms of harm from operators, staff, or others living in the housing (including intimidation or harassment)
- freedom from discrimination based on age, sex, physical or mental disability, race etc.
- choose their own attending physician and the source of pharmacy service
- be free from chemical and physical restraints
- know they have the right to have a decision that has been made by an assisted living provider (or the assessor) reviewed.
- associate and communicate with others in privacy, including visits with anyone of their choice in or outside of the facility, mail and telephone services, participation in resident council activities, access to their records
- not be evicted, transferred or discharged without cause or notice
- be treated without discrimination regardless of source of payment
- make complaints and express grievances without fear of discrimination or reprisal
- manage personal and financial affairs and make choices and independent decisions

[1] Cohen, M. (January, 2003). *"A Dramatic Reversal of Policy on Long Term Care"* in Health Care Restructuring in BC, Policy Brief prepared for Canadian Centre for Policy Alternatives, pg. 13-18 at pg. 14. Retrieved on November 23, 2003 from http://www.policyalternatives.ca/index.html

[2] Honourable K. Whittred. Assisted Living Debates. *Hansard: Debates of the Legislative Assembly*, November 21, 2002 [Page 4588], at 16:10

[3] BC Housing. "Independent Living BC". Retrieved on November 23, 2003 from: http://www.bchousing.ca/files/ILBC/ILBC_Brochure_031103.pdf

[4] Cohen, supra, n. 1.

[5] Ministry of Health Services Press Release, April 22, 2002 "Province Will Develop 3,500 Supportive Living Units" quoting Katherine Whittred, Minister of State for Intermediate, Long Term and Home Care. Retrieved on November 23, 2003 from: www2.news.gov.bc.ca/nrm_news_releases/2002HSER0011-000113.htm

[6] See for example, T. Christensen. Bill 16, Community Care Facility Act. *The Hansard: Debates of the Legislative Assembly*, Vol. 6 No. 6, April 15, 2002. [Page 2837] at 16:40. Retrieved on November 25, 2003 from http://www.legis.gov.bc.ca/hansard/37th3rd/h20415p.htm

[7] See for example, Freeman, R. (May 3, 2002) Chilliwack Progress: Parkholm seniors to get first priority, FHA official vows. Retrieved on November 23, 2003 from: http://www.vcn.bc.ca/srsnetbc/hotitem/justsayno/chwkprogress1.html

[8] Cohen, supra, n. 1 at 16.

[9] Armstrong, W. (September 2002). *Eldercare–On the Auction Block.* Consumers' Association of Canada (Alberta Chapter).

[10] Among the terms that have been used in the past year: "supportive living", "supportive housing" "independent living" (not be confused with Independent Living BC), and "assisted living". The terms are often used interchangeably or with the meanings changing from month to month

[11] Assisted Living Registry Project. (October 1, 2003). Consultation Document 1: Discussion Paper on a Framework for Assisted Living. Pg. 4.

[12] National Council of Welfare. (Summer, 2002). *Poverty profile 1999.* Minister of Public Works and Government Services Canada. Catalogue No. H67-1/4-1999E, Table 2.27. National Council on Welfare. Retrieved on November 17, 2003 from http://www.ncwcnbes.net/htmdocument/reportpovertypro99/Introduction.html#_Toc500047796

Note: This group has seen their income erode even further in British Columbia with changes to the Seniors' Benefit. As the federal Old Age Security/Guaranteed Income Supplement benefits have been raised in response to increased costs of living, the provincial benefits have decreased to the same amount.

[13] s. 26 (3): "A registrant must not house in an assisted living residence persons who are unable to make decisions on their own behalf". Retrieved on November 23, 2003 from http://www.legis.gov.bc.ca/37th3rd/3rd_read/gov73-3.htm

[14] Cohen, supra, n. 1 at 17

[15] Nov. 2, 2002. Ministry of Health Services Press Release "New Community Care Act to Strengthen Protection". Retrieved on November 23, 2003 from : www2.news.gov.bc.ca/nrm_news_releases/2002HSER0051-000944.htm

[16] BC Health Services, Assisted Living. Retrieved on November 23, 2003 from: http://www.healthservices.gov.bc.ca/assisted/index.html

[17] Bill 73, *Community Care and Assisted Living Act.* Retrieved on November 15, 2003 from http://www.legis.gov.bc.ca/37th3rd/3rd_read/gov73-3.htm#section26, see sections 4 (1) (d) (ii)

[18] These include: PriCare; BC Retirement Communities Association; BC Non Profit Housing Association; Supportive and Assisted Living Association; and Okanagan Private Assisted Living Association.

[19] American Bar Association. (August 2001). Assisted Living, Pg. 8. Retrieved November 23, 2003 from: http://www.abanet.org/aging/Assistedliving.doc

[20] Assisted Living Registry Project. (October 1, 2003). *Consultation Document 3: Discussion Paper on Complaint Resolution Process*. pg. 3

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