



Maine Health Care Association

**Testimony of Angela Westhoff, President & CEO
Maine Health Care Association**

Testimony before the Committee on Health and Human Services In Opposition to
LD 759, An Act to Increase Patient Safety in Long-term Care Facilities

Senator Ingwersen and Representative Meyer as well as Distinguished Members of the Health and Human Services Committee:

My name is Angela Westhoff, and I serve as the President & CEO of the Maine Health Care Association. We represent approximately 200 nursing homes, assisted living centers, and residential care facilities across the state. Our mission is to empower members to ensure the integrity, quality, and sustainability of long term care in Maine.

On behalf of our members, I am testifying in opposition to **LD 759, An Act to Increase Patient Safety in Long-term Care Facilities**. This bill would require a long term care facility to equip a resident's bed with side rails if the resident or the resident's legal guardian requests side rails or if side rails are necessary for the safety of the resident. We appreciate the intention of the bill to increase the safety of long term care residents.

Long term care facilities are committed to a patient-centered approach that includes comprehensive assessments to determine the most appropriate care interventions. This approach ensures that decisions, such as the use of bed rails, are based on the individual needs and medical conditions of residents. However, bed rails, depending on a resident's physical and cognitive status, may act as a restraint rather than a safety measure.

According to the Centers for Medicare and Medicaid Services (CMS), there is "no evidence that the use of physical restraints, including, but not limited to, bed rails and position change alarms,

will prevent or reduce falls.”¹ In fact, the use of bed rails can pose a greater risk, especially for residents who are cognitively impaired. There have been numerous cases where residents have tried to escape from bed rails, often resulting in injury or death due to entrapment. Sometimes, the heightened risk of falls and other serious injuries when bed rails are used outweighs any potential benefit.²

In particular, residents with conditions such as Alzheimer’s disease, dementia, Parkinson’s disease, multiple sclerosis, balance disorders, or stroke are at heightened risk of being trapped between the bed rail and mattress, potentially leading to suffocation.

We strongly believe that mandating the installation of bed rails at the request of a resident or family member, without proper evaluation, is a well-meaning but ultimately dangerous policy. Bed rails should be used only after a thorough assessment and consideration of the risks involved. Additionally, providers already often provide bed rails after conducting a thorough assessment and consulting with residents as well as their families.

For these reasons, we urge you to vote “ought not to pass” on LD 759. Thank you for your time and consideration.

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<https://www.cms.gov/files/document/r208soma.pdf#:~:text=falls%20prevention%20approach%2C%20they%20have,will%20prevent%20or%20reduce%20falls> (page 95)

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<https://www.cms.gov/files/document/r208soma.pdf#:~:text=falls%20prevention%20approach%2C%20they%20have,will%20prevent%20or%20reduce%20falls> (page 97)