The Maine Long-Term Care
OMBUDSMAN
Program

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LD 979 Resolve, Regarding Legislative Review of Chapter 113: Assisted Housing Programs Licensing Rule, a Late-filed Major Substantive Rule of the Department of Health and Human Services

Testimony in Support

Joint Standing Committee on Health and Human Services

April 1, 2025

Good afternoon, Senator Ingwersen, Representative Meyer and members of the Health and Human Services Committee, my name is Nicole Marchesi. I am the Public Policy Advocate for the Maine-Long Term Care Ombudsman Program.

The Ombudsman Program provides statewide advocacy for older and disabled residents in nursing homes, assisted living and residential care and for recipients of home care and participants in adult day programs. Additionally, we assist patients in hospitals who experience barriers in accessing the long-term services and supports they need when they are ready for discharge.

We are very pleased to provide testimony in support of the assisted housing program rule proposed in this legislation. If implemented, this rule will do much to improve the quality of care and quality of life for older and disabled residents served in these settings. We greatly appreciate the work of the Department in drafting the new rule, one that has not been updated in seventeen years. During that time, the needs of residents have increased significantly making this change in regulation critical in promoting quality of care and in protecting the wellbeing of residents.

A 2024 report done by the Catherine Cutler Institute, *Residential Care Services in Maine, A Comparison of Characteristics Across Settings,* documents the change in resident needs which LD 979 reflects. In fact, 54% of residents served in PNMI-Cs (Medicaid funded residential care, serving older and disabled individuals) have dementia, a greater percentage than those in nursing homes. Between 2021 and 2023 the needs of residents that include toileting, transfer, eating, bed mobility and locomotion consistently increased.

Some residents in assisted housing are nursing home eligible. In fact, The Department

estimates a few years ago that 1/4 to 1/3 of residents in PNMI-Cs were nursing facility eligible. Aging in place and the closure of nursing facilities across the state have contributed to a significant increase in acuity. Current regulations are simply not adequate to require the standard of care that is needed by these residents.

In FY 24, the Ombudsman Program received 482 complaints from residents and their family members about quality of care. Care and staffing were the two most frequent complaints. While some homes do a very good job of providing care, unfortunately, some do not. In those homes, DHHS, Division of Licensing and Certification have cited deficiencies in care that place residents at risk. Examples of these deficiencies include failure to provide medication for an insulin dependent diabetic, failure to provide medication for an uncontrolled seizure disorder, failure to provide transportation for blood work and medical appointments, neglect such as residents found in urine-soaked undergarments, and the Power of Attorney having to intervene to send a resident to the hospital. These are conditions we must never accept.

Numerous studies demonstrate that there is a direct correlation between quality of care and staffing levels. Current staffing regulations do not reflect resident needs. LD 979 would implement a phased in approach to increased staffing levels. This is a reasonable compromise that over time will achieve the goal of better care and will likely aid in retention of direct care staff.

Direct care staff will not stay when they are consistently faced with the high stress of insufficient staffing levels resulting in inadequate care. (Work stress is a major contributor to intention to quit. Hatton et al., 2001) We have heard repeatedly from direct care staff that they often feel overwhelmed by the number of residents they are required to provide care for. Staff express concerns that while they are employed in an assisted housing program, they are sometimes required to provide care for residents who qualify for nursing home care. When staffing levels are inadequate, this not only contributes to poor outcomes, but it also causes staff burnout and a high turnover rate.

We urge you to support this legislation to require the new rule. It is a critical step forward in improving the quality of care for residents served in assisted housing programs.

Thank you for your consideration.

CARE CONCERNS IN ASSISTED HOUSING REPORTED TO THE OMBUDSMAN PROGRAM (LTCOP)

LTCOP was contacted by the family of a resident in a memory care unit who was assaulted by another resident and injured. There were numerous concerns about care in this setting. The family observed a resident at mealtime who was brought to the table for a meal. The resident wasn't pushed to the table and sat with their hands in their lap. Staff came by the table and said the resident must not want to eat and removed the food. The family also observed a staff member quit during an evening shift leaving only one staff member on shift. The resident went to the hospital after an incident where they were in the bathroom for an extended period of time and staff was unaware until the family called the facility requesting they check on the resident. The hospital discovered that the resident's medications were being mismanaged by the facility.

LTCOP worked with a family and resident who had numerous care concerns, issues with lack of help with eating meals, care plan not followed and staff who were unaware of needs. The resident was often found wet from urine. During one visit the resident was found wearing a wander guard. The family/legal representative was not informed of any incidents requiring the use of a wander guard and was not asked for consent to use the wander guard. Family often asks staff to change the resident after being found wet; staff would change the resident, but not remove the wet bedding until asked to do so. Staff then leave the bed in a high position, so the resident is not able to get back into bed.

LTCOP was contacted by a family member after a resident was hospitalized due to a seizure. The resident takes medication to prevent seizures and the medication had not been provided for 5 days prior to the seizure. The facility said the resident ran out of medication and they were having trouble getting it refilled. The family was then told the resident's doctor would be in touch. The nurse practitioner called late in the day but had no idea why there was a gap in the medication or why they had been told to call the family. The resident ended up in the hospital for a few days because the facility did not refill the medication. On another occasion, the family member visited and found the resident in bed, warm to the touch and nearly unresponsive. An aide was notified who said they noticed the resident was warm so removed their shirt but took no other action to determine if resident was ill. The administrator explained the protocol when a resident appears warm but said this was not followed and they would look into why. The administrator never told

the family why the protocol was not followed. The facility was cited by DHHS, Division of Licensing and Certification for failing to provide the medication as ordered.

LTCOP worked with a resident who had specific food allergies that required an Epi-pen if the allergens were ingested. The facility was aware of the allergies but consistently provided the resident with meals that included the allergens. During one incident the resident had to use an Epi-pen and was hospitalized after eating a meal that the resident was unaware contained the allergens. The facility was cited twice by DHHS, Division of Licensing and Certification related to the issues with the resident's allergies.

LTCOP was informed of numerous concerns about a facility including medications not being provided on time or at all. The residents expressed that they fear retaliation. The residents were also reporting a lack of hot meals on the weekends. Local first responders were receiving calls from residents with concerns about medications. LTCOP visited and was told showers are not always provided weekly, residents are not provided snacks or drinks other than water.

A resident fell during the night and yelled for help, but no one responded. The resident was able to pull themselves to the door and bang on it. Staff did respond and the resident was taken to the hospital and was found to have a fractured hip. The family was told that the staff do rounds every 30 minutes, yet no one found the resident or heard them yelling for help until they were able to reach the door. The family felt that the resident was on the floor for so long because there is not enough staff available at night.

OMBUDSMAN PROGRAM RESPONSE TO COMPLAINTS

Regional Ombudsmen work diligently to address complaints, providing information and support to residents and their family members. With consent, referrals are made to DHHS, Division of Licensing and Certification for investigation. Regional Ombudsmen visit more frequently in response to care concerns. Visits can be several times a week if needed. We establish family groups to address care concerns collectively with facility staff. We support Resident Council. We meet with facility staff to address concerns. We attend care plan meetings to address care concerns.

We sometimes make joint visits with DHHS, Division of Licensing and Certification. For example: Months ago, we made a joint visit with Licensing on a weekend because we had received care complaints that were occurring more frequently on weekends.

We meet with DHHS, Division of Licensing and Certification monthly and more frequently as needed to discuss quality of care issues, sharing information that is helpful in addressing concerns. We also meet with Healthcare Crimes Unit staff monthly to discuss concerns.