Testimony of Mary Hagerty
Owner/Administrator of Four Corners Rest Home, Inc.
In Opposition to
SB 1030- AN ACT CONCERNING LONG-TERM CARE FACILITIES
Public Health Committee Public Hearing, March 17, 2021

Senator Abrams, Representative Steinberg, Senator Somers, Representative Petit, and Esteemed Members of the Public Health Committee, **thank you for the opportunity to offer testimony in opposition to the inclusion of residential care homes in Senate Bill 1030- AN ACT CONCERNING LONG-TERM CARE FACILITIES.**

My name is Mary Hagerty and I am the Owner/Administrator of Rest Four Corners Rest Home, Inc. in Milford, CT. Four Corners Rest Home, Inc. is an 18-bed Residential Care Home that has been run by my family for 47 years. Our home-like setting has made many residents consider this their home, the longest being 23 years. We do not "flip" our beds for more profit. We work diligently to maintain a stable mental and physical health and take great pride in helping our community by maintain a safe, happy, home-like atmosphere to individuals that should no longer live alone. Our residents need assistance in meal preparation, laundry, housekeeping, medication handling, personal caregiving, case management, transportation, and companionship. Ninety percent of our residents have mild to severe mental issues (Schizophrenia, Bipolar, Obsessive Compulsive Disorder, Anxiety, Depression, Suicide, Hallucinations, and Comprehensive Disorders) that require monitoring and guidance that families can no longer handle or that the individuals can't handle on their own. Our residents are mobile and come and go as they please and utilize Milford Transits/Veyo services. Many residents do not have participating family members or no longer have family members. We are the residents' "family."

Senate Bill 1030 seems to want to change our required Residential Care Home environment to an environment that will require special employee training and certifications. Please reevaluate at the Regulations of Connecticut State Agencies, Sec. 19-13-D1 Institutions, classifications and definitions for Residential Care Homes, Definition (3)(A): Residential care home: an institution having facilities and all necessary personnel to furnish food, shelter and laundry for two or more persons unrelated to the proprietor and in addition, providing services of a personal nature which do not require the training or skills of a licensed nurse. Additional services of a personal nature may include assistance with bathing, help with dressing, preparation of special diets and supervision over medications which are self-administered. To be specific, Residential Care Homes are not nursing facilities, but more of a managed residential community with extra services that serve both elderly people and younger people with physical or mental disabilities and provide some help with personal care that is not as extensive as assisted living. If more services are requested and demanded for residential care facilities, then daily rate reimbursements must be modified. There has not been an increase in daily rates, or a cost of living raise for 7 to 12 years in Connecticut for Residential Care Homes.

Our types of clientele require a safe and healthy place to reside with extra services to help them remain as independent as possible. Any acute or chronic medical issues are handled by licensed providers outside of the facility or by a home health care company; Licensed nurses are not employed by most Residential Care Homes and should not be considered a “nursing home” or “assisted living” and should not be considered in the Nursing Home and Assisted Living Workgroup.

Section 1 requests for a full-time infection prevention and control specialist for ongoing training of all employees and requests to have replacement staff in the event of an infectious disease outbreak. This is not reasonably fundable when our employees are working on the frontlines during the pandemic for wages at or slightly above minimum wage. Our administrators and experienced staff often covered additional shifts and at times worked 80 plus hours due to the lack of available staff. If emergency replacement of staff is required in the long-term care facility, emergency funding should be available. Residential Care Homes were required to follow the CDC and Public Health Department guidelines for safety, mental and physical health, and protection to stop the risk of infection and the spreading of disease. Currently our staff and resident education is consistent and time consuming. It is reasonable to add annually training for infection disease, but most of our facilities have shared rooms and do not have private rooms. An infectious disease outbreak would be difficult to isolate. The resident should be upgraded to an assisted living or other type of facility until cleared by a medical provider. The Admission and Retention Policy states that parameters that require care for presence and treatment of communicable diseases and need ongoing licensed medical provider treatment must be treated in the appropriate facility.

Section 3 states that a three-month stockpile of personal protective equipment must be maintained for the staff, which is not unreasonable, but increased funding is needed for supplies and resources must be available. Keep in mind that the residents will also be requiring the supplies. Quarterly fitting of N95 masks or higher rated masks would not be possible without licensed educators and testing supplies on hand. Infectious residents that require N95 masks probably will not be allowable to reside in a shared room or a home with shared bathrooms and living spaces. Therefore, N95 masks testing is unreasonable and will not be necessary.

Section 4 stated that a licensed or certified person must initiate an intravenous line. While we do not employ or treat individuals that require an IV, this must be changed to add a provision for a licensed home health agency registered nurse to start, and administer/supervise the IV, and remain with the resident while in use. Resident Care Homes should not be considered in this category, due to the medication regulations that we currently follow “supervision over medications, which are self-administered.”

Education needs for Section 5, 6 and 7 infection prevention, control committee, and education mandated by the Department of Public Health should be more specific to each facility size and license. Many Residential Care Homes do not have enough staff to have monthly meetings or funding to accommodate these meetings. There are clear differences on the levels of care that each type of facility is licensed for. The

Department of Public Health should have infectious disease testing from a reputable contracted business if testing is required in an outbreak. Residential Care Homes would never be able to afford these services and would not be reimbursed timely, unless approved by Medicaid and we could bill.

Section 8, 9 and 10 requires the establishment of to offer family councils and encourage open communication between the facility and each resident's family members and friends. It also wants to ensure that each resident has a care plan that will address isolation, interaction, depression, emotional needs, and visitations and that the social, emotional and mental health needs of residents is maintained. Please note that Residential Care Homes have many residents that are independent and that have been residing in the homes for years. Again, we do not require to have a licensed staff to create and to oversee a care plan. This would be creating more work for the administrators. If there was a demand for a care plan, then more there would be more demands on licensed providers and billing to Medicaid to provide these care plans.

Section 10 states an essential caregiver must be established. Residential Care Homes do not receive funding for extra staff to be essential caregivers for visitation and infection control purposes. The CDC and DPH guidelines are followed. Again, there have been no cost reporting raises for 7-12 years and there would be no possibilities to pay for extra staff.

Section 12 states each long-term facility to permit the use of a communication device, including a cellular phone, tablet or computer in his or her room for open communication. Whereas most of our residents are independent and can come and go as they please, some facilities do not have enough resources to provide for the up-to-date challenges of new technology. Our caps in reimbursements on our cost report do not allow for proper technology support, such as computers, multiple modems, routers and internet services. Due to the primary population of our residents, mental health individuals often require assistance to use these devices. Supporting staff is not available at all times. Most homes were provided a lender iPad for residential use and found it difficult to teach each resident how to use the iPad. Caregivers on site are focusing on daily care of dietary, cleaning, and assisting residents with personal care. If it should be mandated to have these services available, then internet and equipment should be supplied by the state. Most of the residents are on Title XIX and can not afford to buy new technology.

The requirements in sections 2 through 10 of SB 1030 are not reasonable for residential care homes as a home and community-based model. There are clear differences of residential care homes with nursing homes, assisted living, home care and other models of long-term care. Our level of care is a community setting model and not a medical model, such as this bill. There is not a one size fits all for residential care homes. Funding is limited, our daily rates of pay are frozen for 7 – 12 years now. Many facilities will close their doors if these changes are demanded without proper funding.

With all this in mind, we hope you better appreciate that a one-size fits all approach does not work for residential care homes. If you move forward with this bill, we urge you to remove residential care homes from the bill.

Thank you.

Mary Hagerty