To: The Commonwealth of MA and Joint Committee on Aging & Independence

S.3056/H.5243. - An Act relative to medication administration in rest homes

To Whom it May Concern,

Date: May 11, 2026

I am writing as a long-serving rest home administrator and nurse to provide the Department with an informed perspective on the proposal of the removal of the responsible Person from the rest home model. My testimony is grounded in over twenty years of direct experience in residential care leadership and advocacy for policies that protect both resident dignity and system stability.

My facility operates as a supervised, supportive, and protective residential environment designed to allow residents to safely age in place with grace and dignity. We provide 24-hour staffing and comprehensive oversight, including robust medication management. Care is delivered through an interdisciplinary model that includes collaboration with our Medical Director, who rounds on-site weekly, established pharmacy partnerships, and consistent added coverage and oversight by licensed nurses.

I want to speak briefly to where I believe this proposal originates; from a place of misunderstanding about how Rest Homes function, and, frankly, from bias that leans too heavily toward a skilled nursing framework.

I arrived at the Rest Home sector in 2005 as my facility's nurse manager right from skilled nursing, and I became the administrator in 2018. One of my very first questions to the Department was about the Responsible Person program. Coming from a nursing background, where we talk constantly about scope, skill, and accountability, I had my concerns. I will openly acknowledge that I brought my own bias with me.

Instead of assuming the system was broken, I reached out directly to the Department of Public Health and asked: How do we strengthen this? How do we button this up so that everyone feels safe and confident? They did not answer or offer insight. What I ultimately followed was thoughtful structure, education, and oversight. It worked. People were appropriately trained, residents were safe, and the model aligned with the actual needs of a Rest Home population.

What concerns me now is that rather than addressing the gaps, many of which were created by inconsistent guidance over time, the solution being proposed now is to completely dismantle a system that ***can*** and ***does*** work when properly supported. That is not reform; that is overcorrection.

The Department absolutely has a responsibility to ensure safety and structure and I wholeheartedly respect that. But this approach mirrors a broader pattern of regulation that prioritizes control over practicality, down to rules about the size of a resident's plate (that is actually in CMR:150). That level of micromanagement does not equate to better care. It erodes autonomy, undermines the Rest Home model, and eventually distracts us all from what actually keeps our residents safe.

I am here today to state that there is a better way, one that strengthens oversight without eliminating programs that respect resident independence and the unique mission of each distinct Rest Home.

How will rest homes be impacted?

1. **Operational Impact**

The proposed regulations would fundamentally change how Rest Homes operate day to day. Staffing models that currently function safely and effectively would need to be restructured, adding layers of coverage that do not reflect the actual acuity of our residents. This shifts Rest Homes away from their mission-driven, social model of care and toward a clinical framework that was never intended for this setting.

The current regulation requires rest homes to adapt a staffing and structure model that aligns with resident acuity and to meet the needs of the population where they are. This aligns with the mission of community and allows residents to age in place and receive appropriate clinical oversight. I propose a formalized acuity documentation and review that requires rest homes to demonstrate the alignment between resident needs and staff.

2. **Financial Impact**

Payroll costs would greatly increase under these regulations. Mandatory staffing changes, expanded credentials, and additional coverage requirements come at a time when Rest Homes are already operating on razor-thin margins. These increases are not incremental, they are structural, and there is no corresponding funding mechanism to absorb them. For many homes, this is not a question of belt-tightening; it is a question of financial viability and the ability to keep the doors open.

A more sustainable and effective approach is to allow rest homes to invest in a structured, formalized educational and competency based training program, tailored to meet the rest home level of care. I would encourage the Department not to impose a standard designed for another sector onto rest homes without fully understanding the scope of this level of care and collaborating with stakeholders in real time. Polices may work well in their intended settings, but that does not mean they translate effectively elsewhere.

My Responsible People have worked for me and my organization for a decade or more. They are kind, educated, individuals who are well-trained and capable adults. They are dedicated to the residents in ways that go beyond just being "good employees.' Losing them as leads would devastate my community and significantly impact our residents. The impact is not only to daily operations, but to the communities they sustain. This increased cost would inevitably erode the discretionary resources that allow homes to provide added supports, programs, and environmental enhancements, which elevate resident quality of life beyond the minimal regulatory requirements that some homes are struggling to meet.

3. **Impact on Residents**

Ultimately, residents will bear the consequences. Rising operational costs will limit access, reduce choice, and threaten the stability of homes that residents depend on as their community. The very population these regulations aim to protect, older adults seeking dignity, autonomy, and

social connection, risks displacement, disruption, and fewer safe options for care and community.

None of my residents self-administer their medications and they all require medication management and oversight; this is in part what brought them to the rest home level of care. Residents will be required to leave their homes and possibly return to community living where safety concerns originated. Whose administering the medications then? The alternative is to live within a nursing home community, where there is less autonomy, independence, and dignity offered.

My perspective comes from place of lived experience and responsibility to the residents that I have promised to serve since the age of 19, grounded in the belief that protecting older adults means preserving choice and stability. True protection lies in not dismantling what works, but continuous evaluation, open communication, and collaboration with reality-based stakeholders.

I sincerely thank the Department and all of you here today for the opportunity to lend my voice on behalf of a population that is too often marginalized; individuals who are simply seeking to preserve the safety, community, and sense of family they have come to know, while continuing to live with purpose and surrounded by care.

Respectively Submitted,

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