**Assisted Living Residences (ALR) Commission**

Meeting Minutes

Wednesday, May 7, 2025

10:00 am - 11:30 am

Date of meeting: Wednesday, May 7, 2025

Start time: 10:00 am

End time: 11:30 am

Location: Virtual Meeting (Zoom)

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| **Votes** | **Members** | **Present** | **Vote 1:**  **Approval of 4/2**  **Meeting Minutes** | **Vote II:**  **Approval of**  **4/17**  **Meeting Minutes** | **Vote III:**  **Motion to Adjourn** |
| **1** | **Secretary Robin Lipson** – Secretary, Executive Office of Aging & Independence (AGE) *(Chair)* | X | X | X | X |
| **2** | **Dr. Jessica Zeidman** – Deputy Commissioner/Chief Medical Officer, Department of Public Health | X | X | X | X |
| **3** | **Pavel Terpelets** – Director of Institutional Programs, Office of Long-Term Services and Supports (OLTSS), MassHealth | X | - | - | X |
| **4** | **Carolyn Fenn** – State Ombudsman and Director of the Long-Term Care Ombudsman Program, EOHHS | X | X | X | X |
| **5** | **Representative Thomas Stanley** – State Legislator, Mass. House of Representatives | X | X | X | X |
| **6** | **Senator Patricia Jehlen** – State Legislator, Mass. Senate | X | X | X | X |
| **7** | **Senator Mark Montigny** – State Legislator, Mass. Senate | X | X | X | X |
| **8** | **Matt Salmon** – CEO, Salmon Health and Retirement | X | X | X | - |
| **9** | **Tara Gregorio** – President, Massachusetts Senior Care Association (MSCA) | X | X | X | X |
| **10** | **Mathew Muratore** – Appointee of the House Minority Leader | X | X | X | X |
| **11** | **Beth Anderson**– An Appointee of the Governor, Vice President at EPOCH Senior Living | X | X | X | X |
| **12** | **Kathleen Lynch Moncata** – An Appointee of the Governor, Attorney | X | P | P | X |
| **13** | **TBD** |  |  |  |  |
| **14** | **Liane Zeitz** – Owner, Law Office of Liane Zeitz, the representative of the Massachusetts chapter of the National Academy of Elder Law Attorneys | X | - | X | X |
| **15** | **Elissa Sherman,** President of LeadingAge Massachusetts, Inc. | X | X | X | X |
| **16** | **Brian Doherty,** President & CEO of Massachusetts Assisted Living Association, Inc. (Mass-ALA) | X | X | X | X |
| **17** | **Jennifer Benson** – State Director of AARP Massachusetts | X | - | - | X |
| **18** | **Katherine Ladetto** – Assistant Professor, School of Nursing, Simmons University, the representative of the New England chapter of the Gerontological Advanced Practice Nurses Association | X | X | X | X |
| **19** | **Lainey Titus Samant** – Senior Advocacy Manager, Alzheimer’s Association, MA/NH Chapter | X | - | - | X |
| **20** | **Dr. Jennifer Maynard** –Executive Director, Massachusetts Program of All-Inclusive Care for the Elderly (Mass. PACE) | X | X | X | X |
| **21** | **Lindsay Mitnik** –Staff Attorney, Elder Law- Greater Boston Legal Services | X | X | X | X |

**\*** (X) Voted in favor; (O) Opposed; (A) Abstained from vote; (-) Absent from meeting or during vote; (P) Present

Secretary Robin Lipson, the Secretary of the Executive Office of Aging & Independence, welcomed everyone and called the meeting to order. This slide deck was referenced throughout the meeting: [May 7th 2025 ALR Commission Slide Deck](https://www.mass.gov/doc/alr-commission-may-7th-2025-meeting-deck/download)

Secretary Lipson mentioned that Kate Fillo from the Department of Public Health will be present at today’s meeting. Secretary Lipson noted that this meeting was subject to the Open Meeting Law and any votes the Commission takes will be subject to a roll call vote. Secretary Lipson noted that we have a new Commission member, Kathleen Lynch Moncata. Ms. Moncata has given some insight from the Resident and family perspective at past Commission meetings. Ms. Moncata works as an attorney.

There were no proposed changes to the April 2nd meeting minutes. A motion to accept the meeting minutes for the April 2nd meeting was made and seconded. Bill Travascio took attendance and approval of April 2nd meeting minutes via roll call. *See* chart above, Attendance and Vote I. The April 2nd meeting minutes were approved.

Secretary Lipson asked if any Commission member had proposed changes to the draft April 17th meeting minutes. A motion to approve the April 17th meeting minutes was made and seconded. *See* chart above, Vote II. The April 17th meeting minutes were approved.

Secretary Lipson mentioned that the law requires this Commission to have a public hearing. The public hearing will be held next Thursday virtually on Zoom. She asked that Commission members get the word out to their colleagues and networks about the hearing—this is an opportunity to come forward and share whatever they would like to. We want to hear from Residents and their families about what works well, what can be improved, etc. What happens to Residents as their needs change and any ideas about how to support folks as their needs change while living in an ALR. The balance between safety and the dignity of people making their own decisions. Secretary Lipson noted that if you want to come to the public hearing, we would ask you to register. You are all welcome to come, but Commission members are not required to attend the hearing.

Our presentations today are about safety standards and Basic Health Services. Kate Fillo and Jessica Zeidman from the Department of Public Health will share their thoughts on quality assurance practices. Dr. Katherine Ladetto will discuss Resident outcomes and transparency.

You can see the things we have talked about and the focus of today’s presentation is on safety standards, the delivery of Basic Health Services, and around safety and effective care for the Residents.

Here are some questions to keep in the back of your mind as we go through today. One is around transparency and access to key ALR information for Residents and families—so what kinds of data should we have available. What kinds of regulatory or operational changes would strengthen consumer protections around finances, contracts, and Resident rights. How can Massachusetts ensure that ALRs adapt safely to Residents’ changing care needs, especially complex ones—while preserving autonomy.

Beth Anderson asked about the homework that Secretary Lipson had asked Commission Members to think about for this meeting. Secretary Lipson noted that we will discuss those questions after the presentations.

Whitney Moyer, Chief Operating Officer of the Executive Office of Aging & Independence, began her presentation. *See* Slide 10. Chapter 197 of the Acts of 2024 permanently authorize five Basic Health Services on-site: (1) injections; (2) simple dressing changes; (3) oxygen management; (4) specimen collection with home diagnostic tests; and (5) applying ointment or drops. *See* Slide 11.

The law also indicates that for ALRs who want to provide these Basic Health Services need to be certified and also receive annual compliance reviews by AGE every year. These ALRs will need updated operating plans demonstrating staff competencies, equipment, and protocols.

AGE has been engaged in looking at how do we integrate Basic Health Services within our ALR regulations and within the broader ALR residential model. We have worked in partnership with DPH and others to think about the scope and limits of Basic Health Services, relative to skilled nursing. Basic Health Services does expand the scope of what nurses at an ALR can provide. AGE is looking at the training, staffing, and infrastructure needs for ALRs that provide Basic Health Services and will incorporate these items in the ALR regulations. The regulations will go through public comment and public hearing processes, so everyone will be able to see what AGE is adding to the regulations. AGE will review the comments and modify the regulations appropriately.

AGE is paying attention to what protocols are necessary for emergency back-up when Basic Health Services care exceeds onsite capacity. The core services that are required at all ALRs include assistance and supervision with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), 24/7 on-site staff and personal emergency response systems, private or semi-private apartments. *See* Slide 13.

All ALRs must have SAMM. (Self-Administered Medication Management). *See* Slide 14. SAMM does involve trained staff, but the staff do not need to be nurses. The Limited Medication Administration (LMA) program is optional. About 170 ALRs offer LMA. Nurses do have to administer the medications, which must be non-injectable (i.e. oral, topical, inhalers, eye/ear drops, etc.) from a pharmacy-labeled container. In a future state, Basic Health Services will be an optional service. A nurse will need to administer the Basic Health Services. A physician or licensed practitioner will need to order Basic Health Services.

Some ALRs have specialized care units or memory care units. *See* Slide 15. ALRs are also providing social and recreational activities for Residents as well as coordinating with outside health providers. There is variability in what ALRs are providing. We need to think about how we make it clear about what needs to be provided by an ALR and what is an optional service.

Ms. Moyer discussed the safety standards at ALRs, including the safety standards for the physical environment of ALRs. *See* Slide 16. There needs to be compliance with all applicable state building, fire safety, sanitary, and disability access codes. There needs to be evidence-informed falls prevention programs. There are emergency preparedness and response requirements for ALRs. Additionally, ALRs have incident reporting requirements. There are requirements around quality assurance and performance improvement programs (QAPI) and how to specifically improve quality. *See* Slide 17. There are also requirements around the oversight and auditing of medication programs.

We wanted to try and articulate some of the recommendations that we have heard regarding certain topics such as certification and oversight, staffing levels/ratios, resident assessments, medication and health services, transparency and reporting, consumer protections. *See* Slide 18. We want to have an open conversation with this group about staffing levels and ratios.

Katherine Fillo and Jessica Zeidman from the Department of Public Health presented next. *See* Slide 19. Ms. Fillo noted that DPH serves as the regulatory body for some other types of long-term care facilities like skilled nursing homes and rest homes. Ms. Fillo is the Director for Health Care Strategy and Planning at DPH.

The framework DPH recommends is the quality assurance and performance improvement framework—that purpose is to monitor and ensure that there is a consistent, high quality of care that’s provided to the Residents. When issues are identified, there’s an ability to create, implement, and monitor any improvements. *See* Slide 20. QAPI is the coordinated application of two mutually reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). *See* Slide 21. QAPI starts with an assessment within the ALR about what is in place. For example, when you have a fall, are you monitoring the background about each fall—where it took place, who was involved, was there any resident factors or environmental factors.

There are different elements to a QAPI program. With quality assurance, it’s not just those typical things like falls and medication—but it’s a holistic approach. For example, you need to look at food service and environmental service. In addition, there needs to be some type of process for a team to meet within the ALR. ALRs should foster a culture where all staff are able to speak up about issues. ALRs need to perform root causes analyses so that they can implement corrective actions.

DPH tracks falls with injuries. We are focusing on preventing falls with injuries. We want everyone up and out of bed and moving around—so that does come with some degree risk. We want to reduce the possibility of falls and falls with injuries. Most falls with injury (81%) occur in the Resident’s own room. *See* Slide 23. DPH encourages long-term care facilities to look at whether there was any equipment being used and what equipment should have been used and wasn’t. Regarding falls with injuries, the most commonly used equipment included walkers and wheelchairs. *See* Slide 24. The majority (70%) of falls with injuries involve ambulating, getting out of bed, and getting up from a chair. Among reported falls with injury, 50% occurred in residents that have Alzheimer’s Disease or dementia.

Overnight, falls are relatively low. Falls with injury occurred with high frequency between 7am-8am and 11am-12pm during the morning and afternoon mealtimes. For the afternoon/evening shifts, falls with injuries occurred with very high frequency from 2pm-7pm. See Slide 28. ALRs may want to use this information to address staffing levels.

There are a lot of questions around medication administration—communication is key. *See* Slide 28. With the integration of Basic Health Service, ALR staff and clinical staff become key communication partners with the Resident and their families, and also with the health care providers. There are five stages of the medication process: (a) ordering/prescribing; (b) transcribing and verifying; (c) dispensing and delivering; (d) administering; and (e) monitoring and reporting. With administering medications, confirm every time: right resident, right drug, right time, right route, and right dose.

With oxygen management, oxygen therapy does require medical orders. *See* Slide. 29. A licensed nurse needs to be responsible for providing oxygen—in terms of putting the oxygen on and adjusting the levels. ALR staff should be trained on any equipment and have contact information to be able to reach the vendor. In regard to delegation by a licensed nurse to an unlicensed staff member, one of the things to think about is whether it is the right circumstance or task. Additionally, we must make sure there is supervision and clear instructions.

Ms. Fillo also mentioned infection prevention and control. *See* Slide 30. There are lots of opportunities to foster an environment or prevention within our ALRs. We need to have basic tools available, such as encouraging hand hygiene. Masks should be provided to visitors if they want them. There should be an employee health program that records any staff illness, and that staff stay home when they are sick. Staff should be up to date with their vaccinations. We should have vaccination programs and not just for flu and COVID vaccines. We want to make sure that if we do have any illness within ALRs or staff, that the clinical team should be tracking them—and some illnesses do need to be reported to the local board of health.

In regard to emergency preparedness, ALRs should have emergency plans in place for situations such as loss of power at the ALR or a hurricane or flooding. *See* Slide 31. Emergency plans should address the basic needs of the staff and residents. The emergency plan should address food, water, medical, and pharmaceutical supplies, and alternate sources of energy to maintain: (1) temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (2) emergency lighting; fire detection, extinguishing, and alarm systems; and (4) sewage and waste disposal. ALRs should provide staff training and test the emergency plan.

Dr. Jessica Zeidman spoke next and wanted to highlight that ALRs should have a strong quality assurance and improvement system in place, particularly the ALRs that are providing Basic Health Services or providing care in memory care ALRs.

Dr. Katherine Ladetto, PhD, RN, ANP-BC, GNP-BC spoke next. *See* Slide 34. She noted that she has worked in many different settings over her nursing career—for the last 15 years she has practiced in nursing homes, skilled nursing, hospitals, rehabs, and retirement facilities. Her research interest is in the long-term care workforce. Dr. Ladetto reviewed the admission process at ALRs. The ALR is contacted and the ALR sends an intake nurse to evaluate the care needs of the potential Resident. The financially responsible person is informed about the level of care and the corresponding amount to be paid monthly. This includes the base amount of the rental for living space, in addition to the care needs of the Resident.

The problem is that assessments are not standardized between facilities. *See* Slide 35. Different care levels can be chosen depending on the facility evaluating the same Resident. There is no standardization of reevaluation timing and assessment—therefore no predictability of cost increase. In terms of the promise versus the reality, the financially responsible person is told that nurses are present in the building. The assumption is that these nurses can perform within a basic health care service scope of practice within the confines of the social ALR model. However, the reality is they cannot.

Dr. Ladetto discussed some patient cases showcasing obstacles to effective care delivery. *See* Slide 37. These obstacles included suture removal (basic dressing care), oxygen need assessment and management, insulin, end of life care, vaccination, specimen collection, and unnecessary hospital transfers. ALR nurses have the skills, but they are not allowed to use them.

She recommends defining the nursing scope of practice to stakeholders. *See* Slide 38. We should compare the New Hampshire model. Additionally, we need 24-hour nursing care. There needs to be standardized intake assessments between all ALRs and standardized reevaluations for patient predictability and the associated cost tiers. Transparency would help families make better care setting decisions.

Secretary Lipson noted that some of the issues that Dr. Ladetto mentioned such as oxygen, specimen collection, and insulin, are specifically addressed in the law and with the ability for ALRs at their choice to provide those services. Not all ALRs will provide Basic Health Services, but those that do will cover some of those situations that Dr. Ladetto mentioned.

Secretary Lipson noted that the principle of safety and consistency across settings, no matter where “Mrs. Jones” lives came through loud and clear from Dr. Ladetto’s presentation. Secretary Lipson then referenced the guiding questions which Commission members were asked to think about. *See* Slide 41. These questions were: (1) How can we improve transparency and access to key ALR information for Residents and families?; (2) What regulatory or operational changes would strengthen consumer protections around finances, contracts, and Resident rights; and (3) How can Massachusetts ensure ALRs adapt safely to Residents’ changing care needs—especially complex ones—while preserving autonomy.

Secretary Lipson noted that transparency is especially important to help people think about what things may look like 3, 5, or 10 years out. We talked about consumer protections and we talked about safety for Residents especially as their support needs change during their residency.

Beth Anderson noted that right now, ALRs are not providing Basic Health Services right now. There’s going to be a rulemaking process—and a lot of this conversation will happen there and at the public hearing. She noted that during COVID, some ALRs provided Basic Health Services. She mentioned a survey where over 400,000 residents and families about their approval of assisted living. 90% of the residents surveyed reported high satisfaction with assisted living. 85% of families reported high value. 70% of residents reported improved health outlooks. 75% reported improved quality of life. 95% of seniors said they feel safe and said their communities feel like home. I think that regulating based on some deviations is not the best way to look at this, when you look at these approval ratings. Mass. Gen. Law c. 19D, section 5(d) requires that AGE post reports, responses, and notices of final action on the department website. This is one of the things that we are talking about. I know our industry doesn’t have a problem with that as long as we post the findings by the survey staff, the plans of correction, and then AGE’s final decision.

There are three documents that an ALR is required to provide to a consumer and disclose the essentials in refund policies and the disclosure statement and residency agreement, and the residency agreement cover sheet. The cover sheet has itemized section that an executive director or another individual in an ALR community must review with each Resident or their family member that tells them and itemizes about for example, how long did we do a fee increase, how much notice we need to give them, what the move out rights and obligations are under the lease, and the refund policies.

Ms. Anderson mentioned that guardrails on fines are needed. This is an open-ended ability to impose fines on even ministerial issues. The fines could potentially go back two years because the biennial surveys look back two years. We want to continue to provide choice to our consumers in the Commonwealth who have overwhelmingly said that they would like to choose ALRs. If you fine the communities without any guardrail, then this can prevent some ALRs from operating in the state.

Massachusetts has established minimum staffing standards specifically for memory care and requires that all ALR communities staff appropriately based on Resident needs. Additionally, in regard to QAPI issues, the state mandates that ALRs conduct Resident service training reviews, Resident safety reviews, quarterly medication administration record reviews, staffing level appropriateness reviews, and in special care residences, operation reviews.

Secretary Lipson invited the Commission members to submit studies that we may wish to consider during the public hearing process. Lindsay Mitnik spoke next. Regarding unclear billing, payments, and consumer rights, Ms. Mitnik thinks that continued transparency is really important—it’s not just when a consumer is in the process of looking at ALRs. It is important to have enforcement mechanisms for not only when somebody falls or when there is a complaint, but also when an ALR doesn’t itemize its ledger or something like that, because that has real consequences. She also argues that the fact that there are discrepancies in people’s experiences, why not aim for 100% or closer to that approval. We have heard a lot from consumers and advocates. She thinks those discrepancies are very much a valid reason to be looking for change because that can only improve the experience for more people.

Secretary Lipson noted that Brian Doherty from Mass-ALA left a response about QA/QI in the chat and that Mass-ALA does have a tool and a whole approach to topic. Dr. Jessica Zeidman spoke next. She agrees that we want to find a way to preserve the quality, that experience--the ability for people to remain where they are, where they’re happy and satisfied. We also need to acknowledge that we are seeing that as Residents become more complex, there are some safety challenges that we can work on. These things are related, but they’re not 100% the same. We want to preserve that Resident experience that is so strong in so many cases, while also exploring how to make the ALRs safe enough as people become more complex medically.

Secretary Lipson noted that the statute required us to work with the Department of Public Health on the ALR regulations regarding Basic Health Services.

Mathew Muratore mentioned that with regard to safety and Basic Health Services, he wondered if it would make sense instead of ALRs being required to offer all or none—could there be a case where ALRs could take one or two of the Basic Health Services and then move on to offer others. Secretary Lipson noted that this is something we have talked about. For Secretary Lipson, the intersection of Basic Health Services and the issues around transparency and predictability are paramount. If she were making a decision for her mother, she would want to know which Basic Health Services will be provided not just in her mother’s first month of residency, but as well as her mother’s 36th month of residency. She thinks that is driving our current thinking—that’s it’s the suite of Basic Health Services that makes sense—but that does not mean that we cannot look at other permutations of that. She’s not seeing this as separate from many of the issues of transparency and the need for people to plan. She noted that Residents’ needs change—a Resident may initially need insulin, but then will need oxygen later on.

Dr. Jennifer Maynard asked if we know how many ALRs are intending to be apply to be certified to provide Basic Health Services?

Brian Doherty noted that right now consumers have choice for various different types of Assisted Living communities—rather than creating a one-size-fits-all approach, and rather than raising the floor of cost to be a much higher level than it is now for the entry point to get into Assisted Living. With regard to staffing, the regulations require that all ALRs conduct and document quarterly staffing appropriateness review that ensures that staffing levels can meet the evolving needs of Residents. The review should assess Resident acuity, staff coverage by shift, and any patterns or incidents or service changes. Findings must be documented and available during regulatory visits. It’s both a compliance requirement and a proactive tool to support Resident wellbeing and staff effectiveness. The hallmark of Massachusetts assisted living is staffing to the needs of the Resident, which can be very different from one community to the next—it’s a really good thing for consumers.

He would welcome AGE to present at one of these meetings regarding how AGE surveys the ALR communities and ensure that ALR are doing the quarterly reviews for staffing appropriateness. On the health services, his question is how do we increase access to these services so as the regulations get developed, how do we try to get 50 or 100 communities to give the option of a nurse providing insulin injections. The recommendation of having a registered nurse 24/7 at an ALR might lead to zero ALRs providing Basic Health Services. We have already limited the pool of providers by requiring providers to either offer all or none of the Basic Health Services. To what extent do we want to limit the number of communities that will opt in to provide Basic Health Services. The legislation requires that there be a 24/7 nurse on call for Basic Health Service communities. The Legislature was very careful in adding that language to the bill and not making it a 24/7 nurse on site or 24/7 RN requirement.

Elissa Sherman noted that with regard to whether ALRs will opt to become certified to provide Basic Health Services, the ALR members she works with are playing a wait and see game to see what the regulations are going to look like. She also would be equally concerned about the requirement of a 24/7 registered nurse on site--that’s been a major concern for her nursing home members with the CMS proposals and the lack of availability of registered nurses to hire. With the all or nothing approach of Basic Health Services, there’s a huge range of needs that an individual could have. There’s a need for transparency. However, at some point, Residents might not be appropriate for assisted living from a safety perspective. ALRs are unique from nursing homes, and we want to make sure that we can support Residents in choosing the appropriate level of care. If there’s an expectation that all of these services have to be provided at any level, that will make it difficult for ALRs to work with families to figure out when it’s appropriate for them to be in a different setting.

Jennifer Benson had some questions about some of these issues as far as the transparency piece and understanding that having choice does not mean equity and access. That is something that we need to grapple with and understand at a basic level. What is the cost matrix and who bears that cost—the more we add to ALRs for private pay means less access and equity to these services. We talk a lot about what should be provided, but I think we have to bear in mind the framework within which we are working when we are creating policy. Is it more coordination with other services that are provided in the community? What are some of the mechanisms to pay and make sure that people can continue to have access to these services? She does agree that a lot of the Basic Health Services are needed and they will save costs in other ways—how do we incorporate that idea?

Secretary Lipson noted that she did not think the law suggested that ALRs should become skilled nursing facilities in any way, shape, or form. When we talk about Residents and their conditions changing—that is when the line gets blurry.

Liane Zeitz noted there is a tension between a residential model and a medical model. She started her law practice at the beginning when the nursing home reform law was enacted by Congress, and it created stricter regulations for nursing homes in Massachusetts. She has seen how that has helped consumers and protected consumers. She is not saying there needs to be a corresponding level in ALRs, but as increased services are provided in ALRs, there needs to be increased protections. A decision has to be made about where to draw the line and how much regulation do you have—at what point does it become a medical model, and not a residential model.

Secretary Lipson noted that the public hearing is next Thursday at 1pm—there is a link to register. The Commission’s next meeting is on Wednesday, June 4th where we will discuss regulatory procedures for opening, closing, or changing ownership, including a determination of need process and clustering of facilities. This is required by the law. People from PACE and MassHealth will make some presentations on some of these issues.

A motion to adjourn was made and seconded. *See* Vote III in Chart above.

**Meeting Materials**

1. PowerPoint Presentation referenced throughout the May 7th Meeting: [May 7th 2025 ALR Commission Slide Deck](https://www.mass.gov/doc/alr-commission-may-7th-2025-meeting-deck/download)