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To Whom it May Concern,

I am writing today to share with you the already difficult challenges residential care homes (RCH) face when involuntary discharge of a resident is imminent. The current Connecticut residential involuntary discharge process is governed by state statute 19a-535. The statute outlines the involuntary discharge process for facilities (defined within statute) to remove or discharge a resident deemed not appropriate for RCH levels of care or who is deemed a threat/danger to themselves or others. For many years residential care homes have assumed the responsibility, granted by the state, to care for and accommodate housing shortages formed by the closing of the state's mental health hospitals. Understandably we are just one of many community resource agencies assisting with housing and care of our state's mental health population and disadvantaged elders. Hence the importance of outlining a statute of residential protection. The only question remaining is where are the protections to the discharging facility?

A Residential Care Home is identified as a **non-skilled** nursing facility minimally responsible for housing, meals, lite housekeeping and medication administration. This being the short list of outlined responsibilities not an accurate list nor depiction of the many critical functions residential care homes are tasked with daily. Essex Village Manor and Meadowbrook Manor are staffed twenty-four hours seven days weekly. The staffing compliments are regulated by state statute as follows, one staff per twenty-five residents (Meadowbrook Manor), two staff per thirty-three residents (Essex Village Manor). Appreciating the RCH is a non-skilled nursing facility we have been pressed to assume greater responsibilities to care for residents who not only experience a mental health diagnosis but more often a dual diagnosis. Dual diagnosis residents present a unique set of challenges to the community setting. Managing mental illness in a residential care home setting is challenging especially when community supports are few, staffing compliments are poor and funding is restricted.

Please know an RCH will issue a thirty-day eviction only when resident behavior/condition is chronic/untreatable or poses a health or safety risk to themselves or others. Involuntary discharge from an RCH is a rare but necessary in an effort to maintain healthy productivity levels for staff and residents who work and reside in an RCH. Please understand RCH administrators are often pressured to accept unsuitably screened clients and are deprived of critical identifying features which could best determine a client's appropriateness for an RCH setting. The withholding of critical information has become standard practice in our industry due in part to industry skepticism.

Residents are also removed involuntarily from RCH's via a 911 protocol prompting local police and EMT services to respond. More often 911 protocols are medically driven though they can be behaviorally motivated. Upon the resident's clinical evaluation, the resident is more often discharged back to the RCH with minimum or no follow-up. The responsibility of communication and orchestration of necessary community supports falls on the RCH in an effort to minimize a second 911 activation. The revolving door further intensifies frustrations and administrators are tested, and residential care aides/supervisors are compelled by skilled nursing supervisors to readmit residents not yet suitable for return to an RCH level of care.

Involuntarily discharged residents are typically non-compliant with treatment modalities, committee established house rules, public laws, posted community restrictions or outlined signed contracts. In conjunction with the issuance of a thirty-



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day eviction the resident is provided a list of local resource agencies, to include additional RCH's in the catchment area. Community based providers and assigned case managers are provided more than advanced notice of a client's decline prior to a critical decision to evict is reached. It is the responsibility of the client/resident and treatment team to work in the best interest and the interest of the facility? Is it not our responsibility to build bridges not burn them? When do our state skilled workers assume responsibility for what our non-skilled entities have been saddled.

Administrators and residential care aides are consistently challenged to balance medical/mental health treatment plans with basic facility operations. RCH administrators are pressured to readmit returning residents prior to receiving a satisfactory medical or mental health evaluation. Further, RCH property owners recognize and appreciate facility limitations due in part to facility age, staffing compliments, home locations, community resources/supports, etc. It is in this assessment that adding yet another layer of residential protection to RCH's further complicates the existing statute 19a-535. Residential Care Homes care for and continue to house some of the states most disparaged populations. RCH populations are comprised of individuals with dementia, Alzheimer's, autism, medical restrictions, physical limitations and mental illness diagnosis of all types and stages.

I want to reiterate that an RCH is deemed a **non-skilled** nursing enterprise by state statute. Though it is unambiguously expressed that our role as an RCH is not to assess, evaluate, estimate nature, ability or quality of, we are driven and pressured to perform under this guise. Residential Care Home administrators and staff should be extended the same courtesies and professionalism as skilled enterprises. Adding another layer of confusion to the residential involuntary discharge process further perpetuates skepticism amongst skilled and non-skilled enterprises.

Respectfully Submitted,

Dwayne D Spurley, Director of Operations
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