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3/11/2025

3/15/2026

Dear, State Senator

Glenn Gruenhagen

Rich Draheim

RE: aging, economic jobs (2025)

Human Services and finance policy (2026)

H.F. 3935

I'm asking for a bill regarding Assisted Living and Memory Care

A Certified Nursing Assistant and

A non Certified resident Assistant

Should have different pay grade

Assisted Living has flatten the curve, has placed everyone I just mentioned on the same starting pay, this is unfair to The worker, and for the resident receiving the care.

Another issue is the Memory Care, the memory care in these assisted living facilities should have a 24 hour nurse in the building

Followed by, Trained Medication Aide and Certified Nursing Assistant, Home health Aide

Memory Care should be classified

Longterm care

looking forward to your response

-Maria Cermak



Co-Chair Noor and Members
House Human Services Finance & Policy Committee
Minnesota House

March 18, 2026

Dear Co-Chair Noor and Members,

The Consumer Advocates Coalition writes to express our support for **HF 3935**, which aims to eliminate no-lift policies in assisted living facilities.

This summer, a resident of an assisted living facility in Minnesota died when he slid off his powerchair and became wedged in by a wall. Residents in the same dining room were the first to see the resident and alert staff to the situation. Video aired on Fox 9 shows staff gathering around the resident, discussing what to do, and then calling 911. No staff helped the resident until EMS arrived. At that point, the resident had died.

The assisted living facility had a no-lift policy that prevented staff from intervening in a timely manner. Had aid been rendered to the resident more quickly, it is possible a better outcome would have been achieved.

Calls to 911 occur frequently when residents fall, even when residents are living in an assisted living facility due to having a high risk of falls. Residents have reported to advocates that they are not allowed to get up off the floor after a fall, even when they feel they can, until EMS arrive on scene. Residents and facilities also report being charged by cities for frequent 911 calls.

Care planning and follow-through that supports residents who have a risk of falls is essential. Care plans should include fall prevention plans, a plan to support a resident if they do fall, and criteria for determining when a resident's need for additional medical care warrants a call to 911. Calling 911 should not be the first step if a resident does fall.

We appreciate Representative Klevorn's and the Elder Voice Family Advocates' collaboration on this bill.

For these reasons, we respectfully urge the committee to support HF 3935.

Thank you for your leadership on behalf of older adults and vulnerable Minnesotans.

Sincerely,

Consumer Advocates Coalition

March 16, 2026

The Honorable Mohamed Noor
Co-Chair, Human Services Committee
Minnesota House of Representatives
5th Floor, Centennial Office Building
St. Paul, MN 55155

The Honorable Schomacker
Co-Chair Human Services Committee
Minnesota House of Representatives
2nd Floor, Centennial Office Building
St. Paul, MN 55155

Dear Co-Chair Noor, Co-Chair Schomacker, and Members of the Committee:

I am writing in support of House File 3622. Last summer, my mother-in-law passed away in an assisted living memory care unit 11 days after a fall. The events that occurred following her return to the facility led me to contact my State Representative to express my concerns about what happened and to see if there was something she could do to prevent what happened to my mother-in-law from happening to anyone else. This is my story.

After a three-day hospital stay, my mother-in-law arrived back at the facility. A little after 8:30pm that night, I got a phone call from the triage nurse and then from my mother-in-law, telling me she had fallen. She told me she had pressed her call light because she needed to use the bathroom badly and needed help to get there. She said she couldn't wait any longer, but no one came and that she had been on the floor for a long time.

It was found through a DHS investigation that her call light was on for an hour and 41 minutes with no answer. Based on the timing of my calls and the call from the triage nurse, we believe she was on the floor for approximately 75 minutes.

We also believe that this fall led to a rapid decline in Lorraine's condition. It was after dinner Thursday approximately 24hrs from her fall that she took a rapid decline and passed away 11 days later.

The events from the fall Wednesday night through Friday evening have left my husband and I very traumatized. After talking with each other we both feel that we have not been able to grieve her passing as we have struggled with the lack of care and treatment.

After consulting with a lawyer, it was learned that man facilities do not save their call light logs. I am hopeful that you will consider adding this to legislation for the safety and protection of some of the most vulnerable people in our state.

Thank you.

Sincerely,

Stephanie Johnson