3/13/2025

Chair Patterson, Senator Gelser Blouin and members of the Senate Committee on Human Services

I am Cynthia D'Angiolillo, Oregon Registered Nurse over 40 years, the last 26 in public health practice, recently retired.

Today I am writing in strong support of SB739-3, a proposal which will help correct serious failures in oversight of residential care facilities and will improve safety of elders there.

TRANSPARENCY:
This bill addresses one of my highest concerns; the lack of transparency when there is a finding of immediate jeopardy, licensing violation resulting in death or harm to a resident, substantiated allegation of abuse, license violation or license restriction.

Residents and their families or designated contacts must be made aware of these serious risks to their safety and wellbeing.

SB739-3 requires the facility to maintain a contact list for each resident, and directly notify the resident, their contacts, guardian, ombudsman, case manager, as well as post this information on the facility website and in a prominent location in the facility.

Current practice of posting paper in the entryway or on a bulletin board in the facility is woefully inadequate, as many residents do not have visitors who might see such a notice.

When seeking information about a facility one views the facility website and sees lovely photos of the grounds and statements extolling the virtues of the facility.

However, if one goes to the DHS LTC Licensing website https://ltclicensing.oregon.gov/Facilities to search for licensing status of that same facility, one may find exceptionally concerning information including pages of substantiated violations including elder abuse and neglect.

In one random search, a facility report shows 180 substantiated incidences of abuse and neglect, 27 in the past year, along with 30 licensing violations over the past 7 years.

The facility website does not have a link to the Oregon DHS licensing website. Most residents and their families are likely unaware of the website and unaware this information is available.

Direct notification of residents and their designated contacts is critical.

TIMELY INVESTIGATION: This bill specifies DHS must investigate death or serious injury to a resident within 24 hours, and all other complaints without undue delay. This is critical to the safety of residents. Currently the response time to complaints can be months.

ADMINISTRATOR QUALIFICATIONS: This bill specifies necessary qualifications along with requirements for mentoring and support for newly licensed and inexperienced memory care facilities. This is essential to the safety and well being of very vulnerable residents.

Please do support SB739-3.

Cynthia D'Angiolillo