March 19, 2025

Chair Gelser-Blouin, Vice-Chair Linthicum, and Members of the Committee

Thank you for the opportunity to present testimony regarding Senate Bill 739. My name is Sonda Martin and I am a retired RN and daughter of a 70 yr old woman suffering from dementia.

Our Story

I moved my mom into Arbor Oaks Terrace Memory Care in September of 2022. I thought the place was nice, clean and was hopeful that the seemingly amazing activities program they had would improve my mom's quality of life. For the first few months, it seemed like things were going well, but slowly my mom started having more complaints about other residents, especially her neighbor, whom she accused of regularly taking her stuff.

To be honest, I kinda dismissed this as part of the dementia behaviors, until we came back from my sister's wedding in July 2023 and found my mom's room unlocked (after housekeeping had promised to lock it when finished that morning) and a vase of flowers was broken on the floor and a couple things were knocked off her shelf. The complaints about other residents in her section continued to mount.

Eventually in August, after the executive director (ED) mentioned that my mom had unexpectedly bumped the activities director (whom she adored) with her walker, I asked if it were possible to move my mom into the other section of the facility and away from the ladies that my mom didn't really seem to like. The ED readily agreed and my mom was moved.

Fast forward to October and my mom was hospitalized with a sudden GI bleed. In November, when seeing her new PCP, I was shocked to find out that **my mom had been placed on an antipsychotic med without my knowledge or consent back in August 2023.** The facility, coordinating with an insurance-contracted provider that my mom was temporarily using as her PCP, had done this without notifying me as her health care representative and POA.

That revelation led to the next 7 months of hell for my mom and myself. It took the facility **3 months to provide me with records that I requested multiple times** regarding my mom's behaviors and care. My mom **sustained a head injury that was treated by someone in the facility but never reported and found by me at least a week after it happened**. My mom had **3 inhalers stolen by staff** and reordered because their medication administration system was a mess. My mom had **painful skin rashes and bladder infections that went unnoticed, untreated and/or unreported** because of lack of staff or poor communication. She went **4 weeks in January 2024 where the only shower she received was from me**. A very expensive mattress was ruined because staff failed to put on the mattress protector I had provided and failed to notify me that my mom was wetting the bed every night. Had I known, I could have provided better nighttime incontinence supplies or better mattress protection.

My mom's care plan was not consistently not followed. Her care was not individualized. **Due to inexperience, understaffing and lack of training, the staff frequently were unable to manage her agitation** or other absolutely common behavioral symptoms. Despite the scientific evidence that agitation in dementia patients should be managed by non-pharmacological means such as altering the environment, adequately managing pain, boredom, and other physical needs, the facility pushed for anti-psychotic meds and failed to use evidence-based methods of deescalating. Staff at all levels frequently demonstrated they did not understand the basics of person-centered dementia care. **My**

mom's personal care plan was not updated for a whole year, when state regulations mandate quarterly updates.

Their documentation, when I finally received it, was full of omissions and even a couple downright false statements. Clearly, there was woefully insufficient oversight of the medication administration process. There was a lack of communication about issues between staff and administrators. The fact that there has not yet been a serious injury or death at Arbor Oaks is a flat out miracle.

Mom's head injury from January 2024. Note the lack of dried blood from the open wound. My mom did not receive a shower in the 2 weeks prior to me finding this injury and there is no way she thoroughly cleaned the wound and the hair herself. The lack of reporting of this is scary…she could have had a much more serious head injury.

The facility underwent an administrator change in Oct 2023 without notifying me or other family members. The facility was **without an in-house registered nurse for most of 2023 and 2024**, without a resident care coordinator for at least half of the time my mom was there, was understaffed and was not providing the care that they claimed. I had multiple meetings, phone conversations and email conversations with the new executive director, a nurse, a VP from the managing company, and other staff. **My concerns were dismissed and I was lied to on multiple occasions about the adequacy of the training, staffing or activities being provided**. I was frequently not given updates on my mom and multiple stories about incidents from different people. We were privately paying $8000+/month for my mom's care and she was barely receiving more than food, shelter, intermittent housekeeping and sloppy medication administration for that price.

In January and March of 2024, I submitted two very long, very detailed complaints to the state as well as a couple separate complaints to APS. My second complaint to the state was submitted with pages and pages of the relevant medical records and emails and other documentation, to assist in the investigation. **To this day, those licensing complaint investigations and one of the APS complaints I submitted are NOT COMPLETE, over a year later.**

In October 2024, the facility went through a relicensing survey and was found to have **over 25 deficiencies cited. At least 20 of these deficiencies were items similar to, if not identical, to things in my complaints.** The facility also had multiple violations and abuses noted through 2024. Many of these violations were related to lack of staffing, failure to provide a safe environment, and failure to provide person-centered care or follow individual care plans.

I waited and waited and waited for results, until finally, at the end of January 2025, I started making phone calls (which all went to voice mail) and sending emails, trying to get someone to give me an update and/or results of the investigations. This process was difficult because the department's website is dreadfully difficult to navigate when you're trying to find an actual person to talk to. Eventually, a compliance specialist working on my complaint called me, asking if I had photos related to my complaint. **This person apologized that things were taking so long but explained that there were only 11 compliance specialists in the state and that she personally covered 5 counties.**

It is also very important to point out that this was the first person who had directly spoken to me about the investigation. No investigator ever talked to me. Maybe my initial complaints and all the documentation I provided up front were sufficient, but still.

The state failed my mom. The state failed all the other residents who continued to suffer from the same kind of treatment that I complained about. **There is simply not enough oversight.** Clearly, while my mom's case had aspects that were personally applicable to her, **the overall systemic problems within the facility such as understaffing, insufficient medication administration oversight, lack of appropriate training, lack of regular nursing oversight, failure to update care plans, etc. affected all residents within the facility.**

When I moved my mom out of the facility in May 2024, the facility was (and had been) actively admitting new residents whose families had NO clue that the facility was already understaffed, staff was undertrained, and care was inadequate. **The state's failure to follow up on my complaints in a timely manner contributed to the continuation of the facilities poor compliance that ended up being documented in the facility's relicensing survey in October 2024.**

Specific Comments on SB 739

- This bill is a step in the right direction, but unless it carries weight and is backed with the funding and the licensing department staffing to enforce it, it becomes just one more useless legislative document.

- **These facilities need MORE oversight and enforcement, rather than less.** One of the industry lobbyists stated that Oregon already has some of the most "comprehensive and complex regulatory systems for community-based care in the nation… regulations around staffing standards, training standards, and quality measures just to name a few." **These standards and regulations mean absolutely nothing when facilities regularly ignore them or fail to adhere to them, knowing that oversight and enforcement is negligible.**

- Corporate profits should not be allowed more weight than the wellbeing of our vulnerable senior population in this discussion. It cannot be emphasized enough that these corporation operate these facilities for profit, not for the public benefit. **If they were truly committed to providing the best care for seniors, we would not see so many facilities being run so poorly across the state. The licensing violations and abuses that *have* been investigated and substantiated is evidence enough without adding all that fly under the radar.**

- The state absolute needs to improve the promptness of initiating a complaint investigation and finish their investigations/reports in a timely manner. Delays only lead to more neglect and abuse of residents that could be avoided with proper oversight.

- There needs to be more mandated communication about changes in administration, licensing violations and abuses, etc. to prospective residents and current residents and their families. As things currently stand, it is easy for systemic problems to be hidden by facilities.

- Administrators MUST be licensed and competent in memory care to operate memory care facilities. Allowing unlicensed, undertrained administrators to run things outside of emergency situations is a disaster waiting to happen.

- Exceptions should not be granted except as allowed by statute. Corporations make a lot of profit off of operating these facilities; it is not done as a charitable endeavor. **Granting them exceptions gives them permission to cut corners even more than they already do with the current inadequate oversight.**

- Penalties for violations need to be stiffer. There is currently not enough financial incentive for these companies to do better. They take an approach of getting away with whatever they can for as long as they can because if they get caught, the $250 fine is a slap on the wrist. **If the penalties for failing to meet the regulatory standards continue to be abysmally low, facilities**

will continue to ignore the regulations, making record profits in a growing industry while our parents and grandparents and eventually, perhaps, ourselves are left neglected and powerless.

As our legislators in this state, you have the power to create the changes necessary to protect our vulnerable seniors, many of whom do not have family to speak up for them. The number of seniors needing care will only continue to grow in the forseeable future and the facilities should be caring for them in the way that they deserve and that they pay for. Their rights should be protected.

The industry will fight, saying they can't do better, but they can if they are held to the rigid standards that they should be. This is your responsibility. Please step up.

Thank you,

Sonda Martin