March 18, 2025
Re: Senate Bill 739, -3 amendment
To: Senate Human Services Committee

Chair Gelser Blouin and members of the committee,

Thank you for this opportunity to provide feedback about SB 739, the -3 amendment, and our participation in the workgroup that is continuing the work to improve safety in our community based and memory care settings.

SEIU Local 503 represents thousands of workers across the long-term care continuum, including workers in skilled nursing facilities, in-home care, assisted living and memory care facilities, and more. We also represent the dedicated workers at ODHS who license, oversee, and regulate long-term care facilities. As a union, we have spent decades advocating for increased standards and quality in long-term care, and we have appreciated the opportunity to engage in the workgroup and share the perspective of our members.

Senate Bill 739 is, in part, a response to an April of 2024 report by Oregon's Long Term Care Ombudsman, following a three-month investigation into the tragic death of a resident in a memory care facility.

Key findings of that report include, but are not limited to, the following:

- Gaps in Oregon law allowed an owner with no background or knowledge of long-term care to open a state-licensed memory care facility.
- Current law does not require the Oregon Department of Human Services (ODHS) to closely monitor a newly-opened facility to ensure safety and quality of care.
- The facility failed on multiple fronts to care properly for the residents entrusted to their care, and the State missed multiple red flags that should have been addressed sooner.

Our members would like once again to express our support for the Ombudsmans' role in our long term care system broadly. An independent ombuds office is crucial for ensuring that residents in long-term care facilities receive unbiased advocacy and protection, helping to investigate and resolve complaints effectively. It upholds the rights and dignity of these residents and is critical in fostering an environment free from abuse and neglect while promoting quality care and personal autonomy.

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The workers at the facility subject to the investigation were not part of a union, but the working conditions described in the ombudsman report sound like stories we hear from workers in these settings, especially those workers trying to organize a union to improve their working conditions. Oregon must do more to improve long term care, and the ombuds office is a valuable resource in creating better, safer, long term care facilities. The report findings are consistent with what we hear from front line workers – including those who work in long term care facilities and state workers familiar with APD regulatory systems.

SB 739 is structured to improve safety and quality for residents in all community-based care facilities. SEIU Local 503 supports the major provisions of SB 739 and eagerly looks forward to engaging in this ongoing and important conversation. We in particular appreciate the inclusion of Section 8(4). When a facility has experienced repeated administrator turnover in a short period of time, the State should take action to understand the circumstances that are contributing to that turnover. It is important to note that while we think this is essential legislation for the 2025 session, the regulatory policy cannot stand alone.

The facility where this tragic death occurred clearly needed much more oversight, better staff training, reasonable staffing ratios, and more on-the-job support to ensure the safety and well-being of its residents. When facilities are understaffed, it is not because caregivers are unwilling to work, but because the administration fails to hire enough staff or to create working conditions that attract and retain qualified professionals.

The Legislature, in order to ensure its investments in community-based care are supporting direct care staff, should ensure that facilities are providing detailed cost reports that detail their actual costs. These cost reports should be reviewed and utilized by the Department and the Legislature to inform appropriate reimbursement rates, and to evaluate whether facilities are paying their staff competitive wages and benefits. Additionally, ODHS should require ownership transparency in line with the requirements for SNFs.

In addition to the caregivers at facilities, the front line APD investigators also need additional resources. It is the responsibility of ODHS to ensure that care settings are safe, adequately staffed, and compliant with all regulations. Our members who do this work feel completely overwhelmed by the volume of work relative to the staffing of their unit, and don't always feel confident they have the right tools when a facility is out of compliance. A recent report conducted by Alvarez and Marsal backs them up.

The report, published in February of this year, includes interviews with staff from the Safety, Oversight, and Quality (SOQ) unit that speak to understaffing. The report says, "The majority of interviewees noted that staffing levels did not feel sufficient to complete the workload assigned to them. Multiple CBC staff compared the number of staff that

the unit currently has to the number of facilities that the unit manages and pointed out a substantial, unfavorable differential between CBC staffing levels compared to either NFSU or APS." The report found that there is a backlog of over 4,000 complaints for CBC providers, and that there may be misaligned expectations between statute and practice at ODHS. The legislature must support ODHS in this effort, including authorizing more regulatory and compliance positions in APD.

These financial resources along with continued legislative oversight are vital, as ODHS leadership has a history of failing to implement legislatively mandated improvements. SEIU Local 503 members have repeatedly raised concerns about the department's failure to implement SB 1556, passed in 2022. SB 1556 (2022) is a certification and registry bill that required ODHS to create a public facing registry that included verification that workers had passed a background check and completed state-required training. The registry would be available to consumers and family members looking for a placement or current residents wanting to verify that staff caring for vulnerable adults were trained and qualified.

Our members, alongside the legislature, fought for this bill because we knew facilities were routinely failing to provide basic training or even meet background check requirements for their staff – leading to unsafe facilities where workers and residents alike were put at risk every day. The public registry adds a layer of accountability for facilities, protects workers, and allows families to check facilities for compliance with staff training. The registry was supposed to be up and running by December 2023, yet rulemaking is just starting in March of 2025.

Oregon's population is aging rapidly, increasing the demand for long-term care facilities that can provide safe and reliable services to our seniors. As the oversight body for these facilities, the Oregon Department of Human Services (ODHS) must be given the resources and tools to hold facilities accountable and ensure that facilities are safe and that both consumers and workers are protected. By improving transparency, accountability, and enforcement, ODHS can help prevent tragedies, such as the one at Mt. Hood Senior Living, and build a long-term care system that meets the highest standards of safety and quality care.

Thank you for your time and attention to this important effort,

Courtney Graham
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