

Chair Prozanski and Members of the Committee:

My name is Alicia Parker. My father, Richard Parker, was a resident at the now-closed Healthcare at Foster Creek nursing home in Southeast Portland. In early February of this year, I was able to visit my father at his long-term care facility. I introduced him to his only baby granddaughter. Never would I have thought this would be the last time I would see him alive. He was in good health and expressed love for us both.

My father moved into Foster Creek in 2015 due to dementia. Throughout his time living there, I had several concerns regarding his diet, continued weight loss and lack of physical activity. I tried to express these concerns to staff during his quarterly case conferences. I never got any assurances or updates these changes were being made or considered.

In late February, I called the administrative office to inquire about their plans/protocol in case of COVID-19 outbreak. I did not receive a call back. Later I learned the state issued a letter to all nursing homes with guidelines to handle the pandemic, but I never received communication from administrators at Foster Creek about this. I have since learned they were cited for multiple instances of ignoring these guidelines and eventually shut down.

On March 22<sup>nd</sup>, my father's Nurse Practitioner told me he had fallen ill. He had pneumonia in one of his lungs and was prescribed antibiotics. During this conversation, I was told they wanted to take him off what they called "Full Code" status, so they could treat my dad at the nursing home, without having to take him to the hospital. They assured me his treatment would be the exact same at the nursing home as it would be at a hospital; including antibiotics, fluids and aspirin for his fever. On March 25<sup>th</sup>, I learned my dad contracted COVID-19. He was the first diagnosed case at Foster Creek.

I asked the staff what kinds of protocols were in place for dealing with sick patients, and how they planned to isolate them from other patients and staff. I was informed there were no protocols. Staff were clueless as to any protocols. They informed me my father would be sharing a room with three other patients, several of which I suspect were not infected with Covid 19.

Later that day, I asked the staff to set up a Facetime call with my father. When I spoke to him, he was verbally unresponsive and didn't seem to understand what he was looking at or who he was talking to. Staff members told me they didn't expect my dad to recover, and that they had no plans to move him to the hospital but wanted to continue treatment to keep him comfortable. Up until this point, the only details I had been given on his condition was that his breathing and temperature were stable. On March 28<sup>th</sup>, his temperature had spiked to 102 degrees. When I talked to staff, they had no plans to update his treatment except to give him morphine to make him comfortable.

Two days later, the staff informed me they were no longer giving him fluids or oxygen and were only giving him morphine to help with the pain. This ensured his death—despite promises they could treat my dad just as well at Foster Creek as they could at the hospital. I now suspect that keeping my father at the facility was financially motivated, and by removing fluids from my father and ensuring his death, they were certainly not taking care of him in the same way a hospital would. They offered no explanation as to why they stopped giving him fluid treatment and were instead treating my dad as a hospice patient. I spoke with the nurse about reinstating his fluid treatment, but I was rebuked and was given no explanation as to why they were allowing him to die. At no point did I give my consent to stop actively treating him for pneumonia or COVID-19, but they unilaterally decided to stop those

treatments. I'll never know whether or not my father could have pulled through with full treatment. My daughter will never be able to meet her grandfather again.

The next day, again I called Healthcare at Foster Creek to Facetime with my dad to get my own sense of his condition and to personally request he be sent to the hospital. When I saw him, his breathing was severely labored and he was barely conscious. That night, around 10:30, I received a call informing me that my father passed.

At every step of the way, I struggled to communicate with staff and get clear and straightforward updates on my father's condition. I feel misled from the very beginning about the nature of my dad's treatment and it is clear that my wishes for his treatment were ignored.

- Why did HealthCare at Foster Creek suggest that my Dad's "Full Code" status be revoked?
- Why did they stop giving him fluids that had been helping him?
- Why did they place him on end-of-life treatment instead of sending him to the hospital where a ventilator could have saved his life?
- Were these decisions even made by medical providers?
- How many people were infected by this facility's;
  - Failure to train their employees to wash their hands?
  - Housing infected patients in the same room as healthy patients?
  - Management's failure to provide more than one mask to workers per day?
  - Or any of the dozens of violations the State of Oregon has found put these patients lives in jeopardy.
- How did 119 residents and staff become infected with Covid-19? How many of the 30 dead residents would be alive if the owners would have simply followed state law?

You may have heard it, but my father's story is just the tip of the iceberg at Foster Creek. In all, there were 119 positive cases and 30 deaths at the facility. In addition to lack of communication with patient families and lack of treatment, they were also entirely incapable of handling this outbreak, even though outbreaks in long-term care facilities were already happening across the country. They had no protocols in place for dealing with sick patients and failed to protect anyone in the facility, residents or staff, from contracting COVID-19. Staff were often wearing one N-95 mask for the whole day and sharing gowns used by multiple staff in each patient room.

On April 15<sup>th</sup>, DHS finally stepped in by giving Foster Creek firm instructions to conform to the rules and guidelines put into place by the state in order for them to continue operation. They were failing to properly respond to the outbreak. I was relieved the state took action, but I wish it had been done a month sooner. After a host of violations far too long to list and a failure to comply with the new guidelines, Healthcare at Foster Creek was forced to close on May 7<sup>th</sup>.

I understand the nature of this outbreak and the difficulties in responding to them. When a healthcare facility fails to meet the standard of care, ignores state guidelines put in place to protect the community, and continues to put more people at risk, those families deserve answers. To take away a grieving family or injured person's rights to hold their wrongdoers accountable is an injustice and endangers every resident in Oregon.

I speak today on behalf of my father, Richard Parker, and urge you protect the constitutional rights of a grieving family to seek justice for our loved ones during these challenging times.

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