Good morning, Chair Gelser Blouin and members of the committee. For the record, my name is Melissa Fisher, and I am here today representing the family of Bonnie Everett, a former resident of Mount Hood Senior Living.

First, I want to say how terrible I feel for the family of Ki Soon Hyun. What happened was incredibly senseless and tragic and it should never have happened. I am so very sorry for your loss.

In the interest of time, I will submit our entire testimony for the record, but will abbreviate and focus on just the events following the closure.

As I share my Aunt's story, I want to request you ask yourselves two questions:

Who is **responsible** for Bonnie Everett? and Who is **accountable** for Bonnie Everett?

Bonnie Everett is my aunt.

- Lifelong Oregonian
- 72 years of age.
- Until she began to experience severe symptoms of dementia, she lived alone in an apartment in Troutdale.
- She receives both Medicare / Medicaid benefits.
- My cousin Tammy Olson and I have been co-durable and medical POAs for Bonnie since April 25, 2023. We took responsibility for her when no other family members stepped forward, fully understanding that her safety and well-being were at risk if we did not do so.

It took a long time to get our aunt placed in long-term care, and the breakdown of the systems who were to support her, failed her, and us, every step of the way.

In March of 2023, our aunt had multiple ED visits over a one week. If we could get her to the ER, it was always the same, diagnosis of severe UTI and immediately released.

- She exhibited extreme delusion and paranoia
- Unable to adhere to care plans or medications – she couldn't even get to a pharmacy
- Tammy observed that her apartment was uninhabitable – rotting food, filth, severe odor, and saw evidence of mentally unstable activities (blocking windows with pillows and foil and Sharpie marker used on light switch plates.)

March 9, 2023 – OHSU

- At our extreme prompting, OHSU finally admitted Bonnie on March 9. Besides the severe UTI, they found nothing physically wrong was found with her, but her mental state was severely compromised. She believed that she was blind, although she could see, and believed that she had many other medical issues and that several of our family members had died. None of this was true.
- Transfer out of OHSU was challenging and we worked with OHSU's case manager to get her a Medicaid bed at a local SNF. She couldn't go back to her apartment.

In early March Bonnie was transferred from OHSU to a bed at Prestige Park Forest skilled nursing facility.

In the last two weeks of March, ODHS interviewed my cousin and I, and Bonnie for Medicaid long-term housing benefit. She was approved and the search was on.

IT TOOK OVER THREE MONTHS TO FIND A SUITABLE PLACE. April - June

Once approved by ODHS for the Medicaid long-term housing benefit, the search began with my cousin and Aging, Disability and Veterans Services. We needed East County in order to have her close to a family member. I already was caring for both my parents and would be unable to respond quickly for anything requiring us to go to her. Finding an available Medicaid bed at a facility that we approved of, was incredibly challenging. **There are simply not enough available long-term Medicaid beds.**

On June 29 Bonnie had her assessment with Mt Hood Senior Living.

- I asked our Multnomah County coordinator if Mount Hood had any flags or issues in the complaints database – NONE WERE FOUND.

Our aunt Bonnie moved into Mt Hood Senior Living on July 10, 2023.

January 26, 2024 – Removal from Mt Hood Senior Living

The first word I received that there was a problem, was through my cousin Tammy shortly after 3:00 p.m. on Friday, January 26. She told me on the call that they were going to shut down Mt Hood Senior Living.

Carlos from the ODHS Estacada branch had contacted Tammy at 3pm with the news of the suspension & advised our aunt would be sent to the hospital until a place the family agreed on could be determined.

Just two days earlier I had med transported my dad w late-stage Frontotemporal Dementia from Maui to his new memory care facility in Hillsboro, joining my mom w Parkinson's who came earlier to Oregon and was recovering from recent multiple bone breaks. At the time of the Mt Hood closure, I was sleeping on her couch and caring for her 24/7, so I could not be of more help. Tammy was experiencing a medical emergency with her eye, and she too was not readily available to assist.

Not one mention was made on the initial call to Tammy she'd be moved that night. Not one. Carlos even told Tammy that she could go visit her Saturday morning to calm her fears & discuss this with her.

Finally, at 5:51 p.m. Tammy received an email from the Mount Hood Senior Living facility. A short, brief, no real information email. Just stating their license was suspended and residents will be moved by midnight that night. We were given less than 9 hours' notice regarding this move.

Estacada ODHS asked if Tammy or I would take her into our homes, which we could not safely do or on such short notice, and then they asked if it was OK to send her to a hospital or somewhere down in Salem – neither option was acceptable.

Our aunt was taken at 11 p.m. to McLoughlin Place a facility that was not approved by her family. Bonnie talked to her sister, Tammy's mom, beforehand and she was as to be expected, incredibly upset and confused.

Bonnie had been happy at Mount Hood, and what we observed was someone who was doing quite well; she loved doing crafts, had told us that the food was amazing, and she seemed very content when we took her out for hair cuts and family lunches. This may not have been the actual situation, but to see the facility, and talk to the people we did, my cousin Tammy and I would have had no idea how poorly run it was.

While clearly the events that took place necessitated the closure, so many injustices were experienced by the residents and families of Mount Hood Senior Living because of the manner in which ODHS operated. It is incomprehensible to our family that a facility was deemed unsafe, did not have a comprehensive, person-centered, AND dementia-informed plan created by ODHS to close it.

Our aunt, like many who were at Mount Hood, is extremely vulnerable and has care needs that were not only ignored, but exacerbated by the manner in which the state closed the facility. It is as if no one who made this decision had any knowledge about the needs of those with dementia, advanced age, and complex medical conditions.

Here are just a few of the things we think they should have considered:

- Immediate disruption to routines for someone with dementia is harmful.

- Nighttime is the worst time for someone with dementia - are you familiar with the term "sundowning"?

- Evenings and weekends at SNFs, ALFs, and memory care facilities have lower staffing ratios. How can a facility adequately prepare, or support, a person, or persons with dementia that they know nothing about SAFELY with fewer staff and no information from their family. (I just med transported my father with late-stage frontotemporal dementia on 1/24 from Maui to Hillsboro. Planning with both his discharging facility and new facility took MONTHS.) So, I know exactly what is needed- NONE of that was done for our loved ones.

- MOST importantly, we were not brought in soon enough. The facilities they were transferred to were not instructed to contact us when our loved one arrived. I spent a very stressful morning on Saturday trying to get someone to answer at the facility our aunt was taken to. NO proactive communication ever by anyone.

- The contact phone we were given by ODHS of the contact person at the Estacada ODHS branch had an OOO message that said they were not in till Tuesday. Why wouldn't someone have been assigned over the weekend and updating their voicemail with a message saying who was the contact person in their absence? This was an emergent situation and there should have been a person for us to talk to over the weekend. There needed to be coordination between the state and the Estacada office. There was NONE.

- In terms of the receiving facility, it was not safe. Our aunt fell on Saturday. This is not unexpected as she was exhausted and her new environment not familiar to her. She fell on her knees and was checked out, but the risk of her falling could have been reduced had there been an actual dementia-centric transfer plan in place.

- Her room had oxygen tanks and old clothes stored in it, and the mattress and box spring were sitting on the floor directly. Tanks in a room with someone mobile with dementia? NOT SAFE!

- If the stated determined that Mount Hood was unsafe, why would they put the proverbial “fox in charge of the hen house”?

- Mount Hood was cited for not ensuring medication and treatment plans were being adhered to, but ODHS gave them oversight of the transfers.

- Our aunt did not have enough medication on her when she transferred, and NO information was given to the receiving facility that she was diabetic.

I spent the entire weekend trying to piece together what happened to Bonnie and it wasn’t until 10 am on Saturday, January 27 was I able to get ahold of someone at McLoughlin Place – I actually had to search for their number and figure out who the contact was, as nothing was provided directly to us, and they didn’t know who we were! I learned that she was received the night before.

When I talked to McLoughlin Place on Saturday, they let me know she enjoyed two pieces of pie and a big glass of lemonade. So, I asked if they had her files and copies of our POAs and they said no, they had nothing. I had to send the DPOA / MPOA paperwork myself. They didn’t have a doctor’s order to check her blood sugar levels either. And when they did, it was high at 230. IF the state had done a better job of planning to move residents, besides working with families before acting, (NOT JUST HOURS BEFORE LATE ON A FRIDAY) all of this could have been avoided.

ODHS was negligent in its actions and added to the danger.

The Mount Hood Senior Living residents were treated by ODHS like cattle, not people. Their human rights were violated, as power of attorney, OURS were violated as well. ODHS took away all capacity of the people who love them to protect them and proactively help in the SAFE transfers.

Because I was providing 24/7 caregiver to my parents and Tammy couldn’t drive, we were unable to go in-person to where they had taken our aunt Bonnie. A good friend who knows long term facilities very well did that on Sunday evening for me, and he shared that the place was dirty, and the public areas smelled of urine.

Again, I ask, who is responsible? Who is accountable?

When I finally talked to someone at the Estacada office on the Monday after the closure, I learned that ODHS did not have my POA paperwork scanned into EDMS as part of Bonnie’s records. It should have been available for viewing if needed by ODHS employees and County Employees as well that have access to EDMS.

The search for a new long-term home for our aunt Bonnie lasted almost 3 months: January 27 – April 2.

We did not want Bonnie kept at a facility that had even worse scores and violations on their records that Mt Hood Senior Living. We wanted her out of their quickly - but instead the process to move her dragged on and on. Again, there are not enough Medicaid beds anywhere.

My aunt called my cousin and I multiple times DAILY from McLoughlin Place to ask the same thing - she wanted out and her things returned to her. We could tell from the sound of her voice that she was experiencing a great deal of stress and anxiety. Not once during our aunt's time at McLoughlin Place did any of their staff reach out to us with updates on how she was doing - and we did request it in conversations and email.

Our family was kept in the dark most of the time and nothing happened unless we pushed. We went many days with no updates from DHS, and no one seemed to be coordinating – we were passed around a lot. It was all wholly life disrupting and traumatizing for our entire family.

Feb 6 - Feb 19 Time frame for location #1 assessment (The Springs at Clackamas Woods)

The first assessment process took two weeks. Following the assessment, the nurse called me and said that they didn't select Bonnie because the resident she would be placed with is argumentative and possibly someone who would throw a punch. So, then I asked, WHO would they place in that bed that they thought would be a match? She didn't answer. They had two weeks and could have told us that upfront. Why share this NOW?

Again, I ask, who is responsible? Who is accountable?

Eventually after an assessment and a facility tour by Tammy, Bonnie was accepted at Rose Linn Vintage Place on April 2nd. That's 67 days after the closure of Mt Hood Senior Living.

In case you were wondering how things are now for our aunt Bonnie, she is still not OK. She gained over 28 pounds while at McLoughlin Place. Twelve days after she moved to Rose Linn, she had a bad UTI was taken to the ER on a Saturday, and then the next day she fell and was taken to Legacy Emanuel ER for a broken humerus and they checked her blood sugars, and without consulting Tammy or I, decided to put her on insulin – she was there until the end of April and then transferred to Regency Gresham Rehab. This of course was necessary due to the poor diet at McLoughlin House, but because of the insulin type they used, Rose Linn would not accept her back from Regency because they couldn't administer the type of insulin medication she was put on. So, after Tammy pushed back on insurance and the rehab facility, she remains there until they can get her blood sugars manageable. Bonnie will finally moving back to Rose Linn on May 31st having gotten her blood sugar levels stabilized – all in part to my cousins persistence and advocacy.

This entire situation has been an utter nightmare for our aunt and for us and because of this experience she has declined significantly.

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We are requesting that the state do a thorough audit of how ODHS handles closures in the future, and to consider that all future long-term planning for memory care facilities should be inclusive of families with loved ones of persons with dementia and organizational representatives from the Alzheimer's Association and other dementias – including The Association for Frontotemporal Dementia – as it so happens, I have been the State of Oregon Ambassador for the AFTD for the past five years, and I for one would love the opportunity to sit

on a dementia task force or participate on a work group representing Oregonians who have lived experience in this area. Our voices should be heard and used to inform plans that significantly impact the lives of Oregonians with dementia and their families.

Until that happens, I worry about my mom's fate, mine, my family's, and really all Oregonians. How can we fail such a vulnerable population so completely like this?

Please let me end by sharing that this is not our family's first experience with the mishandling of a loved one with dementia in Oregon. Our grandma, Anabel Neill, the mother of my aunt Bonnie and my mom and Tammy's, had Alzheimer's and died of a heart attack on the floor next to her bed in a dilapidated geriatric psych ward out in Forest Grove, only a week after she had been transferred there from her memory care facility – they deemed her combative and with only hours' notice had her transported there without our family's consent.

My questions asked throughout my testimony were rhetorical. I know who is responsible for our aunt. LEGALLY, MY COUSIN AND I ARE. And accountable? The Oregon Department of Human Services.

I appreciate your time and listening to our family's story.