Senate Human Services Committee

Wednesday, May 29, 2024

Chair Gelser Blouin, members of the committee, my name is Alice Longley Miller, and I am here representing SEIU Local 503. I appreciate the opportunity to speak to you today about the urgent need for regulatory reforms in memory care settings. First, I would like to express my condolences to the family and my appreciation for their presence here today.

Our union represents workers across the long-term care continuum, including workers in skilled nursing facilities, in-home care, assisted living and memory care facilities, and more. The workers at Mt Hood Senior Living 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. Unions are beneficial for long-term care because they empower workers to advocate for better wages, benefits, and working conditions, leading to improved staff retention and higher quality care for residents.

I want to express SEIU Local 503's support for the Ombudsman investigation and report, as well as their 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. 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. We support the recommendations and hope legislators will work with ODHS and other stakeholders to implement them. If the department needs more resources to reform a broken regulatory system, legislators should provide them. Agencies need more resources *and* accountability to do better.

I want to emphasize that the blame for the failures at Mt. Hood should not fall on the shoulders of the caregivers working there. Direct care workers are overworked, underpaid, and inadequately supported in most facilities, especially those that are not unionized. These dedicated individuals are on the front lines, providing essential care under incredibly challenging circumstances. They deserve our support and investment, not our condemnation. 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. In this particular facility, we know workers were not receiving adequate training and that the facility was not meeting minimum staffing requirements.

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. These basic measures equip caregivers with necessary skills, ensure adequate supervision, provide opportunities for professional growth, and support the emotional and physical demands of their work, leading to higher standards of care. It is the responsibility of ODHS to ensure that care settings are safe, adequately staffed, and compliant with all regulations. Yet, too often, we see a lack of transparency and accountability. Families place their trust in these facilities, believing they will provide a safe environment for their loved ones, only to be met with devastating outcomes when that trust is broken.

I want to uplift the comments from the ombudsman about ODHS failing to implement legislatively mandated improvements and offer an example that our members are particularly upset about. In 2022, the legislature passed SB 1556, 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. The bill also created a caregiver certification. 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. As far as we can tell, ODHS has made no progress in implementing this critical bill. As we heard from the Ombudsman today, SB 1556 is not the only example of ODHS undermining the legislature's efforts to make our facilities safer places for staff and residents.

In addition to implementing existing laws, we need to commit to reforming our failing regulatory structures. The audit called for in the report is a good first step. 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 enhance its processes and respond promptly to red flags to ensure that facilities are safe and that both consumers and workers are protected. The legislature must support ODHS in this effort, including authorizing more regulatory and compliance positions in APD. With a growing number of elderly residents depending on these services, it is imperative that ODHS implements stronger consumer protections and robust oversight mechanisms. 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 the time,

Alice Longley Miller, MSW, MPH

Long Term Care and Disability Policy Strategist

Service Employees International Union Local 503

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International Union
Local 503

Mailing Address:
P.O. Box 1259
Salem, OR 97309-1259

1730 Commercial St. SE
Salem, OR 97301

525 NE Oregon St.
Portland, OR 97232

1.844.503.SEIU (7348)

www.seiu503.org