Senate Bill 739 - Long Term Care Bill

Chair Gelser Bluoin and members of the committee, my name is Lara Johnson and I am an attorney in Eugene. I practice with my husband, Don, and both of us are Past Presidents of the Oregon Trial Lawyers Association.

One area I have focused my work on is fighting for Oregon seniors who have been injured or neglected in nursing homes and other long term care facilities. I am here today to testify on behalf of seniors who, due to no fault of their own, are injured or neglected by the institutions who were supposed to be keeping them healthy and safe.

Senate Bill 739 goes a long way to ensure more meaningful enforcement of Oregon's existing laws, to provide more transparency to residents and their families regarding problems at facilities, and to require more experienced residential care administrators.

Over the years, I have seen investigations of abuse or neglect in facilities delayed. Families and residents want answers about their concerns, especially if safety is at issue. And, if one resident has a concern about safety, there may be other residents who are at risk. This bill requires DHS to start investigations regarding complaints of serious injuries or death within 24 hours or one business day. If there is a substantiated finding of abuse of a resident by DHS, the facility would be required to report the finding to all residents. Residents and their families should be informed about abuse in the facility, so that they can make an informed choice about whether to remain there or leave.

The bill also specifies what is involved in a DHS investigation. Quality of investigations vary and can consist of an investigator asking a single person whether something did or did not happen. Given that residents may not be able to understand or communicate effectively, evidence of abuse or neglect may come in the form of a pattern of bruising or a change in behavior. Family members, facility employees or volunteers may have information that the resident cannot convey. This bill requires the interviewing of relevant witnesses. The bill requires also that DHS shares its findings with the Long Term Care Ombudsman. The ombudsman's office may have a volunteer in the facility and may know much more about what is going on there than a DHS investigator can determine in a short series of visits in a compressed time period. If the goal is to gather the relevant information to make sure people are safe and, if not, to take steps to protect them, these changes are reasonable and targeted towards that goal.

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Sometimes a facility is underperforming on a consistent basis and the residents are in substantial jeopardy of serious harm. DHS can place restrictions on a license. These license restrictions are posted on the entryway. These postings may not get to family members who live outside the area or to residents with dementia. This bill helps with those problems. The bills provides that the facility facing these restrictions must notify case managers and designated contact persons. The notice requirement applies to residents and potential residents. I have seen where facilities are not meeting safety standards and facilities do not tell the families of potential new residents about these problems and families placed their loved one ignorant of those issues. Potential new residents and their families should be able to make informed choices and these provisions help with that.

I have been told that being an administrator at a residential care facility can be incredibly difficult and requires a wide range of skills; from HR to budgeting to marketing, and also fundamentally ensuring the provision of quality care to residents. Making sure that administrators have relevant experience will likely ensure better care to residents.

There are many more good components to this bill, but based on the provisions I have discussed, I would urge the committee to support this bill.

Thank you for the Committee's consideration of this important bill.

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