May 27, 2020

To: Timothy E. Ginter

Re: Public Testimony regarding Covid-19's impact on nursing homes and long term care facitlities

I would like to thank you for the opportunity to present our testimony on SB308 on behalf of my mother, Mabel Porter. After nine years of caring for my mother at my home we found it necessary to place her in a nursing home. Mabel is 96 years old. She had two strokes and a craniotomy for brain bleed and is confined to a wheel chair and is totally dependent on care givers. She is blind in one eye, has very limited tunnel vision in the other and has dementia.

In February of 2018 we admitted my mother to The Little Sisters of the Poor in Oregon, Ohio. In January of 2019 the facility was sold to The Gardens of Saint Francis/CHI Living. Shortly after the takeover we requested a meeting with the new administrator because we felt my mother was not getting adequate care, especially at night. The staff complained that she was frequently yelling out, needed to go to the bathroom and wanted attention. We would go to the facility late at night to check on her and inevitably there was something wrong. It appeared that the aides were not tending to her needs timely, especially when she had a UTI. Mabel seemed afraid of an aide named Howard. She told me that she did not want him to give her a shower.

On the first of February we met with the administrator and we specifically told him that we thought he needed to provide more oversight in the facility at night, and our concerns because my mother was getting UTI's every five weeks. We suggested that he or the director of nursing visit at night unannounced. We also asked that he ensure the protocol for administering my mother's eyedrops was followed because the nurses were not following the doctor's directions. He seemed to agree with our suggestions. However, the UTI's continued.

We found that records were falsified showing administration of eye drops when they were not given. We discovered in early August there were two instances on the night shift when my mother tried to get out of bed herself and was found on the floor, once with a cut on her head.

Finally, we decided we needed to record at night to find out what was occurring. We recorded the night of August 13th, 14th and 15th. We discovered that an aide names Howard, a white burly male, was disguising himself as a black female named Martha. He severely abuse and mentally tortured and possibly physically abused my mother. We were able to determine that this had gone for months. This was reported to The Gardens of Saint Francis/CHI Living, Department of Health and the Oregon Police Department. It was investigated. Howard was charged, convicted and sentenced on March 9, 2020, one week prior to the lockdown.

During the time that my mother has been at the Gardens I have visited her from two to four times daily. We continued to tape since August 13th until the facility locked down due to COVID-19. Our findings included, but were not limited to, improper administration of medications, falsification of administering medications, inappropriate response time, less than acceptable behavior by staff, lack of communication, lack of training, lack of coverage, improper feeding, violation of protocol and care plans and abuse. We continued to report our findings to the administrator and the ombudsman and scheduled meetings with them to develop plans to improve the situation. We struggled to get the administrator and CHI to take appropriate measures. Conditions were beginning to improve.

On the evening of April 2, I was contacted by a staff member from the Gardens she stated a staff member tested positive, that a couple residents were taken to the hospital and that one tested positive. She told me that the staff was prohibited from wearing PPE for three days after the first staff member had told the facility that she was positive for the virus. She stated that the director of nursing quit after 25 years, that a nurse supervisor was in quarantine and that the administrator was off sick with a fever. This was very disturbing information and was not unlike what we expected after the interaction we had over the last year.

That being said, there were subsequent contacts and calls from other sources stating similar issues. I immediately emailed and tried to call the facility and the administrator. Late Saturday evening, on April 4th, I called the regional administrator. Her voice was shaking as she spoke, but she tried to assure me in a generic statement that "we are doing everything we need to be in accordance with the CDC guidelines." She would not deny or confirm if there were cases and stated that she could not because of HIPPA concerns. I asked where infected residents would be isolated and she said they would be in their room. I asked if the staff that cared for the infected would also care for the others and she said they would.

Finally, around April 15th, Governor DeWine stated that the numbers in the LTC's will be made public. They were posted on the first Wednesday but were then taken down due to inaccuracies. From week to week the numbers posted for the Gardens sometimes did not make sense. When we asked the administrator or the director of nursing about this, they either said they do not know the counts or they told us to look at the dashboard. For some reason the correct numbers are being kept from the families and probably the residents.

On April 26th, the Lucas County Department of Health issued a letter to all rest homes that tests were available to test all residents and highly recommended that staff be tested. The Gardens called on May first and claimed that they were testing all residents as mandated by the governor. With the upward movement in cases, I talked with The Gardens director of operations and their director of clinical operations about testing staff. I referenced the letter from the Lucas County Health Department and their response was either that they are following the CDC guidelines or that tests were not available.

We were stonewalled every step of the way and even though the administration and management at CHI Living knew we were recording nightly, we continued to hear ongoing problems with staff not following CHI protocol, doctor's orders, and the care plan a large percentage of the time. If this is the case when we were visiting 2-3 time a day, and recording nightly, one can only imagine what would occur if oversight and accountability is prevented or excused and they are left to their own devices any time, but especially in a time of emergency. Last week when we asked the clinical director why the current number on the dashboard increased by one but the cumulative number did not, he seemed to indicate that was because they were taking COVID-19 cases from hospitals. Of course, that was disturbing because of what has occurred in other states. If they continue to accept and admit COVID-19 patients from hospitals, that will prolong the lockdown. This will severely affect the well-being of the residents who are basically under house arrest. After all that we have outlined above, and that is only a small sample of the problems we encountered, no one would trust these people to make the decisions that can severely affect the life of their loved ones. To pass a bill that protects them from litigation during an emergency is the worst thing that can happen right now. We understand the need for protection for businesses opening up during this time, but there is a balance of accountability and responsibility that this nursing home and many others have failed to exhibit. If they are not responsible when there is oversight, what would you expect with no oversight? Giving them a pass right now when 70% of the deaths from the virus in Ohio are in nursing homes is the exact opposite of what should happen.

The one and only good thing that this COVID-19 did for rest home residents, is emphasize and validate the shortcomings in oversight and management that this population has been forced to live with for years so that we can help.

I will reiterate. During this time when family members are locked out of the facilities, the Health department, who governs them will not go in to inspect the facilities, the ombudsman has been told she cannot go in, OSHA has refused the request from staff to go in and the new director of nursing and administrator get upset and are evasive when we ask questions. It is beyond time for this to end. Not only should these facilities not be included in these bills but inspections and investigations should begin immediately and nursing home operators should be called into account to try to save the remaining vulnerable residents.

Respectfully, we strongly request that nursing homes be removed from SB308.

We would like to thank you again for taking the time to read our testimony. We appreciate your attention to this matter.

Thank you,

Julie and David Griffith