May 20, 2020

To: Senator John Eklund

I would like to thank you for the opportunity to present our testimony on SB308 and HB606 on behalf of my mother, Mabel Porter, who is 96 years old and a resident of The Gardens of Saint Francis long-term care facility in Oregon, Ohio.

I have cared for my mother for many years after my father died. In her later years she has had many health problems. My mother resided with me from 2008 to October 2017 during that period she suffered from two strokes, underwent two surgeries for a brain bleed. She developed dementia, her hearing diminished and she is legally blind due to glaucoma, macular degeneration and cataract surgery with complications. Because of her strokes she was confined to a wheelchair and dependent on caregivers for all her needs. After her second stroke, my husband and I cared for her an additional nine months in our home. I have been my mother's care giver and no one knows my mother like I do.

In September, we decided we needed help and looked for a long-term care facility. We looked at many and had my mother stay short increments of time at four facilities to evaluate them and see what my mother thought. Then, when we walked into Little Sisters of the Poor, both my mother and I felt that the sisters provided a feeling of being home. They had a waiting list so I put mom on the list. Meanwhile, in October, we chose Perrysburg Commons as a temporary placement. In early January 2018, we received a call from Sisters that there was a room coming available. In late February, early March, we transferred mom. Transitioning to a long-term care facility was extremely hard for my mother and us because we had to adapt to others providing her care.

Shortly after mom was moved to this facility, she developed urinary tract infections about every five weeks which caused hallucinations and increased toileting day and night, which irritated the staff. Soon, she started mentioning a mean woman named Martha. When I asked Mabel about Martha, she said she didn't know who she was, but said Martha was terrible and would try to make her smoke. Each time she mentioned her, I went to the aides and nurses and asked if there was anyone there by the name of Martha either employed or a volunteer. Each time, I would receive the same answer that there wasn't anyone by that name. Not knowing anything more at that time, I concluded that Martha must have been one of the hallucinations caused by her UTI. My mother also adamantly said she did not want an aide named Howard to give her a shower. Therefore, I requested that my mother only be given a shower by a female. In addition, I asked that she have another aide assigned to her room at night. We successfully changed her shower schedule, but it wasn't long after that, when I would visit my mom randomly at different times of day and night, that I found Howard was still assigned to her room.

Over the next year, we discovered many issues. The most prevalent issue is that there is the lack of management and oversite in the facility, especially at night, on weekends and holidays. After my mother was admitted, the staff complained that my mother was calling out in her room and in the common area wanting attention. Because of those complaints my husband and I made a point of going to the facility late at night a couple times per week to check on her. Invariably, we would find problems which usually involved the stna ignoring my mother. My mother would be calling out for help because she either could not find her call light or she was being ignored and she needed to go to the bathroom. Because of this, we purchased a small audio recorder but decided not to use it at that time.

In February, 2019, we requested a meeting with the administrator of CHI. In that meeting, we specifically told the administrator that we believed that there needed to be more management and oversight in the facility, especially at night. We described some of the things we observed. We also discussed the importance of the proper administration of my mother's eye drops because I had been having ongoing conversation with the nurses about the administration per doctor's orders and they were not following the doctor's direction. In April, we found that records were falsified showing administration of medications when they were not given.
In a meeting with the administrator and the director of nursing we were assured that this would not happen again. We again emphasized the need for oversight.

In August 2019, we were out of town. We received a call from my sister and her husband. They said they were with my mom and that she had a large bruise on her left forearm. I instructed them to go directly to the director of nursing and report it. As it turned out, Howard had caused the bruise. He was suspended. He had to go through transfer training and was allowed to return to work.

My mother was in constant fear. She would tell me and my siblings that we just don't know what goes on there. When we would ask her about it, she would not elaborate on what she meant.

The Little Sisters of the Poor sold their facility in 2019 and it was turned over to CHI/The Gardens of Saint Francis on February 1st. This meant, that there was less oversight than before. Prior, the sisters lived on the third floor. One was assigned to manage each hall. They would randomly walk and check on things at all different hours. However, our struggle with the UTI's, hallucinations, bruise and my mother's fear kept us asking questions. I would check on my mother from 2-4 times daily. We requested to meet with the new owners' multiple times and asked that they increase the oversight at night because we just couldn't get good answers from their nursing staff as to how mom was sleeping and if she was receiving her eyedrops and medications properly.

Then, the end of July to early August 2019, my mother experienced a particularly bad UTI. At least we thought it was the UTI, but in fact, it was something much worse.

On August 1, 2019, we went to check on mom about 10 p.m. I walked in her room. She was sideways and hanging off her bed yelling help, please! I ran out to the aide station, located 20 feet from her doorway. Howard was sitting there. I told him I needed him now, that I just came in and mother was hanging off the bed with a pillow over her head and yelling help. When I removed the pillow, she had blood on her forehead so I ran to get the nurse. The nurse called the doctor and washed the cut on her forehead. My mother was soaked with urine, so I cleaned her up and asked them both to keep an extra eye on her. I returned at 8:10 a.m. the next morning and she was slumped over in her wheelchair in her room.

On August 4, 2019 at 7:44 a.m. I received a call from The Gardens of Saint Frances that my mom had slipped out of her bed and was on her knees, like she was praying, (In fact she was trying to get out of bed to go to the bathroom.) I asked for her to be checked on hourly every evening thereafter. These instructions are in my mother's care plan. In fact, the aide and nurse each are to check on mom every two hours, alternating, so that means every hour, but they were not following protocol.

On August 12, 2019, I went to see mom in the evening to feed her dinner. I asked a nurse supervisor how my mom had been the night before and she stated that there were no special notes documented in her file so she felt she had a fairly good night. Upon leaving the facility, I went to the aide's station to see who was on duty. It was Howard. I asked him if he had heard that mom's night was better. His response just made me shake in my shoes. He said, "let me tell you", and he pointed his finger at me, and said "she is still yelling and banging all night long." His tone and the way he said that, just shook me. I knew something was wrong. I left and went

home. When I got home, I told my husband what happened. I told him to do whatever he needed to do to get a small recorder we had ready for the following evening, because we needed to record to find out what was going on at night.

On August 13, 2019, I went to CHI at dinner time and placed the recorder behind a picture in my mom's room. When we picked up the recorder the morning of August 14th, we listened to it and I almost died when I heard MARTHA. As I listened, my heart was in complete agony. I reviewed the recordings with my family and we decided that we needed to continue recording so that it could be demonstrated that the MARTHA character was not a one-time occurrence. We recorded on the evenings of August 14th and August 15th. Sure enough, on August 15th we heard Martha again tormenting my mother. My mother had been banging on her bedrails and crying out for help to be taken to the bathroom. Finally, you could hear Howard enter the room and Mabel screamed, "no no no no no" and Howard said, "shhhhhhhhhh, It's Martha, remember me." Martha did not take my mother to the bathroom, but instead Martha asked Mabel to smoke a cigarette and continued to coax her to smoke a cigarette despite my mother's insistence that she has no desire to do so. My mom had never been a smoker and it was very clear that she had no interest in smoking. Despite this, Martha repeatedly asked Mabel to smoke. Martha made Mabel promise to go to sleep otherwise Martha told Mabel that she would take her outside to smoke. Martha then left the room and Mabel was not taken to the bathroom.

Howard is a large burley white male and he disguised his voice as a black female and he told my mother that he was the most attractive black female at The Gardens.

In these recordings you can hear my mother shaking the bedrails, yelling for help and pleading for hours just because she needed to be taken to the bathroom. At one point you can hear her scream and say "Don't do that! Get away from me!" When Howard finally took my mother to the bathroom, you could hear Mabel complaining about her hand hurting. Howard as Martha said to her "do you want the doctor to cut your hand off." He told her that his cigarette dropped on her pullup and that he had to change it and then it sounded like he bumped her head on the wall and she yelled "owe!" and he asked her if she wanted a Tylenol. He would leave her there for extremely long periods of time even though she asked to get up while he sat in her room listening to his phone. She must have sat for hours nightly on the toilet, and she pleaded and yelled and hit the alarm weights against the wall to get attention. As proof of the mental torture he put her through, the bathroom wall next to her toilet was actually damaged reflecting the months this went on. This damage started out looking like loose or bubbling paint, but over some months, the paint and wall particles would be on the floor. The divots made in the wall were significant. I thought it was water damage. The maintenance man at Little Sisters repaired it once, but soon after the loose paint and bubbling appeared again. The wall was patched and painted again when CHI took over in February 2019. However, it was a short time later that again I noticed the same type damage. Soon after the repair, it wasn't even a month and the paint appeared to be coming off again and the wall appeared roughed up. When my mother was hitting the weights against the wall, not only could the noise be heard throughout the whole wing, but the alarm light above her door was activated, which triggered the alarm lights by the nurses' stations.

However, no one ever stated that they knew anything unusual was going on in Mabel's room. They would complain about her yelling, but they said no more. My poor mother was going through Hell. At times in the tapes you hear her asking God to just stop her heart and that she cannot do this anymore. She blames family for putting her there. She called Martha the devil

In addition, he said, **"NOW, don't YOU tell anybody! YOU PROMISE?"** To this day, I don't know if my mother will ever be over the fears he caused.

After hearing as much as I could bear of this second recording on August 16th, I called my son, an attorney, and my daughter, a doctor. I sent them both the audio file and we all agreed that we needed to act immediately. My son sent an email to the CEO of CHI and the administrator, stating the issue and demanding immediate suspension of all employees on duty both nights. He called the Department of Health and they referred him to The Ombudsman. I called the Ombudsman. She, promptly returned my call and asked if I could meet her at The Gardens of Saint Francis at 3 p.m. and to bring the tapes. We met with the administrator, the Ombudsman and the Chief Operating Officer of CHI who was conferenced on the phone. We listened to the tapes. They understood and agreed on the grievous severity of this issue. The COO instructed the administrator to suspend all five employees immediately and conduct an investigation. They were to file a report with the Oregon Police Department and Department of Health.

My husband and I filed a report with the Oregon Police Department. When the detective assigned to my mother's case listened to the recording he was astounded by Howard's conduct. He also wondered why no one else in the facility was aware of what had occurred. He was also amazed at the lack of oversight by the management at the facility and the unprofessional attitude of the administrator. The Detective, the ombudsman, the prosecutor and the inspector from the department of health all commended us for recording. They stated that most families are reluctant to do so.

On March 9, 2020, this individual was sentenced in the Oregon Municipal Court.

We continued to tape each night we were in town from 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.

Now, when the governor locked down the facilities because of COVID-19 it was very hard knowing that I could not check on my mother. I tried to just put it out of my mind. I would talk with her twice per week. She cannot hear well as I mentioned earlier, so we bought her head phones to plug in to the iPad which allows better communication. On April 2nd, I had a care conference with The Gardens via phone. The social worker and activities director were present. My first question was, "Is there any virus?" There was a long delay in response. Then, the social worker stated they could only talk about my mother and that if I had further questions, that I needed to talk to the administrator or director of nursing. Well, this caught my attention.

That evening, I received a message on my phone that a staff member was trying to contact me. I made contact and was told that I needed to get my mother out of there, that a staff member tested positive, that a couple residents were taken to the hospital and that one tested positive. She stated that there was a locked closet full of ppe supplies. The staff was not allowed to wear it until three days after the first staff tested positive. Then, they notified all staff of the positive test and handed out ppe supplies. She stated that the director of nursing quit after about 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 for the last year. (The staff member that contacted me wrote a detailed description of this and would be willing to share and has shared with multiple resources we have tried to contact for help.)

I might say throughout this whole lockdown until now the lack of curiosity from the media has been astounding.

That being said, there were subsequent contacts and calls from other sources. I immediately emailed and tried to call the facility and the administrator. Late Saturday evening, on April 4th, I called the regional administrator and left two messages. The second message stated that I understand there is virus at The Gardens and that the

cases are not being reported to the department of health. She responded promptly, about 10:30 p.m. 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." I asked if there was virus and where was the isolation was being set up. I also asked if the staff that cared for the infected were also caring for the other residents. She stated, the residents would be closed in their rooms and that caregivers would care for both. I said that we had spoken to the ombudsman and she indicated that the facility had reported nothing to the health department. The regional manager would not comment on that. She was very uncomfortable and ended the conversation.

Up until April 2nd, we were trying to abide by the rules and the only contact with my mother was the phone calls. We did have knowledge of the cases that occurred in nursing homes starting around March 20. We listened to the daily briefings by the governor but by in large, nursing homes were not mentioned.

Since I could not get any response from the facility, I sent emails to the department of health, the governor and the Ombudsman. I filed urgent complaints with the (800) coronavirus hotline. The individual said he would send the complaint up the line, but that I should call my commissioner's office to get help. In addition, I called the Lucas county health department and they were closed, as I understand they had the virus. I made a contact at 13ABC news to report the fact that the facility is locked down and there is no communication. Efforts in trying to obtain some information were not responded to. I continued efforts to obtain answers from the facility. In addition to the above contacts I called Bob Latta's office and spoke with David Wirt. David referred us to Mike Sheehy and Ben Pushke at the commissioner's office.

On April 13th I spoke with another family member whose mother had been infected at The Gardens and she expired on Easter Sunday. He shared the same thoughts and concerns about The Gardens, the lack of oversight and accountability and too could not get any responses from them. He and I spoke on a brief interview pertaining to these issues with 13ABC in Toledo.

My flow of emails and calls continued to the governor's office to ask that he mandate case details from the rest homes be made public for families. Finally, around April 15th, he did state in his press conference that this detail would be made public. However, the initial numbers were to include current and cumulative cases by residents and separate by staff and I believe total deaths. However, this has just been unreliable. The details of the numbers to be posted have changed, they reported, then the numbers were taken down because of inaccuracy. From week to week the numbers posted for the Gardens sometimes don't make sense. When we asked the administrator or the director of nursing about this, they either say they don't know the counts or they tell 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 and that they should test all residents and they highly recommended that the staff be tested. The Gardens called on May first and claimed that they were testing all residents as mandated by the governor and that my mother was tested. I have talked with The Gardens director of operations and asked her about testing staff. She claimed she wished they could. I asked her why she thinks the numbers increased and she did not know. I recommended staff testing to find out what staff may be asymptomatic and, again, she said she wished she could test. Further, she said that she would have their director of clinical operations call me. I sent her the April 26th letter from the Lucas county health commissioner as mentioned above and she responded via email that they will continue to follow the CDC guidelines. I never did receive a call from the director of clinical operations. Therefore, on May 20th I called him and left a message and spoke with him May 21st. He claimed they would test staff if kits were available. I explained to him the Lucas county health department issued a letter stating tests were available for resident and staff testing. However, he disagreed. I placed a call with

Lucas county department of health's office on May 22nd to find out about the test kits and did not receive a response from the health director or any other staff.

We were stonewalled every step of the way 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 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 to us because of what has occurred in other states. He stated that they continue the quarantine in the facility and that he is satisfied that there is no danger of spreading the virus from them. 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 out lined 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 protections 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. 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. 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 and HB606.

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