My name is Roxann Montgomery.
Thank you for this opportunity to submit testimony in favor of HB0576.

My mom spent nearly 29 months in long term care. She spent 4 months in assisted living until she fell and broke her hip. Then she spent 25 months in skilled nursing facilities. I spent between 14 and 24 hrs with her each day because the facilities were insufficiently staffed to care for her basic needs. Being in the facilities at all hours of the day and night, on holidays and weekends allowed me to observe the dangerous conditions that vulnerable residents routinely experience, but visitors rarely see.

The facilities I observed (an assisted living, a 5-star for profit nursing home, and a 4-star non-profit nursing home) were insufficiently staffed - both in quantity and quality. The staff were also insufficiently supervised. In every one of the facilities there were one or two caregivers who had the desire and skill to provide good care, but they were assigned far too many residents. Those caregivers were exhausted both physically and emotionally. To compound the problem, on almost every shift, one of the scheduled caregivers would not show up for work. In every one of the facilities, there was an adversarial relationship between management and caregivers. There was no mutual respect - no collaboration on how to work together to provide adequate care for the residents.

Video cameras in facilities are essential because the facilities are understaffed and so many of the residents are unable articulate their needs or answer questions about their experiences. This isn't just about getting evidence to prosecute abuse or neglect, but it would be so useful for analyzing and correcting dangerous situations that occur every day.

Let me give an example of a positive use. I was sitting with my mom in the lobby of her assisted living facility. I observed a caregiver pushing a frail resident in a wheel chair. The wheelchair didn't have foot rests. The resident was trying to hold her feet up but she became tired. Her toes dropped and caught on the carpet. The caregiver didn't notice and kept on pushing the chair. The resident face-planted on the floor. So then there was a call for a nurse and a manager. I watched the activity as they mopped up blood and waited for an ambulance. The manager asked the caregiver what happened. The caregiver declared that the woman had jumped up out of the wheelchair and then fell forward. I believe that the caregiver actually thought that was how the woman came to be on the floor. If there had been a video to review, they would have determined that lack of foot rests resulted in this fall. There would be an opportunity for the staff to learn a safety precaution and for the management to implement a training/policy that footrests are to be used whenever a caregiver is transporting a resident in a wheelchair. It would be an opportunity to collaborate to improve care. As it was, the event was attributed to a resident's unpredictable behavior.

Another use would be to document resident on resident violence that occurs when multiple residents are congregated together in a common area and there is not enough staff to adequately supervise them. Being able to identify physically aggressive residents would be

very helpful in creating and implementing appropriate and care plan or in providing evidence that the needs of that individual are beyond the scope of care that the facility can provide.

Cameras in long term care facilities are an essential tool for improving care. We need to have an understanding the current operating conditions in order to identify what is being done well and what needs to be changed.

Thank you,
Roxann Montgomery