Marion County
OREGON
Health & Human Services

03/15/2019

Mentor Oregon
Attn Stephanie Brooks
11010 SE Division St STE 300
Portland, OR 97266

RE: OTIS Case No: DD180879
Marion County: 18-605
Date of incident: 11/02/2018

Dear Stephanie,

Enclosed is the redacted protective services report that is being sent to you as a courtesy. The Accused Person will be notified of the outcome by OTIS and your agency will be copied on the notification letter as well.

Much of the information is confidential under State and Federal law. Please do not share this report and refer anyone requesting a copy of this report to send their request in writing to our office.

Sincerely,

Sadie Haynes
Marion County Adult Abuse Investigation Team

I WORK WE SUCCEED
EMPLOYMENT FIRST

Marion County
OREGON

CDDP
Abuse Investigation Report

CDDP Case Number:	18-605	**Investigator:**	Kathy Pestrikoff
OTIS Case Number:	DD 180879	**County:**	Marion

Provider:	Mentor Oregon	**Provider Type:**	24 Hour Residential
Provider Address:	XXXXXXXXXXX		

Incident Date:	11/2/2018	**Incident Reported Date:**	11/2/2018	**Investigation Assigned Date:**	11/13/2018
Incident Location/Address:	XXXXXXXXXX				

Alleged Victim Name	**Address**	**Phone**	**DOB**
AV	**XXXXXXXXXX**	**XXX-XXX-XXXX**	**XX/XX/XXXX**
Case Management Entity	Marion County Health and Human Services	CDDP	

Alleged Person Name	**Address**	**Phone**	**DOB**	*Is AP*
Debra Bowlin	**XXXXXXXXX**	XXX-XXX-XXXX	**XX/XX/XXXX**	☐ DHS Employee ☐ Independent Provider

Alleged Abuse	Neglect	**AV:**	AV	**AP:**	[redacted]	**Finding:**	Substantiated
Alleged Abuse	Verbal Abuse	**AV:**	AV	**AP:**		**Finding:**	Not Substantiated

Allegation(s)

Allegation 1 It is alleged [redacted], House Manager, neglected the care of AV by failing to provide the care, supervision or services necessary to maintain AV's physical and mental health that may result in physical harm or significant emotional harm in violation of ORS 430.735 (1)(e)(10)(a).

Allegation 2 It is alleged [redacted], House Manager, verbally abused AV by threatening significant physical or emotional harm to AV through the use of derogatory or inappropriate names, insults, verbal assaults, profanity or ridicule in violation of ORS 430.735(1)(f)(15)(a).

Investigation Summary

Did [redacted], House Manager, neglected the care of AV by failing to provide the care, supervision or services necessary to maintain AV's physical and mental health that may result in physical harm or significant emotional harm in violation of ORS 430.735 (1)(e)(10)(a)?

Did [redacted], House Manager, verbally abused AV by threatening significant physical or emotional harm to AV through the use of derogatory or inappropriate names, insults, verbal assaults, profanity or ridicule in violation of ORS 430.735(1)(f)(15)(a)?

Interview with AV and W1

- AV and W1 were interviewed by phone on 11/9/2018 by OP1 regarding the incident having occurred on 11/2/2018, resulting in AV's move from the group home. AV reported when AV left the home, [redacted] refused to let AV take AV's medications or AV's clothing with AV. W1 further supported that [redacted] told them AV could not have these things when AV left.

- AV stated [redacted] is not nice to AV and calls AV names and AV does not want to go back to that house ever again. W1 added they have made several attempts to call the home to obtain AV's medications and clothes and [redacted] and the staff just hang up on them when they call.

- AV added AV was not allowed to take naps at the home as [redacted] and the staff would purposely wake AV up; AV has had personal belongings disappear; [redacted] and staff would not give AV's spending money to AV; and would not take AV to the Doctor when AV had medical complaints including severe chest pain and ear pain.

- W1 stated AV pays for AV's own food and they feed AV peanut butter and jelly sandwiches every day. W1 further added W1 had attempted to speak to the Services Coordinator about these concerns, but alleges the Services Coordinator would not talk to W1.

Interview with W2

- W2 reported W2 observed the negative and dismissive interactions between [redacted] and AV and said it appeared to be the routine of the home. W2 added W3 and W5 would also engage in this behavior with AV with an example being; anytime AV would approach [redacted] with a complaint of pain or other medical issue, [redacted] would tell AV to go find something to do, or otherwise dismiss AV's complaints as not valid.

- According to W2, the days leading up to October 31, 2018, AV had told W2 AV had punched walls and cement and hurt AV's hand. These events were not taken seriously, with most of the staff dismissing AV. [redacted] said to W2 something to the effect of "AV just does that" when W2 asked her about how to handle the situation.

- W2 stated that AV had been complaining of chest pain for the past 4 days and W2 thinks AV had reported it to [redacted] and staff who did not take AV seriously. On [10/31/2018], after AV's appointment with the Cardiologist, AV was again complaining of chest pain and W2 asked W3 if there was an on-call nurse to notify. W3 replied there was not, and all calls had to go to [redacted] first, W2 said W2 did not do this as W2 felt she was biased towards AV.

- AV had allegedly been complaining for four days to the [redacted] and staff and had thrown up at work both the day of and day before this incident, October 31, 2018. W2 reports AV was

appearing to feel better a bit later and W2 did nothing more at this time for AV. W2 stated in general, AV would tell [redacted] and the other staff AV was having a medical or other significant issue and it would generally be responded to as not important.

- On the day AV's family came to the house to move AV out, W2 was present when they arrived at about [time]. W2 stated [redacted] took AV in to AV's office when AV's family arrived, and it sounded like AV was lecturing AV for having AV's family come down here to get AV and move AV out of the home like this. W2 stated the communication by [redacted] sounded very negative and W2 also heard [redacted] tell AV and AV's family AV could not take AV's medications or the majority of AV's clothing with AV. AV then joined AV's family in looking for AV's important belongings and eventually left the home without AV's medications or the majority of AV's clothing,

Interview with W3

- W3 states W3 believes the home was running smoothly until this investigation began, then W3 stated things got real messed up. W3 stated whenever a medical, behavioral or other serious issue would arise staff was always instructed to contact [redacted] first who would then give direction. W3 also added if the situation was really severe, staff would call 911 first, then to contact [redacted].

- W3 stated on the day AV was noted as complaining of chest pain, October 31, 2018, AV was observed by W3 to be having stomach upset, not chest pain. W3 added that everyone had gone on a long walk for a community activity, and after they returned home was when another staff told W3 AV was having chest pain. W3 believes this complaint lasted about 30 minutes and W3 did not call [redacted] about this as W3 did not feel it was serious. W3 then also added W3 called the on-call nurse at AV's Doctor's office and W3 took AV in the following day and AV was seen, according to W3.

- W3 stated W3 has never participated in or observed any yelling, harassment, or other demeaning or disrespectful behavior. According to W3, the [individuals'] rights are honored at all times by [redacted] and all of the staff working in the home.

- According to W3, AV's primary behavior challenge is medical attention-seeking, and these incidents would be documented in the daily log notes. When AV had complaints, W3 stated W3 and other staff would offer AV a XXX medication, which was XXX and give to AV if AV wanted it.

- In regard to medical management, W3 stated [redacted] was responsible for managing the medical calendar and if issues arose, staff would notify [redacted]. [redacted] would coordinate an appointment and staff would take them. [redacted] also reviews shift logs daily, in order to monitor conditions or changes in them for the [individuals].

- When asked about when AV first became aware of AV's heart issues, W3 stated W3 thinks it was around the end of September and was noted at a routine Doctor appointment, as the Doctor stated AV's heart rhythm was off and referred AV to a Cardiologist. W3 added it took a long time for AV to get in to see a Cardiologist however W3 is not aware of any change in AV's condition or chest pain until the day of AV's appointment with [provider] on 10/31/2018.

Interview with W5

- W5 states the [individuals] living in the home are always treated fairly and W5 did not engage in

any of the verbally abusive behavior being investigated. W5 adds that W5, W3 and [redacted] have naturally loud voices and that could sound like yelling to someone.

- W5 described AV's behavior supports as mostly medical attention-seeking behavior and when AV displays this, the staff are directed to talk to AV about what is going on and try to get to the problem. They would also redirect or suggest to AV to go listen to music or watch a movie and most of the time AV would. Staff also directed to take what AV says with a grain of salt due to AV's medical attention-seeking behaviors.

- In regard to medical appointments and coordination, W5 states [redacted] handled all of the coordination of medical appointments and would review daily log notes in order to keep on top of what was going on with everyone. W5 is not aware with there being any issues with any of the [individuals] not receiving medical care. W5 stated W5 became aware of AV's heart issues after a visit to AV's PCP awhile back, who referred AV to a Cardiologist. W5 recalls AV complaining of heartburn that was in the middle of AV's chest and this was not for very long before AV saw the Cardiologist. AV also would refuse to attend medical appointments at times.

Interview with W9

- W9, XXXXXX, states that [redacted]'s communication style is direct and W9 feels this is a personality trait of AV's. W9's experience has been that [redacted] works many shifts throughout the day due to staffing shortages, so she is there at the home frequently.

- According to W9, AV would call frequently, about various things. During all these many contacts, W9 does not recall AV ever saying AV was having problems, feeling picked on or anything like that. W9 recalls back in November, [redacted] called W9 and told W9 about AV's appointment with the Cardiologist and the outcome of the findings of this examination.

- W9 states W9 is surprised there would be anything AV would complain about, as W9 had not observed any of the issues alleged in the initial report. Additionally, W9 states AV sees many medical professionals and W9 has always observed [redacted] to have good follow through on all such issues.

- W9 stated on the day of the sudden move, AV's [family] came to the office, however W9 did not speak to them. They then went out to the home and hastily moved AV out without AV's medications or belongings.

Interview with W7

- W7 stated at the beginning of the interview W7 believes it would be detrimental to the residential program to have [redacted] come back as House Manager. W7 stated W7 has experienced the culture of the home to be one that encourages the [individuals] to be in their rooms, be quiet and not ask for or need anything. W7 states the overall interactions observed have been quite aggressive, and especially pertaining to AV.

- W7 recalled an incident that occurred in September 2018 in which one of the clients was in the process of taking [client's] medication within the allotted time, and [redacted] came into the house, yelling at [client] for not taking [client's] medications on time and being lazy. The client actually thanked her for this as W7 believes all three of the [individuals] are conditioned to be accepting of

this type of treatment.

- W7 added all Support Staff were directed to do what [redacted] said and to disregard the behavior support plan, as [redacted] believed it was wrong and needed to be updated, which never happened.
- W7 described AV's behavior support plan to direct staff to watch for physical cues in AV, as well as medical attention-seeking behavior. W7 said this behavior support plan is rarely, if ever followed.
- W7 stated W7 believed there was some racially driven behavior towards AV by [redacted], W5 and W3. One example W7 recalled was during a shift at the home, W5 and W3 were in the living room area as was AV, and W5 and W3 were discussing how their [partners] both have XXX tattoos on them.
- In regard to AV receiving medical care, W7 stated W7 felt AV did receive necessary medical care and that most staff kept an eye on AV for injury or illness. W7 shared that back in October, W7 thinks, AV's Doctor heard a heart murmur and referred AV to a Cardiologist and several diagnostic tests as well. W7 believes [redacted] attempted to stand in the way of AV attending these appointments by telling AV they weren't necessary and she discouraged AV from receiving care.

Interview with W6

- W6 states W6 immediately saw the verbally aggressive behavior upon starting her job there. W6 states [redacted] would come in to the home, yelling at the individuals living in the home and the staff, first thing and demand them to do things, and to get things done. W6 states W6 did not report this to anyone as W6 wasn't sure about doing this and feared retaliation.
- According to W6, [redacted] also told all the staff that AV's family could only call on [day] to schedule visits and if they called outside of this time frame staff are to not answer the phone. W6 felt this was harassment towards AV.
- According to W6 W6 really couldn't understand why AV was treated like this as the other [individuals] were not, and they also have families who are involved. W6 also feels W3 and W5 were discriminatory against AV, due to random racial comments they would make in front of AV but not directly about AV.
- W6 states W6 was not present at the home at the time of AV's move as W6 had gotten off shift just prior to the arrival of AV's family. W6 added that W6 was aware AV had been asking to move and talking about it more recently, and [redacted] would consistently harass AV significantly about wishing to move. W6 said [redacted] would say to AV things such as; "can't move out", "won't be well taken care of", "nobody else will want to take care of AV."
- W6 states about the past four months, [redacted] would refuse to take AV up to see AV's family and would insist they meet halfway. W6 added since [redacted] has left, things have been more peaceful and smooth at the house even though W3 and W5 have continued to engage in some of this behavior.

Interview with W8

- W8, stated [redacted] would commonly come to the DSA program and would share personal information about all three [individuals] living at the home, including information specifically regarding their diagnoses, plans, etc.

- According to W8, she would especially talk about AV and say AV was just faking all of AV's medical complaints so AV wouldn't have to do anything. W8 states [redacted] referred to AV in a derogatory manner and called AV a [derogatory name] and stated she "hated AV and wished AV wasn't in her program." W8 stated W8 stopped the conversations when she did this, and she then began ignoring W8 and no longer communicating with W8.

Interview with Debra Bowlin

- Mentor Oregon Program Manager, [redacted] was notified of her identification as an Accused Person in this investigation, agreed to and acknowledged this in writing, and was provided with a copy of the documentation of this.

- According to [redacted], she has not ever yelled at anyone at the home, the clients or staff at any time. [redacted] denies the allegations involving verbal abuse such as: ridiculing AV for seeking medical attention, disregarding AV, dismissing AV's complaints and not following AV's BSP. [redacted] said AV's Behavior Support Plan states staff are to wait two days when AV makes a complaint of a medical issue or pain. If, after two days AV is still complaining of the same thing, a medical appointment would be made for AV.

- [redacted] stated she had only heard about AV's complaints of chest pain one day prior to AV's Cardiology appointment on 10/31/2018. AV would go to her daily with complaints of pain, or other medical issues and she denies she did not respond to them. [redacted] references the medical attention-seeking behavior she spoke about as being a part of AV's safety plan and this is where the information states to wait for two days before acting on AV's complaints.

- [redacted] states she did not know about the complaints of chest pain until about the last week in October just a day prior to AV's appointment with the Cardiologist when [program] notified her of this. [redacted] contends that after the Cardiology appointment on 10/31/2018, she did not receive any calls from staff reporting chest pain to her; however, she does recall W3 may have sent her a text message, but not that it was regarding AV having chest pain. She further verified there is no on-call nurse at the agency.

- According to [redacted], she did not speak negatively about AV's family to anyone and did not tell them they could only call the home on [day]. [redacted] further states however [day] was a good day for them to plan any weekend visits to the family home, so she would have time to schedule staff in order to provide transportation to AV. [redacted] also added she did not have signed Releases of Information to speak to the family however there was never a rule about them not being allowed to come into the home.

- On the day AV moved from the home, [redacted] states it was as typical day at the home and at about 4:00 pm AV's [relative] called the home and said they were on their way to pick AV up. [redacted] alleges she then asked AV what was going on and AV told her they were coming to take AV out for dinner. When the family arrived at the home, [redacted] states she went out to see them and asked what was going on. [redacted] states the family wanted to speak to W9 and W1 stated they felt AV was not safe in the home.

- [redacted] states she contacted OP2 as well as W9 at that time to notify them of the situation. W9 told [redacted] on the phone that W9 was on W9's way over to the home, and [redacted] relayed this information to AV's family. According to [redacted], W9 showed up at the house and spoke to AV and W1 and they then went on their way. [redacted] contends she did not refuse to send AV's medications or AV's belongings as AV and AV's family did not request these items.

- [redacted] states on the following day, both OP2 and W9 called and told her she needed to get AV's medications and belongings up to AV at W1's home, in [city]. [redacted] arranged for this to occur and was then placed on administrative leave. She states she has had no contact since then.

- [redacted] states she does not understand where this all came from, does not recall yelling at the [individuals] and emphasizes she loves AV. [redacted] states she feels saddened and devastated about this situation. She states she is not responsible for neglect involving AV as well as is absolutely not responsible for the verbal abuse of AV or the other [individuals].

Investigation Conclusion

During this investigation, many witness interviews were conducted, a significant amount of documentation was reviewed, as well as consideration was given to AV's overall support needs and AV's behavioral challenges. Despite AV's documented behavioral challenges and mental health support needs, there was a significant amount of consistency amongst the witness interviews and documentation to demonstrate the findings of this investigation as follows.

Allegation 1

The allegation [redacted] [redacted] neglected the care of AV by failing to provide the care, supervision or services necessary to maintain AV's physical and mental health that may result in physical harm or significant emotional harm in violation of ORS 430.735 (1)(e)(10)(a) is **Substantiated.**

Witness testimonies from W2, W7, W6, W3, W5 as well as communication logs written by her employer, [program], and daily logs from the home documented that AV had complained of chest pain many times. It was specifically noted by the [programs] daily logs that AV complained of chest pain on [8 dates] as well as multiple times as documented at the home and there are no documented attempts to provide medical follow up.

During a routine visit with her Primary Care Physician on [date], [provider] identified an abnormality with AV's heart and subsequently referred AV to a Cardiologist at AV's return visit with [provider] on [date]. The documentation of this visit to the Physician does not state AV's complaints of chest pain were reported to [provider] by the staff. During subsequent consult with Cardiologist on October 31, 2018, AV was diagnosed with [diagnosis 1], and it was strongly recommended AV have surgical repair due to the seriousness of the condition. It was further identified in the documentation of this visit on 10/31/2018 that the home was to notify [cardiology office] of any worsening or new symptoms AV may experience. On [date], documentation reflects AV reported chest pain again, but medical attention was not sought. In fact, witnesses reported [redacted] stated on this and past occasions when AV complained of chest pain that AV was just engaging in medical attention-seeking behavior, and to disregard AV's complaints.

[Cardiology nurse] stated the risk of not obtaining medical attention for complaints of chest pain was quite high, as just with the identified issue of AV's [diagnosis 1], there is a likelihood of open heart

surgery in the near future, and there are other potentially severe conditions in AV's heart that have yet to be diagnosed.

During her interview, [redacted] references AV's chronic medical attention-seeking behavior as being a part of AV's safety plan (Exhibit 5). The safety plan states to wait for two days before taking action on AV's complaints. However, this same safety plan also states, "in the event of a medical emergency, staff will immediately call 911 and provide emergency first aid." Examples listed for when to seek emergency medical attention are noted as; seizures for an individual who does not have a seizure protocol, difficulty breathing, **chest pains**, uncontrolled bleeding or any possible life-threatening event.

Upon review of all available evidence and witness interviews, it is clear AV's overall medical needs were not fully attended to, as [redacted] failed to provide these supports as well as she directed her Staff to not follow established protocol, resulting in a significant risk of physical and emotional harm.

Therefore, the allegation [redacted] neglected the care of AV by failing to provide the care, supervision or services necessary to maintain AV's physical and mental health that may result in physical harm or significant emotional harm in violation of ORS 430.735 (1)(e)(10)(a) is **Substantiated.**

Allegation 2

The allegation [redacted] [redacted] verbally abused AV by threatening significant physical or emotional harm to AV through the use of derogatory or inappropriate names, insults, verbal assaults, profanity or ridicule in violation of ORS 430.735(1)(f)(15)(a) is **Not Substantiated.**

After a thorough review of AV's documents related to AV's support needs and witness interviews it is evident the behavior supports in place do not accurately reflect the practices [redacted] and all the Direct Support Staff were actually utilizing. There is sufficient evidence through witness interviews of a verbally negative and controlling environment at the home, with significant focus being placed on AV.

However, a preponderance of the evidence was not established demonstrating there was resulting emotional harm to AV based upon these verbal interactions.

Based upon all evidence reviewed and witness interviews, it is not clearly evident AV was subjected to emotional harm due to the derogatory language, insults, verbal assaults and ridicule directed at AV by [redacted] as well as by several of the Direct Support Staff who [redacted] provided direction to. Therefore, the allegation [redacted] verbally abused AV is **Not Substantiated.**

Recommended Actions

It is recommended all staff working at the program receive additional training in regard to client rights, HCBS, Mandatory Abuse rules and reporting.

It is further recommended the Program Manager at the home receives additional training in regard to expectations of a Manager and implementation and monitoring of the training and expectations of all staff as noted.

Report Distribution

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☐ DHS HR
☐ LEA
☐ Other

Investigator Name Printed:	Katherin Pestrikoff, Adult Abuse Investigator, Marion CDDP		
Investigator Signature:		**Date:**	2/21/2019
Approving Supervisor Name Printed (Optional):	Corissa Neufeldt, Adult Abuse Investigations Supervisor, Marion CDDP		
Approving Supervisor Signature:		**Date:**	Click here to enter a date.
Abuse Investigation Coordinator Name Printed:	Sheli Spees, Adult Abuse Investigations Coordinator, OTIS		
Abuse Investigation Coordinator Signature:		**Date:**	2/26/2019