Oregon
Kate Brown, Governor

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February 9, 2018

Chair Keny-Guyer and members of the House Committee on Human Services and Housing:

My name is Fred Steele. I am the State Long-Term Care Ombudsman and Agency Director for the Office of the Long-Term Care Ombudsman.

The Mission of the Long-Term Care Ombudsman program is to protect individual rights, enhance quality of life, improve care, and promote dignity of residents living in Oregon's licensed long-term care facilities. This mission is achieved through a foundation of approximately 180 volunteers – Oregonians who volunteer significant amounts of time to advocate for their fellow community members who happen to live in long-term care settings.

I provide this testimony to request your **support for HB 4129**.

HB 4129 will establish professional licensing of care facility administrators and a licensing board to oversee their profession. In the opinion of the Ombudsman program, this professionalization of the administrator role may be one of the most effective improvements that can occur for Oregon's long-term care system.

Administrators are positioned to lead all aspects of care and service delivered in Oregon's assisted living and residential care facilities, which also includes most memory care facility settings. Oregonians living in licensed long-term care effectively rely on every aspect of the knowledge and leadership that comes from the administrators in these settings. As our Certified Ombudsman volunteers observe daily throughout Oregon, a high performing administrator often establishes an environment that results in high quality of care and high quality of life for residents. A poor performing administrator quickly erodes the environment at a facility, which generally reduces the quality of services and care, often results in violations of residents' rights, and may – and does – result in neglect and abuse situations for the Oregonians living there.

Throughout Oregon, there are many excellent administrators who act with a high degree of professionalism. Unfortunately, given the over 530 licensed settings that each require their own administrator, there are also administrators who quite frankly need a professional board to hopefully prevent poor performance on the front end, but to also monitor problem licensees when needed.

To better understand some of the problems with licensees that would benefit by this type of board, I have attached recent articles demonstrating significant issues with, and failures of, administrators. Three of the four articles do recognize conduct that will most likely prevent these administrators from passing even current background check processes and becoming administrators in the future, but the hope would be that this type of conduct can be prevented on the front end through proper training requirements and with a professional license to which these individuals would be faced with losing.

The attached articles include:

- ***"Employee at Lloyd District Senior Home Sues for Racial Discrimination After Two Alleged Nooses Are Found Hanging in Break Room: The former employee of Pacifica Senior Living Calaroga Terrace says her boss dismissed the nooses as 'just ropes.'"*** Willamette Week, January 21, 2016.
    - Note: the online version of this article provides a link to the filed lawsuit, which alleges, among other concerns, that the administrator prevented an internal investigation into this noose incident. DHS does not have authority over administrators to review their conduct in this type of situation. This administrator now works in the same capacity at another facility in Oregon.
- ***"Ex-director of Eugene care facility sentenced for criminal mistreatment."*** Eugene Register-Guard, January 31, 2018.
    - Note: In the opinion of the Ombudsman program, an argument can be made that this administrator, though now criminally convicted, could have been stopped years in advance if an administrator licensing board were in place to review repeated patterns of misconduct.
- ***"Salem care home employee accused of stealing meds."*** Salem Statesman-Journal, September 14, 2016.
    - Note: the "employee" in this article was the administrator.
- ***"Elder sexual abuse investigation closed: Male caregiver terminated from Baycrest Memory Care Center."*** The World, November 8, 2016.
    - Note: the "male caregiver" in this article was not the administrator. However, within this article it is noted that the administrator pled guilty to not reporting the allegations regarding this caregiver; administrators are mandatory reporters of abuse per Oregon law.

I provide these articles as merely a factual basis demonstrating the need for this legislation. I believe they define the problem that dictates the need for professional licensing of administrators and a licensing board to monitor them.

On a more positive point, I also believe this legislation has the potential to create a professional career goal that can lead to a more committed caregiver population. Specifically, with the

significant rate of caregiver turnover and shortages experienced in Oregon's ever-growing care facility industry, I am hopeful that this professionalized role will give caregivers a career goal to which they can aspire – which may hopefully lead to some stabilization in this caregiver workforce.

On behalf of Oregonians living in care facility settings, thank you to the legislators and partners who have committed themselves over the past couple of legislative sessions to improve Oregon's long-term care system.

Sincerely,

Fred Steele, MPH, JD
State Long-Term Care Ombudsman
Director, Office of the Long-Term Care Ombudsman

WILLAMETTE WEEK

Employee at Lloyd District Senior Home Sues for Racial Discrimination After Two Alleged Nooses Are Found Hanging in Break Room

The former employee of Pacifica Senior Living Calaroga Terrace says her boss dismissed the nooses as "just ropes."

By Jayce Wagner |

Published January 21, 2016 Updated October 3, 2016

A former employee of Pacifica Senior Living Calaroga Terrace has filed a racial-discrimination lawsuit against the operators of the Lloyd District senior living center.

Ebony Hankins sued Encore Senior Living and other operators of Calaroga Terrace in Multnomah County Circuit Court on Dec. 31, alleging that her dining staff found two nooses hanging from the employee break-room rafters in September 2014.

Hankins, who is black, says Calaroga Terrace's white director laughed about the nooses and said they were "just ropes" used to move furniture.

The lawsuit says Encore Senior Living held a town hall-style meeting about the nooses, but Hankins' contract wasn't renewed after she complained.

Calaroga Terrace managers did not return calls seeking comment.

EX-DIRECTOR OF EUGENE CARE FACILITY SENTENCED FOR CRIMINAL MISTREATMENT

By Chelsea Deffenbacher
The Register-Guard

Jan. 31, 2018

The former executive director of a Eugene care facility has been sentenced to two months in jail and three years of supervised probation for the mistreatment of a person under the facility's care.

David Scott Meisner, 50, pleaded guilty Tuesday morning to the charge of felony first-degree criminal mistreatment in front of Lane County Circuit Court Judge Karsten Rasmussen. Meisner was the director of Southtowne Memory Care, formerly Southtowne Living Center, at 389 W. 29th Ave. in south Eugene.

The mistreatment occurred between June and September 2016.

A charge of identity theft against Meisner was dropped through the plea agreement. He was fined $200.

As a condition of his plea, Meisner is required to cooperate and testify in any Medicare fraud investigations involving the facility.

According to Jodie Bureta, a prosecutor with the state Department of Justice, the facility had several scabies outbreaks among residents during Meisner's time as director of the facility.

Meisner failed to properly address the outbreak, including treating the residents, particularly one female patient named in the case, Bureta said.

The Register-Guard typically does not name victims.

Scabies is a severely itchy and contagious condition caused by a mite that burrows in one's skin.

The former nursing manager of the facility, Jandyra Maria Dubofsky, 35, was sentenced to three years of probation earlier this month after pleading guilty to a criminal mistreatment charge in Lane County Circuit Court in what Bureta called a "companion case" to Meisner's. Dubofsky also agreed to help state officials in an ongoing investigation.

Many details of the investigation have not been released. However, the Oregon State Board of Nursing disclosed in a written decision to suspend Dubofsky's nursing license last year that she had not properly administered medication as ordered; knowingly removed patient labels from their medications; gave patients' medication to coworkers; failed to meet her obligations as a mandatory reporter; and failed to fully and accurately report residents' skin conditions to their care providers.

The board's decision states that SouthTowne residents suffered from ongoing skin irritations related to a lack of adequate showering and nail care, which led to infections, skin "breakdown" and was "a possible contributor to at least three patient deaths."

Follow Chelsea on Twitter @ChelseaDeffenB . Email chelsea.-deffenbacher@registerguard.com.

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SALEM CARE HOME EMPLOYEE ACCUSED OF STEALING MEDS

Whitney Woodworth Updated 9:19 p.m. PT Sept. 14, 2016

A Salem woman has been arrested after allegedly stealing medication, including narcotics and muscle relaxers, from residents at the care facility where she was employed, officials said.

Elizabeth Roark, 29, was arrested Friday on seven counts of first-degree criminal mistreatment following a months-long investigation by Salem police.

According to a probable cause statement filed in Marion County, Roark stole medication from at least seven care home residents over a three-month period. Roark, who worked as a facility administrator at Four Seasons Residential Care Facilities, is no longer employed with the company.

The statement gave the following information:

An employee contacted police in June after several care workers reported that Roark was stealing medications like morphine, oxycodone and hydrocodone from residents. The investigation revealed that she was taking prescription narcotics from seven residents, all of whom were considered elderly or dependent.

The investigator interviewed employees and residents, reviewed the facility's narcotics log and found Roark would sign out medication but then not administer it to the residents. Roark would also allegedly sign out narcotics for "melt down" — destroying medication that is no longer needed — for unknown reasons. Another employee reported that Roark admitted to her that she had stolen 100 tablets of Vicodin and sold them.

A victim's wife told the investigator Roark confiscated 60 of her husband's hydrocodone tablets and destroyed them without asking. The man was in pain from not getting his medication multiple times. Other victims included a woman with dementia, a woman with an amputated leg and residents who could not care for themselves. Their ages ranged from 58 to 98.

In a notice filed in Marion County, Deputy District Attorney Keir Boettcher stated Roark showed deliberate cruelty to multiple, vulnerable victims, violated the public's trust and demonstrated a lack of remorse.

Lt. Dave Okada, a Salem police spokesman, said police are investigating whether Roark mistreated any more victims. The investigation remains underway.

According to Oregon law, a person commits criminal mistreatment if they violate their duty to provide care for an elderly or dependent person by knowingly taking and misusing property. First-degree criminal mistreatment, a class C felony, carries a maximum sentence of five years imprisonment.

Four Seasons is 60-bed, three building facility in North Salem. Roark was listed as an administrator for two of the buildings on the facility's website, but the company said she is no longer an employee.

On the advice of her attorney, Roark did not make a statement to police and turned herself in on Friday. After her Monday arraignment, she was released from jail and ordered to have no contact with her former employer and any elderly or dependent people while being in a fiduciary position.

Her next court appearance was scheduled for Oct. 12 at 1:30 p.m. at the Marion County Circuit Court Annex.

Email wmwoodwort@statesmanjournal.com, call 503-399-6884 or follow on Twitter @wmwoodworth

Elder sexual abuse investigation closed

Male caregiver terminated from Baycrest Memory Care Center

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Lou Sennick, The World

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COOS BAY — Coos Bay Police Department has closed a year-long investigation into elderly sexual abuse at Baycrest Memory Care, but the results have resulted insufficient evidence to prosecute anyone for a crime.

And they have proven less than satisfying for relatives of the alleged victims.

In a press conference Tuesday morning, Coos County District Attorney Paul Frasier explained that there was insufficient evidence to prove beyond reasonable doubt that any abuse had happened. Not only had the reported abuse taken place months before the investigation started, but the four women who may have been abused were not in a state of mind to confirm it.

“My mother can't even remember her own name,” said Darrell Smith, the son of one of the victims

during the press conference. “This whole thing is abhorrent.”

Frasier said the investigation began in February after an anonymous complaint was called into

Department of Human Services about a patient who had been physically and/or sexually abused. The DHS caseworker got in touch with the Baycrest Memory Care manager, who informed her that she had been aware of the allegations and had conducted her own investigation.

“The caregivers reporting these incidents surrounded one male caregiver that none of them liked,” Frasier said. “This manager saw the complaints as a way to get him out of the facility for that reason.”

However, DHS continued with its own investigation. The caregivers, after realizing their complaints were being ignored, began writing down the incidents as they heard about them from the patients.

“One victim is quoted saying, 'He touches me and

makes me touch him,'" Frasier quoted. Another was observed by a witness being touched over her clothes by this male caregiver.

Fraiser said that in his 32 years as a prosecutor he had never encountered a case like this. One of the difficulties of the case was proving sexual abuse without forensic evidence, which could not be done since it happened long before the investigation started.

"Part of the problem is one of the alleged victims passed away," Frasier said, adding that because she was deceased, any statement she made prior could not be used. Frasier said all of those statements had been made to people outside of the courtroom, which would be hearsay.

Frasier and the investigative team brought in an expert to interview the other victims, a specialist comparable to those who handle child abuse cases. The expert reported that one patient was clearly

incapable of telling anyone what happened. Two were communicative, but couldn't remember making statements or whether or not they had been abused. The final victim indicated something had happened, but it was also clear she was describing abuse that took place several years ago. When she was shown a picture of the caregiver, she couldn't identify him. "I went through the reports to see if there was some way to prove abuse occurred," Frasier said. "I couldn't see anything to prove it without reasonable doubt. The team agreed with my assessment. Still, I didn't want to give up on the case because this is an important matter, and I wanted to make every step we could."

Frasier continued to pour over documents throughout the summer, but made the determination in September that there was nothing to be done. Though the caregiver, Matthew Meinen, 29, of Coos Bay, couldn't be taken to court, DHS is in the

process of putting him on a database that will flag during any security background check. This will prevent him from being hired at another care facility or at a school.

"One thing that did come out of this," Frasier said. "The manager had reasonable suspicion that this was going on. Oregon has a mandatory report law for elder abuse, and she should have reported it. As a consequence, she was cited on four counts on failure to report elder abuse, which is the maximum. She pled guilty and was terminated by the new management company and will not be allowed by DHS to work in another care facility in the state of Oregon."

As soon as the investigation began, the male caregiver Meinen, was put on administrative leave by the new management. After DHS made their findings, he was also terminated.

During the press conference, it became clear that the victim's families were not notified of the investigation until recently when DHS sent them letters.

"Why it took so long," Frasier said. "We were doing a criminal investigation, and we don't want to tell people what we're doing until we know what's going on. As for (Meinen), I can't do anything. I can't do something for what someone might do in the future to someone else. We know about this guy. If something with his name on it crosses my desk, it will catch my attention. That I can tell you."

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