

A System of Neglect

LONG-TERM CARE FACILITIES ACROSS OREGON ABUSE RESIDENTS AND FAIL TO MEET STANDARDS

by Kelly Kenoyer

She moved into River Grove Memory Care in Lane County in October of 2016, needing a little more rehabilitation and care before she could go home with her husband. This 62-year-old woman had vascular dementia, but her diabetes was under control and she was able to walk more than 100 feet without stopping, a feat after spinal surgery in August 2013.

Her husband hoped that she would be out of the facility in 6 months with proper care.

Soon after Susan Bliven was admitted, the Oregon Department of Human Services forced the facility to restrict admissions. That means the facility was too far out of compliance with regulations to safely admit new residents, and the state had intervened to prevent new residents from coming in.

When last surveyed by DHS on Feb. 9, River Grove was out of compliance with more than a dozen Oregon Administrative Rules. The facility was understaffed, the staff was undertrained, and diet and hydration programs did not meet standards of frequency, nor did the facility meet sanitation standards.

Retirement homes are meant to be places where the elderly can live comfortably. But many facilities in Oregon are rife with abuse and neglect. Severe understaffing can set up caregivers for failure, and all it takes is one mistake to kill a member of this vulnerable community.

There is regulatory oversight on the state and local level, but legislation written in the 1970s and 1990s caps the civil penalties, or monetary fines, with which DHS can reprimand negligent and abusive facilities.

Ana Potter, DHS's community based care manager, says, "for example, a fall resulting in a broken hip requiring hospitalization of a resident where the facility was substantiated for abuse may result in a fine as low as \$300, with a cap of \$500 for most cases of abuse, neglect or wrongdoing."

The penalty structure for community based care facilities has not been substantially updated since 1977.

Unless they are restricted from admitting new residents, there is little incentive for facilities to change their policies in order to prevent neglect.

Demitria Haffenreffer, a consultant for River Grove who has worked in the field for 43 years, says, "I can just tell you on a national level that civil penalties don't help. I don't know what helps." She adds, "Their only recourse, the state's only recourse, is to restrict admissions."

Haffenreffer's consulting company, Haffenreffer & Associates Inc., helps facilities come into compliance with regulation.

The owner of River Grove is Terri Waldroff of Benicia, LLC, a company that owns several other retirement facilities in and out of state. She says that "when the state came in to do that survey, they admitted to the team that was here that they were going to get us. And that's what they found, because they chose to."

Waldroff adds that the families of residents at River Grove who have complained about conditions are uniquely unstable. "I'm talking about very dysfunctional families with mental health issues," Waldroff says.

As for Susan Bliven, after she moved to River Grove her tests for hemoglobin A1c "went from a three-year average of 6.2 or 6.3, and after three months at River Grove it was 8.4," according to her husband, Lee Bliven. The normal A1c range for those without diabetes is 4 to 5.9 percent, and anything over seven percent is concerning in diabetics. This jump signifies a sudden change from good to poor control of her glucose levels.

Her husband alleges that the jump came from poor food quality at River Grove.

Bliven fought for his wife's well-being. He's a large man with a long white beard and glasses, retired at 66. As a younger man he worked in four different states drilling water wells, but now in his free time he acts as a volunteer ombudsman at several other retirement facilities in Lane County, monitoring the care in the facility and making sure the residents are happy and healthy.

He kept close contact with the long-term care ombudsman at River Grove who gathers and reports complaints of poor care. Bliven continued reporting inadequate staffing and negligence to the ombudsman and Adult Protective Services (APS), and visited his wife almost daily to help take care of her.

"I changed her, I took her to the bathroom, I showered her a couple times because they didn't have enough staff to shower her," he says. "Anytime I was there I was her caregiver because there wasn't enough staff."

A new administrator, Samantha Borden, took over River Grove on Feb. 1. Lee kept up his complaints to the facility and his reports to APS regarding the state of the facility.

Soon after Borden took over River Grove, Lee Bliven received two letters from the facility claiming that his behavior was unacceptable. They alleged that he was making sexual comments to caregivers and that he frightened staff.

On April 3, Lee Bliven received a phone call from the administrators at River Grove that they were calling paramedics to take Susan to the hospital after she had fallen the previous night.

Bliven has power of attorney over his wife's financial and medical decisions, so he has the right to refuse care on her behalf.

He rushed to the facility to try to stop EMTs from taking her, as he had scheduled a doctor appointment for later that afternoon.

Here the two accounts of the incident diverge somewhat. Borden claims Lee was behaving erratically, and she feared he might attack her. Lee says he was angry and claims they were trying to remove his wife from the property against his and her consent and were refusing to provide her care. What is clear, however, is that the police were called.

Borden claims that Bliven had locked himself inside with two caregivers, though Bliven says no one else was in the room while he provided care to his wife. The Eugene Police Department event reports for this incident do not mention any caregivers trapped in the room with him, though they do call the situation "a bit of a dispute over patient care."

When Bliven left his wife's room, he saw two police cars and three officers outside the facility.

Borden says, "Lee Bliven exited the building, he had his hands in the air saying 'I'm leaving, I'm leaving, I'm leaving,' the cops asked him to stop — he kept walking."

The officers detained Bliven. "They grabbed my arms and held them behind my back," he says. "They forced me down on the curb."

Lee says he was held for 45 minutes before being released, and was told that he was banned from the facility where his wife lived. The EPD event report says Borden did not want Bliven "on the property any more and did not want him contacting the staff in any way, including by phone."

The facility did not file charges and refused to provide an incident report regarding what happened on April 3.

Former staff at the facility say that the allegations of Lee's inappropriate behaviors aren't true. Erica Adams, who was fired in March after working for two years in various positions at River Grove, including lead caregiver, says she never heard from a single caregiver about inappropriate comments or behavior from Bliven.

"From my understanding, the management there thought that he was too nosy, and they didn't want to deal with him," Adams says.