

SENIOR: Not all complaints the same

Continued from 1A

called Suttle Care had one of the lowest rates in the state, with zero complaints made since 2005.

While that appears to paint a clear picture at first glance, Tom Peine, a public affairs officer for DHS, urged people to realize it's not that simple.

"Say you have a facility with five licensing violations, and another with just one. Is the one with five violations worse? Not necessarily," he said. "If the five violations were things like failing to post a daily meal plan, whereas the one violation was failure to provide a proper medication system — that's of concern to us."

The Oregonian's report provides links to specific complaints for each facility, and the complaints are varied, including residents wandering from the facility, exposure to potential harm and loss of resident's property. Some reports are much more serious, such as inappropriate sexual contact by one resident to another. The report states that failure by caregivers to protect a resident from such incidents constitutes abuse.

Peine said there are two aspects to the complaints.

"There's abuse, and there's licensing or oversight," he said.

When DHS first receives a complaint, it goes through a screening process.

"Someone looks to see if this fits into one of the nine definitions of abuse covered by the law," Peine said.

If the action does not fit into the abuse definition, it may be a violation on the licensing side.

Once the complaint has been categorized, it is forwarded to the correct agency, be it law enforcement, a long-term care ombudsman, or a licensing agency.

For complaints of abuse, DHS sends someone to the facility within 24 hours. The investigator explores possible leads, looks for



Staff photo by Kathy Aney

Dietary aide Ashley Wilson sets tables for dinner Thursday at Sun Terrace in Hermiston.

paperwork and talks to people at the facility who may be involved. They then forward their findings to the safety oversight committee in Salem, which determines what happens next.

If the claims of abuse are substantiated, the facility may be sanctioned or an employee may be fired and/or charged with a crime.

Investigators may also discover that the issue is not abuse. In that case, the department has to determine whether the violation is a licensing or oversight issue.

"For example, if someone suffered a fall while transferring from a bed to a chair, that may not rise to the level of abuse," Peine said. "But if (a resident's) care plan states that someone is supposed to be around, that's their obligation."

Each facility has to get re-licensed every two years, at which time surveyors check on everything from resident meals and care plans to medical services.

"There are hundreds, if not thousands, of things they need to do," Peine said.

Megan Moon, the director of nursing at Regency Hermiston Nursing and Rehabilitation Center, said it's difficult to make a judgment about a facility based solely on the complaints data.

Regency received a fairly high rate of complaints, with only 16 percent of facilities throughout the state receiving

more. "We are aware of the complaints," Moon said. "Those reports kind of give facilities a bad rap, they don't accurately represent what we do."

Moon said Regency received seven complaints in 2015 and one in 2016. Of those complaints, three were determined to be abuse.

"A lot of them are things we call in ourselves," she said. "Say a person got out of the building. I'm mandated to call that in."

She said that some of the complaints are investigated by Adult Protective Services, but some are just matters of compliance.

"It's kind of a raw deal for a lot of facilities," she said of the reports. "They don't reflect what is going on inside."

Matt Joice, the executive director of Hermiston assisted living facility Sun Terrace, said any time they have complaints, they are investigated by the state. The report had four complaints listed for Sun Terrace in 2015, and none in 2016. Of those four, two were cited as abuse.

"We do our best to avoid complaints from the get-go," he said. Sun Terrace had one of the lowest complaint ratings in Umatilla County, with 69 percent of facilities in the state showing higher complaint rates. "Accidents will always happen, but we

do anything we can."

Joice said he was proud of Sun Terrace's rating.

"It validates all the hard work the team puts in," he said.

Peine said if an action is identified as abuse, the department then has to determine who is in the wrong.

"If it's abuse, an individual may be involved, but there's also responsibility by the facility," he said.

For example, an investigation will take into account how quickly a facility acted to fix a problem after they found out about it.

"If a facility, as soon as they discovered (the problem), did all they could, the employee may have been sanctioned or terminated. That may be all you can expect from the facility. You may have to the conclusion that they're not responsible, and that the individual is at fault," Peine said.

If it is determined a facility is out of compliance, it may be closed to new tenants until the problems are fixed or, in more serious situations, may be closed altogether, and alternate homes found for the residents.

Overall, Peine said, the department's goal is to identify problems and prevent them from happening again.

"Part of the process as an abuse investigator is to figure out, what are you going to do to prevent that from happening?" he said.

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VILLEGAS: Primus wants to review raw data from suspect's analysis

VILLEGAS someone fakes mental problems.

Primus, again referring to the report, said Templeman found Villegas "endorsed a very high number of psychiatric symptoms, including unusual symptoms that occur infrequently in genuine patient populations. He also reported symptoms with far greater severity than most patients with genuine psychiatric disorders. Results suggest that he was feigning psychiatric symptoms during this assessment."

Primus said he needed the defense to provide the "raw data" that created the report so an independent psychologist could evaluate it. The prosecutor said this also matters in light of the news reports about Montwheeler, "who was able to fake it for 20 years," under the eyes of the state Psychiatric Security Review Board.

Montwheeler, 49, feigned insanity for 20 years to avoid prison, according to the reporting of Les Zaitz of the *Malheur Enterprise*.

The Oregon State Hospital released Montwheeler in December. The next month, police allege Montwheeler kidnapped his ex-wife from Idaho, drove to Ontario and stabbed her to death in the front seat of his pickup. And while fleeing police

with the body, he crashed into another vehicle, killing the other driver and injuring that man's wife.

Montwheeler is in the Malheur County Jail on charges of aggravated murder, assault and kidnapping.

Defense attorney Kara Davis said the state already had the ability to examine Villegas as much as it wanted, although it was not ideal.

"I'm not necessarily comfortable with letting the state have chance after chance to talk to doctor after doctor to get the results, to get whatever results they're looking for," she told the court.

Primus clarified he was not seeking another examination of Villegas, but to have an expert look at the raw data the defense experts used in making conclusions. He also said the state has requested this kind of data in previous murder cases.

Judge Hampton said if the two sides can't work it out, the state can file a motion with the court, and she would set a date to hear the arguments.

The issue is likely to come up Thursday afternoon in Hampton's courtroom, where Villegas has another status check.

Contact Phil Wright at pwright@eastoregonian.com or 541-966-0833.

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