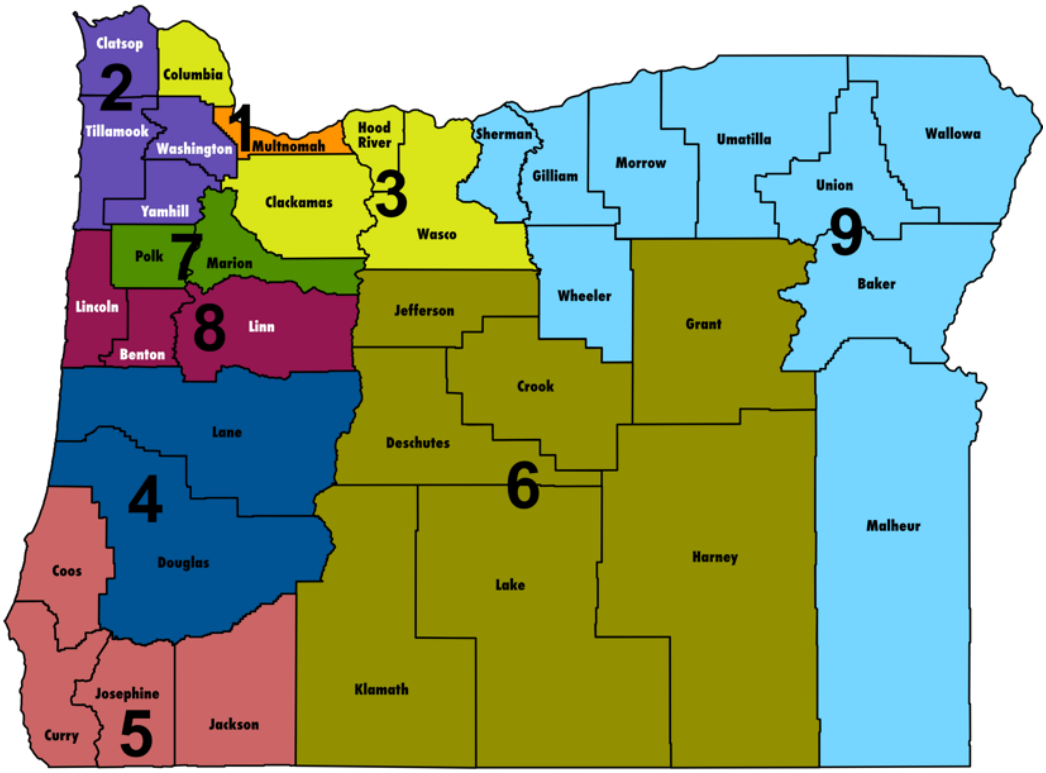
OREGON LONG-TERM CARE OMBUDSMAN



COVID-19 Cases & Deaths in Long-Term Care Facilities

Complaints from Oregonians – Residents, Staff, Families & Other Concerned Persons

March 2020 – March 2021

OREGON LONG-TERM CARE OMBUDSMAN

About this Report:

COVID-19 Cases & Deaths in Long-Term Care Facilities

This data is compiled from the OHA Weekly report as of the end of February 2021.

Complaints from Oregonians – Residents, Staff, Families & Other Concerned Persons

The complaints are taken by our office, referred to other agencies where appropriate, and are written to avoid any identifiable information about residents and families in order to protect confidentiality.

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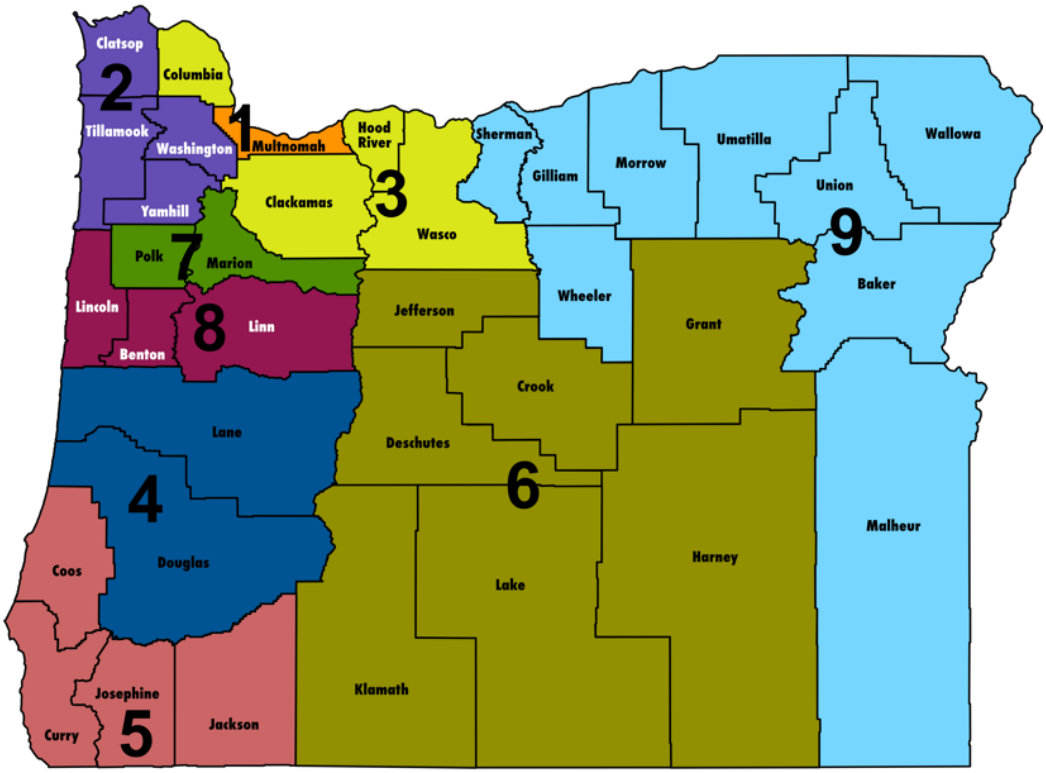

District 1 – Deputy Long-Term Care Ombudsman – David Berger

Multnomah County:

⇒ COVID-19 deaths 542 with 309 in Long-Term Care. Long-Term Care accounts for 57% of deaths in Multnomah County.

⇒ **Top Ten worst outbreaks**:

1. Gracelen Terrace, 123 cases, 18 deaths
2. Healthcare at Foster Creek, 116 cases, 39 deaths
3. Marquis Centennial, 111 cases, 10 deaths
4. Cascade Terrace, 99 cases, 15 deaths
5. Sapphire at Gateway, 92 cases, 12 deaths
6. Prestige Care Menlo Park, 89 cases, 5 deaths
7. Creekside Rehab and Nursing, 77 cases, 7 deaths
8. Gresham Post-Acute, 71 cases, 5 deaths
9. Avamere Laurelhurst Village (ICF and Rehab), 64 cases, 6 deaths
10. Brookdale Mt. Hood, 59 cases, 6 deaths

Scenarios/Complaints that come to LTCO:

- Resident in memory care sent to hospital. Facility was using temporary staff not familiar with the residents' care needs. One resident, who was dependent on staff to provide water and encouragement to drink because of dementia, became so severely dehydrated that they went into kidney failure and were hospitalized for two weeks.
- During a COVID outbreak, temporary workers left resident with dementia up all night in their wheelchair, sitting in soiled incontinence briefs, resident eventually fell asleep, fell out of the wheelchair and cracked their head open. Staff called the resident's family member to take the resident to the hospital to get stiches. Two weeks later, this same fragile resident with dementia contracted COVID, was hospitalized and sent to a COVID surge capacity unit before being able to return home.
- A resident in a nursing facility enhanced care unit for people with nursing and mental health needs was evacuated from their stable home of almost a decade to a COVID surge capacity early in the pandemic. During the month-long stay there, facility staff were unfamiliar with how to care for the resident and the resident lost the ability to sit up in their power chair and now is completely bed bound. This would not have happened but for the COVID outbreak in the facility.
- A memory care resident's family asked for a window visit to see resident, as it had been several weeks since visitation was allowed. The family member was shocked by the striking weight loss they observed, the resident had lost over 20 pounds because staff were not providing the encouragement to eat. The family had provided this support during their regular visits before the pandemic. The facility was dismissive of the concern. After ombudsman intervention, an untreated urinary tract infection was discovered and finally addressed. Even after Ombudsman intervention, a visiting nurse noted the following two weeks later during a visit that "[The resident} was in bed without any blankets covering them, wearing a small, light-weight clothes, and resident was visibly shivering. This RN pulled blankets over resident and asked [staff]to help cover with the numerous blankets that were available on the bed. Oxygen concentrator was off, nasal cannula draped over concentrator. Dermasaver pad for foot of bed was crumpled on one side of the bed. Vital signs were taken. Oxygen levels were dangerously low."
- A change in ownership during the pandemic led to terrible outcome for the resident of a residential care facility. The previous facility owner was RN and offered nursing and PT services that are no longer available by new ownership. Resident has declined dramatically as a result: pressure ulcers on heels, decline in function for walking, left too long in bed by staff who didn't want to deal w/ resident's bowel incontinence leaks, restraints used, therapeutic diet ignored on several occasions that resulted in resident having abdominal thrusts administered, hospitalized for pneumonia, probably secondary to aspiration.
- Resident left in soiled and unattended in shower, call-light delays, concern about price increases, claims to be paying $6,000/month per resident.
- Poor care, left wet and bleeding, call-light delays
- Insufficient staffing, lack of infection control, 1 caregiver on duty for day and swing shift
- Told will only receive two showers per week

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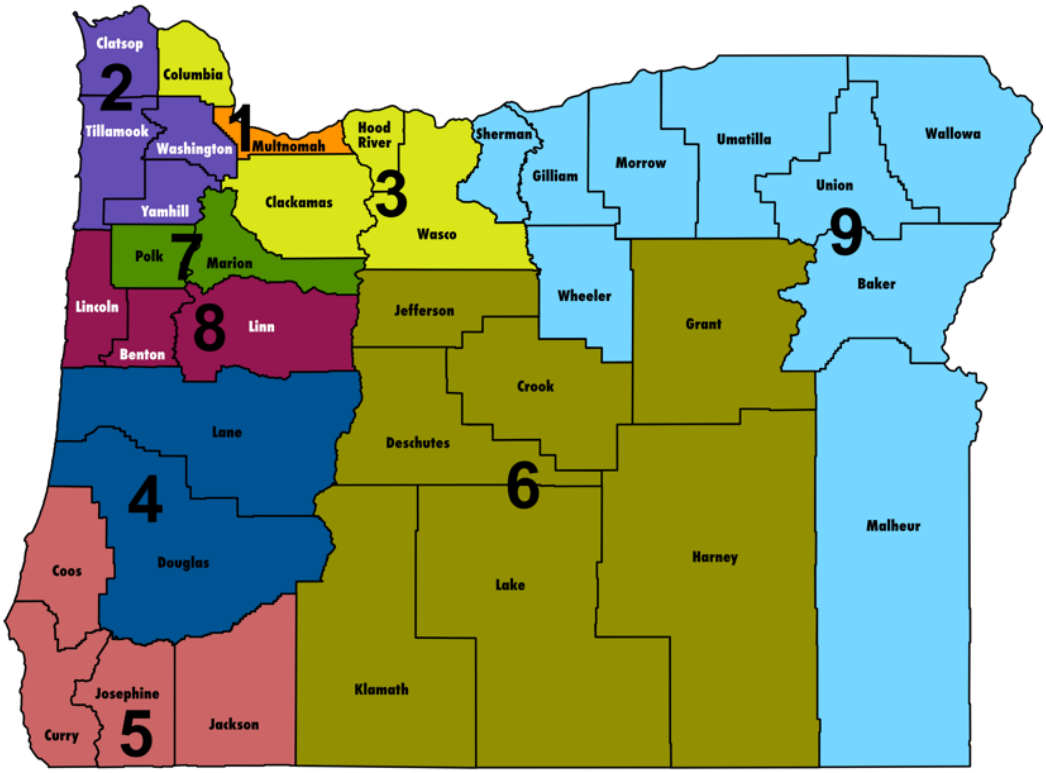

District 2 – Deputy Long-Term Care Ombudsman – Melissa Bosworth

Washington County:

- ⇒ COVID-19 deaths 212 with 110 in long-term care. Long-term care accounts for 51.8% of deaths in Multnomah County.
- ⇒ Worst Outbreaks:
  - Maryville Memory Care, 93 cases, 13 deaths
  - Forest Grove Rehab, 83 cases, 8 deaths
  - Harmony Guest House, 58 cases, 5 deaths
  - Cedar Crest Memory Care, 56 cases, 7 deaths

Scenarios/Complaints that come to LTCO:

- ⇒ Resident's family had taken resident from a memory care facility to a dental appointment. The dentist noted the resident had heavy plaque, cracks in teeth, and the start of an abscess. Family states toothbrushing is a task included in the resident's care plan but it's not being done.

⇒ Visitation during COVID won't allow for family to provide basic care. Facility is on an Executive Order (COVID) and family could not maintain a safe, 6-foot distance, while performing care.

⇒ Family wants to visit with resident with advanced dementia. OLTCO regarding visitation with her husband, whom she described as having "pretty advanced dementia."

⇒ Resident moved into secure memory care facility prior to the pandemic. Family hadn't been able to see resident except through the window and with 6-foot distance on the patio. Further, the family states they've had "no real care conference" since resident moved in; only brief emails responding to the family to let them know resident is ok.

⇒ Family purchased 2 hours of 1-1 care three times per week to ensure resident would be walked outside and well groomed. They state very little outdoor walking has occurred, when she sees resident from the window or a 6-foot distance, resident is not well groomed and is wearing the same clothes.

⇒ After extended period of 6 Executive Orders, primarily due to staff outbreaks of COVID, 3/20/20, 7/20/20, 8/18/20, 9/23/20, 11/12/20, 12/2/20, OLTCO advocated for compassionate care visits to allow the family to check on the welfare of the resident inside the facility.

Yamhill County:

⇒ COVID-19 deaths 68 with 47 in long-term care. Long-term care accounts for 69.1% of deaths in Yamhill County.

⇒ Worst Outbreaks:

- Life Care Center of McMinnville (skilled and rehab), 72 cases, 7 deaths
- Marjorie House, 46 cases, 16 deaths
- Rock of Ages, 38 cases, 2 deaths
- Sheridan Care Center, 30 cases, 5 deaths

Scenarios/Complaints that come to our Agency:

⇒ Staff person called OLTCO to report that the facility is extremely short staffed, and the administrator won't hire additional agency staff. Showers and scheduled toileting checks are not being done as care planned, one resident suffered an injurious fall resulting in a hip fracture, and two residents were involved in an altercation. Licensing Complaint Unit and Adult Protective Services were contacted.

⇒ Family concerned about repeat UTI infections, not getting level of care needed

⇒ Resident not getting Physical Therapy despite that being the reason they are there

⇒ Staff aren't getting resident up, resident lying in bed all day, left on bedpan, made to do PT on bedpan.

⇒ Resident has been falling quite a bit, facility states that resident must purchase 7 hours of 1 on 1 care to prevent falls.

Tillamook County:

- ⇒ COVID-19 deaths 2 with 0 in long-term care.
- ⇒ Only Outbreak:
  - Five Rivers Assisted Living, 5 cases, 0 deaths

Scenarios/Complaints that come to our Agency:

- ⇒ Resident contacted OLTCO to report he has a scooter and wants to go outside. The facility administrator and receptionist told the resident they will face a 14-day quarantine in their apartment if they go out and return. Staff state the resident is using the scooter to go to local stores and visit with others.
- ⇒ Owner telling families they cannot visit outside due to "state rule" – not true.
- ⇒ Multiple falls, poor hygiene

Clatsop County:

- ⇒ COVID-19 deaths 6, 0 in long-term care.
- ⇒ Only Outbreak:
  - Clatsop Retirement Village, 7 cases, 0 deaths

Scenarios/Complaints that come to our Agency:

- ⇒ Resident's family contacted OLTCO to report that the resident has been at the facility for 5.5 years and has lost weight, had several falls and was experiencing increased confusion. The family noted that the resident was being assessed for hospice. The facility was refusing the request for an indoor visit from the resident's priest. OLTCO staff contacted the state licensor for this building who agreed to a compassionate care visit.
- ⇒ Quarantining residents to rooms if they leave the facility, which is not allowed.
- ⇒ Residents not being fed, short staffing, falls, seems to all have fallen apart with COVID
- ⇒ Resident on hospice needs help with eating, facility says they don't help with eating

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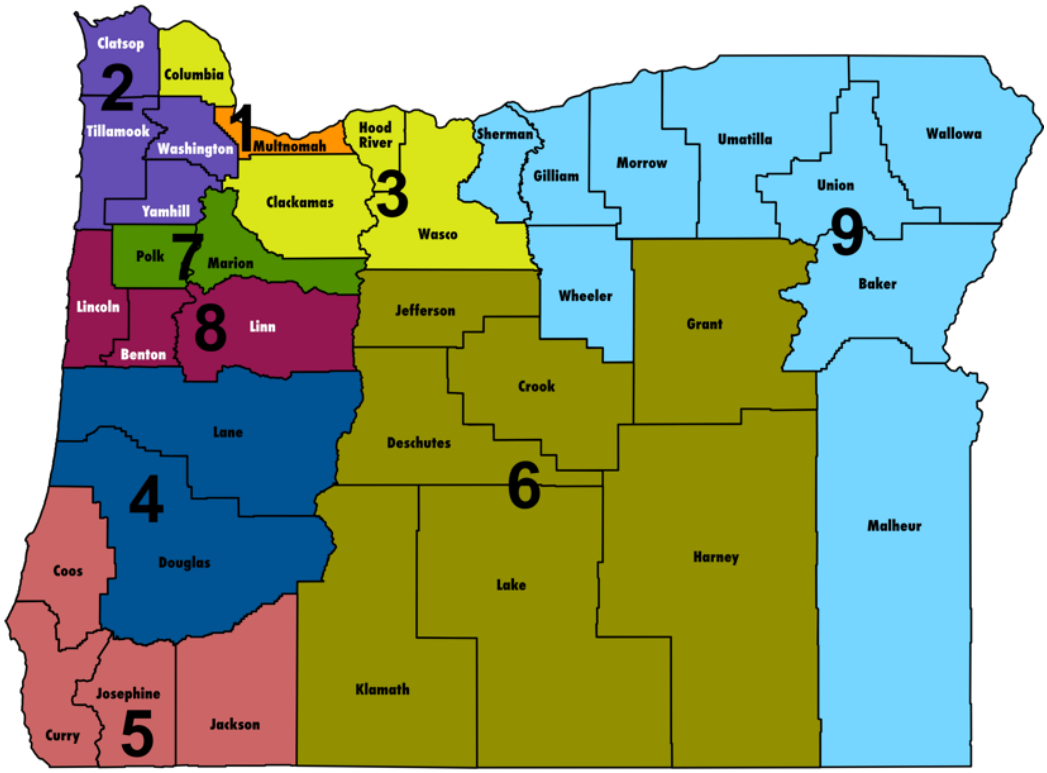

District 3 – Deputy Long-Term Care Ombudsman – Steph Delage

Clackamas County:

- ⇒ COVID-19 deaths - 183 total, with 91 of those in Long-Term Care. Long-term care accounts for 49.7% of COVID-19 deaths in Clackamas County.
- ⇒ Worst Outbreaks:
  - Marquis Hope Village (all settings combined) 165 cases, 26 deaths
  - Mary's Woods 116 cases, 5 deaths
  - Sunnyside Meadows Memory Care 53 cases, 8 deaths
  - Pearl at Kruse Way 44 cases, 5 deaths
  - Mountain Park Memory Care 56 cases, 5 deaths
  - Countryside Living of Canby, 51 cases, 4 deaths

Types of complaints that come to LTCO:

- ⇒ Related residents on same campus not allowed to see each other unless they are isolated afterward for two weeks. Resident is depressed
- ⇒ Resident not receiving care (incontinence garments not being changed, left wet too long) causing recurring urinary tract infections (UTIs)
- ⇒ Facility not allowing compassionate care visits

- ⇒ Too short staffed to take resident to a medical appointment
- ⇒ Facility charging residents and visitors for PPE
- ⇒ Memory Care – called facility in early morning to pick up family member later that day, resident not dressed, not given food. Short staffed, resident lost weight and was dehydrated and is now on hospice
- ⇒ Facility no allowing compassionate care hospice visits
- ⇒ Staffing issues in Memory Care, only window visits allowed
- ⇒ Physical therapist not allowed to come in due to COVID.
- ⇒ Residents threatened with and put in quarantine when they leave for any reason
- ⇒ Residents using public transportation isolated for 72 hours, those going out with family quarantined for 14 days

Columbia County:

- ⇒ COVID-19 deaths 21 with 9 in Long-Term Care. Long-Term Care accounts for 42.8% of deaths in Columbia County.
- ⇒ **Worst outbreaks**:
  - Meadowpark Health and Specialty Care, 60 cases, 3 deaths
  - Brookdale Rose Valley Scappoose, 37 cases, 2 deaths
  - Columbia Care Center, 30 cases, 4 deaths

Scenarios/Complaints that come to LTCO:

- ⇒ Facility pressuring staff to work when showing signs/symptoms of COVID or after having tested positive
- ⇒ Resident found by visiting hospice nurse with ostomy bag leaking/not being cared for, resident covered in excrement, room not clean, horrible smells
- ⇒ Diabetic not given food choices beyond pasta, rice, hot dogs, hamburgers and corn, blood sugar not checked for days, never receives protein drink
- ⇒ Resident not getting the services they are paying for
- ⇒ Resident needs protein drinks, can't eat food at facility due to illness
- ⇒ Elevator often not working, no meal choices, needs low sodium diet
- ⇒ Facility not allowing full visitation for hospice residents, resident cries when complaint leaves doesn't want to be alone
- ⇒ Missing personal items and laundry
- ⇒ Concern with how a caregiver is treating residents, rude behavior
- ⇒ Pain medication wasn't ordered
- ⇒ Residents did not know what to do in case of a fire
- ⇒ Staff purchasing narcotic medications from residents

Hood River County:

- ⇒ COVID-19 deaths – 29 total, with 24 of those in long-term care. Long-term care accounts for 82.7% of the COVID-19 deaths in Hood River County.
- ⇒ Worst Outbreaks:
  - Hood River Care Center, 74 cases, 16 deaths
  - Ashley Manor Pacific Heights, 17 cases, 3 deaths
  - Providence Brookside Manor, 9 cases, 2 deaths

Types of complaints that come to LTCO:

- ⇒ Family angry that resident contracted COVID and was sent to a surge facility, issues with getting resident back to their facility/home
- ⇒ Heat off for days, very cold in facility, two different complaints, owner not aware of situation (not during recent ice storms)
- ⇒ Resident eviction/move out issue – resident with UTI and behaviors, had lived in facility very short time
- ⇒ Staff not wearing PPE, not wearing PPE appropriately
- ⇒ During COVID outbreak, staff report too busy to provide care for residents in isolation
- ⇒ COVID-19 negative resident put in shared room with COVID-19 positive resident for 2 days before staff noticed.

Wasco County:

- ⇒ COVID-19 deaths - 26 total with 21 of those in Long-Term Care. Long-Term Care accounts for 80.7% of the deaths in Wasco County.
- ⇒ Worst Outbreaks:
  - Flagstone Senior Living, 51 cases, 14 deaths
  - Oregon Veterans Home, 51 cases, 3 deaths

Types of complaints that come to LTCO:

- ⇒ Staffing issues, long-time staff quitting
- ⇒ Move out notice/eviction for behaviors, not valid
- ⇒ Not wanting resident moved due to COVID surge unit without their consent
- ⇒ Resident being moved after recovering from COVID against wishes
- ⇒ Neglect, short staffing, meds missed, food not served, laundry not done
- ⇒ Staff refuse to assist resident outside to go on a drive with family member

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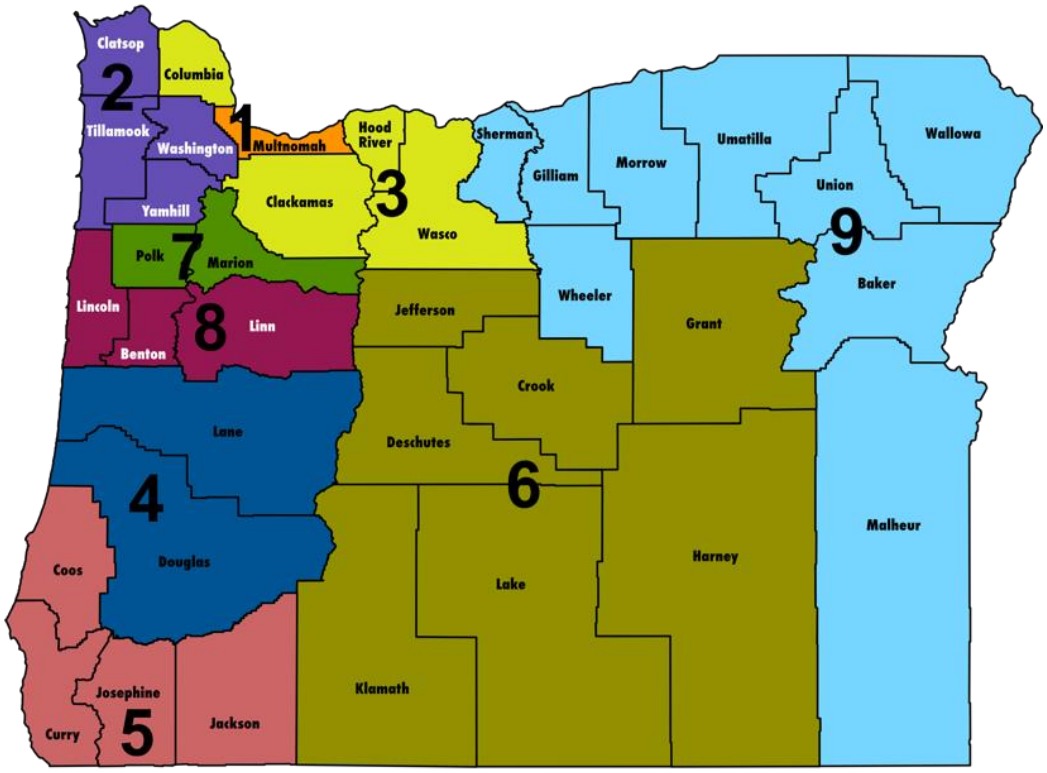

District 4 – Deputy Long-Term Care Ombudsman – Debbie Boures

Lane County:

- ⇒ COVID-19 deaths – 129 deaths total, 72 in long-term care. Long-term care accounts for 55.8% of COVID-19 deaths in Lane County.
- ⇒ Worst Outbreak:
  - Avamere Riverpark, 139 cases, 9 deaths
  - Marquis Springfield Post-Acute, 71 cases, 2 deaths
  - Hillside Heights, 55 cases, 6 deaths
  - Creswell Health and Rehab, 54 cases, 3 deaths
  - The Rawlin at Riverbend, 48 cases, 8 deaths
  - Evergreen Memory Care, 40 cases, 13 deaths
  - SouthTowne Memory Care, 33 cased, 8 deaths
  - Elder Health and Living, 32 cases, 5 deaths

Types of Complaints Received by our Agency:

- ⇒ Needs specialized pureed diet, not being given. Very small sizes for servings. Nurses don't respond to caregiver requests, waited a whole day for help and then sent to hospital

- ⇒ Wants to hold hand of dying hospice patient unclear on COVID restrictions
- ⇒ Family wants to visit resident on hospice, facility said they don't have enough staff to accommodate a weekend visit
- ⇒ Short staffed due to COVID, care concerns. Not always two caregivers present, so they quarantine residents to their rooms
- ⇒ Resident's briefs not changed – caregivers have said for the resident to do it by their self
- ⇒ Laundry is backed up, soaking beds, agency staff don't know residents' needs, wrong clothes and sheets delivered

Douglas County:

- ⇒ COVID-19 deaths – 55 deaths total, 14 in long-term care. Long-term care accounts for 25.4% of COVID-19 deaths in Douglas County.
- ⇒ Worst Outbreaks:
    - Forest Hills Assisted Living, 67 cases, 2 deaths
    - Curry Manor Memory Care, 65 cases, 9 deaths
    - Rose Haven Nursing Care, 54 cases, 1 death
    - Umpqua Valley, 30 cases, 0 deaths

Types of complaints received by our Agency:

- ⇒ Staffing and care concerns, facility not on top of care, resident lost weight is bed bound and on hospice now, resident afraid to complain for fear of retaliation
- ⇒ Dropped off at residential care facility with no Dr. orders, or report to staff, very weak, had a fall right away
- ⇒ Facility tells residents they cannot leave due to COVID, which isn't true. Overmedication, falls
- ⇒ Bed bugs, again
- ⇒ Resident with itchy eyes, lack of foot care and now bedsores from not being repositioned regularly
- ⇒ COVID protocols not followed, resident was subjected to staff caring for COVID positive residents, staff told to report to work with had pending COVID test, no hazard pay.

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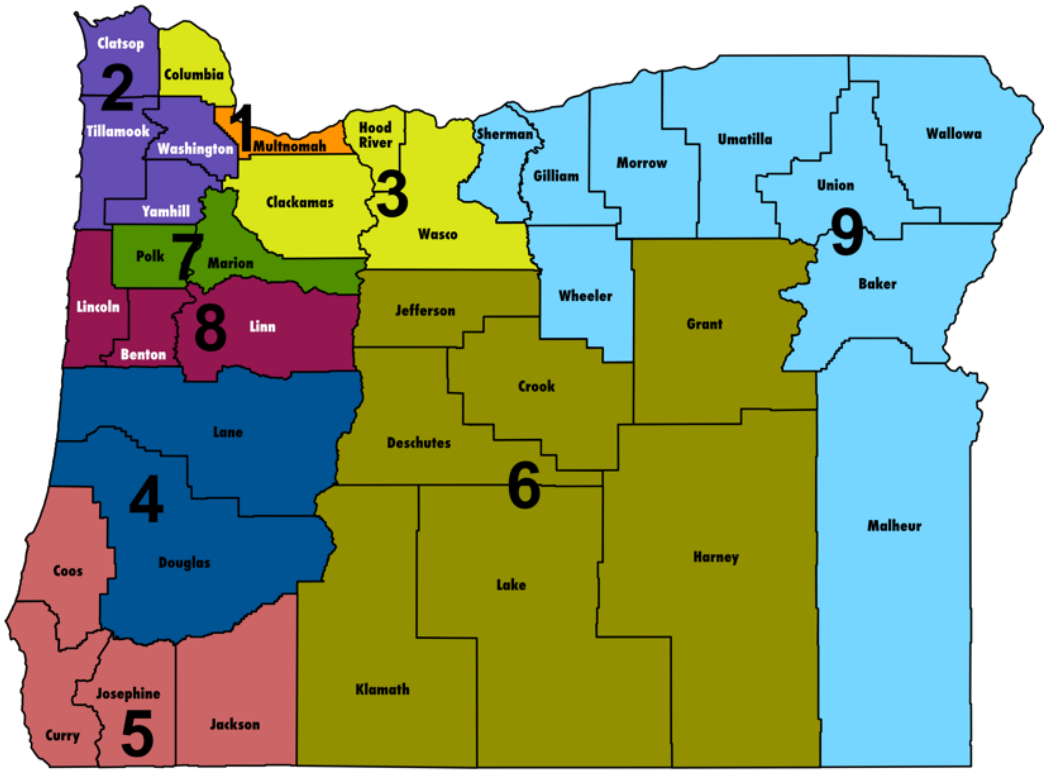

District 5 – Deputy Long-Term Care Ombudsman – Lonnie Douglas

Coos County:

- ⇒ COVID-19 deaths – 20 deaths total, 7 in long-term care. Long-term care accounts for 35% of COVID-19 deaths in Coos County.
- ⇒ Worst Outbreak:
  - Life Care Center of Coos Bay, 83 cases, 7 deaths

Types of Complaints Received by our Agency:

- ⇒ Takes too long get incontinence briefs changed
- ⇒ Move out/eviction notice due to resident care needs – facility saying they can't do the care needed
- ⇒ Short staffing, limiting availability of food for residents
- ⇒ Quarantining of residents if they leave for appointments – which is not allowed
- ⇒ Fee increases, no physical therapy, no satisfactory food options
- ⇒ Lack of personal hygiene care – wants haircut and toenail care

Josephine County:

- ⇒ COVID-19 deaths – 53 deaths total, 30 in long-term care. Long-term care accounts for 56.6% of COVID-19 deaths in Josephine County.
- ⇒ Worst Outbreaks:
  - Oak Lane Retirement, 72 cases, 13 deaths
  - The Suites Assisted Living Community, 53 cases, 8 deaths
  - Royale Gardens Health and Rehab, 47 cases, 3 deaths

Types of complaints received by our Agency:

- ⇒ Not allowed to leave the facility, can't go outside without supervision.
- ⇒ Billing issues, not clear on level of care
- ⇒ Vaccine issue – being told they can't get the first dose because they missed the first clinic due to being in the hospital.
- ⇒ Personal belongings not being returned
- ⇒ Not getting oxygen in a timely manner, resident is gasping for close to an hour while waiting for call light to be responded to
- ⇒ Lack of personal hygiene, lack of showers, hair so matted it had to be cut, rash from lack of incontinence briefs being changed
- ⇒ Isolation to room, no physical therapy

Jackson County:

- ⇒ COVID-19 deaths – 114 deaths total, 62 in long-term care. Long-term care accounts for 54.3% of COVID-19 deaths in Jackson County.
- ⇒ Worst Outbreaks:
  - Avamere Three Fountains, 138 cases, 15 deaths
  - Table Rock Memory Care, 113 cases, 19 deaths
  - Hearthstone Nursing & Rehab, 107 cases, 8 deaths
  - Avamere Health Services of the Rogue Valley, 78 cases, 5 deaths
  - Linda Vista Nursing & Rehab, 68 cases, 9 deaths

Types of complaints received by our Agency:

- ⇒ Medication concerns, resident didn't want sedatives, was being coerced to take them
- ⇒ Bed bound resident, two-hour wait time for help when pushes call button
- ⇒ Pressure sores to the bone
- ⇒ Poor care, lays in wet clothing for hours
- ⇒ Resident not given choice in being removed from home and sent to COVID surge unit
- ⇒ Staffing concerns, problems reaching people at the facility
- ⇒ Multiple unreported falls, chemical restraints

Curry County:

- ⇒ COVID-19 deaths – 6 deaths, 4 in long-term care. Long-term care accounts for 66.6% of COVID-19 deaths in Curry County.
- ⇒ Worst Outbreak:
  - Seaview Assisted Living and Memory Care, 50 cases, 4 deaths

Types of complaints received by our Agency:

- ⇒ 14 quarantine if you leave the facility for any reason other than a medical appointment, which is not allowed.
- ⇒ Family not allowed to visit, worried about isolation and depression
- ⇒ Food not edible, half of a hot dog for lunch
- ⇒ Resident to resident conflict resulting in hospitalization
- ⇒ Chronic short staffing, residents left sitting in urine for hours, false documentation of staffing who were actually there on a day/shift/etc.

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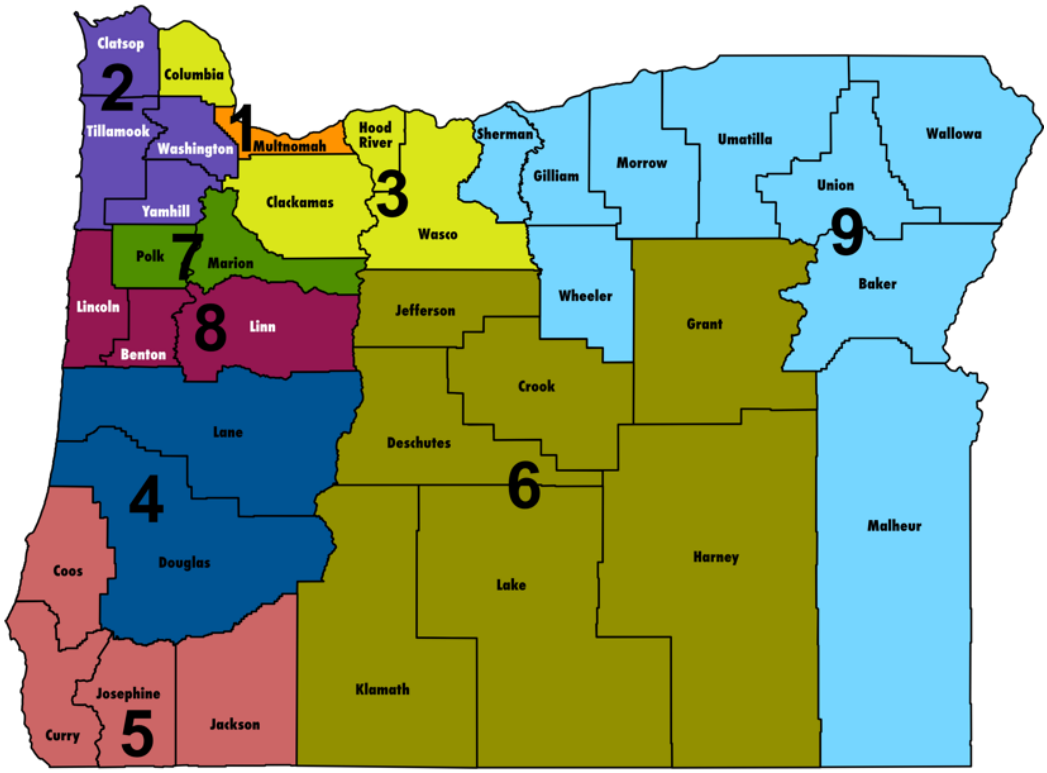

District 6 – Deputy Long-Term Care Ombudsman – Todd Steele

Deschutes County:

- ⇒ COVID-19 deaths - 61 total, with 33 of those in long-term care. Long-term care accounts for 54% of COVID-19 deaths in Deschutes County.
- ⇒ Worst outbreaks:
  - Mt. Bachelor Memory Care and Assisted Living, 120 cases, 17 deaths
  - Brookdale Redmond, 36 cases, 2 deaths
  - Recency Care of Central Oregon, 34 cases, 4 deaths
  - Regency Redmond, 34 cases, 4 deaths

Complaints that have come to our Agency:

- ⇒ Facility ran out of medications more than once, failed to act on urgent doctor's orders
- ⇒ Wanted someone to check on resident who was in quarantine, resident wants out of the facility
- ⇒ Mental and physical decline since COVID, resident has been on lock down and not allowed to come and go (which isn't allowed)
- ⇒ Poor treatment complaint, not given dignity and respect, lost belongings, not provided peri care after toileting, facility saying person must use adult diapers

- ⇒ Questions about staffing and activity documentation, questions about how to know if resident is actually getting services – feels that oral care isn't provided and not checking on residents frequently enough
- ⇒ A resident has harmed their family member, who is a resident, not enough interventions to protect the resident who was harmed
- ⇒ Resident not getting the rehab they need, were getting PT prior to COVID diagnosis, now they aren't
- ⇒ Housekeeping complaints, showers not cleaned, toilets not cleaned floors are dirty

Crook County:

- ⇒ COVID-19 deaths – 18 total, with 7 in long-term care. Long-term care accounts for 38.8% of COVID-19 deaths in Crook County.
- ⇒ Worst outbreaks:
    - Regency Prineville, 58 cases, 6 deaths

Complaints that have come to our Agency:

- ⇒ Resident in isolation, can't even look out of a window, unhappy with care
- ⇒ Family with two residents at a facility, residents are distressed and agitated due to COVID lockdown, worried about overmedication
- ⇒ Rent/service plan doubled in cost, facility was an elderly bond tenant program
- ⇒ Family being denied entry but was giving additional care to resident
- ⇒ Resident had unidentified fractures and serious medical issues, facility wasn't helping, complainant called the ambulance to figure out what was wrong on their own, then RN wasn't giving pain medication after the surgery

Klamath County:

- ⇒ COVID-19 deaths – 55 total, with 20 in long-term care. Long-term care accounts for 36.3% of the deaths in Klamath County.
- ⇒ Worst outbreaks:
    - Pelican Pointe, 61 cases, 15 deaths
    - Pacifica Senior Living, 29 cases, 4 deaths

Complaints that have come to our Agency:

- ⇒ Food complaints, burned dishes, dog that attacks residents
- ⇒ Personal care not given while at dr. appointments due to the facility not having anyone to escort, severe infection found
- ⇒ Resident fell and broke hip also had major surgery, became so dehydrated after surgery that at Dr. advised not sending back to that facility
- ⇒ Poor care, no utensils when food is provided, resident fears retaliation
- ⇒ Staff worried about bringing COVID in to building when sick was reprimanded for not coming to work anyway
- ⇒ Family member on two visits saw most employees not wearing masks, wearing them below their chins, or wearing a shield with no mask. Residents have COVID.

Jefferson County:

⇒ COVID-19 deaths – 28 total, 0 in long-term care.
⇒ Worst outbreak:
    - High Lookee Lodge, 15 cases, 0 deaths

Complaints that have come to our Agency:
⇒ COVID compassionate care visitation issues
⇒ Falls with injury in facility, medications not administered, family not notified
⇒ Refrigerator quit working and facility won't fix it
⇒ Staff turnover concerns, no housekeeping
⇒ Facility turning memory care into COVID unit
⇒ Multiple falls, resident with late stage dementia
⇒ Resident had to crawl on floor to get something to eat and drink, was given an antipsychotic (but isn't prescribed any)

Lake County:
⇒ COVID-19 deaths – 6 total, 0 in long-term care.

Complaints that have come to our Agency:
⇒ Resident feels they are being targeted
⇒ Quarantining people for 14 days if they left facility (which is not allowed)

Grant County:
⇒ COVID-19 deaths – 1 total, 0 in long-term care.
⇒ Worst outbreak:
    - Blue Mountain Care Center, 8 cases, 0 deaths

Complaints that have come to our Agency:
⇒ Infection control issues, facility not taking care of residents
⇒ Resident giving money to caregiver for over 6 months, financial exploitation
⇒ Missing mail, quarantining mail for 3 days
⇒ Resident may have to move out of room to create COVID only wing

Harney County:
⇒ COVID-19 deaths – 6 total, 0 in long-term care.
⇒ Worst outbreak:
    - The Aspens Assisted Living, 38 cases, 0 deaths

Complaints that have come to our Agency:
⇒ Lost belongings, one shower per week, being told they can't leave their room and wants to go for a walk
⇒ Request to not be woken up in the middle of the night for temperature checks, not per a doctor's order
⇒ Facility is in disrepair, non-working toilet, light fixtures don't work, facility drags feet to fix

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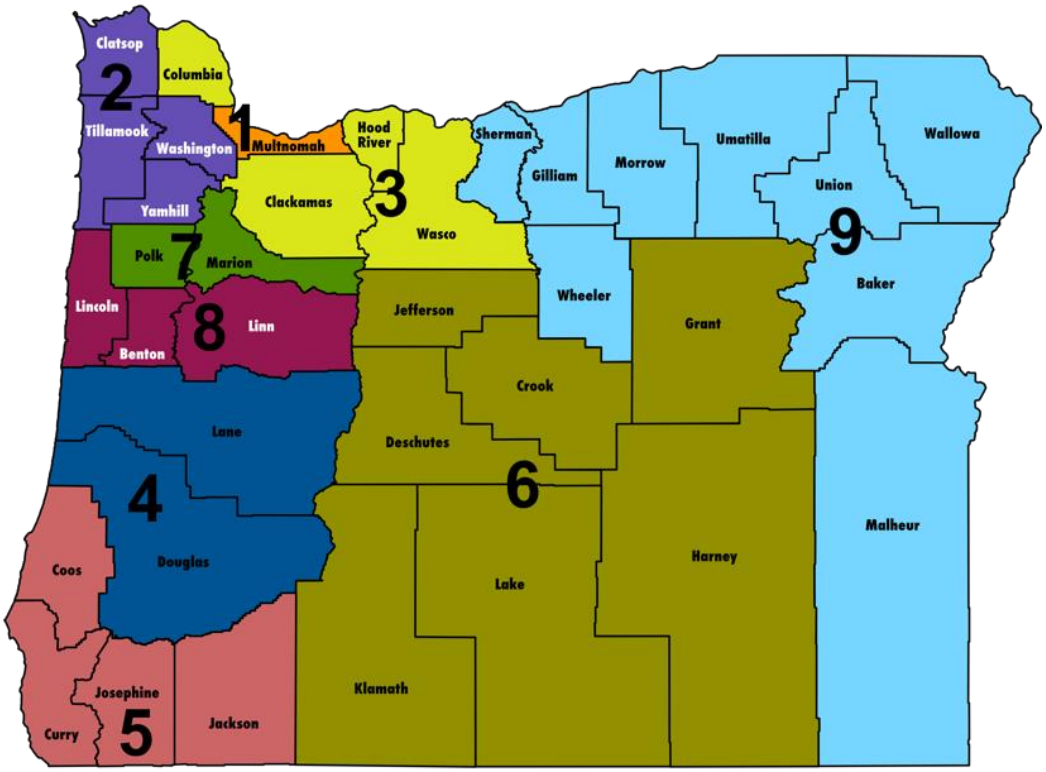


District 7 – Deputy Long-Term Care Ombudsman – Tanya Patzer

Marion County:

- ⇒ COVID-19 deaths 285 with 137 in long-term care. Long-term care accounts for 48% of deaths in Marion County.
- ⇒ Worst Outbreaks:
  - Sweet Bye n Bye (several locations combined), 113 cases, 10 deaths
  - French Prairie Nursing & Rehab, 106 cases, 16 deaths
  - Providence Benedictine Nursing Facility, 81 cases, 8 deaths
  - Brookstone Alzheimer's Care, 71 cases, 14 deaths
  - Boone Ridge Senior Living, 68 cases, 6 deaths
  - Battle Creek Memory Care, 60 cases, 4 deaths
  - Rosewood Memory Care, 58 cases, 7 deaths

Scenarios/Complaints that come to LTCO:

- ⇒ Facility stopped critical medication, resulted in heart issues and hospitalization
- ⇒ No oversight in building, staff not wearing masks, not having new staff quarantine to protect residents, staff are bringing in COVID-19

- ⇒ Resident neglected, not fed or given water, lost weight, no personal hygiene
- ⇒ Resident wasn't helped with toileting, call light not answered, soiled one's self frequently, was there for help after surgery
- ⇒ Resident being released from ER, ending right back in ER, not appropriate care
- ⇒ Facility not securing medications, has contacted DHS and nothing happens
- ⇒ During ice storm, residents left with no power, generator not hooked up, people were very cold and one was shaking nonstop, administrator quit.
- ⇒ Visitation complaint – wants to visit with family member in their private rooms instead of lobby
- ⇒ Food issues – reuse of food multiple times, cold when arrives, not following menu, citing budget issues, shortage of staff in kitchen and facility.

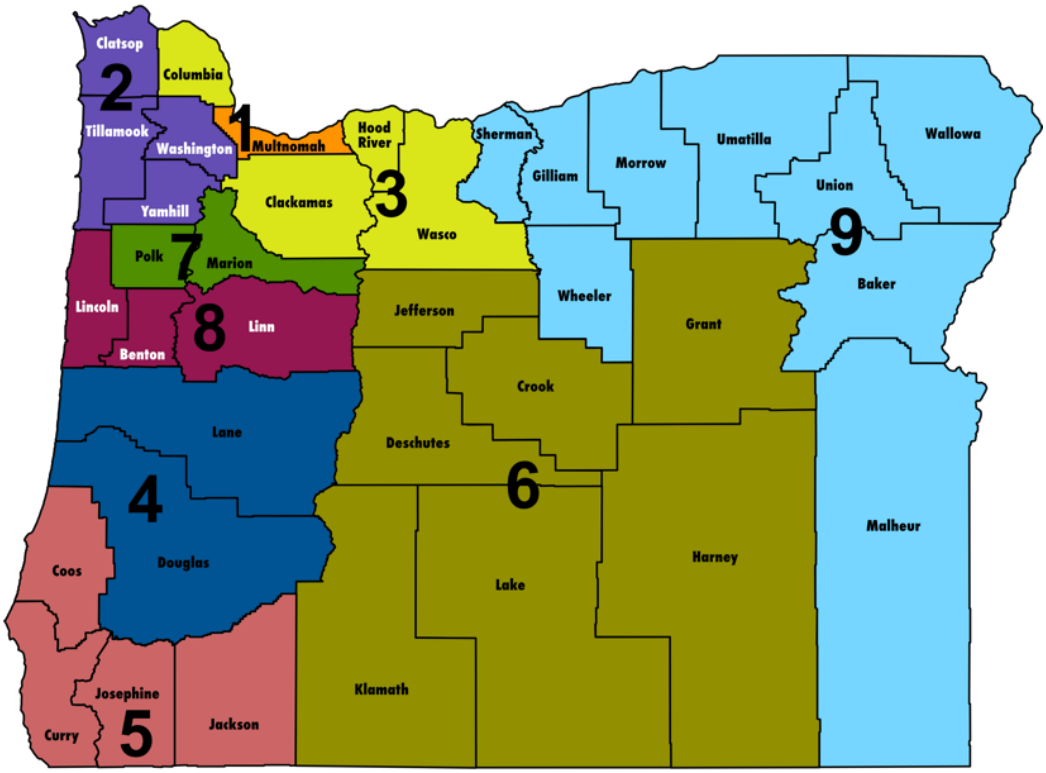
Polk County:

- ⇒ COVID-19 deaths 43 with 29 in long-term care. Long-term care accounts for 67.4% of deaths in Yamhill County.
- ⇒ Worst Outbreaks:
  - Dallas Retirement Village, 99 cases, 8 deaths
  - Prestige Orchard Heights, 58 cases, 10 deaths
  - Jefferson Lodge, 51 cases, 8 deaths

Scenarios/Complaints that come to our Agency:

- ⇒ Resident returned from hospital and concerned about COVID in the building, worried they will be exposed by positive caregiver
- ⇒ Medication for infection not working, needs help, has a wound as well
- ⇒ Resident concern about short staffing
- ⇒ Rent increase complaint
- ⇒ Visitation complaints not equitable treatment for residents and families, based on facility's preference at that time
- ⇒ Missing personal belongings
- ⇒ Facility not letting related residents spend time together because they are in different parts of the facility, resulting in depression, isolation, etc.
- ⇒ Resident wants a whole real egg vs. liquid scrambled eggs
- ⇒ Resident eviction issue, assistance with a move out notice

OREGON LONG-TERM CARE OMBUDSMAN



District 8 – Deputy Long-Term Care Ombudsman – Ann Fade

Benton County:

- ⇒ COVID-19 deaths 12, total 17. Long-Term Care accounts for 70.5% of deaths in the Benton County
- ⇒ Worst outbreak, Corvallis Manor, 142 cases and 10 deaths

Types of complaints that come to LTCO:

- ⇒ Family member is not getting bathed regularly. Facility says resident refuses care. Family expects staff to try different strategies and techniques to get family member to agree to care. At care conference with facility staff admitted resident had only had 4 showers in 1 month.
- ⇒ Resident's family called for assistance getting family member the care needed. Facility has been asking family to hire private caregivers, which they have refused to do. Resident requires 2 staff to assist with many of care needs and there are seldom two caregivers available at the same time, so long waits for toileting, etc.

⇒ Facility refusing to allow resident to return after a hospitalization. Facility told family they don't have sufficient staff to meet the resident's needs. Move out notice given by facility was not valid. Facility was informed and 2nd notice issued. Resident transferred to hospice and died before appeal heard.
⇒ Family not allowed to visit resident who is on hospice.
⇒ Resident's family member called, resident was having breathing difficulty and facility couldn't find resident's inhaler. Family called 911 to get resident the assistance needed. Family reported incident to nursing facility complaint line.
⇒ Family called because resident tested COVID positive. Family worried resident won't be able to be with family for Christmas.

Linn County:

⇒ COVID-19 deaths 22, total 57. LTC accounts for 38.5% of deaths in Linn County
⇒ Worst outbreaks:
  - Oregon Veteran's Home, 38 cases, 9 deaths
  - Bridgecreek Memory Care, 37 cases, 4 deaths

Types of complaints that come to LTCO:

⇒ Resident had 10 lb. weight loss in past month. Reported to adult protective services for investigation into possible neglect.
⇒ Facility is not facilitating communication between residents and family, facility has 1 tablet, but it is only compatible with iPhone, which family does not have.
⇒ Resident complained that there is not enough staff to meet the residents' needs. Residents who cannot feed themselves independently do not get enough assistance at meals. Staff have been told they can spend only 20 minutes per resident, meals go cold while staff leave to assist other residents. Resident states he made a complaint to licensing and investigators came in but resident has not seen written report and does not know what the investigation concluded. LTCO requested copy of report, which confirmed staff not adequately assisting resident who cannot eat independently, as well as failure to shower residents (one of whom went 11 days without a shower), meal trays left in residents' rooms until the next meal and resident left in a wet bed for hours.
⇒ Resident fell and broke both legs after staff had him use the wheelchair scale instead of the regular scale. Resident caught foot in textured surface of wheelchair ramp. Doctors told resident he was not a surgical candidate so he cannot get his legs surgically repaired. Hospital doctors told resident he likely will never walk again. This was reported to adult protective services as possible gross neglect.
⇒ Resident's family complains that resident has had two recent medical appointments. Both times staff brought resident to family's car and pants were soiled with urine and feces. Family reports inconsistent use of personal protective equipment by staff.
⇒ Family had a window visit with resident in memory care and saw resident lying on a bare mattress. Family called the facility and was told resident has only one fitted sheet, which

is being laundered. Family had provided seven fitted sheets when resident was admitted.

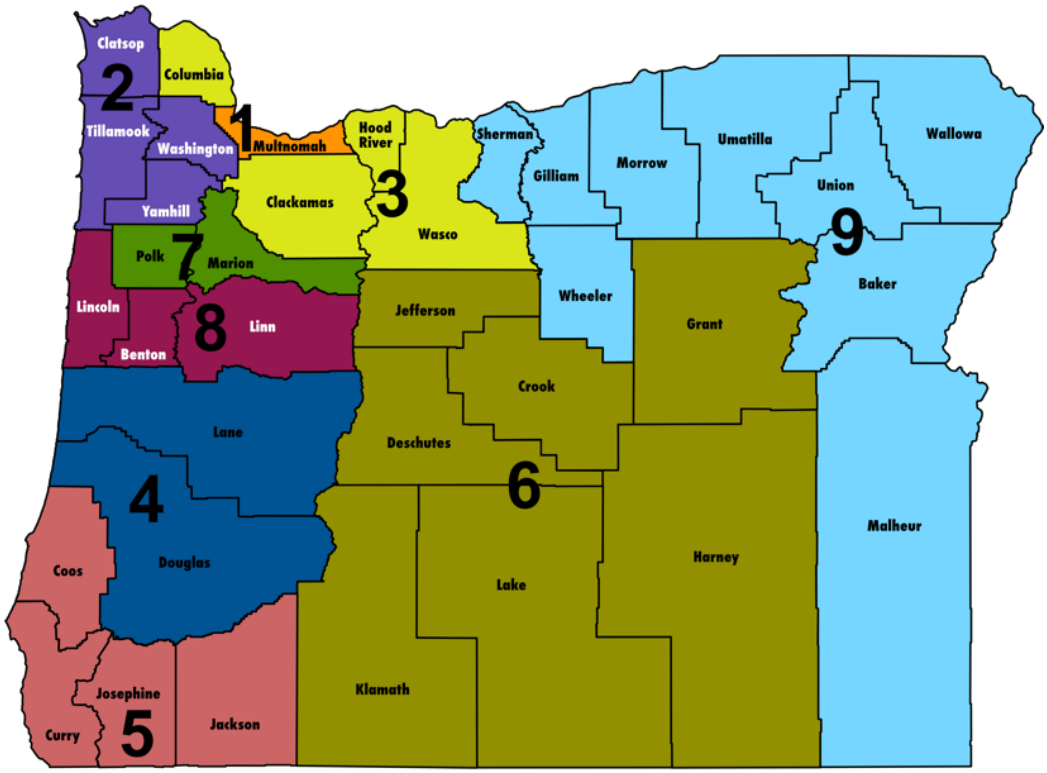
Lincoln County:

- ⇒ COVID-19 deaths 12, total 20. LTC accounts for 60% of deaths in Lincoln County
- ⇒ Worst Outbreaks:
  - Avamere Rehab of Newport, 58 cases, 7 deaths
  - Hillside Place, 28 cases, 4 deaths

Types of complaints that come to LTCO:

- ⇒ Bottle of pain medicine missing from room of resident who gave themself medication. Facility responded by removing all medications from resident's room, and staff began giving resident his medication. Facility staff failed to give resident pain medication for 2 days.
- ⇒ Resident not allowed to return to assisted living facility after stay in nursing home for rehabilitation after a fall (nursing home had COVID outbreak). Nursing home discharged resident to motel while waiting results of COVID test. Assisted living refused to take resident back even after 3 negative COVID tests.
- ⇒ Resident afraid to go to doctor visit because they have been told they would have to quarantine in room alone for 2 weeks after returning to assisted living facility.
- ⇒ Resident not allowed to use electric scooter without doctor's order, in violation of the Americans with Disabilities Act.
- ⇒ Resident's "volunteer physical therapist" not allowed in the facility because of COVID concerns. Resident advised that a licensed physical therapist treating resident pursuant to doctor's order must be allowed in.
- ⇒ Vegetables taste like metal. Resident cannot eat diary and gets food with cheese on it. Alternative meal is peanut butter and jelly sandwich.

OREGON LONG-TERM CARE OMBUDSMAN



District 9 – Deputy Long-Term Care Ombudsman – Kat Thomas

Umatilla County

- ⇒ COVID-19 deaths - 82 total, with 23 of those in Long-Term Care. Long-term care accounts for 28% of COVID-19 deaths in Umatilla County.
- ⇒ Worst Outbreaks:
  - Regency Hermiston, 103 cases, 15 deaths
  - Avamere Hermiston, 47 cases, 4 deaths

Types of complaints that come to LTCO:

Umatilla County:

- ⇒ Staff transports Resident with mental health diagnosis to hospital and leaves without providing oversight: resident alone, without medical records and medications. Hospital staff reported to Adult Protective Services.
- ⇒ Broken window near Resident bed; ongoing cold draft on Resident. Facility doesn't respond to Resident's requests to repair.
- ⇒ Resident reports that staff not wearing PPE and kitchen extremely unclean. Surveyors enter facility and observe 24 deficiencies, including one extreme safety issue.

- ⇒ Refusal to re-admit Resident after transferred to hospital due to fall/injury. Facility refuses to assess and also to accept Resident back to facility upon discharge.
- ⇒ Medication error where Resident did not receive proper dosage; medications paperwork not reflecting error and reported to Licensing. Resident health adversely effected.
- ⇒ Family transports Resident to ER when window visit shows Resident unkempt and sweating. ER diagnoses an infection and crystals located around catheter tube due to poor care by facility.
- ⇒ VA physician reports that facility nursing staff not following orders for wound care. Physician waits at least 30 minutes during weekly visits for Resident care as staff are not available to assist. Calls go unanswered and physician orders ignored.
- ⇒ Resident calls family during COVID-19 outbreak and states that they now have bed sores, and they need help. Family calls facility and asks for call back; family never receives call back.
- ⇒ Resident is immobile and unable to communicate, travels 45 minutes to nearest medical specialist in facility van; facility failed to make appointment and Resident waits for over 6 hours. Resident goes without food, fluid, or changing. Facility brings Resident back without seeing physician and fails to notify Power of Attorney about the incident.
- ⇒ Resident unable to provide own dental care sees dentist for pain and inflammation. Dental hygienist spends several hours cleaning tartar and plague from teeth before dentist can even complete exam. Dentist pulls three teeth and tells family all teeth may need to be extracted due to facility failing to assist Resident. Numerous efforts to work with facility prior to this incident regarding dental hygiene

Baker County:

- ⇒ COVID-19 deaths – 9 total, 2 in long-term care. Long-term care accounts for 22.2% of the COVID-19 related deaths.

Types of complaints that come to LTCO

Baker County:

- ⇒ Resident with dementia climbs out of window and enters residential home several blocks from facility. Law enforcement called and Resident returned to facility. Facility responds by installing motion sensors in hidden locations and revises service plan to add strategies for elopement.
- ⇒ Certified Ombudsman informed by facility that Resident attempted suicide and was transported to ER. Facility filed incident report and notified APS. Family contacted and new service plan and services secured.
- ⇒ Facility reports COVID-19 but calls OLTCO for a better understanding of resident rights and visitation policies during pandemic. Facility reaches out to local public health for infectious disease control recommendations.

Union County:

- ⇒ COVID-19 deaths – 19 deaths from COVID-19, 7 in long-term care. Long-term care accounts for 36.8% of the COVID-19 related deaths.
- ⇒ Worst Outbreaks:

- Wildflower Lodge, 75 cases, 6 deaths
- Grand Ronde Retirement, 12 cases, 1 death

Wallowa County:

⇒ COVID-19 deaths – 5 deaths from COVID-19, 0 in long-term care.

Types of complaints that come to LTCO:

Wallowa and Union Counties:

⇒ Resident needs to use commode but waits over 40 minutes despite cries for help and pushing call light. Sits in soiled clothing while waiting for staff to respond to call light.

⇒ Resident has dentures and in need of dental care; asks facility to cut up food so that resident can swallow. Facility fails to perform this task and resident loses 15 pounds before family is aware of resident's failure to thrive.

⇒ Resident is refused transportation to kidney dialysis treatments. Transportation states bariatric wheelchair and person's weight a safety issue; in meantime Resident becomes discouraged and refuses dialysis treatment. Resident dies from complications.

⇒ Reports by residents, family members, and facility employees that assisted living is not practicing COVID precautions and DHS is notified. COVID outbreak in facility and survey repeatedly notes that facility is not following recommendations. Outbreak continues...

⇒ Resident transported to local ER where physician shares that catheter has not been changed despite doctor's earlier orders and Resident now has sepsis. Physician reports to Adult Protective Services. Resident now on hospice and family requests records, with facility refusing to cooperate.

⇒ Resident admitted to ER from facility with pneumonia and COVID-19. ER shares that Resident has dried feces in rectal area, multiple bruises, dried food on call pendant, mouth black and tongue dry and scabby. Additional signs of abuse; resident dies at hospital.

Morrow County:

⇒ COVID-19 deaths – 14 deaths from COVID-19, 0 in long-term care.

⇒ Worst Outbreak:

- Willow Creek Terrace, 3 cases, 0 deaths

Sherman County:

⇒ COVID-19 deaths – 0 deaths from COVID-19 in Sherman County.

Gilliam County:

⇒ COVID-19 deaths – 1 death from COVID-19, 0 in long-term care.

Wheeler County:

⇒ COVID-19 deaths – 1 death from COVID-19, 0 in long-term care.

Types of complaints that come to LTCO:

Morrow, Sherman, Gilliam and Wheeler Counties:

- ⇒ Received a call from an elderly resident that Medicaid benefits were denied. Resident confused as to why they are no longer eligible. With the onset of COVID-19, Resident benefits were extended, but may have faced homelessness without benefit extension.
- ⇒ Prior to COVID, Resident unable to shop for groceries and personal items, as well as attend church due to a lack of transportation services. If facility bus was in need of repairs, resident(s) were unable to obtain outside services in remote, rural area.
- ⇒ Family member called with concerns about resident. With COVID visitation restrictions family visits with resident via phone and no longer enters facility. Family shares that they use to visit daily to provide emotional support. Family worries about care, while Resident's emotional well-being declines. Resident shares they are lonely without family.
- ⇒ Deputy speaks with facility about technology to keep residents connected with family and friends. Facility writes three community grants for devices, and all have been denied. Staff using personal cell phones and iPads to assist residents with outreach strategies.