CDDP
Abuse Investigation Report
REDACTED REPORT

CDDP Case Number:	74	**Investigator:**	Scott Christoferson
OTIS Case Number:	DD200113	**County:**	Curry

Provider:	Mentor of Oregon	**Provider Type:**	24 Hour Residential
Provider Address:	P.O. Box 7623 Brookings Oregon 97415		

Incident Date:	5/8/2020	**Incident Reported Date:**	5/11/2020	**Investigation Assigned Date:**	5/15/2020
Incident Location/Address:	[redacted]				

Alleged Victim Name	**Address**	**Phone**	**DOB**
[redacted]	[redacted]	[redacted]	[redacted]
Case Management Entity	Community Living Case Management	CDDP	

Accused Person/Program Name	**Address**	**Phone**	**DOB**	*Is AP*
[redacted]	[redacted]	[redacted]	[redacted]	☐ DHS Employee ☐ Independent Provider

Alleged Abuse	Neglect	**AV:**	[redacted]	**AP:**	[redacted]	**Finding:**	Substantiated

Allegation(s)

It is alleged [redacted] neglected the care of [redacted] resulting in physical harm, in violation of ORS 430.735 (1)(e) and (10)(a).

Individuals Interviewed

Name	DOB	Title	Date/Time	Document
[redacted]	Unknown	[redacted]	5/12/2020	☐ Recorded ☒ Hand Written
[redacted]	[redacted]	Cypress House [redacted]	5/12/2020	☐ Recorded ☒ Hand Written
[redacted]	[redacted]	Direct Care Staff	5/20/2020	☐ Recorded ☒ Hand Written

Protective Services

☒ **Immediate Protection** ☐ **Assess Ability to Self-Protect/Give Consent.**
☐ **Understand and Accept Protective Services** ☐ **Verify Physical/Mental Status**
☐ **Alternate Living Arrangements** ☐ **Medical/Legal/Financial/Other** ☐ **Advocacy**
☒ **Consult with Provider/Program/Brokerage/Other.**

[redacted] was put on administrative leave pending outcome of this investigation by [redacted]

Additional Information (site visit, investigation process, additional information**)**

No site visit was conducted due to COVID-19.

[redacted] was not interviewed due to her disabilities and has no way to communicate.

On 5/11/2020, I was notified of an alleged neglect case and received an Incident Report (Exhibit 1). It was reported accused person [redacted] allegedly left consumer [redacted] in the dinner chair for approximately 3 hours to the point she had bruises marks on her back and had scratched her face. [redacted] was found with blood on her face, hands and shirt.

On 5/15/2020, I opened an investigation of neglect against [redacted] and filed the paperwork with OTIS (Exhibit 2).

Staff [redacted] sent me all the pictures of the dried blood on [redacted] hand and clothing (Exhibit 3).

Included is a T-Log from [redacted] shift stating that [redacted] had enjoyed her dinner and was in her recliner in the living room getting ready for bed. This was reportedly not true according to staff [redacted] who stated when she entered the home at 8 pm [redacted] was still in the dining room chair. (Exhibit 4).

Supporting Documents List

[redacted]

Investigation Summary

[redacted] is a 65-year-old female diagnosed with [redacted]. [redacted] requires 24 hour a day assistance in all aspects of her life. [redacted] lives in the Cypress house in Brookings, Oregon ran by Mentor of Oregon.

[redacted] frequently engages in "stimming," which is a common term for repetitive behavior. Typical examples of this include hand waving, teeth grinding, rocking movements and nail biting. In some cases, like this one, it can involve self-injurious behaviors such as picking of the skin and self-hitting. Mentor has a Stimming and Self Injury information packet that explains [redacted] issues with stimming. [redacted] has stimming that at times will cause her to self-injure herself. [redacted] stimming usually happens when she is in pain or ready for her down time, as stated in the Stimming and Self injury paperwork (Exhibit 5).

On 5/8/2020, [redacted] was allegedly left at the kitchen table for dinner at 5pm during the swing shift by staff [redacted] and was still there at 8pm when [redacted] showed up for her graveyard shift. It was reported [redacted] checked in to work and [redacted] was in office on a computer and [redacted] was in the kitchen. Reportedly when [redacted] sat down with [redacted] she noticed the blood on her. [redacted] asked [redacted] if she and noticed blood and [redacted] had not and [redacted] sent [redacted] home.

[redacted] had allegedly been sitting at the table long enough to have engaged in self-injurious behavior (SIB) to the point of bleeding on her face, hands and shirt. [redacted] was also reportedly found was in soiled undergarments.

[redacted] was not interviewed as she is not verbal and has no way of communicating other than reaching out for physical touch.

On 5/8/2020 [redacted] [redacted] stated she received a phone call from [redacted] at about 8 pm about the blood and bruise found on [redacted]. [redacted] stated when she showed up to Cypress house on 5/9/2020 at 8am she could still see the bruise marks on [redacted] back and the sore that was on [redacted] nose. [redacted] stated in the morning she called and put [redacted] on administrative leave pending this investigation. [redacted] stated she did not tell knight anything more than she was on suspension and left it to the abuse investigator to speak with [redacted].

[redacted] stated she was at the Cypress house by 8am on 05/09 and the bruises/marks on [redacted] back were still visible 12 hours later from allegedly being left in the chair for 3 hours. [redacted] stated she had not seen the blood on [redacted] as [redacted] had given her a shower and got her cleaned up but had seen the pictures of [redacted].

[redacted] stated [redacted] has worked for mentor since 03/16/2020, and has been trained on [redacted] Individual Support Plan (ISP) and care protocols (Exhibit 6).

[redacted] stated that is all she knew as it was just the two staff ([redacted] and [redacted]) that had been present at the time, so I concluded the interview.

[redacted] stated she was coming in to work the 8pm to 7am shift and as she was walking into the office to see how the prior shift went, she noticed [redacted] still at the kitchen table and [redacted] was in the office on her computer.

[redacted] stated she went to check on [redacted] and noticed blood on her hands, shirt and face. [redacted] stated [redacted] was completely unaware of any blood on [redacted] when [redacted] confronted [redacted] about it, and [redacted] sent [redacted] home.

[redacted] stated she called [redacted] and informed her about [redacted] being left in the kitchen chair for 3 hours. She also told [redacted] that [redacted] engaged in self-injurious behavior.

[redacted] stated she got [redacted] in the shower and got her cleaned up and when doing so, she noticed the bruising on her back from what she assumed was being in the chair so long. [redacted] stated she gave [redacted] a PRN (aspirin) for any possible pain and then held her for sensory touch till she went to sleep.

[redacted] stated there were two quarter size bruising indentations right by [redacted] shoulder blades that matched the wood pattern on top of the chair [redacted] had been left in. [redacted] took photos of the bruising between her shoulder blades (exhibit 3).

I asked [redacted] for the shift note (T-Log) on that evening which is included in the exhibits. [redacted] stated [redacted] had not told the truth in the shift notes. [redacted] shift notes at 7:48pm stated, "Upon arrival [redacted] was in the recliner. [redacted] was checked every 1 to 2 hours for fluids, voids, and BM's. [redacted] enjoyed her dinner and is now resting in the living room recliner again. She is about ready to relax in her room for the night."

[redacted] stated [redacted] was in the kitchen chair still when she arrived and not in the recliner, and she clearly had not been checked on in a long time due to the condition of her depends (exhibit 3). There was dried blood on [redacted] hands, face, and clothing from SIB.

When interviewing [redacted], I asked her if she knew why she had been suspended. [redacted] was unaware of the reason, so I informed [redacted] she was under investigation for neglect of [redacted]. I asked [redacted] what she was doing when [redacted] showed up and [redacted] stated she was doing some shift notes.

I informed [redacted] I had been told she was on her personal computer. [redacted] denied being on her personal computer at the time. [redacted] stated her computer was open and was using it earlier but not when [redacted] showed up.

I asked [redacted] if she was aware of how long [redacted] had been in her dinner chair. [redacted] stated she had been there for 2 to 3 hours and she had been checking on [redacted] every 15 to 20 minutes.

I asked [redacted] if she had seen any blood on [redacted]. [redacted] stated she did not and even after she had been asked to go home, she said goodbye to [redacted] and did not notice anything. I informed [redacted] also had some bruising marks on her back from the chair. [redacted] acknowledged the marks were probably from her leaving [redacted] in the chair too long, but she never saw any blood on [redacted]

I asked [redacted] why her shift notes did not match up to what was seen at the house when [redacted] showed up. [redacted] stated she was just getting ready to move [redacted] after making the T-Log and then she was asked to leave.

I asked [redacted] if she felt like she had neglected [redacted] care, and she stated, "No, I would never do that."

Investigation Conclusion

ORS 430.735(1)(e) and (10(a) defines neglect as: Failure to provide the care, supervision or services n necessary to maintain the physical and mental health of an adult that may result in physical harm or significant emotional harm to the adult.

The allegation that [redacted] neglected the care of [redacted] resulting in physical harm, in violation of ORS 430.735 (1)(e) and (10)(a), is **Substantiated.**

[redacted] falsified her T-logs regarding [redacted] condition and activities on the evening of this incident. [redacted] T-Log stated [redacted] was resting in her recliner when she had clearly been left in her kitchen chair for roughly two to three hours, based on statements from both [redacted] and [redacted].

During that time in her dinner chair, [redacted] sustained bruising to her back, although it is unclear exactly how, and injury to her face as a result of her "stimming," or self-injurious behavior (SIB), which [redacted] is prone to engage in. [redacted] has a stimming and self-injury protocol which [redacted] has been trained on. The protocol outline's examples of when and how [redacted] will engage in stimming and SIB. This protocol states [redacted] frequently engages in stimming by hand waving, teeth grinding, rocking movements and nail biting. In some cases, like this one, [redacted] stimming can involve self-injurious behaviors such as picking of the skin and self-hitting. [redacted] engaged in stimming behavior while left unattended in her dinner chair, and she was found with blood on her hands, face and shirt by [redacted] when she arrived for her shift.

[redacted] was trained on [redacted] Individual Support Plan and care protocols. [redacted] admitted she left [redacted] in the kitchen chair for 2 to 3 hours, likely causing the bruising marks on her back, but denied any knowledge of blood on [redacted] from her SIB. However, when [redacted] came to work at 8 pm she found [redacted] in the staff office on her personal computer. [redacted] then saw the condition of [redacted] at the table and immediately sent [redacted] home. She photographed [redacted] condition and reported the incident to [redacted], who suspended [redacted] the following morning.

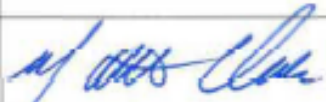
[redacted] denied neglecting the care of [redacted] and stated she checked on [redacted] every 15 to 20 minutes during the time [redacted] was in her dinner chair. Despite [redacted] denial of neglect, she admittedly left [redacted] in her dinner chair for roughly 2-3 hours. During this time [redacted] sustained bruising on her back and engaged in stimming and self-injurious behavior to her face, resulting in bleeding and minor injury. [redacted] failed to provide the care and supervision necessary to keep [redacted] safe from physical harm. Therefore, based on the information obtained, the allegation of neglect is **substantiated.**

Recommended Actions

Staff was put on administrative leave pending the outcome of this investigation. Mentor will follow their established procedures when a staff has been substantiated for abuse.

Notification/Distribution

☒ Accused Person [redacted]	☒ AV's Case Management Entity [redacted]	☐ ODDS Provider Recommendations
☐ AV's Guardian	☐ DHS HR	☐ Professional Licensing Boards
☐ Background Check Unit	☐ Health Care Regulation and Quality Improvement	☐ Other
☐ CDDP Director or Designee	☐ LEA	
☒ CDDP Investigator/Supervisor [redacted]	☐ Medicaid Fraud	
☒ Facility/Agency who oversees AP	☒ DHS/DD Licensing	

Investigator Name Printed:	Scott Christoferson		
Investigator Signature:		**Date:**	7/17/2020
Approving Supervisor Name Printed (Optional):	Matthew Clark		
Approving Supervisor Signature (Optional):		**Date:**	7/17/2020
Abuse Investigation Coordinator Name Printed:	Eric Wiseman		
Abuse Investigation Coordinator Signature:		**Date:**	7/17/2020