

Life at Cypress House: An Examination of Care Provided by MENTOR Oregon

Staff Report

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Senator Ron Wyden

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Executive Summary

Following media reports of abuse and neglect in facilities caring for adults with intellectual and developmental disabilities (I/DD), the Finance Committee launched a bipartisan investigation in April 2019. The investigation focused on The Mentor Network's (MENTOR) operations in Oregon and Iowa (namely, MENTOR Oregon and REM Iowa) and culminated in two reports. MENTOR is one of the largest providers of human services in the country.

The report written by the Finance Committee's Democratic oversight staff principally looks into MENTOR's operations of I/DD facilities in Oregon between 2013 and 2019. However, key incidents at one particular facility—Cypress House, located in Brookings, Oregon—demonstrate a consistent, substandard level of care delivered by MENTOR Oregon employees. Despite conditions previously imposed on the company by the State of Oregon, previous intents to revoke the facility's license by the State, a settlement agreement between the company and its State regulator, and following a company-led evaluation of its footprint across Oregon, the company chose to keep this facility open. Notwithstanding all of this institutional scrutiny, in May 2020, this facility was once again the subject of a neglect allegation and ensuing investigation—which substantiated the allegation. In October 2020, this facility was also the subject of a complaint and subsequent licensing review by the State of Oregon. As a result of the onsite review (following the October complaint by a client's parent), numerous violations were found, statewide conditions were reimposed by the State on MENTOR Oregon, and a revocation letter for Cypress House was issued by the Oregon Department of Human Services—the second revocation letter for the same facility in a year and a half. MENTOR Oregon elected to close the facility in October 2020.

From the standpoint of Finance Committee staff, the most recent events demonstrate that despite years of regulatory attention, the company has not turned the corner regarding the level of care provided to its clients. In the concluding days of the 19-month investigation, these new incidents at Cypress House were happening in real time, not years in the past. The State was forced to take action once again. In *Life at Cypress House: An Examination of Care Provided by MENTOR Oregon*, the report highlights key findings from a number of incidents across the state over a period of years, from Northeast Portland, to the coastal town of Brookings, to Klamath Falls.

To be clear, MENTOR Oregon is one of dozens of providers offering critical services to adults with I/DD in 24-7 residential as well as community settings. The company does not stand alone when it comes to allegations of neglect among large providers. In fact, it has taken steps to improve trainings and take corrective actions with staff members who run afoul of standards of care. However, despite these steps, they have fallen short. State licensing actions in 2020 make it plain to see. Going forward, it is important for all providers caring for this vulnerable adult population—particularly during a national pandemic—to adhere to the highest level of care possible and for regulators to rigorously oversee them.

Introduction

Adults with intellectual and developmental disabilities (I/DD) are some of the most vulnerable individuals in our communities. We see them in grocery stores. We see them on walks around the neighborhood with their family or caregivers. They battle cognitive and physical conditions such as autism, cerebral palsy and epilepsy. But far too often these individuals are on the receiving end of private caregivers' poor decisions and neglectful acts. Behind each positive step forward to improve care or streamline the process, there is often a preceding story or licensing action that prompted it.

Across the country, States and a combination of for-profit and non-profit providers deliver services to this vulnerable population. Many of these individuals are unable to communicate or take care of themselves, whereas others are high functioning and require limited assistance. According to a study by University of Colorado researchers, there were an estimated 5.1 million Americans with an intellectual or developmental disability in 2015, with that figure on the rise.¹

The Senate Finance Committee (the Committee) has broad jurisdiction over health care and social support programs authorized pursuant to the Social Security Act, including Medicare and Medicaid. Policies affecting providers who deliver care to adults with I/DD are largely guided at the State level, though significant Medicaid funds are utilized by the States. Indeed, Medicaid started paying for services in I/DD facilities (ICFs-I/DD) in 1972; the ensuing decades led to an increasing number of I/DD patients being treated in more community-based, residential settings (transitioning away from institution-based care).²

The MENTOR Network (MENTOR) is one of the largest providers of human services in the United States. It is currently a privately-held, for-profit company, though it was previously listed on the New York Stock Exchange until March 8, 2019, a month prior to the Finance Committee launching its investigation.³ Headquartered in Boston, Massachusetts, the company currently operates in more than 30 states. MENTOR Oregon and REM Iowa are the company affiliates providing I/DD services in those states.⁴ In April 2019, Chairman Grassley and Ranking Member Wyden sent MENTOR two letters (one to MENTOR Oregon, the other to REM Iowa) seeking additional information about company operations, investigative reports and performance reviews conducted by State- and County-level entities, in addition to information concerning all residential facilities.^{5, 6, 7} MENTOR Oregon is "certified as a Medicaid Agency with a 24 HOUR Residential Services Endorsement" by the Oregon Department of Human Services (OR DHS).

¹ "The State of the States in Intellectual and Developmental Disabilities," Dr. David Braddock, 2017, 11th Edition, as cited in the 2018 Form 10-K for Civitas Solutions, Inc., pp. 4–5 (See Footnote 10).

² "Community-Based Medicaid Funding for People with Intellectual and Developmental Disabilities," Richard Hemp, David Braddock and Martha King, February 2014, Vol. 22, No. 7. [LINK](#).

³ Confirmed by the company in September 25, 2020 written responses to Committee staff. See Appendix C, Item 1.

⁴ "Our Partners – National Network of Local Providers," The MENTOR Network. [LINK](#).

⁵ "Grassley, Wyden Probe Reports of Abuse at Group Homes in Iowa & Oregon," Press Release, April 3, 2019. [LINK](#)

⁶ Letter to MENTOR Oregon from Grassley and Wyden, April 2, 2019. [LINK](#)

⁷ Letter to REM Iowa from Grassley and Wyden, April 2, 2019. [LINK](#)

This report documents the findings of the Committee’s inquiry into the I/DD service performance of MENTOR Oregon, with a particular focus on Cypress House, one of the company’s 24-hour facilities. A companion report—*A Case Study: REM Iowa’s Failure to Ensure Workforce is Properly Trained to Care for Iowans with Disabilities*—outlines the Committee’s inquiry into the performance of REM Iowa.

The MENTOR Network

Previously listed as Civitas Solutions, Inc. (Civitas) in SEC filings,⁸ MENTOR’s FY 2018 10-K filing showed the company serving “approximately 12,700 individuals in residential settings and...19,000 individuals in non-residential settings.”⁹ At the time, MENTOR utilized “approximately 23,600 full-time equivalent employees...as well as more than 3,500 independently-contracted host home providers” to offer services across some 36 states.¹⁰

The company offers an array of services to those in need, including adults and children with I/DD, those with brain and spinal cord injuries, therapeutic foster care (TFC) services, adoption services, and other behavioral challenges.¹¹ I/DD services are housed in its Community Support Services operating division, or CSS. These services include “residential support, day habilitation, vocational services,” among others.¹² Primarily carried out through small group homes and intermediate care facilities (“ICFs-I/DD”), MENTOR provided CSS services to approximately 18,500 individuals across 21 states in FY 2018, occupying an estimated 1,500 group homes and 150 ICFs-I/DD.¹³ The CSS operating division was, at the time, the company’s largest income source in its business line, generating net revenues surpassing \$1 billion in FY 2018, and comprising 64% of its total net revenue for the year.^{14, 15}

⁸ In 2006, Civitas was acquired by Vestar Capital Partners, which took MENTOR public in 2014. Four years later, the for-profit service agency revamped its corporate structure on December 18, 2018, in which Civitas sold its shares to Centerbridge Partners L.P. for a value of \$641 million—and an enterprise value of \$1.4 billion. The deal was finalized March 8, 2019 as Celtic Intermediate Corp. (an affiliate of Centerbridge) acquired Civitas for \$17.75 per share. Furthermore, National Mentor Holdings, Inc. became a direct, wholly-owned subsidiary of the new parent company (Celtic Intermediate Corp.) and Civitas no longer existed as a separate entity on the stock exchange after the merger. Additional sources: “Civitas to sell itself to Centerbridge Partners for \$641 million,” Reuters, December 18, 2018, [LINK](#); “Centerbridge Partners Completes Acquisition of Civitas Solutions, Inc.,” Businesswire, March 8, 2019, [LINK](#); Civitas Solutions, Inc., 2019 Form 15-12B - Securities Registration Termination Filing (March 18, 2019), [LINK](#).

⁹ Please see Appendix C, Item 1, particularly the answer to Question #7, regarding the company’s current corporate structure. Put simply: National Mentor Holdings, Inc. is the “parent holding company of approximately 86 subsidiaries, including National Mentor Services, LLC, which is registered to do business as MENTOR Oregon.”

¹⁰ “Form 10-K,” September 30, 2018, Civitas Solutions, Inc., U.S. Securities and Exchange Commission p. 3. [LINK](#).

¹¹ “About the Network,” The Mentor Network, [LINK](#).

¹² See Footnote 10, “Form 10-K,” p. 4.

¹³ Ibid.

¹⁴ Ibid.

¹⁵ In an October 9, 2020 email to Committee staff, the company cited the 2017 University of Colorado study, which presents information through FY 2015. Based on Dr. Braddock’s report, FY 2015 total spending for I/DD services in the United States was approximately \$65.2 billion. In 2015, MENTOR collected approximately \$895.3 million in revenues for its I/DD services across 21 states, representing approximately 1.37% of the total I/DD market. As the

As noted above, the company is now entirely privately held and no longer makes public company filings with the SEC. As such, there is substantially less public transparency and insight into one of the largest providers of human services in the U.S. In written responses provided to Committee staff on September 25, 2020, the company reiterated that the merger agreement “was in the best interest of the company.” Additionally: “The company, with Centerbridge’s support, seeks to invest in and further reinforce the company’s history of quality care with a focus on compassion and putting the person first.”¹⁶

Initiation of Committee Investigation – January 2019 Oregon Press Report

On January 10, 2019, an article was published in a major Oregon newspaper—*The Oregonian*—that detailed gruesome acts of neglect by MENTOR employees at a 24-hour residential facility (Park Place Home) in Brookings, a small community located along Oregon’s southern Pacific coast.¹⁷ According to investigative documents obtained by the media outlet and provided to Committee staff, the neglectful incidents concerned an individual (AV, or alleged victim) who was non-verbal and began experiencing pain from developing pressure sores in early June 2017.¹⁸ The pain persisted, sufficient medical records and logs were not maintained, appointments were missed, and AV’s infected area only became worse. A subsequent pressure sore developed in September 2017 and appropriate steps were not taken. Once the problem was reported to the local oversight entity—the county-level Community Developmental Disabilities Program, or CDDP—and following an initial visit by AV to the Curry General Hospital Emergency Department on October 7, 2017, the client was ultimately transferred to Good Samaritan Regional Medical Center in Corvallis, Oregon (five days later on October 12) because of the level of medical care AV required.¹⁹ Good Samaritan is located 240 miles north, nearly five hours away. Following AV’s release from the hospital, AV was placed into an adult foster home after being removed from the care of MENTOR Oregon.²⁰

Both the CDDP investigative report and accompanying forensic medical opinion noted careless missteps throughout 2017, ultimately resulting in six substantiated allegations of neglect levied on the facility in Brookings and five company staff members, as detailed by Curry County’s CDDP, Community Living Case Management (CLCM).²¹ These neglectful acts were followed by licensing actions issued by the State Office of Developmental Disabilities Services

FY 2018 10-K document illustrated, the company’s share of the national I/DD market of services remains small, though the Community Support Services (CSS) division comprised a significant share of its net revenue.

¹⁶ See Appendix C, Item 1, pp. 3–4.

¹⁷ Zarkhin, Fedor. “Neglect victim smelled of ‘rotting flesh,’ state finds, shuttering home for people with disabilities,” *The Oregonian*, January 10, 2019, [LINK](#).

¹⁸ “Curry County CDDP Abuse Investigation Report, OAAPI Case Number: DD170850, Finalized: May 1, 2018, p. 15. See Appendix C, Item 2. *Note: Committee staff received permission from Oregon DHS to make public (with appropriate redactions) documents originating with the State of Oregon.

¹⁹ *Ibid*, p. 18.

²⁰ *Ibid*, p. 24.

²¹ From an oversight standpoint, the State contracts with County CDDPs to regularly monitor providers as “boots on the ground” when issues arise (i.e. protective services investigations). As mentioned, CLCM is the oversight entity responsible for Coos, Curry, Douglas and Josephine counties.

(ODDS), the licensing unit within OR DHS. These licensing actions began in November 2017—which included a statewide “imposition of conditions” restricting admissions and transfers to any MENTOR Oregon 24-hour residential home without CDDP and ODDS approval—as CLCM’s protective services investigation was underway.^{22, 23} Following the CDDP investigative report, in June 2018, the statewide conditions were narrowed in scope to just the Park Place home, followed by an “intent to revoke” the license for the home on July 20, 2018.²⁴ The company voluntarily shut down the home on December 11, 2018.

Over the next two months (early 2019), two additional protective services investigations would commence: another in Brookings (Cypress House) and the other in Klamath Falls. Following these two incidents, statewide impositions of conditions were re-issued by the State once more.²⁵ It was during this timeframe that *The Oregonian* piece was published, sparking the Finance Committee’s bipartisan inquiry.

The company and its representatives responded to the Committee’s original letter (April 2nd letter) over the course of 2019 and 2020. On September 5, 2019, the company asked to narrow the scope of incident reports requested by the Committee—from all levels (totaling over 8,000 for Oregon) to only the most serious, Level IV reports—in addition to documentation demonstrating that all staff had completed required trainings. Committee staff agreed to pare back specific requests on a select basis, at the company’s request. These focused on mandatory reports concerning suspected abuse (e.g. Level IV incident reports) and detailed aspects about staffing and training at particular facilities. The company produced nine Level IV reports and the Committee reiterated it reserved the right to ask for additional reports on a case-by-case basis.²⁶

The ensuing sections of this report summarize the Committee’s findings from those document productions and responses.

MENTOR Oregon’s State Presence, Regulatory Structure and Enforcement Actions

The company has operated in Oregon since 2003, providing 24-hour residential group home services, supported living services and community living services from the start, with employment services beginning in 2014. Through 2018, its residential group homes were located

²² “Notice of Imposition of Conditions on Mentor Oregon’s 24 Hour Residential Endorsement,” Office of Developmental Disability Services (ODDS), Oregon Department of Human Services (OR DHS), November 21, 2017. See Appendix C, Item 3.

²³ A December 4, 2017 amended notice sent from OR DHS added “or transfers to” language to the notice sent November 21, 2017. See Appendix C, Item 4.

²⁴ “Notice of Intent to Revoke 24-Hour Residential License,” RE: Park Place Home, ODDS, OR DHS, July 20, 2018. See Appendix C, Item 5.

²⁵ See Appendix C, Items 6 and 7. Item 6 (January 17, 2019 Letter) shows OR DHS restricting admissions or transfers to Mentor Oregon 24-hour facilities in Curry County following the reported incident at Cypress House; Item 7 (February 15, 2019 Letter) shows the imposition of conditions expanding to include all counties in Oregon.

²⁶ After the company provided its document productions over the course of eight months, Committee staff submitted written follow-ups on January 28, 2020. MENTOR produced follow-up responses starting February 28 through October. The large majority of these follow-ups sought further clarification, such as redacted addresses.

in the following counties: Multnomah, Marion, Douglas, Klamath, Curry and Deschutes (the principal towns being Portland, Gresham, Salem, Roseburg, Klamath Falls, Brookings, Gold Beach and Bend).²⁷ MENTOR Oregon has both a two-year agency certificate to perform supported living services, employment services and community living support services, as well as individual licenses for its 24-hour residential facilities. The current agency certificate expires June 30, 2022.²⁸

Many human services providers in Oregon directly contract with ODDS. According to the State, in September 2020, there were 410 Medicaid agencies certified to provide I/DD services, with 175 endorsed to provide 24-hour residential services.²⁹ As of January 2019, there were an estimated 861 group homes caring for individuals with intellectual or developmental disabilities across Oregon.³⁰ As of October 4, 2019, there were 3,349 beds in Oregon residential facilities for adults with I/DD; MENTOR Oregon clients occupied 1.85% of these beds (or 62 beds), a small figure taken together.³¹ However, it should be noted the company had a significantly larger presence in two sparsely populated counties, with MENTOR clients occupying (at the time) 83% of adult I/DD beds in Curry County and 75% of beds in Klamath County, both located in southern Oregon.³² As of October 9, 2020, the company serves 27 individuals in 11 group homes across the State.³³

Though its presence extended (at the time) from the State's largest metro areas to more rural communities on the coast, it's important to bear in mind the company's *share* of services offered in those regions. In rural areas, MENTOR Oregon has a disproportionate share of care. In response to the State's review of MENTOR's I/DD programs, in December 2019, MENTOR proposed to close its 24-hour homes and reduce other programs in the north portion of Oregon, notably in Multnomah and Marion counties, underscoring its emphasis on rural areas of the state.³⁴ MENTOR reports that it is currently executing that plan.³⁵

As mentioned, ODDS is the primary regulator of MENTOR's activities and licenses. After being issued a license for a new group home, OR DHS conducts an initial (unannounced) 120-day review, then an unannounced review at least once during the two-year window of the license. In addition, the County CDDP conducts other reviews (both scheduled and not scheduled) during the year, including investigations when incidents arise. This underscores an important point: the actions taken by ODDS are, in part, *dependent* on the oversight conducted by the CDDPs.

²⁷ MENTOR Oregon began consolidating its statewide footprint in 2019 and through 2020, in which it closed its 24-hour residential facilities in Multnomah and Marion counties.

²⁸ "Agency Certificate – Developmental Disability Services," National Mentor Services, LLC Db a Mentor Oregon, June 30, 2020 – June 30, 2022. See Appendix C, Item 8. Note: this certificate was amended in October 2020.

²⁹ September 30, 2020 Oregon DHS Responses to Committee Staff.

³⁰ See Zarkhin, Fedor (Footnote 17).

³¹ "Bed Capacity in Oregon," OR DHS Email to Committee Staff on October 4, 2019. See Appendix C, Item 9.

³² Ibid, "Bed Capacity in Oregon."

³³ October 9, 2020 Email from MENTOR Oregon to Committee Staff.

³⁴ "Settlement Agreement Updates and Footprint Evaluation," Letter from MENTOR Oregon to OR DHS, December 30, 2019. Note: this document was also revised on February 7, 2020. Both documents are included in Appendix C, Item 10.

³⁵ Confirmed by the company in an October 9, 2020 Email to Committee Staff.

Below is a timeline of key events and State enforcement actions regarding MENTOR Oregon I/DD facilities stemming from the incidents described above in Brookings (Park Place and Cypress House) as well as Klamath Falls, prior to the Finance Committee investigation:

- **November 21, 2017:** Restriction of admissions for all 24-hour residential homes operated by MENTOR Oregon following the Curry County incident, which was reported in the January 2019 *Oregonian* article (Park Place Home).
- **December 2017:** Amended imposition of conditions (adding “transfers to”).
- **January 2018:** Second amended imposition of conditions, narrowing the scope to specific counties (Coos, Curry, Klamath and Douglas).
- **February 2018:** Park Place Home in Brookings is now empty (no staff or clients).
- **April 2018:** OR DHS removes license conditions on Mentor Oregon’s Medicaid Agency Certificate Endorsement.
- **June 1, 2018:** OR DHS informs MENTOR Oregon of six substantiations of neglect following the CDDP abuse investigation concerning Park Place Home.³⁶
- **June 4, 2018:** Imposition of conditions on Park Place (No admissions/transfers):³⁷
 - 24-Hour Residential Facility License revised to reflect this;
 - “Reliable evidence of abuse, neglect or exploitation by Mentor Oregon...”;
 - “Mentor Oregon neglected the care of a resident, resulting in hospitalization for medical treatment, constituting abuse under ORS 430.735 (1)(e) and (10)(c).”
- **July 20, 2018:** Notice of “Intent to Revoke” the license for Park Place Home.
- **July 31, 2018:** Assessment of civil penalties, totaling \$6,000.
- **December 11, 2018:** Park Place Home voluntarily shut down by MENTOR Oregon.
- **January 7, 2019:** Signed incident report involving two additional Curry County clients (Cypress House).
- **January 10, 2019:** News report published in *The Oregonian*.
- **January 17, 2019:** Re-imposition of conditions on the company in Curry County.

³⁶ “Notice of Substantiated Outcome and Right to a Review,” Letter to MENTOR Oregon from the Office of Adult Abuse Prevention and Investigations (OAAPI), OR DHS, OAAPI Case #DD170850, June 1, 2018. See Appendix C, Item 11.

³⁷ “Notice of Imposition of Conditions on Mentor Oregon’s 24 Hour Residential License,” RE: Park Place Home, ODDS, OR DHS, June 4, 2018. See Appendix C, Item 12.

- **February 15, 2019:** Expanded imposition of conditions to cover all counties in Oregon, following the death in Klamath County on February 12, 2019.

On January 17, 2019, ODDS issued an imposition of conditions restricting admissions and transfers into MENTOR Oregon 24-hour residential facilities in Curry County.³⁸ Following a death of a MENTOR client in Klamath Falls in February 2019—coupled with a statewide review by case management entities for company violations—the State imposed even further restrictions on the company, expanding the Curry County restrictions to all counties in Oregon where it provided services.³⁹

According to a special division investigation (February 19, 2019) conducted by the Klamath County CDDP, MENTOR Oregon reported that on February 12, 2019, an alleged victim (AV) passed away at Sky Lakes Medical Center ICU following a massive stroke just days before, which subsequently led to pneumonia (later re-diagnosed as a fatal stroke).⁴⁰ The investigator noted “there is no reason to believe that Mentor OR staff neglected AV; therefore, the allegation is **Not Substantiated**.” [emphasis in original]⁴¹ The company was notified of this decision on April 22, 2019, about three weeks after the Finance Committee sent its letter.⁴²

Committee staff followed up on an item noted in investigative interviews carried out by Klamath County CDDP concerning the February 2019 death. AV visited her doctor every six months for check-ups, with the last one taking place about three months before her death. Though no new medications were prescribed, the investigator noted that “Mentor was unable to find a summary of this visit [November 12, 2018] for review.”⁴³ Given the detailed account of irregularities of AV’s breathing in the hours before her stroke, Committee staff further inquired about the missing document concerning her last medical visit. In response, the company stated it is required to keep summaries of medical appointments on file and to date it is “unable to locate documentation of AV’s last check-up prior to her death.”⁴⁴

Cypress House

Regarding the other two clients referenced in the Committee’s April 2nd letter, the company indicated that it reported to the Curry County CDDP—on January 4, 2019—that “two individuals living in a 24-hour residential group home did not receive timely and appropriate hygiene care.”⁴⁵ According to the incident report, the two individuals noted with hygiene issues were located at Cypress House in Brookings. The first client had experienced neglect for a long

³⁸ See Appendix C, Item 6.

³⁹ See Appendix C, Item 7.

⁴⁰ “Special Division Investigation (SDI), Klamath County CDDP Abuse Investigation Report,” SDI 19004, February 19, 2019. See Appendix C, Item 13.

⁴¹ Ibid, p. 7.

⁴² “Notice of Final Outcome,” Office of Training, Investigations & Safety (OTIS), OTIS Case No.: SDI 19004, April 22, 2019. See Appendix C, Item 14. MENTOROR Bates 1308.

⁴³ See Appendix C, Item 13, p. 5.

⁴⁴ “March 13, 2020 MENTOR Oregon Follow-up Responses to Committee Staff,” Appendix A, p. 2. See Appendix C, Item 15.

⁴⁵ “April 30, 2019 MENTOR Oregon Production to Committee Staff,” Appendix A, pp. 2–3. See Appendix C, Item 16.

period of time, resulting in a host of personal hygiene issues, as observed by a staffer who noted these on their first day at the home:

On 12/30/18: Staff 1 reported for her first day at this home and she was advised to look at the books and was not assigned to provide direct care on this date. Staff 1 went to wake up Person Served 1 at 10am and reported his shin was red and indented. Person Served 1 is quadriplegic and Staff 1 told Staff 3 that he needs pillows between legs. She also alleged that his diaper wasn't put on properly and he smelled very badly. Staff 1 reported she saw him trying to itch under arms and Staff 1 reports that the buildup under his arms was as thick as cottage cheese. Staff 3 said, "I think he should have had a shower yesterday but because it is such a pain in the butt and a big job he probably didn't." Staff 3 got a wash cloth and wiped out his arm pits. She alleged on this date Person Served 1 was never repositioned in bed, his clothes were sideways, and he never had his teeth brushed. Staff 1 stated that Staff 3 told Staff 1 that Person Served 1 only showers every 4 days. Staff 1 reported this to Staff 2. Staff 2 stated he is supposed to shower every other day but because they are short staffed they can't shower him so it equates to every 4 days.⁴⁶

The incident report went on to detail how the second individual was neglected in the same home, in which the client was left on the toilet for a long period of time and later taken to the shower by a staff member:

Staff 1 also reported Person Served 2 was left on toilet for 30 minutes, and when she was helped up her bottom was very red [redacted]. [Redacted], Staff 2 put Person Served 2 in the shower [redacted].⁴⁷

Further reading with respect to the personal hygiene care received by these clients follows in this report.

Problems Persist

Near the end of the Committee's investigation in September 2020, Committee staff learned new information regarding Cypress House in Brookings. A CDDP investigation report dated May 15, 2020 (finalized July 17, 2020) substantiated neglect involving direct care staff assigned to the home. In this case, AV was a 65-year-old female requiring "24 hour a day assistance in all aspects of her life;"⁴⁸ she also had a history of "stimming," a common term for repetitive behavior, which sometimes involves "self-injurious behaviors such as picking of the skin and self-hitting."⁴⁹ According to the civil penalty letter:

⁴⁶ "Level 3 Incident Report," The Mentor Network, Cypress House, Incident Date: December 30, 2018, Signed Date: January 7, 2019, p. 1. See Appendix C, Item 17.

⁴⁷ Ibid, p. 2.

⁴⁸ "Curry County CDDP Abuse Investigation Report," OTIS Case Number: DD 200113, RE: Cypress House, May 15, 2020, Finalized Date: July 17, 2020, p. 3. See Appendix C, Item 18.

⁴⁹ "Notice of Assessment of Civil Penalty and Notice of Opportunity for a Hearing," Case Number: DD200113, Cypress House, August 20, 2020, p. 3. See Appendix C, Item 19.

AP falsified his/her T-logs regarding AV's condition and activities on the evening of this incident. AP's T-log stated AV was resting in his/her recliner when AV had clearly been left in his/her kitchen chair for roughly two to three hours, based on statements from multiple staff.

During that time in AV's dinner chair, AV sustained bruising to his/her back, although it is unclear exactly how, and injury to AV's face as a result of his/her "stimming," or self-injurious behavior (SIB), which AV is prone to engage in. AV engaged in stimming behavior while left unattended in his/her dinner chair, and she was found with blood on his/her hands, face and shirt by a staff.

AP admitted he/she left AV in the kitchen chair for 2 to 3 hours, likely causing the bruising marks on AV's back.

AP failed to provide the care and supervision necessary to keep AV safe, resulting in physical harm to AV.⁵⁰

One of the core issues Committee staff has with this incident is that the direct care staff—hired after the improved training regimen was implemented—falsified T-log entries regarding AV's condition and even denied neglecting AV, even after admitting the client was left in her kitchen chair for nearly three hours. Dinner for AV began at 5:00pm; the shift notes at 7:48pm state: "[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."⁵¹ Unfortunately, when the next staffer arrived for their shift at 8:00pm, AV was still found in her kitchen chair—with bruise marks on her back and scratches on her face.

The company put the neglectful direct care staff on administrative leave the very next morning.⁵² But again, a larger issue remains. This act of neglect did not take place due to understaffing, or because there were too many clients to take care of at the same time. This was pure neglect, as the relief staff found the accused staffer on the computer in a separate room, allegedly unaware of the blood on AV.

Three Strikes at Cypress House

On October 26, 2020, just weeks before concluding its investigation, Committee staff were made aware of more recent licensing actions taken by the State involving Cypress House. On October 6th, the State licensing office (ODDS) received an email complaint from one of the parents of an adult client at the facility; this parent identified concerns about their adult child not being taken to medical appointments, medications being missed and a general lack of care. Over the next several days, ODDS sent a licensing team to the facility to investigate. ODDS noted seven violations in its report.

⁵⁰ Ibid.

⁵¹ See Appendix C, Item 18, p. 4.

⁵² Ibid, p. 3.

The State determined that multiple licensing actions needed to be taken. First, new statewide conditions on MENTOR Oregon 24-hour facilities were imposed in a letter mailed October 15, 2020.^{53, 54} Additionally, ODDS sent the company a revocation letter with the State's intent to close Cypress House.⁵⁵ Following receipt of these notices, MENTOR Oregon indicated its intention to voluntarily give up its license for the facility.

Committee staff further learned there were four clients residing at the facility at the time. According to the State, the local CDDP (CLCM in this case) has successfully worked with the individuals impacted by these recent actions to find them new providers. As of October 27, 2020, CLCM has found placements for all four individuals, with all having moved out of the facility except for one, who was scheduled to move the first week of November. Once the last client has been moved, the facility will close.

Below is a timeline highlighting key licensing actions taken this year by the State:

- **February 21, 2020:** OR DHS lifts statewide imposition of conditions on MENTOR Oregon following an August 2019 settlement agreement and subsequent commitments made by the company (discussed in more detail in this report).
- **May 15, 2020:** CDDP abuse investigation begins regarding a neglect allegation concerning staff at Cypress House.
- **June 30, 2020:** OR DHS issues new 2-year certificate to MENTOR Oregon.
- **July 17, 2020:** CDDP investigation finalized with a neglect allegation substantiated.
- **August 20, 2020:** OR DHS issues a \$500 civil penalty for finding of substantiated neglect at Cypress House.
- **October 7–9, 2020:** ODDS licensing staff conduct an onsite complaint review visit at Cypress House and found the facility out of compliance with multiple rules.
- **October 15, 2020:** Notice of “Intent to Revoke” the license for Cypress House sent by OR DHS, the second such notice for this facility in the last 17 months.⁵⁶
- **October 15, 2020 Part II:** The State also amended MENTOR Oregon’s 2-year certificate by imposing statewide conditions on the company’s 24-hour residential facilities.⁵⁷

⁵³ “Notice of Conditions Order on 24 Hour Residential Endorsement & Right to Request a Hearing,” ODDS, OR DHS, October 15, 2020. See Appendix C, Item 20.

⁵⁴ These statewide conditions are like those imposed in late 2017 as well as February 2019.

⁵⁵ “Intent to Revoke License & Right to Request a Hearing,” RE: Cypress House; ODDS, OR DHS, October 15, 2020. See Appendix C, Item 21.

⁵⁶ The first “intent to revoke” came on May 22, 2019, following the substantiated neglect concerning the hygiene issues (Please see Appendix A). As mentioned earlier, the company voluntarily agreed to close this facility in an October 20, 2020 letter.

⁵⁷ Printed on the revised certificate: “Restriction of Admissions: No admissions or transfers into Mentor Oregon’s 24-Hour Residential homes without ODDS and CME prior written approval.

Results from Licensing Reviews and Assessments

In response to the Committee's inquiry, the company provided licensing reviews, incident reports and investigative reports of suspected abuse or neglect (authored by CDDPs). These assessments covered reviews and incidents from January 1, 2013 to April 2, 2019, the date kick-starting the Committee's investigation into MENTOR Oregon. There were scores of homes not found in substantial compliance; other assessments showed many properties in compliance at various points throughout the six-year period. The most common violations observed: physicians' orders not being followed; missed medications; lack of training; incident reports not being completed; unsafe objects not being locked or stored properly, in addition to others.

Of the documents produced, several onsite reviews and associated incidents stood out. Committee staff organized them by topic while also noting corresponding dates, addresses and additional context where necessary to help fill in the gaps.

→ Insufficient Training

Multnomah County

On January 25, 2017, the MENTOR Oregon Program Director for Multnomah County raised concerns about the actions of fellow staffer, Staff C, alleging she "involuntarily secluded AV by locking AV's [wheelchair] brakes..." in the sensory room.⁵⁸ Following a CDDP abuse investigation, the allegations of involuntary seclusion were inconclusive; county investigators were unable to definitively say *who* locked AV's brakes. However, it's clear from the report that AV was unable to lock them independently.

Additional findings in the CDDP report with respect to staff trainings caught the attention of Committee staff. In one staff interview, when asked if another staffer trained them on sensory room use, the individual responded: "there is no training provided on the sensory room use, staff are able to use it however they want."⁵⁹ In Staff C's interview, she said "maybe she [Staff C] locked the brakes and ran to get another client." An additional staffer was asked about being trained on when to lock the brakes on wheelchairs; this individual was trained to lock the brakes only when transferring a client, but not at other times. However, this training did not take place at MENTOR Oregon, as it had been "pushed back due to being short staffed."⁶⁰

There are normally 12 clients at this location with six staff present, though at the time of the investigator's staff interviews there were four staff present at the facility. The company's response to this incident underscores this Multnomah location as a day program, meaning the minimum required staffing ratio (per OAR 411-066-0020(6)(d)) is one staff for six clients. In this case, there were two staff for the approximately 12 clients served. The company emphasized the CDDP report "makes no finding that staffing was insufficient on the day of the incident."

⁵⁸ "Multnomah County CDDP Abuse Investigation Report," OAAPI Case Number: DD170047, Assigned: January 31, 2017, Finalized: June 6, 2017, p. 1. See Appendix C, Item 22. MENTOROR Bates 4336-4341.

⁵⁹ Ibid, p. 2.

⁶⁰ Ibid, p. 3.

Indeed, this looks to be the case, as the CDDP report notes how two staff were present at the site during the incident. However, the investigator *did* say: "...though the possibility exists that Staff C may have set the brakes in an attempt to address her client responsibilities at hand, with only two staff at the site. If that were to have happened, the act would constitute involuntary seclusion, as the act would have been for the convenience of the caregiver."⁶¹ But, since the investigator could not say with certainty why AV's brakes were locked, they could not substantiate the allegations of involuntary seclusion. Further, it seems that two staff onsite the day of the incident (though meeting the statute) were not sufficient to meet the needs of all clients. It's also noteworthy that a training *specifically geared* for appropriate wheelchair brake use kept getting postponed due to staff shortages.

Notable Staff Trainings

In addition to providing licensing reviews, the company also produced specific training certification documents for a handful of MENTOR Oregon staff. The company only produced training documents for MENTOR Oregon employees involved in the incidents cited in the Committee's April 2, 2019 letter (with nearly all of the documents focused on staff involved with the incident in Brookings). Some observations during the course of review:

- **Staff 1** completed "skin integrity" training in December 2015.⁶² In addition, Staff 1 passed mandatory abuse report trainings on multiple occasions in 2016 and 2017 (scoring 90–99.25% on her tests).⁶³ As noted from the CDDP investigation involving Park Place, Staff 1 was the Program Coordinator assigned to Park Place as a client's bedsore (which began in June 2017) worsened over the course of the summer, yet the client's condition went unreported to the CDDP case manager. When asked if the Program Director at the time, Staff 3, had trained her as Program Coordinator, Staff 1 stated how she "didn't get any training as she has been doing this [...] type of work forever."⁶⁴ Staff 1 transitioned from being Program Coordinator at Park Place in mid-September 2017 after being *promoted* to Program Director—at the same time a second bedsore was intensifying for AV.⁶⁵
- **Staff 2** was hired by MENTOR Oregon on August 2, 2016. He acknowledged his mandatory abuse reporter responsibilities the same day. During the year of AV's bedsore condition, he was retrained on mandatory abuse reporting as recently as October 24, 2017.⁶⁶ During the onboarding process, Staff 1 checked his references, signed off on his orientation checklist and certified his ISP (individual service plan) training was

⁶¹ Ibid, p. 5.

⁶² "Staff Training Report – Skin Integrity," Staff 1, December 4, 2015. See Appendix C, Item 23. MENTOROR Bates 4000-4002.

⁶³ Select Mandatory Abuse Reporting Training Documents for [Staff 1] in 2016–2017. See Appendix C, Item 24. MENTOROR Bates 4213-4224.

⁶⁴ See Appendix C, Item 2, p. 8.

⁶⁵ See Appendix C, Item 2, p. 4.

⁶⁶ Select Training Documents for Staff 2 for 2016–2017 (including Mandatory Abuse Reporting & Acknowledgement), p. 6. See Appendix C, Item 25. MENTOROR Bates 3790-3798.

complete.⁶⁷ Staff 2 relieved Staff 1 in mid-September 2017 as Program Coordinator at Park Place, just days before the most recent bedsore (at the time) was reported by another staff member.⁶⁸ According to the CDDP report, Staff 2 often remarked how AV was “too much of a hassle” and “too much work to care for.”⁶⁹ The investigator concluded that Staff 2 “was assigned this position with little to no training or oversight from Mentor management.”⁷⁰

Committee staff also asked the company to confirm that Staff 1 was the acting house manager at Cypress House (in late 2018) when the aforementioned incident involving two clients was reported, following her stint as Program Coordinator at Park Place (in which allegations of her neglecting a client were substantiated). The company confirmed this, though emphasizing how Staff 1 “had limited involvement in the incident or the events that precipitated it, and thus it was not appropriate to terminate her.” In fact, MENTOR Oregon found the Park Place incident “principally attributable to policy violations by [Staff 2].”

At the time the incident was reported (October 4, 2017), Staff 2 was the house manager. His new role at Park Place began September 16, 2017. However, the first known documentation of AV’s subsequent bedsore occurred on September 16 or 17 (depending on which document one references), while also indicating “it had been present previous to this but with no documentation.”⁷¹ In fact, the associated CDDP report describes how home health charts and clinical notes indicate “a previous XXX dating 6/14/17 thru 8/1/17,” though “CDDP was never notified of this incident, nor were any incident reports written by Mentor.”⁷² When Staff 1—the former Program Coordinator—was asked why an incident report had not been completed for this bedsore from the summer, Staff 1 replied, “she didn’t know she was supposed to.”⁷³

Furthermore, a forensic medical opinion was conducted, noting that “AV first developed pressure sores to AV’s sacral region in early June 2017,”⁷⁴ which involved “numerous daily dressing changes by facility staff.”⁷⁵ Even though the client did not have “the ability to verbalize if AV were experiencing pain,” the doctor believed AV “had to have been experiencing significant pain in June-July.”⁷⁶ In the doctor’s opinion, “[Staff 1] and [Staff 3]’s failure to create a Turn Schedule placed AV at risk for physical harm which eventually resulted in physical harm.”⁷⁷

⁶⁷ “ISP Training, Reference Checks and Orientation Checklist for Staff 2,” 2016. See Appendix C, Item 26. MENTOROR Bates 3823-3835.

⁶⁸ See Appendix C, Item 2, p. 12.

⁶⁹ Ibid, pp. 7 and 20.

⁷⁰ Ibid, p. 20.

⁷¹ Ibid, p. 3.

⁷² Ibid.

⁷³ Ibid, p. 8.

⁷⁴ Ibid, p. 15.

⁷⁵ Ibid, p. 17.

⁷⁶ Ibid, p. 15.

⁷⁷ Ibid, p. 16.

In a medical service review completed August 29, 2017 by Staff 1, it noted that AV had bedsores; under the section titled “Notes/Concerns/Need,” Staff 1 wrote: “meds.”⁷⁸ And on September 15, 2017, her last day as house manager at Park Place, “[Staff 1] stated there was a reddish area that looked like start of sore.”⁷⁹ This is the date Curry CDDP officials discovered there was a previous bedsore that went unreported to them.

- At the time of the Park Place incident, **Staff 3** was Program Director for MENTOR’s group homes in Curry County. The company provided training documents completed by Staff 3 dating back to 2011. As far back as March 2012—and reaffirmed multiple times thereafter—Staff 3 was trained on mandatory abuse reporting for adults with developmental disabilities.⁸⁰ Her signature acknowledged that she understood the State of Oregon’s mandatory abuse reporting requirements. When notified by email on September 25, 2017 about the condition of AV’s bedsore, she took no further action to notify her superiors.

Staff 3 further acknowledged that she was responsible for training the program coordinators (which did not take place on a sufficient basis, given the investigator’s interview with Staff 1, and the actions taken by Staff 2). Staff 3 offered no answer when asked why no documentation was provided to the CDDP regarding the bedsore until *after* the company was informed of the neglect investigation.⁸¹ The investigator also showed Staff 3 an incident report (written in early October, after the company had been notified), which stated, “The sore was healing remarkably well,” and included Staff 3’s signature approving the document.⁸² Staff 3 realized the error in her assessment after being shown photos by the investigator of AV’s bedsore from October 2–6, and from when AV arrived in the hospital in Corvallis.⁸³

- **Staff 4**, the Regional Administrator for MENTOR Oregon in Curry County at the time, began her tenure with the company in June 2009. Her first mandatory abuse reporting training dates back to the same month.⁸⁴ As she rose in the company, she also trained many employees, including Staff 5, the staff member who first alerted Staff 4 and Staff 3 to AV’s bedsore condition at Park Place. Staff 4 was copied on the same email from Staff 5 in September 2017, and like Staff 3, took no further action, including keeping the current Program Coordinator (Staff 2) at Park Place, even though she was aware of his mistakes. When interviewed by the investigator, she remarked: “In hindsight, we could have done things differently.”⁸⁵

⁷⁸ Ibid.

⁷⁹ Ibid, p. 10.

⁸⁰ “Mandatory Abuse Reporting Training & Acknowledgement by [Staff 3],” MENTOR Oregon, March 26, 2012. See Appendix C, Item 27. MENTOROR Bates 4063-4066.

⁸¹ See Appendix C, Item 2, p. 9.

⁸² Ibid.

⁸³ Ibid.

⁸⁴ “Mandatory Abuse Reporting Training & Acknowledgement by [Staff 4],” MENTOR Oregon, June 22, 2009. See Appendix C, Item 28. MENTOROR Bates 3672.

⁸⁵ See Appendix C, Item 2, p. 24.

Lack of training, Lack of action

On January 17, 2019—less than three months before the Finance Committee opened its investigation into MENTOR Oregon and REM Iowa—“Staff 1” at Orenda Home did not change a client at midnight (after being notified by the client).⁸⁶ Staff 1 was placed on leave pending the outcome of the investigation.

According to the abuse report, AV is wheelchair-bound and must be transferred via Hoyer lift. When the client notified Staff 1, the staffer “looked at AV and acted like they didn’t hear him. AV asked again, and the staff member just walked away.”⁸⁷ There was no record of Staff 1 being trained on what to do if a client voided themselves, according to the CDDP report.⁸⁸ In the interview, AV was asked to rate the pain from the incident on a 1-10 scale. AV indicated an 11.⁸⁹ Three pressure sores were open and bleeding; AV ended up going to the urgent care after a (second) 3:00pm skin check the day following the incident.

Staff 1, who had been a DSP at Mentor for six months remarked, “Mentor provides training on documentation, but not on how to serve the clients.”⁹⁰ Additional shift notes by Staff 1 the night of the incident detail how “[s]taff was unable to clean person because they could not lift him and clean him alone.”⁹¹ Upon reviewing AV’s ISP, it was noted that a “full assist,” meaning one person can complete it alone, was applicable to changing AV’s briefs. In the report’s “Recommended Actions,” the investigator concludes:

*It is recommended that all Mentor staff, to include [Staff 1] if he remains with Mentor, be trained on how and when to change an individual in a timely and safe manner after the individual has voided themselves. Although it is naturally expected of a paid caregiver to know how and when to change an individual, and to do so in a timely and safe manner, it can be speculated that there is room for error if a staff member doesn’t know how to change an individual.*⁹²

The neglect allegation was substantiated. According to the company, Staff 1 “was terminated in connection with this incident on April 30, 2019.” When Staff 1 was asked if he felt like he neglected the care of AV, he noted how “it was out of his control, but that in a way yes.”⁹³ W2 (also interviewed), who started her shift at Orenda Home the following morning and gave AV a bed bath with another staffer, remarked how Staff 1 was playing video games when she arrived the morning of January 18, 2019.

⁸⁶ “Level 3 Incident Report, Orenda Home,” MENTOR Oregon, Incident Date: January 17, 2019, Signed Date: January 18, 2019, p. 1. See Appendix C, Item 29. MENTOROR Bates 4792-94.

⁸⁷ “Klamath County Abuse Investigation Report,” OTIS Case Number: DD190063, Investigation Assigned: January 31, 2019, p. 2. See Appendix C, Item 30. MENTOROR Bates 4795-4802.

⁸⁸ Ibid, p. 3.

⁸⁹ Ibid.

⁹⁰ Ibid.

⁹¹ Ibid, p. 4.

⁹² Ibid, p. 7.

⁹³ Ibid, p. 4.

This would not be the last time Orenda Home would attract attention from County or State officials. On June 30, 2019, the *Herald & News* published an additional piece on MENTOR Oregon, this time noting two additional closures in Klamath Falls. One of them was Orenda Home. In discussions with local officials earlier that month, Committee staff learned that Orenda Home was in the process of being shut down, largely due to client pressure wounds and a severe lack of training on the part of staff.

On May 1, 2019, the State issued a “Notice of Intent to Revoke” for the license of the facility.⁹⁴ This stemmed from a 120-day licensing review conducted on December 21, 2018 and a follow-up onsite review on February 21, 2019. As the article mentioned, “records show state regulators found no documentation of mandatory care and abuse training, background checks or job contracts for 15 to 25 caretakers.”⁹⁵ Eight specific violations (by subject matter) were outlined, with the specific issues being quite numerous, including ongoing concerns and new problems arising in the follow-up review. Orenda Home closed on June 24, 2019.

In discussions with Committee staff, local officials in Klamath could see the writing on the wall, even as new staff were brought on prior to the closure. One remarked, “They were bringing people in I *knew* weren’t trained to do it—and I couldn’t stop them.” In fact, County-level officials only get to see the new training documents during an investigation. In those instances, it’s already too late.

Hoyer Lift incident in Klamath Falls (Patterson Home)

On December 21, 2018, a MENTOR staffer neglected the care of a client “when AV fell out of her Hoyer lift while being transferred to her wheelchair, which resulted in AV breaking her right leg.”⁹⁶ The accused staffer was set to go through Hoyer lift training...on December 24, three days after the incident. This staffer told investigators “it was possible that no staff in the house had received Hoyer lift training.”⁹⁷ Indeed, the investigator did not find any Hoyer training records prior to December 24. AV was subsequently transported to the ER and required surgery to repair the lower leg fractures. Following the substantiated finding, a \$500 civil penalty was assessed by ODDS on May 3, 2019; it was paid by the company on May 10, 2019, the same day Yvette Doan, MENTOR Oregon’s Executive Director, was let go.

Previous Issue with Lift Platform

This was not the first time staff associated with the Patterson Home had issues with lifts. Following an incident in August 2013, a January 2014 abuse investigation substantiated a neglect allegation in which AV was wheeled out the back of a transport van while the lift platform was

⁹⁴ “Notice of Intent to Revoke License,” RE: Orenda Home, Klamath Falls, ODDS, OR DHS, May 1, 2019, p. 2. See Appendix C, Item 31.

⁹⁵ Novotny, Tess. “Mentor Oregon: A failure in care,” *Herald & News*, June 30, 2019, [LINK](#).

⁹⁶ “Klamath County CDDP Abuse Investigation Report,” OTIS Case Number: DD180987, Klamath County Developmental Disabilities, Assigned: December 28, 2018, p. 1. See Appendix C, Item 32. MENTOROR Bates 4744-4751.

⁹⁷ *Ibid*, p. 3.

still on the ground. The accused staff was sincere about the lapse in judgment. After wheeling the client to the rear of the van and onto the threshold warning plate, the internal alarm system failed to activate, thereby not warning staff that the lift was still lowered. When the van was taken for an inspection in January 2014, it was revealed the lift had not been serviced in 18 months—putting the last service in July 2012, more than a year prior to the incident. Another witness interviewed noted the alarm is intermittent, though they did not report this malfunction to their supervisor.⁹⁸

Patterson Home Shut Down

On May 31, 2019, ODDS sent MENTOR Oregon an “order of immediate suspension” regarding the Patterson facility in Klamath Falls.⁹⁹ This followed a May 22, 2019 on-site review and was the other notable facility referenced in the June 2019 *Herald & News* report. A range of deficiencies were documented in the State’s 27-page letter. In discussions with County officials in early June 2019, they notably referenced the January 2019 Hoyer Lift incident and the associated lack of training and lack of healthcare provided. When issues are pointed out to MENTOR, they said, “company officials rush to fix it...give it a couple months and we’re back at it again.” The county cannot take further action beyond the State (i.e. ODDS). In the case of the Patterson facility, the clients being served had to start all over again with a support network, being relocated outside of Klamath County (to Douglas and Curry counties). These were high medical needs individuals, requiring an intimate support network to ensure their needs were met.

→ Neglectful Acts

Declining Personal Hygiene

As mentioned earlier, two clients were neglected at Cypress House in Brookings, launching a CDDP investigation in January 2019.¹⁰⁰ Both required incredible amounts of assistance for their daily needs: one was confined to his wheelchair or bed at all times (being quadriplegic) and the second (after being treated with substandard hygiene care during a trip to the restroom) was unable to provide a statement to the local investigator, due to her I/DD condition. If it weren’t for the fortuitous visit by a different MENTOR Oregon employee not normally assigned to work at the facility, their conditions likely would have gone unreported.

The ensuing investigation by the Curry County CDDP substantiated neglectful acts against Cypress House, leading the State to propose revoking the company’s license for the

⁹⁸ “Abuse Investigation and Protective Services Report,” OAAPI Investigation Report Number: DO131018, Klamath County Department of Mental Health, January 30, 2014, p. 5. See Appendix C, Item 33.

⁹⁹ “Order of Immediate Suspension – 24 Hour Residential License,” RE: Patterson, Klamath Falls, ODDS, OR DHS, May 31, 2019. See Appendix C, Item 34.

¹⁰⁰ “Curry CDDP Abuse Investigation Report,” OTIS Case Number: DD190022, Community Living Case Management, RE: Mentor Cypress House, Assigned: January 14, 2019, Finalized: May 16, 2019. See Appendix C, Item 35. MENTOROR Bates 4812–4823

facility in May 2019.¹⁰¹ A few weeks later, in June 2019, the company requested a hearing to challenge the findings and argue their case. An Administrative Law Judge (ALJ) ultimately sided with MENTOR Oregon in a final order issued in January 2020, reversing the May 2019 neglect findings. In response to Committee staff on February 28, 2020, the company noted, “Cypress House is in full compliance and its license is in good standing.” A longer description of the neglectful hygiene care reported in January 2019 and the subsequent legal battle described above follows in the report’s first appendix.

However, as this report also details, in May 2020, a new allegation of neglect was reported at Cypress House and substantiated in the resulting investigation. On August 20, 2020, the State issued a civil penalty to MENTOR Oregon because of this finding.

Client Soaked in Wet Clothing

In late December 2017, a Level III incident report was filed in Curry County documenting an adult foster home client being left in wet clothing, causing a rash while attending a MENTOR Oregon vocational center/retirement center during the day.^{102, 103} This finding was substantiated by the Curry County CDDP. The investigative report noted the alleged victim was brought back from the MENTOR facility “soaked in urine on at least two occasions” while in the care of the same staffer.¹⁰⁴ This staffer was also supervising two other clients the day of the incident, but could not be reached for comment by the investigator since he left his job at the company and did not return phone calls.

Wrongful Restraint^{105, 106}

On November 29, 2017, it was alleged Staff L, a MENTOR Oregon direct support professional (DSP), wrongfully restrained a client by wrapping the blanket too tight while the client was in bed, thereby restricting movement so the client couldn’t sit up. The following allegations were substantiated following investigation: wrongful restraint; involuntary seclusion; neglect.¹⁰⁷ MENTOR Oregon placed Staff L on administrative leave pending the investigation’s outcome.

¹⁰¹ “Intent to Revoke License & Right to Request a Hearing,” RE: Cypress House, Brookings, Office of Developmental Disability Services, Oregon Department of Human Services, May 22, 2019. See Appendix C, Item 36. MENTOROR Bates 4804–4811

¹⁰² “Level 3 Incident Report,” RE: DSA – CURRY, The MENTOR Network, December 26, 2017. See Appendix C, Item 37. MENTOROR Bates 4383–4385

¹⁰³ “Curry County CDDP Abuse Investigation Report,” OAAPI Case Number: 180029, Community Living Case Management. See Appendix C, Item 38. MENTOROR Bates 4386–4387

¹⁰⁴ Ibid, p. 2.

¹⁰⁵ “Level 3 Incident Report,” RE: Glenwood Home, The MENTOR Network, Incident Date: November 29, 2017, Signed Date: December 3, 2017. See Appendix C, Item 39. MENTOROR Bates 4443–4445

¹⁰⁶ “Klamath County CDDP Abuse Investigation Report,” OAAPI Case Number: DD171042, Klamath County Developmental Disabilities, Investigation Assigned: December 5, 2017. See Appendix C, Item 40. MENTOROR Bates 4446–4456

¹⁰⁷ Ibid, pp. 9–11. Note: allegations of verbal and physical abuse were inconclusive.

According to staff interviews, the morning following the incident in question, one staff overheard Staff L remark to AV: “You know bud, if you don’t stop I’m going to put you back in bed like I did yesterday.”¹⁰⁸ This staff feared retaliation from Staff L. Another staffer summarized that “[Staff L] would push the boundaries of right and wrong. At times, his handling of AV would seem rough.”¹⁰⁹ This staffer also felt the blanket issue went “way above and beyond.” Per the company, Staff L was terminated on December 28, 2017 for substantiated allegations of abuse.

Lack of Supervision

On April 2, 2018 in Curry County, an investigation was initiated regarding a March 28th outing in which one staff took four clients into the community on an errand, due to another staffer calling in sick. Though staff said they did not neglect the care of the individuals, per se, the investigation concluded: “Based on the information obtained, there was no possible way for W1 to provide the proper care and supervision...considering W1 was also responsible for XXX other consumers requiring the same levels of staff supervision on this community outing. Additionally, W1 suffered an injury on the outing, making W1 responsibilities even more challenging, and with no other assistance available to W1 at that time.”¹¹⁰ It was alleged that Staff 4, the same MENTOR Oregon Area Director noted in the Park Place incident, neglected all four clients by failing to provide appropriate staffing and supervision. In her interview, “[Staff 4] did not state exactly how 1 staff W1 was supposed to deal with the XXX consumers, but did state that W1 knew them and how to handle them.”¹¹¹

It’s important to bear in mind all four clients were “not independent in the community due to health and safety reasons,” yet when “W1 spoke to management regarding W1 concerns about having too many consumers with high tier risks...W1 was instructed by Area Director [Staff 4], through W2, to take the group on the outing anyway.”¹¹² Staff 4 confirmed this.¹¹³ Three of the four allegations were substantiated. A \$1,500 penalty was levied June 27, 2018 and it was paid by the company on September 17, 2018.

Neglect in Marion County

The case begins on November 2, 2018 with the mother and older brother of a client (PBS-1) taking PBS-1 home with them from the MENTOR Oregon facility as they viewed the

¹⁰⁸ Ibid, p. 4.

¹⁰⁹ Ibid, p. 5.

¹¹⁰ “Curry County CDDP Abuse Investigation Report,” OAAPI Case Number: DD180254,” Incident Date: March 28, 2018, Investigation Assigned: April 2, 2018, p. 4. See Appendix C, Item 41. MENTOROR Bates 4779–4784.

¹¹¹ Ibid, p. 3.

¹¹² Ibid, p. 4.

¹¹³ Ibid, p. 3.

residence as too dangerous.¹¹⁴ When AV's family arrived, program staff refused to send along AV's medications or belongings with the family. An allegation of neglect was substantiated.¹¹⁵

AV said MENTOR Staff D was not nice to AV and calls AV names. AV stated that they did not want to go back to that house ever again. AV further stated how staff would purposefully not let AV nap; AV had personal belongings disappear, would not get spending money, and staff would not take AV to the doctor after complaining of chest and ear pain. According to the one of the witnesses interviewed as part of the investigation, Staff D routinely dismissed AV's complaints of pain or other medical issues.¹¹⁶

Three other staff interviewed said the home was fine and didn't relay negative feelings about Staff D. However, other staff seemed to confirm AV's anecdotes. Per W7: it would be "detrimental to the residential program to have [Staff D] come back as House Manager." Though AV did ultimately receive medical care, Staff D attempted to stand in the way of these appointments by telling AV they weren't necessary.¹¹⁷ Additionally, Staff D directed all support staff to follow what she said and to "disregard the behavior support plan."¹¹⁸ Staff D believed it was wrong and needed an update, but that never happened.

Staff D maintained she did nothing wrong. She denied ever yelling at clients in the home and repeatedly notes that AV's BSP stated to wait two days before seeking medical attention after hearing a complaint from AV. The CDDP investigator noted the interviews and available documentation support the lack of medical follow-up. A routine visit to AV's primary care physician led to a referral to a cardiologist, who "strongly recommended AV have surgical repair due to the seriousness of the condition."¹¹⁹ The October 31, 2018 visit further documents that the home was required to notify the cardiology office of "any worsening or new symptoms."

Again, according to witnesses, Staff D stated "AV was just engaging in medical attention-seeking behavior, and to disregard AV's complaints." Though Staff D noted the two-day window in AV's safety plan, the *same* safety plan notes how "in the event of a medical emergency, staff will immediately call 911 and provide emergency first aid." One example listed was "chest pains."¹²⁰ The investigator concluded "[Staff D] failed to provide these supports as well as she directed her Staff to not follow established protocol, resulting in a significant risk of physical and emotional harm."¹²¹ MENTOR Oregon terminated Staff D on March 20, 2019 after learning the results of the CDDP investigation.

¹¹⁴ "Level 2 Incident Report," RE: Doris Home, The MENTOR Network, Signed Date: November 12, 2018, p. 1. See Appendix C, Item 42. MENTOROR Bates 4669-4670.

¹¹⁵ "Marion County CDDP Abuse Investigation Report," OTIS Case Number: DD180879, Marion County Health and Human Services, Assigned: November 13, 2018, Finalized: February 26, 2019, p. 1. See Appendix C, Item 43. MENTOROR Bates 4671-4680.

¹¹⁶ *Ibid*, p. 2.

¹¹⁷ *Ibid*, p. 4.

¹¹⁸ *Ibid*.

¹¹⁹ *Ibid*, p. 7.

¹²⁰ *Ibid*, p. 8.

¹²¹ *Ibid*.

→ Missing or Incomplete Incident Reports

NE Multnomah County, Portland

A facility in Northeast Multnomah County stood out more than most. In the reviews provided for 2013–2016, this facility had compliance issues across the board. Not only were conditions in the home less than satisfactory, but issues with one client became so troubled that they resulted in a transfer. A long list of problems was evident from the multiple onsite reviews, though the failure to complete incident reports was the most noticeable.

Following a September 2013 onsite review, an October 2013 document noted the following deficiencies: physician’s orders not being followed;¹²² four staff not being trained on physical intervention training, given the behaviors displayed by several individuals in the home;¹²³ and GERs/IRs not completed following emergency room visits.¹²⁴ Two years later, findings from October 2015 based on an August 2015 onsite visit found five out of nine staff not receiving all required trainings, including core competency trainings required within the first three months of being hired;¹²⁵ eight out of nine staff were not trained on the home’s emergency plan.¹²⁶ Additionally, behavior support plans¹²⁷ and individual support plans¹²⁸ were not fully implemented, documented, or followed.

April 2016 Findings, following a March 10, 2016 onsite review—due to a complaint

The complaint was based on “several protective services investigations at the program since September 2015 that involved the lack of supervision, power struggles and not administering medications as ordered.”¹²⁹ Physician’s orders were not followed for five out of five individuals;¹³⁰ GERs were not completed as required for three of five individuals sampled.¹³¹ These GERs did not include appropriate follow-up measures to prevent the following from reoccurring:

- Roughhousing turning into an altercation between housemates;
- Injury due to name calling turned into attempted choking;

¹²² “Findings: September 25, 2013 Onsite Review for [NE Multnomah County], Portland,” Office of Licensing and Regulatory Oversight, OR DHS, pp. 1–4. Appendix C, Item 44. MENTOROR Bates 2644–2647.

¹²³ Ibid, pp. 7–8. MENTOROR Bates 2658–59.

¹²⁴ Ibid, pp. 5–6. Note: GER stands for “general event report,” similar to an incident report, or IR. MENTOROR Bates 2650–51.

¹²⁵ “Findings: August 19, 2015 Onsite Review for [NE Multnomah County], Portland,” Office of Licensing and Regulatory Oversight, Oregon Department of Human Services. See Appendix C, Item 45. MENTOROR Bates 1737–1738.

¹²⁶ Ibid, See Appendix C, Item 46, p. 1. MENTOROR Bates 1748.

¹²⁷ Ibid, pp. 4–5. MENTOROR Bates 1751–1752.

¹²⁸ Ibid, pp. 7–14. MENTOROR Bates 1754–1761.

¹²⁹ “Findings: March 10, 2016 Onsite Review for [NE Multnomah County], Portland,” Office of Licensing and Regulatory Oversight, Oregon Department of Human Services. See Appendix C, Item 47, p. 1. MENTOROR Bates 2221.

¹³⁰ Ibid, p. 3. MENTOROR Bates 2223.

¹³¹ Ibid, p. 6. MENTOROR Bates 2226.

- Lack of supervision by staff;
- Repeated medication errors by staff;
- Additional occurrences of assault between housemates (clients).¹³²

Issues involving incident or general event reports were not limited to just these. Seven incident reports “addressing physical aggression, facility destruction and medication errors” were not sent to Multnomah CDDP within five business days as required.¹³³ In addition, incident reports from September 2015 illustrated how staff left knives unlocked, resulting in one of the clients threatening to do self-harm when left unsupervised (September 7); one week later, another staff member was verbally aggressive to the same client, which caused the client to be physically aggressive toward staff in return (September 16).¹³⁴

In response to GERs not being completed, the Program Director and Area Director retrained staff from March to April 2016, addressing staff intervention, behavioral support plans (BSPs), individual support plans (ISPs), and properly dispensing medications and supervision requirements for each client. Similarly, retraining took place on how to keep sharp objects locked (the verbally aggressive staff member was no longer employed with the company). Bear in mind: these trainings took place *after* an onsite licensing review occurred, prompted by a complaint.

This March 2016 onsite review noted additional line-of-sight and behavioral support issues dating back to late 2015/early 2016. On December 29, 2015, one client was left unsupervised and began choking another client.¹³⁵ In January 2016, the same client was “roughhousing with a housemate and then got slapped, punched holes in the wall and doors, broke a chair, attempted suicide and went AWOL resulting in arrest.”¹³⁶ The review found that a “refresher training on supervision levels for all staff” would take place by March 10, 2016, though that training did not take place prior to the onsite review.

In theory, incidents like those listed above should *decrease* in frequency following a jam-packed series of trainings, which followed the March 10, 2016 onsite review. They did not. In five additional onsite reviews taking place May–December 2016, the facility in NE Multnomah County was not in substantial compliance four out of five times, with plans of improvement (POI) required for deficiencies in each case: more missed medications; additional physical altercations; more verbal abuse; incident reports not completed in a timely manner; broken items in many rooms.

This facility later came to the attention of Committee staff in subsequent reviews of company documents, though these interviews were focused on a separate series of incidents at the Alameda Home based in Klamath Falls. A more detailed narrative of the events surrounding Alameda Home follows in Appendix A.

¹³² Ibid. MENTOROR Bates 2226.

¹³³ Ibid, p. 9. MENTOROR Bates 2229.

¹³⁴ Ibid. MENTOROR Bates 2229.

¹³⁵ Ibid, p. 10. MENTOROR Bates 2230.

¹³⁶ Ibid. MENTOROR Bates 2230.

October 2016: Notice of Intent to Revoke

On October 26, 2016, ODDS sent MENTOR Oregon a letter noting its intent to revoke the license for the NE Multnomah County facility.¹³⁷ The 20-page letter outlined abundant violations as previously described. Of particular note to Committee staff:

- May 4, 2016: P4 (client) was “admitted to the hospital on a psychiatric hold. No corresponding incident report was found for P4 being admitted.”¹³⁸
- August 30, 2016: P4 went to the emergency room. “No documentation was found that immediate notifications were made.”¹³⁹
- September 22, 2016: Documentation showed P2 (different client) went to the emergency room, “however, no documentation was found that indicated when P2 went to the emergency room and no documentation was found that immediate notifications were made.”¹⁴⁰

In addition to other violations identified, it is troubling that basic notification and documentation of clients being admitted to the hospital emergency room did not take place.

February 2017: Settlement Agreement

On February 23, 2017, the company and the State entered into an agreement regarding ODDS licensing actions involving this facility.¹⁴¹ In the agreement, MENTOR Oregon agreed to 1) Have all Doctor’s orders entered into client record via Therap; 2) QI (Quality Improvement) or Director-level Operations staff will be assigned as compliance mentor to the 116th Group Home; 3) Withdraw request for a Contested Case Hearing; 4) Implement New Leader On-boarding training within the first 90 days of employment.¹⁴² In addition to withdrawing the “intent to revoke,” the State maintained it would conduct “unannounced monitoring visits until the next licensing renewal in October 2019.”¹⁴³ MENTOR Oregon voluntarily closed this home on June 29, 2019.¹⁴⁴

→ Not Meeting Clients’ Medical Needs

Park Place Home, Brookings

¹³⁷ “Notice of Intent to Revoke 24-Hour Residential License,” RE: [NE Multnomah County], Portland, ODDS, OR DHS, October 26, 2016. See Appendix C, Item 48.

¹³⁸ Ibid, p. 10.

¹³⁹ Ibid.

¹⁴⁰ Ibid. pp. 10–11.

¹⁴¹ “Stipulated Final Order and Settlement Agreement,” RE: [NE Multnomah County], Portland, ODDS, OR DHS, February 23, 2017. See Appendix C, Item 49.

¹⁴² Ibid, p. 4.

¹⁴³ Ibid.

¹⁴⁴ “June 12, 2020 Follow-up Responses from MENTOR Oregon to Committee Staff,” Appendix A, p. 4. See Appendix C, Item 50.

This is the same facility featured in the January 2019 *Oregonian* article. Back in May 2015, the facility was found to be in substantial compliance by ODDS, though it needed to submit a plan of improvement for the “deficiencies found during the review.”¹⁴⁵ Among those identified: staff not ensuring health/medical concerns of clients are being met, including not consistently taking client’s blood pressure,¹⁴⁶ nor administering a client’s dehydration protocol.¹⁴⁷

Following a review in October 2014 (prompted by a complaint),¹⁴⁸ key issues were substantiated: consistent staff shortages; required trainings not being completed; and individual health care needs of clients not being met.¹⁴⁹ Additional details revealed:

- P1’s weight loss protocol was not being followed throughout the summer of 2014, having lost 23 pounds over a 1-month period (June–July) with no weight measurements recorded in August.¹⁵⁰ An incident report wasn’t written until late September on the matter.
- Several dates in which contract requirements for staff ratios in the home were not met.¹⁵¹

The home was in substantial compliance back in August 2013, though it was not in substantial compliance following an earlier review in April that same year. Similar issues were noted:

- Physicians’ orders not being implemented, including weighing P1 once per month instead of twice per week;¹⁵²
- Emergency preparedness plans did not include information pertaining to the health needs (i.e. allergies, dietary restrictions, physical limitations) of individuals living in the home;¹⁵³
- Individual support plan needs not being met: documentation, activity tracking.¹⁵⁴

→ Poor Facility Conditions

White Home, Klamath Falls

¹⁴⁵ “Findings: May 6, 2015 and October 29, 2014 Onsite Reviews of National Mentor Services, LLC Db a Mentor Oregon, 24-Hour program,” RE: Park Place Home, Office of Licensing and Regulatory Oversight, OR DHS, p. 1. See Appendix C, Item 51. MENTOROR Bates 1993-2017.

¹⁴⁶ Ibid, p. 2. MENTOROR Bates 1994.

¹⁴⁷ Ibid, p. 3. MENTOROR Bates 1995.

¹⁴⁸ Ibid, p. 13. MENTOROR Bates 2005.

¹⁴⁹ Ibid, pp. 20–25. MENTOROR Bates 2012–2017.

¹⁵⁰ Ibid, p. 23. MENTOROR Bates 2015.

¹⁵¹ Ibid, pp. 24 – 25. MENTOROR Bates 2016–2017.

¹⁵² “Findings: April 24, 2013 Onsite Review of National Mentor Services, LLC Db a Mentor Oregon, 24-Hour program located at [XXX] in Brookings, Oregon,” April 26, 2013, Office of Licensing and Regulatory Oversight, Oregon Department of Human Services. See Appendix C, Item 52, pp. 1 – 3. MENTOROR Bates 2775-2777

¹⁵³ Ibid, pp. 6–7. MENTOROR Bates 2780–2781.

¹⁵⁴ Ibid, pp. 11–14. MENTOROR Bates 2785–2788.

Both properties were “not in substantial compliance,” dating back to September 2015.¹⁵⁵ All seven staff did not have sufficient training/knowledge of individual support plans (ISPs). Quarterly fire drills were not taking place for all four quarters of 2013, Q1 2014 and Q4 2015.¹⁵⁶ Scores of items needing documentation were not completed, ranging from maintaining an accurate ledger of expenses to items necessary for a client’s behavioral support plan (BSP). Moreover, the poor physical conditions of the properties stood out: a missing toilet seat lid; shower handle broken/missing; dirty/rusted stove with broken coil; open trash containers and flies found in food storage room.¹⁵⁷

These two properties closed in November 2018, according to the revised spreadsheet provided by the company. In follow-up responses to Committee staff, MENTOR Oregon clarified that the closure took place “so that it could be converted into four supported living apartments where residents require less than 24-hour care.”¹⁵⁸

April 2019 News Report

These reviews dovetailed with a news report (April 17, 2019) by the *Herald & News* in which Klamath County officials took action and broke two long-term leases with MENTOR Oregon.¹⁵⁹ Committee staff confirmed the leases were the properties at White Home (technically, one lease for two duplexes, converted from the previous residential home). Local officials recently toured the facilities and decided to act. ‘Absolutely appalling’ living conditions were observed: “...not only does it look horrible, it’s not livable in some situations, yet they have people living in it.”¹⁶⁰ According to a Klamath County Commissioner: “I think Mentor Oregon has totally let our citizens and the people that live in Klamath County down.”

Since MENTOR Oregon is the largest provider of residential services in Klamath County, this created a tension. Phillip Squibb, the former Developmental Disabilities Director for Klamath County, said that, given Klamath Falls is a small community in rural Oregon, it cannot simply kick out a bad actor without adverse consequences: “If I am just chucking everybody out and not trying to collaborate and work with folks, am I ultimately doing a disservice to our people?”¹⁶¹

According to the news report, Klamath officials “agreed to pursue a mutual termination agreement with the company” and would “take over individual leases for the three Mentor clients who live in the properties.” The clients included a mother and her two young children (ages 1

¹⁵⁵ “Not in substantial compliance” is shorthand for: “It was determined your program was not in substantial compliance with the Oregon Administrative Rules, Chapter 411, Division 325, 24-Hour Residential Settings for Children and Adults with Intellectual or Developmental Disabilities.”

¹⁵⁶ “Findings: September 23, 2015 Onsite Review on National Mentor Services, LLC Dba Mentor Oregon, 24-Hour program located at [XXX], Klamath Falls, Oregon,” October 9, 2015, Office of Licensing and Regulatory Oversight, OR DHS. See Appendix C, Item 53, pp. 5–6. MENTOROR Bates 2156–2157.

¹⁵⁷ *Ibid*, pp. 1–2. MENTOROR Bates 2152–2153.

¹⁵⁸ See Appendix C, Item 50, p. 3.

¹⁵⁹ Novotny, Tess. “Mentor Oregon: County to terminate lease for ‘appalling’ conditions at homes for people with disabilities,” *Herald and News*, April 17, 2019, [LINK](#).

¹⁶⁰ *Ibid*, April 17, 2019 *Herald and News* article.

¹⁶¹ *Ibid*, April 17, 2019 *Herald and News* article.

and 3 at the time). The properties had one staff serving 8–9 individuals. Following the County’s actions in April, the lease for White Home remained until July 1, 2019.

→ Additional Allegations

Unsanitary Practices

DSP Staff L was cited in an incident report at the Logan Home in Klamath County; it was alleged Staff L urinated in a cup while standing in the kitchen. This separately occurred while Staff L sat a desk (the cups were later sanitized by the house manager). These events took place July 11, 2018. An internal supervisor (Program Director) was verbally informed two days later (July 13) and senior MENTOR supervisors were later informed via email on September 12, two months later.¹⁶² The Klamath CDDP was not informed until August 31.

Three allegations of neglect were investigated: one focused on Staff L, and two regarding MENTOR Oregon supervisors for failing to report the incident to the county office. In interviews, one witness had been told that Staff L was “not very mobile, and not able to get up off of the floor.” They were also told Staff L had been “taking water pills and instead of going to the bathroom when he needs to go, he peed in cups instead in the kitchen because he couldn’t make it to the bathroom.”¹⁶³

According to the report, the house manager at Logan Home, who had been with the company for 10 years, “did not feel like [Staff L] was intentionally trying to do anything that would put any of the clients at risk...Unfortunately, [Staff L] exercised bad judgement.”¹⁶⁴ The manager logged these performance issues in a separate document, noting the actions “could have potentially been neglectful, if someone were to have fallen ill...” However inappropriate, she felt “she did not neglect the clients in the home, as she took care of it by washing the cups and doing [Document 2] with [Staff L].”

All three allegations of neglect were not substantiated, as “no serious physical injury or emotional harm befell AV (or anyone else).”¹⁶⁵ However, the CDDP report did note that Staff L was placed on administrative leave on October 23, 2018 for not changing a client when asked to do so.¹⁶⁶ He was terminated October 25. According to the company, “[Staff L] was terminated based on the results of an internal investigation regarding his conduct, which found that he had failed to adequately serve individuals in his care and had potentially falsified documentation.”¹⁶⁷

¹⁶² “Level 2 Incident Report,” RE: Logan, Klamath Falls, The MENTOR Network, Incident Date: July 11, 2018, Signed Date: September 12, 2018, p. 1. See Appendix C, Item 54. MENTOROR Bates 4717-4720.

¹⁶³ “Klamath County CDDP Abuse Investigation Report,” OTIS Case Number: DD180831, Klamath County Developmental Disabilities, Assigned: October 25, 2018. See Appendix C, Item 55, p. 3. MENTOROR Bates: 4721-4729.

¹⁶⁴ Ibid, p. 6. MENTOROR Bates 4726.

¹⁶⁵ Ibid, p. 8. MENTOROR Bates 4728.

¹⁶⁶ Ibid, p. 7. MENTOROR Bates 4727.

¹⁶⁷ See Appendix C, Item 50, p. 17, “June 12, 2020 Follow-up Responses.”

Facilities Providing 24/7 Care

As part of its productions to the Committee, the company provided a spreadsheet in response to the original letter asking for locations and addresses of all MENTOR Oregon 24-hour facilities. The company's written response: "a spreadsheet identifying the locations and addresses of **all** 24-hour residential group homes for individuals with [I/DD] operated by MENTOR Oregon since January 2013."¹⁶⁸ [emphasis added] The initial response failed to achieve this.¹⁶⁹ In fact, the facility in Brookings that prompted the public reporting of MENTOR Oregon's shortcomings was not listed.¹⁷⁰

The Park Place Home in Brookings was later added in an amended version of the spreadsheet, noting its closure in December 2018. However, a few additional facilities were noted in the licensing reviews provided for 2013–2016, yet were not listed on the amended spreadsheet sent to Committee staff. Furthermore, the document indicated that a handful of facilities had closed since 2013, but did not state the reasons why. Follow-up questions were sent to ensure the Committee had a complete record of all 24-hour facilities in the state. Follow-up responses arrived in June 2020, filling numerous gaps regarding closures and address discrepancies, though key issues remained and are detailed in the section that follows.

Given the Finance Committee's jurisdiction over the federal Medicaid program, one of its objectives was to assess whether MENTOR Oregon was being a good steward of the Medicaid revenue it received from the care being provided at its facilities. Financial data was requested for each of the MENTOR Oregon homes. As a point of reference, in 2018, MENTOR Oregon's 24-hour group homes treating adults with I/DD brought in \$7,770,494.24 from Medicaid.¹⁷¹

Reasons for Facility Closures Not Tracked

Committee staff asked for information on the status of all MENTOR Oregon I/DD facilities, particularly the reason for the closure of 12 facilities identified by the company in its own spreadsheet. The company wrote that it "does not track the varying reasons in a centralized way."¹⁷² In short, the company has no central tracking system for the reasons its 24-hour group homes closed over the years. Ultimately, explanations for closures were offered for eight out of 12 facilities. This matter is further discussed in Appendix A of the report.

¹⁶⁸ See Appendix C, Item 16, p. 4, "April 30, 2019 MENTOR Oregon Production, Appendix A."

¹⁶⁹ The company amended this spreadsheet multiple times over the course of the investigation. It was more complete than the first submission and it included the total amount of money each facility received in Medicaid reimbursements for each calendar year requested by Committee staff, in addition to the numbers of clients served and staff assigned to each facility throughout each calendar year requested (2013–2018).

¹⁷⁰ "April 30, 2019 MENTOR Oregon Production to Committee Staff," Response to Request 5, Spreadsheet located at MENTOROR Bates 1316.

¹⁷¹ Committee Staff calculation based on the company's submission in it May 17, 2019 Production (Spreadsheet located at MENTOROR Bates 3428). *To be clear, one facility included in calculations provided 24-hour supported living services, not 24-7 residential services.

¹⁷² Other challenges identified by the company regarding the closures: data that may not be captured in available documentation, or the data being "extremely time-consuming and burdensome to locate."

Clients Served, Staff to Client Ratios

The Committee's original request asked MENTOR to provide a comprehensive list of its facilities including the number of clients served and staff to client ratios. MENTOR Oregon stated its 24-hour residential group homes are "staffed to meet or exceed the staffing requirements set forth in state regulations."¹⁷³ To be specific, a home with five or fewer individuals must have at least one staff member present. The company also reiterated that a home must meet staffing requirements as contractually outlined in a client's ISP. Hence, staffing requirements could be higher than 1 to 5 in residential group homes. MENTOR Oregon also noted that its residences providing supported living services are "not subject to state regulations prescribing minimum staffing ratios;" instead, these staffing requirements are determined by ISPs, along with individual needs determined by state- or county-authorized funding levels.¹⁷⁴

Amended versions of the list of facilities also showed the number of clients served and staff employed at each facility by calendar year. Committee staff appreciated the revised spreadsheet with additional data points included, though questions remained regarding a few facility closures.

List of Staff/Tenures/Subject of Investigation

The original April 2019 letter asked for the names of employees holding specific positions at each residential facility since 2013, including their tenures in their current positions and with the company overall. Staff also asked if any of these former or current employees had been the subject of an alleged abuse/neglect investigation as well as confirming each employee passed a comprehensive background check prior to their hire date. Findings from the company's response:

- 26 residential employees were the subject of an external investigation into alleged abuse or neglect since January 1, 2013. Ten of those individuals had substantiated findings and are no longer employed by the company. These included Staff 3, Staff 1, Staff 2 and Staff 4 from the substantiated neglect at Park Place in 2017.
- With the exception of two employees (both no longer employed by MENTOR Oregon), MENTOR located documentation confirming those who have been a subject of an abuse or neglect investigation passed a CRIMS background check prior to employment.
- All current employees on the spreadsheet also passed this background check.

However, Committee staff could not discern which position the employees most recently held, or if all employees were still employed by the company, or still worked at the assigned

¹⁷³ "October 8, 2019 MENTOR Oregon Production to Committee Staff," Appendix A, p. 2. See Appendix C, Item 56; *See also* OAR 411-325-0170.

¹⁷⁴ *Ibid*, Appendix C, Item 56, p. 2.

facility.¹⁷⁵ Consequently, additional employment and disciplinary actions may have been required or taken, which are not reported.

Settlement Agreement with the State of Oregon

On August 5, 2019, MENTOR Oregon reached a settlement with OR DHS in an effort to “resolve a statewide hold on referrals in its residential and supported living services,” per the updated imposition of conditions issued on February 15, 2019. As part of this settlement, the State agreed to lift its hold on the company starting February 21, 2020. In return, MENTOR Oregon had to make the following changes to its statewide operations:

- Hire and retain a registered nurse, and replace its current State Director and Quality Improvement Manager;
- Continue capital investments to improve living spaces;
- Establish a five-day new hire orientation before new staff begin direct service;
- Standardize employee information on a statewide basis;
- Convert MENTOR Oregon’s recordkeeping system to be more in line with those used by other ODDS licensed providers;
- Evaluate its “footprint,” in order to determine what geographic distribution of homes will maximize good management and improve compliance with rules and statutes.¹⁷⁶

Additionally, another provision instructed MENTOR Oregon managers across the state to meet with their “CME” (case management entity, in this case, the local CDDP) monthly “to review each individual served and to address supports and concerns.” Updates from these meetings would be relayed to the State. MENTOR Oregon further disclosed the recordkeeping system it would adopt would be Therap Electronic Health Record system.

On September 19, 2019, just weeks after the company entered the settlement agreement with the State, Committee staff had a phone call with OR DHS to discuss the terms of the agreement. The State iterated that should the company not make the necessary corrections outlined in the agreement (at the time), the conditions would be re-imposed. Moreover, the settlement formalized the process it was already engaged in; instead of a hearing, the company elected to go this route. When asked if the components of the agreement were primarily State-driven or pro-actively instituted by the company, OR DHS staff noted that the State was the primary driver of the settlement’s provisions.

When asked about the five-day new hire program, OR DHS remarked: “This is what we require of them.” With respect to recordkeeping: “Their [MENTOR] staff could literally not

¹⁷⁵ MENTOR Oregon listed the name of the home, staff first/last name, years of service with MENTOR, and years of service in their current position. However, MENTOR did not provide the address, city or county for the home aliases provided; which position (of the four requested) each employee held; “N/A” was indicated if the employee was not in their current position.

¹⁷⁶ “Stipulated Final Order, Settlement Agreement, and Withdrawal of Request for Hearing,” OAH Case Number: 2019-DHS-10161, Office of Administrative Hearings, Office of Developmental Disabilities Services, Oregon Department of Human Services. See Appendix C, Item 57. MENTOROR Bates 4280-4283.

access information;” “Frontline staff had no idea how to use their system.” Regarding the footprint evaluation, OR DHS staff remarked how things in Portland/Multnomah County were “going generally OK, but not in Southern Oregon.” They asked the company to look seriously at its system. State staff also mentioned how monthly meetings with the County-level case managers (the CDDPs) were occurring on a regular basis.

Footprint Evaluation Submitted

Committee staff were keenly interested in the footprint evaluation, which was to be submitted to OR DHS by December 31, 2019. Staff also inquired about the capital improvements, the five-day new hire orientation and other issues identified in the settlement. MENTOR Oregon’s initial submission arrived on time (December 30, 2019). An amended version was completed February 7, 2020 and the State removed the imposed conditions on the company, effective February 21, 2020.¹⁷⁷

Committee staff received the final February 7, 2020, footprint evaluation about a month after it was submitted (March 13, 2020), in addition to status updates on the settlement and answers to the Committee’s follow-ups. Since the bipartisan investigation began, this was the Finance Committee’s first look into the company’s future statewide plans.¹⁷⁸ MENTOR Oregon maintains it has “sole discretion over implementation of its plan,”¹⁷⁹ though some of those decisions (and future decisions), in part, depend on “discussions with County and state partners prior to execution.”¹⁸⁰ Those updates are summarized below.¹⁸¹

Capital Investments

The company is focusing on kitchen remodels, furniture replacement, and painting and deck remodels. Following reports of the closures in Klamath County and the alarming details about the interior conditions of the facility in NE Multnomah County in Portland, it is encouraging to see the company take these steps.

Five-day New Hire Orientation

In response to Committee staff, “All new employees working in 24-hour residential services and supported living services are now participating in the updated new hire orientation.”¹⁸² According to the company, this additional training goes “beyond what is required by the OARs.”¹⁸³ These new employees receive five days of in-classroom training in addition to

¹⁷⁷ “Letter to MENTOR Oregon re: Stipulated Final Order and Settlement Agreement,” Office of Developmental Disabilities Services, Oregon Department of Human Services, February 21, 2020. See Appendix C, Item 10, pp. 1–2. MENTOROR Bates 4857-4858.

¹⁷⁸ Ibid, Appendix C, Item 10, pp. 7 – 10, “Status of the Settlement Elements and the Evaluation of Mentor Oregon’s ‘footprint’ in the State,” February 7, 2020. MENTOROR Bates 4863-4866.

¹⁷⁹ See Appendix C, Item 15, p. 3.

¹⁸⁰ Ibid.

¹⁸¹ In late September 2020, both MENTOR Oregon and OR DHS confirmed there have been no changes or updates to the February 7, 2020 footprint document.

¹⁸² See Appendix C, Item 15, p. 3.

¹⁸³ Ibid.

five days of in-program training in the field, largely focused on specific schedules, emergency preparedness and other program-specific matters. Committee staff are pleased to see this incorporated into MENTOR Oregon’s training regimen, though are mindful of the numerous follow-up trainings undertaken by select facilities following complaints, license reviews and investigations over the past several years.

In responses to Committee staff, the company also emphasized how its updated new hire orientation was “initiated at the direction of the company.”¹⁸⁴ These responses arrived subsequent to the September 2019 call Committee staff had with OR DHS, in which the State iterated, “This is what we require of them.” Since the company’s responses differed from the State’s account, Committee staff followed up with the State to better understand how the ‘new hire curriculum’ came about. OR DHS maintains that, “Yes. They were told it needed to be developed based on [its] history of substantiated abuse findings identifying staff were not prepared to meet the needs of clients they were serving.”¹⁸⁵ The State also iterated how the company was responsible for the development of the curriculum and the length of the trainings, though the State specified what the trainings had to include.¹⁸⁶ In short, Committee staff do not dispute that this new training regimen goes beyond OAR requirements and that MENTOR Oregon designed the program. However, the Committee does take issue with the company’s characterization of how it originated.

Key Footprint Decisions

- The company plans to close all 24-hour licensed homes in the “North” by end of February 2020.¹⁸⁷
- Close Keizer DSA in Marion County; close Community Option DSA in Portland
- Maintain current services in Douglas and Klamath counties.
- Maintain all services in Curry County, except employment services,
- With the exception of Curry County (noted above), MENTOR Oregon intends to maintain all other employment services statewide and explore the potential for expansion of employment services in Marion County.¹⁸⁸
- MENTOR Oregon is “not planning expansion of its residential programs (group homes) for the foreseeable future.”¹⁸⁹

In addition, MENTOR Oregon was asked by the State to “comment on how this footprint will allow for enhanced communication of significant incidents and other concerns” to its top management.¹⁹⁰ The company stated: “Retraining on Incident Reporting and heads up notification process has occurred with all Program Supervisor staff and above.” The company

¹⁸⁴ Ibid, pp. 2–3.

¹⁸⁵ See Footnote 28. (September 30, 2020 OR DHS Responses)

¹⁸⁶ September 30, 2020 Call w/OR DHS.

¹⁸⁷ In September 25, 2020 written responses, the company confirmed all 24/7 residential homes in Multnomah and Marion counties are closed. OR DHS confirmed this as well, noting 12 homes have closed.

¹⁸⁸ On September 25, 2020 written responses, the company “continues to consider an expansion of employment services in Marion County...but has not finalized its plans.”

¹⁸⁹ See Appendix C, Item 10, p. 9. MENTOROR Bates 4865.

¹⁹⁰ Ibid.

also included an attachment of its incident reporting process currently in place. Other actions included:

- The MENTOR Oregon State Director scheduling weekly meetings with each Area Director to review any significant incidents;
- Each County CDDP agreed to continue monthly check-ins with the company;
- The new MENTOR Oregon registered nurse will review individual care in each 24-hour residential home at least every other month.

New State Directors

Yvette Doan was the State Director of MENTOR Oregon for nearly the entire period of incidents investigated by the Finance Committee (2013–2019). In most letters involving State licensing actions sent to the company, her name was at the top. Her tenure with the company dates back to 2003. Local officials described Ms. Doan as very nice, yet unassertive and unable to get her arms around staffing issues. In June 2019, Committee staff learned that Ms. Doan was let go by MENTOR Oregon on May 10, 2019, five weeks after the bipartisan Grassley/Wyden investigation began.¹⁹¹

Her replacement was named in late August 2019 as part of the settlement agreement with the State. The Committee first learned of the new state director (Kelli Houston) during a September 2019 phone call with OR DHS. Following the August 5, 2019, settlement, MENTOR Oregon promptly sent the Committee a copy of the agreement in early September, yet did not inform Committee staff of the new director.¹⁹²

Local Oregon officials had decent first impressions of Ms. Houston, but some still had reservations as more steps were needed to show meaningful progress. Other officials noted her lack of experience in the developmental disability space. Ms. Houston's time with the company did not last long. In March 2020, Committee staff learned that Ms. Houston decided to step down after just seven months as the company's top official in Oregon.¹⁹³ In the interim between executive directors, Stacey Risotti, Vice President of Operations for the Community Support Services (CSS) Operating Group in the Pacific region, filled in. According to The MENTOR Network's website, Ms. Risotti oversees human services operations in Arizona, California, Iowa, Missouri, Nevada and Oregon.

Duane Law is the current State Director of MENTOR Oregon. Committee staff first learned of the new director (and that a replacement for Ms. Houston had been hired) through

¹⁹¹ To be clear, the company did not relay this information to the Finance Committee in real time. Subsequent document productions indicated a change in state leadership indeed took place; the August 2019 settlement and the subsequent leadership chart made this clear. However, it wasn't until Committee staff directly asked the company in September 2020 that the company confirmed Ms. Doan's final date of employment.

¹⁹² On September 25, 2020, written responses, the company noted Ms. Houston's first day was August 19, 2019, two weeks after the settlement was signed.

¹⁹³ Committee staff learned this information informally in March 2020 (not in writing from the company), though not the reasons for her departure, nor about plans for Ms. Houston's replacement.

conversations with local Oregon officials in late summer 2020.¹⁹⁴ Mr. Law’s hire marked the third State Director of MENTOR Oregon since the Finance Committee investigation began.

From 2012–2015, Mr. Law was the CEO at the Kern Regional Center in Bakersfield, CA, a private, non-profit center that coordinated and funded services for adults and children with I/DD. In April 2014, a report brought to light how the Kern High School District (KHSD) investigated allegations that “without the district’s knowledge or consent, some of its special education employees used district vans and other resources to operate a private, for-profit business on the side.”¹⁹⁵ Specifically, KHSD investigated a company that “operated an after-school program for special education students through a contract with the Kern Regional Center;” the school district said the company on the side “used district facilities and vehicles in order to operate its business without providing any compensation or reimbursement to the district for the use of its facility and without obtaining any approval from the district’s board of trustees.”¹⁹⁶ In an emailed statement when this story ran, Mr. Law wrote, “We take seriously any expressed concerns regarding the individuals served through KRC and initiated an investigation into the history, services and community partnerships associated with this vendor.”¹⁹⁷ One year later, by a two-thirds affirmative vote, the Kern Regional Center’s board voted to terminate Mr. Law’s contract without cause during a May 2015 board meeting. Attendees from the community voiced that Law “lacks transparency and doesn’t have the disabled community’s best interest at heart.”¹⁹⁸

Additional Licensing Actions by the State

Though the State reached a settlement agreement with MENTOR Oregon in August 2019, ODDS still took licensing actions when the circumstances required it.

On September 25, 2019, following an on-site review from September 3rd—one month after the settlement agreement was reached—ODDS sent a letter to the company proposing to deny the license renewal for a second 24-hour facility located in Multnomah County. In a September 26 letter, nine separate violations were listed, including not completing incident reports at the time of (or immediately following) the incident (nine separate occurrences), failing to implement physician’s orders and not properly securing client medications. The civil penalty assessed was \$4,500 and the facility ultimately closed on December 4, 2019. When Committee staff asked MENTOR Oregon for the reason of the facility’s closure, it noted: “License not renewed.” It did not provide further details.

This was not an isolated action taken by OR DHS in September 2019. Additional action was taken regarding the license of a third facility in Multnomah County, this time for the Alder facility. Like the previous case, the State proposed to deny the license renewal for this home

¹⁹⁴ It wasn’t until September 2020 that Committee staff learned Mr. Law began working with the company in April.

¹⁹⁵ Edelhart, Courtenay. “KHSD investigating unauthorized use of resources,” *Bakersfield Californian*, April 25, 2014, [LINK](#).

¹⁹⁶ Ibid, Edelhart.

¹⁹⁷ Ibid, Edelhart.

¹⁹⁸ “Kern Regional Center fires CEO,” 23 ABC News | KERO, May 15, 2015, [LINK](#).

following an August 20 onsite review that noted five distinct violations (and \$2,500 in civil penalties). Notable in this set of violations: repeated failure to include follow-up actions (in an incident report) to prevent recurrence of the incident. In its letter to the company, ODDS included 18 distinct examples of incident reports where this did not happen from November 2018 through August 2019.¹⁹⁹

In its June 12, 2020 response to Committee staff describing the reason for the Alder facility's closure, the company cited its revised February 7, 2020, footprint analysis sent to the State, which noted that MENTOR Oregon planned to close all 24-hour licenses in the "North" (i.e. Multnomah County), clients were being transitioned out of Alder and that the facility was set to close December 19, 2019.²⁰⁰ It ended up closing March 5, 2020.²⁰¹ Following the August 2019 settlement agreement with the company, ODDS carried out the August 20th and September 3rd onsite reviews (and ensuing licensing actions) as the company crafted its footprint analysis due by year-end 2019. It's unclear whether these licensing actions played a role in the company's ultimate decision to close all 24-hour homes in Multnomah County.

Conclusion

As noted, near the end of the Committee's investigation in September 2020, Committee staff learned new information regarding Cypress House in Brookings, Oregon. A CDDP investigation began May 15, 2020 (and finalized July 17, 2020) substantiated neglect involving direct care staff assigned to the home. This was troubling for several reasons.

First, the incident and resulting CDDP investigation occurred following years of regulatory review of this specific facility, as well as MENTOR Oregon overall, as documented in this report. It occurred after MENTOR Oregon was back in good graces with OR DHS following its submission of a revised footprint evaluation, completion of a regulatory settlement, and the lifting of the statewide conditions on February 21, 2020. The direct care staff with the substantiated charge had only worked for the company since March 16, 2020. Supposedly, this staffer was trained on the five-day new hire orientation (required as part of the settlement) and was also trained on AV's ISP and care protocols. This was supposed to be a new day for the company, coming less than two months before the State was to issue, and did issue, a new two-year certificate, effective June 30, 2020. Yet, it appears to fit a pattern of substandard care by MENTOR in the State of Oregon.

Second, the civil penalty for substantiated neglect was issued by the State on August 20, 2020 and OR DHS confirmed the company paid the \$500 penalty. It's notable that the company did not choose to contest this substantiated finding and request a hearing like it did the year before. Does this signal a change in how the company and its new State Director approach these sorts of violations? Perhaps, though it's hard to say for certain, since the Committee's first

¹⁹⁹ "Notice of Assessment of Civil Penalty," RE: Alder, Portland, OR, Office of Developmental Disabilities Services, Oregon Department of Human Services, September 26, 2019, pp. 4–6. See Appendix C, Item 58.

²⁰⁰ See Appendix C, Item 10, p. 8. MENTOROR Bates 4864.

²⁰¹ See Appendix C, Item 50, p. 4.

update from the company about Duane Law's tenure came in brief, indirect references in a July 2, 2020 letter (three months after he assumed the role), in which his name did not appear in the letter, nor when he started with the company.^{202, 203} On July 9, 2020, just a week later, the company sent Committee staff a copy of the statewide leadership organization chart showing Kelli Houston as State Director.²⁰⁴ As recently as November 27, 2020, the MENTOR Oregon website still listed Ms. Houston as its State Director, eight months after she departed.

With respect to the May 8, 2020 incident at Cypress House, to be clear, it is more than troubling that a facility with this history, managed by a company with as much regulatory oversight as both have had, would experience an event like this at a critical time. When one further considers the fact that it occurred *after* the company reduced its operational footprint in the state, and *after* the company brought in new Oregon leadership, it is all the more concerning.

Since that time, the Committee has learned about the additional events that unfolded at Cypress House in the fall of 2020 (which the company has agreed to voluntarily close). Following its footprint evaluation this past winter, MENTOR Oregon made a conscious decision to keep this facility open. The result: the aforementioned events from May, an October complaint from a client's parent, and a subsequent October licensing review and revocation letter from ODDS, stating its intent to revoke the Cypress Home license as well as newly imposed statewide conditions on all 24-hour facilities operated by MENTOR Oregon.

Despite all the steps taken by the company over the past year, it is clear the company still has room for improvement. While the company would have Committee staff believe that the glass is half full and it is improving its performance, Committee staff must conclude otherwise.

²⁰² "Letter from MENTOR Oregon to Finance Committee Chairman and Ranking Member," July 2, 2020. See Appendix C, Item 59.

²⁰³ In September 25, 2020 written responses, when directly asked the question by Committee staff, the company indicated Mr. Law's start date was April 6, 2020.

²⁰⁴ "Oregon Organization Chart Structure 2020," The MENTOR Network. See Appendix C, Item 60. MENTOROR Bates 4867-4869.

Appendix A: Alameda Home and Cypress House

In the course of reviewing more than 5,000 pages of documents, two properties illustrated not only a series of issues and deficiencies, but the complex paths of the investigative and legal processes that followed. The two narratives below showcase insufficient training, neglect, poor facility conditions, and not meeting client medical needs, among others. The two properties: Alameda Home in Klamath Falls and Cypress House in Brookings.

Alameda Home

This narrative starts with the client (AV) allegedly neglected by MENTOR Oregon on May 22, 2017 in Klamath Falls, resulting in a substantiated finding by Klamath CDDP.²⁰⁵ However, the Alameda facility was not the client's first home with the company. AV previously resided in a Portland location from August 27, 2011 until November 2, 2016, before being transferred.²⁰⁶ That facility: the first NE Multnomah County facility, referenced earlier.

Portland to Klamath: November 2016

Before diving into the specific issues at the Klamath residence, the Klamath CDDP report notes how the Portland facility was issued a 'Notice of Intent to Revoke' regarding its 24-hour license on October 26, 2016.²⁰⁷ The reasons were numerous: physician's orders not followed; GER's not written when required; incident reports not completed; BSP incomplete, inaccurate and not followed; individual supports "not followed for all five clients resulting in protective service investigations..."²⁰⁸ To be clear, this client had a host of serious behavioral issues that required 1:1 staffing.²⁰⁹

On November 15, 2016, MENTOR Oregon staff in Portland were interviewed after it was alleged staff chased the client, "trying to drag AV to the bathroom and forcing AV into the shower XXX."²¹⁰ It's also reported staff yelled at AV and said, "Get in the damn shower. XXX. Get in the [expletive] shower."²¹¹ This series of incidents occurred September 2, 2016, according to the company. AV reportedly got away from staff and went outside. Once outside, staff reportedly "shut the patio door, XXX and hosed AV off in the back yard."²¹² The ensuing investigation substantiated abuse against staff for wrongful restraint (grabbing AV's arm and attempting to force AV to shower), verbal abuse (threats, profanity and humiliating the client by

²⁰⁵ Investigative documents associated with the onsite reviews at Alameda Home in Klamath Falls, OR. See Appendix C, Item 61. MENTOROR Bates 4461-4474. *For this reference: "Klamath County CDDP Abuse Investigation Report," OAAPI Case Number: SDI17011, Assigned: June 1, 2017, Finalized: August 8, 2017, pp. 5–14. MENTOROR Bates 4465-4474.

²⁰⁶ See Appendix C, Item 50, p. 9. "June 12, 2020 Mentor Oregon Follow-up Responses to Finance Committee."

²⁰⁷ See Appendix C, Item 61, p. 6. MENTOROR Bates 4466.

²⁰⁸ Ibid, p. 7. MENTOROR Bates 4467.

²⁰⁹ Ibid, p. 6. MENTOROR Bates 4466.

²¹⁰ Ibid, p. 10. MENTOROR Bates 4470.

²¹¹ Ibid. MENTOROR Bates 4470.

²¹² Ibid, p. 11. MENTOROR Bates 4471.

showering AV unclothed in the backyard) and involuntary seclusion (by placing restrictions on AV's access to the home). When interviewed, the staff member facing the allegations remarked, "No wonder there is so much turn over and when W5 came in W5 started firing everyone and I did see people who were abusive and malicious and just abusing the [clients]."213 According to the company, OR DHS ultimately lifted the "intent to revoke" notice after verifying the company was in compliance with "certain terms it identified in connection with the notice."214

Klamath Falls: March–April 2017

Staff (W1) was interviewed on March 22, 2017, as part of an investigation into AV not being administered medications at the Alameda facility. At the time of AV's transfer from Portland (early November 2016), AV had adequate medications. The facility subsequently ran out of them and AV did not receive the needed medication until December 21, 2016. In the interview, "W1 alleged that W2 had falsified the MAR (medication administration record) entries displaying the [medication 1] as having been dispensed, when it had not. W1 said W2's employment with Mentor Oregon was terminated as a result of the false entries."215

W2 was interviewed April 13, 2017. Both W2 and W1 were "tasked with establishing the group home at that location [797 S. Alameda]."216 From the investigative summary: AV "ran out of medications several weeks after AV arrived. W2 said W2 tried to get AV's prescription filled, but Mentor Oregon had demoted W2 to the position of direct care staff and W2 was no longer XXX. W2 said refilling prescriptions was the duty of the XXX and he no longer felt responsible for ensuring the client (AV) had adequate medications."217 Furthermore, W2 said W2 "did not sign the MAR indicating the [medication 1] was dispensed when it was not." W2 detailed that during the group home's first month in operation, "there were constant problems with the computer and passwords;" "Records were lost and entries on the MAR were filled out by hand." Sufficient training was not provided to staff regarding the Therap software program. Moreover, W2 had "never opened a group home in the past and the task was overwhelming for W2." The summary also noted that W2 was "suspended from employment with Mentor Oregon with no prior discipline or notice."218

W4 provided additional details in an April 18, 2017 interview with investigators. AV ran out of "medication 1" two to three weeks after arriving in Klamath Falls. Opening the group home was "chaotic." According to W4: "W4 and W2 had been given documentation and verbal insights into AV's behaviors," but the information was "not accurate." There was no computer provided when the staff opened the group home; for two weeks, they documented in longhand on paper forms.219

Unannounced Visits: May 22–23, 2017

213 Ibid. MENTOROR Bates 4471.

214 See Appendix C, Item 50, pp. 9 – 10.

215 See Appendix C, Item 61, p. 11. MENTOROR Bates 4471.

216 Ibid.

217 Ibid.

218 Ibid.

219 Ibid, p. 12. MENTOROR Bates 4472.

The incidents from November 2016 to March 2017 are the backdrop. New revelations unfolded during two unannounced visits to the facility in May. On May 22, front and back handrails were either missing or not anchored. The investigator observed AV “through the chain link fence...sitting on the ground...AV's hair and face was dirty and unwashed, AV's clothes were very dirty, with some sort of dried food smeared on the front of AV's shirt.”²²⁰ Staff noted that AV has a right to refuse a shower and it was often dangerous when showering AV, “which could be because AV was sprayed with hoses” at a different MENTOR Oregon facility.²²¹ OP4 (interviewee) stated that the staff who was supposed to train OP4 on AV’s BSP did not do so before moving on. Additionally, they did not receive needed information on AV from the previous (Portland) location and what they were told when AV was dropped off: “was not the truth, or accurate.”²²²

A second unannounced visit took place the following day, May 23. AV had broken a window with his/her hand that morning; AV was also wearing the same clothes as the day before. OP5 said AV had been in these same clothes since the previous Monday, May 15.²²³ Staff reiterated it was AV’s right not to shower. When pressed about still attempting to provide necessary care, staff did not respond. Further, “[w]hen staff were asked about monitoring for skin breakdown, they also did not respond.”²²⁴

That same day, “after a referral was made to investigate the level of care AV was receiving from Mentor Oregon,” the company informed Klamath County CDDP “they would no longer be providing services for AV.”²²⁵ Investigative staff on the ground reviewed the 9-1-1 tape. MENTOR Oregon staff indicated on the call that AV was “currently a danger from self and others and exceeding our ability to serve.” Residential staff further described how difficult it was for staff to get close to AV to provide care, including not being able to get into the home while AV was inside.²²⁶ There is no disputing that AV had a high tendency to act out toward staff and needed a higher level of care. The question becomes: would AV continue to reside in this home if the Klamath CDDP did not make a formal referral to further investigate the level of care being provided?²²⁷ AV was officially admitted to the Oregon State Hospital (OSH) at 10:30pm, May 26, 2017.

September 2017 – MENTOR Oregon’s Rebuttal

In response to the investigative report stemming from the onsite visits in May 2017, the company provided a supplemental letter to OR DHS defending its practices, including additional

²²⁰ Ibid, p. 8. MENTOROR Bates 4468.

²²¹ Ibid, p. 9. MENTOROR Bates 4469.

²²² Ibid.

²²³ Ibid.

²²⁴ Ibid.

²²⁵ Ibid.

²²⁶ Ibid, p. 10. MENTOROR Bates 4470.

²²⁷ In the original CDDP report (SDI17011), it notes how on May 23, 2017, after a referral was made to investigate the level of care AV was receiving, the company informed the CDDP it would no longer provide services to AV. In response to Committee questions, the company maintains it was “not informed by CDDP of the date of the referral, and was not aware that a referral had been made until it received the CDDP report.”

details about AV's transfer from Portland to Klamath Falls. It is worth addressing several points made by MENTOR Oregon.

AV's transition: the company contends "informal conversations" took place months prior to AV's transfer. A formal call and official exit meeting occurred in late October 2016. Moreover, "[t]he group home in [city 3] was selected specifically to meet AV's support needs."²²⁸

- Observation: It's difficult to comprehend how tasking two staff members to establish a new group home and not ensuring they were sufficiently trained or equipped is "specifically selecting" staff to meet AV's support needs.

Individual Support Plan (ISP): MENTOR Oregon contends the team in Klamath Falls was provided AV's ISP documents and that upon entry, "all staff at AV's new location had access to these via Therap."²²⁹

- Observation: Documented interviews with company staff show that a computer equipped with Therap software was *not* provided for the first two weeks of AV's arrival. Instead, medication entries were made by hand in paper form and many were lost in the shuffle. Per the investigative report, a licensing review from February 2017 "revealed...not all employees were trained on AV's Individual Support Plan."²³⁰

Behavior Support Plan (BSP): The company asserts a BSP was written in preparation for AV's transition on October 31, 2016, and also emphasizes how "alteration criteria" were included on page 13 of the plan, in which the team "should have a discussion about whether supports in the BSP are sufficient if...physical aggression incidents lasting over 2 minutes increase to more than once a week for a period of 4 consecutive weeks..." Moreover, the "review rule should be implemented after [AV] has resided in his new home for 60 days..." The company further states how the writer of the transitional BSP and other behavior specialists spent additional time reviewing AV's BSP starting in late December 2016, following the transfer.

- Observation: The same February 2017 licensing review noted how "there was no clear alteration criteria found in AV's Behavior Support Plan dated 10/31/2016..."²³¹ When interviewed by investigators, staff reiterated how they received inaccurate documentation and insights regarding AV's behaviors.

Staff Training: To buttress the argument that staff at the Alameda facility were trained, the company points out that the staff member brought on as manager of the new home "worked for 1 month under another group home manager who had opened 2 homes previously and trained this manager...on areas such as documentation using Therap...and licensing processes involved

²²⁸ See Appendix C, Item 61, p. 2. For this reference: "MENTOR Oregon Supplemental Letter to OR DHS," RE: SDI17011, September 20, 2017. MENTOROR Bates 4462.

²²⁹ Ibid.

²³⁰ See Appendix C, Item 61, p. 13 ("Klamath CDDP Report SDI17011," p. 9). MENTOROR Bates 4473.

²³¹ Ibid.

with establishing a new group home.”²³² The new manager also received medication administration training on October 13, 2016, where “Therap training is also reviewed.”²³³

- **Observation:** The company’s argument that a brand new manager who had not previously opened a group home is qualified to open a new home because of a one-month understudy is questionable at best. The available evidence does not show this new manager directly opened a new home prior to Alameda. Second, MENTOR Oregon’s supplemental letter mentions that although the new manager attended an October 13th training where Therap software was also mentioned, the letter also notes that “a scheduled formal training...on Therap use by group home managers was **not** attended on 10/27/2016.”²³⁴ [emphasis added] Investigative interviews with staff demonstrate that sufficient training did not take place. Nevertheless, on November 2, 2016, the company decided it was fine to proceed with the transfer.

Documentation of supports: Though staff still had to attempt to provide necessary care when AV refused to shower, company staff documented dates in which they attempted to get AV to shower or performed skin checks. Numerous dates are listed throughout May 2017.

- **Observation:** Despite numerous attempts to shower AV and check the client’s skin for breakdowns, it is troubling that onsite staff elected not to answer investigators when asked these questions during both unannounced visits. They could have referenced the written logs, or at least offered an explanation to the question. Neither occurred.

Amended Investigative Report

Following a review of the company’s September 2017 letter, OR DHS’s Office of Adult Abuse Prevention and Investigations (OAAPI) re-opened the investigative report completed by Klamath CDDP, as detailed in a December 28, 2017 letter sent to the company. OR DHS assigned an additional investigator to the case and an amended report was issued the following year, which cleared the substantiated finding of neglect.²³⁵ Besides summarizing many of the same findings from the original report, some new commentaries made it into the second edition:

- *WI states that prior to AV’s arrival new staff were hired and trained in preparation for AV per existing Mentor Oregon policies.*²³⁶

Observation: It is difficult to see how this conclusion could be reached given previous documentation and interviews show the new manager was not fully prepared for the role.

- *WI stated there was concern that by AV refusing to bath or even change clothes, there would be a risk of skin breakdown if not addressed over any long period of time. WI said*

²³² See Appendix C, Item 61, p. 3. MENTOROR Bates 4463.

²³³ Ibid.

²³⁴ Ibid.

²³⁵ “Amended Abuse Investigation Report,” OAAPI Special Division Investigation (SDI-DD),” Klamath County, RE: Alameda, Klamath Falls, OR, p. 1. See Appendix C, Item 62. MENTOROR Bates 4475.

²³⁶ Ibid, p. 4. MENTOROR Bates 4478.

*this was always an issue with AV but staff were always able to convince AV to bathe or change clothes within a reasonable period of time.*²³⁷

Observation: As documented in the original investigative report, AV had been in the same clothes for eight days. Most health experts would not consider eight days to be a reasonable period of time.

The concluding paragraphs of the amended investigative report offered further commentary:

- *AV's physical description as indicated in the [Program 1] report is certainly troubling on the surface. However, given the explanation provided by Mentor Oregon, **the situation was being appropriately monitored and addressed in a manner that was the least intrusive to AV without risking a physical confrontation.** Additionally, while everyone would agree the lack of bathing and having fecal matter and such present on the clothing is a matter of great concern, **it still must meet the statutory definition of neglect,** "that may result in physical harm or significant emotional harm to the person." Given the circumstances and short period of time there is no evidence to support the allegation that the conditions presented a risk of harm to AV.²³⁸ **[emphasis added]***

Observation: It's difficult to see how leaving AV in the same clothes for eight days with visible fecal matter and urine stains could be termed "being appropriately monitored and addressed." Moreover, the amended report does not firmly address the litany of issues outlined in the original CDDP report. A brief timeline summarizes key events from this narrative:

- May 22–23, 2017: unannounced visits to Alameda Home in Klamath Falls;
- June 1, 2017: CDDP Investigation assigned;
- August 7, 2017: CDDP Investigation concludes; neglect finding substantiated;
- September 25, 2017: OR DHS in receipt of MENTOR Oregon's supplemental letter;
- December 7, 2017: \$500 fine assessed by OR DHS;
- December 22, 2017: additional documentation provided by MENTOR Oregon to OR DHS (documents referenced in its September 20, 2017 letter);
- December 28, 2017: OAAPI re-opens the investigation;
- January 8, 2018: Based on additional documentation received from MENTOR Oregon, OR DHS decreases the fine from \$500 to \$250;
- May 3, 2018: OR DHS formally withdraws the penalty first assessed December 7, 2017 due to the finding no longer being substantiated.

Ultimately, Alameda Home closed in April 2018, but not because of licensing actions. Local officials thought the reason may have been cost. Committee staff asked the company directly as part of the follow-up questions regarding the closures of 12 properties listed on the company's spreadsheet. As previously mentioned, MENTOR Oregon only provided an explanation for eight of these facilities. Among the four it did not explain was the Alameda

²³⁷ Ibid.

²³⁸ Ibid, p. 5. MENTOROR Bates 4479.

facility: “Given time and resources constraints posed by responding to questions amid the national health crisis presented by the COVID-19 pandemic, information is not readily available.”²³⁹ Despite company resources, it could not locate the reason for a facility closure two years ago.

Cypress House

The Investigation

On December 30, 2018, a MENTOR Oregon staff member—during her first day at this home—reported a series of issues concerning the personal hygiene of two clients. The issues were first reported to MENTOR Oregon on January 4, 2019, and an incident report was submitted to OR DHS on January 7, 2019.

The first client being neglected was a “55-year-old male with developmental disabilities and is confined to a wheelchair or his bed 24 hours a day. [Redacted] is non-verbal and incontinent, which requires all his needs be met 24 hours a day by Mentor's Cyprus home staff.”²⁴⁰ According to the incident report, the male client was quadriplegic and staff alleged “his diaper wasn’t put on properly and he smelled very badly.”²⁴¹ This man “had reportedly been left unbathed for approximately a week and had...a ‘cottage cheese’ build up under his arms. There was no mention of a bedsore initially.”²⁴² A different staff member assigned to the home remarked, “I think he should have had a shower yesterday but because it is such a pain in the butt and a big job he probably didn’t.”²⁴³

The second client was a 64-year-old female receiving 24-hour care from Mentor: “[Redacted] is mobile, but still needs assistance with all daily needs including medications, food and hygiene.”²⁴⁴ The incident report also indicated the client had been left on toilet for 20 to 30 minutes. When she was attended to, instead of being taken care of appropriately, “she was put in the shower and sprayed off.”²⁴⁵ This client was not able to provide a statement “due to her intellectual disabilities.”²⁴⁶

These are the very individuals who need the highest level of care provided on a daily basis. It is regrettable this did not happen. When the reporting staff and Staff G went to change the first client, “he smelled so badly it was ‘gagable.’”²⁴⁷ Staff G further remarked: “[redacted] was supposed to have a bath Saturday but ‘since it is such a pain in the butt probably no one did

²³⁹ See Appendix C, Item 50, p. 2 (June 12, 2020 Responses, Appendix A)

²⁴⁰ See Appendix C, Item 35, p. 4. MENTOROR Bates 4815.

²⁴¹ See Appendix C, Item 17, p. 1. MENTOROR Bates 1278.

²⁴² See Appendix C, Item 35, p. 3. MENTOROR Bates 4814.

²⁴³ See Appendix C, Item 17, p. 1. MENTOROR Bates 1278.

²⁴⁴ See Appendix C, Item 35, p. 9. MENTOROR Bates 4820.

²⁴⁵ Ibid, p. 3. MENTOROR Bates 4814.

²⁴⁶ Ibid, p. 9. MENTOROR Bates 4820.

²⁴⁷ Ibid, p. 5. MENTOROR Bates 4816.

it.”²⁴⁸ The reporting staff voiced concerns regarding Staff G, “but nothing ever seems to get done by Mentor administrators,” according to the investigator’s summary. The staffer continued: “nobody seems to be properly trained to work, and if they are, nobody follows the rules and they are definitely not enforced by Mentor management.”²⁴⁹

The story quickly comes full circle: “[redacted] was promoted and retained by Mentor Oregon for more than a year after being substantiated for neglect, in which the victim was hospitalized after leaving Mentor’s care (DD170850). [Redacted] went from [redacted] in case [redacted] to [redacted] and oversaw hiring and training of Mentor staff in Brookings and Gold Beach.”²⁵⁰ The previous incident referenced: Park Place Home. The staff member: Staff 1 who was promoted to Program Director in mid-September 2017. As the report notes, “[Redacted] was terminated just before *The Oregonian* released a story regarding the victim in case [redacted]...” Staff 1 was relieved of her duties in December 2018.²⁵¹ The *Oregonian* story ran January 10, 2019.

Explanations abound for the neglectful acts. According to one staff interview, “all Mentor homes are understaffed due to various reasons from pay, or people not cut out for the work and failing background checks.”²⁵² Moreover, “[Redacted] stated staff are not allowed to cut the toenails of consumers with medical conditions such as diabetes and they go to the podiatrist for that.”²⁵³ Asked if short staffing played a role in the client’s toenails being neglected to such a degree, the staff replied, “it is more of a lack of training in her opinion.”²⁵⁴

In her interview, Staff G “stated she was a Direct support Professional at the Cypress house and then when [redacted] was terminated she was asked to be the House Manager for Cypress.”²⁵⁵ Staff G was only the house manager at Cypress “for a couple days before being put on leave”²⁵⁶ (on January 4, 2019).²⁵⁷

One staffer was asked about the male client’s podiatrist appointments and whether or not they were attended: “[Redacted] stated she knows they were not able to transport [redacted] safely to his last appointment as his belt on his wheelchair had broken.”²⁵⁸ Staff G ordered a new harness for the van in late 2018 and the “new belt for seatbelt for his wheelchair” arrived January 6, 2019. The investigator asked approximately how many appointments were missed. As a rough estimate, the available documentation suggests two to three appointments were not attended over a 5–6 month period.²⁵⁹ If one’s nails were to go that long without being tended to, one can imagine the consequences.

²⁴⁸ Ibid.

²⁴⁹ Ibid, p. 5. MENTOROR Bates 4816.

²⁵⁰ Ibid, p. 2. MENTOROR Bates 4813.

²⁵¹ Ibid, p. 3. MENTOROR Bates 4814.

²⁵² Ibid, p. 7. MENTOROR Bates 4818.

²⁵³ Ibid.

²⁵⁴ Ibid.

²⁵⁵ Ibid, p. 6. MENTOROR Bates 4817.

²⁵⁶ Ibid.

²⁵⁷ Ibid, p. 7. MENTOROR Bates 4818.

²⁵⁸ Ibid, p. 8. MENTOROR Bates 4819.

²⁵⁹ Ibid.

Regarding the female client, the interviewed staffer said, “[Staff G] took off [redacted] shirt and put her directly in the shower without checking to see if she was done on the toilet, or in need of being wiped.”²⁶⁰ In short, Staff G simply put her in the shower and sprayed off the client. This staffer further remarked “she was shocked by how this was handled, as there was no apparent care involved.”²⁶¹ In Staff G’s interview, she did not feel this constituted neglect on her part.

One further note should be made about the investigator’s site visit on January 11, 2019. After assessing the condition of the male client, he immediately instructed staff to take him to Urgent Care. But it wasn’t this simple. In fact, “neither staff on duty at the time had the training or been approved to drive [redacted] in the Mentor vehicle. Calls were made to get [redacted] to Urgent care and it took over an hour and a half for Mentor to pull enough qualified staff together to move [redacted] a few blocks down the street to the Urgent Care clinic.”²⁶²

Investigative Conclusions

The neglect allegation regarding client #2 levied against Staff G was not substantiated: though troubling in many respects, “there is no evidence to indicate this incident placed [redacted] at risk of harm, which is required for substantiating an allegation of neglect.”²⁶³

The neglect allegation concerning the first client was not directly attributed to Staff G. Instead, the substantiated acts of neglect were levied on *the entire* “Mentor Cypress House.”²⁶⁴ In the investigator’s concluding words:

Even though [Staff G] was the House Manager, she only held that title for a few days after being promoted from direct care staff. The condition [redacted] was in at the time this investigation was initiated cannot be blamed solely on [Staff G]...Several witnesses stated Cyprus house staff are poorly trained, the home is chronically understaffed, and several staff stated they have made their concerns known to Mentor management with no response.

*Given the variety of staff who worked in the home during this time, **it is reasonable to conclude that all staff at Mentor Cyprus house bore some responsibility** for [redacted] lack of care and hygiene, as did any manger or administrator who had been made aware of the ongoing concerns, or who had set foot in the Cyprus home during this time.*

***It is concerning that only because a staff from another Mentor home filled in at Cyprus house and saw the condition of [redacted] was this reported to the county office and resulted in this investigation.** No other staff, manager or administrator came forward on*

²⁶⁰ Ibid, p. 9. MENTOROR Bates 4820.

²⁶¹ Ibid.

²⁶² Ibid, p. 3. MENTOROR Bates 4814.

²⁶³ Ibid, p. 11. MENTOROR Bates 4822.

²⁶⁴ Ibid, p. 10. MENTOROR Bates 4821.

*behalf of [redacted] with any concerns regarding the condition he was living in, and based on the information obtained in this investigation, it appears nobody else at Cyprus fulfilled their role as a mandatory reporter.*²⁶⁵ ***[emphasis added]***

Following these substantiated neglectful acts, the State sent MENTOR Oregon a letter on May 22, 2019, proposing to revoke the license of the facility.²⁶⁶ A few weeks later, the company challenged these findings. The next section illustrates how the company was prepared to fight until the slate was clean.

The Legal Battle

On June 11, 2019, MENTOR Oregon requested a hearing to contest the notice to close the facility and a pre-hearing conference was conducted on July 18, 2019. A two-day hearing was held November 13–14, 2019, with Administrative Law Judge (ALJ) Kate Triana from the Office of Administrative Hearings (OAH) for OR DHS presiding.

According to the final order handed down by OAH and OTIS (the Office of Training, Investigation and Safety within OR DHS), Committee staff learned the identity of Staff J, the DSP who relayed concerns about Cypress House following her first visit to the facility.²⁶⁷ In addition to many facts outlined in the CDDP report, we learned that DSP Staff J “told [MENTOR] Area Director [Staff S] about the bedsore and was told ‘not to worry about it or track it.’”²⁶⁸ Staff S further told the investigator in her interview how “there was no official bathing policy, but that she believed AV should be bathed every day because he was incontinent...;” she also included how “AV had the right to refuse to be bathed (until it became a health and safety concern)” and estimated that “it took six months or more for AV’s toenails to grow that long...”²⁶⁹

It is notable that the team at Cypress House did not consider AV’s condition (prior to December 30, 2018) to be a health concern. Similar to the onsite visit at Alameda Home in Klamath Falls, there is a pattern of staff referencing “clients having the right to refuse” hygiene care.

From all the findings listed in this case, one item stood out to the ALJ: “Investigator Christoferson did not request activity of daily living (ADL) logs, shift notes, medication administration records (MARs), or turn logs from Cypress House.”²⁷⁰ There was also testimony indicating “[b]ed sores can appear in a little as a few hours’ time.”²⁷¹ Despite the ample amount

²⁶⁵ Ibid, p. 10. MENTOROR Bates 4821.

²⁶⁶ See Appendix C, Item 36.

²⁶⁷ “In the Matter of Mentor – Cypress House, Respondent,” Office of Administrative Hearings, State of Oregon – For the Department Of Human Services, Proposed Order, OAH Reference No. 2019-DHS-10973, Department Case No. DD190022, p. 3. See Appendix C, Item 63. MENTOROR Bates 4846.

²⁶⁸ Ibid, p. 4, MENTOROR Bates 4847

²⁶⁹ Ibid, pp. 6–7, MENTOROR Bates 4849–4850.

²⁷⁰ Ibid, p. 7. MENTOROR Bates 4850

²⁷¹ Ibid.

of evidence in this case, the ALJ concluded, “A preponderance of the evidence does not support a substantiated finding of abuse by neglect against Respondent.”²⁷² In several respects, this conclusion is difficult to grasp.

MENTOR Oregon’s attorney cited OAR 407-045-0300 in its defense, arguing the investigator did not complete the abuse investigation “in accordance with all the requirements” of the statute.²⁷³ With respect to records and documentation, the statute requires investigations of alleged abuse to “Review all records or evidence relevant and material to the complaint.”²⁷⁴ Since the investigator did not request the aforementioned documents from Cypress House staff, the ALJ wrote: “It is undisputed that Respondent would have provided these documents to the investigator, had he requested them.”²⁷⁵

- Observation: During the onsite visits concerning the Alameda facility in Klamath Falls, investigators inquired about AV’s personal hygiene. When staff was asked about showering AV and how not doing so could become a health issue, they had no comment and chose not to disclose or reference the written logs that were later produced. Given these facts, it may not be “undisputed” that staff would have handed the documents to the investigator at the scene.

The respondent (MENTOR Oregon) also cited how the investigation “was not completed in an unbiased manner. Specifically, that the investigator’s focus on a prior abuse investigation involving Mentor Network...clouded his ability to be unbiased when investigating this situation;” the ALJ noted that “[w]hile it is certainly reasonable for an investigator to take prior incidents of abuse by the same company into consideration...the rules still require that the investigation be conducted in a thorough and unbiased manner.”²⁷⁶

- Observation: In a sparsely populated county with more limited resources, the lead protective services staff is most likely responding to most every instance, which may include multiple visits to the same addresses. Given the frequency of investigations of alleged abuse and neglect, CDDP offices would have to hire significantly more staff to ensure the availability of unbiased investigators. It is true that any investigator must remain objective. But if a report of alleged abuse came in and no other (unbiased) investigative staff were available, does the local investigative entity choose not to investigate and report the findings to the State?

With respect to the client’s physical condition and personal hygiene, the ALJ wrote: “while AV was not showered or bathed on a daily basis, the evidence failed to show that at any point he went so long without bathing that it created a health and safety concern...” On a similar vein, the ALJ determined the evidence “failed to show that the long toenails were causing AV any pain...”²⁷⁷

²⁷² Ibid.

²⁷³ OAR 407-045-0300.

²⁷⁴ See Appendix C, Item 63, p. 9. MENTOROR Bates 4852.

²⁷⁵ Ibid.

²⁷⁶ Ibid, p. 10. MENTOROR Bates 4853.

²⁷⁷ Ibid.

- Observation: The client in this case was “non-verbal” and incontinent, unable to express discomfort resulting from the lack of care. Just because the non-verbal client did not expressly communicate pain, does that mean a health concern was not present?

In concluding thoughts, the ALJ notes “the Department has failed to meet its burden to show that AV’s bedsore was the result of Respondent’s neglect.” Additionally, acting house manager Staff S’s “failure to act is not sufficient to support a finding of neglect against Respondent, as a whole.”²⁷⁸

- Observation: After reviewing the legal summary of the case, if the investigator had requested and reviewed the daily turn logs, would that impact the ALJ’s conclusion? As the investigative report demonstrates, it wasn’t just Staff S who failed to act. The *full team* assigned to Cypress House did not act.

In the end, the final order issued on January 14, 2020 cleared MENTOR Oregon of the underlying allegations and reversed the original May 22, 2019 findings of substantiated neglect, formalized in a letter from OR DHS to the company signed on February 5, 2020. In response to Committee staff on February 28, 2020, the company noted, “Cypress House is in full compliance and its license is in good standing.”

End Note

As mentioned earlier in the report, near the end of its investigation in September 2020, Committee staff learned about an additional incident of neglect taking place at Cypress House, which transpired in May of 2020. The CDDP report substantiated the abuse on July 17, 2020, and the State issued an associated civil penalty letter on August 20, 2020. In October 2020, Committee staff learned about the most recent licensing actions involving the facility taken by the State, following a complaint made by a client’s parent. After the ensuing license review and the State’s intent to revoke the company’s license to operate the facility, MENTOR Oregon closed the facility. These events raise concerns that about whether the company is still not performing at a level necessary to care for clients needing 24/7 assistance.

²⁷⁸ Ibid, p. 11. MENTOROR Bates 4854

Appendix B: Responding to COVID-19

As the Committee was beginning to wrap up its investigation into MENTOR Oregon, the COVID-19 pandemic reached and rapidly spread through the U.S., especially impacting congregate care facilities. Information on the incidence of COVID-19 in I/DD homes is limited. News reports have highlighted how those in the I/DD community could be particularly vulnerable in group care facilities.²⁷⁹ According to a state survey conducted by the *Associated Press*, “at least 5,800 residents in such facilities nationwide have already contracted COVID-19, and more than 680 have died.”²⁸⁰ The true count could be much higher due to roughly a dozen states not disclosing their data to the AP. And most recently, *The New York Times* cited a new FAIR Health study that says individuals with intellectual or developmental disabilities are three times more likely to die from COVID-19 than those without the underlying conditions.²⁸¹

Specific to intermediate care facilities (ICFs-I/DD), regulators found about 40% (around 2,300) “failed to meet safety standards for preventing and controlling the spread of infections and communicable diseases.”²⁸² According to a *Boston 25 News* report in June 2020, of the more than 9,000 adults living in I/DD group homes in Massachusetts, 1,575 adult residents tested positive as of early June and 98 of those adults have died.²⁸³ Additionally, the same report noted over 1,800 staff at these group homes tested positive. Particularly in smaller homes, the spread of infection can be especially pronounced under the right circumstances, which could include unsanitary conditions, residents who are non-verbal and cannot communicate when they’re feeling sick, and the close interaction between staff and residents who need a lot of personal assistance in close quarters. A June 2020 study of COVID incidence in I/DD group homes in New York State found dramatically higher risks for this population: “case rates – 7,841 per 100,000 for people with IDD compared to 1,910 for New York State; case-fatality – 15.0% for people with IDD compared to 7.9% for New York State; and mortality rate – 1,175 per 100,000 for people with IDD compared to 151 per 100,000 for New York State.”²⁸⁴

On April 1, 2020, Committee staff sent MENTOR five questions related to its response to COVID and the incidence of the disease in its facilities. The questions asked about new guidance; whether any clients or staff had tested positive in Oregon, Iowa, or nationally; whether staff, clients and visitors were being screened on a regular basis; what protocols were put in place for those receiving employment services; and whether MENTOR Oregon has experienced difficulties due to the pandemic (i.e. adequate support from the State, suppliers, etc.). The company responded to some of these questions. Answers included:

²⁷⁹ Hakim, Danny, “It’s Hit Our Front Door: Homes for the Disabled See Surge of Covid-19,” *The New York Times*, April 8, 2020, <https://www.nytimes.com/2020/04/08/nyregion/coronavirus-disabilities-group-homes.html>; and Holbrook Mohr, Mitch Weiss and Reese Dunklin, “Thousands sick from COVID-19 in homes for the disabled,” *Associated Press*, June 11, 2020. Link: <https://apnews.com/bdc1a68bcf73a79e0b6e96f7085ddd34>

²⁸⁰ Ibid, *Associated Press*.

²⁸¹ Caryn Rabin, Roni. “Developmental Disabilities Heighten Risk of Covid Death,” *The New York Times*, November 11, 2020, [LINK](#).

²⁸² See *Associated Press*.

²⁸³ Hegedus, Heather. “Group homes for those with disabilities hit hard by coronavirus,” *Boston 25 News*, June 29, 2020, [LINK](#).

²⁸⁴ Landes, Scott D. et al. “COVID-19 outcomes among people with intellectual and developmental disability living in residential group homes in New York State,” *Disability Health Journal* 13(4), published online on June 24, 2020, [LINK](#)

- Reformatting programs to observe social distancing guidelines where possible, including virtual capabilities;
- Screening staff for symptoms upon entry (and taking temperatures where required by the state);
- Launching a “COVID-19 Update Center” on its website:
<https://www.thementornetwork.com/coronavirus/>;
- MENTOR Oregon restricted visitors consistent with the “no visit” requirements for residential care facilities issued by the Oregon Department of Human Services;
- Closed day programs as necessary to comply with state social distancing requirements;
- Increased daytime staffing in 24-hour homes;
- Creating alternative programming (consistent with social distancing) that is designed to engage individuals throughout the day;
- Proposed a series of policy recommendations to state, county and local governments:
<https://www.thementornetwork.com/assets/Covid19-Public-Policy-Response-One-Pager-3-23-20-003.pdf>;
- As of April 3, 2020 (in response to Committee staff’s initial inquiry), no confirmed cases of COVID-19 were identified by state authorities among clients or staff in both Oregon and Iowa.

Committee staff followed up on three areas of particular interest: 1) Examples of specific guidance directly sent to providers in the field; 2) Re-asking the question of positive infections in MENTOR facilities nationally (outside Oregon and Iowa); and 3) Further clarification into screening and testing of clients/staff in Oregon. The company reported that all MENTOR Oregon staff are screened prior to beginning their shift; temperature checks are occurring at all residential facilities. Staff are required to wear protective masks while on duty. Testing is done by medical professionals, so it is not within the scope of services directly provided by MENTOR Oregon.

For a second time, the company elected not to answer the question of clients and staff testing positive for COVID-19 outside of Oregon and Iowa. Given the pandemic is national in scope, the Senate Finance Committee has chief jurisdiction over the Medicaid program (in which MENTOR receives funds), and the reported incidence of COVID in congregate care settings across the country, the importance of this information is self-evident. Indeed, MENTOR’s medical director, Edwin Mikkelsen, published an op-ed in April 2020 stating how people with severe I/DD in 24-hour facilities are more vulnerable to COVID-19 than the average American.²⁸⁵ Further, he noted how caregivers in these facilities are “on the front lines” like hospital staff, and “[w]ithout their commitment and expertise, one of the country’s most vulnerable populations would be left with literally nowhere else to go.”²⁸⁶ Given these statements, it is surprising the company elected not to answer a question asking for a brief accounting of the “heroic and saintly work of their caregivers,” as Mr. Mikkelsen phrased it.²⁸⁷ MENTOR refused to provide this information.

²⁸⁵ Mikkelsen, Edwin. “In responding to COVID-19, Congress must not overlook people with severe disabilities,” *Roll Call*, April 20, 2020, [LINK](#).

²⁸⁶ Ibid, Edwin Mikkelsen.

²⁸⁷ Ibid.

Committee staff also requested information from the U.S. Department of Health & Human Services (HHS), which oversees distribution of Medicaid funding to I/DD facilities and state programs regarding the national scope of COVID-19 preparedness among adult I/DD providers. The agency provided examples of guidance it, the CDC, CMS and other regulators have issued, most notably the CDC’s “Guidance for Group Homes for Individuals with Disabilities.”²⁸⁸ When asked how many adults with I/DD had tested positive thus far, the department acknowledged it “does not currently have a cumulative number of adults with IDD under the care of a state-contracted provider who have tested positive for COVID-19.”

Committee staff also asked HHS about whether it tracked “either incidence of COVID-19 or COVID-19 related deaths by facility, provider, and/or state.” In response, it noted that the “CDC’s National Healthcare Safety Network (NHSN) provides health care facilities, such as long term care facilities (LTCF), with a customized system to track infections and prevention process measures in a systematic way.”²⁸⁹ Facilities eligible to report into the new COVID-19 Module for LTCFs include nursing homes/skilled nursing, long-term care for the developmentally disabled, and assisted living facilities. As of June 26, 2020, around 600 assisted living facilities and 67 developmental disability facilities are reporting in NHSN.²⁹⁰ The health department also added that “to the extent other facilities are monitored, data is usually compiled, tracked, and reported at the State level.” Furthermore, “differences in terminology, reporting requirements and methodologies at the State level may complicate aggregation and analysis of state level data across categories of facilities.”²⁹¹

In short, Committee staff were unable to obtain concrete national figures on the pandemic’s impact on the adult I/DD community in state-contracted facilities from either HHS or from one of the largest providers of I/DD care.

²⁸⁸ “Coronavirus Disease 2019 (COVID-19): Guidance for Group Homes for Individuals with Disabilities,” Centers for Disease Control and Prevention, Updated May 30, 2020, [LINK](#).

²⁸⁹ Office of the Assistant Secretary for Legislation (ASL), U.S. Department of Health & Human Services, July 7, 2020 Email Response to Finance Committee Staff.

²⁹⁰ Ibid, ASL.

²⁹¹ Finance Committee staff are quite familiar with data at the state level being inconsistent from one state system to the other, following its 2017 bipartisan investigation and analysis of U.S. foster care data.

Appendix C: Supporting Documents

For the full list of supporting documents referenced in this report, please click the hyperlink available at the bottom of the December 3, 2020 press release, which can be found in “Chairman’s News” under the “Newsroom” tab on the Finance Committee’s [website](#).