Oregon
Kate Brown, Governor

Department of Human Services
Office of Developmental Disabilities Services
DD Licensing Unit
PO Box 14540
Salem, OR 97309-0435
Phone: 503-945-7800
Fax: 503-373-2228

DHS
Oregon Department of Human Services

October 26, 2016

Yvette Doan, Registered Agent
305 NE 192nd Ave Ste 350
Portland, OR 97220

Dear Ms. Doan:

Enclosed you will find the Office of Developmental Disabilities Services Notice of Intent to Revoke 24-Hour Residential License for your home located at [redacted] in Portland, OR.

If you have any questions, please call me at 503-373-1992

Sincerely,

Nicole Estrada

Nicole Estrada, Corrective Action Coordinator
DD Licensing Unit
Office of Developmental Disabilities Services

Enclosure: Notice of Intent to Revoke 24-Hour Residential License
Oregon Administrative Rules
cc: Shari Davis, Multnomah CDDP
Chelas Kronenberg, ODDS (via email)
24 Hour Residential File

Certified Mail #7015 0920 0001 4871 9372
Date Mailed: 10/26/2016

Oregon Department of Human Services
Office of Developmental Disabilities Services
PO Box 14540
Salem, Oregon 97309

In the Matter of
Mentor Oregon
d.b.a. [redacted] Group Home
a 24-Hour Residential Care Facility

) Notice of Intent to
) Revoke 24-Hour
) Residential License

TO: Yvette Doan, Registered Agent
Mentor Oregon
305 NE 192nd Ave Ste 350
Portland, OR 97220

AUTHORITY[1]

This Notice is being sent to you as required by Oregon Revised Statutes ("ORS") 443.400 through 443.455 and ORS 410.070 and 409.050, and the Oregon Administrative Rules (OARs) that implement those statutes.

FACILITY RESPONSIBILITY

You are hereby notified that the Oregon Department of Human Services, hereinafter referred to as "Department," intends to revoke the license of Mentor Oregon, hereafter referred to as "Licensee" to operate a 24-hr adult residential facility at [redacted] in Portland, Oregon.

1 Section titles are provided solely as a convenience and should not be construed as having any legal significance

Based on the Office of Developmental Disabilities Services licensing complaint review dated March 10, 2016, the 1st complaint follow up dated May 4, 2016, the 2nd complaint follow up dated June 30, 2016, the 3rd complaint follow up dated August 30, 2016 and the 4th complaint follow up dated September 22, 2016 and incorporated into this notice by reference, there is reliable evidence the Licensee substantially violated OARs governing 24-hour residential care facilities as stated below.

STATEMENT OF VIOLATIONS

Violations of Program Management OAR 411-325-0025

• **3/10/16:** P1 had General Event Records (GER's) indicating medications were signed for but were not administered as the medications were found in the bubble packs.

P2's physician orders were not followed. An incident report was found for staff not administering medication.

The above conduct constitutes a violation of OAR 411-325-0120 (2)(c).

• **5/4/16**, there was a *new* issue: P2's medication was not given as ordered on multiple occasions:

- 3/29/16- Potassium 5PM dose missed.
- 3/29/16- Docusate Sodium, Lamotrigine, and Propananol 6pm doses missed.
- 3/29/16-Quetiapine, Hydroxyzine, and Trazadone 8PM doses missed.
- 3/30/16-Quetiapine, Hydroxyzine, and Trazadone 8PM doses missed.
- 5/2/16 Docusate 5pm dose missed.

There were no incident reports addressing the missed medications. This conduct constitutes a violation of OAR 411-325-0120 (3)(b)(A-F).

• **6/30/16,** Medication errors continued to be an *ongoing* issue: Medications were reviewed at 10:20am. It was noted that all of P4's 7am and 8am medications were popped out of the corresponding bubble packs, however the MARs were not signed. This conduct constitutes a violation of OAR 411-325-0120 (3)(b)(A-F).

• **9/22/16,** there was a *new* issue: Staff did not take action based on a health change for P2. Staff administered Milk of Magnesia to P2 for a small amount of blood in P2's stool. No documentation was found that staff notified the physician or took

any other actions. This conduct constitutes a violation of OAR 411-325-0120(2)(a)(D).

• **3/10/16:** P3 had GER's indicating medications were not administered due to not receiving medications from the pharmacy. No documentation was found indicating when the medications were ordered. This conduct constitutes a violation of OAR 411-325-0120 (2)(c).

• **6/30/16:** Medications not being administered continued to be an *ongoing* issue: The physicians order prescribed Albuterol and Guaifenesin. Neither of these medications were added to the Medication Administration record (MAR). Staff reported the pharmacy did not deliver the medications in a timely manner, however, Guaifenesin is an over the counter medication.

• **6/30/16,** it was noted there was an *ongoing* issue: P3's physician's orders were not followed. P3 went to the ER for serious illness. The physician prescribed Albuterol. Albuterol was not on the MAR. The order also directed P3 to return to see a primary physician in 2-3 days. There was no documentation provided to indicate the follow-up visit had been completed.

• **8/30/16,** physician's orders continued to be an *ongoing* issue: P3's physician's order was still not followed. The Albuterol was not added to the MAR for this order.

• **9/22/16,** there was an *ongoing* issue with a new example: P3 had physician's orders that were not implemented. Examples include:

- P3 had a physician's order that indicated staff were to encourage exercise 30 minutes daily. There was no documentation found to indicate that this order was implemented.
- P3 had a physician's order that indicated P3's fluid intake restriction and calorie count diet were lifted/discontinued. The Medication Administration Record (MAR) for May, June, July, August, and September 2016 continued to list that P3 had a 2000 calorie count diet and a fluid restriction. Additionally, the Behavior Support Plan (BSP) for P3 continued to indicate that P3 was on a calorie count diet and fluid restriction.

- P3 had a physician's order that was not implemented. The order changed P3's dosage of Risperidone to 0.5 mg in the am and 2mg at the hour of sleep. Upon review, the new dosages of Risperidone were in an unopened bubble pack, but had not been transcribed to the MAR or administered to P3.
- The physician's order prescribed Fluoxetine 20mg times 2 caps one time daily. The MAR for P3 in August and September 2016 indicated that P3 was being administered Fluoxetine 40mg 2 times daily for a total of 80mg daily.

The above conduct constitutes a violation of OAR 411-325-0120 (2)(c).

• **3/10/16:** P4's physician orders were not followed. Incident reports were found for medication errors (staff not administering or the medication was not available from the pharmacy). No documentation was found to indicate when the medications were reordered.

• **3/10/16:** P4's physician orders were not followed. P4 received an order to soak their fingers 2 times per day for 3 days and after the soak apply Triple Antibiotic Ointment. No documentation was found that these orders were completed.

• **5/4/16,** there was an *ongoing* issue: Unexplained blanks were found on P4's MAR for the dates of 3/29 (Divalproex, Quetiapine, Docusate Sodium, Miralax, Senna) 3/31 (Quetiapine) and 5/2 (Diphenhydramine, Divalproex, Prune Juice and Quetiapine). No documentation was found to indicate if these medications were administered or if they were missed on these dates. No documentation was found that any administrative action was taken in response to these unexplained blanks.

• **6/30/16,** there was an *ongoing* issue: P4's physician order stated if P4 sleeps 4 or less hours in a 24 hour period, staff are to administer Diphenhydramine. A review of P4's sleep tracking showed that P4 slept 4 or less hours 16 occasions between the dates: 5/6/16 - 6/27/16. No documentation was found that Diphenhydramine was administered for any of these dates.

• **8/30/16,** there was an *ongoing* issue: Documentation was found that P4 slept less than 4 hours on eight occasions between the dates of 7/21/16 - 8/14/16. No documentation was found that Diphenhydramine was administered on any of these dates.

• **9/22/16,** there was an *ongoing*: Documentation was found that P4 slept less than 4 hours on 9/7/16 and 9/8/16. No documentation was found that Diphenhydramine was administered for either of these dates.

The above six examples of conduct constitutes a violation of OAR 411-325-0120 (2)(c).

• **8/30/16,** there was an *ongoing* issue: Unexplained blanks were found on P2's MAR for Hydroxyzine; ACT Fluoride Rinse; Clotrimazole; Docusate; Lamotrigine; Quetiapine and Trazadone. Unexplained blanks were found on P4's MAR for Amoxicillin; Benzotropine; Polyethylene Glycol;Prune Juice; Quetiapine; Diphenhydramine; Divalproex; Docusate Sodium; Quetiapine Fumarate and Senna. No documentation was found that any administrative action was taken in response to these unexplained blanks.

• **8/30/16,** there was a *new* issue: P4's physician orders were not followed. P4's physician ordered that if P4 does not have a bowel movement (BM) in 10 days, staff are to contact the PCP for further instructions. No documentation was found that P4 had a BM 7/21/16 - 7/31/16. No documentation was found that staff contacted P4's PCP for further instructions.

P4's physician changed P4's bowel regimen on 8/24/16 to administer Miralax the evening of day 3 of no BM and continue administering twice per day until P4 has a BM. No documentation was found that P4 had a BM 8/24/16 – 8/27/16. No documentation was found that staff administered Miralax the evening of 8/27/16.

• **9/22/16,** P4's physician orders not being followed continued to be an *ongoing* issue: No documentation was found that P4 had a BM 8/29 - 9/1/16. No documentation was found that Miralax was administered on 8/31/16 or 9/1/16. In addition, no documentation was found that P4 had a BM 9/3/16 – 9/8/16. No documentation was found that Miralax was administered 9/6/16 or 9/7/16.

The above three examples conduct constitutes a violation of OAR 411-325-0120 (2)(c).

• **8/30/16,** there was a *new* issue: Physician visit documentation was not maintained

for P4. Documentation was found that P4 had physician appointments on 7/7/16 (psychiatrist) and 7/15/16 (emergency room). No corresponding physician visit forms were found.

• **9/22/16,** there was an *ongoing* issue: Documentation was found that P2 had an appointment on 9/2/16 for an emergency room visit follow up. No corresponding physician visit form was found for this visit. In addition, no documentation was found that indicated when P2 went to the emergency room.

The above two examples of conduct constitutes a violation of OAR 411-325-0120 (2)(d)(B).

• **9/22/16,** there was a *new* issue: Staff administered a PRN with no physician's order. P2 received an order for Milk of Magnesia PRN due to complaints of constipation on 5/26/16. On 9/9/16, staff administered Milk of Magnesia to P2 for a small amount of blood in P2's stool. No corresponding order was found for this. This conduct constitutes a violation of OAR 411-325-0120 (2)(c).

• **5/4/16,** there was a *new* issue: P4's Quetiapine was not administered but signed for. The medication was found still in the bubble pack. No documentation was found that any administration action was taken. This conduct constitutes a violation of OAR 411-325-0120 (3)(b)(l).

• **5/4/16,** there was a *new* issue: P4's incident report for the date of 4/17/16 was not written until 4/19/16. No documentation was found to indicate why the incident report was not completed on 4/17/16.

• **6/30/16,** there was an *ongoing* issue: P4's incident report for the date of 5/2/16 was not written until 5/11/16. P4's incident report for the date of 5/19/16 was not written until 5/20/16. P2's incident report for the date of 5/18/16 was not written until 5/20/16. No documentation was found to indicate why these incident reports were not completed the day of the incident.

• **8/30/16,** late incident reports continued to be an *ongoing* issue: No documentation was found in any incident reports to indicate why they were not completed on the day of the incident.

The above three examples of conduct constitutes a violation of OAR 411-325-0120(7)(a).

• **3/10/16:** P5 had GERs indicating medications were not administered on 13 occasions between 12/11/15 – 3/3/16.

• **5/4/16:** P5 had GERs indicating medications not being administered.
- Hydrocortisone was not delivered by the pharmacy, however, the program did not order the medication until the night before missing the dose.
- Methylphenidate and Vitamin D3, P5 did not receive these medication on 4/27/16 and the medication was ordered on 4/26/16.

The above two examples of conduct constitutes a violation of OAR 411-325-0120(2)(c).

• **5/4/16,** there was a *new* issue: P5 had an incident on 4/6/16 for an altercation, however the incident report was not completed until 4/19/16. Another incident occurred on 4/18/1, an incident report was not completed until 4/22/16. This conduct constitutes a violation of OAR 411-325-0120 (7)(a).

• **5/4/16,** there was a *new* issue: P5 had the medication Amoxicillin administered without documentation on the MAR.

• **6/30/16,** there was an *ongoing* issue: P1, P2, P3 and P4 had medications administered without documentation on the MAR.

• **6/30/16,** there was a new issue: P3 had a PRN medication administered without documentation of its effectiveness. Also, P1 had a PRN medication administered without documentation as to why the PRN was administered.

• **8/30/16,** documentation errors continued to be an *ongoing* issue: P3 had medications administered without documentation of their effectiveness.

The above four examples of conduct constitutes a violation of OAR 411-325-0120(3)(b)(A-F).

• **8/30/16,** there was a *new* issue: A progress note for P1 was found in P4's record.

This conduct constitutes a violation of OAR 411-325-0120(6).

• **8/30/16,** there was a *new* issue: Expired medications were not disposed of for P1. Documentation was found that these medications continued to be administered. This conduct constitutes a violation of OAR 411-325-0120(3)(f)(A-F).

• **9/22/16,** there was a *new* issue: P1's physician orders were never implemented. The physician order directed the program to take P1's Blood Pressure two times a week and call if the number was less than 100 or over 140. No documentation was found that these orders were implemented as required. The physicians ordered Abreva for a cold sore on P1's lip. Abreva was not added to the MAR nor was it found in P1's medication crate. This conduct constitutes a violation of OAR 411-325-0120(c).

Violations of Incident Reports and Emergency Notifications, OAR 411-325-0190

• **3/10/16**: There were GER's without appropriate follow-up to prevent recurrences of the incidents. Examples include:

- P1: P1 grabbed another housemate by the neck to choke him/her. Staff reported this incident would not have occurred had supervision levels been maintained. This incident involved a new staff that had not yet received OIS training and the behavior was ended with assistance from another staff.
- P3: AWOL; property damage; roughhousing turned into altercation between housemates; injury due to name calling turned into attempted choking; lack of supervision: 3 staff on duty were in the office with the door closed leaving housemates P1, P3 and P5 without adequate supervision.
- P5: Property damage; medication error; lack of supervision; and assault.

This conduct constitutes a violation of OAR 411-325-0190(1)(d).

• **3/10/16:** Seven of 27 incident reports (addressing physical aggression, property destruction and medication errors) were not sent to the CDDP in 5 business days as required.

• **5/4/16,** there was an *ongoing* issue: There were GER's without adequate follow-up to prevent recurrences, including: roughhousing; unwanted sexual behavior; assault

resulting from roughhousing; property damage; behavior - beating her/his own chest; and P3 overeating causing vomiting.

• **6/30/16,** adequate follow-ups pertaining to GER's continued to be an *ongoing* issue. GER's without adequate follow-up to prevent recurrences include: bleeding (P3 threw a cup at housemate after housemate was throwing items at P3 and staff); serious illness (P3 was sent to the ER by ambulance without staff supervision. According to P3's BSP, P3 requires line of sight and within sight and sound in the community); and medication not available.

• **8/30/16,** adequate follow-ups pertaining to GER's continued to be an *ongoing* issue. P3 had GER's without adequate follow-up to prevent recurrences, including: fall without injury, P3 slipped on a grape on the floor. The review indicated staff would be met with to discuss health and safety hazards. There was no documentation indicating a discussion about health safety hazards occurred.

The above four examples of conduct constitutes a violation of OAR 411-325-0190(2).

• **9/22/16,** there was a *new* issue: A GER was not written for an incident that required one. P3's Aspiration/Chocking Protocol indicated that if P3 experienced signs and symptoms of aspiration that a GER is to be written. A T-log indicated that P3 vomited. There was no corresponding GER for this incident.

• **5/4/16,** there was an *ongoing* issue: There were GER's without adequate follow-up to prevent recurrences, which included: AWOL, (protocol not followed for P1); assault related to roughhousing; behavior of verbal aggression; and behavior of property destruction.

• **5/4/16,** GER's without adequate follow-up continued to be an *ongoing* issue: P5 had several GER's without adequate follow-up to prevent recurrences, examples include:

- Altercation with staff, P5 then went missing after leaving grandparent, no preventions identified;
- Medication missed as the medication was not ordered from the pharmacy until the night before;

- P5 hit housemate;
- Medications not available.
- Property damage;
- Behavior, P5 joined a housemate in yelling, staff attempted contact with P5's probation officer. No preventions were provided in the GER;
- Altercation

• **5/4/16**, there was a *new* issue: P4 was admitted to the hospital on a psychiatric hold. No corresponding incident report was found for P4 being admitted.

• **8/30/16,** there was an *ongoing* issue: Documentation was found that P2 and P4 got into a physical altercation. While an incident report was found for P2, no corresponding incident report was found for P4.

The above five examples of conduct constitutes a violation of OAR 411-325-0190(1)(a-d).

• **8/30/16,** there was a *new* issue: P4's incident report was not complete. The description of what was happening prior to the incident stated, "(P4) has been aggressive with staff and clients throwing things like cups and chairs and other objects, (P4) walked out of the bedroom looking very agitated into the living room." This date had three separate incidents that resulted in staff calling police and P4 being taken to the emergency room. This conduct constitutes a violation of OAR 411-325-0190(1)(a-b).

• **8/30/16,** there was a *new* issue: P4's incident reports were not complete. Two separate incident reports were written, both related to property destruction. Neither of these incident reports indicated what the response of staff was at the time of the incident. This conduct constitutes a violation of OAR 411-325-0190(1)(c).

• **8/30/16,** there was a *new* issue: P4 went to the emergency room. No documentation was found that immediate notifications were made.

• **9/22/16,** there was an *ongoing* issue: Documentation was found that P2 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.

The above two examples of conduct constitute a violation of OAR 411-325-0190(4)(a-b).

• **9/22/16,** there was a *new* issue: P3 had blanks on the Mar for scheduled medications/treatments without an explanation of the irregularity, including brushing and flossing teeth. This conduct constitute a violation of OAR 411-325-0190(3)(b)(I).

Violations of Behavior Support OAR 411-325-0340

• **9/22/16,** there was a *new* issue: P1's Behavior Support Plan (BSP) was incomplete. The BSP indicated that P1 was to be in-line-of-sight when using the internet on the computer. The BSP did not indicate why this supervision was required, what staff were monitoring for or how they were to intervene if P1 was using the computer inappropriately. This conduct constitute a violation of OAR 411-325-0340(4)(c)(d).

• **9/22/16,** there was a *new* issue: Not all of the supports listed in P1's BSP were being adhered to. The BSP stated that P1 should avoid community locations that are frequented by minors. One of the examples of a venue to avoid was a video game stores. Upon review of T-log notes, P1 went to a video game store on multiple occasions.

• **9/22/16,** there was a new issue: It was observed that not all of P1's environmental supports outlined in P1's BSP were functioning at the time of review. The BSP indicated that an alarm was to be on all exit doors, windows and bedroom door. It was observed upon entering the home that the sliding glass door to the back yard was open, which made the alarm not functional if P1 was to leave the home. It was also observed that the alarm on P1's window did not go off when tested.

The above two examples of conduct constitute a violation of OAR 411-325-0340(4)(d).

• **9/22/16,** there was a *new* issue: P1's BSP did not have a clear procedure to

evaluate P1's BSP for effectiveness. The plan did not list an alteration criteria and

stated that the behavior specialist would review the plan in a "timely manner." This conduct constitute a violation of OAR 411-325-0340(4)(h).

• **9/22/16,** there was a *new* issue: P3's BSP was not accurate. Examples include:
  - The BSP lists interventions for P3's 2000 calorie diet and fluid intake restriction, but these restrictions were discontinued by the physician.
  - The BSP indicated that an activity calendar would be located in the dining room for P3 to review. There was no calendar located in the dining room.

This conduct constitute a violation of OAR 411-325-0340(4)(c).

• **9/22/16,** there was a *new* issue: The BSP for P3 did not have a measurable procedure for evaluating the effectiveness of the plan. There was no measurable criteria to evaluate the effectiveness of the plan regarding undesired sexual behavior, yelling/name calling, verbal aggression, property destruction, false allegations, and use of objects as weapons, making inappropriate comments, unsafe social behavior, self-injurious behavior, and extreme liquid/food seeking. This conduct constitute a violation of OAR 411-325-0340(4)(h).

• **9/22/16,** there was a *new* issue: No alteration criteria was found for P2's BSP. In addition, the BSP indicated that all doors and windows are alarmed. The alarms were checked during the review in P2's bedroom and were not found to be functioning.

• **9/22/16,** there was a *new* issue: No alteration criteria was found for P4's BSP. In addition, the BSP indicated that all doors and windows are alarmed. The alarms were checked during the review in P4's bedroom and were not found to be functioning.

The above two examples of conduct constitute a violation of OAR 411-325-0340(4)(d-h).

Violations of Individual Support Plan OAR 411-325-0430

• **9/22/16,** there was a *new* issue: P2's known risks, located in the Risk Identification Tool (RIT) was not complete or current.

- A risk of diabetes was marked "no' on the RIT. Documentation was found that P2 is diagnosed with diabetes and has a Diabetes Protocol.
- A risk of other mental health issues was marked "yes" on the RIT for P2. The other mental health issues was not identified.

• **9/22/16,** there was a *new* issue: P4's known risks, located in the Risk Identification Tool (RIT) was not current. Unreported pain or illness and refusing medical care on the RIT were both marked "no." The Safety Plan for P4 addresses the risks of not receiving medical care and unreported pain.

The above two examples of conduct constitute a violation of OAR 411-325-0430(4)(b).

• **9/22/16,** there was a *new* issue: P4's Safety Plan was not complete. The Safety Plan indicated that P4 requires sedation prior to all invasive medical and dental appointments. No post sedation monitoring directions were found in place for P4. In addition, the Safety Plan indicated that for the risk of unsafe social behavior, staff are to monitor all interactions and intervene as trained. No documentation was found to indicate what training staff have gone through to intervene on P4's behalf to mitigate this risk. This conduct constitutes a violation of OAR 411-325-0430(4)(c).

• 9/22/16, there was a *new* issue: P4's supports were not complete. Question 12 of the Risk Identification Tool (RIT) was marked "yes." This question is an extra medical question identified as allergies to Benzodiazepines, Haloperidol and Olanzapine. No support document was found for this risk, nor was this risk documented on the Provider Risk Management Strategies page. This conduct constitutes a violation of OAR 411-325-0430(4)(c)(e).

• 9/22/16, there was a *new* issue: The Provider Risk Management Strategies (PRMS) page of P4's ISP was not complete or current.

- Non-edible objects in mouth and extreme food and/or liquid seeking of the RIT for P4 were both marked "yes." These risks were not found documented on the PRMS page of P4's ISP.
- The PRMS page indicated that the Safety Plan that is in place was dated 4/8/16. The Safety Plan that was found in place at the program was dated

5/23/16. No Change Form was found for this update, thus no documentation was found that the ISP team approved of this Safety Plan.

- P4's Constipation Protocol was updated with the Change Form dated 9/15/16. The PRMS page was not updated to coincide with the change.

This conduct constitutes a violation of OAR 411-325-0430(4)(e).

• **9/22/16,** there was a *new* issue: Know risks, located on The Risk Identification Tool (RIT) for P3 was not complete. Examples include:

- The RIT identified P3 to be at risk for aspiration, choking, and extreme liquid/food seeking. The RIT requires an evaluation by a qualified professional be completed in order to determine the severity of the risk and determine support needed. There was no documentation on the RIT to indicate these evaluations had been completed.
- The Behavior Support Plan (BSP) and the Safety Plan indicated that P3 was at risk of using objects as weapons. This risk was marked "no" on the RIT as a current risk for P3.

This conduct constitutes a violation of OAR 411-325-0430(4)(b).

• **9/22/16,** there was a *new* issue: The Provider Risk Management Strategies (PRMS) page that corresponds to P3's ISP was not accurate. Examples include:

- The PRMS listed the date of the Safety Plan as 3/17/16 for P3's risk of sharps, but the Safety Plan found in P3's program book was updated on 5/23/16.
- The RIT identified the risk of mental health for P3. This risk was not listed on the PRMS.
- An ISP Change form dated 3/24/16 indicated that P3's Behavior Support Plan (BSP) was updated on 3/2/16. The BSP listed on the PRMS was still dated 10/30/15.

This conduct constitutes a violation of OAR 411-325-0430(4)(e).

• **9/22/16,** there was a *new* issue: P2's Diabetes Protocol and High Blood Pressure Protocol were not followed. Both of these protocols indicate that P2 is to engage in cardiovascular exercise for 30 minutes four times per week with the documentation to be completed on the MAR. No documentation was found that this has been completed.

• **9/22/16,** there was a *new* issue: P4's Ingestion of Non-Edible Objects Protocol was not followed. According to P4's Ingestion of Non-Edible Objects Protocol, staff are to complete a sweep for targeted items at the beginning of each shift, with the exception of graveyard shift, and document in the behavior tracking. No documentation was found that these sweeps were being completed.

• **9/22/16,** there was a *new* issue: Activities were not completed as directed for P4. According to P4's ISP, P4 is to:

- go to Full Life Cafe two times per month;
- take P4's plate to the sink with verbal cues five times per week;
- put belongings in P4's bin four times per week and
- get ready for shower with verbal cues one time per day.

P4's ISP has been in place for a total of 5 months (144 days) and the following was found documented:

- go to Full Life Cafe a total of two times;
- take P4's plate to the sink with verbal cues a total of 54 times;
- put belongings in P4's bin a total of 35 times and
- get ready for shower with verbal cues a total of 43 times.

No documentation was found that explained these discrepancies.

• **9/22/16,** there was a *new* issue: P3's Desired Outcomes listed in P3's ISP were not occurring at the frequencies outlined in the ISP. Examples include (2016 ISP data tracking):

- Use EBT to build financial skills 2 times per month occurred 3 times from April 2016-August 2016;
- Attend gym 1 time weekly did not occur April 2016-September 21, 2016;
- Household chores one time a week occurred a total of 7 times from April 2016-August 2016;
- Community activities 1 time weekly occurred a total of 6 times from April 2016-August 2016.

The above four examples of conduct constitutes a violation of OAR 411-325-0430(6).

Violations of Individual Rights OAR 411-318-0010

• **3/10/16:** Supports were not followed for all (five) individuals resulting in Protective Service Investigations. A review of incident reports and progress notes showed the following:

- The support documents for all five individuals indicate that knives are to be locked. On 9/7/15, staff left the knives unlocked resulting in P2 obtaining a knife and threatening to do self-harm;
- On 9/16/15 staff were verbally aggressive to P2 resulting in P2 physically aggressing towards staff;
- P4 required line of sight supervision when outside of their bedroom. On 9/16/15, staff left P4 unsupervised for approximately 10 minutes;
- P4 required line of sight supervision when outside of their bedroom. On 12/7/15, P4 was found in the office with the medications and knives unlocked and
- P5 required line of sight supervision. On 12/29/15 staff left P5 unsupervised resulting in P5 choking P3.

• **3/10/16,** supports not followed for individuals was an *ongoing* issue: Supports were not followed for individuals resulting in Protective Service Investigations for the following incidents:

- P5 requires one on one supervision and only one staff was supervising P5 and P2. P2 and P5 became verbally aggressive towards each other which escalated into a physical altercation;
- P5 had scissors without staff's knowledge. The supports for P2, P3 and P4 all indicate that sharps are to be locked at all times and only used with staff's supervision;
- Staff got into a verbal and physical altercation with P5. P5 obtained leather cleaner and a toaster in an attempt to do self-harm. As a result, P5 went to the emergency room and was left unsupervised in the emergency room for three hours.

• **5/4/16,** supports for individuals continued to be an *ongoing* issue: Staff did not maintain the supervision requirements for P3. P3 went to the emergency room without staff when P3 is to remain within sight and sound while in the community.

• **8/30/16,** there was an *ongoing* issue with a new example: During the review, P3 reported to the review team that a staff threatened P3 the previous week by saying that if P3 did not "listen to staff and behave" then staff would call P3's parents.

• **9/22/16,** supports for individuals continued to be an *ongoing* issue: No documentation was found that staff were trained on the supports of the individuals since the last review to stop potential abuses.

• **8/30/16,** there was a *new* issue: According to P2's incident report, P2 became verbally aggressive towards a housemate. No documentation was found that staff attempted to redirect P2 until P2 attempted to follow the housemate at which point staff used body positioning. P2 then went around the staff and continued the verbal aggression towards the housemate. P2 eventually deescalated when a second staff came and assisted with the situation.

• **8/30/16,** there was a *new* issue: Documentation for P4 was not clear and descriptive. A T-Log for P4 documented that staff wrote that P4 "...was very agitated today with random spaz outs...". Since no description of what a "spaz out" looks like for P4, it is unclear what behaviors P4 was displaying this day.

• **9/22/16,** there was a *new* issue: Evaluations were not completed as required. A risk of extreme food and/or liquid seeking on the Risk Identification Tool (RIT) for P4 was marked "yes." This question directs the ISP team to get an evaluation to determine the level of risk. No evaluation was found for this risk.

• **9/22/16,** there was a *new* issue: Supports were not being followed for individuals in the program. According to P4's Behavior Support Plan and Safety Plan indicated that all chemicals and food are to be locked. During the review, food, Clorox wipes, dishwasher tablets and Formula 409 cleaner were all found unlocked.

• **3/10/16:** The Behavior Support Plans (BSPs) were not followed for P3 and P5. Both P3's BSP and P5's BSP indicated they were to have line of sight supervision and able to hear and see all interactions when in common areas of the home with housemates. Examples of the BSP not being followed include:

- Three staff were found in the staff office with the office door closed leaving P1, P3, P4 and P5 unsupervised, the review indicated a refresher training on

supervision levels for all staff would occur by 3/10/16, however that training was not completed by the time of the onsite review.

- Lack of supervision, P5 left the residence without staff.
- P5 was roughhousing with a housemate and got slapped, punched holes in the wall and doors, broke a chair, attempted suicide and went AWOL resulting in arrest.
- P5 had an argument with a housemate and then broke the bathroom mirror, there were no staff in line of sight until P5 went into the bathroom.

• **5/4/16,** there was an *ongoing* issue: P3 and P5 had GER's indicating adequate supports were not in place and/or the BSP's were not followed. Examples include:
P3:

- Roughhousing (3/19/16)
- Roughhousing (4/6/160
- Assault victim, P3 was punched in the face by a housemate on an outing.

P5:

- Altercation between housemates in the van, the outing did not meet supervision requirements as P5 had supervision levels of one on one in the community.
- Self-injury with scissors found in room.
- P5 had a large altercation with staff (choked staff due to staff escalated behaviors); P5 later called the program after leaving with her/his grandparent and left their supervision; no supports were in place to address the issue of leaving the program while escalated.
- P5 was kicking the wall in the bedroom and housemate spoke derogatively of P5, which led P5 to target housemate. Police were called.
- Altercation as a result of roughhousing.
- P5 became verbally aggressive after about 2 hours of listening to housemate's verbal aggressive behavior, no supports were identified to assist P5 in dealing with this situation or to keep housemates safe from the behaviors of the housemate.
- P5 was aggressing toward staff, staff used evasion techniques, however, P5 hit housemate when P5 walked past housemate.

• **6/30/16,** there was an *ongoing* issue: P3'S BSP was not followed. Examples

include:

- Serious illness, staff sent P3 to the ER without staff. The BSP indicated P3 was to be within sight/sound when out in the community.
- Bleeding, P3 threw a cup at housemate after housemate threw items at P3 and staff. There was no staff intervention as required by the BSP.

• **8/30/16,** there was an *ongoing* issue: A Therap T-log indicating P3 was yelling at staff (verbal aggression) and banged on the office door. P3 then went to his/her room and staff left the area. Staff then heard P3 yelling at a housemate then yelled at another housemate, kicked walls and doors and pulled a chair back as if to throw it. The BSP indicated GER's were to be completed for verbal/physical aggression and when escalated, staff were to remain in line of sight. A GER had not been completed and staff left P3 when P3 went to his/her room. The BSP also indicated signs of escalation was "making fists, raised booming voice, cussing, etc. and staff were to respond by asking to go with staff to a quiet area. There was no indication P3 was asked to go with staff to a quiet area.

• **9/22/16,** there was a *new* issue: It was observed throughout the course of the review staff responsible for P4 was in the living room sitting in a recliner with their feet up and eyes closed, with P4 sitting on the adjacent couch. At one point a reviewer went to the front door to check the alarms. The staff seemed startled when the alarm was tested.

• **9/22/16,** there was a *new* issue: Supports for P3 were identified as risk of aspiration, choking, and food/liquid seeking according to the Risk Identification Tool (RIT). These risks were not thoroughly developed and implemented. Examples include:

- The RIT indicated that P3 was at risk for aspiration, choking, and extreme liquid/food seeking. The RIT indicated that an evaluation by a qualified professional was required for these risks in order to evaluate the severity of the risk and determine supports needed. There were no evaluations found for these risks.
- The Aspiration/Choking Protocol for P3 indicated that as a preventative strategy for P3's extreme food seeking risk that all food would be locked. During the inspection all food was left unlocked.
- The Aspiration/Choking Protocol for P3 indicated that as a preventative

measure staff were to encourage P3 to take small bites and slow down. P3 sat at the table with a reviewer and was eating heaping spoonfuls of Reese's cereal without staff in the area to encourage him/her to slow down and take small bites. Additionally, when it was lunch time staff gave P3 his/her lunch and P3 headed to P3's room to eat.

- A t-log indicated that P3 came home from an outing and vomited. There was no documentation found that P3's protocol was followed which include temperature taken, the supervisor notified, the physician notified, or that a GER written as instructed in the protocol.

• **9/22/16,** there was a *new* issue: P3's Safety Plan and Behavior Support Plan (BSP) was not implemented. The environmental modification sections indicated that there would be chime alarms on P3's window, bedroom door, and exterior doors of the home. Upon review of the home the chime alarm on P3's bedroom window was not in working order. Additionally, there was no plan and/or documentation as to the frequency the chime alarms needed to be checked in order to make sure they were in proper working order.

• **9/22/16,** there was a *new* issue: P1 was not receiving adequate support to ensure medical appointments were obtained and followed up on. Examples include:

- P1 was scheduled to see a Neurologist. No documentation was located to indicate P1 went to see the Neurologist.
- P1 had a fainting spell according to a GER with the same date as a fall according to a GER that the administrative review linked to the fainting spell. P1's physician referred P1 to a Neurologist at that time. The Neurologist ordered an EEG. No results or documentation was found that P1 was taken to get an EEG after the Neurologist ordered it.
- According to a physician's visit form, P1 was seen by their physician for a "bad cough". The physician ordered a chest x-ray at that time. No results or follow-up on the chest x-ray were found.
- P1's Balancing test and psych visit, dated 11/18/15, indicated that P1 was to return in 3 months. The next psych visit form found was dated 5/11/16. No documentation was found as to why P1 did not return in 3 months as ordered.

The above seventeen examples of conduct constitutes a violation of OAR 411-318-0010(1)(n).

Licensee's Conduct constituted a violation of the following Oregon Administrative Rules:

2016

Medical Services.....OAR 411-325-0120 (2)(c), (2)(a)(D), (2)(d)(B), (3)(b)(A-F), (3)(b)(C), (3)(b)(H), (3)(b)(I), (6), (7)(a)

Incident Reports and Emergency Notifications.....OAR 411-325-0190(1)(a-d), (1)(c), (2), (3)(b)(B, (3)(b)(B), (4)(a-b)

Behavior Support.....OAR 411-325-0340 (4)(c), (4)(c)(d), (4)(d), (4)(h), (4)(d-h)

Individual Support Plan.....OAR 411-325-0430 (4)(b), (4)(c), (4)(e), (4)(c)(e), (6) *Effective 6/29/16 thru present*

Individual Rights.....OAR 411-318-0010 (1)(n) *Effective 1/1/16 – 6/28/16* and (1)(n) *Effective 6/29/16 thru present*

REVOCATION OF LICENSE

This revocation is based upon the fact the Licensee substantially violated OARs governing 24-hour residential care facilities as stated above.

License Denial, Suspension, Revocation, and Refusal to Renew.....OAR 411-325-0470(1) and (2).

APPEAL RIGHTS

Contested Case Hearing: Licensee is entitled to a contested case hearing as provided by the Administrative Procedure Act (ORS Chapter 183). Licensee may be represented by counsel at the hearing. If Licensee desires a contested case hearing,

Licensee must request the hearing in writing within **21-days** of the date that Licensee receives this Notice. Upon receipt of a written hearing request, Licensee will be notified of the time and place of the hearing. The Licensee may also request an informal administrative conference prior to the hearing.

Default: You will be in default if you: do not request a hearing within the time allowed; request a hearing and later withdraw your request; request a hearing and do not appear at the time and place; or notify the Department that you will not appear at the hearing and the Department does not reschedule the hearing. If you are in default, the Department will not hold a hearing. The record of the proceedings to date (including the information in the Department's file or files on the subject of the contested case) will automatically become part of the contested case record for the purpose of making a *prima facie* case and the Department may issue a final order by default.

CONTACT PERSON

The request for a contested case hearing or an informal administrative conference should be sent to:

Nicole Estrada, Compliance Specialist
Oregon Department of Human Services
Office of Developmental Disabilities Services
PO Box 14540
Salem, OR 97309
Telephone: 503-373-1992/Fax: 503-373-2228
Nicole.Estrada@state.or.us

Barbara Southard for
Lilia Teninty, Director
Office of Developmental Disabilities Services

10/26/16
Date