ADDICTIONS AND MENTAL HEALTH DIVISION
Kate Brown, Governor

Oregon Health Authority

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State of Oregon
Oregon Health Authority
Addictions and Mental Health Division

In the Matter of: Heeran Center Residence	**Notice of Immediate Suspension and Notice of Opportunity for Hearing** License Number ORR202

To: Susan Ban, Director
Sheltercare, Heeran Center Residence
2222 Coburg Road
Eugene, Oregon 97401

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440 East Broadway, Suite 300
Eugene, Oregon 97401

I.

The Oregon Health Authority, Addictions and Mental Health Division hereby immediately suspends, effective on March 2, 2015, the Class 2, Secure Residential Treatment License of the Heeran Center Residence, operating at 2222 Coburg Road Eugene, Oregon 97401.

This is being sent to you pursuant to Oregon Revised Statute (ORS) 443.400 through ORS 443.455, ORS 443.410, ORS 443.425, ORS 443.440, ORS 183.415; Oregon Administrative Rules (OAR) 309-035-0100 through OAR 309-035-0190; and OAR 309-033-0500 through OAR 309-033-0560.

II.
LICENSE STATUS

Sheltercare ("Licensee") was licensed by the State of Oregon through the Oregon Health Authority, Addictions and Mental Health Division ("OHA" or "AMH") to provide 24 hour secure residential treatment services at the Heeran Center Residence, located at 2222 Coburg Road Eugene, Oregon 97401. The Heeran Center is a Class 2 secure facility pursuant to OAR 309-033-0520(3) (a secure residential facility that is approved under OAR 309-035-0100 through 309-035-0190 and that is approved by the Division to be locked to prevent a person from leaving the facility).

Sheltercare is licensed to have up to 16 residents at the Heeran Center. As of 2/26/15, twelve individuals live at the Heeran Center, including seven who are committed to the facility under a civil court order (civil commitment) and five individuals who are committed to the facility under jurisdiction of the Psychiatric Security Review Board.

On 10/3/2014, 10/6/2014, 10/17/2014, 12/5/2014, 12/9/2014, 12/10/2014, 12/22/2014, 1/22/2015, and 2/26/2015, AMH or Lane County conducted a series of scheduled and unscheduled inspections and the review of records for those residents of Heeran Center Residence. Through these inspections, resident record reviews, and ongoing monitoring, AMH identified violations of rule and law.

For example, during the inspection on 10/3/2014 and 10/6/2014, AMH identified 12 resident records containing items of noncompliance. During the inspection on 10/15/2014, AMH identified 19 medication errors in one resident record, including deficient medication administration records. During the inspection on 12/9/2014, AMH identified 38 total errors in the medication administration records, and Licensee promised to address those errors. Upon follow up inspection on 12/12/2014, Licensee had not corrected the errors.

During the inspection on 12/15/2014, AMH identified further medication errors. Licensee then delivered a plan of correction for deficiencies reported from the 12/19/14 inspection. During a follow-up inspection on 1/22/2015, AMH identified 11 medication errors.

During and after these various inspections and reviews, Licensee repeatedly represented that Licensee would implement plans of correction, properly train staff, and/or make lasting improvements, but AMH continued to find noncompliance.

On 1/28/2015, AMH issued a notice of Proposed Order of Revocation regarding the Heeran Center license, and on 1/30/2015, Licensee requested a hearing on the matter, via its attorney. A hearing on the proposed revocation is set for 4/22 and 4/23/2015.

On 2/24/2015, a resident eloped from the Heeran Center by escaping through the fence in facility's fenced yard while the resident was in the yard without supervision. This was the third time that a resident had eloped from the Heeran Center in the past four and a half months.

During an inspection on 2/26/2015, AMH identified additional items of noncompliance, including but not limited to deficient medication administration records, and noncompliance related to the resident's elopement on 2/24/2015.

AMH concluded that the Licensee's repeated or continued noncompliance and violation of administrative rules creates an imminent danger to the health and safety of residents and to other members of the public. AMH hereby immediately suspends the Heeran Center license.

AMH's findings are summarized herein. Excerpts of law are printed in bold lettering.

III.

OAR 309-035-0159

(4) Progress Notes. Progress notes will be maintained within each resident's record and document significant information relating to all aspects of the resident's functioning and progress toward desired outcomes identified in the residential service plan. A progress note will be entered in the resident's record at least once each month.

(5) Re-assessments and Revisions to the Residential Service Plan. The assessment and residential service plan will be reviewed and updated at least annually. On an ongoing basis, the residential service plan will be updated, as necessary, based upon changing circumstances or upon the resident's request for reconsideration.

OAR 309-035-0105

(37) "Progress Notes" means the notations in the resident record documenting significant information concerning the resident and

summarizing progress made relevant to the objectives outlined in the residential service plan.
[…]

(41) "Residential Service Plan" means an individualized, written plan outlining the care and treatment to be provided to a resident in or through the facility based upon an individual assessment of care and treatment needs. The residential service plan may be a section or subcomponent of the individual's overall mental health treatment plan when the RTF is operated by a mental health service agency that provides other services to the resident.

On 2/20/2015, four days before the resident's elopement from the Heeran Center, Licensee's staff identified that the resident was decompensating and therefore required the resident to be supervised at all times. Despite the resident's medical status, need for supervision, and history of eloping from Heeran Center, Licensee permitted the resident to be in the yard outside without supervision, which is when the resident eloped.

Licensee's staff members, who were responsible for the resident on 2/24/2015, reported that they had not been aware that the resident was to be supervised at all times. Licensee had failed to document the resident's need for supervision in the progress notes and residential service plan. Licensee failed to maintain an individualized, updated written service plan documenting resident treatment, needs, and care. Licensee also failed to maintain progress notes documenting significant information about the resident. If Licensee had assured that its staff had had access to key information in the residents' progress notes and records, they would have known not to leave the resident unsupervised in the yard. Licensee violated OAR 309-035-0159 (4) and (5). This also constitutes a violation of OAR 309-035-0155 (1) & (2)(b), for failure to provide an individualized written service plan with services based upon the review and reassessment of service needs.

In addition to failing to maintain written documentation among staff about resident care needs, Licensee failed to assure that staff had a system to orally communicate to each other the relevant information to keep residents safe. Licensee lacks communication processes and protocols to assure that relevant staff is timely apprised of resident needs and to assure appropriate entry and organization of records about resident needs. These are reasonable processes required to protect residents from harm. Licensee violated OAR 309-035-0155 (2)(h) & (5) for failure to implement a service environment that affords all residents with reasonable protection from harm.

The lack of timely, accessible, accurate, and complete records about resident needs, especially combined with the lack of a system of communication among staff, places resident health and safety in imminent danger.

AMH previously found similar noncompliance by Licensee concerning deficient resident service plans, progress notes, information about medication administration, and treatment needs. For example, this was documented in reports from 5/7/13, 10/6/14, and 12/10/14.

IV.

OAR 309-035-0155

(2) Rights of Service Recipients. In accordance with ORS 430.210, residents will have the right to:[…]
(h) A humane service environment that affords reasonable protection from harm and affords reasonable privacy; […]

(4) The Resident's Right to Fresh Air. […]
(c) If a resident requests access to fresh air and the outdoors or the resident's treating health care provider determines that fresh air or the outdoors would be beneficial to the resident, the facility in which the resident is receiving services shall provide daily access to fresh air and the outdoors unless this access would create a significant risk of harm to the resident or others.
(d) The determination whether a significant risk of harm to the resident or others exists shall be made by the resident's treating health care provider. The treating health care provider may find that a significant risk of harm to the resident or others exists if:

(A) The resident 's individual circumstances and condition indicate an unreasonable risk of harm to the resident or others which cannot be reasonably accommodated within existing programming should the resident be allowed access to fresh air and the outdoors; or
(B) The facility's existing physical plant or existing staffing prevent the provision of access to fresh air and the outdoors in a manner than maintains the safety of the resident or others.
[…]

(5) Program Requirements. The program will have and implement written policies and procedures which protect residents' rights, and encourage and assist residents to understand and exercise their rights. The program will post

a listing of resident rights under these rules in a place readily accessible to all residents and visitors.

On 2/24/2015, while in the Heeran Center's yard, the resident escaped through a fence that lacks structural integrity and is not secured. Licensee failed to adequately maintain the fence to secure the facility's perimeter. Licensee was required to identify the extent to which the Heeran Center's physical plant or staffing could safely allow residents access to fresh air. In the example of the elopement on 2/24/2015, Licensee left the resident outside without supervision in the yard and did so in a yard that lacked a secure fence. Licensee knew that resident was decompensating and that the resident had a history of elopement from this facility. Licensee has failed to implement a policy and procedure to meet the requirements of OAR 309-035-0155 (4) (c)&(d). Licensee has failed to comply with OAR 309-035-0155 (4) (c)&(d) and (5).

Identifying physical hazards, adjusting service to accommodate resident needs, supervising residents, and securing the perimeter of a secure residential treatment facility are necessary to reasonably protect residents from harm. In particular, the Heeran Center's residents have been placed in a 24-hour, secure facility due to their high levels of need. Licensee failed to provide a service environment that affords reasonable protection from harm, in violation of OAR 309-035-0155(2)(h). Failure to identify and appropriately provide for resident care needs and security, including potential physical hazards, places resident health and safety in imminent danger.

AMH previously found noncompliance by Licensee concerning Licensee's failure to identify and eliminate physical hazards such as cigarette lighters, a power drill, and other hazardous items in the facility. For example, see the reports from 5/7/13 and 10/6/2014. (See Section VII. herein regarding violations of OAR 309-035-0125 (4) (b) & (c)).

Licensee's failure to appropriately supervise and observe residents resulted in a resident's elopement on 2/24/2015. In that incident, Licensee's lack of supervision also delayed its ability to discover the elopement and hindered its ability to immediately locate the resident afterward, endangering the resident who remained at large in the community.

This was not the first time that Licensee's failure to appropriately supervise or observe residents contributed to a resident eloping and remaining at large in the community. On or about 11/6/2014, a different resident of the Heeran Center had eloped through an unsecured window. In that incident, Licensee's staff had failed to adequately check on residents. As a result, about eight hours passed from the

last time resident had been observed before Licensee realized that the resident had eloped. After the incident, on 11/6/2014 Licensee promised to implement procedures for conducting safety checks and for closely observing residents. Licensee has failed to implement processes for appropriate observation and supervision, which are necessary to provide a service environment that affords reasonable protection from harm. Licensee has violated OAR 309-035-0155(2)(h). Failure to appropriately supervise and observe residents places resident health and safety in imminent danger.

V.

OAR 309-033-0300

(4) Authority to retake persons. A Class 1 or Class 2 facility shall immediately notify a peace officer and the Division of any person who has left the facility without lawful authority and shall immediately request the assistance of a peace officer(s) in retaking and returning the person to a Division-approved hospital or facility. The director shall show the peace officer a copy of the order of commitment.

On Tuesday, February 24, 2015, Licensee discovered that a resident had eloped from the facility. The next day, on Wednesday, February 25, 2015, Licensee notified AMH about the elopement. As a Class 2 facility, the Licensee failed to immediately notify AMH. Licensee violated OAR 309-033-0300(4).

The Licensee's failure to immediately notify AMH delayed AMH's ability to provide supportive services or assistance and deprived AMH of its ability to immediately assess the risk to the health and safety of residents.

VI.

OAR 309-035-0175
Health Services

(4) Written Orders for Special Needs. A written order, signed by a physician or other qualified health care professional, is required for any medical treatment, special diet for health reasons, aid to physical functioning or limitation of activity.

(5) Medications. A written order signed by a physician or other qualified health care professional is required for all medications administered or supervised by RTF staff. This written order is required before any medication is provided to a resident. Medication will not be used for the convenience of staff or as a substitute for programming. Medications will not

be withheld or used as reinforcement or punishment, or in quantities that are excessive in relation to the amount needed to attain the client's best possible functioning.

(a) Medications will be self-administered by the resident if the resident demonstrates the ability to self-administer medications in a safe and reliable manner. In the case of self-administration, both the written orders of the prescriber and the residential service plan will document that medications will be self-administered. The self-administration of medications may be supervised by facility staff who may prompt the resident to administer the medication and observe the fact of administration and dosage taken. When supervision occurs, staff will enter information in the resident's record consistent with section (5)(h) below.

(b) Staff who assist with administration of medication will be trained by a Licensed Medical Professional on the use and effects of commonly used medications.

(c) Medications prescribed for one resident will not be administered to, or self-administered by, another resident.

(d) Stock supplies of prescription medications will not be maintained. The facility may maintain a stock supply of non-prescription medications.

(e) The facility will provide and implement a policy and procedure which assures that all orders for prescription drugs are reviewed by a qualified health care professional, as specified by a physician or other qualified health care professional but not less often than every six months. Where this review identifies a contra-indication or other concern, the resident's primary physician, LMP or other primary health care professional will be immediately notified. Each client receiving psychotropic medications will be evaluated at least every three months by the LMP prescribing the medication, who will note, for the resident's record, the results of the evaluation and any changes in the type and dosage of medication, the condition for which it is prescribed, when and how the medication is to be administered, common side effects (including any signs of tardive dyskinesia, contraindications or possible allergic reactions), and what to do in case of a missed dose or other dosing error.

(f) All unused, discontinued, outdated or recalled medications, and any medication containers with worn, illegible or missing labels will be disposed. The method of disposal will be safe, consistent with any applicable federal statutes, and designed to prevent diversion of these substances to persons for whom they were not prescribed. A written record of all disposals will be maintained and specify the date of disposal, a description of the medication,

its dosage potency, amount disposed, the name of the individual for whom the medication was prescribed, the reason for disposal, the method of disposal, and the signature of the staff person disposing the medication. For any medication classified as a controlled substance in schedules 1 through 5 of the Federal Controlled Substance Act, the disposal must be witnessed by a second staff person who documents their observation by signing the disposal record.

(g) All medications will be properly and securely stored in a locked space for medications only in accordance with the instructions provided by the prescriber or pharmacy. Medications for all residents will be labeled. Medications requiring refrigeration must be stored in an enclosed locked container within the refrigerator. The facility will assure that residents have access to a locked, secure storage space for their self-administered medications. The facility will note in its written policy and procedures which persons have access to this locked storage and under what conditions.

(h) For all residents taking prescribed medication, staff will record in the medical record each type, date, time and dose of medication provided. All effects, adverse reactions and medications errors will be documented in the resident's record. All errors, adverse reactions or refusals of medication will be reported to the prescribing professional within 48 hours.

(i) P.r.n. medications and treatments will only be administered in accordance with administrative rules of the Board of Nursing, chapter 851, division 47.

(6) Delegation of Nursing Tasks. Nursing tasks may be delegated by a Registered Nurse to direct care staff within the limitations of their classification and only in accordance with administrative rules of the Board of Nursing, chapter 851, division 47.

Licensee failed to comply with OAR 309-035-0175 by failing to manage and implement an appropriate medication administration program. In prior inspections, AMH identified that the Heeran Center records lacked current physician's orders for each resident in violation of OAR 309-035-0175(5)(e). Medication administration records (MAR) lacked entries for current medication orders in violation of OAR 309-035-0175(5)(h). MAR entries for medications lacked corresponding physician orders in violation of OAR 309-035-0175(5)(a). Staff were found to be administering medications incorrectly or without receiving required training in violation of OAR 309-035-0175(5)(b). Licensee failed to provide adequate nursing care by failing to employ a registered nurse to provide training and oversight of delegated nursing tasks in violation of OAR 309-035-0175(6), OAR 851-047-0030 and ORS 443.445(4). Incident reports and MAR documentation showed that medications had been mistakenly administered without current physician orders and on multiple occasions were administered to

the wrong resident in violation of OAR 309-035-0175(5)(e)&(c). Licensee continually failed to maintain current and accurate documentation of medications within the resident records in violation of OAR 309-035-0117(4)(g). These violations are described in, for example, the reports of noncompliance from 5/7/13, 7/16/2013 10/6/14, 12/8/14, 12/10/14, and 1/23/15.

Substantially complying with OAR 309-035-0175 is essential to protecting and maintaining each individual's psychiatric and physical health. Although Licensee submitted plans of correction to correct the medication administration and record issues, Licensee failed to implement those plans. The provider continually violated OAR 309-035-0175 and its subsections by failing to adequately implement corrective action sufficient to achieve and maintain compliance.

Failure to appropriately administer medication and maintain records places resident health and safety in imminent danger. This also constitutes a violation of OAR 309-035-0155 (2)(h) & (5) for failure to implement a service environment that protects resident rights and affords all residents with reasonable protection from harm.

VII.

OAR 309-035-0125
Facility Requirements

(4) General Storage. The facility will include sufficient and safe storage areas. These will include but not be limited to:

(b) All maintenance equipment, including yard maintenance tools, will be maintained in adequate storage space. Equipment and tools which pose a danger to facility residents will be kept in locked storage;

(c) Storage areas necessary to insure a functional, safe and sanitary environment consistent with OAR 309-035-0125, 309-035-0130, 309-035-0135, 309-035-0140, 309-035-0170, and 309-035-0175.

During various inspections, Licensee failed to identify hazardous items and keep them in a locked location. This constitutes a violation of OAR 309-035-0125 4 (b) and (c). Examples of the hazardous items that were available to residents in the facility include but are not limited to: cigarette lighters, a power drill, fish hooks, meat grinder, cheese grater, and hot glue gun.

Failure to appropriately identify and secure hazardous items places resident health and safety in imminent danger. Implementing a system to identify and eliminate physical hazards from the facility is necessary to implement a service environment that reasonably protects residents from harm. Licensee has violated OAR 309-035-0155 (2)(h) & (5).

VIII.

OAR 309-035-0115
Administrative Management
(1) Licensee. The licensee will be responsible for insuring that the facility is operated in compliance with these rules and all other applicable federal, state and local laws and regulations.

Under OAR 309-035-0115, Licensee is ultimately responsible for insuring that facility staff operates the facility appropriately and in compliance with all applicable rules and law. As described above, Licensee has failed to do so. License has placed residents in imminent danger to their health and safety.

IX.
IMMEDIATE SUSPENSION

ORS 443.440 Revocation and suspension of licenses; procedure.

The Department of Human Services or the Oregon Health Authority may revoke or suspend the license of any residential facility that is not operated in accordance with ORS 443.002 or 443.400 to 443.455 or the rules of the licensing agency. Such revocation or suspension shall be taken in accordance with rules of the licensing agency and ORS chapter 183. However, in cases where an imminent danger to the health or safety of the residents exists, a license may be suspended immediately pending a fair hearing not later than the 10th day after such suspension.

OAR 309-035-0110
Licensing

(8) Findings of Noncompliance. The Division will require an owner to submit and complete a plan of correction for each finding of noncompliance with these rules.
(a) If the finding(s) of noncompliance substantially impact the welfare, health and/or safety of residents, the plan of correction will be submitted and

completed prior to issuance of a license. In the case of a currently operating RTF, such findings may result in suspension or revocation of a license.

(14) Denial, Suspension or Revocation of License. The Division will deny, suspend or revoke a license where it finds there has been substantial failure to comply with these rules; or where the State Fire Marshal or authorized representative certifies that there is failure to comply with the Fire Code.

Under ORS 443.440 and OAR 309-035-0110, AMH may suspend the license of any residential treatment facility that is not operated in accordance with ORS 443.002 or 443.400 to 443.455 or AMH's rules.

In prior months, Lane County Mental Health officials and AMH have repeatedly told Licensee about the need to comply with all rules and law for the facility. Staff members from both Lane County and AMH have also provided technical assistance to Licensee. Over the prior months, Licensee has also promised to make lasting improvements, properly train staff, and/or implement correction plans. However, Licensee has substantially failed to comply with rules.

Ongoing noncompliance with rules and repeated conduct and omissions by Licensee constitutes a serious danger to the public health or safety. The recent elopement and ongoing review of Heeran Center further demonstrate that providing Licensee with additional opportunity for corrective action is not sufficient to protect public health and safety and is inconsistent with the public interest.

The foregoing rule violations, individually and in their totality, establish failures by Licensee to substantially comply with the standards applicable to maintaining a license to operate a secure residential treatment facility. The violations create a particular danger to residents and to the public, because of the level of care and 24-hour security needed by individuals whom have been entrusted to Licensee's care. Licensee's noncompliance has substantially impacted the welfare, health, and safety of residents and has resulted in imminent danger to residents. AMH concludes that the license to operate the Heeran Center is immediately suspended.

Effective immediately, Licensee must stop accepting new clients and must immediately relocate current residents until further AMH order.

AMH will assist with ensuring that current residents may be safely transferred to other appropriate facilities.

X.

NOTICE OF RIGHT TO LEGAL REPRESENTATION

You have the right to be represented by counsel. Legal aid organizations may be able to assist those with limited financial resources. If you are an agency, corporation, partnership, limited liability company, trust, government body or an unincorporated association, you must be represented by an attorney licensed in Oregon.

XI.
NOTICE OF RIGHT TO HEARING

Pursuant to ORS 443.440, you are entitled to a hearing within 10 days of this suspension. A hearing will be held before an administrative law judge pursuant to the Administrative Procedures Act described in the contested case procedures, ORS 183.310 through 183.550 and the Attorney General's Model Rules of Procedure (OAR 137-003-0000 et seq). The Office of Administrative Hearings will provide you with the time and place of the hearing, and with additional information about the procedure and conduct of the hearing and your rights.

If you fail to appear at a scheduled hearing, you will have waived your right to hearing and AMH may issue a final order by default suspending your license. If AMH issues a final order by default, AMH designates the relevant portions of its files on this matter, including all materials that you have submitted relating to this matter, as the record for purpose of proving a prima facie case upon default.

XII.
NOTICE TO ACTIVE DUTY SERVICEMEMBERS

Active duty servicemembers have a right to stay these proceedings under the federal Servicemembers Civil Relief Act. For more information contact the Oregon State Bar at 800-452-8260, the Oregon Military Department at 800-452-7500 or the nearest United States Armed Forces Legal Assistance Office through http://legalassistance.law.af.mil.

DATED this ___ day of _____ 2015.

_____

Deputy Director
Addictions and Mental Health Division
Oregon Health Authority
State of Oregon