United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510–6200

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Mr. McKinney, Ms. Pakkebier, Mr. Law:

For more than a year-and-a-half, the Senate Finance Committee investigated REM Iowa and MENTOR Oregon (together, "the Companies") following reports of abuse, neglect, and, in some cases, death at group homes serving individuals with intellectual and developmental disabilities (I/DD).[1] On December 3, 2020, the Committee completed its investigation and issued two reports, one for REM Iowa and one for MENTOR Oregon, finding that, despite increased scrutiny by State regulators, the Companies' clients continue to suffer from reoccurring incidents that put the health and safety of the I/DD community in jeopardy.[2] Following the issuance of these reports, on December 11, 2020, counsel transmitted a letter to the Committee on behalf of the Companies to "request correction and clarification" of the Committee's reports on the basis that certain points "are either factually incorrect or presented in a way that leaves the reader with a false impression."[3] While we appreciate the Companies' efforts to provide the Committee with additional context and clarification following the completion of its investigation, we believe that many of the points outlined in the December 11th letter are misleading and/or selectively quote

[1] Press Release, Grassley, Wyden Probe Reports of Abuse at Group Homes in Iowa and Oregon (Apr. 3, 2019), https://www.grassley.senate.gov/news/news-releases/grassley-wyden-probe-reports-abuse-group-homes-iowa-oregon.
[2] Press Release, Grassley, Wyden Issue Reports on Developmental Disability Care Facilities in Iowa and Oregon (Dec. 3, 2020), https://www.grassley.senate.gov/news/news-releases/grassley-wyden-issue-reports-developmental-disability-care-facilities-iowa-and.
[3] Letter from Reginald Brown and Jeremy Dresner, Counsel, Kirkland & Ellis LLP, on behalf of REM Iowa and MENTOR Oregon, to Senator Grassley and Senator Wyden (Dec. 11, 2020).

passages from the Committee's reports without providing additional context for the reader. Therefore, we would like to respond to the December 11th letter.

A. The Committee's Iowa Report

1. Re: Distinction between REM Iowa, Inc.'s Intermediate Care Facilities for Individuals with Intellectual Disabilities and REM Iowa Community Services, Inc.'s HCBS Waiver Group Homes.

According to REM Iowa,

> [T]he Committee's Iowa Report . . . conflates REM Iowa, Inc.'s Intermediate Care Facilities for Individuals with Intellectual Disabilities ("ICF/ID") with REM Iowa Community Services, Inc.'s Home and Community Based Services ("HCBS"), also known as Medicaid "waiver" group homes. These are two entirely different service lines—they are operated by different REM corporate entities, they provide different levels of care, they have different requirements and practices, and they have different state regulators.[4]

Based on internal correspondence produced to the Committee by REM Iowa, on August 10, 2015, the Iowa Department of Human Services (Iowa DHS) placed REM Iowa Community Services and REM Developmental Services on probation pursuant to 441 Iowa Administrative Code § 79.2(3)(a)(1).[5] In response to Iowa DHS's sanction of probation letter, REM Iowa submitted one self-assessment for both corporate entities which informed Iowa DHS that the "REM entities operate as one agency . . . [t]herefore it is expected that *all of the REM entities operate under one set of operational policies and procedures.*"[6] (During the course of Committee's investigation, REM Iowa did not rebut or respond to Iowa DHS's determination.)

Prior to its decision to place REM Iowa on probation, Iowa DHS's HCBS Quality Oversight staff conducted targeted reviews and, in some cases, required REM Iowa to submit corrective action plans to correct issues like abuse reporting, communication, incident reporting, medication administration, member health and safety, and so on.[7] However, REM Iowa failed to successfully implement these corrective action plans.[8] Iowa DHS then required REM Iowa to submit an agency-wide corrective plan.[9] In response, "[t]he REM entities submitted a *single agency-wide corrective action plan* attempting to come into compliance" with the areas identified by HCBS Quality Oversight staff.[10] (This gave further credence to Iowa DHS's determination that REM Iowa operates as "one agency".) However, REM Iowa "failed to

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[4] Letter from Reginald Brown and Jeremy Dresner, Counsel, Kirkland & Ellis LLP, on behalf of REM Iowa and MENTOR Oregon, to Senator Grassley and Senator Wyden (Dec. 11, 2020).
[5] REMIOWA-00001575.
[6] REMIOWA-00001575. Emphasis added.
[7] REMIOWA-00001575, at REMIOWA-00001576.
[8] REMIOWA-00001575, at REMIOWA-00001576.
[9] REMIOWA-00001575, at REMIOWA-00001576.
[10] REMIOWA-00001575, at REMIOWA-00001577. Emphasis added.

demonstrate adequate remediation of the identified issues" which forced Iowa DHS to place REM Iowa on probation soon thereafter.[11]

While Iowa DHS's decision to place REM Iowa on probation concerned REM Iowa Community Services and REM Developmental Services, the Committee's investigation shows that REM Iowa's ICF/ID group homes also suffer from issues similar to those identified by Iowa DHS in 2015. Therefore, as Iowa DHS determined that REM Iowa and its affiliated entities operate as "one agency",[12] REM Iowa must address these issues for all of its corporate entities, not piecemeal.

2. Re: Factually Inaccurate Incident Descriptions

REM Iowa identified—what it believed to be—inaccurate descriptions and mischaracterizations on page 11 and 12 of the Committee's report.[13] We will respond to each of these assertions in turn.

First, REM Iowa argues that "[t]he Committee's Iowa Report incorrectly states that a nurse 'discovered' a direct service provider ("DSP") hitting clients."[14] REM Iowa goes on to say, "[t]his is not the case … [r]ather, the nurse was informed of an *allegation*, which was then investigated and never *substantiated* . . . the DIA investigatory report plainly states, '[t]he REM Iowa Incident Investigation concluded there was no information to support or negate alleged incidents of abuse occurred.'"[15] REM Iowa also points out that "the individual who alleged that the staff had hit him had no indications that he suffered physical abuse; instead, he had 'a small mark on [his] back which might have been from rubbing his/her back against something or a pimple.'"[16]

Based on incident reports produced to the Committee by REM Iowa, in May 2017, the Iowa Department of Inspections and Appeals (DIA) fined an ICF/ID facility in Cedar Rapids, Iowa $500 for failing to follow the proper procedures for reporting allegations of dependent adult abuse.[17] According to Iowa DIA, DSP A observed "several client's . . . 'flinching.'"[18] DSP A reported this information to the registered nurse on duty on March 14, 2017, who then subsequently interviewed the client.[19] According to the registered nurse, "[the client] communicated that DSP B had hit him/her."[20] In a separate incident, DSP A also reported that she had witnessed a "a situation on March 5, 2017 [roughly two weeks earlier] after the lunch, in

[11] REMIOWA-00001575, at REMIOWA-00001578.
[12] REMIOWA-00001575.
[13] Letter from Reginald Brown and Jeremy Dresner, Counsel, Kirkland & Ellis LLP, on behalf of REM Iowa and MENTOR Oregon, to Senator Grassley and Senator Wyden (Dec. 11, 2020).
[14] Letter from Reginald Brown and Jeremy Dresner, Counsel, Kirkland & Ellis LLP, on behalf of REM Iowa and MENTOR Oregon, to Senator Grassley and Senator Wyden (Dec. 11, 2020).
[15] Letter from Reginald Brown and Jeremy Dresner, Counsel, Kirkland & Ellis LLP, on behalf of REM Iowa and MENTOR Oregon, to Senator Grassley and Senator Wyden (Dec. 11, 2020).
[16] Letter from Reginald Brown and Jeremy Dresner, Counsel, Kirkland & Ellis LLP, on behalf of REM Iowa and MENTOR Oregon, to Senator Grassley and Senator Wyden (Dec. 11, 2020).
[17] REMIOWA-00003008, at REMIOWA-00003013.
[18] REMIOWA-00003008, at REMIOWA-00003015.
[19] REMIOWA-00003008, at REMIOWA-00003016.
[20] REMIOWA-00003008, at REMIOWA-00003016.

which DSP B was verbally inappropriate with Client #2 and grabbed the client's wrist after the client had been rectal digging . . . [and while DSP A] did not feel the staff's behavior was abusive . . . she did think DSP B's verbalization were degrading and had an affect [sic] on him/her."[21] Following these events, DSP A "felt she needed to report the situations."[22] While DSP A was right to report his or her suspicions of abuse and neglect, she failed to follow REM Iowa's policies and procedures for reporting allegations of abuse and neglect, resulting in Iowa DHS fining REM Iowa $500.[23]

While REM Iowa takes issue with the way we characterized this incident, internal memoranda clearly shows that DSP B had a history of inappropriate behavior towards clients with I/DD. So much so that a fellow colleague felt it necessary to escalate the situation and report the incident to MENTOR's 1-800 hotline. (Later, we will discuss how DSP B was later investigated for allegations of dependent adult abuse at another ICF/ID facility.)

Second, REM Iowa argues that "the Committee's Iowa Report inaccurately states that 'staff were aware that the DSP had a history of physically and verbally abusing clients' . . . [and that] [t]he only prior incident mentioned in the DIA report was the DSP 'grabb[ing] the client's wrist' – [which] another DSP 'stated, at the time, she did not feel the staff's behavior was abusive but more reactive to the situation.'"[24]

As outlined above, this was not the first time DSP A witnessed DSP B displaying inappropriate behavior, verbal or otherwise, towards clients. According to the incident report, "[DSP A] had also witnessed a situation on March 5, 2017 after the lunch, in which DSP B was *verbally inappropriate with Client* #2 and grabbed the client's wrist after the client had been rectal digging."[25] The incident report goes on to say that while "DSP A . . . did not feel the staff's behavior was abusive but more reactive to the situation . . . *she did think DSP B's verbalizations were degrading to the client and had an affect [sic] on him/her*."[26] REM Iowa takes issue that the Committee's report characterized this incident as abuse. However, as the state of Iowa includes "personal degradation" in its definition of dependent adult abuse, we disagree.[27]

Third, REM Iowa argues that "the Committee's Iowa Report also inaccurately suggests that, after this incident, the DSP was improperly hired by a separate REM Iowa facility."[28] According to REM Iowa, "[t]he internal investigation from the 2017 incident determined that there was no evidence of wrongdoing, and therefore the DSP, in full compliance with

[21] REMIOWA-00003008, at REMIOWA-00003016.
[22] REMIOWA-00003008, at REMIOWA-00003016.
[23] REMIOWA-00003008, at REMIOWA-00003013, REMIOWA-00003017.
[24] Letter from Reginald Brown and Jeremy Dresner, Counsel, Kirkland & Ellis LLP, on behalf of REM Iowa and MENTOR Oregon, to Senator Grassley and Senator Wyden (Dec. 11, 2020).
[25] REMIOWA-00003008, at REMIOWA-00003016. Emphasis added.
[26] REMIOWA-00003008, at REMIOWA-00003016. Emphasis added.
[27] In Iowa, dependent adult abuse includes "personal degradation" or acts that are intended to shame, degrade, humiliate, or harm the dignity of a dependent adult. Iowa Code § 235B.2; Iowa Code § 235E.1.
[28] Letter from Reginald Brown, Counsel, Kirkland & Ellis LLP, on behalf of REM Iowa and MENTOR Oregon, to Senator Grassley and Senator Wyden (Dec. 11, 2020).

regulations, began working at different REM facility . . . [and] DIA chose not investigate due to lack of credible evidence."[29]

Based on incident reports produced to the Committee, in January 2018, DSP B was accused of "hitting" clients again, but this time at a different ICF/ID facility in Hiawatha, Iowa.[30] According to the Iowa DIA's incident report, a client alleged that DSP B hit him/her because the client "pooped in her bed while making a slapping motion to the left side of her face."[31] The staff reported the allegations to their supervisor who then alerted the Program Director; however, the registered nurse found no injuries present.[32] DSP B was suspended pending the results of REM Iowa's internal investigation.

While one can argue that a single allegation is not enough to prove guilt, three separate complaints imply a pattern of aggressive behavior towards clients with I/DD. More so, in both cases, internal memoranda suggest that REM Iowa suspended the DSP following the outcome of their internal investigation. However, REM Iowa failed to produce any memoranda, interviews, notes, or other documentation describing their efforts to investigate these allegations. It is easy to say that, because the State did not investigate, no abuse occurred. However, it is well-reported that individuals with disabilities are at higher risk of abuse and neglect and are unable to communicate with others what happened to them.[33] Therefore, we disagree with REM Iowa's argument that the Committee's report is inaccurate.

Lastly, REM Iowa says "the [Centers for Medicare and Medicaid Services] did not issue a notice of deficiency [against REM Iowa] . . . [t]he cited deficiency notices are from Iowa DIA, which regulates REM's ICF/IDs and operates under CMS rules."[34] It's important to note that REM Iowa's fourth point selectively quotes from the Committee's report. The Committee's report concludes, "[w]e also identified several incident reports where *the State and/or the Centers for Medicare and Medicaid Services (CMS)* issued a notice of deficiency against REM Iowa."[35] Several deficiency reports produced to the Committee include CMS letterhead and do not say whether CMS or the state of Iowa issued the incident report.[36] Therefore, we assumed that these deficiency notices could have come from either CMS or the state of Iowa. (This fact is made clear in the Committee's report.) Regardless, we appreciate that REM Iowa has now clarified that these notices are CMS approved forms used by Iowa DIA.[37]

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[29] Letter from Reginald Brown and Jeremy Dresner, Counsel, Kirkland & Ellis LLP, on behalf of REM Iowa and MENTOR Oregon, to Senator Grassley and Senator Wyden (Dec. 11, 2020).
[30] REMIOWA-00003862.
[31] REMIOWA-00003862.
[32] REMIOWA-00003862.
[33] *Violence against adults and children with disabilities*, WORD HEALTH ORGANIZATION, https://www.who.int/disabilities/violence/en/ (last viewed Feb. 12, 2021). For further reading, *see also* Karen Hughes, et al., *Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies*, 379 THE LANCET 1621-29 (2012).
[34] Letter from Reginald Brown and Jeremy Dresner, Counsel, Kirkland & Ellis LLP, on behalf of REM Iowa and MENTOR Oregon, to Senator Grassley and Senator Wyden (Dec. 11, 2020).
[35] *A Case Study: Opportunities Remain to Improve Care for Iowans with Intellectual and Developmental Disabilities at REM Iowa and in the State, Sen. Comm. Fin.* 116th Cong. 12 (2020).
[36] For example, *see* REMIOWA-00000306.
[37] Letter from Reginald Brown and Jeremy Dresner, Counsel, Kirkland & Ellis LLP, on behalf of REM Iowa and MENTOR Oregon, to Senator Grassley and Senator Wyden (Dec. 11, 2020).

3. Re: Training.

REM Iowa argues that "the Committee's Iowa Report includes several inaccuracies or mischaracterizations regarding REM's training" and goes on to point out several examples where it believes the Committee mischaracterized REM Iowa's training routine.[38] We will address one of these points.

The Committee's report concludes that "[i]ncident reporting training is not mandatory for DSPs which could explain why REM Iowa continuously gets cited for staff failing to complete incident reports or document incident remediation."[39] REM Iowa argues that this statement is "factually inaccurate . . . [because] REM Iowa requires incident report training for DSPs . . . [a]s an example, the training materials for Bruce Enger . . . include documentation that he reviewed incident report procedures as part of his training."[40]

Here, REM Iowa glosses over several key facts identified and discussed by the Committee's report which helped form its conclusion. The Committee's report acknowledges that new hires are required to complete "on-the-job" training packets during the first few days of employment and must attest that they have reviewed REM Iowa's policies and procedures.[41] The Committee's report also acknowledges that new hires are even required to complete a certain amount of supervised work experience.[42] However, the Committee's report also goes on to explain that new hires are *not* required to complete mock incident reports as part of this training.[43] (REM Iowa's training protocols are discussed on page 14 through 16 of the Committee's report.[44]) REM Iowa believes that it is sufficient to require DSPs to attest that they reviewed REM Iowa's policies and procedures as part of their training. However, as REM Iowa continues to suffer from incidences relating to incident report trainings, we disagree. Hands-on training in areas like incident reporting must be mandatory for DSPs.

4. Re: Unsupported Conclusions.

According to REM Iowa, "the Committee's Iowa Report reaches conclusions that we believe are unsupported by the facts identified."[45] The Committee's report states that "REM

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[38] Letter from Reginald Brown, Counsel, Kirkland & Ellis LLP, on behalf of REM Iowa and MENTOR Oregon, to Senator Grassley and Senator Wyden (Dec. 11, 2020).
[39] *A Case Study: Opportunities Remain to Improve Care for Iowans with Intellectual and Developmental Disabilities at REM Iowa and in the State, Sen. Comm. Fin.* 116th Cong. (2020).
[40] Letter from Reginald Brown, Counsel, Kirkland & Ellis LLP, on behalf of REM Iowa and MENTOR Oregon, to Senator Grassley and Senator Wyden (Dec. 11, 2020). Emphasis added.
[41] *A Case Study: Opportunities Remain to Improve Care for Iowans with Intellectual and Developmental Disabilities at REM Iowa and in the State, Sen. Comm. Fin.* 116th Cong. (2020).
[42] *A Case Study: Opportunities Remain to Improve Care for Iowans with Intellectual and Developmental Disabilities at REM Iowa and in the State, Sen. Comm. Fin.* 116th Cong. (2020).
[43] *A Case Study: Opportunities Remain to Improve Care for Iowans with Intellectual and Developmental Disabilities at REM Iowa and in the State, Sen. Comm. Fin.* 116th Cong. (2020).
[44] For example, *see* REMIOWA-00000593, at REMIOWA-00000602.
[45] Letter from Reginald Brown and Jeremy Dresner, Counsel, Kirkland & Ellis LLP, on behalf of REM Iowa and MENTOR Oregon, to Senator Grassley and Senator Wyden (Dec. 11, 2020).

Iowa staff appear to have difficulties adhering to a client's [individual program plans]" and identified at least eight deficiency notices issued against REM Iowa over the course of seven years.[46] REM Iowa goes on to say "we do not believe that *eight* notices over the course of *seven years* . . . supports the general conclusion that 'REM Iowa staff appear to have difficulties adhering to a 'clients IPP.'"[47]

During this investigation, the Committee focused on identifying reoccurring incidents at REM Iowa's group homes in order to help the company improve the level of care it provides to the I/DD community. Along this vein, we identified areas where REM Iowa suffers from reoccurring incidents, including incident report training, medication administration, and following clients' individual program plans. However, these were not the only incidences we identified during our investigation. Indeed, between 2013 and 2019, we reviewed over fifty separate incident reports—many of which concerned REM Iowa's ICF/ID facilities—relating to staff's failure to report abuse and neglect, drug administration errors, death of residents, elopement, failure to implement a client's IPP, and failure to conduct background checks of REM Iowa employees. If REM Iowa believes that evidence of reoccurring incidents, regardless of quantity, is not enough for the company to consider additional improvements or remedial efforts, then we strongly disagree.

B. The Committee's Oregon Report

1. Re: Factually Inaccurate and Misleading Descriptions

With respect to *Life at Cypress House: An Examination of Care Provided by MENTOR Oregon*, the company identified—what it believed to be—factually inaccurate and misleading descriptions, the omission of a company response to an incident from 2017, and additional factual errors. We would like to respond to each in turn.

First, the company writes that the report characterized certain incidents as "neglect," even though some were ultimately not substantiated.[48] With respect to the 2019 incidents at Cypress House (described on report pages 10 through 11 and in Appendix A), it is true the administrative law judge (ALJ) ruled in favor of the company and dismissed the previously substantiated allegations of neglect, originally documented by the local Community Development Disabilities Program (CDDP) investigator. To be clear, we went to great length to include full and appropriate context regarding these incidents at Cypress House,[49] including the ultimate ruling.[50] Though the ALJ overturned the neglect finding, we nonetheless believe that, based on the record presented, the care delivered by MENTOR Oregon staff in these cases fell far short of its own standards.

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[46] *A Case Study: Opportunities Remain to Improve Care for Iowans with Intellectual and Developmental Disabilities at REM Iowa and in the State, Sen. Comm. Fin.* 116th Cong. (2020).
[47] Letter from Reginald Brown and Jeremy Dresner, Counsel, Kirkland & Ellis LLP, on behalf of REM Iowa and MENTOR Oregon, to Senator Grassley and Senator Wyden (Dec. 11, 2020). Emphasis included in the original.
[48] Letter from Reginald Brown and Jeremy Dresner, Counsel, Kirkland & Ellis LLP, on behalf of REM Iowa and MENTOR Oregon, to Senator Grassley and Senator Wyden (Dec. 11, 2020).
[49] *Life at Cypress House: An Examination of Care Provided by MENTOR Oregon*, *Sen. Comm. Fin.* 116th Cong. 45-50 (2020).
[50] *Id.* at 49.

The company also disputes the Committee's characterization of an incident at Alameda Home in Klamath Falls.[51] The report notes how the incident "result[ed] in a substantiated finding [of neglect] by Klamath CDDP."[52] The company states:

> While true, this statement is misleading because DHS subsequently re-examined the finding and "cleared the substantiated finding of neglect," a fact that the Committee's Report does not acknowledge until four pages later on page 43.[53]

There is no mischaracterization here. As the company itself acknowledges, the Committee's Oregon report *clearly* mentions that the substantiated finding was cleared. The full story was told and the company does not dispute any of the underlying facts of this particular narrative. As with the incident above, we nonetheless believe that based on the record presented the care delivered by MENTOR Oregon staff in this instance fell far short of its own standards.

2. Re: Omission of MENTOR Oregon's Response to January 2017 Park Place Incident

The company criticizes the Committee's Oregon report for omitting material regarding MENTOR Oregon's response to the 2017 incident at Park Place House in Brookings. The company maintains that it "terminated every staff member with involvement in the matter, five in total, including those responsible for providing direct care and the managers responsible for providing oversight."[54] Further, the company's response to the incident also included "an extensive quality improvement plan that included enhanced training on pressure injuries and skin integrity care," training now provided to each of its employees in Oregon before they are allowed to provide direct services to individuals.[55]

With respect to the terminations, we believe MENTOR's characterization is misleading. The Committee's Oregon report provides additional context about the involvement of "Staff 1," who we believe was one of the principal actors in the care delivered to AV over the summer and fall of 2017.[56] "Staff 1" had allegations of neglect substantiated against them in the CDDP report associated with this incident; however, MENTOR Oregon *did not* terminate this employee at that time. In fact, "Staff 1" was *promoted* to Program Director and transitioned out of the role as Program Coordinator at Park Place, "at the same time a second bedsore was intensifying for AV," facts not disputed by the company.[57] The evidence demonstrates the staffer was associated with this incident, given it was reported just a handful of days following the staff transition:

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[51] *Id.* at 39-44.
[52] *Id.* at 39. *See also* Appendix C, Item 61, specifically MENTOROR Bates 4465–4474.
[53] Letter from Reginald Brown and Jeremy Dresner, Counsel, Kirkland & Ellis LLP, on behalf of REM Iowa and MENTOR Oregon, to Senator Grassley and Senator Wyden (Dec. 11, 2020).
[54] *Id.* at 9.
[55] *Id.*
[56] *Life at Cypress House: An Examination of Care Provided by MENTOR Oregon*, *Sen. Comm. Fin.* 116th Cong. 15-17 (2020).
[57] *Id.* at 15. *See also* Appendix C, Item 2, p. 4.

> 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."[58]

Notably, it wasn't until more than a year later that "Staff 1" was terminated as a MENTOR Oregon employee, in connection with the Cypress House incidents in late 2018 or early 2019. This employee was terminated in December 2018 prior to the *Oregonian* story that ran on January 10, 2019.[59]

Regarding the "extensive quality improvement plan," we believe the Committee's Oregon report speaks for itself. There were numerous incidents where MENTOR Oregon staff—supposedly trained on these new measures—did not heed the lessons from these trainings, leading to substandard care delivered to clients.

3. Re: Other Factual Errors.

Lastly, MENTOR Oregon points out an inconsistency regarding the timing of events associated with Cypress House in the fall of 2020. Following an October 6th complaint from a client's parent, the State's Office of Developmental Disability Services (ODDS) directed a licensing team to investigate. This resulted in an October 15th letter from the State moving to revoke the company's license to operate Cypress House, as well as new statewide conditions being placed on the company. MENTOR Oregon points out that it previously sent a letter (October 8th) giving notice that it planned to close Cypress House.

To be clear, when we were first alerted to this incident in late October by the Oregon Department of Human Services (OR DHS), we also learned that MENTOR Oregon elected to close this home. This finding is noted on multiple occasions throughout the report.[60] In fact, at the company's request, the Committee also included the October 8th letter as an additional supporting document. This letter was made public simultaneously with the Committee's Oregon report and made available via a link in the joint press release.[61]

The date of the letter does not change the fact that the company elected to close Cypress House *after* a complaint was made and in the middle of an ODDS licensing review at the facility (which took place October 7 through 9). Nevertheless, even if the State was in receipt of the earlier letter from the company, OR DHS *still* sent their October 15th letter proposing to revoke the license for Cypress Home. The company's letter sent the previous week did not obviate the need for the State to send along the results from the licensing review—and its ultimate decision.

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[58] *Id.* at 17. *See also* Appendix C, Item 2, p. 10.
[59] *Life at Cypress House: An Examination of Care Provided by MENTOR Oregon*, *Sen. Comm. Fin.* 116th Cong. 46 (2020)
[60] *Id.* at 13, 50.
[61] Press release, Grassley, Wyden Issue Reports on Developmental Disability Care Facilities in Iowa and Oregon (Dec. 3, 2020), https://www.finance.senate.gov/chairmans-news/grassley-wyden-issue-reports-on-developmental-disability-care-facilities-in-iowa-and-oregon. *See also* Letter from Duane Allen Law, State Director, MENTOR Oregon, to Nicole Winje, Corrective Action Coordinator, Department of Human Services, Office of Developmental Disabilities Services, https://www.finance.senate.gov/imo/media/doc/120220%20Additional%20Wyden%20MENTOR%202020%20Documents_Redacted.pdf.

The underlying facts speak for themselves. The step taken by the company the previous week was the right one; however, it did not take place in the absence of a complaint or licensing review.

In conclusion, the purpose of the Committee's investigation was to identify deficiencies in the Companies' operations in order to raise the level of care for individuals living with I/DD. However, as of the date of this letter, the Companies have failed to provide the Committee with any indication that they plan to address the problems identified by the Committee. Therefore, the Committee continues to have concerns about the health and well-being of its constituents.

Ron Wyden
Chairman
Senate Finance Committee

Chuck Grassley
Member
Senate Finance Committee

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December 11, 2020

By Email

The Honorable Chuck Grassley
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Dear Chairman Grassley and Ranking Member Wyden:

On behalf of REM Iowa and MENTOR Oregon (together, "the Companies"), we write to thank you for your continued commitment to raising standards of care provided to people with intellectual and developmental disabilities ("I/DD"). The MENTOR Network's top priority is the safety and wellbeing of the people in its care, and it is always working to improve as a company and an industry leader. As you know, the Companies voluntarily cooperated throughout the course of the Committee's year-and-a-half inquiry, providing over 10,000 pages of materials and narrative responses to over 200 questions. Today, we write to share some perspectives in connection with the Committee's reports dated December 3, 2020 (together the "Committee's Reports"), and to request the correction and clarification of the points outlined below prior to submitting the reports for inclusion in the congressional record or to the Government Publishing Office ("GPO") for printing.

The MENTOR Network was founded over 40 years ago to provide care and services to individuals who are vulnerable with disabilities, and who often have complex medical conditions, so that those individuals can live life to their fullest potential in their communities. Every day, committed staff in Iowa and Oregon strive to provide care and support to people with I/DD to help them grow and lead as independent a life as possible. This work is challenging and the Companies acknowledge they have sometimes fallen short, and take responsibility for those times when they

have not lived up to their own standards or the standards of state partners. The Companies' leaders and teams are committed to learning and continually evaluating and improving the services they provide.

We appreciate the recommendations contained in the Committee's Iowa Report, which REM Iowa is evaluating, and share the Committee's goal of raising standards to positively impact the lives of people with I/DD. REM Iowa and The MENTOR Network agree that training, access to data and data analytics, and tracking and monitoring critical incidents are all important components of enhancing the quality of care for individuals with I/DD across the service sector. As described below, REM Iowa is taking a number of steps in these areas already, and will study the Committee's recommendations as it assesses additional enhancements consistent with state and local licensing requirements.

We are concerned, however, that several items in both of the Committee's Reports, as detailed below, are either factually incorrect or presented in a way that leaves the reader with a false impression. We are hopeful that by bringing these issues to your attention promptly, the Committee will consider correcting them. Alternatively, we request the Committee include this letter as an appendix to the Committee's Reports, as it has done in the past, to ensure a complete record.

A. The Committee's Iowa Report

Inaccuracies in the Committee's Iowa Report broadly fall into the following four categories:

1. ***Distinction between REM Iowa, Inc.'s Intermediate Care Facilities for Individuals with Intellectual Disabilities and REM Iowa Community Services, Inc.'s HCBS Waiver Group Homes.*** First, the Committee's Report conflates REM Iowa, Inc.'s Intermediate Care Facilities for Individuals with Intellectual Disabilities ("ICF/ID") with REM Iowa Community Services, Inc.'s Home and Community Based Services ("HCBS"), also known as Medicaid "waiver" group homes. These are two entirely different service lines—they are operated by different REM corporate entities, they provide different levels of care, they have different requirements and practices, and they have different state regulators.

- The most important example of this mistake is with respect to the discussion of the 2015 Iowa Department of Human Services ("DHS") probation.[1] The probation applied only to

[1] There are numerous other examples as well. For instance, the Committee's Report repeatedly suggests that Individual Program Plans ("IPPs") are applicable for all of REM's services, but IPPs are only required for ICF/IDs; there are no IPPs in HCBS programs. As another example, on page 6, the report states, "If DIA identifies a problem,

REM Iowa Community Services and REM Developmental Services, which operate the HCBS and nonresidential day services, respectively. The Iowa DHS probation letter, cited by the report, states this explicitly: "Effective August 10, 2015, the Department of Human Services, Iowa Medicaid Enterprise is placing REM-Iowa Community Services and REM Developmental Services (collectively referred to as REM or the REM entities) on Probation."[2] The Iowa DHS probation did not apply to REM's ICF/IDs, which are an entirely different service line operated by a different entity—REM Iowa, Inc.—and are regulated by a different state agency, the Iowa Department of Inspections and Appeals ("DIA"). The Committee's Iowa Report repeatedly suggests, however, that the ICF/IDs were also subject to the 2015 DHS probation.

- For instance, on page 7, the Committee's Iowa Report states, "We discovered that several REM Iowa facilities—a majority of which were ICF/IDs—had overwhelmingly more critical incident reports, letters of deficiencies, and unannounced visits than the rest of REM Iowa's group homes. . . . A significant portion of these incidents also occurred after the State lifted REM Iowa's probation, calling into question whether REM Iowa adequately addressed the problems identified by Iowa DHS in 2015." The ICF/IDs were never subject to the probation.

- As another example, on page 13, the Committee's Iowa Report states, "We identified at least eight deficiency notices issued against REM Iowa between 2013 and 2019, several of which occurred after DHS lifted REM Iowa's probation in 2016." The example deficiency notices all relate to ICF/IDs—but, again, they were never on probation, so the relevance of the reference to the deficiency notices occurring "after DHS lifted REM Iowa's probation" is misleading and could lead a reader to believe the ICF/IDs were encumbered by a probationary hold, which is incorrect.

2. ***Factually Inaccurate Incident Descriptions.*** Second, the Committee's Iowa Report inaccurately describes the following incidents on pages 11 and 12:

- On pages 11 and 12, the Committee's Iowa Report mischaracterizes a 2017 Iowa DIA investigatory report. The Committee's Iowa Report incorrectly states that a nurse "discovered" a direct service provider ("DSP") hitting clients. This is not the case. Rather, the nurse was informed of an *allegation*, which was then investigated and *never substantiated*. Specifically, the Committee's Iowa Report states on page 11, "Upon further investigation, the registered nurse discovered that a DSP was hitting clients and being

it notifies the company and requests a corrective action plan[.]" However, a "corrective action plan" is required by DHS, not DIA, which does not use such terminology.

[2] REMIOWA-00001575.

verbally abusive." However, the DIA investigatory report plainly states, "The REM Incident Investigation concluded there was no information to support or negate alleged incidents of abuse occurred."[3] The DIA report also states that the individual who alleged that the staff had hit him had no indications that he suffered physical abuse; instead, he had "a small mark on [his] back which might have been from rubbing his/her back against something or a pimple."[4]

- Further, on page 11, the Committee's Iowa Report inaccurately states that "staff were aware that the DSP had a history of physically and verbally abusing clients." The only prior incident mentioned in the DIA report was the DSP "grabb[ing] the client's wrist"—and another DSP "stated, at the time, she did not feel the staff's behavior was abusive but more reactive to the situation."[5] It is not accurate to say that staff were aware of prior physical abuse.

- On page 12, the Committee's Iowa Report also inaccurately suggests that, after this incident, the DSP was improperly hired by a separate REM Iowa facility. The Committee's Iowa Report states: "The incident report further indicates that REM Iowa suspended the employee immediately after the incident in order to conduct an internal investigation. However, we discovered that this employee was able to secure employment at another REM Iowa facility in Hiawatha, Iowa, where he was later investigated for suspicions of physical abuse one year later." The internal investigation from the 2017 incident determined that there was no evidence of wrongdoing, and therefore the DSP, in full compliance with regulations, began working at a different REM facility. As to the "later investigat[ion] for suspicions of physical abuse," DIA chose not to investigate due to a lack of credible evidence.

- On page 12, the Committee's Iowa Report states that the Committee "identified several incident reports where . . . the Centers for Medicare and Medicaid Services (CMS) issued a notice of deficiency against REM Iowa." CMS did not issue a notice of deficiency. The cited deficiency notices are from the Iowa DIA, which regulates REM's ICF/IDs and operates under CMS rules.[6]

[3] REMIOWA-00003015.
[4] REMIOWA-00003014.
[5] REMIOWA-00003016.
[6] The form that Iowa DIA uses is an approved form from CMS—however, CMS did not investigate or issue the deficiency notice.

3. ***Training.*** Third, the Committee's Iowa Report includes several inaccuracies or mischaracterizations regarding REM's training, which are particularly important to clarify in light of the report's recommendations that REM enhance its training.

- On page 15, the Committee's Iowa Report states, "[I]ncident report training is not mandatory for DSPs which could explain why REM Iowa continuously gets cited for staff failing to complete incident reports or document incident remediation." This statement is factually inaccurate. REM Iowa requires incident report training for DSPs. As an example, the training materials for Bruce Enger, which the report cites, include documentation that he reviewed incident reporting procedures as part of his training.[7]

- On page 14, the Committee's Iowa Report states, with respect to ICF/IDs, "[I]f a facility provides nursing services, physicians also train staff on illness detection, first aid, and other basic skills like oral care, bathing, toileting, and laboratory tests." This is not accurate. The cited portion of the Iowa Administrative Code does not require physicians to be involved in training at ICF/IDs.

- On pages 14 and 15, the Committee's Iowa Report criticizes REM's training materials, stating that "a 'trail making activity' to spell the word lemon and a 'verb generation' worksheet … appears to test a person's basic intelligence … However, it is unclear how these activities relate to caring for individuals with I/DD." This training was not an intelligence test. Rather, both training exercises were part of a module designed to teach DSPs how the brain works in order to prepare them for serving individuals with brain injuries.[8]

4. ***Unsupported Conclusions.*** Fourth, at times, the Committee's Iowa Report reaches conclusions that we believe are unsupported by the facts identified. For example:

- On page 13, the Committee's Iowa Report states, "Based on our review of internal incident reports collected for this investigation, REM Iowa staff appear to have difficulties adhering to a client's IPP. We identified at least eight deficiency notices issued against REM Iowa between 2013 and 2019." Respectfully, while REM regrets these deficiency notices, we do not believe that *eight* notices over the course of *seven years* in connection with providing ICF/ID services to approximately 100 people annually supports the general conclusion that "REM Iowa staff appear to have difficulties adhering to a client's IPP."

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[7] *See* REMIOWA-00000606.

[8] REM Iowa services people with brain injuries and I/DD in its waiver group homes.

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REM Iowa continually strives to improve, and appreciates the Committee's recommendations in the report that are aimed at enhancing services provided to individuals in its care. REM Iowa agrees that training, access to data and data analytics, and tracking and monitoring critical incidents are all important components of enhancing the quality of care to individuals with I/DD. It looks forward to studying the feasibility of implementing these recommendations, and also would like to highlight for the Committee progress it is already making in several of these areas:

- **Improve Training Practices**. REM Iowa continually enhances its training and believes its recent efforts are bearing real results. For example, in DHS's most recent re-certification of REM's HCBS programs—which resulted in a three-year re-certification, the longest available—DHS specifically commended REM on its training practices. Regarding the Committee's specific recommendation that REM Iowa incorporate competency-based training (*i.e.*, including examinations or exercises to determine if staff absorbed training materials and can demonstrate competency in those areas), REM Iowa agrees that competency-based training can play an important role. REM's HCBS programs already include such measurement tools and, in light of the Committee's recommendations, REM Iowa will also assess the feasibility of expanding these tools into training for its ICF/IDs.

- **Improve Access to Data and Data Analytics.** The company shares the Committee's view that enhancing access to data and data analytics can play an important role in enhancing quality. In 2017, REM Iowa transitioned away from paper-based incident reporting to an electronic incident management system and, earlier this year, The MENTOR Network invested in and implemented a nation-wide employee system for time and attendance, pay, and scheduling. In the coming months, the company plans to leverage other modules in this system to improve its access to real-time data, and it will take into account the Committee's recommendations as it evaluates these enhancements.

- **Tracking and Monitoring Incidents.** The company is deeply committed to reducing the number of preventable incidents, including by implementing processes that will allow it to better identify trends and patterns of incidents. While existing systems do provide the ability to track critical instances electronically in Iowa, state and local requirements vary with respect to incident reporting, creating barriers to centralizing all aspects of incident reporting and tracking. As available technology evolves, the company will evaluate feasible opportunities to leverage new capabilities, and appreciates the Committee's recommendation in this regard.

- **Other Recommendations.** REM Iowa also supports the Committee's recommendation to require enhanced COVID-19 case reporting and, of course, welcomes oversight and support from its state partners. With respect to COVID-19 reporting, REM Iowa already provides reports of confirmed COVID-19 cases to state authorities, and supports the Committee's recommendation in this regard as our nation combats the global pandemic during this unprecedented time.

REM Iowa also works hard to be a trusted partner of the State of Iowa in providing access to quality services and programs for people with I/DD. In 2015, REM Iowa promptly enhanced and standardized training and reporting practices across the state, and also made investments to improve services, in response to the State's concerns. While we appreciate the Committee's conclusion that opportunities remain to improve care for Iowans with I/DD, we also believe we are making measurable progress in Iowa. Earlier this year, Iowa's DHS provided a three-year re-certification—the longest available—to REM's HCBS programs in each of REM's four regions throughout Iowa. In one of those regions, REM received a three-year certification with excellence, the highest certification a provider can receive. In March 2020, The MENTOR Network also established a new Community Support Services Center of Excellence, which will aid efforts to strengthen our programs by providing dedicated resources and expertise to facilitate the implementation of standardized quality improvement projects in Iowa and across the country.

REM Iowa is constantly looking to strengthen its operations by embracing needed changes. Indeed, learning to adapt is a defining feature of the past nine months, as REM Iowa has confronted the challenges of serving a vulnerable population during the COVID-19 pandemic. REM Iowa—and all of The MENTOR Network's state operations—led by The Network's COVID-19 Task Force, have prioritized the safety and well-being of the individuals in its care and its caregivers, continuously implementing new policies and protocols consistent with and reflective of evolving federal, state, and local guidelines.

B. Oregon Report

The report on MENTOR Oregon also contains several factual errors and important omissions, which we respectfully request be corrected.

1. ***Factually Inaccurate and Misleading Descriptions.*** First, the Committee's Oregon Report characterizes certain incidents as neglect, when in fact those incidents were explicitly determined *not* substantiated for neglect.

- On pages 10-11, the Committee's Oregon Report describes two incidents from 2019 at Cypress House related to staff allegedly failing to provide appropriate hygienic care. It states, "The first client had experienced neglect for a long period of time," and "the second individual was neglected in the same home." It is factually incorrect to say that these individuals experienced "neglect," a term with specific legal meaning. An Administrative Law Judge ("ALJ") at the Oregon Department of Human Services Office of Administrative Hearings—a neutral party—determined that "[a] preponderance of the evidence does **not** support a substantiated finding of abuse by neglect" with respect to these incidents.[9] The report acknowledges the ALJ's conclusion (on page 49, in an Appendix)—but by inaccurately referring to these incidents as "neglect" in the body of the report, it ignores this conclusion and appears to substitute a new and legally inaccurate determination in place of a judge's careful adjudication of the matter.

- On pages 39-44, the Committee's Oregon Report discusses an individual who resided at two MENTOR Oregon facilities, first in Portland and then in Klamath Falls. This section of the report begins by stating, on page 39, that an incident at Klamath Falls "result[ed] in a substantiated finding [of neglect] by Klamath CDDP." While true, this statement is misleading because DHS subsequently re-examined the finding and "cleared the substantiated finding of neglect," a fact that the Committee's Report does not acknowledge until four pages later on page 43.

2. ***Omission of MENTOR Oregon's Response to January 2017 Park Place Incident.*** Second, the Committee's Oregon Report omits material information regarding MENTOR Oregon's response to the incident that occurred three years ago at the Park Place House. We request the Committee consider supplementing the record to include the following information.

- On pages 6-7, the Committee's Oregon Report describes neglect that a non-verbal client experienced three years ago at the Park Place House. There is no place at MENTOR Oregon for failures like those that occurred at the Park Place House, which it voluntarily

[9] *See* MENTOROR-00004850 (emphasis added).

closed in 2018. While the report details the investigations into the incident, it omits MENTOR Oregon's response: MENTOR Oregon terminated every staff member with involvement in the matter, five in total, including those responsible for providing direct care and the managers responsible for providing oversight. In consultation with DHS, MENTOR Oregon also developed an extensive quality improvement plan that included enhanced training on pressure injuries and skin integrity care. That training is now provided to every employee in the state before they are permitted to provide direct services to individuals in our care. More recently, MENTOR Oregon also recruited a fulltime Registered Nurse and a new quality improvement manager in Oregon who together are focused on delivering consistent quality care statewide to the 23 individuals residing in the 10 homes that MENTOR Oregon currently operates.

3. ***Other Factual Errors.*** Third, the Committee's Oregon Report includes other factual errors, including the timing of events, which provides a misleading impression to the reader.

- On page 13, in discussing the timeline related to MENTOR Oregon's voluntary closure of Cypress House, the Committee's Oregon Report states, "ODDS sent the company a revocation letter with the State's intent to close Cypress House. Following receipt of these notices, MENTOR Oregon indicated its intention to voluntarily give up its license for the facility." This is not true; MENTOR Oregon provided formal notification that it planned to voluntarily close Cypress House *before* receiving the ODDS Revocation Letter. Specifically, on October 8, 2020—a week prior to ODDS sending the revocation letter on October 15—MENTOR Oregon wrote, "In accordance with our conversation this morning, this letter is Mentor Oregon's official notification of our intention to give notice to CLCM and ODDS of closure of Cypress Home."

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For purposes of ensuring the long-term probative value of the Committee's Reports, we respectfully request that the Committee update its Reports to reflect this feedback prior to submission for printing and inclusion in the congressional record. Alternatively, we request that the Committee include this letter as an appendix to the Committee's Reports, or separately enter it into the congressional record.

REM Iowa and MENTOR Oregon are proud of the work they do and are fully committed to their mission of offering individuals and their families innovative, quality services and supports that lead to growth and independence, regardless of the physical, intellectual, or behavioral challenges they face. The Companies value the Committee's work in ensuring that this mission is fulfilled. Should the Committee wish to further discuss these issues, we are happy to do so. We

look forward to continuing to work with you and our state and local regulators to make sure that people with I/DD receive the care that they need and deserve.

Sincerely,

Reginald J. Brown
Jeremy D. Dresner