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LTCO Investigation:
Resident Fatality & Regulatory Gaps at Mt Hood Senior Living

Fred Steele, State Long Term Care Ombudsman

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Resident Harm & Trauma

LTCO investigated Department of Human Services (ODHS) actions and inactions due to the harm & trauma experienced by residents (and families) at 4 points in time:

- Resident Ki Soon Hyun died due to an catestrophic system failure
- Residents at Mt Hood Senior Living were left unprotected for 28 days before ODHS licensing responded
- Residents then moved by ODHS from their homes on a dark, rainy, Friday night with little notice
- A majority of residents then moved into unsafe locations

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Mt Hood Senior Living Overview

- December 24, 2023 – resident Ki Soon Hyun walked out an open door of an ODHS-endorsed, “locked” memory care
  - December 25 – resident found approximately ½ mile from facility; cause of death: hypothermia
- December 26: Adult Protective Services (APS) entered
- December 27: ODHS staff began communicating with the facility’s owner for a “safety plan”
- January 22: ODHS licensing enters to inspect the facility
- January 25: ODHS issues condition for “immediate jeopardy”

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Mt Hood Senior Living Overview cont'd

- January 26, 2024: ODHS conducts emergency closure of Mt Hood Senior Living
  - Residents & families began receiving notification mid/late-afternoon
  - Intent was to close facility by midnight
  - Residents "evacuated" that night to other licensed facilities, family homes, and hospitals

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LTCO Investigative Key Findings

- **Gaps in Oregon law allowed an owner with no background or knowledge of long-term care to open a state-licensed memory care facility** for a very vulnerable older adult population with minimal requirements to ensure Oregonians would be safe in the setting.
  - Prior to opening this facility, owner's background in marketing and real estate
  - Only requirement in Oregon law is to have an industry "consultant" involved in first 6 months of the facility's opening

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LTCO Investigative Key Findings

- **ODHS did not take urgent action to address, or potentially did not recognize, the seriousness of the numerous red flags** at this facility known by staff of the ODHS regulatory unit in the months leading up to the resident's death.
  - July & August 2023: APS conveyed concerns to ODHS licensing that facility had concerns about staffing at the facility
    - Nov. 6, 2023 licensing investigated these concerns, confirming multiple staff untrained, some w/o required background checks, and insufficient staffing levels – no formal action taken by ODHS on these findings until Dec. 28.
  - Nov. 4: ODHS informed that a 3rd Administrator had left
  - Nov. 14: ODHS informed by "interim" that she did not have qualifications to be Administrator and needed guidance

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LTCO Investigative Key Findings

- **ODHS is not required under current law to closely monitor a newly-opened facility to ensure residents are safe** and receiving required care due to gaps in the regulatory framework.
  - Even with an industry "consultant" in place the first 6 months, status reports are not required to be submitted.
  - Current law relies on complaints and allegations of licensing violations in the first 2 years of a facility's opening.

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LTCO Investigative Key Findings

- **ODHS licensing did not respond with effective urgency**, as expected under Oregon law, to immediately assess the overall safety of the facility following the resident's death.
  - Despite the statutory requirement to issue a condition for "immediate jeopardy" following the death on December 25, ODHS did not issue the condition until January 25.
  - APS had entered to investigate the single case of abuse/neglect, but the regulatory/licensing unit relied on verbal and written communication with the owner to ensure the safety of the residents still at the facility.

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LTCO Investigative Key Findings

- **ODHS did not utilize laws that their own agency (ODHS) requested**, and the legislature passed, in 2009 to avoid trauma to the residents and families when residents are living in an immediate jeopardy or immediate license revocation situation.
  - In 2009, ODHS requested new statutory authority to manage a facility's closure over time, recognizing harm and trauma to residents/families with sudden closures.
  - The 2009 law was not utilized in this instance.

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LTCO Investigative Key Findings

- **ODHS moved 13 of 18 residents to potentially unsafe settings in the middle of the night** - presumably because of the decision to rapidly close the facility.
  - 8 to 3 different licensed settings on which DHS had a condition
  - 2 to the hospital
  - 1 to a relative's home
  - 2 to settings with residents who are known to have extreme behaviors
- Some residents moved w/o care plans, medications, or wheelchairs

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LTCO Investigative Key Findings

- **Mt Hood Senior Living failed on multiple fronts to care properly for Ki Soon Hyun and the rest of the residents living there.**
  - A private business, entrusted with the care of Oregonians with cognitive impairment and intensive care needs, did not follow the laws and rules.

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LTCO Recommendations

- As called for in LTCO's investigation report:
  - **Processes must be developed to identify and more urgently respond to red flags at a state-licensed long-term care facility**
  - An audit to review:
    - ODHS compliance with letter and intent of consumer protection laws;
    - Internal conflict of consumer protection and provider support within the regulatory unit;
    - ODHS staffing levels to ensure timeliness of regulatory response.
  - Address recognized gaps in law to:
    - Compel additional action by ODHS when immediate jeopardy exists.
    - Address resident safety if inexperienced owners allowed.

LTCO Additional Recommendation

- The long-term care regulatory functions must separate out:
  - Consumer Protection role
    - Current approach blurs consumer protection and provider support functions
  - Provider support – education / training / technical assistance
    - Important for providers to be assured they can receive TA w/o investigation
  - Caregiver support
    - Build on SB 1556 (2022)
    - Develop robust training, education supports
    - State investment in career ladder for caregivers
    - Develop certification program opportunities