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LTCO Investigation:

Resident Fatality and Regulatory Gaps at Mt Hood Senior Living

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

On December 25, 2023,[1] a resident of Mt Hood Senior Living[2], Ki Soon Hyun, was found deceased after exiting this privately-owned, state-licensed memory care setting, becoming lost outdoors due to her dementia and, as understood at this time, succumbing to the cold weather overnight. Oregonians trust that state-licensed memory care providers are following the laws and rules, and when a facility does not, Oregonians expect the Oregon Department of Human Services (ODHS) to take strong action to correct non-compliance on behalf of their loved ones.

> December 24, 2023 - **Excerpt from the Sandy Police Report** - *I spoke with Ki Soon's son, John Hyun. He told me that his mother does get lost and confused and that was why she was moved into that facility.*

It is clear that Mt Hood Senior Living failed to protect and care for Ki Soon Hyun and other residents. Mt Hood Senior Living failed to lock and secure doors, as is required in licensed memory care communities[3], failed to properly train staff, and failed to staff appropriately to meet care needs. These failures, among others identified by ODHS licensing once they entered the building on January 22, 2024, resulted in Ms. Hyun's death and the ongoing safety concerns for residents at the facility. The culmination of serious concerns that developed over the short licensure of Mt Hood Senior Living led ODHS to close it on January 26, 2024.

> December 25, 2023 - **Excerpt from the Sandy Police Report** - *I arrived on scene and located the Portland Mountain Rescue Team #5. They directed me where to go and I eventually found the team at the site. I spoke to Mr. Steve Rollins who was the team lead. He informed me Ms. Hyun was located and had not been disturbed. I obtained photographs of Ms. Hyun. She was laying on her left side and had her back to some tree roots and a log. It was pointed out to me that she was also missing one shoe. the shoe was not recovered. I also noted she was wearing the same clothing as in the picture that was released when she went missing. Near her head there were two pieces of paper, one had writing on it. I seized them and placed them in a plastic bag.*

[1] see: https://www.kgw.com/article/news/local/sandy-police-search-rescue-ki-soon-hyun-mt-hood-senior-living/283-1e3ba240-9275-4b75-aa8d-99018e35fb24

[2] The name of the business is registered as Mt Hood Senior Living without the period or Mount Hood Senior Living, LLC – therefore, this report will refer to the facility as Mt Hood with no period after the Mt

[3] https://www.oregon.gov/DHS/SENIORS-DISABILITIES/SPPD/APDRules/2010-11-1%20Perm%20411-057.pdf

This report includes the findings of Oregon's Long-Term Care Ombudsman (LTCO) program's investigation of the regulatory response. Due to regulatory inactions and failures, LTCO finds that this resident's death and the additional harm and trauma that occurred to residents at this facility in the weeks following could have been prevented.

> December 25, 2023 – **Excerpts from the Sandy Police Report** - *Ms. Hyun's son in law was on scene and asked that we check if she still had her necklace with an "air-tag" type device that tracked her via GPS. We noted the necklace was still present around her neck. The Medical Examiner later removed the GPS necklace, a second green necklace, Ms. Hyun's watch, and Ms. Hyun's ring. He placed them into a plastic bag. He asked that I hand the bag to Ms. Hyun's son in law, which I did.*

No one should have a loved one, placed in what they believe to be a safe and well-regulated care facility, endure what Ki Soon and her family have, at the end of her life. To prevent a future tragedy, we must collectively and urgently fix the issues in our long-term care regulatory system and ensure safe and high-quality care for older adults and people with disabilities.

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.
- **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.
- **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.[4]
- **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.

[4] HB 2139 (2009) (see: https://olis.oregonlegislature.gov/liz/2009R1/Measures/Overview/HB2139)

- **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.
- **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.
- **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.

Background and Overview

In Oregon, the Department of Human Services (ODHS) is responsible for licensure of long-term care and residential care settings. ODHS further provides an "endorsement" process for a licensed care setting to provide state-approved memory care to individuals diagnosed with dementia. Mt Hood Senior Living received their license on February 7, 2023 to operate a 50-bed care facility, and an endorsement to operate a unit of 33 of those beds as a memory care setting. The memory care endorsement was issued by ODHS on the same day as the overall licensure.

> **Mt Hood Senior Living Website**: *We take pride in our specialized memory care program, designed to empower residents with cognitive challenges to lead fulfilling lives. Our team utilizes innovative techniques and engaging activities to enhance cognitive function and promote emotional well-being.*

The primary purpose of a state-endorsed memory care setting is to meet the care needs of individuals with Alzheimer's Disease or other dementias, while also ensuring their safety. Ensuring safety includes the requirement that a building keep their exterior doors alarmed and locked to prevent a resident with dementia from wandering away from the facility, become confused, lost or frightened, and fall victim to potentially dangerous conditions away from the facility.

> November 14, 2023 – **Email from Mt Hood Senior Living Business Manager to ODHS Policy Analyst after the third Administrator in 6 months left:** *…we do not have a current E.D. as she was terminated, with an email sent to you afterwards notifying you of the change. I do not believe I have the credentials, training, or education to fill in as an interim, as I have only been a bookkeeper/Business Office Manager with a High School Diploma; no college education or formal medical training or work experience.*
>
> **Business Office manager was still the interim Administrator when Ki Soon Hyun eloped and died December 25, 2023.**

On December 24, 2023, Mt. Hood Senior Living catastrophically failed resulting in a resident's death. On December 28, 2023, Oregon's Long-Term Care Ombudsman (LTCO) program began investigating the actions and inactions of the circumstances related to Ki Soon Hyun's death. The initial purpose of LTCO's investigation was to identify if there were any ongoing concerns for the individuals still residing at Mt Hood Senior Living. As LTCO investigated the situation on behalf of the residents still living at this facility, the expectation was that ODHS would take quick licensing action to ensure the safety of the remaining residents at Mt Hood Senior Living, which is required of ODHS by current state law.[5] Unfortunately, that was not the case.

> December 27th – **Email from the Facility Consultant to ODHS Policy Analyst:** *I have asked the building for a safety plan but have not received it. Also, I probably was not clear… I have not been in the building since September. Their 6 month mandate was up at that time. I went to an on call status and have rarely heard from them. I was not aware of the decision of letting the prior Administrator go until I received an email the same day you did. I gave notice on 12/1/2023 to end the on call status. I have attached the notice. I will talk with them today regarding the safety plan. I went over yesterday what that should look like. I have no problem completing one but if they do not agree or commit to follow it I do not want to send you one on false pretense.* ***[See Appendix A]***

Almost one month after the death of Ki Soon Hyun, on January 22, 2024, ODHS licensing entered the building to conduct a licensing investigation of Mt Hood Senior Living. On January 26, 2024, ODHS conducted a rapid and chaotic closure of the facility. Out of concerns that this late night same-day closure potentially traumatized the residents still living at the facility and their families,[6] LTCO also began investigating both the delayed response by licensing and this rapid closure.

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[5] ORS 443.441(3)(a) requires that ODHS investigate such instances "without undue delay," and ORS 441.736(2)(a) requires that "[t]he department … shall impose a condition on the license in response to a finding of immediate jeopardy, whether or not the finding of immediate jeopardy is substantiated at the time the license condition is imposed." ORS 441.736(1)(a) defines immediate jeopardy to mean "a situation in which the failure of a residential care facility or a long term care facility to comply with a rule of the Department of Human Services has caused or is likely to cause serious injury, serious harm, serious impairment or death to a resident."

[6] See: https://katu.com/news/local/family-members-demand-answers-days-after-senior-living-facility-forced-to-close

January 26th ODHS Preliminary Survey Findings: **Failure of facility to comply with the Department's rules** that were likely to cause residents serious harm. Excerpts from the 243-page document:

- Facility was feeding multiple people solid food when the Physician ordered mechanically soft diets – leaves people at risk of aspiration, choking or death.
- Residents were not receiving baths or showering assistance.
- Resident left in a recliner for over 8 hours with no meals or hydration offered.
- Failure to report abuse – multiple falls (11 for one resident alone) and providing wrong medications.
- 17 of 17 staff sampled failed to complete required pre-service training prior to beginning work responsibilities.

The overall goal of this LTCO investigation is to identify gaps in process and laws that should be in place to protect the health, welfare, safety, and rights of Oregonians living in state-licensed long-term and residential care facilities. LTCO's hope is that a review of the circumstances surrounding this tragedy will lead to improvements in the way Oregon regulates facilities. The entire purpose of regulation of private businesses, in this case, memory care facilities, is to ensure vulnerable Oregonians are safe and have high-quality long-term care.

Investigative Findings

Lack of Urgency:

1. **ODHS did not issue a condition for an "immediate jeopardy" situation until 30 days following the resident's death, in violation of statutory expectations.**
    a) ORS 441.736(2)(a) was updated in 2021 by the Oregon legislature, via SB 266,[7] establishing that "[t]he department … **shall impose a condition on the license in response to a finding of immediate jeopardy, whether or not the finding of immediate jeopardy is substantiated at the time the license condition is imposed**." The language underlined here was added in 2021, with the full language in bold identifying what LTCO recognizes as an expectation of urgency when immediate jeopardy exists for residents at a facility.

[7] Senate Bill (SB) 266: https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/SB266.

i. For purposes of this statutory mandate, ORS 441.736(1)(a) defines "immediate jeopardy" to include "**a situation in which the failure of a residential care facility** or a long term care facility to comply with a rule of the Department of Human Services **has caused** or is likely to cause serious injury, serious harm, serious impairment or **death to a resident**." (emphasis added)

b) In the ODHS, January 24, 2024 letter responding to LTCO's January 11, 2024 investigative letter, ODHS wrote that their licensing unit "was satisfied that short term interventions effectively removed the 'immediacy' of the potential IJ [immediate jeopardy]." **This statement ignores the Oregon statutory mandate of "shall impose" a condition that is required of ODHS. The law, as written, does not give ODHS discretion to choose whether other "short term interventions" are sufficient to satisfy this statutory requirement.** Yet, on the same day, ODHS finally ended up issuing a condition on the license related to the fatality.

2. **ODHS assessments of the situation at Mt Hood Senior Living in the days following the resident's death should have triggered an immediate response by the ODHS licensing unit, not just local Adult Protective Services.**

a) An ODHS Adult Protective Services (APS) investigation on December 26, 2023 presumably confirmed on that same day that the initial resident of concern had in fact eloped on December 24, 2023 and died the next day. This preliminary finding should have been sufficient for ODHS to recognize that the statutory definition of "immediate jeopardy" had been reached and that the ODHS regulatory unit should have issued an immediate condition on the facility's license. Yet, ODHS licensing still did not enter the facility to initiate their own investigation for another 27 days.

i. SB 266 also mandated that ODHS **"shall begin an investigation without undue delay"** for complaints of licensing violations "other than abuse."[8] In this instance, ODHS appears to have considered the resident's death only as abuse (and neglect, specifically, as an element of "abuse") and initially only responded with an investigation by Adult Protective Services (APS). However, the law passed in 2021 does not prohibit an investigation by ODHS licensing when the case is identified as also requiring an abuse-specific investigation. Given the circumstances and what should have been immediately known following the media coverage and the APS investigative visit on December 26, 2023, ODHS licensing had the

[8] See ORS 443.441(3)(a).

option to respond "without undue delay," but appears to have waited weeks for a preliminary report from APS.

ii. An APS investigation is initiated and is generally responsive to an *individual* instance of alleged abuse or neglect. A licensing investigation is designed to be responsive to more systemic failure and protection of the entire resident population, and should have been initiated in this instance, to ensure the protection of the remaining residents of Mt Hood.

b) An initial safety plan submitted by the provider on December 27, 2023 to address safety concerns in the facility was noted via email by ODHS regulatory staff as insufficient to protect residents from further harm. ODHS requested more detail and timelines for implementation from the provider. However, on that same day, a communication to that same ODHS regulatory staff from the consultant hired by the facility when it opened describes that the consultant was not confident that the provider would follow a safety plan.[9]

c) Included in a December 27, 2023 email communication from the consultant to ODHS regulatory staff, the consultant shared her December 1, 2023 resignation notice. That notice included concerns the consultant had with the facility owner's lack of compliance with laws and policies intended to keep residents safe. Specifically, the consultant wrote in this December 1, 2023 letter to facility owner, Joy Zhou: "I must also express my concerns regarding compliance with the policies and procedures we have established. Although our involvement has been limited to non-onsite interactions this past quarter, **we are concerned a lapse in adherence to set policies, including but not limited to fire and life safety, resident evaluations, assessments, and service plans.** It is crucial to recognize that adherence to rules and regulations set forth by the State is mandatory, especially in the critical phase of opening a new community." (emphasis added; any errors were in the original document)

<u>Unsafe and Traumatic Move</u>:

1. The immediate closure by ODHS of Mt Hood Senior Living on January 26, 2024, appears to have ignored 1) the statutory authority for ODHS to have an immediate

[9] In a December 27, 2023 email from consultant Tammy Thwaite to ODHS regulatory staff, she responded to the ODHS request for a safety plan stating, "I have no problem completing one [a safety plan] but if they do not agree or commit to follow it I do not want to send you one on false pretense."

trustee appointed to assume control of the facility,[10] and 2) ODHS legislative efforts from 2009 to avoid trauma to residents and families related to rapid closures.[11]

a) The January 26, 2024, closure of Mt Hood Senior Living was conducted by ODHS out of the serious concerns and immediate jeopardy they found at this facility once ODHS regulatory inspectors finally entered the facility on January 22. We agree that immediate jeopardy existed at this facility and had existed since the elopement of Ki Soon Hyun, however the method (a nighttime immediate closure and move) chosen to address the situation was not safe and did not minimize further harm to the residents.

b) In 2009, ODHS requested and successfully passed legislation to allow ODHS to 1) obtain an expedited court order for trusteeship of a facility when "there exists a serious and immediate risk of harm or death"[12] to the residents of a facility, or 2) appoint a temporary manager of a facility for up to 6 months. ODHS legislative testimony stated the legislation was needed as, prior to 2009, "[t]he only option that we [DHS] have had available in that kind of a situation is to evacuate the facility, **which causes trauma to the residents and the families, and which isn't good for anyone**."[13] (emphasis added)

c) In the afternoon of January 26, 2024, ODHS licensing informed LTCO that they would be issuing an immediate suspension of the facility's license and that they need to move all residents by midnight. It is unclear to LTCO why ODHS believed they needed to evacuate the facility before midnight.

2. As the details of the late-night move became clear to LTCO, we learned that 13 of 18 residents rapidly moved by ODHS from Mt Hood Senior Living were moved to locations that ODHS should have considered to be unsafe. The outcome could have been different if the process developed by the 2009 legislature and other past building closures was followed.

a) Eight individuals were moved to three ODHS-licensed care settings where ODHS had active conditions on those facility licenses. As known to ODHS, a facility will have a regulatory condition placed on their license when the facility is found to be out of compliance with the laws in place to keep residents safe in a state-licensed facility. For the three facilities referenced here, all three had conditions due to insufficient staffing or insufficiently complying with the staffing requirements and acuity-based staffing in Oregon law. A facility out of compliance with staffing laws should have been

[10] ORS 441.281(5)

[11] HB 2139 (2009); see: https://olis.oregonlegislature.gov/liz/2009R1/Measures/Overview/HB2139

[12] ORS 441.281(5)

[13] See February 18, 2009 verbal testimony of Mary Gear, ODHS Administrator for the Office of Licensing and Quality of Care, to the House Judiciary committee on HB 2139.

recognized by ODHS as an inappropriate location to which they moved individuals.

b) Two individuals were checked into the hospital that night. Hospital stays are generally considered to be an unsafe location for the overall health of an older adult.[14] As reported to LTCO, one of these individuals needed medical attention after experiencing a fall during the closure of the facility. The other individual was reported to LTCO by ODHS as having moved to a licensed care facility, but LTCO learned from the individual resident that they checked into a hospital rather than go to the facility ODHS had chosen. The facility ODHS had chosen for this individual was one of the receiving facilities with an active condition on their license, due to ongoing regulatory failures.

c) Two individuals were sent to ODHS-licensed specialty care settings where other residents are known to have extreme behavior support needs. These settings are ideal for the residents they are designed to assist, but for an individual without these support needs, it is an inappropriate placement. At a minimum, these residents would most likely not have been considered for placement in these locations if they were evaluated to assess their care needs for proper placement.

d) One individual went to their family home, without their medications and where the long-term care support needs for that individual had not yet been secured. This individual was in a state-licensed care setting to receive necessary care, and that care could not be provided, even in the short term, when necessary in-home supports were not first secured.

3. **Following the move, LTCO began reaching out to residents and family members to offer support and assistance. Transfer trauma is a known concern for this population under these circumstances.[15] LTCO identified numerous instances of trauma or emotional harm caused to residents due to the ODHS-initiated rapid closure.**

a) Some resident's belongings were moved by being placed in garbage bags while being removed from the facility.

b) Reports to LTCO indicated several residents were moved without their lifesaving medications.

c) At least one resident immediately began exhibiting behaviors related to transfer trauma, including dementia-related anger towards others entering

[14] For a brief summary of the researched concerns for older adults in hospitals, see: https://www.jeffersonhealth.org/your-health/living-well/the-mental-and-physical-effects-of-a-hospital-stay-on-seniors; see also: https://psnet.ahrq.gov/perspective/patient-safety-frail-older-patients#:~:text=Older%20adults%20are%20at%20an,(HAC)%20or%20safety%20event.&text=For%20example%2C%20prolonged%20bed%20rest,increased%20likelihood%20of%20a%20fall.

[15] See: https://emancipatorysciences.ucsf.edu/eslabblog/nursing-home-residents-transfer-trauma-or-relocation-stress-syndrome.

the individual's room in the evening after dark. That behavior may have been associated with the trauma of being removed from their home, Mt Hood Senior Living, in the dark of night.

d) Overall, in the weeks following the closure, various residents were moved additional times, were missing personal belongings, medical equipment, and medical orders related to allergies and other medical conditions. Several individuals appeared to have had significant health declines and at least one died potentially related to the transfer trauma.

See Appendix B for select summaries with details of the resident harm and trauma caused with the rapid closure of Mt Hood Senior Living.

<u>Red Flags</u>:

1. **ODHS did not appear to recognize the collection of red flags in the Agency's possession for at least the seven weeks prior to the December 25th tragedy. If the facts available to ODHS had been collectively recognized, LTCO believes this information should have triggered a more aggressive regulatory response before and following the fatality. Our finding of red flags include:**
    a) The ODHS licensing unit was informed on November 4, 2023 that Mt Hood Senior Living was **without an administrator** since November 2, 2023.[16] A licensed, full-time administrator is required by OAR 411-054-0065. The administrator role is critical for proper functioning of a licensed care facility, as this role is responsible for all aspects of a facility's functions.
        i. Appearing to miss an opportunity to understand and intervene in the situation, the responsible ODHS licensing staff did not, at least not in written email communication, request to have the background and qualifications of the interim administrator submitted to ODHS as required by OAR 411-054-0065(6).
    b) On November 14, 2023, the facility's Business Office Manager, who was identified by the facility as overseeing all functions as the interim administrator, emailed the ODHS-assigned licensing policy analyst, stating **"… I do not believe I have the credentials, training, or education to fill in as an interim, as I have only been a bookkeeper/Business Office Manager with a High School Diploma; no college education or formal**

[16] On November 4, 2023, the owner of Mt. Hood Senior Living, Joy/Yi Zhou, emailed DHS licensing "to notify you that our facility's Executive Director, [name redacted], is no longer employed with us. Her last day of work was Nov 2nd, 2023." The email further stated, "During this transitional period, our Business Office Manager, Amanda Gardner, will assume responsibility for managing the facility."

medical training or work experience." The email goes on to request direction from ODHS on when a licensed Administrator needs to be in place, and further confirms their inexperience in managing a licensed care facility by requesting guidance to understand how many staff are required to be working in the facility.

   i. The ODHS licensing policy analyst responded, "if you don't feel qualified to be interim then yes, someone needs to be administrator and you may have to hire an agency staff or have the owner fill in temporarily…let me know who will be interim admin." Unless conveyed through other means, the ODHS licensing policy analyst again did not reiterate the requirements of the Oregon Administrative Rule that an interim administrator must, as indicated by the OAR, have background and experience to be the person overseeing the operations of the facility. In fact, as evidenced by the email, the ODHS staffer deferred to whether the Business Office Manager personally felt qualified.

c) The ODHS regulatory unit finally conducted an inspection on November 6, 2023 to investigate complaints received from their intra-agency colleagues in APS on July 7, 2023 and August 18, 2023 regarding concerns about staffing at this facility. The November 6th investigation[17] determined:

   i. Numerous staff were not fully trained (as required by law) to provide caregiving services;
   ii. At least two staff were found to have provided care without required background checks (as required by law); and
   iii. The facility was regularly understaffed to deliver the necessary care to the residents in the facility.
      1. No formal ODHS licensing action occurred to address the November 6th serious violations of law until December 28, 2023 – after Ki Soon Hyun's death. And, even then, the only "condition" issued to the facility on December 28th was effectively a reminder to the facility to use an acuity-based staffing tool to identify the number of staff needed to properly care for their residents, as already required by Oregon law.
      2. ORS 441.736 details the type of licensing conditions that ODHS is allowed (and required in certain instances) to use for staffing concerns at a facility. Such conditions ODHS is authorized to enforce under the law include the ability to 1)

[17] see: https://ltclicensing.oregon.gov/Facilities/Details/50R515

restrict the total number of residents in the facility, 2) require additional staff or staff qualifications, 3) require additional staff training, and 4) restrict new admissions into the facility.

3. Additionally, in the past, ODHS has required a management company to be secured by a provider immediately to address non-compliance and protect residents. It is unclear why ODHS failed to do so in this instance.

d) Between the opening of the facility in March 2023 and November 2, 2023, this facility had three different administrators. It is not known to LTCO why each of these three administrators left their position. What is known to LTCO is that, in general, regular administrator turnover is often a strong indicator of concerns with a facility's ability to provide quality care and services to residents.

2. Current Oregon law only requires a consultant "for a period of at least six months" when a facility first opens,[18] and allows ODHS to approve "the terms and length of employment." As a result, ODHS did not know that the consultant to the facility stopped providing services to the owner in September of 2023.

a) Consultant provided notice to owner of Mt Hood Senior Living on December 1, 2023 **[*See Appendix A*]**

b) Within the materials reviewed for LTCO's investigation, there were no indicators that ODHS ever contemplated any additional "terms and length of employment" for Mt Hood Senior Living's consultant.

c) ODHS licensing staff, based on a December 27, 2023 email communication with the consultant, did not appear to be aware that the consultant had not provided on-site services to Mt Hood Senior Living since September of 2023.

d) A gap in current law does not require that a consultant (or, alternatively, a management company) provide any status report(s) to ODHS during the first six months of operation. With this lack of reporting, ODHS does not have knowledge of a consultant's status with a provider. In this instance, the consultant was no longer providing regular services to Mt Hood Senior Living, nor did ODHS know that the consultant had concerns with the facility's ability to follow applicable laws and policies to keep resident's safe. If known, and in the context of what became known in early November 2023, this clearly would have provided additional support for an urgent intervention by ODHS regarding the operations and lack of leadership at the facility.

[18] OAR 411-054-0016(4).

3. **Following the fatality, an additional action of concern was identified in the LTCO investigation.**
    a) On January 10, 2024 – 16 days after the resident's death – ODHS licensing staff took action to support the owner of this troubled facility. In particular, the policy analyst inexplicably issued a waiver of Oregon Administrative Rule (OAR) requirements to allow the inexperienced owner, to serve as the interim administrator. This decision came even after the same ODHS licensing policy analyst received the December 27, 2023 communication from Mt Hood Senior Living's consultant conveying her concerns with the owner's potential lack of adherence to the regulatory laws required to operate the facility. **Devastatingly, concerns which were confirmed by the catastrophic failure at this facility resulting in a resident's death. The lack of leadership experience and qualifications to run a facility or be an administrator were clearly known by ODHS regulatory staff by this time.**
    b) LTCO is concerned by the process used by ODHS to waive Administrative Rules. It appears that policy analysts are granting waivers that potentially violate resident rights or other consumer protections. Given that these rules are a form of state law, governed through the Administrative Procedures Act after significant stakeholder and public engagement, it is imperative that ODHS management or other leadership approve of, and confirm legal justification for any waiver granted.

<u>Additional Gaps in Law</u>:

1. **The owner of Mt Hood Senior Living, Joy/Yi Zhou, had no experience delivering long-term care services.** Prior to her application to open this facility, she was a real estate agent with a prior background in marketing. Current law, however, does not put significant expectations (that the public likely already expects) for an inexperienced owner when opening a state-licensed memory care facility. The lack of regulatory requirements for an inexperienced owner opening a facility for services to individuals with extraordinary care needs associated with dementia is particularly concerning. Enhanced regulatory requirements and expectations must be developed before allowing inexperienced owners to provide these health and safety services in the future.
2. **There is no clear regulatory requirement for ODHS to enter a facility for a complete inspection early-on in a building's licensure.** In this case, Mt Hood Senior Living operated from March 2023 until January 22, 2024 without a regulatory inspection. Complaint-driven investigators (different from the full-blown inspection team) visited the facility on November 6, 2023 to investigate staffing-related concerns and not

broader or systemic compliance with regulatory laws. Current law does not require a full-blown regulatory inspection of a facility, except once every two years, even for a newly-opened facility.

3. **Prior to the opening of the facility, the Oregon Health Authority's (OHA) Facilities Planning & Safety Unit conducted an on-site inspection on September 28, 2022. This inspection covers only the physical building requirements.** OAR 411-054-0200(11)(b) requires alarms on exit doors to alert staff when residents exit any door of a Residential Care Facility. The September 28, 2022 inspection identified this as a deficiency and the facility would need to come into compliance. **The inspection report, however, indicates the follow-up needed was only for the facility to "provide a picture when doors and electronic locking system is installed."** The facility did provide a picture of a computer screen demonstrating the electronic system and a picture of a facility map with color markings of which doors were on the electronic system. This approach has presumably been sufficient in the past but should be re-evaluated for sufficiency given the critical importance of door locking systems in a memory care unit.
    a) **After Ki Soon Hyun's death, on December 29, 2023, the owner of Mt Hood Senior Living provided a "safety plan"** to ODHS to ensure future safety of residents at the facility. That safety plan included a plan **to install an alarm system on certain exit doors, indicating that they may not have had the alarms in place as required by OAR, or as approved by the Oregon Health Authority review of pictures.**

<u>Recommendations</u>

Based on LTCO's investigation and findings, LTCO recommends the following to improve the consumer protection regulatory function of Oregon's long-term care system:

- **Processes must be developed to identify and more urgently respond to red flags at a state-licensed long-term care facility** – the public is counting on ODHS to keep their loved ones safe, and to prevent catastrophic events such as the one at Mt Hood Senior Living.
- **An independent audit of ODHS's licensing and regulatory functions should occur** to ensure the regulatory system operates effectively, in compliance with Oregon laws, and with a primary focus on consumer protection. An audit must review:
    - **Regulatory approach**:
        - As evidenced by this situation, both in the lead-up to the fatality on December 25th and in the weeks following, the current

regulatory approach does not prioritize the consumer protection functions, of a traditional regulatory and licensing program, as is needed for Oregonians living in state-licensed long-term care settings.

- The current regulatory approach effectively requires that ODHS operate in conflict with itself. Specifically, the ODHS regulatory system embraces a "provider support" function while also attempting regulatory accountability and safety for consumers. These two functions can create conflicts within the body and contrary to regulatory purpose when ODHS is positioned to support the businesses they license while attempting to ensure the consumers served under these licensed settings are protected.

- **Timeliness of licensing investigations**: The licensing investigation that occurred on November 6, 2023 was from a referral received as early as July 7, 2023. The December 25, 2023 fatality did not have a licensing investigation initiated until January 22, 2024. LTCO understands that the 2024 legislative session resulted in additional investigative staff being allocated to ODHS but an independent audit is still necessary to review current processes in order to identify opportunities for program improvement, including in the timeliness of regulatory responses.
- **Application of existing laws**: Through this investigation, it was identified that a number of regulatory (consumer protection) laws were either not followed, or not effectively utilized by ODHS, to protect individuals living in long-term care. It is unclear why ODHS is reluctant to use the full-force and effect of the laws in existence. ODHS should be placing conditions on facility licenses for the purposes of protecting consumers. The full breadth of available statutes and Administrative Rules need to be reviewed for compliance and opportunity for regulatory improvement.
- **Waivers of Administrative Rule/Law:** The waiving of Administrative Laws established by ODHS should require a more rigorous process, including, at a minimum, review by management. Waiving consumer protection rules and laws through siloed decision-making by a single staff member is an unacceptable practice for a regulatory body.

- **Gaps in current law must be evaluated and addressed, including:**
  - The regulatory oversight of new long-term care facilities, including the need for enhanced intervals for regulatory inspections, such as:
    - Quarterly for a facility with an owner who has never operated an RCF/ALF/memory care facility.

        - No later than the first 6 and 12 months for any other newly licensed facility.
    - Whether a prospective owner, with no experience delivering long-term care services, should be allowed to open a care setting for individuals with some of the most complex care needs associated with Alzheimer's Disease and dementia.
    - If a consultant or management company is required under any state law, regular reporting to ODHS must be required, with specific reporting and documentation requirements.

LTCO Investigative Process

Federal[19] and state[20] authority exists for the Long-Term Care Ombudsman to investigate actions and inactions of a facility or a public agency that impact the health, safety, welfare, or rights of residents in licensed care facilities.

Following the death that occurred on December 25, 2023, LTCO staff visited the facility on December 28, 2023, to begin a preliminary investigation on behalf of the residents still living at Mt Hood Senior Living. An LTCO investigation however is not a regulatory inspection reviewing a facility's compliance with law. Rather, LTCO investigations are generally focused on the overall care and well-being of those living in a state-licensed care setting and ensuring that the rights of individuals are being upheld.

Following this initial visit, and as LTCO continued reviewing the background of this facility, LTCO decided to expand its investigation of the circumstances that led to the resident's death. On January 11, 2024, LTCO sent an investigative letter to the Oregon Department of Human Services (ODHS) requesting information and materials related to the licensing and regulatory involvement for this facility. ODHS provided the requested information and materials to LTCO in the evening of January 24, 2024.

Based on the materials received from that initial investigative inquiry, LTCO then sent follow-up investigative letters to:

[19] See 45 CFR 1324.13

[20] ORS 441.406(1)(a) provides the LTCO investigative authority. ORS 441.402(1) defines administrative actions to including "any action, inaction or decision made by an owner, employee or agent of a long term care facility **or by a public agency** that affects the services to residents of long term care facilities." (emphasis added)

- The Oregon Health Authority's Facilities Planning and Safety Unit, which is responsible for the review and approval of the physical structure of new care facilities seeking ODHS licensure;
- The local ODHS Adult Protective Services office for the purposes of reviewing the lists of abuse allegations reported and investigated; and
- The ODHS licensing unit to gather additional details from the original January 24, 2024 response they provided.

Additional research included:

- Considerable review of applicable laws, both statutory and Administrative Rules, as well as review of relevant legislative history.
- A review of the background of the owner, Joy/Yi Zhou, including the official filing with the Oregon Secretary of State's office for the business entity she established to open Mt Hood Senior Living;
- A review of the background of the consultant hired by Mt Hood Senior Living to assist in the operation of the facility in its first six months as required by Oregon Administrative Rule;
- A review of the facility's licensing history; and
- Intense follow-up with and for all the residents moved from Mt Hood Senior Living in an effort to support them and ensure the ongoing protection of their rights during their moves.

Conclusion

The events that occurred at Mt Hood Senior Living, including the actions and inactions leading to Ki Soon Hyun's death and further harm to the residents in the weeks following her passing, are unacceptable and must be addressed. Licensing and regulatory structures established by the legislature are created with a purpose of protecting consumers. If consumers – in this case, consumers of state-licensed long-term care services – are put in harm's way in a setting licensed and regulated by the state, then improvements must be demanded.

The Long-Term Care Ombudsman program investigated the situation at Mt Hood Senior Living to assess how the State of Oregon can regain trust to ensure Oregonians or their loved ones will be safe, receive quality care, and be treated with dignity and respect when they enter a state-licensed care facility. Trust is currently broken. This report and its recommendations are intended to move our state closer to that goal and improve the lives of residents in long-term care.

Appendix A

December 1, 2023

Joy Zhou
Mt Hood Senior Living
39641Scenic Street
Sandy, OR 97055

Dear Joy Zhou,

Subject: Termination of Services Notice

I am writing to officially provide a 30-day notice of termination of services by Avant Senior Housing Managers and Consultants to Mt Hood Senior Living, as per the terms of our contractual agreement.

Over the course of our collaboration, we have appreciated various aspects of working with Mt Hood Senior Living. However, we believe that we have extended all the resources and support within our capacity.

The tools and services provided by Avant Senior Housing Managers and Consultants include, but are not limited to, Operating Manuals (covering Caregiver, Med Tech, Health Services, Maintenance, Activities, Food Services, Administration), comprehensive documents like Resident and Employee Onboarding materials, Job Descriptions, Orientation Checklists and PowerPoint presentations, Competency Checklists, New Hire and New Resident Checklists, Training on Rules and Regulations, Kitchen and Maintenance Inspection and Temperature Logs, Infection Control Protocols, and more.

Should you require any copies of these documents, please submit your request within this 30-day notice period.

I must also express my concerns regarding compliance with the policies and procedures we have established. Although our involvement has been limited to non-onsite interactions this past quarter, we are concerned a lapse in adherence to set policies, including but not limited to fire and life safety,

Appendix A (continued)

resident evaluations, assessments, and service plans. It is crucial to recognize that adherence to rules and regulations set forth by the State is mandatory, especially in the critical phase of opening a new community.

Additionally, as we approach the end of the year, I would like to discuss a feasible payment plan for the outstanding balances owed to Avant. Understanding the financial challenges faced, we are open to agreeing on a monthly payment structure, aiming to settle the dues by July 1, 2024. Your input on a comfortable arrangement for this would be greatly appreciated.

In closing, I extend my best wishes to you and acknowledge the hard work and dedication invested in making Mt Hood Senior Living a success. We hope for a smooth transition and resolution of the aforementioned matters.

Thank you for your attention to these issues. I look forward to your prompt response.

Sincerely,

Tammy Thwaite

Tammy Thwaite
Avant Senior Housing Managers and Consultants

Appendix B

Resident Charles Hess[21] (Now Deceased):

On the night of the abrupt closure of Mt Hood Senior Living, Mr. Charles Hess was moved to a facility in Clackamas County. The Hess family was not notified of the closure, nor were they given an option on where he would be moved. His granddaughter wanted to move him closer to her in Arizona and was working with ODHS staff to move him. Mr. Hess had been on Hospice services for more than 1 year for a terminal diagnosis and severe pain. He arrived at the new facility at 11:30 pm. The new facility did not have his durable medical equipment (walker, bed) or personal belongings and early the next day he suffered a fall.

- January 29, three days after the move Mr. Hess was provided a pendant alarm to summon assistance when needed.
- February 2, the ODHS case manager made a face-to-face visit and noted Mr. Hess had increased swelling in legs and need for his CPAP machine for his sleep apnea.
- February 3, the receiving facility documents Mr. Hess complained about pain in his lower legs.
- February 6, hospice ordered oxygen. Hospice also documented Mr. Hess was developing a small pressure ulcer on his back side. (Case manager was still waiting for approval to move him to Arizona)
- February 9, LTCO visited Mr. Hess and spoke with staff. LTCO asked staff about the CPAP machine and staff were unaware. LTCO requested that the administrator talk with Hospice and coordinate getting a CPAP machine quickly.
- February 12, eleven days after the case manager raised the issue of the CPAP machine, Hospice ordered, and the facility received, the CPAP machine.
- February 16, four days later, the facility's LPN inquired about the CPAP machine and requested that the facility not get the CPAP as Mr. Hess had a beard and refused to shave.
- February 19, Mr. Hess had a second fall, and stated he was always in pain. He was subsequently diagnosed with a yeast infection. The facility ordered a hospital bed, fall mat, a wheelchair pad, and Hospice ordered oxygen for the second time. The oxygen was to be provided for Mr. Hess' shortness of breath and air hunger; this was 13 days after the first order.
- February 22, Mr. Hess has another fall.
- February 23, Mr. Hess is found deceased in a recliner.

[21] LTCO has permission to use these residents' names or initials and personal medical information and story.

Appendix B (continued)

The family was not happy with where Mr. Hess had been placed the night of the closure. The family was concerned about his health, fall risks and lack of care. Family wanted assistance in finding a different placement.

Resident DS:

Former resident of Mt Hood Senior Living, DS, is 86 years old and married. In August 2023 he suffered a stroke and moved into a long-term care facility, but family felt he needed more substantial care and he moved to Mt Hood Senior Living on January 20, 2024, just 16 days before the closure and after the death of Ki Soon Hyun.

- DS's wife reports during the closure on the evening of 1/26/24 she did not get a choice. Oregon Department of Human Services (ODHS) staff told her they were sending DS to a facility an hour and a half away in Keizer, Oregon.
- During the week of the closure at Mt Hood, DS suffered falls resulting in fractures of his spine and on the evening of the closure DS suffered another fall.
- During the discharge from Mt Hood Senior Living; DS did not receive his medications or doctor's orders.
- Afraid that he would be moved to Keizer, and because he was in pain, his wife took him to the Emergency Department. While at the hospital his spouse coordinated family friends to assist in his care and brought him home.
- Four days after the move to the hospital, DS's spouse stated her stress was so extreme she was close to a mental breakdown.
- On February 3, 2024, DS's spouse reported her husband was still at home. She hired a caregiver and family helped provide care when they could. They were doing the best they could, but the stress was taking a toll on her and she had been sent to the hospital emergency room due to her own health conditions, worsened by stress.
- Seventeen days after the closure DS's spouse stated they were still looking for a placement, and that they do not have enough help from the in-home care giver.

Appendix B (continued)

- A placement was found in Beaverton area with the goal for DS to then be moved back to Sandy when a vacancy was available. However, due to the distance from his family and disruption of additional transfers and transfer trauma, the family decided against another temporary move.
- On February 26, 2024, DS was moved to an Adult Foster Home (AFH). Family reports DS was accepting the move but not adjusting well. The AFH is having difficulty dealing with DS's verbal outbursts at the AFH. Spouse has now provided notice to the facility that she will move DS after 30 days, because DS's doctor believes DS should be in a memory care.
- Another receiving facility, near the location of the spouse, has a vacancy which the family is looking into, but the receiving facility is requesting DS be on Medicaid. As of 3/19/24 DS is still waiting for a Medicaid decision. DS's spouse is uncertain what will happen when she needs to move DS from the AFH.

Resident Elaine Pardue:

Mrs. Pardue has been bedbound for the past 2 years. Her family members are very involved in her care. On the night of the closure, Mrs. Pardue's family received a call around 4:00 pm from ODHS stating they were calling all family members to see if families could take residents home with them and provide their care on the night of the closure. They were unable to take Mrs. Pardue into their home. At 5:00 pm the family arrived at Mt. Hood to find chaos. When family attempted to speak with someone in charge, they were told they were too busy to talk and were not given a choice as to where Mrs. Pardue would be moved that evening. While sitting with Mrs. Pardue, 5-6 people unknown to her or family came into the room to check her pressure wounds on her back side. Family reported there were "official" looking people all over the facility, but no one was in charge, residents were everywhere and panicked. They were told that if they couldn't find a facility for her to go to, she would be sent to the hospital. The family told the state worker that a facility an hour and a half away was too far to visit every day, ODHS responded that the family was going to have to go with what we have. Besides a facility in Salem/Keizer the only other option was a facility over half an hour away.

Appendix B (continued)

- During the move Mrs. Pardue reported residents were being fed fast food that week.

- On Friday evening Mrs. Pardue was transported to the receiving facility via stretcher ambulance because she is bedbound.

- Her medications nor her doctor's orders were sent with her that evening.

- The daughter-in-law had to go to Mt. Hood two days after the transfer to pick up all of her medications.

- When Mrs. Pardue arrived at the receiving facility, she was placed in a cluttered room with extension cords across the floor. Her room was the farthest room from the common areas. She was very frightened and vulnerable due to her inability to move from bed. The first few nights at the facility three to four other residents wandered into her room, traumatizing her more.

- On Saturday, January 27th Mrs. Pardue was forced to sit in a wheelchair and taken to the dining room to eat breakfast. She verbalized her objections and expressed the severe pain in her back due to being forced in the wheelchair to no avail. The family had explained to the new facility's staff Mrs. Pardue's care needs and limitations, but it appeared to Mrs. Pardue and family members the staff did what they wanted despite prior information and objections.

- The new facility's staff refused to allow the use of bed rails although it was explained by Mrs. Pardue and her family that she had used these at her last facility to reposition herself taking pressure off her back.

- Although, she is completely bed-bound the family reported the pull cord is not functional leaving her in especially vulnerable when she is unable to summon assistance.

Appendix B (continued)

- On January 31, 2024, the facility's Executive Director was notified of Mrs. Pardue's need for bedrails and functional pendant. The facility also began locking her door to thwart any unwanted visitors.

- On February 2, 2024, LTCO deputy visited with her, Deputy confirmed Mrs. Pardue still does not have bedrails to make her limited mobility accessible. Mrs. Pardue began suffering from increased nausea. The Executive Director was uncertain if an assessment was done. After many correspondences and advocacy by LTCO and family the facility finally put bed rails on her bed.

- 12 days after the move, Mrs. Pardue was in bed without the ability to reposition herself. Then the facility staff required her once again, to be moved to the wheelchair while they attached the rails to the bed. When she cried out in pain the staff stated she was in pain due to her daughter in-law's instance of placing bedrails on the bed. Mrs. Pardue reported she was afraid and wanted out of the facility. The family contacted ambulance services and requested their mother be transferred to the hospital. Mrs. Pardue remained at the hospital for two (2) nights as it was determined not safe for her to return to the facility.

- Mrs. Pardue is now at another long-term care facility. This facility has reported she is doing better but having a difficult time trusting people.

The family reports her care and treatment after the move from Mt Hood was horrific. She was placed in a facility that was not well staffed, was dirty and had strong urine odors. Finally, Mrs. Pardue did not receive her medications upon discharge and at the end of her time at the first placement after Mt Hood, and family believe she was overmedicated suffering from grogginess and hallucinations. Now, after her move to a permanent placement, family report Mrs. Pardue is doing much better, and her care needs and emotional needs are now being met.

Contact us:
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