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Oregon Department of Human Services
Aging and People with Disabilities
SAFETY, OVERSIGHT & QUALITY

In the Matter of St. Jude Operating Company, LLC, d.b.a. Healthcare at Foster Creek, Respondent.	Order of Emergency Suspension & Right to Request a Hearing Case No. #NFSUS20-00282

TO: Melchor Balaz, Registered Agent
St Jude Operating Company, LLC
dba Healthcare at Foster Creek
6003 SE 136th Avenue
Portland, OR 97230

The Department of Human Services (DHS) is the state agency charged with licensing Nursing Facilities under ORS 441.015 *et seq.* and Oregon Administrative Rules (OAR) Chapter 411, Division 073 and 085 through 089.

St. Jude Operating Company, LLC, d.b.a. Healthcare at Foster Creek (Respondent) is licensed to operate a Nursing Facility at 6003 SE 136th Avenue, Portland, OR 97230.

Respondent is responsible for the operation of the facility and the quality of care rendered in the facility. Respondent is also responsible for the supervision, training, and overall conduct of the staff when acting within the scope of their employment. OAR 411-085-0200.

Based on the following statement of violations, DHS finds that Respondent's continued operation poses a serious danger to the public health and safety. DHS therefore suspends Respondent's license, effective immediately.

BACKGROUND

On or about March 24, 2020, Respondent notified DHS that a resident was presumed to have the novel coronavirus (COVID-19). The same day, DHS issued Executive Order NFEO20-00071 outlining infection control measures for the facility. On March 26, DHS received a complaint expressing concerns about infection control practices at the facility.

DHS conducted a complaint investigation and COVID-19 focused survey from March 27, 2020 to April 6, 2020 (Event ID 3OIV11; Intake# OR00024098) that was unsubstantiated for violations. Meanwhile, the number of residents and staff showing symptoms of COVID-19 continued to rise in the facility's Sandy Unit, and concerns were raised about the facility's staffing level. On April 4, the Oregon Health Authority (OHA), Public Health Division conducted a tele-infection control assessment. On April 5, DHS communicated with the facility administrator regarding necessary infection control measures, including cohorting residents and use of dedicated staff.

On or about April 9, the state entered into a Letter of Intent with

Respondent to assist Respondent with securing minimum staff. On April 10, the county and state assisted in delivering a shipment of personal protective equipment (PPE) to the facility. On April 10-11, DHS visited the facility and observed concerning infection control practices, training, and staffing. DHS provided technical assistance (i.e., explanation and/or demonstration) regarding proper practices. The number of residents and staff showing symptoms of COVID-19 continued to rise and spread in the facility.

On April 11, DHS issued Amended Executive Order NFEO20-0071 outlining specific staffing levels, staff cohorting, and infection control measures for the facility. The same day, DHS and Respondent entered into a Letter of Agreement for AMR to assess the condition of residents at the facility, which resulted in numerous resident transports to local hospitals.

On April 12, the county and state assisted in delivering another shipment of PPE to the facility. On April 12-14, DHS surveyors conducted monitoring visits and continued to observe concerning infection control practices, the facility not cohorting residents, staff working across units, an apparent lack of training, and not meeting required staffing levels. DHS provided technical assistance to the facility on multiple occasions during these visits. On April 15, DHS issued a Notice & Order Imposing License Condition #NFCD20-00224, instituting further infection control measures and staffing standards, and requiring the facility receive assistance from a management company to help oversee operations.

DHS surveyors continued daily monitoring visits and were still observing concerning infection control practice, the facility not cohorting residents, staff working across units, an apparent lack of training, and not meeting required staffing levels. DHS continued to provide technical assistance

regarding practices observed. Then, on April 18, the state, through the Office of Emergency (OEM), issued a Partial Evacuation Order declaring an emergency and ordering the evacuation of residents as needed to curb the spread of COVID-19 in the facility.

The state began transferring residents from the facility pursuant to the OEM order over the course of several days. The state continued to receive complaints about infection control practices at the facility. By April 20, the county and state assisted in another shipment of PPE to the facility. On April 22, OHA Public Health Division conducted a second tele-infection control assessment.

On April 24, DHS concluded a multi-day survey of the facility (0Y3L11), citing violations identified in more detail below, and imposing a finding of immediate jeopardy under federal law. On April 25, AMR again visited to facility to conduct resident assessments. On April 28, OHA Public Health Division conducted a third infection control assessment. On April 28, the Centers for Medicare and Medicaid Services (CMS) issued a notice of involuntary termination of the Medicare provider agreement if Respondent fails to remove the Immediate Jeopardy findings on or before May 17, 2020. On April 29, DHS issued an Amended Notice & Order Imposing License Condition #NFCD20-00224, further updating cohorting and infection control standards. On May 1, DHS received reports that staff considered COVID-19 positive were on the facility grounds (albeit not providing direct case), despite stay-at-home guidance.

By the date of the issuance of this Order, over 100 residents and staff have been confirmed positive for COVID-19, around 21 residents have died, about 55 residents were sent to the hospital and about 21 residents with suspected or confirmed COVID-19 were transferred to other facilities.

STATEMENT OF VIOLATIONS

Violation 1: INFECTION CONTROL AND PREVENTION OF COVID-19.

Based on observations, interviews and record review it was determined Respondent failed to implement adequate infection control practices to prevent the spread of COVID-19 (Coronavirus).

On or about April 10, 2020, a site visit was conducted by DHS and the following facility observations were made:

- Facility staff were not treating every resident as potentially infected for COVID-19 per the Center for Disease Control (CDC) Long-Term Care Guidelines.
- Facility staff were observed to provide incontinent care without wearing a gown.
- Facility staff were observed to not always wash their hands after removing their gloves and subsequently retrieved items with contaminated hands.
- Facility staff were observed to not wash their hands after touching their face masks.
- Facility staff were observed wearing face masks outside of their assigned unit, and later observed wearing the same masks after re-entering the unit.
- Interview with agency staff revealed staff were only provided one face mask per shift, and there was no access to obtain a back-up mask. On one occasion, staff had a mask with a broken strap and there were no administrative staff available to provide a replacement mask.
- Facility staff were observed to work across units.
- Dietary staff were observed to assist a resident with meal tray delivery, even though no dietary or laundry staff were supposed to be

in resident rooms.

- Facility staff were observed not enforcing social distancing in the smoking areas.
- Interviews with facility staff revealed there was no housekeeping being performed between 7:00 pm and 6:00 am the next day. Staff were not observed performing housekeeping or cleaning services.
- Staff were assigned to work across units and observed passing medications between the Sandy unit and the Wilson unit, even though staff were not to be working across units. Two of the three rooms assigned to one staff member on Sandy unit had confirmed COVID-19 positive residents. The other resident was not determined to have COVID-19.
- Interview with agency staff on the Sandy unit revealed the facility did not provide training regarding COVID-19 infection control.

On or about April 11, 2020, a site visit was conducted by DHS and the following facility observations were made:

- Facility staff were observed on the Sandy unit to wear the same face mask the entire shift and were observed to provide care to both COVID-19 positive and non-COVID-19 positive residents without changing face masks.
- Facility staff were observed to remove their masks when near other staff or residents.
- Facility staff were observed to not treat all residents as potentially COVID-19 positive per the Center for Disease Control (CDC) Long-Term Care Guidelines.
- Facility staff were observed to not use gowns while caring for residents who were not confirmed as COVID-19 positive.
- DHS staff were not screened when they entered the facility as required in CMS Memo QSO-20-14-NH, DHS Provider Alert NF-20-

67 and in the Executive Order placed against the facility.

- Facility staff were observed to not wash hands at all between residents, or not wash their hands correctly, in accordance with the CDC guidelines on handwashing.
- Record review of three residents revealed the facility staff were not performing regular respiratory status assessments, not notifying the residents physician when residents' condition changed, did not chart the positive COVID-19 test results, and did not update the residents' care plans.
- Interview with facility staff revealed staff did not feel like they had adequate staff to meet the needs of the residents.

On or about April 12, 2020, a site visit was conducted by DHS and the following facility observations were made:

- One facility staff were observed wearing full Personal Protective Equipment (PPE) and exited one resident's room and attempted to go into another resident's room without changing PPE. DHS staff intervened to ensure the resident's safety.
- Record review of two residents revealed there were no physician notes in the electronic health record and the care plans were not updated for two resident who tested positive for COVID-19. One resident tested COVID-19 positive on 4/2/20, the other resident tested positive for COVID-19 on 4/11/20.

In a continuation of the survey-related site visits mentioned above, from on or about April 12, 2020 through April 24, 2020, further onsite visits were conducted by DHS (Event ID 0Y3L11), and the following facility failures occurred:

- Based on observations and record review, it was determined the facility failed to implement infection control practices to prevent

facility-wide spread of COVID-19 virus.

- DHS observed facility staff not following infection control requirements and guidelines as required by CMS, the CDC and state and local public health departments on multiple days, across all shifts, despite DHS staff repeatedly providing real time technical assistance to staff and administration as violations were observed. These observations included poor hand hygiene, incorrect use of PPE including, but not limited to, staff not practicing social distancing when mask doffed, staff not changing face masks between infected and non-infected residents, staff not removing potentially contaminated PPE after exiting a room, staff placing contaminated PPE on clean surfaces, staff not observed working on assigned units, staff observed inappropriately moving between and crossing units, staff donning same mask while crossing units and exiting/re-entering the facility and minimal observations of high touch surface area disinfection.
- Interviews with staff revealed a lack of awareness of when and how to use the PPE correctly for the care of all residents and had received inadequate training regarding COVID-19.
- Based on observations and interviews the facility failed to maintain adequate certified and licensed nursing staffing to ensure dedicated staff worked in the four separate and distinct units, failed to ensure staff did not cross units within the facility and failed to ensure staff were in each of the units at all times, resulting in residents being exposed to the COVID-19 virus. This staffing practice resulted in the potential for all residents to be infected with COVID-19 virus with the likelihood of serious illness and death.
- On 4/17/20, it was determined a resident tested positive for COVID-19 in a unit that previously had no residents with COVID-19. Due to this being a locked unit, and the fact that residents do not leave the unit, the spread of COVID-19 was more likely that not to have been

caused by staff working across units.
- Staff was observed on at least one occasion to have no facility staff in on the locked Enhanced Care Unit, leaving residents at risk for serious injury or harm.

On or about April 18, 2020, the facility was informed of the above violations and that these violations created a serious and immediate risk to resident's health and safety under Centers for Medicare and Medicaid Services (CMS) regulation. Respondent was required to develop and implement an immediate plan of correction to remediate the immediate risk to residents' health and safety related to the spread of COVID-19. After four revisions, the facility submitted an acceptable plan of correction on April 23, 2020.

On or about April 25, 2020 through April 26, 2020, DHS conducted an onsite visit to the facility daily to determine if Respondent had implemented their immediate plan of correction related to infection control and staffing. Based on observations and interviews, DHS found Respondent had not corrected the immediate concerns regarding violations of infection control practices outlined above. The finding of immediate jeopardy remains in place to date.

The facility's failure is a violation of the following OARs:

OAR 411-086-0060(2)(a) — **Comprehensive Assessment and Care Plan:** for failing to asses respiratory changes, for failing to update COVID-19 diagnosis, and failing to update resident care plans;

OAR 411-086-0100(3) — **Nursing Services: Staffing:** for failing to provide sufficient

	staff to prevent staff from going between units in order to prevent the spread of COVID-19
OAR 411-086-0120(1)	**Nursing Services: Changes of Condition:** for failing to notify residents' physician(s) of change in resident condition that warranted medical or nursing intervention;
OAR 411-086-0140(1)(a)(E)	**Nursing Services: Problem Resolution and Preventative Care:** for failing to prevent the spread of COVID-19; and
OAR 411-086-0330(1)	**Infection Control and Universal Precautions:** for failing to appropriately use personal protective equipment to prevent the spread of COVID-19.

ORDER OF SUSPENSION

Based on the violations outlined above, DHS finds that Respondent's actions create a serious danger to the public health and safety. That is because, despite numerous enforcement actions, infection control guidance and oversight, and facility support, Respondent has demonstrated a consistent inability to adhere to basic infection control standards and Oregon Administrative Rules. This has resulted in, and continues to result in, a persistent source and spread of COVID-19 in a facility with extremely vulnerable residents, and in the community at large.

DHS therefore suspends Respondent's license pursuant to ORS 183.430(2). **This order is effective immediately.**

NOTICE OF RIGHT TO REQUEST HEARING

You are entitled to a contested case hearing, to be held as soon as practicable, as provided by ORS 183.415. You are entitled to be represented by an attorney at the hearing. Legal aid organizations may be able to assist a party with limited financial resources. **To request a contested case hearing, your request must be in writing and must be received within ninety (90) days from the date this Notice was personally served or mailed to you, based on the Date of Mailing at the top of this document.** A request sent by U.S. mail is "received" on the date it is postmarked. You may also email your request for hearing. Your request should be sent to:

ATTN: Hearing Request
Oregon Department of Human Services
Aging and People with Disabilities
Safety, Oversight and Quality
PO Box 14530
Salem, OR 97309
NF.ActionRequest@dhsoha.state.or.us

If you submit a request for hearing, you will be notified of the time and place of the hearing. Information on the hearing process will be provided to you in accordance with ORS 183.413(2).

If you fail to request a hearing within the time allowed, request a hearing and later withdraw the hearing request, request a hearing and fail to appear

at the time and place set for the hearing, or notify DHS that you will not appear at the hearing and DHS has not rescheduled the hearing, you will be in default. If you are in default, DHS will not hold a hearing and DHS may issue a final order by default based on the record of this proceeding to date (including the information in DHS's files on this matter). In other words, DHS's records to date will automatically become part of the contested case record for the purpose of making a *prima facie* case.

AGENCY CONTACT INFORMATION

Questions or requests concerning this notice should be directed to:

Lori Robins
Oregon Department of Human Services
Aging and People with Disabilities
Safety, Oversight & Quality
PO Box 14530
Salem, OR 97309
NF.ActionRequest@dhsoha.state.or.us
Fax: 503-378-8966

05.04.2020

Jack Honey, Administrator
Safety, Oversight & Quality

Date

NOTE TO MILITARY PERSONNEL: Active duty service members have a right to stay these proceedings under the federal Servicemembers Civil Relief Act. For more information, you may contact the Oregon State Bar

(800-452-8260), Oregon Military Department (800-452-7500), or the nearest legal assistance office, http://legalassistance.law.af.mil.

cc: Local Office: Multnomah Co NF Unit
LTCO: Director