

**Health Systems Division**  
**Home and Community-Based Services**  
**Heightened Scrutiny**  
**Evidence Report and Packages**

## Health Systems Division (HSD) Heightened Scrutiny Evidence Report

OHA, HSD initially identified zero (0) Adult Foster Homes (AFH), two (2) Residential Treatment Facilities (RTF) and four (4) Residential Treatment Homes (RTH) for additional review for potential heightened scrutiny. These sites were selected for review based on the physical proximity to a public institution, being co-located and operationally related, or facilities that are authorized to use interventions/restriction used in institutional setting (e.g., restraints).

HSD requested additional information from these sites regarding the services provided and the characteristics possessed that meet the HCBS settings requirements. An internal review process focused on the following four areas:

- Physical site location
- Individual access to the community
- Access to visitors at any time
- Provider support of individual independence

The below criteria were used to determine in which category the site should be “bucketed”. Any “yes” answers resulted in the need for an onsite visit by HSD regulatory staff and potential heightened scrutiny referral to CMS

- The setting is located on the grounds of or adjacent to a public institution.
- The setting location potentially has the effect of isolating.
- The setting is approved to use interventions/restriction used in institutional setting or deemed unacceptable in Medicaid institutional setting (e.g., restraints).

This information and evidence was reviewed and validated by the licensing team with direct knowledge of the operations of these sites. Based on this internal review process settings were sorted into the following three categories:

- Meets HCBS
- Expected to Meet HCBS
- Onsite review needed

The following is the breakdown from this phase of the Heightened Scrutiny review process:

*Table 1*

Setting Type	Meets HCBS	Expected to meet HCBS	Onsite Review Needed	Total
Residential Treatment Facility	0	1	1	2
Residential Treatment Home	0	1	3	4
<b>Total</b>	0	2	4	6

Following further review of the settings identified in Table 1, the following residential sites were identified as meeting at least one of the CMS criteria for Heightened Scrutiny referral.

1. any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,
2. any setting that is located in a building on the grounds of, or immediately adjacent to, a public institution, or
3. any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

Table 2

Setting name and location	Setting Type	Reason: 1,2, or 3 from above
Horizon House	RTF	2
Via Verde	RTH	2
Salmon Run	RTH	2, 3
New Roads	RTH	2, 3

### HSD Home and Community-Based Setting Referrals for Heightened Scrutiny

The following two tables are based on HCBS site-specific reviews of Salmon Run and New Roads on Tuesday, October 26, 2016 and HCBS site-specific reviews of Horizon House and Via Verde on Wednesday, October 27, 2016. Onsite reviews included a review of documentation, a review of the geographical area and interviews with staff and residents. Residents were out in the community and unavailable to interview at Via Verde.

Table 3

Provider Name	Facility Name	Integrated Environment	Individual's Access to Broader Community	Visitors	Supporting Self-Direction & Independence
Marion County Health Department	Horizon House	Meets Expectation	Meets Expectation	Meets Expectation	Meets Expectation
Shangri-La Corp.	Via Verde	Meets Expectation	Meets Expectation	Meets Expectation	Meets Expectation
Columbia Care Services, Inc.	Salmon Run	Meets Expectation	Meets Expectation	Meets Expectation	Meets Expectation
Columbia Care Services, Inc.	New Roads	Meets Expectation	Expected to Meet Expectation	Meets Expectation	Meets Expectation

**Issues of Concern for CMS and HCBS Qualities (Initial Evidence) Demonstrating Compliance**

<p><b>Horizon House</b></p>	<p><b>Issues of Concern relating to compliance with HCBS setting regulations:</b></p> <ol style="list-style-type: none"> <li>1. Located on the grounds of the Oregon State Hospital in Salem, Oregon.</li> <li>2. Adjacent to homes housing the State Hospital population.</li> <li>3. Adjacent to the Oregon State Penitentiary (correctional institution).</li> </ol> <p><b>HCBS Qualities Demonstrating Integrated Environment, Access to Broader Community, Visitors, and Supporting Self-Direction and Independence:</b>  Greenway Drive NE ends at 24<sup>th</sup> St. NE where a residential neighborhood begins. Services being provided to residents are in a home environment where residents have free access to the community. Each resident also has unrestricted use of their own mobile phone. The home is within a 10 minute walk to a city bus stop. The facility will offer transportation services and the residents may use taxi cabs, insurance transport services, or have friends/family transport them. The provider facilitates outings to various city, county, and state events, including events via Salem’s All Activities listings. The provider offers outings, which often include recreational/senior centers, banking, shopping, and religious activities, etc. Residents may choose to work and/or volunteer, which often include the local human society, the local food share program, and Old Style Barber Shop. The provider allows individuals to leave the home at will and at any time. The provider does not restrict visitors of any resident’s choosing at any time. The provider encourages all residents to leave the facility to engage in various community offerings and offers bus training to allow for greater confidence in community engagement.</p>
<p><b>Via Verde</b></p>	<p><b>Issues of Concern relating to compliance with HCBS setting regulations:</b></p> <ol style="list-style-type: none"> <li>1. Located on the grounds of the Oregon State Hospital in Salem, Oregon.</li> <li>2. Adjacent to homes housing the State Hospital population.</li> <li>3. Adjacent to the Oregon State Penitentiary.</li> <li>4. Is a PSRB program, in which residents may have a Conditional Release stating certain restrictions, such as curfew, locations, and persons to interact.</li> </ol> <p><b>HCBS Qualities Demonstrating Integrated Environment, Access to Broader Community, Visitors, and Supporting Self-Direction and Independence:</b>  24<sup>th</sup> Street is adjacent to a residential neighborhood. Services being provided to residents are in a home environment where residents have free access to the community. Each resident also has unrestricted use of their own mobile phone. The home is within a 10 minute walk to a city bus stop. The facility will offer transportation services and the residents may use taxi cabs, insurance transport services, or have friends/family transport them. The provider facilitates outings to various city, county, and state events, including events via Salem’s All Activities listings. The provider offers outings, which often include recreational/senior centers, banking, shopping, hair dressing appointments, etc. Residents may choose to work</p>

	<p>and/or volunteer, which often include the local human society, lawn care services, and the local food share program. Currently, there is one resident attending Chemeketa Community College. The provider allows individuals to leave the home at will and at any time. The provider does not restrict visitors of any resident's choosing at any time. The provider encourages all residents to leave the facility to engage in various community events and resources and offers bus training to allow for greater confidence in community engagement.</p>
<p><b>Salmon Run</b></p>	<p><b>Issues of Concern relating to compliance with HCBS setting regulations:</b></p> <ol style="list-style-type: none"> <li>1. Adjacent an Oregon State Hospital cottage, a class 1 SRTF.</li> <li>2. Adjacent to the Eastern Oregon Correctional Institution.</li> <li>3. Adjacent to a co-located and operationally related facility.</li> <li>4. Shares a common wall with another separate and distinct RTH operated by another social service agency.</li> <li>5. Is a PSRB program, in which residents may have a Conditional Release stating certain restrictions, such as curfew, locations, and persons to interact.</li> </ol> <p><b>HCBS Qualities Demonstrating Integrated Environment, Access to Broader Community, Visitors, and Supporting Self-Direction and Independence:</b></p> <p>The home is within a 20 minute walk to the center of Pendleton, within a 5 minute walk to Blue Mountain Community College, Pendleton's 5 mile River Walk trail, and local parks, including a skate and water park. The home is within 800 yards of a city bus stop. Each resident may purchase taxi tickets for a nominal price. The facility will offer transportation services. Residents may use Dial-a-Ride for \$1.00 and any insurance provided transport services. The facility facilitates outings to various city, county, and state events, including events in neighboring cities and into Washington. The provider offers a minimum of four outings a day, which often include a recreational center, bowling, shopping, etc. Residents may choose to work and/or volunteer, which currently include local grocery outlets, social service organizations, and religious affiliations. Currently, there is one resident attending Blue Mountain Community College. The provider allows individuals to leave the home at will and at any time and encourages all residents to leave the facility to engage in various community events and resources. The provider does not restrict visitors of any resident's choosing at any time. Each resident also has unrestricted use of their own mobile phone.</p>
<p><b>New Roads</b></p>	<p><b>Issues of Concern relating to compliance with HCBS setting regulations:</b></p> <ol style="list-style-type: none"> <li>1. Not located in a residential area.</li> <li>2. Adjacent an Oregon State Hospital cottage, a class 1 SRTF.</li> <li>3. Adjacent to the Eastern Oregon Correctional Institution.</li> <li>4. Adjacent to a co-located and operationally related facility.</li> </ol> <p><b>HCBS Qualities Demonstrating Integrated Environment, Access to Broader Community, Visitors, and Supporting Self-Direction and Independence:</b></p>

	<p>The home is within a 20 minute walk to the center of Pendleton, within a 5 minute walk to Blue Mountain Community College (BMCC), Pendleton's 5 mile River Walk trail, and local parks, including a skate and water park. The home is within 800 yards of a city bus stop. Each resident may purchase taxi tickets for a nominal price. The provider will offer transportation services. Residents may use Dial-a-Ride for \$1.00 and any insurance provided transport services. The facility facilitates outings to various city, county, and state events, including events in neighboring cities and into Washington. Currently there are four residents attending BMCC. The provider allows individuals to leave the facility at will and at any time and encourages all residents to leave the facility to engage in various community events and resources. The provider does not restrict visitors of any resident's choosing at any time. Each resident also has unrestricted use of their own mobile phone.</p>
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**Health Systems Division**  
**Home and Community-Based Services**  
**Evidence Package**

**Horizon House**

**OREGON HEALTH AUTHORITY  
RESIDENTIAL TREATMENT FACILITY LICENSE**

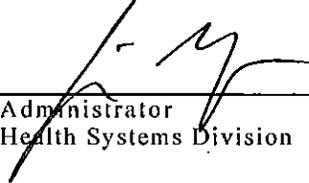
Name: **Horizon House RTF**  
Address: **2435 Greenway Drive N.E.**  
**Salem, Oregon 97301**

License No.: **514449**  
Payment Received: **\$60.00**

**08/18/2016**                      **08/17/2018**  
Effective Date                      Expiration Date

Occupancy: **SR-3 Class: 3**  
License Capacity: **8**  
Owner: **Marion County Health**  
**Department #**  
Administrator: **DeGiulio, Ben**



  
\_\_\_\_\_  
Administrator  
Health Systems Division

HSD 9106 (3/08)

Variances: **OAR 309-035-0125(7)(c) Facility Requirements: OAR 309-035-0117(3) Personnel Records**

This license is not transferable to any person or address.

## Health Systems Division

*Please verify the information below, and fill in any changes or corrections in the space to the right of each item.*

### FACILITY DEMOGRAPHICS:

Name: Horizon House RTF \_\_\_\_\_  
 Address: 2435 Greenway Drive \_\_\_\_\_  
           N.E. \_\_\_\_\_  
 City: Salem \_\_\_\_\_  
 State: OR \_\_\_\_\_  
 Zip: 97301 \_\_\_\_\_  
 County: Marion \_\_\_\_\_  
 Phone (ext): 503-362-5918 () \_\_\_\_\_  
 Mailing Address: P.O. Box 12098 \_\_\_\_\_  
 Mailing City: Salem \_\_\_\_\_  
 Mailing State: OR \_\_\_\_\_  
 Mailing Zip: 97309 \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 TTD: \_\_\_\_\_  
 Provider Name: Marion County Health Department # \_\_\_\_\_

### CONTACTS:

Name ~~Ed King~~ Prog superv Lana Winnie \_\_\_\_\_  
 Title 503-588-5351 \_\_\_\_\_  
 Phone (Ext) () 503-361-2674 \_\_\_\_\_  
 Cell \_\_\_\_\_  
 Email \_\_\_\_\_

Name Leslie Stainbrook \_\_\_\_\_  
 Title \_\_\_\_\_  
 Phone (Ext) 503-588-5357 () \_\_\_\_\_  
 Cell \_\_\_\_\_  
 Email lstainbrook@co.marion.or.us \_\_\_\_\_

Name Ben DeGiulio \_\_\_\_\_  
 Title Administrator \_\_\_\_\_  
 Phone (Ext) 503-362-5918 () 503-576-4671 \_\_\_\_\_  
 Cell \_\_\_\_\_

Email

Name Scott Richards

Title

Phone (Ext) 503-361-2695 ()

Cell

Email srichards@co.inarion.or.us

**VARIANCES:**

Variance OAR 309-035-0125(7)(c)  
Facility Requirements

Issue Date 08/18/2014

Expiration Date 08/17/2016

Variance OAR 309-035-0117(3)  
Personnel Records

Issue Date 08/18/2014

Expiration Date 08/17/2016

# Health Services Division (HSD) License Renewal Application Residential Treatment Program

**FACILITY NAME:** Horizon House RTF

HSD MUST RECEIVE THIS APPLICATION 30 DAYS PRIOR TO THE DATE OF LICENSE EXPIRATION. The applicable renewal fee is required by Oregon Revised Statutes (ORS) 443.415(1). Check or money order made payable to **Oregon Health Authority**. (*Government bodies excluded from fee*)

**EACH LICENSE IS VALID FOR A TWO (2) YEAR PERIOD AFTER APPROVAL AND DATE OF LICENSURE. A license will be issued to any facility that is in substantial compliance with OAR 309-035-0100 through 309-035-0460.**

**Are you changing Administrator at this time?** Yes  No

If yes, please provide us with the following:

Administrator Name: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Resume  Criminal History/Background  Job Description

### Occupancy Rating

Please submit documentation of Residential Occupancy as determined by Building Codes.

### Ownership Information:

Has a change occurred during the current license period? Yes  No . If yes, provide the required information and attach any supporting documentation.

Operated by:  State  County  Individual  
 Non-profit  Other(specify) \_\_\_\_\_

If individual, list full name and address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

If partnership, list each partner having interest in 10% or more (use additional sheets if necessary)

Name	Full Address	%

If corporation:

Exact corporate name: _____ _____ and/or register assumed name: _____ _____ Phone Number: ( _____ ) _____ - _____ Email: _____
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Has the corporation received a certificate of incorporation or a certificate of authority to do business in the State of Oregon from the Corporation Commission?

Yes  No

If yes, quote certificate number: \_\_\_\_\_

If corporation, list all officers and directors and/or persons owning 10% or more.

Name	Full Address	%



Department of Human Services  
Addictions and Mental Health Division  
REQUEST FOR VARIANCE

Please print clearly and complete all required sections.

1. Facility Type:			
<input type="checkbox"/> Adult Foster Home	[5 or fewer]	OAR 309-040-0350	Variance
<input checked="" type="checkbox"/> Residential Treatment Facility	[6 or more]	OAR 309-035-0110	Variance
<input type="checkbox"/> Residential Treatment Home	[5 or fewer]	OAR 309-035-0270	Variance
2. County: <u>Marion</u>		3. Facility name: <u>Horizon House</u>	
4. Provider name: <u>Marion County Health Dept.</u>		Contact person: <u>Ben DeBunko</u>	
5. Site address: <u>2435 Greenway dr NE</u>			
City: <u>Salem</u>	State: <u>OR</u>	Zip: <u>97301</u>	Phone #: <u>503-362-5918</u>
6. OAR: <u>309-035-0125</u> Facility requirements Section: <u>(7)(c) Clothes Closet</u>			
7. Reason for proposed variance: <u>Built in Closets do not meet the minimum space requirement of 64 cubic feet per resident.</u>			
8. Alternative practice proposed: <u>Stand alone closet or Armoire will be provided for each resident with out adequate closet space.</u>			
9. Time table for compliance: <u>Currently in use</u>			
10. Provider Signature: <u>Ben DeBunko</u>			Date: <u>3-7-14</u>
11. County Mental Health Representative recommendation, with comments:			
12. <u>Roderick P. Galkins</u>			<u>3-8-16</u>
Signature of County Mental Health Director			Date
13. AMH Recommendations:			
Name:			Date:
14. AMH designated authority - Title/Signature			Date:
15. <input type="checkbox"/> Denied/Comments:			
<input type="checkbox"/> Approved			
Variance effective date:		Review/renewal date:	



Department of Human Services  
Addictions and Mental Health Division  
REQUEST FOR VARIANCE

Please print clearly and complete all required sections.

1. Facility Type:			
<input type="checkbox"/> Adult Foster Home	[5 or fewer]	OAR 309-040-0350	Variance
<input checked="" type="checkbox"/> Residential Treatment Facility	[6 or more]	OAR 309-035-0110	Variance
<input type="checkbox"/> Residential Treatment Home	[5 or fewer]	OAR 309-035-0270	Variance
2. County: <u>Marion</u>		3. Facility name: <u>Horizon House</u>	
4. Provider name: <u>Marion county Health Dept</u> - Contact person: <u>Ben DeGiulio</u>			
5. Site address: <u>2435 Greenway dr. NE</u>			
City: <u>Salem</u>	State: <u>OR</u>	Zip: <u>97301</u>	Phone #: <u>503-362-5918</u>
6. OAR: <u>309-035-117</u> : <u>Records</u> Section: <u>(3)</u> <u>Personnel Records</u>			
7. Reason for proposed variance: <u>Marion County Health dept. Maintains and stores all health department personnel and payroll records in a central location at 3180 Center st. NE, Salem OR 97301. Horizon House staff are not authorized access to those records.</u>			
8. Alternative practice proposed: <u>Health department personnel records, confidential medical records, and criminal history information is stored and maintained at the health dept. Records will be available at Horizon House at the time of inspection for review</u>			
9. Time table for compliance: <u>Currently in use.</u>			
10. Provider Signature: <u>[Signature]</u>			Date: <u>3-7-16</u>
11. County Mental Health Representative recommendation, with comments:			
12. <u>Roderick P. Galbraith</u>			<u>3-8-16</u>
Signature of County Mental Health Director			Date
13. AMH Recommendations:			
Name:		Date:	
14. AMH designated authority - Title/Signature			Date:
15. <input type="checkbox"/> Denied/Comments:			
<input type="checkbox"/> Approved			
Variance effective date:		Review/renewal date:	

**Supporting documentation or information:**

Please respond and/or enclose all required documents and/or information.

● **Policies and Procedures:**

Did you revise your manuals during the current license period?

Yes  No

● **Do you currently have a variance?** Yes  No  If yes, please complete the attached request for variance forms.

During the current licensed period has any facility staff had a sustained allegation of abuse?

Yes  No  If yes, provide us with this information at the on site inspection.

Was there a critical or significant investigation of any type within the program?

Yes  No  If yes, provide us with this information at the on site inspection.

During the current licensed period has any facility staff been convicted of any crime identified in ORS 161.505 through ORS 161.565, during the licensed period?

Yes  No  If yes, please explain below.

**REQUIRED SIGNATURES:**

*The renewal application information submitted for review is true to the best of my knowledge and understanding.*

Ben DeGiulio

*Printed name of Administrator*

Ben DeGiulio

*Signature of Administrator*

Date: 3-7-16

Roderick P. Calkins

*Printed name of Licensee and/or authorized individual*

Roderick P. Calkins

*Signature of Licensee and/or authorized individual*

Date: 3-8-16



PROGRAM: Horizon RPT

REVIEWED BY: CJ

RESIDENT ID: D 2

INTAKE DATE: 4/19/16 12/20/15

**RTF(H) - TERMINATION OF RESIDENCY** OAR 309-035-0150/0370

Documentation of discussions and meetings held concerning termination of residency and copies of notices will be maintained in the resident's record OAR 309-035-0150(6)/0370(7)

Date of Discharge: 4/5/16

Discharge Summary Narrative: \_\_\_\_\_

**Reason for Termination:** OAR 309-035-0150(2)(3)(4)/0370(2)(3)(4)(5)

Voluntary: Notice of intent to move submitted by the resident or guardian 0150(2)/0370(3)

Explanation: \_\_\_\_\_

Emergency: Resident behavior poses serious and immediate threat to health & safety of others. 24 hour written notice with resident's right to appeal in accordance with OAR 309-035-0157/0390. 0150(4)/0317(4)

Explanation: \_\_\_\_\_

Other Termination of Residency: If a decision is made to terminate residency, the administrator will provide at least a 30 days written notice specifying the causes of termination to the resident or guardian. This notice will also specify the resident's right to appeal the termination decision in accordance with OAR 309-035-0157/0390. An effort will be made to establish a reasonable termination date both facility needs and the needs of the terminated resident to find alternative living arrangements. 0150(4)/0370(5)

Termination Notice(s) in Compliance with OAR 309-035-0157/0390: 0150(2)(3)(4)/0370(2)(3)(4)(5)

Explanation: \_\_\_\_\_

**Criteria Establishing Grounds for Termination Include:** OAR 309-035-0150(4)(a)-(f)/0370(5)(a)-(f)

Resident no longer needs or desires services provided at the facility and/or expresses a desire to move to an alternative setting 0150(4)(a)/0370(5)(a)

Resident is assessed by a Licensed Medical Professional or other qualified health professional to require services, such as continuous nursing care or extended hospitalization, that are not available, or can not be reasonably arranged, at the facility 0150(4)(b)/0370(5)(b)

Resident's behavior is continuously and significantly disruptive or poses a threat to the health or safety of self or others and these behavioral concerns cannot be adequately addressed with services available at the facility or services that can be arranged outside of the facility 0150(4)(c)/0370(5)(c)

Resident cannot safely evacuate the facility in accordance with the facility's SR Occupancy Classification after efforts described in OAR 309-035-0130(5)(b)/0330(5)(b) have been taken 0150(4)(d)/0370(5)(d)

Nonpayment of fees in accordance with program's fee policy 0150(4)(e)/0370(5)(e)

Resident continuously and knowingly violates house rules resulting in significant disturbance to others

Absences without Notice: 0150(9)/0370(9)

Documentation that attempts were made to contact the resident or guardian as applicable to confirm the resident's intent to discontinue residency

**Pre-Termination Meeting:** OAR 309-035-0150(5)/0370(6)

Except in the case of emergency termination or crisis respite; Two weeks prior to the termination date with the resident, guardian if applicable, and with the resident's permission, others interested in the resident's circumstances

Meeting held on: \_\_\_\_\_ and attended by: \_\_\_\_\_

Explanation of why a Pre-Termination Meeting was not held: \_\_\_\_\_

**Additional Supporting Documentation Leading to Termination:** OAR 309-035-0150(6)/0370(7)

Incident Reports  Progress Notes  Hospital Documentation  Police Reports

Attempts at Making a Reasonable Accommodation at the Facility  Other: \_\_\_\_\_

**Disposition of Personal Property and Funds:** OAR 309-035-0150(7)/0370(8)

Statement of Account  Balance of Funds 0150(7)(a)/0370(8)(a)

Inventory of Personal Property 0150(7)(b)/0370(8)(b)

Signed by All 0117(1)/0300(1)

Disposition of Medications: OAR 309-035-0175(5)(f)/0440(5)(g)

Copies of MARs and accounting of medications signed by: \_\_\_\_\_



PROGRAM: Home PR

REVIEWED BY: CJ

RESIDENT ID: D 1

INTAKE DATE: 2/16/13

**RTF(H) - TERMINATION OF RESIDENCY** OAR 309-035-0150/0370

Documentation of discussions and meetings held concerning termination of residency and copies of notices will be maintained in the resident's record OAR 309-035-0150(6)/0370(7)

Date of Discharge: 4/11/16

Discharge Summary Narrative: \_\_\_\_\_

**Reason for Termination:** OAR 309-035-0150(2)(3)(4)/0370(2)(3)(4)(5)

Voluntary: Notice of intent to move submitted by the resident or guardian 0150(2)/0370(3)

Explanation: \_\_\_\_\_

Emergency: Resident behavior poses serious and immediate threat to health & safety of others. 24 hour written notice with resident's right to appeal in accordance with OAR 309-035-0157/0390. 0150(4)/0317(4)

Explanation: \_\_\_\_\_

Other Termination of Residency: If a decision is made to terminate residency, the administrator will provide at least a 30 days written notice specifying the causes of termination to the resident or guardian. This notice will also specify the resident's right to appeal the termination decision in accordance with OAR 309-035-0157/0390. An effort will be made to establish a reasonable termination date both facility needs and the needs of the terminated resident to find alternative living arrangements. 0150(4)/0370(5)

Termination Notice(s) in Compliance with OAR 309-035-0157/0390: 0150(2)(3)(4)/0370(2)(3)(4)(5)

Explanation: \_\_\_\_\_

**Criteria Establishing Grounds for Termination Include:** OAR 309-035-0150(4)(a)-(f)/0370(5)(a)-(f)

Resident no longer needs or desires services provided at the facility and/or expresses a desire to move to an alternative setting 0150(4)(a)/0370(5)(a)

Resident is assessed by a Licensed Medical Professional or other qualified health professional to require services, such as continuous nursing care or extended hospitalization, that are not available, or can not be reasonably arranged, at the facility 0150(4)(b)/0370(5)(b)

Resident's behavior is continuously and significantly disruptive or poses a threat to the health or safety of self or others and these behavioral concerns cannot be adequately addressed with services available at the facility or services that can be arranged outside of the facility 0150(4)(c)/0370(5)(c)

Resident cannot safely evacuate the facility in accordance with the facility's SR Occupancy Classification after efforts described in OAR 309-035-0130(5)(b)/0330(5)(b) have been taken 0150(4)(d)/0370(5)(d)

Nonpayment of fees in accordance with program's fee policy 0150(4)(e)/0370(5)(e)

Resident continuously and knowingly violates house rules resulting in significant disturbance to others

Absences without Notice: 0150(9)/0370(9)

Documentation that attempts were made to contact the resident or guardian as applicable to confirm the resident's intent to discontinue residency

**Pre-Termination Meeting:** OAR 309-035-0150(5)/0370(6)

Except in the case of emergency termination or crisis respite; Two weeks prior to the termination date with the resident, guardian if applicable, and with the resident's permission, others interested in the resident's circumstances

Meeting held on: 3/5/16 and attended by: \_\_\_\_\_

Explanation of why a Pre-Termination Meeting was not held: Refused to participate

**Additional Supporting Documentation Leading to Termination:** OAR 309-035-0150(6)/0370(7)

Incident Reports  Progress Notes  Hospital Documentation  Police Reports  
 Attempts at Making a Reasonable Accommodation at the Facility  Other: \_\_\_\_\_

**Disposition of Personal Property and Funds:** OAR 309-035-0150(7)/0370(8)

Statement of Account  Balance of Funds 0150(7)(a)/0370(8)(a)

Inventory of Personal Property 0150(7)(b)/0370(8)(b) - *Recommend additional correspondence documentation after initial D/C regarding where belongings were*

Signed by All 0117(1)/0300(1)

Disposition of Medications: OAR 309-035-0175(5)(f)/0440(5)(g)

Copies of MARs and accounting of medications signed by: \_\_\_\_\_



# STAFF RECORD REVIEW

PROGRAM NAME: \_\_\_\_\_ LICENSING PERIOD: \_\_\_\_\_

STAFF	Hire Date @ Facility <sup>1</sup>	Date of Approved Criminal History Check <sup>1</sup>	Job Description <sup>2</sup>	TB Read Within Two Weeks <sup>3</sup>	Hep B Accept or Decline Within Two Weeks <sup>3</sup>	16 Hours of Pre-Service Training <sup>4</sup>	8 Hours In-Service Training Yearly <sup>4,7</sup>	Medication Training by RN <sup>5</sup>	Date of Abuse Reporting Training <sup>6</sup>	Date of Grievance Process Training <sup>6</sup>	Date of Incident Reporting Training <sup>6</sup>
S <sub>7</sub>	3/16/08	✓	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	1. 6.5 2. 8	Date: ✓	✓	✓	✓			
S <sub>16</sub>	5/9/16	✓	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	1. NA 2. NA	Date: ✓	✓	✓	✓			
S <sub>12</sub>	3/16/15	✓	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	1. ✓ 2. NA	Date: ✓	✓	✓	✓			
S <sub>15</sub>	5/9/16	✓	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	1. NA 2. NA	Date: ✓	✓	✓	✓			
S <sub>16</sub>	5/9/16	✓	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	1. NA 2. NA	Date: ✓	✓	✓	✓			
S <sub>11</sub>	8/11/15	✓	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	1. 3 @ 0.5 2. NA	Date: ✓	✓	✓	✓			
S			<input type="checkbox"/> Y <input type="checkbox"/> N	1. _____ 2. _____	Date: _____						
S			<input type="checkbox"/> Y <input type="checkbox"/> N	1. _____ 2. _____	Date: _____						
S			<input type="checkbox"/> Y <input type="checkbox"/> N	1. _____ 2. _____	Date: _____						
S			<input type="checkbox"/> Y <input type="checkbox"/> N	1. _____ 2. _____	Date: _____						
S			<input type="checkbox"/> Y <input type="checkbox"/> N	1. _____ 2. _____	Date: _____						
S			<input type="checkbox"/> Y <input type="checkbox"/> N	1. _____ 2. _____	Date: _____						
S			<input type="checkbox"/> Y <input type="checkbox"/> N	1. _____ 2. _____	Date: _____						
S			<input type="checkbox"/> Y <input type="checkbox"/> N	1. _____ 2. _____	Date: _____						

TURN OVER FOR APPLICABLE OARs

★ Missing physical orientation to home

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1 OAR 309-035-0117(3)(b)/300(3)(b) Individual employee records including, but not limited to, written documentation of employee identifying information and qualifications, criminal record clearance (per OAR 309-035-0120(1)(b)/0320(1)(b)), T.B. test results(per OAR 309-035-0120(1)(c)/3020(1)(c)), Hepatitis B status, performance appraisals, and documentation of pre-service orientation and other training (Per 309-035-0120(3)(a)&(b)/0320(3)(a)&(b)).

2 OAR 309-035-0117(3)(a)/300(3)(a) Personnel Records. Records documenting personnel actions will include: (a) Job descriptions for all positions;

3 OAR 309-035-0120(1)(c)/0320(1)(c) In accordance with OAR 333-071-0057 and 437, Division 2, Subdivision Z, 4f (1)(2), all RTF staff who have contact with residents will be tested for tuberculosis and Hepatitis B within two weeks of first employment, additional testing will take place as deemed necessary; and the employment of staff who test positive for tuberculosis will be restricted if necessary.

4 OAR 309-035-0120(3)/0320(3) The administrator will provide or arrange a minimum of 16 hours pre-service orientation (per OAR 309-035-0120(3)(a)/0320(3)(a)) and 8 hours in-service training annually for each employee (per OAR 309-035-0120(3)(b)/0320(3)(b)).

5 OAR 309-035-0175(5)(b)/0440(5)(b) Staff who assist with administration of medication will be trained by a Licensed Medical Professional or other qualified health care professional on the use and effects of commonly used medications.

6 OAR 309-035-0120(3)(a)/0320(3)(a) Pre-service training for direct care staff will include, but not be limited to, a comprehensive tour of the facility; a review of emergency procedures developed in accordance with OAR 309-035-0130; a review of facility house rules, policies and procedures; background on mental and emotional disorders; an overview of resident rights; medication management procedures; food service arrangements; a summary of each resident's assessment and residential service plan; and other information relevant to the job description and scheduled shift(s).

7 OAR 309-035-0120(3)(b)/0320(3)(b) In-service training will be provided on topics relevant to improving the care and treatment of residents in the facility and meeting the requirements in these administrative rules. In-service training topics include, but are not limited to, implementing the residential service plan, behavior management, daily living skills development, nutrition, first aid, understanding mental illness, sanitary food handling, resident rights, identifying health care needs, and psychotropic medications.

PROGRAM: Fluza

REVIEWED BY: CS

RESIDENT ID: RS

ADMISSION DATE: 4/22/16

**RTF(H) - ADMISSION TO THE HOME OAR 309-035-0145/0360**

*Documents in this section are to remain in the resident record:*

- Summary Sheet**  name,  admission date,  DOB,  gender,  legal status,  marital status,  religious preference,  physician info,  dental info,  evacuation capability,  diagnosis,  health concerns,  medication/food allergies,  mental health directives,  adv. health directives,  burial plan,  emergency contact 0117(4)(a)-(b)/0300(4)(a)-(b) *initials*
- Referral & Background Information** 0145(10)/0360(10)
- Admission Criteria** 0145(6)/0360(6)
- Initial Health Screening** 0175(2)/440(2) *10/22/15*
  - Crisis Admit Health Screen** (within 24 hrs)  NA 0175(2)(C)/440(2)(C)
- TB** (TB test results prior to admission) (not for crisis respite) 0175(2)(b)/440(2)(b)
- Guardianship Documents** Guardian(s): \_\_\_\_\_  NA 0145(5)(d)/0360(5)
- Safety & Emergency Orientation** 0145(9)/360(9)
- Orientation to the Home at Admission** 0145(9)/0360(9)
- Release of Info Forms** 0145(3)/0360(3)

- Informed Consent for Services** 0145(8)/0360(8)
- Advance Health Directives** 0145(9)/0360(9) *accepted*
- Mental Health Directives** 0145(9)/0360(9)
- Money Management Support** 0145(8)/0360(8)
- Abuse Reporting** (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- House Rules** (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- Grievance Procedures** (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- Resident Rights** (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- PSRB Conditional Release** (if applicable) NA  0145(5)(d)/0360(5)(d)

**RESIDENT ASSESSMENT / RESIDENTIAL SERVICE PLAN OAR 309-035-0159/0400**

- Initial Residential Assessment** (within 30 days of admission) 0159(1)/0400(1)
  - Crisis Respite** (within 48 hrs. of admission; includes plan for end date of service)  NA 0159(3)/0400(3)
- Initial Residential Service Plan** (within 30 days of admission) 0159(2)/0400(2) *- see last*
  - Signed by the**  resident,  administrator and  guardian if applicable 0159(2)(c)/0400(2)(c)
- ADL Support in Residential Service Plan** 0159(2)(b)/0400(2)(b)
- Annual Update or Re-Assessments/Changes to Service Plan**  NA 0159(5)/0400(5)
- Signed by the**  resident,  administrator and  guardian if applicable 0159(2)(c)/0400(2)(c)
- Progress Notes** (reflecting progress towards the goals in the RSP) (daily for crisis respite) 0159(4)/0400(4)  
Progress Notes Present (month & year): *see last*

- Incident Reports** 0117(2)(h)/0300(2)(h)
- Mental Health Assessment & ISSP** 0117(4)(c)(e)/0300(4)(c)(e)

**HEALTH SERVICES OAR 309-035-0175/0440**

- Regular Health Exams** 0175(3)/440(3)
- Dental Examinations** 1075(3)/440(3)
- Special Needs Including ADA Support**  NA 0175(4)/440(4)

RESIDENT RECORD REVIEW FINDINGS

RSP comment - could be more measurable. If no need in way, no need for goal  
Monthly comment - if no need in way, no need for <sup>monthly</sup> that way (discussion capabilities)  
- could use more specific staff instructions

PROGRAM: Fluza rot

REVIEWED BY: CJ

RESIDENT ID: P-9

ADMISSION DATE: 7/20/15

**RTF(H) - ADMISSION TO THE HOME OAR 309-035-0145/0360**

*Documents in this section are to remain in the resident record:*

- Summary Sheet  name,  admission date,  DOB,  gender,  legal status,  marital status,  religious preference,  physician info,  dental info,  evacuation capability,  diagnosis,  health concerns,  medication/food allergies,  mental health directive  adv. health directives,  burial plan,  emergency contact 0117(4)(a)-(b)/0300(4)(a)-(b)
- Referral & Background Information 0145(10)/0360(10)
- Admission Criteria (0145(6)/0360(6))
- Initial Health Screening 0175(2)/440(2)
  - Crisis Admit Health Screen (within 24 hrs)  NA 0175(2)(C)/440(2)(C)
  - TB (TB test results prior to admission) (not for crisis respite) 0175(2)(b)/440(2)(b)
- Guardianship Documents Guardian(s): \_\_\_\_\_  NA 0145(5)(d)/0360(5)
- Safety & Emergency Orientation 0145(9)/360(9)
- Orientation to the Home at Admission 0145(9)/0360(9)
- Release of Info Forms 0145(3)/0360(3)  
*No pol for advance dental*

- Informed Consent for Services 0145(8)/0360(8)
- Advance Health Directives 0145(9)/0360(9)
- Mental Health Directives 0145(9)/0360(9)
- Money Management Support 0145(8)/0360(8)
- Abuse Reporting (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- House Rules (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- Grievance Procedures (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- Resident Rights (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- PSRB Conditional Release (if applicable) NA  0145(5)(d)/0360(5)(d)

**RESIDENT ASSESSMENT / RESIDENTIAL SERVICE PLAN OAR 309-035-0159/0400**

- Initial Residential Assessment (within 30 days of admission) 0159(1)/0400(1) *— send form to Ben DeLio*
- Crisis Respite (within 48 hrs. of admission; includes plan for end date of service)  NA 0159(3)/0400(3)
- Initial Residential Service Plan (within 30 days of admission) 0159(2)/0400(2)
  - Signed by the  resident,  administrator and  guardian if applicable 0159(2)(c)/0400(2)(c) *common sense, RS*
- ADL Support in Residential Service Plan 0159(2)(b)/0400(2)(b)
- Annual Update or Re-Assessments/Changes to Service Plan  NA 0159(5)/0400(5)
  - Signed by the  resident,  administrator and  guardian if applicable 0159(2)(c)/0400(2)(c)
- Progress Notes (reflecting progress towards the goals in the RSP) (daily for crisis respite) 0159(4)/0400(4)
  - Progress Notes Present (month & year): Missing May 2016, June 2016

- Incident Reports 0117(2)(h)/0300(2)(h)
- Mental Health Assessment & ISSP 0117(4)(c)(e)/0300(4)(c)(e)

**HEALTH SERVICES OAR 309-035-0175/0440**

- Regular Health Exams 0175(3)/440(3)
- Dental Examinations 1075(3)/440(3) *None, no documentation of referral*
- Special Needs Including ADA Support  NA 0175(4)/440(4)



PROGRAM: Horizon House RTF

REVIEWED BY: Lestie

RESIDENT ID: R1

ADMISSION DATE: 3/8/13

**RTF(H) - ADMISSION TO THE HOME OAR 309-035-0145/0360**

*Documents in this section are to remain in the resident record:*

- Summary Sheet**  name,  admission date,  DOB,  gender,  legal status,  marital status,  religious preference,  physician info,  dental info,  evacuation capability,  diagnosis,  health concerns,  medication/food allergies,  mental health directive  adv. health directives,  burial plan,  emergency contact 0117(4)(a)-(b)/0300(4)(a)-(b)
- Referral & Background Information** 0145(10)/0360(10)
- Admission Criteria** (0145(6)/0360(6))
- Initial Health Screening** 0175(2)/440(2)
- Crisis Admit Health Screen** (within 24 hrs)  NA 0175(2)(C)/440(2)(C)
- TB** (TB test results prior to admission) (not for crisis respite) 0175(2)(b)/440(2)(b)
- Guardianship Documents** Guardian(s): \_\_\_\_\_  NA 0145(5)(d)/0360(5)
- Safety & Emergency Orientation** 0145(9)/360(9)
- Orientation to the Home at Admission** 0145(9)/0360(9)
- Release of Info Forms** 0145(3)/0360(3)

- Informed Consent for Services** 0145(8)/0360(8)
- Advance Health Directives** 0145(9)/0360(9)
- Mental Health Directives** 0145(9)/0360(9)
- Money Management Support** 0145(8)/0360(8) *None being provided.*
- Abuse Reporting** (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- House Rules** (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- Grievance Procedures** (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- Resident Rights** (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- PSRB Conditional Release** (if applicable) NA  0145(5)(d)/0360(5)(d)

**RESIDENT ASSESSMENT / RESIDENTIAL SERVICE PLAN OAR 309-035-0159/0400**

- Initial Residential Assessment** (within 30 days of admission) 0159(1)/0400(1)
- Crisis Respite** (within 48 hrs. of admission; includes plan for end date of service)  NA 0159(3)/0400(3)
- Initial Residential Service Plan** (within 30 days of admission) 0159(2)/0400(2)
  - Signed by the  resident,  administrator and  guardian if applicable 0159(2)(c)/0400(2)(c)
- ADL Support in Residential Service Plan** 0159(2)(b)/0400(2)(b)
- Annual Update or Re-Assessments/Changes to Service Plan**  NA 0159(5)/0400(5)
  - Signed by the  resident,  administrator and  guardian if applicable 0159(2)(c)/0400(2)(c)
- Progress Notes** (reflecting progress towards the goals in the RSP) (daily for crisis respite) 0159(4)/0400(4)
  - Progress Notes Present** (month & year): 7/16; 6/16; 5/16; 4/16; 3/16; 2/16; 1/16; 12/15; 11/15; 10/15; 9/15; 8/15; 7/15; 6/15; 5/15; 4/15; 3/15; 2/15; 1/15; 12/14; 11/14; 10/14; 9/14; 8/14 -> 3/13
- Incident Reports** 0117(2)(h)/0300(2)(h)
- Mental Health Assessment & ISSP** 0117(4)(c)(e)/0300(4)(c)(e)

**HEALTH SERVICES OAR 309-035-0175/0440**

- Regular Health Exams** 0175(3)/440(3)
- Dental Examinations** 1075(3)/440(3)
- Special Needs Including ADA Support**  NA 0175(4)/440(4)



# FIRE EVACUATION DRILL CHECK SHEET

- OAR 309-035-0130(6),(7),(8),(9)&(13) /0330(6),(7),(8),(9)&(13)

Program: Horizon House RTE

Licensing Period: \_\_\_\_\_

1	Date of Drill 0130(6)(d)/0330(6)(d)	Time A.M. or P.M. 0130(6)(d)/0330(6)(d)	Night Drill 11 pm to 6 am 0130(6)(a)/ 0330(6)(a)	Location Of Mock Fire 0130(6)(b)(d)/ 0330(6)(b)(d)	Safety Program 0130(13)/0330(13)			
					Smoke Detectors 0130(9)/ 0330(9)	Window Operation 0130(7)/ 0330(7)	Exit Door or Egress Blockage 0130(7)/ 0330(7)	Emergency Lights 0125(15)(e)/ 0330(13)
1	7/12/16	2305 A.M. / P.M.	<input checked="" type="checkbox"/>	kitchen	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2	6/12/16	905 A.M. / P.M.	<input type="checkbox"/>	"Horizon House"	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3	5/9/16	650 A.M. / P.M.	<input type="checkbox"/>	garage	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4	5/2/16	1100 A.M. / P.M.	<input checked="" type="checkbox"/>	"RTE Horizon House"	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5	4/6/16	0800 A.M. / P.M.	<input type="checkbox"/>	dining room	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6	3/2/16	540 A.M. / P.M.	<input type="checkbox"/>	"Horizon House"	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7	2/9/16	2300 A.M. / P.M.	<input checked="" type="checkbox"/>	kitchen	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Mark ?	<input checked="" type="checkbox"/>
8	1/22/16	0725 A.M. / P.M.	<input type="checkbox"/>	kitchen	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9	12/31/15	2038 A.M. / P.M.	<input type="checkbox"/>	- BLANK -	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
10	11/13/15	1800 A.M. / P.M.	<input type="checkbox"/>	kitchen	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
11	10/23/15	2330 A.M. / P.M.	<input checked="" type="checkbox"/>	kitchen	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
12	9/25/15	1230 A.M. / P.M.	<input type="checkbox"/>	- BLANK -	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
13	8/17/15	1319 A.M. / P.M.	<input type="checkbox"/>	"Horizon House"	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
14	7/9/15	540 A.M. / P.M.	<input checked="" type="checkbox"/>	dining room	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
15	6/13/15	2255 A.M. / P.M.	<input type="checkbox"/>	downstairs bedroom	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
16	5/16/15	2035 A.M. / P.M.	<input type="checkbox"/>	living room	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
17	4/16/15	1106 A.M. / P.M.	<input checked="" type="checkbox"/>	upstairs office	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
18	3/14/15	2017 A.M. / P.M.	<input type="checkbox"/>	kitchen	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
19	2/11/15	1030 A.M. / P.M.	<input type="checkbox"/>	kitchen	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
20	1/26/15	2301 A.M. / P.M.	<input checked="" type="checkbox"/>	kitchen	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
21	12/23/14	1400 A.M. / P.M.	<input type="checkbox"/>	living room	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
22	11/18/14	2315 A.M. / P.M.	<input checked="" type="checkbox"/>	kitchen	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
23	10/22/14	135 A.M. / P.M.	<input type="checkbox"/>	- form had no space for loc.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
24	9/22/14	2300 A.M. / P.M.	<input checked="" type="checkbox"/>	- "	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

bathroom window needs prop.

NAME: \_\_\_\_\_ INSPECTION DATE: \_\_\_\_\_

LICENSING PERIOD: \_\_\_\_\_ INSPECTED BY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ LICENSED CAPACITY: \_\_\_\_\_ CENSUS AT REVIEW: \_\_\_\_\_

SR RATING: \_\_\_\_\_

CIVIL:  PSRB:  OTHER:

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ OWNER/PROVIDER: \_\_\_\_\_

ADMINISTRATOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_

VARIANCES: *No access to basement - keys*

*Counter top - water damage*

*Backsplash - peeling away from wall*

NOTES: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



<b>SECTION:</b>	Professional Conduct	<b>POLICY #:</b>	601
<b>TITLE:</b>	Public Official Ethics	<b>PROCEDURE #:</b>	
		<b>ORDER #:</b>	10-71
<b>DEPT:</b>	Board of Commissioners	<b>DIVISION:</b>	
<b>ADOPTED:</b>	4/84	<b>REVIEWED:</b>	12/07, 8/10
		<b>REVISED:</b>	12/07, 8/10

**PURPOSE:** To set forth the ethical government standards and practices required of all Marion County employees engaged in any aspect of governmental and professional business while representing Marion County.

**AUTHORITY:** The Marion County Board of Commissioners may establish rules and regulations in reference to managing the interest and business of the county under ORS 203.010, 203.035 and 203.111.

The Marion County Board of Commissioners expresses the governing body's formal, organizational position of fundamental issues or specific repetitive situations through formally adopted, written policy statements. The policy statements serve as guides to decision making for both elected and appointed officials on the conduct of county business.

The Administrative Policies and Procedures Manual of the Board of Commissioners outlines the forms and process through which the board takes official action on administrative policy, and is the official record of county administrative policy.

Statutory References

Oregon Revised Statutes chapters 162, 164, 165, and 244, ORS 166.715 to 166.735, 180.750 to 180.785, 260.432, 411.670 to 411.690, 646.505 to 646.656, 659A.200 to 659A.224, 659A.230 to 659A.233, Oregon Administrative Rules 199-005-0005 to 199-005-0035, 410-120-1395 to 410-120-1510, 31 USC Chapter 38, 31 USC 3729-3733, 42 USC 1320a-7b and section 6032 of the federal Deficit Reduction Act of 2005, section 1902(a)(68) of the Social Security Act.

**APPLICABILITY:** All public officials, including county officers, employees or agents, irrespective of whether or not the person is compensated for services.

**SUBJECT: EMPLOYEE ETHICS**

**GENERAL POLICY:**

**1. Prohibited Actions with Financial Impact:**

- 1.1. A public official shall not use or attempt to use his or her official position or office to obtain financial gain or avoidance of financial detriment for the public official, a relative or member of the household of the public official, or any business with which the public official or a relative or member of the household of the public official is associated if the financial gain or avoidance of financial detriment would not otherwise be available but for the public official's holding of the official position or office. This section does not apply to: any part of an official compensation package approved by the public body, allowed honorarium, reimbursement of expenses, an unsolicited award for professional achievement, gifts within the annual limit from a source that could reasonably be known to have a legislative or administrative interest in the public official's decision or vote as defined in ORS 244.020(9) and OAR 199-005-0003(2), gifts from a source that could not reasonably be known to have a legislative or administrative interest in the public official's governmental agency or scope of authority, items expressly excluded from the definition of gift under ORS 244.020, or contributions to an allowed legal expense trust fund established for the benefit of the public official.
- 1.2. A public official shall not solicit or receive, either directly or indirectly, any pledge or promise of future employment based on any understanding that the vote, official action or judgment of the public official would be influenced by the pledge or promise.
- 1.3. A public official shall not further or, attempt to further, the personal gain of the public official through the use of confidential information gained in the course of or by reason of holding position as a public official or the activities of the person as a public official.
- 1.4. During a calendar year, a public official or a relative or member of the household of a public official shall not solicit or receive, directly or indirectly, any gift or gifts with an aggregate value in excess of \$50 from any single source that could reasonably be known to have a legislative or administrative interest in the public official decision or vote.

**SUBJECT: EMPLOYEE ETHICS**

2. Prohibited Political Activities:

- 2.1. No public official shall attempt to, or actually, coerce, command or require a public employee to influence or give money, service or other thing of value to promote or oppose any political committee or to promote or oppose the nomination or election of a candidate, the gathering of signatures on an initiative, referendum or recall petition, the adoption of a measure or the recall of a public office holder.
- 2.2. No public employee shall solicit any money, influence, service or other thing of value or otherwise promote or oppose any political committee or promote or oppose the nomination or election of a candidate, the gathering of signatures on an initiative, referendum or recall petition, the adoption of a measure or recall of a public office holder while on the job during working hours. However, this section does not restrict the right of a public employee to express personal political views. Public employee as used in this section does not include elected officials.

3. Prohibited Conduct Related to Application for Employment:

- 3.1. No public official shall individually or in cooperation with one or more persons deceive or obstruct any person in the exercise of rights to employment granted pursuant to rules or regulations adopted by the board.
- 3.2. No public official shall falsely mark, grade, estimate or report upon the examination or proper standing of any person examined or certified for County employment, or aid in so doing.
- 3.3. No public official shall furnish to any person information not available to all applicants for the purpose of either improving or injuring the prospects or chances for County employment.
- 3.4. No public official shall impersonate any other person or permit or aid in any manner any other person to impersonate another in connection with any examination or application for County employment.

4. False Claims Acts– Prohibiting Medicaid Fraud, Waste and Abuse:

- 4.1. No public official shall knowingly, in reckless disregard or in deliberate ignorance of the truth or falsity of the information, present, cause to be presented, permit or aid another in presenting to the state or federal government a false or fraudulent claim for payment or approval, or a claim for payment or approval that the person knows to be based on false or fraudulent information.
- 4.2. No public official shall knowingly, in reckless disregard or in deliberate ignorance of the truth or falsity of the information, make, use or cause to be made or used, a false record or statement material to a false or fraudulent claim.

**SUBJECT: EMPLOYEE ETHICS**

- 4.3. No public official shall individually, or conspire with other persons to, commit a violation of the state or federal false claims acts or Medicaid fraud, waste and abuse.
- 4.4. No public official shall knowingly, in reckless disregard or in deliberate ignorance of the truth or falsity of the information, make, use, or cause to be used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government.
- 4.5. No public official who has possession, custody, or control of property or money used, or to be used by the government shall knowingly deliver or caused to be delivered, less than all of that money or property, or that the person knows is less than the amount for which the person receives a certificate or receipt.
  - 4.5.1. No public official who is authorized to make or deliver a document certifying receipt of property used, or to be used by the government and, intending to defraud the government, shall make or deliver a receipt without completely knowing that the information on the receipt is true, or that the person knows contains false or fraudulent information.
  - 4.5.2. No public official shall knowingly buy, or receive as a pledge of an obligation or debt, public property from an officer or employee of the government, or a member of the Armed Forces, who lawfully may not sell or pledge the property.
  - 4.5.3. No public official shall fail to disclose a false claim within a reasonable time after discovering that the false claim has been presented or submitted for payment or approval.
  - 4.5.4. No public official shall retaliate against any person for reporting conduct prohibited under the state or federal False Claims Acts, or Medicaid fraud, waste and abuse.

**POLICY GUIDELINES:**

- 1. **Responsibilities:** All Marion County public officials are responsible for compliance and will be subject to this policy.
- 2. **Implementation:** All Marion County departments will adhere to the policy and procedures.
- 3. **Periodic Review:** Review of this policy shall be conducted annually to ensure compliance with any legal changes that may occur.

<b>MARION COUNTY</b>		No: 2.38 500.9
Area: Personnel	<b>Health Department</b>	
		Created: Revised: 10/12/10
Subject: Clinical Credentialing Behavioral Health Services	Revised By: Scott Richards, Karri Tinney	Approved By: <i>Roderick P. Galikin</i> Date: 10-13-10

**PURPOSE:**

The purpose of Clinical Credentialing within Behavioral Health Services is to thoroughly assess the training, experience and education of each staff person, prior to providing services to clients in behavioral health programs and to determine that each staff person meets or exceeds the clinical standards for:

- 1) Peer Support Specialist, Qualified Mental Health Professional (QMHP), Qualified Mental Health Associate (QMHA), or Licensed Medical Professional (LMP) as described in Oregon Administrative Rules (OAR).

OR

- 2) Pending CADC, CADC I, CADC II, or CADC III as defined by the Addiction Counselor Certification Board of Oregon (ACCBO).

**POLICY:**

It is the policy of Marion County Health Department that behavioral health care is delivered by professional staff with high clinical standards. Assurance of delivery of quality care will be maintained through careful review of an individual's qualifications including education, training, and experience in the behavioral health field. The provisions described in the OAR and/or confirmation of pending CADC status or an active CADC will be the acceptable qualifications used in assessing and determining staff credentialing for the delivery and billing of behavioral health services. Initial determination of credentialing status will be completed prior to hiring, promoting, and/or reassigning direct service staff.

**PROCEDURE:**

1. When applying for regular or temporary positions that require credentialing, applicants will be required to submit a Credentialing Determination Request form and a copy of applicable transcripts, license, and/or certification with their application. Contractor's licenses and/or certifications will be verified by Health Department contract staff prior to the execution of the contract.
2. Prior to making a job offer, the supervisor will review the "Credentialing Determination Request" form and transcripts. If a license or certification is used as proof of meeting credentialing requirements, the supervisor or designee will verify the license or certification through the licensing body's website. A copy of the verification page and a copy of the certification or license will be attached to the Credentialing Determination Request form. The supervisor will also determine that the applicant can demonstrate the necessary competencies. Competencies will be determined through the use of approved practical exams, interview questions and/or reference checks.

3. The "Credentialing Determination Request" form, transcripts and/or copy of certification or license verification page, practical exam and references documenting competencies will be submitted with new hire paperwork.
4. If transcripts are used for proof of the education requirement for credentialing, the supervisor will inform the new hire that they must submit official transcript to Administration within thirty days from their date of hire. The offer letter will also state that continued employment is contingent upon receiving official transcripts and a final approval of credentialing status.
5. Final determination and approval of credentialing will be the responsibility of the Health Department Administrator or designee.
6. When the Administrator or designee has made final approval of credentialing, the staff person and their supervisor will receive credentialing verification that indicates the approved credential and the provider number assigned to the employee for billing of behavioral health services.
7. Staff that are credentialed based on license and/or certification must maintain current licensure and/or certification. If circumstances arise that a valid license or certification cannot be maintained, staff must notify their supervisor within 5 business days prior to the license or certification expiration date.
8. Documentation of all credentialing determinations and verifications will be retained in Health Department Administration personnel files and made available to supervisors, employees, representatives from the Office of Mental Health and Addictions Services (OMHAS), representatives from the Mid-Valley Behavioral Care Network, and other approved payers upon request.

#### **CREDENTIALING QUALIFICATIONS:**

To provide direct behavioral health services, an individual must meet the qualifications in one of the credential classifications described below:

##### **A. Peer Support Specialist**

An individual must meet the following minimum qualifications to be credentialed as a Peer Support Specialist:

"Peer Support Specialist" means a person providing peer delivered services to an individual or family member with similar life experience, under the supervision of a qualified Clinical Supervisor.

- (a) A Peer Support Specialist must complete an AMH approved training program;

**AND BE**

- (b) A self-identified person currently or formerly receiving mental health services; or

- (c) A self-identified person in recovery from a substance use disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs; or
- (d) A family member of an individual who is a current or former recipient of addictions or mental health services.

**AND**

- (e) Has the competencies necessary to:
  - (1) Demonstrate knowledge of approaches to support others in recovery and resiliency, and demonstrate efforts at self-directed recovery.

**B. Qualified Mental Health Associate**

An individual must meet the following minimum qualifications to be credentialed as a Qualified Mental Health Associate (QMHA):

"Qualified Mental Health Associate" or "QMHA" means a person delivering services under the direct supervision of a Qualified Mental Health Professional (QMHP) and meeting the following minimum qualifications as documented by the provider:

- (a) A bachelor's degree in a behavioral sciences field; or
- (b) A combination of at least three year's relevant work, education, training or experience;

**AND**

- (c) Has the competencies necessary to:
  - (1) Demonstrate the ability to communicate effectively;
  - (2) Understand mental health assessment, treatment and service terminology and apply each of these concepts;
  - (3) Implement skills development strategies and identify, implement and coordinate the services and supports identified in an Individual Service and Support Plan (ISSP).

Credit will be given for education, training and experience using the following formulas:

<b>Coursework</b>	Coursework in behavioral science, i.e., psychology, counseling <b>13 credits = 1 year</b>
<b>Training</b>	Relevant training (verification required) <b>450 hours = 1 yr.</b>
<b>Experience</b>	Relevant experience in behavioral health field (Experience working with Individuals with Developmental Disabilities and in Alcohol & Drug field may count as half depending on actual work duties) <b>2080 hours = 1 year</b>

**C. Qualified Mental Health Professional**

An individual must meet the following minimum qualifications to be credentialed as a Qualified Mental Health Professional (QMHP):

"Qualified Mental Health Professional" or "QMHP" means a Licensed Medical Practitioner (LMP) or any other person meeting one or more of the following minimum qualifications as authorized by the LMHA or designee:

- (a) Bachelor's degree in nursing and licensed by the State of Oregon;
- (b) Bachelor's degree in occupational therapy and licensed by the State of Oregon;
- (c) Graduate degree in psychology;
- (d) Graduate degree in social work;
- (e) Graduate degree in recreational, art, or music therapy; or
- (f) Graduate degree in a behavioral science field.

**AND**

- (g) Has the competencies necessary to:
  - (1) Demonstrate the ability to conduct an assessment, including identifying precipitating events, gathering histories of mental and physical health, alcohol and other drug use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and conducting a mental status examination, complete a five-axis DSM diagnosis, write and supervise the implementation of an Individual Service and Support Plan (ISSP) and provide individual, family or group therapy within the scope of their training.

\*Marion County Health Department direct service personnel with QMHP status prior to April 2, 1996 who do not meet the revised QMHP criteria outlined in the revised OAR, Medicaid Payment for Rehabilitative Mental Health Services Rule, effective April 2, 1996, have been grandfathered under the current QMHP definitions. Individual variances may be granted by OMHAS on a case-by-case basis.

**C. Licensed Medical Practitioner**

An individual must meet the following minimum qualifications to be credentialed as a Licensed Medical Practitioner (LMP):

"Licensed Medical Practitioner" or "LMP" means a person who meets the following minimum qualifications as documented by the Local Mental Health Authority (LMHA) or designee:

- (a) Physician licensed to practice in the State of Oregon; or
- (b) Nurse Practitioner licensed to practice in the State of Oregon; or
- (c) Physician's Assistant licensed to practice in the State of Oregon

**AND**

- (d) Whose training, experience and competence demonstrate the ability to conduct a mental health assessment and provide medication management.
- (e) For ICTS and ITS providers, LMP means a board-certified or board-eligible child and adolescent psychiatrist licensed to practice in the State of Oregon.

**D. Pending CADC**

An individual must meet the following minimum qualifications to be credentialed as a Pending CADC:

- (a) Completion of all educational requirements for entry-level certification of a certifying body accepted by the state of Oregon (ACCBO, NAADAC or the Northwest Indian Alcohol and Drug Specialist Certification Board) at the time of hire.
- (b) At the time of hire, the supervisor will formulate a plan for the employee to complete the necessary contact and supervision hours to obtain certification within 6 months from the date of hire.
- (c) The employee will obtain CADC 1 within 1 year from date of hire.

**E. CADC I**

An individual must show proof of CADC I certification through the Addiction Counselor Certification Board of Oregon (ACCBO).

**F. CADC II**

An individual must show proof of CADC II certification through the Addiction Counselor Certification Board of Oregon (ACCBO).

**G. CADC III**

An individual must show proof of CADC III certification through the Addiction Counselor Certification Board of Oregon (ACCBO).

**SECOND YEAR MASTER'S INTERNS:**

Second year graduate students may work as a Qualified Mental Health Professional to provide services to MVBCN clients under the following conditions:

- (1) The supervisor will submit the Credentialing for Adjunct Service Provider form and a copy of the intern's official transcripts to Administration. The Administrator of the Health Department must approve credentialing prior to the intern beginning their internship.

- (2) The supervisor will provide the student with a copy of the Essential Job Functions for the intern position that defines the scope of practice.
- (3) A Clinical Supervisor will be assigned. "Clinical Supervisor" is defined by OAR (QMHP with a Master's degree and at least two years post-graduate clinical experience in a mental health treatment setting). The Clinical Supervisor oversees and evaluates the outpatient mental health treatment services provided by a QMHP.
- (4) A contract with the school, defining responsibilities of agency, student, and school must be in place prior to the student beginning their internship.
- (5) An educational agreement between the agency Clinical Supervisor and student will be created, including a plan for direct, weekly supervision. The QMHP Clinical Supervisor will keep documentation regarding weekly clinical supervision meetings.
- (6) The QMHP clinical supervisor will review and sign off on all Mental Health Assessments and Treatment Plans developed by the intern, providing feedback and support as needed.
- (7) Intern Scope of Practice includes: Mental Health Assessment and Treatment Planning under close supervision; Individual, family and group counseling; Case Coordination, Attendance at Treatment Team meetings; and documentation of clinical activities (i.e. MHA's, progress notes, etc).

Second-year graduate students may be granted QMHP status for up to one year and may deliver and bill for services per MVBCN guidelines.

**MARION COUNTY HEALTH DEPARTMENT  
ALCOHOL & DRUG TREATMENT SERVICES**

Pending CADAC ; CADAC I; CADAC II; CADAC III Credentialing Determination Request

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Position Applying For: \_\_\_\_\_

Credential Status Applying For:

Pending CADAC       CADAC I       CADAC II       CADAC III

Supervisor: \_\_\_\_\_

EDUCATION				
School	Major	Minor	Degree Earned	Date(s)

Certification / License	
<input type="checkbox"/> CADAC # (attach copy of ACCBO certificate):	CADAC Expiration Date:
<input type="checkbox"/> Pending CADAC (attach copy of ACCBO certification application)	Date of Scheduled Exam:
<input type="checkbox"/> Other professional certification or license	Type:

ALCOHOL & DRUG EXPERIENCE - Paid and Volunteer			
Position/Title	Employer / Location	Start / End Dates	Hours Per Week

List your education, training, and experience that demonstrates your competencies in each of the areas identified in the credentialing status you are applying for:

Pending CADC: CADC I: CADC II: CADC III		
Skill Area	Education/Training	Experience
Individual assessments		
Individual, group, family and other counseling techniques		
Program policies and program delivery and documentation		
Identification, implementation and coordination of services identified to facilitate intended outcomes		

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR DEPARTMENT USE ONLY**

**Determination Findings:**

The applicant's education, training, and experience have been reviewed. Based on information and documentation obtained, the applicant is:

\_\_\_\_\_ Approved as:  Pending CADC     CADC I     CADC II     CADC III

\_\_\_\_\_ Denied

Copy of ACCBO Certification application for Pending CADC attached

Copy of applicable CADC certificate attached

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

For Administration Use:

Provider #: \_\_\_\_\_

**MARION COUNTY HEALTH DEPARTMENT**

**QMHP/QMHA/LMP Credentialing Determination Request**

<b>Name:</b>		<b>Date:</b>	
<b>Position Applying For:</b>			
<b>Credential Status Applying For:</b>	<input type="checkbox"/> QMHA	<input type="checkbox"/> QMHP	<input type="checkbox"/> LMP
<b>Supervisor:</b>			

Attach all educational (including copies of degrees, licenses and transcripts), experience and training documentation that supports this request. For QMHA credentialing, if you do not hold a Bachelor's degree, please include verification of a combination of at least 3 years of work, education, training or experience in the behavioral science field.

<b>EDUCATION</b>				
<b>School</b>	<b>Major</b>	<b>Minor</b>	<b>Degree Earned</b>	<b>Date(s)</b>

<b>LICENSES / CERTIFICATIONS</b>		
<b>Current</b>	<b>Type</b>	<b>Expiration Date</b>
Yes <input type="checkbox"/> No <input type="checkbox"/>		
Yes <input type="checkbox"/> No <input type="checkbox"/>		
Yes <input type="checkbox"/> No <input type="checkbox"/>		

<b>MENTAL HEALTH EXPERIENCE – Paid and Volunteer</b>			
<b>Position/Title</b>	<b>Employer / Location</b>	<b>Start / End Dates</b>	<b>Hours Per Week</b>

List your education, training, and experience that demonstrates your competencies in each of the areas identified in the credentialing status you are applying for:

<b>QUALIFIED MENTAL HEALTH ASSOCIATE (QMHA)</b>		
<b>Skill Area</b>	<b>Education/Training</b>	<b>Experience</b>
Effective communication		
Understanding of mental health assessment, treatment, and service terminology		
Skills development strategies		
Implementation and coordination of service and supports identified in an ISSP		

<b>QUALIFIED MENTAL HEALTH PROFESSIONAL (QMHP)</b>		
<b>Skill Area</b>	<b>Education/Training</b>	<b>Experience</b>
Conducting a comprehensive mental health assessment including: <ul style="list-style-type: none"> <li>• Identification of precipitating events</li> </ul> Gathering Histories of: <ul style="list-style-type: none"> <li>• Mental and physical health</li> <li>• Alcohol and drug use</li> <li>• Prior mental health services</li> <li>• Criminal justice contact</li> <li>• Assessing family, social, cultural and work relationships</li> <li>• Documenting a five-axis DSM diagnosis</li> </ul>		
Conducting a mental health status examination		
Writing, supervising and implementing an ISSP		

(Treatment Plan)		
Providing individual, family or group therapy within scope of training		

LICENSED MEDICAL PRACTITIONER (LMP)		
Skill Area	Education/Training	Experience
Conducting a comprehensive mental health assessment		
Providing medication management		

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Department Use Only**

**Determination Findings:**

The applicant's education, training, and experience have been reviewed. Based on information and documentation obtained, the applicant's request for credentialing is:

- Approved (Check Status):
- QMHA     QMHP     LMP
- Denied (Does Not Meet Criteria)

Copies of applicable licenses, degrees, transcripts, training documents, etc., attached

\_\_\_\_\_  
Supervisor

\_\_\_\_\_  
Date

For Administration Use:  
Provider #: \_\_\_\_\_

**MARION COUNTY HEALTH DEPARTMENT**

**QMHP/QMHA/LMP Credentialing Determination Request**

List your education, training, and experience that demonstrates your competencies in each of the areas identified in the credentialing status you are applying for.

<b>CLINICAL SUPERVISOR - QUALIFIED MENTAL HEALTH PROFESSIONAL (QMHP)</b>		
<b>Skill Area</b>	<b>Education/Training</b>	<b>Experience</b>
<b>Leadership:</b> <ul style="list-style-type: none"> <li>• Leadership competence</li> <li>• Oversight and evaluation of services</li> <li>• Staff development</li> <li>• Implementation of provider policies</li> </ul>		
<b>Clinical:</b> <ul style="list-style-type: none"> <li>• Wellness competence</li> <li>• ISSP planning</li> <li>• Case management/ coordination experience</li> <li>• Utilization of community resources</li> <li>• Counseling experience</li> <li>• Documentation of services intended to promote intended outcomes</li> </ul>		

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Department Use Only**

**Determination Findings:**

The applicant's education, training, and experience have been reviewed. Based on information and documentation obtained, the applicant's request for credentialing is:

Approved as QMHP – Clinical Supervisor

Denied (Does Not Meet Criteria)

Copies of applicable licenses, degrees, transcripts, training documents, etc. attached

\_\_\_\_\_  
Supervisor

\_\_\_\_\_  
Date

Revised 10/8/10

For Administration Use:  
Provider #: \_\_\_\_\_





# Marion County OREGON

## CERTIFICATE OF SELF-INSURANCE

The undersigned hereby certifies that the following described self-insurance is in force as of the date below:

Name of Self-Insured: Marion County

Principal Address: 555 Court St NE, 4th Floor, Salem, Oregon, 97301  
PO Box 14500, Salem, OR, 97309-5036

Policy Period: July 1, 2009 until cancelled

	<u>Description of Coverage</u>	<u>Limits of Liability</u>
I.	General Liability	\$10,000,000 Per Occurrence \$10,000,000 Aggregate
II.	Automobile Liability	\$1,000,000 Per Accident Per ODOT Certificate Number 58
III.	Workers' Compensation	\$750,000
IV.	Employer's Liability	\$1,000,000

Marion County is self-insured for the above coverages in accordance with the provisions of ORS 30.270 (Tort Claims Act) and ORS 656.403 (Workers' Compensation). The county maintains an insurance fund from which to pay all costs and expenses relating to claims for which it is self-insured. This document is furnished to you as a matter of information only. The issuance of this document does not modify in any manner the issuer's self-insurance program.

Marion County Risk Management

*Justine Flora*

Justine Flora, Benefits and Risk Manager  
Phone: 503-584-7786 Fax: 503-588-5495

<b>Program:</b> Health  <b>Area:</b> Client Services	<b>MARION COUNTY</b>  <b>Health Department</b>	<b>No:</b> <del>1.17</del> 100.17  <b>Page:</b> 1 of 5  <b>Revised:</b> February 1, 2011 <b>Date:</b> November 8, 2001
<b>Subject:</b> Rights and Responsibilities for Individuals Receiving Behavioral Health Services	<b>Prepared By:</b> Katie Bechtel Scott Richards	<b>Approved By:</b> <i>Roderick P. Galhina</i>

**PURPOSE:** To assure that individuals who receive behavioral health services offered by Marion County Health Department are guaranteed and informed of their rights and responsibilities. To assure that the Department supports and promotes individual rights and responsibilities and agency responsibilities as described in applicable Oregon Administrative Rules, Department policies, and by payor requirements.

**POLICY:**

**I. Individuals receiving services or participating in activities offered by Marion County Health Department have the right to:**

**BASIC RIGHTS**

1. Access and receive services regardless of race, color, religion, sex, sexual orientation, age marital status, national origin and mental or physical disability.
2. Receive courteous and timely service in an environment that offers reasonable safety, protection from harm, and reasonable privacy.
3. Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation.
4. Be treated with dignity and respect.
5. Be free from participation in involuntary experimentation.
6. Be free from seclusion and restraint.

**ACCESS AND INFORMATION RIGHTS**

7. Access and receive services in a manner and language consistent with an individual's culture including access to an interpreter if needed.
8. Be informed at the start of services, and periodically thereafter, of the rights guaranteed by this policy and the Integrated Services and Supports Rule.
9. Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law.
10. Receive information about the policies and procedures, service agreements and fees applicable to the services provided. If services are covered by insurance, reimbursement is made directly to Marion County Health Department. If the individual is responsible for any portion of payment, the individual has the right to receive a copy of the fee scale for the service area and a written fee agreement describing the amount to be paid and the payment schedule. Individuals may have a

custodial parent, guardian, or representative assist with understanding any information presented.

11. Receive information about other community resources and other available treatment.
12. Receive services and treatment without custodial parent or legal guardian consent when lawfully married, 16 or older and legally emancipated by the court, or age 14 or older for outpatient services only. For purposes of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs.

The custodial parent or legal guardian of a minor, age 14 or older who has consented to outpatient treatment or diagnosis shall be involved before the end of treatment unless:

- a. the parent refuses
- b. there are clear clinical indication to the contrary
- c. the child has been sexually abused by the parent
- d. the child has been legally emancipated by the court or has been self sustaining for 90 days prior to obtaining treatment

13. Receive emergent care 24 hours per day, 7 days per week and to be informed how and where to receive the care.

#### **TREATMENT RIGHTS**

14. Request information concerning the credentials and training of staff.
15. Participate in the development of a written ISSP, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and to receive a copy of the written ISSP. Additionally, family and others of the individual's choice may participate in this planning and review. Individuals have the right to ask why any form of treatment or service is recommended, if alternative training or treatment methods are available, the benefits of treatment, and/or any risks that might be involved.
16. Choose from available services and supports, those that are consistent with the ISSP and provided in the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual and that provide for the greatest degree of independence.
17. Have all services and medications explained, including expected outcomes and possible risks. Individuals may question why a medication is being prescribed and will be informed about potential side effects of the medication.
18. Receive medication specific to your diagnosed clinical need.
19. Access the materials in their Individual Service Record, clinical and/or medical record which were originated by the Health Department. It is preferred that the staff person working with the individual be present during the record review in order to explain the materials. Prescribers can withhold information believed to be harmful to an individual.

Individuals must submit a written request for copies of any material contained in their clinical or medical record. Copies will be made available to the individual within 5 working days from the date of the request. Individuals may be charged for the copying costs.

Access to Individual Service Records will be maintained in accordance with ORS 179.505.

20. Confidentiality of material relating to treatment and services. Individuals must give written permission before information concerning their treatment or services can be shared. Confidential information can be released without consent when:
  - a. A court orders release of information under certain limited circumstances
  - b. There is a clear danger to the individual or others
  - c. There is reasonable cause to believe that neglect or abuse of a child, elder, person with developmental disabilities or nursing home patient has been or is occurring
  - d. Under limited circumstances if the individual is a minor (dependent on the type of treatment being delivered.)

A verbal release of information from an individual is accepted to facilitate care coordination for a individual in an urgent situation. The verbal release must be documented in the individual's clinical/medical record. The information covered by the verbal release may not be re-released.

Limited information for MVBCN/OHP covered behavioral health individuals receiving services within the Marion County Integrated Delivery System network may be shared without a release of information from the individual. The information is to be shared on a need-to-know basis to coordinate care among multiple providers in the best interest of the individual and is limited to dates of services, therapist/case manager's name, diagnosis, and prescribed medication.

Confidentiality and the right to consent to disclose will be maintained in accordance with ORS 107.154, ORS 179.505, ORS 179.507, ORS 192.515, ORS 192.507, 42 CFR Part 2 and 45 CFR Part 205.50.

21. Choose to agree to treatment, refuse treatment including any specific procedure, and/or choose to stop taking a medication. These choices are without any punitive consequences. If adverse consequences are an expected result, the information and facts must be explained verbally to the individual and, if appropriate, the individual's guardian, and that discussion documented in the individual's record.
22. Individuals receiving adult behavioral health services have the right to execute a Declaration of Mental Health Treatment and to receive help with completing the Declaration.
23. You have the right to receive information about medical Advanced Directives.
24. Receive prior notice of service conclusion or transfer, unless the circumstances necessitating service conclusion or transfer pose a threat to health and safety.

#### **OTHER RIGHTS**

25. OHP/MVBCN members have additional rights and responsibilities. These additional rights and responsibilities will be distributed to OHP/MVBCN members at intake and be made available in the reception areas. These can also be found on the MVBCN website, [www.mvbcn.org](http://www.mvbcn.org).
26. Individuals receiving residential services have additional rights and responsibilities, as outlined in OAR 309.032.1515(2).
27. File a written or oral grievance or complaint relating to treatment or providers and receive assistance in filing the complaint. Retaliation or punitive consequences to the individual resulting

from the complaint are not permitted. Individuals may also appeal the Department's decision about a complaint. Appeal rights are outlined in the Department's Complaints and Appeals Policy.

28. Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined the Integrated Services and Supports Rule.
29. Exercise all rights set forth in ORS 426.385 if the individual is committed to DHS.
30. Exercise all rights described in the Integrated Service and Supports Rules without any form of reprisal or punishment.

**II. Individuals receiving services or participating in activities offered by Marion County Health Department have the responsibility to:**

1. Treat others with courtesy and respect.
2. Provide information that is needed in order to provide care.
3. Participate, in the degree possible, in developing mutually-agreed upon treatment goals.
4. Follow the treatment plans and instructions for care that have been agreed upon.
5. Inform care givers/practitioners of any dissatisfaction with services or treatment.
6. Arrive on time for scheduled appointment or call in advance if an appointment must be cancelled or rescheduled.
7. Contact care givers/practitioners in an emergency.
8. Inform care givers/practitioners of changes in address, telephone numbers, and other personal information relating to their treatment.
9. Bring insurance information and cards to appointments and inform care givers/practitioners of any changes in coverage.
10. Take medications as prescribed or consult the prescriber before making any medication changes.
11. Seek help for any addiction issues that may interfere with treatment.
12. Protect the confidentiality and safety of other individuals.
13. Satisfy any legal requirements involving Health Department treatment and services.
14. Pay for any services detailed in a fee agreement.

**III. Marion County Health Department and staff have the following responsibilities to individuals receiving services or participating in activities offered by the Department:**

1. Report incidents of abuse directly to the State authority when there is reasonable cause to believe that an individual has suffered neglect or abuse as described in ORS 430-735 through 765 and OAR 309-040-0200 through 0290, Abuse Report Procedures.

2. Make modifications and updates to service area and Department policies, procedures, and practices to avoid discrimination.
3. Comply with the American Disabilities Act (ADA).
4. Post Individual Rights & Responsibilities in a visible location and in language appropriate formats in all service locations.
5. Post sliding fee scales in a visible location in all service locations.
6. Treat individuals with dignity and respect.
7. Provide services to individuals regardless of their race, color, religion, sex, sexual orientation, age marital status, national origin and mental or physical disability.
8. Provide services in a manner and language consistent with an individual's culture including access to an interpreter if needed.
9. Provide courteous and timely service in an environment that offers reasonable safety, protection from harm, and reasonable privacy.
10. Provide individuals with a copy of the complaint process, have forms and information about the process easily accessible, and provide assistance to individuals completing the process if requested. The agency has the responsibility to respond to complaints in accordance to the timelines and in the method described in Health Department Policy 1.2 Client Complaints and Appeals.
11. Uphold and protect confidentiality of individual information as described in the MHDDSD Confidentiality Handbook, OAR 415-51-020, ORS 179.505, 42CF Part 2, Health Department policies 2.29, Employee Confidentiality Statement, and 1.1, Client Privacy and Confidentiality.
12. Include individuals and others identified by the individual in treatment/service planning.
13. Provide written notification to individuals when benefits, treatment, and/or services are being denied, reduced, or suspended.

**Health Systems Division**  
**Home and Community-Based Services**  
**Evidence Package**

**Via Verde**

**OREGON HEALTH AUTHORITY  
RESIDENTIAL TREATMENT HOME LICENSE**

Name: **Via Verde**  
Address: **545 24th Place N.E.  
Salem, Oregon 97301**

License No.: **516845**  
Payment Received: **\$30.00**

**01/05/2017**                      **01/04/2019**  
Effective Date                      Expiration Date

Occupancy: **SR-3 Class: 3**  
License Capacity: **5**  
Owner: **Shangri-La #**  
Administrator: **Montgomery, Tammie**



Administrator  
Health Systems Division

HSD 9106 (3/08)

This license is not transferable to any person or address.

## Health Systems Division

Please verify the information below, and fill in any changes or corrections in the space to the right of each item.

### FACILITY DEMOGRAPHICS:

Name: Via Verde  
Address: 545 24th Place N.E.  
City: Salem  
State: OR  
Zip: 97301  
County: Marion  
Phone (ext): 503-485-1979 ()  
Mailing Address: 4080 Reed Road S.E.,  
Suite 150  
Mailing City: Salem  
Mailing State: OR  
Mailing Zip: 97302  
Fax:  
TTD:  
Provider Name: Shangri-La Corp.

# Received

NOV 11 2016

Licensing and Certification

### CONTACTS:

Name ~~Jenifer McIntosh~~  
Title  
Phone (Ext) ~~503-488-5357 ()~~  
Cell  
Email ~~jenifer@shangrilacorp.net~~

Nicole Busse  
QA/QI Manager  
541 221 7147  
nicole.busse@shangrila-or.org

Name ~~Robin Winkle~~  
Title ~~Res. Manager~~  
Phone (Ext) ()  
Cell  
Email

Alisa Walker  
Program Director  
alisa.walker@shangrila-or.org

Name Tammie Montgomery  
Title Administrator  
Phone (Ext) ()  
Cell

503 932 1916

Email tammie@shangrilacorp.org \_\_\_\_\_

Name Leslie Stainbrook \_\_\_\_\_

Title \_\_\_\_\_

Phone (Ext) 503-361-2642 () \_\_\_\_\_

Cell \_\_\_\_\_

Email lstainbrook@co.marion.or.us \_\_\_\_\_

Name ~~Steve Marick~~ \_\_\_\_\_

Title \_\_\_\_\_

Phone (Ext) ~~503-581-1732 (354)~~ \_\_\_\_\_

Cell \_\_\_\_\_

Email \_\_\_\_\_

N/A

**VARIANCES:**

Health Services Division (HSD)  
License Renewal Application  
Residential Treatment Program.

Received

NOV 11 2016

Licensing and Certification

**FACILITY NAME:** Via Verde

HSD MUST RECEIVE THIS APPLICATION 30 DAYS PRIOR TO THE DATE OF LICENSE EXPIRATION. The applicable renewal fee is required by Oregon Revised Statutes (ORS) 443.415(1). Check or money order made payable to **Oregon Health Authority**. (*Government bodies excluded from fee*)

EACH LICENSE IS VALID FOR A TWO (2) YEAR PERIOD AFTER APPROVAL AND DATE OF LICENSURE. A license will be issued to any facility that is in substantial compliance with OAR 309-035-0100 through 309-035-0460.

Are you changing Administrator at this time? Yes  No

If yes, please provide us with the following:

Administrator Name: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Resume  Criminal History/Background  Job Description

**Occupancy Rating**

Please submit documentation of Residential Occupancy as determined by Building Codes.

**Ownership Information:**

Has a change occurred during the current license period? Yes  No  If yes, provide the required information and attach any supporting documentation.

Operated by:  State  County  Individual  
 Non-profit  Other(specify) \_\_\_\_\_

If individual, list full name and address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

If partnership, list each partner having interest in 10% or more (use additional sheets if necessary)

Name	Full Address	%

If corporation:

Exact corporate name: <u>Shangri-La Corporation</u>
and/or register assumed name: _____
Phone Number: <u>(503) 581 - 1732</u> Email: _____

Has the corporation received a certificate of incorporation or a certificate of authority to do business in the State of Oregon from the Corporation Commission?

Yes  No

If yes, quote certificate number: 992081-92

If corporation, list all officers and directors and/or persons owning 10% or more.

Name	Full Address	%

**Supporting documentation or information:**

Please respond and/or enclose all required documents and/or information.

● **Policies and Procedures:**

Did you revise your manuals during the current license period?

Yes  No

● **Do you currently have a variance?** Yes  No  If yes, please complete the attached request for variance forms.

During the current licensed period has any facility staff had a sustained allegation of abuse?

Yes  No  If yes, provide us with this information at the on site inspection.

Was there a critical or significant investigation of any type within the program?

Yes  No  If yes, provide us with this information at the on site inspection.

During the current licensed period has any facility staff been convicted of any crime identified in ORS 161.505 through ORS 161.565, during the licensed period?

Yes  No  If yes, please explain below.

**REQUIRED SIGNATURES:**

*The renewal application information submitted for review is true to the best of my knowledge and understanding.*

Tammie Montgomery

*Printed name of Administrator*

T. Montgomery

*Signature of Administrator*

*Date:* 10/5/16

Nicole Busse

*Printed name of Licensee and/or authorized individual*

N. Busse

*Signature of Licensee and/or authorized individual*

*Date:* 10/5/16

# INSPECTION PARTICIPANT SIGN-IN

Location: Via Verde Date: 12/7/16

Name	Organization and Position	Contact Phone	Email Address
Chris Judson	Health Systems Division (HSD) Compliance Specialist		
Nicole Bussell	Shangri-la QA/QI Manager	541 221 7147	nicole.bussell@shangri-la-or.org
Alisa Walker	Shangri-la MHH Director	541 515 8890	alisa.walker@shangri-la-or.org
Tammie Montgomery	Shangri-la MHH RTH Manager	503 932-1916	tammie.montgomery@shangri-la-or.org
Lucas Pitman	Shangri-la Quality Transition Specialist	541-206-7419	Lucas.Pitman@shangri-la-or.org

NAME: \_\_\_\_\_ INSPECTION DATE: \_\_\_\_\_

LICENSING PERIOD: \_\_\_\_\_ INSPECTED BY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ LICENSED CAPACITY: \_\_\_\_\_ CENSUS AT REVIEW: \_\_\_\_\_

SR RATING: \_\_\_\_\_

CIVIL:  PSRB:  OTHER:

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ OWNER/PROVIDER: \_\_\_\_\_

ADMINISTRATOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_

VARIANCES: upstairs - lights are status inspectable

NOTES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

STAFF RECORD REVIEW LICENSING PERIOD:

PROGRAM NAME: \_\_\_\_\_

STAFF	Hire Date @ Facility <sup>1</sup>	Date of Approved Criminal History Check <sup>1</sup>	Job Description <sup>2</sup>	TB Read Within Two Weeks <sup>3</sup>	Hep B Accept or Decline Within Two Weeks <sup>3</sup>	16 Hours of Pre-Service Training <sup>4</sup>	8 Hours In-Service Training Yearly <sup>4,7</sup>	Medication Training by RN <sup>5</sup>	Date of Abuse Reporting Training <sup>6</sup>	Date of Grievance Process Trainings <sup>6</sup>	Date of Incident Reporting Trainings <sup>6</sup>
S2	12/1/14	1/22/16	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	1. <u>  </u> 2. <u>  </u>	Date: <u>  </u>	<input checked="" type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/>			
S5	1/1/16	1/17/16	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	1. <u>  </u> 2. <u>  </u>	Date: <u>  </u>	<input checked="" type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/>			
S6	6/15/17	7/2/17	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	1. <u>  </u> 2. <u>  </u>	Date: <u>  </u>	<input checked="" type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/>			
S	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	1. <u>  </u> 2. <u>  </u>	Date: <u>  </u>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>			
S	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	1. <u>  </u> 2. <u>  </u>	Date: <u>  </u>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>			
S	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	1. <u>  </u> 2. <u>  </u>	Date: <u>  </u>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>			
S	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	1. <u>  </u> 2. <u>  </u>	Date: <u>  </u>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>			
S	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	1. <u>  </u> 2. <u>  </u>	Date: <u>  </u>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>			
S	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	1. <u>  </u> 2. <u>  </u>	Date: <u>  </u>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>			
S	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	1. <u>  </u> 2. <u>  </u>	Date: <u>  </u>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>			
S	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	1. <u>  </u> 2. <u>  </u>	Date: <u>  </u>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>			
S	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	1. <u>  </u> 2. <u>  </u>	Date: <u>  </u>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>			
S	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	1. <u>  </u> 2. <u>  </u>	Date: <u>  </u>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>			
S	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	1. <u>  </u> 2. <u>  </u>	Date: <u>  </u>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>			

# FIRE EVACUATION DRILL CHECK SHEET

OAR 309-035-0130(6),(7),(8),(9)&(13) / 0330(6),(7),(8),(9)&(13)

Program: Vic Verde Licensing Period: \_\_\_\_\_

Date of Drill 0130(6)(d)/0330(6)(d)	Time A.M. or P.M. 0130(6)(d)/0330(6)(d)	Night Drill 11 pm to 6 am 0130(6)(a)/ 0330(6)(a)	Location Of Mock Fire 0130(6)(b)(d)/ 0330(6)(b)(d)	Safety Program			Emergency Lights 0125(15)(e)/ 0330(13)
				Smoke Detectors 0130(9)/ 0330(9)	Window Operation 0130(7)/ 0330(7)	Exit Door or Egress Blockage 0130(7)/ 0330(7)	
1	4/24/16	1:45 A.M. / P.M.	Office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	10/17/16	8:50 A.M. / P.M.	Bed 10-flw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	1/18/16	11:20 A.M. / P.M.	Kitchen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	8/17/16	9:24 A.M. / P.M.	Br 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	7/21/16	8:47 A.M. / P.M.	Kitchen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	6/21/16	4 A.M. / P.M.	Front yard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	5/11/16	7:45 A.M. / P.M.	Living Room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	4/22/16	8 A.M. / P.M.	Back Br flw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	3/28/16	7:52 A.M. / P.M.	Back porch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	2/25/16	5:15 A.M. / P.M.	Staircase	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	1/31/16	4 A.M. / P.M.	Back lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	12/8/15	4:35 A.M. / P.M.	Garage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	11/23/15	6:30 A.M. / P.M.	Outside area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	11/14/15	4:25 A.M. / P.M.	Kitchen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	9/16/15	4 A.M. / P.M.	Teacher	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	8/14/15	10:40 A.M. / P.M.	Back porch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	7/8/15	5 A.M. / P.M.	Staff office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	6/5/15	4 A.M. / P.M.	Drug can	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	5/4/15	10:58 A.M. / P.M.	Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	4/10/15	12:40 A.M. / P.M.	Re br	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	3/10/15	5 A.M. / P.M.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	2/25/15	5:10 A.M. / P.M.	Kitchen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	2/18/15	4:15 A.M. / P.M.	Garage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	1/7/15	6:30 A.M. / P.M.	Kitchen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PROGRAM: Via Verde  
RESIDENT ID: R1

REVIEWED BY: Jennife Partain  
ADMISSION DATE: 7-26-13

**RTF(H) - ADMISSION TO THE HOME OAR 309-035-0145/0360**

*Documents in this section are to remain in the resident record:*

- Summary Sheet  name,  admission date,  DOB,  gender,  legal status,  marital status,  religious preference,  physician info,  dental info,  evacuation capability,  diagnosis,  health concerns,  medication/food allergies,  mental health directive  adv. health directives,  burial plan,  emergency contact 0117(4)(a)-(b)/0300(4)(a)-(b)
- Referral & Background Information 0145(10)/0360(10)
- Admission Criteria (0145(6)/0360(6))
- Initial Health Screening 0175(2)/440(2)
  - Crisis Admit Health Screen (within 24 hrs)  NA 0175(2)(C)/440(2)(C)
- TB (TB test results prior to admission) (not for crisis respite) 0175(2)(b)/440(2)(b)
- Guardianship Documents Guardian(s): \_\_\_\_\_  NA 0145(5)(d)/0360(5)
- Safety & Emergency Orientation 0145(9)/360(9)
- Orientation to the Home at Admission 0145(9)/0360(9)
- Release of Info Forms 0145(3)/0360(3)

- Informed Consent for Services 0145(8)/0360(8)
- Advance Health Directives 0145(9)/0360(9)
- Mental Health Directives 0145(9)/0360(9)
- Money Management Support 0145(8)/0360(8) *N/A*
- Abuse Reporting (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- House Rules (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- Grievance Procedures (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- Resident Rights (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- PSRB Conditional Release (if applicable) NA  0145(5)(d)/0360(5)(d)

**RESIDENT ASSESSMENT / RESIDENTIAL SERVICE PLAN OAR 309-035-0159/0400**

- Initial Residential Assessment (within 30 days of admission) 0159(1)/0400(1)
  - Crisis Respite (within 48 hrs. of admission; includes plan for end date of service)  NA 0159(3)/0400(3)
- Initial Residential Service Plan (within 30 days of admission) 0159(2)/0400(2)
  - Signed by the  resident,  administrator and  guardian if applicable 0159(2)(c)/0400(2)(c)
- ADL Support in Residential Service Plan 0159(2)(b)/0400(2)(b)
- Annual Update or Re-Assessments/Changes to Service Plan  NA 0159(5)/0400(5)
  - Signed by the  resident,  administrator and  guardian if applicable 0159(2)(c)/0400(2)(c)
- Progress Notes (reflecting progress towards the goals in the RSP) (daily for crisis respite) 0159(4)/0400(4)  
Progress Notes Present (month & year): monthly
- Incident Reports 0117(2)(h)/0300(2)(h) *N/A*
- Mental Health Assessment & ISSP 0117(4)(c)(e)/0300(4)(c)(e)

**HEALTH SERVICES OAR 309-035-0175/0440**

- Regular Health Exams 0175(3)/440(3)
- Dental Examinations 1075(3)/440(3)
- Special Needs Including ADA Support  NA 0175(4)/440(4)

PROGRAM: Via Verde REVIEWED BY: Jennif Pastore  
 RESIDENT ID: R2 ADMISSION DATE: 6-8-15

**RTF(H) - ADMISSION TO THE HOME** OAR 309-035-0145/0360

*Documents in this section are to remain in the resident record:*

- Summary Sheet  name,  admission date,  DOB,  gender,  legal status,  marital status,  religious preference,  physician info,  dental info,  evacuation capability,  diagnosis,  health concerns,  medication/food allergies,  mental health directive,  adv. health directives,  burial plan,  emergency contact 0117(4)(a)-(b)/0300(4)(a)-(b)
- Referral & Background Information 0145(10)/0360(10)
- Admission Criteria 0145(6)/0360(6)
- Initial Health Screening 0175(2)/440(2)
- Crisis Admit Health Screen (within 24 hrs)  NA 0175(2)(C)/440(2)(C)
- TB (TB test results prior to admission) (not for crisis respite) 0175(2)(b)/440(2)(b)
- Guardianship Documents Guardian(s): N/A  NA 0145(5)(d)/0360(5)
- Safety & Emergency Orientation 0145(9)/360(9)
- Orientation to the Home at Admission 0145(9)/0360(9)
- Release of Info Forms 0145(3)/0360(3)

- Informed Consent for Services 0145(8)/0360(8)
- Advance Health Directives 0145(9)/0360(9)
- Mental Health Directives 0145(9)/0360(9)
- Money Management Support 0145(8)/0360(8) N/A
- Abuse Reporting (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- House Rules (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- Grievance Procedures (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- Resident Rights (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- PSRB Conditional Release (if applicable) NA  0145(5)(d)/0360(5)(d)

**RESIDENT ASSESSMENT / RESIDENTIAL SERVICE PLAN** OAR 309-035-0159/0400

- Initial Residential Assessment (within 30 days of admission) 0159(1)/0400(1)
  - Crisis Respite (within 48 hrs. of admission; includes plan for end date of service)  NA 0159(3)/0400(3)
- Initial Residential Service Plan (within 30 days of admission) 0159(2)/0400(2) none / OKAY
  - Signed by the  resident,  administrator and  guardian if applicable 0159(2)(c)/0400(2)(c)
- ADL Support in Residential Service Plan 0159(2)(b)/0400(2)(b)
- Annual Update or Re-Assessments/Changes to Service Plan  NA 0159(5)/0400(5)
  - Signed by the  resident,  administrator and  guardian if applicable 0159(2)(c)/0400(2)(c)
- Progress Notes (reflecting progress towards the goals in the RSP) (daily for crisis respite) 0159(4)/0400(4)
 

Progress Notes Present (month & year): RSP + Progress notes need to reflect same goals + progress updates RSP not updated yet. Progress notes from Nov.
- Incident Reports 0117(2)(h)/0300(2)(h)
- Mental Health Assessment & ISSP 0117(4)(c)(e)/0300(4)(c)(e)

**HEALTH SERVICES** OAR 309-035-0175/0440

- Regular Health Exams 0175(3)/440(3)
- Dental Examinations 1075(3)/440(3)
- Special Needs Including ADA Support  NA 0175(4)/440(4)

PROGRAM: Vic Verb

REVIEWED BY: CJ

RESIDENT ID: R4

ADMISSION DATE: 10/10/15

**RTF(H) - ADMISSION TO THE HOME** OAR 309-035-0145/0360

*Documents in this section are to remain in the resident record:*

- Summary Sheet  name,  admission date,  DOB,  gender,  legal status,  marital status,  religious preference,  physician info,  dental info,  evacuation capability,  diagnosis,  health concerns,  medication/food allergies,  mental health directive  adv. health directives,  burial plan,  emergency contact 0117(4)(a)-(b)/0300(4)(a)-(b)
- Referral & Background Information 0145(10)/0360(10)
- Admission Criteria 0145(6)/0360(6)
- Initial Health Screening 0175(2)/440(2)
  - Crisis Admit Health Screen (within 24 hrs)  NA 0175(2)(C)/440(2)(C)
- TB (TB test results prior to admission) (not for crisis respite) 0175(2)(b)/440(2)(b)
- Guardianship Documents Guardian(s): \_\_\_\_\_  NA 0145(5)(d)/0360(5)
- Safety & Emergency Orientation 0145(9)/360(9)
- Orientation to the Home at Admission 0145(9)/0360(9)
- Release of Info Forms 0145(3)/0360(3)

- Informed Consent for Services 0145(8)/0360(8)
- Advance Health Directives 0145(9)/0360(9)
- Mental Health Directives 0145(9)/0360(9)
- Money Management Support 0145(8)/0360(8)
- Abuse Reporting (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- House Rules (required to be reviewed at admission or if changes are made) 0145(9)/0360(9) - *HCRS*
- Grievance Procedures (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- Resident Rights (required to be reviewed at admission or if changes are made) 0145(9)/0360(9)
- PSRB Conditional Release (if applicable) NA  0145(5)(d)/0360(5)(d)

*visiting team  
- weights  
- requiring  
adherence to  
schedule*

**RESIDENT ASSESSMENT / RESIDENTIAL SERVICE PLAN** OAR 309-035-0159/0400

- Initial Residential Assessment (within 30 days of admission) 0159(1)/0400(1)
  - Crisis Respite (within 48 hrs. of admission; includes plan for end date of service)  NA 0159(3)/0400(3)
- Initial Residential Service Plan (within 30 days of admission) 0159(2)/0400(2)
  - Signed by the  resident,  administrator and  guardian if applicable 0159(2)(c)/0400(2)(c)
- ADL Support in Residential Service Plan 0159(2)(b)/0400(2)(b)
- Annual Update or Re-Assessments/Changes to Service Plan  NA 0159(5)/0400(5)
  - Signed by the  resident,  administrator and  guardian if applicable 0159(2)(c)/0400(2)(c)
- Progress Notes (reflecting progress towards the goals in the RSP) (daily for crisis respite) 0159(4)/0400(4)
  - Progress Notes Present (month & year): \_\_\_\_\_

- Incident Reports 0117(2)(h)/0300(2)(h)
- Mental Health Assessment & ISSP 0117(4)(c)(e)/0300(4)(c)(e)

**HEALTH SERVICES** OAR 309-035-0175/0440

- Regular Health Exams 0175(3)/440(3)
- Dental Examinations 1075(3)/440(3)
- Special Needs Including ADA Support  NA 0175(4)/440(4)

PROGRAM: VK Vnde

REVIEWED BY: CS

RESIDENT ID: D v

INTAKE DATE: 7/28/16

**RTE(H) - TERMINATION OF RESIDENCY** OAR 309-035-0150/0370

Documentation of discussions and meetings held concerning termination of residency and copies of notices will be maintained in the resident's record OAR 309-035-0150(6)/0370(7)

Date of Discharge: 7/27/16

Discharge Summary Narrative: \_\_\_\_\_

**Reason for Termination:** OAR 309-035-0150(2)(3)(4)/0370(2)(3)(4)(5)

Voluntary: Notice of intent to move submitted by the resident or guardian 0150(2)/0370(3)

Explanation: move closer to family

Emergency: Resident behavior poses serious and immediate threat to health & safety of others. 24 hour written notice with resident's right to appeal in accordance with OAR 309-035-0157/0390. 0150(4)/0317(4)

Explanation: \_\_\_\_\_

Other Termination of Residency: If a decision is made to terminate residency, the administrator will provide at least a 30 days written notice specifying the causes of termination to the resident or guardian. This notice will also specify the resident's right to appeal the termination decision in accordance with OAR 309-035-0157/0390. An effort will be made to establish a reasonable termination date both facility needs and the needs of the terminated resident to find alternative living arrangements. 0150(4)/0370(5)

Termination Notice(s) in Compliance with OAR 309-035-0157/0390: 0150(2)(3)(4)/0370(2)(3)(4)(5)

Explanation: \_\_\_\_\_

**Criteria Establishing Grounds for Termination Include:** OAR 309-035-0150(4)(a)-(f)/0370(5)(a)-(f)

Resident no longer needs or desires services provided at the facility and/or expresses a desire to move to an alternative setting 0150(4)(a)/0370(5)(a)

Resident is assessed by a Licensed Medical Professional or other qualified health professional to require services, such as continuous nursing care or extended hospitalization, that are not available, or can not be reasonably arranged, at the facility 0150(4)(b)/0370(5)(b)

Resident's behavior is continuously and significantly disruptive or poses a threat to the health or safety of self or others and these behavioral concerns cannot be adequately addressed with services available at the facility or services that can be arranged outside of the facility 0150(4)(c)/0370(5)(c)

Resident cannot safely evacuate the facility in accordance with the facility's SR Occupancy Classification after efforts described in OAR 309-035-0130(5)(b)/0330(5)(b) have been taken 0150(4)(d)/0370(5)(d)

Nonpayment of fees in accordance with program's fee policy 0150(4)(e)/0370(5)(e)

Resident continuously and knowingly violates house rules resulting in significant disturbance to others

Absences without Notice: 0150(9)/0370(9)

Documentation that attempts were made to contact the resident or guardian as applicable to confirm the resident's intent to discontinue residency

**Pre-Termination Meeting:** OAR 309-035-0150(5)/0370(6)

Except in the case of emergency termination or crisis respite; Two weeks prior to the termination date with the resident, guardian if applicable, and with the resident's permission, others interested in the resident's circumstances

Meeting held on: 7/27/16 and attended by: ✓ ~ 10 days prior to exit - PSF included

Explanation of why a Pre-Termination Meeting was not held: \_\_\_\_\_

**Additional Supporting Documentation Leading to Termination:** OAR 309-035-0150(6)/0370(7)

Incident Reports  Progress Notes  Hospital Documentation  Police Reports

Attempts at Making a Reasonable Accommodation at the Facility  Other: \_\_\_\_\_

**Disposition of Personal Property and Funds:** OAR 309-035-0150(7)/0370(8)

Statement of Account  Balance of Funds 0150(7)(a)/0370(8)(a)

Inventory of Personal Property 0150(7)(b)/0370(8)(b)

Signed by All 0117(1)/0300(1)

Disposition of Medications: OAR 309-035-0175(5)(f)/0440(5)(g)

Copies of MARs and accounting of medications signed by: \_\_\_\_\_

PROGRAM: V/L Vrdh

REVIEWED BY: CS

RESIDENT ID: D 2

INTAKE DATE: 12/25/17

**RTF(H) - TERMINATION OF RESIDENCY** OAR 309-035-0150/0370

Documentation of discussions and meetings held concerning termination of residency and copies of notices will be maintained in the resident's record OAR 309-035-0150(6)/0370(7)

Date of Discharge: 1/20/16

Discharge Summary Narrative: \_\_\_\_\_

**Reason for Termination:** OAR 309-035-0150(2)(3)(4)/0370(2)(3)(4)(5)

Voluntary: Notice of intent to move submitted by the resident or guardian 0150(2)/0370(3)

Explanation: Independent living

Emergency: Resident behavior poses serious and immediate threat to health & safety of others. 24 hour written notice with resident's right to appeal in accordance with OAR 309-035-0157/0390. 0150(4)/0317(4)

Explanation: \_\_\_\_\_

Other Termination of Residency: If a decision is made to terminate residency, the administrator will provide at least a 30 days written notice specifying the causes of termination to the resident or guardian. This notice will also specify the resident's right to appeal the termination decision in accordance with OAR 309-035-0157/0390. An effort will be made to establish a reasonable termination date both facility needs and the needs of the terminated resident to find alternative living arrangements. 0150(4)/0370(5)

Termination Notice(s) in Compliance with OAR 309-035-0157/0390: 0150(2)(3)(4)/0370(2)(3)(4)(5)

Explanation: \_\_\_\_\_

**Criteria Establishing Grounds for Termination Include:** OAR 309-035-0150(4)(a)-(f)/0370(5)(a)-(f)

- Resident no longer needs or desires services provided at the facility and/or expresses a desire to move to an alternative setting 0150(4)(a)/0370(5)(a)
- Resident is assessed by a Licensed Medical Professional or other qualified health professional to require services, such as continuous nursing care or extended hospitalization, that are not available, or can not be reasonably arranged, at the facility 0150(4)(b)/0370(5)(b)
- Resident's behavior is continuously and significantly disruptive or poses a threat to the health or safety of self or others and these behavioral concerns cannot be adequately addressed with services available at the facility or services that can be arranged outside of the facility 0150(4)(c)/0370(5)(c)
- Resident cannot safely evacuate the facility in accordance with the facility's SR Occupancy Classification after efforts described in OAR 309-035-0130(5)(b)/0330(5)(b) have been taken 0150(4)(d)/0370(5)(d)
- Nonpayment of fees in accordance with program's fee policy 0150(4)(e)/0370(5)(e)
- Resident continuously and knowingly violates house rules resulting in significant disturbance to others
- Absences without Notice: 0150(9)/0370(9)
  - Documentation that attempts were made to contact the resident or guardian as applicable to confirm the resident's intent to discontinue residency

**Pre-Termination Meeting:** OAR 309-035-0150(5)/0370(6)

Except in the case of emergency termination or crisis respite; Two weeks prior to the termination date with the resident, guardian if applicable, and with the resident's permission, others interested in the resident's circumstances

Meeting held on: 1/27/16 and attended by: ~ 9 days prior to intended Feb 5th move with apartment available

Explanation of why a Pre-Termination Meeting was not held: 1/20/16

**Additional Supporting Documentation Leading to Termination:** OAR 309-035-0150(6)/0370(7)

- Incident Reports  Progress Notes  Hospital Documentation  Police Reports
- Attempts at Making a Reasonable Accommodation at the Facility  Other: \_\_\_\_\_

**Disposition of Personal Property and Funds:** OAR 309-035-0150(7)/0370(8)

- Statement of Account  Balance of Funds 0150(7)(a)/0370(8)(a)
- Inventory of Personal Property 0150(7)(b)/0370(8)(b)
- Signed by All 0117(1)/0300(1)
- Disposition of Medications: OAR 309-035-0175(5)(f)/0440(5)(g)
- Copies of MARs and accounting of medications signed by: \_\_\_\_\_



HEALTH SYSTEMS DIVISION

Kate Brown, Governor

Oregon  
**Health**  
Authority

December 29, 2016

500 Summer Street NE, E-86  
Salem, OR 97301-1118  
Voice: 503-945-5763  
Fax: 503-378-8467  
TTY: 800-375-2863  
[www.oregon.gov/OHA/amh](http://www.oregon.gov/OHA/amh)

Shangri-La  
Tammie Montgomery, Administrator  
Via Verde  
4080 Reed Road S.E., Suite 150  
Salem, OR 97302

Dear Tammie Montgomery:

Chris Judson, Compliance Specialist(s) for the Health Systems Division (HSD) conducted an inspection on December 7, 2016 of your RTH, located at 545 24th Place N.E., Salem, Oregon. Jennifer Pastorino from the Mental Health Department of Marion County also participated in the review.

This inspection was completed for the purpose of licensing your RTH under the provisions of applicable Oregon Administrative Rules and Oregon Revised Statutes as referenced in the attached report.

Please review the enclosed report and submit a written Plan of Correction (POC) where indicated. This report is to be submitted with the POC information on the right side of the report. Please submit your POC **within 30 days of receipt of this certified letter.**

Your POC should include the following components:

- Action(s) to be taken to correct the rule violations for each cited deficiency.
- Date corrective action was or will be completed.
- Describe procedures to prevent the violation from reoccurring.
- Describe how administration will ensure the procedures are followed.
- Include supportive documentation for each corrected action.

If the POC is unacceptable for any reason, we will notify you. You are ultimately accountable for your own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of your POC is not made timely.



Shangri-La  
December 29, 2016  
Page 2

Please be sure to sign and date the first page of the report before returning your POC. Keep a copy of the report for your files and for the required public access.

You will be notified directly by HSD regarding other corrective action that may be required.

If you have questions, please call me at 503-945-7817.

Sincerely,



Chris Judson  
Compliance Specialist



LuAnn Meulink  
Licensing and Certification Manager

CJ/ks

CC: Jennifer Pastorino, Marion County  
File

DEPARTMENT OF HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ORH328</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/07/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VIA VERDE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2430 GREENWAY DRIVE SALEM, OR 97301</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments  On 7 December 2016 a re-licensure inspection of Via Verde RTH was conducted by Chris Judson, Compliance Specialist with the Health Systems Division under the Oregon Health Authority. Jennifer Pastorino from Marion County also participated in the Review. The following report identifies deficiencies found during the review.	C 000		
C 255	OAR 309-035-0330(6) Safety: Evacuation Drills  (6) Evacuation Drills. Every resident will participate in an unannounced evacuation drill each month. (See Section 408.12.5 of the Fire Code.) (a) At least once every three months, the drill will be conducted during resident sleeping hours. (b) Drills will be scheduled at different times of the day and on different days of the week with different locations designated as the origin of the fire for drill purposes. (c) Any resident failing to evacuate within the established time limits will be provided with special assistance and a notation made in the resident record. (d) Written evacuation records will be retained for at least three years. They will include documentation, made at the time of the drill, specifying the date and time of the drill, the location designated as the origin of the fire for drill purposes, the names of all individuals and staff present, the amount of time required to evacuate, notes of any difficulties experienced, and the signature of the staff person conducting the drill.  This Rule is not met as evidenced by: Comment:  No evacuation drill was conducted for March	C 255		

STATE OF OREGON LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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DEPARTMENT OF HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ORH328</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/07/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VIA VERDE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2430 GREENWAY DRIVE SALEM, OR 97301</b>
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C 255	Continued From page 1  2015. Per the evacuation drill schedule, this should have been a drill conducted during sleeping hours, resulting in a 6 month gap between sleeping drills. Note: this happened under a previous administrator of the home.	C 255		
C 318	OAR 309-035-0360(9) Admission to Home: Orientation  (9) Orientation. Upon admission, the administrator or his/her designee will provide an orientation to each new resident that includes, but is not limited to, a complete tour of the home, introductions to other residents and staff, discussion of house rules, explanation of the laundry and food service schedule and policies, review of resident rights and grievance procedures, explanation of the fee policy, discussion of the conditions under which residency would be terminated, and a general description of available services and activities. During the orientation, advance directives will be explained. If the resident does not already have any advance directive(s), she/he will be given an opportunity to complete them. Orientation will also include a description of the RTHs emergency procedures in accordance with OAR 309-035-0330(2).  This Rule is not met as evidenced by: General comment:  House rules currently in use by Via Verde RTH conflict with new HCBS rule language regarding visiting hours, overnight guests, and requirements for residents to adhere to a schedule. Note: Shangri-La is in process of updating and implementing house rules at all residential sites to reflect the new HCBS rules.	C 318		

DEPARTMENT OF HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ORH328</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/07/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VIA VERDE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2430 GREENWAY DRIVE SALEM, OR 97301</b>
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C 337	<p>OAR 309-035-0370(8) Termination of Residency: Disp- Pers Property</p> <p>(8) Disposition of Personal Property. At the time of termination of residency, the resident will be given a statement of account, any balance of funds held by the RTH and all property held in trust or custody by the RTH.</p> <p>(a) In the event of pending charges (such as long distance phone charges or damage assessments), the program may hold back the amount of funds anticipated to cover the pending charges. Within 30 days after residency is terminated or as soon as pending charges are confirmed, the resident will be provided a final financial statement along with any funds due to the resident.</p> <p>(b) In the case of resident belongings left at the RTH for longer than seven days after termination of residency, the RTH will make a reasonable attempt to contact the resident, guardian (as applicable) and/or other representative of the resident. The RTH must allow the resident, guardian (as applicable) or other representative at least 15 days to make arrangements concerning the property. If it is determined that the resident has abandoned the property, the RTH may then dispose of the property. If the property is sold, proceeds of the sale, minus the amount of any expenses incurred and any amounts owed the program by or on behalf of the resident, will be forwarded to the resident or guardian (as applicable).</p> <p>This Rule is not met as evidenced by: Discharge Resident D2</p> <p>No disposition of medications at discharge could be found in the records reviewed.</p>	C 337		

DEPARTMENT OF HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ORH328</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/07/2016</b>
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C 373	Continued From page 3	C 373		
C 373	<p>OAR 309-035-0400(4) Resident Assessment &amp; Serv Plan:Progress Note</p> <p>(4) Progress Notes. Progress notes will be maintained within each resident's record and document significant information relating to all aspects of the resident's functioning and progress toward desired outcomes identified in the residential service plan. A progress note will be entered in the resident's record at least once each month for regular residents and at least daily for crisis-respite residents.</p> <p>This Rule is not met as evidenced by: General comment:  Resident R2</p> <p>The information in the progress notes does not reflect the goals stated in the Residential Service Plan, which makes it difficult to see a clear connection between the goals and the progress toward the goals.</p>	C 373		
C 414	<p>OAR 309-035-0440(5)(j) Health Services: P.R.N. Medication</p> <p>(j) P.r.n. medications and treatments will only be administered in accordance with the parameters specified by the prescribing health care professional, or in cases where a nurse assigns or delegates p.r.n. medication or treatment administration, in accordance with administrative rules of the Board of Nursing, Chapter 851, Division 47.</p> <p>This Rule is not met as evidenced by: Resident R1</p>	C 414		

DEPARTMENT OF HUMAN SERVICES

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C 414	Continued From page 4  A physician's order and matching MAR entry for PRN Benadryl 25mg contained a variable dose.	C 414		

DEPARTMENT OF HUMAN SERVICES

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C 000	Initial Comments  On 7 December 2016 a re-licensure inspection of Via Verde RTH was conducted by Chris Judson, Compliance Specialist with the Health Systems Division under the Oregon Health Authority. Jennifer Pastorino from Marion County also participated in the Review. The following report identifies deficiencies found during the review.	C 000		
C 255	<p>OAR 309-035-0330(6) Safety: Evacuation Drills</p> <p>(6) Evacuation Drills. Every resident will participate in an unannounced evacuation drill each month. (See Section 408.12.5 of the Fire Code.)</p> <p>(a) At least once every three months, the drill will be conducted during resident sleeping hours.</p> <p>(b) Drills will be scheduled at different times of the day and on different days of the week with different locations designated as the origin of the fire for drill purposes.</p> <p>(c) Any resident failing to evacuate within the established time limits will be provided with special assistance and a notation made in the resident record.</p> <p>(d) Written evacuation records will be retained for at least three years. They will include documentation, made at the time of the drill, specifying the date and time of the drill, the location designated as the origin of the fire for drill purposes, the names of all individuals and staff present, the amount of time required to evacuate, notes of any difficulties experienced, and the signature of the staff person conducting the drill.</p> <p>This Rule is not met as evidenced by: Comment:  No evacuation drill was conducted for March</p>	C 255	<h1>Received</h1> <p>JAN 23 2017</p> <p>Licensing and Certification</p>	

STATE OF OREGON  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X8) DATE \_\_\_\_\_

STATE FORM 6899 B7SD11 If continuation sheet 1 of 5

*Montgomery* RTH Administrator  
*WPAUSE* QA/QI Manager  
1/19/17

DEPARTMENT OF HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  ORH328	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/07/2016
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NAME OF PROVIDER OR SUPPLIER  VIA VERDE	STREET ADDRESS, CITY, STATE, ZIP CODE 2430 GREENWAY DRIVE SALEM, OR 97301
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C 255	Continued From page 1  2015. Per the evacuation drill schedule, this should have been a drill conducted during sleeping hours, resulting in a 6 month gap between sleeping drills. Note: this happened under a previous administrator of the home.	C 255		
C 318	OAR 309-035-0360(9) Admission to Home: Orientation  (9) Orientation. Upon admission, the administrator or his/her designee will provide an orientation to each new resident that includes, but is not limited to, a complete tour of the home, introductions to other residents and staff, discussion of house rules, explanation of the laundry and food service schedule and policies, review of resident rights and grievance procedures, explanation of the fee policy, discussion of the conditions under which residency would be terminated, and a general description of available services and activities. During the orientation, advance directives will be explained. If the resident does not already have any advance directive(s), she/he will be given an opportunity to complete them. Orientation will also include a description of the RTHs emergency procedures in accordance with OAR 309-035-0330(2).  This Rule is not met as evidenced by: General comment:  House rules currently in use by Via Verde RTH conflict with new HCBS rule language regarding visiting hours, overnight guests, and requirements for residents to adhere to a schedule. Note: Shangri-La is in process of updating and implementing house rules at all residential sites to reflect the new HCBS rules.	C 318		

DEPARTMENT OF HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ORH328</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/07/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VIA VERDE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2430 GREENWAY DRIVE SALEM, OR 97301</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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C 337	<p>OAR 309-035-0370(8) Termination of Residency: Disp- Pers Property</p> <p>(8) Disposition of Personal Property. At the time of termination of residency, the resident will be given a statement of account, any balance of funds held by the RTH and all property held in trust or custody by the RTH.</p> <p>(a) In the event of pending charges (such as long distance phone charges or damage assessments), the program may hold back the amount of funds anticipated to cover the pending charges. Within 30 days after residency is terminated or as soon as pending charges are confirmed, the resident will be provided a final financial statement along with any funds due to the resident.</p> <p>(b) In the case of resident belongings left at the RTH for longer than seven days after termination of residency, the RTH will make a reasonable attempt to contact the resident, guardian (as applicable) and/or other representative of the resident. The RTH must allow the resident, guardian (as applicable) or other representative at least 15 days to make arrangements concerning the property. If it is determined that the resident has abandoned the property, the RTH may then dispose of the property. If the property is sold, proceeds of the sale, minus the amount of any expenses incurred and any amounts owed the program by or on behalf of the resident, will be forwarded to the resident or guardian (as applicable).</p> <p>This Rule is not met as evidenced by: Discharge Resident D2</p> <p>No disposition of medications at discharge could be found in the records reviewed.</p>	C 337	<p>Termination OARs have been reviewed. In the future the RTH administrator and QA/QI team will be responsible for ensuring compliance.</p>	
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DEPARTMENT OF HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ORH328</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/07/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VIA VERDE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2430 GREENWAY DRIVE SALEM, OR 97301</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 373	Continued From page 3	C 373		
C 373	<p>OAR 309-035-0400(4) Resident Assessment &amp; Serv Plan:Progress Note</p> <p>(4) Progress Notes. Progress notes will be maintained within each resident's record and document significant information relating to all aspects of the resident's functioning and progress toward desired outcomes identified in the residential service plan. A progress note will be entered in the resident's record at least once each month for regular residents and at least dally for crisis-respite residents.</p> <p>This Rule is not met as evidenced by: General comment:  Resident R2</p> <p>The information in the progress notes does not reflect the goals stated in the Residential Service Plan, which makes it difficult to see a clear connection between the goals and the progress toward the goals.</p>	C 373		
C 414	<p>OAR 309-035-0440(5)(j) Health Services: P.R.N. Medication</p> <p>(j) P.r.n. medications and treatments will only be administered in accordance with the parameters specified by the prescribing health care professional, or in cases where a nurse assigns or delegates p.r.n. medication or treatment administration, in accordance with administrative rules of the Board of Nursing, Chapter 851, Division 47.</p> <p>This Rule is not met as evidenced by: Resident R1</p>	C 414		

DEPARTMENT OF HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ORH328</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/07/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VIA VERDE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2430 GREENWAY DRIVE SALEM, OR 97301</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 414	Continued From page 4  A physician's order and matching MAR entry for PRN Benadryl 25mg contained a variable dose.	C 414	See attached order clarification. Order now states "resident may choose 1 or 2 tabs." In the future the RTH administrator and QA/QI Team will review medication orders to ensure compliance with nursing rules.	



# Certificate of Insurance (Con't)

## OTHER Coverage

INSR LTR	TYPE OF INSURANCE	ADDL INSR	WVD SUBR	POLICY NUMBER	EFFECTIVE DATE (MM/DD/YY)	EXPIRATION DATE (MM/DD/YY)	LIMIT
A	Professional Liability			PHPK1615472	03/01/17	03/01/18	\$3,000,000 Aggregate Limit \$1,000,000 Each Occurrence
A	Auto Physical Damage			PHPK1615472	03/01/17	03/01/18	Comprehensive \$500. Ded. Collision \$1,000. Ded.
A	Forgery or Alteration			PHPK1615472	03/01/17	03/01/18	\$100,000 \$1,000 Deductible



**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

**GENERAL LIABILITY DELUXE ENDORSEMENT:  
HUMAN SERVICES**

This endorsement modifies insurance provided under the following:

**COMMERCIAL GENERAL LIABILITY COVERAGE**

It is understood and agreed that the following extensions only apply in the event that no other specific coverage for the indicated loss exposure is provided under this policy. If such specific coverage applies, the terms, conditions and limits of that coverage are the sole and exclusive coverage applicable under this policy, unless otherwise noted on this endorsement. The following is a summary of the Limits of Insurance and additional coverages provided by this endorsement. For complete details on specific coverages, consult the policy contract wording.

Coverage Applicable	Limit of Insurance	Page #
Damage to Premises Rented to You	\$1,000,000	2
Extended Property Damage	Included	2
Non-Owned Watercraft	Less than 58 feet	2
Medical Payments	\$20,000	2
Medical Payments – Extended Reporting Period	3 years	3
Athletic Activities	Amended	3
Supplementary Payments – Bail Bonds	\$2,500	3
Supplementary Payment – Loss of Earnings	\$500 per day	3
Employee Indemnification Defense Coverage for Employee	\$25,000	3
Additional Insured - Medical Directors and Administrators	Included	3
Additional Insured – Managers and Supervisors	Included	3
Additional Insured – Broadened Named Insured	Included	3
Additional Insured – Funding Source	Included	4
Additional Insured – Home Care Providers	Included	4
Additional Insured – Managers, Landlords, or Lessors of Premises	Included	4
Additional Insured - Lessor of Leased Equipment – Automatic Status When Required in Lease Agreement With You	Included	4
Additional Insured – Grantor of Permits	Included	4
Limited Rental Lease Agreement Contractual Liability	\$50,000 limit	5
Damage to Property You Own, Rent, or Occupy	\$30,000 limit	5
Transfer of Rights of Recovery Against Others To Us	Clarification	5
Duties in the Event of Occurrence, Claim or Suit	Included	5
Unintentional Failure to Disclose Hazards	Included	5
Liberalization	Included	6
Bodily Injury – includes Mental Anguish	Included	6
Personal and Advertising Injury – includes Abuse of Process, Discrimination	Included	6
Key and Lock Replacement – Janitorial Services Client Coverage	\$5,000 limit	6



**A. Damage to Premises Rented to You**

1. If damage by fire to premises rented to you is not otherwise excluded from this Coverage Part, the word "fire" is changed to "fire, lightning, explosion, smoke, or leakage from automatic fire protective systems" where it appears in:
  - a. The last paragraph of **SECTION I – COVERAGES, COVERAGE A BODILY INJURY AND PROPERTY DAMAGE LIABILITY**, Subsection 2. Exclusions;
  - b. **SECTION III - LIMITS OF INSURANCE**, Paragraph 6.;
  - c. **SECTION V – DEFINITIONS**, Paragraph 9.a.
2. If damage by fire to premises rented to you is not otherwise excluded from this Coverage Part, the words "Fire insurance" are changed to "insurance for fire, lightning, explosion, smoke, or leakage from automatic fire protective systems" where it appears in:
  - a. **SECTION IV - COMMERCIAL GENERAL LIABILITY CONDITIONS**, Subsection 4. Other Insurance, Paragraph b. Excess Insurance
3. The Damage To Premises Rented To You Limit section of the Declarations is amended to the greater of:
  - a. \$1,000,000; or
  - b. The amount shown in the Declarations as the Damage to Premises Rented to You Limit.

This is the most we will pay for all damage proximately caused by the same event, whether such damage results from fire, lightning, explosion, smoke, or leaks from automatic fire protective systems or any combination thereof.

**B. Extended "Property Damage"**

**SECTION I – COVERAGES, COVERAGE A BODILY INJURY AND PROPERTY DAMAGE LIABILITY**, Subsection 2. Exclusions, Paragraph a. is deleted and replaced by the following:

- a. **Expected or Intended Injury**  
"Bodily Injury" or "Property Damage" expected or intended from the standpoint of the insured. This exclusion does not apply to "bodily injury" or "property damage" resulting from the use of reasonable force to protect persons or property.

**C. Non-Owned Watercraft**

**SECTION I - COVERAGES, COVERAGE A BODILY INJURY AND PROPERTY DAMAGE LIABILITY**, Subsection 2. Exclusions, Paragraph g. (2) is amended to read as follows:

- (2) A watercraft you do not own that is:
  - (a) Less than 58 feet long; and
  - (b) Not being used to carry persons or property for a charge;

This provision applies to any person, who with your consent, either uses or is responsible for the use of a watercraft. This insurance is excess over any other valid and collectible insurance available to the insured whether primary, excess or contingent.

**D. Medical Payments - Limit Increased to \$20,000, Extended Reporting Period**



If **COVERAGE C MEDICAL PAYMENTS** is not otherwise excluded from this Coverage Part:

1. The Medical Expense Limit is changed subject to all of the terms of **SECTION III - LIMITS OF INSURANCE** to the greater of:
  - a. \$20,000; or
  - b. The Medical Expense Limit shown in the Declarations of this Coverage Part.
2. **COVERAGE C MEDICAL PAYMENTS**, Subsection 1. **Insuring Agreement**, the second part of Paragraph a. is amended to read

provided that:

- (2) The expenses are incurred and reported to us within three years of the date of the accident;

**E. Athletic Activities**

**SECTION I – COVERAGES, COVERAGE C MEDICAL PAYMENTS**, Subsection 2. **Exclusions**, Paragraph e. **Athletic Activities** is deleted and replaced with the following:

- e. **Athletic Activities**  
To a person injured while taking part in athletics.

**F. Supplementary Payments**

Under the **SUPPLEMENTARY PAYMENTS - COVERAGE A AND B** provision, Items 1.b. and 1.d. are amended as follows:

1. The limit for the cost of ball bonds is changed from \$250 to \$2,500; and
2. The limit for loss of earnings is changed from \$250 a day to \$500 a day.

**G. Employee Indemnification Defense Coverage**

Under the **SUPPLEMENTARY PAYMENTS - COVERAGES A AND B** provision, the following is added:

3. We will pay, on your behalf, defense costs incurred by an "employee" in a criminal proceeding.

The most we will pay for any "employee" who is alleged to be directly involved in a criminal proceeding is \$25,000 regardless of the numbers of "employees", claims or "suits" brought or persons or organizations making claims or bringing "suits".

**H. SECTION II - WHO IS AN INSURED** is amended as follows:

1. If coverage for newly acquired or formed organizations is not otherwise excluded from this Coverage Part, Paragraph 3.a. is changed to read:
  - a. Coverage under this provision is afforded until the end of the policy period.
2. Each of the following is also an insured:
  - a. **Medical Directors and Administrators** - Your medical directors and administrators, but only while acting within the scope of and during the course of their duties as such. Such duties do not include the furnishing or failure to furnish professional services of any physician or psychiatrist in the treatment of a patient.



- b. **Managers and Supervisors** - If you are an organization other than a partnership or joint venture, your managers and supervisors are also insureds, but only with respect to their duties as your managers and supervisors.
- c. **Broadened Named Insured** - Any organization and subsidiary thereof which you control and actively manage on the effective date of this Coverage Part. However, coverage does not apply to any organization or subsidiary not named in the Declarations as Named Insured, if they are also insured under another similar policy, but for its termination or the exhaustion of its limits of insurance.
- d. **Funding Source** - Any person or organization with respect to their liability arising out of:
  - (1) Their financial control of you; or
  - (2) Premises they own, maintain or control while you lease or occupy these premises.

This insurance does not apply to structural alterations, new construction and demolition operations performed by or for that person or organization.

- e. **Home Care Providers** - At the first Named Insured's option, any person or organization under your direct supervision and control while providing for you private home respite or foster home care for the developmentally disabled.
- f. **Managers, Landlords, or Lessors of Premises** - Any person or organization with respect to their liability arising out of the ownership, maintenance or use of that part of the premises leased or rented to you subject to the following additional exclusions:

This insurance does not apply to:

- (1) Any "occurrence" which takes place after you cease to be a tenant in that premises.
- (2) Structural alterations, new construction or demolition operations performed by or on behalf of that person or organization.

- g. **Lessor of Leased Equipment – Automatic Status When Required In Lease Agreement With You** – Any person or organization from whom you lease equipment when you and such person or organization have agreed in writing in a contract or agreement that such person or organization is to be added as an additional insured on your policy. Such person or organization is an Insured only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" caused, in whole or in part, by your maintenance, operation or use of equipment leased to you by such person or organization.

A person's or organization's status as an additional insured under this endorsement ends when their contract or agreement with you for such leased equipment ends.

With respect to the insurance afforded to these additional insureds, this insurance does not apply to any "occurrence" which takes place after the equipment lease expires.

- h. **Grantors of Permits** – Any state or political subdivision granting you a permit in connection with your premises subject to the following additional provision:
  - (1) This insurance applies only with respect to the following hazards for which the state or political subdivision has issued a permit in connection with the premises you own, rent or control and to which this insurance applies:
    - (a) The existence, maintenance, repair, construction, erection, or removal of advertising signs, awnings, canopies, cellar entrances, coal holes, driveways, manholes, marquees, hoist away openings, sidewalk vaults, street banners or decorations and similar exposures; or



- (b) The construction, erection, or removal of elevators; or
- (c) The ownership, maintenance, or use of any elevators covered by this insurance.

**I. Limited Rental Lease Agreement Contractual Liability**

The following is added to **SECTION I – COVERAGES, COVERAGE A. BODILY INJURY AND PROPERTY DAMAGE LIABILITY**, Subsection 2. Exclusions, Paragraph b. Contractual Liability:

- (3) Based on the named insured's request at the time of claim, we agree to indemnify the named insured for their liability assumed in a contract or agreement regarding the rental or lease of a premises on behalf of their client, up to \$50,000. This coverage extension only applies to rental lease agreements. This coverage is excess over any renter's liability insurance of the client.

**J. Damage to Property You Own, Rent or Occupy**

**SECTION I – COVERAGES, COVERAGE A BODILY INJURY AND PROPERTY DAMAGE LIABILITY**, Subsection 2. Exclusions, Paragraph J. Damage to Property, Item (1) is deleted in its entirety and replaced with the following:

- (1) Property you own, rent, or occupy, including any costs or expenses incurred by you, or any other person, organization or entity, for repair, replacement, enhancement, restoration or maintenance of such property for any reason, including prevention of injury to a person or damage to another's property, unless the damage to property is caused by your client, up to a \$30,000 limit. A client is defined as a person under your direct care and supervision.

**K. Transfer of Rights of Recovery Against Others To Us**

As a clarification, the following is added to **SECTION IV – COMMERCIAL GENERAL LIABILITY CONDITIONS**, Paragraph 8. Transfer of Rights of Recovery Against Others To Us:

Therefore, the insured can waive the insurer's Rights of Recovery prior to the occurrence of a loss, provided the waiver is made in a written contract.

**L. Duties In the Event of Occurrence, Claim or Suit**

1. The requirement in Paragraph 2.a. of **SECTION IV - COMMERCIAL GENERAL LIABILITY CONDITIONS** that you must see to it that we are notified as soon as practicable of an "occurrence" or an offense, applies only when the "occurrence" or offense is known to:
  - a. You, if you are an individual;
  - b. A partner, if you are a partnership; or
  - c. An executive officer or insurance manager, if you are a corporation.
2. The requirement in Paragraph 2.b. of **SECTION IV – COMMERCIAL GENERAL LIABILITY CONDITIONS** that you must see to it that we receive notice of a claim or "suit" as soon as practicable will not be considered breached unless the breach occurs after such claim or "suit" is known to:
  - a. You, if you are an individual;
  - b. A partner, if you are a partnership; or
  - c. An executive officer or insurance manager, if you are a corporation.



**M. Unintentional Failure To Disclose Hazards**

It is agreed that, based on our reliance on your representations as to existing hazards, if you should unintentionally fail to disclose all such hazards prior to the beginning of the policy period of this Coverage Part, we shall not deny coverage under this Coverage Part because of such failure.

**N. Liberalization**

If we revise this endorsement to provide more coverage without additional premium charge, we will automatically provide the additional coverage to all endorsement holders as of the day the revision is effective in your state.

**O. Bodily Injury - Mental Anguish**

SECTION V – DEFINITIONS, Paragraph 3. is changed to read:

“Bodily Injury”:

- a. Means bodily injury, sickness or disease sustained by a person, and includes mental anguish resulting from any of these; and
- b. Except for mental anguish, includes death resulting from the foregoing (Item a. above) at any time.

**P. Personal and Advertising Injury – Abuse of Process, Discrimination**

If COVERAGE B PERSONAL AND ADVERTISING INJURY LIABILITY COVERAGE is not otherwise excluded from this Coverage Part, the definition of “personal and advertising injury” is amended as follows:

1. SECTION V – DEFINITIONS, Paragraph 14.b. is revised to read:

- b. Malicious prosecution or abuse of process;

2. SECTION V – DEFINITIONS, Paragraph 14. is amended to include the following:

“Personal and advertising injury” also means discrimination based on race, color, religion, sex, age or national origin, except when:

- (1) Done intentionally by or at the direction of, or with the knowledge or consent of:
  - (a) Any insured; or
  - (b) Any executive officer, director, stockholder, partner or member of the insured; or
- (2) Directly or indirectly related to the employment, former or prospective employment, termination of employment, or application for employment of any person or persons by an insured; or
- (3) Directly or indirectly related to the sale, rental, lease or sublease or prospective sales, rental, lease or sub-lease of any room, dwelling or premises by or at the direction of any insured; or
- (4) Insurance for such discrimination is prohibited by or held in violation of law, public policy, legislation, court decision or administrative ruling.

The above does not apply to fines or penalties imposed because of discrimination.

The following additional coverage is added to A. COVERAGE 4. ADDITIONAL COVERAGES:



**Q. Key and Lock Replacement – Janitorial Services Client Coverage**

1. We will pay for the cost to replace keys and locks at the "clients" premises due to theft or other loss to keys entrusted to you by your "client", up to a \$5,000 limit per occurrence/\$5,000 policy aggregate.
2. We will not pay for loss or damage resulting from theft or any other dishonest or criminal act that you or any of your partners, members, officers, "employees", "managers", directors, trustees, authorized representatives or any one to whom you entrust the keys of a "client" for any purpose commit, whether acting alone or in collusion with other persons.
3. The following, when used on this coverage, are defined as follows:
  - a. "Client" means an individual, company or organization with whom you have a written contract or work order for your services for a described premises and have billed for your services.
  - b. "Employee"
    1. Any natural person:
      - a. While in your service or for 30 days after termination of service;
      - b. Who you compensate directly by salary, wages or commissions; and
      - c. Who you have the right to direct and control while performing services for you; or
    2. Any natural person who is furnished temporarily to you:
      - a. To substitute for a permanent "employee" as defined in Paragraph 1. above, who is on leave; or
      - b. To meet seasonal or short-term workload conditions;while that person is subject to your direction and control and performing services for you.
  3. "Employee" does not mean:
    - a. Any agent, broker, person leased to you by a labor leasing firm, factor, commission merchant, consignee, independent contractor or representative of the same general character; or
    - b. Any "manager", director or trustee except while performing acts coming within the scope of the usual duties of an "employee".
  - c. "Manager" means a person serving in a directorial capacity for a limited liability company.





**Shangri-La**  
Enriching Lives Together

# Employee Handbook



**Shangri-La**  
**EMPLOYEE HANDBOOK**  
**TABLE OF CONTENTS**

SECTION	INDEX	PG #
<b>1.0</b>	<b>INTRODUCTION</b>	
1.1	Equal Employment Opportunity	1
1.2	Appropriate Support for People Served	1
1.3	Rights of People Served by Shangri-La	1
1.4	Personnel Policy Handbook; Not a Contract	2
<b>2.0</b>	<b>DEFINITIONS</b>	
2.1	Immediate Family Members and Relatives	3
2.2	Employment of Immediate Family Members and Relatives	3
2.3	Employee Classification	3
2.4	Employee Status	3
2.5	Trial Service Period	4
2.6	In Good Standing	4
2.7	Conflict of Interest	5
<b>3.0</b>	<b>REQUIREMENTS, EXPECTATIONS AND GENERAL INFORMATION</b>	
3.1	Employee Responsibilities	6
3.2	Outside Employment	6
3.3	Public Relations	6
3.4	Personal Property	6
3.5	Dress Code, Appearance & Conduct	7
3.6	Personal Matters	7
3.7	Personal Telephone Use	7
3.8	Personnel Record	7
3.9	Change of Personal Information	7
3.10	Confidential Information	8
3.11	Record Keeping	8
3.12	Tardiness and Absenteeism	8
3.13	Harassment and Discrimination	8
3.14	Reporting a Complaint of Harassment or Discrimination	9
3.15	Electronic and Telephonic Communication	9
3.16	Solicitation, Distribution and Posting	11
3.17	Human Interaction Principles (Vision/Mission/Values/Culture)	12
3.18	Issue Resolution Process	14
3.19	Reporting Dishonest, Unethical or Illegal Activity	15
<b>4.0</b>	<b>SAFETY</b>	
4.1	Safety Committee	16
4.2	Workplace Violence	16
4.3	Criminal Background Checks	19
4.4	Use of Alcohol or Illegal Drugs	19
4.5	In Case of Snow or Other Adverse Weather Conditions	21
4.6	Children or Visitors in the Work Place	21
4.7	Personal Outings Away from Home Environment	22
4.8	Photographic and Non-Photographic Identification	22
4.9	Use of Shangri-La or Privately Owned Vehicles	24
4.10	Use of Mobile Communication Device While Driving	25
4.11	Tobacco Products	25
4.12	Health Requirements	26

TABLE OF CONTENTS

Page 2 of 3

<b>SECTION</b>	<b>INDEX</b>	<b>PG #</b>
<b>5.0</b>	<b>WAGE AND SALARY INFORMATION</b>	
5.1	Compensation	27
5.2	Time Sheets	31
5.3	Paychecks	31
5.4	Payroll Deductions	31
5.5	Advances	31
5.6	Garnishments	32
5.7	Correction of Status, Pay or Benefits	32
5.8	Mileage Reimbursement	32
<b>6.0</b>	<b>REGULAR WORK PERIODS</b>	
6.1	Workday	33
6.2	Workweek	33
6.3	Regular Employees Working as Relief Staff	33
6.4	Overtime	33
6.5	Breaks and Meals	34
6.6	Rest Breaks for Breast Feeding or to Express Milk	34
<b>7.0</b>	<b>EMPLOYEE BENEFITS</b>	
7.1	Holidays	35
7.2	Paid Leave	35
7.3	Planned Absences	36
7.4	Unplanned Absences	36
7.5	Unpaid Leaves of Absence	37
7.6	Family and Medical Leave and Oregon Family Leave Table Family & Medical Leave – Table Oregon Family Leave	37
7.8	Jury Duty Leave	40
7.9	Military Leave	40
7.10	Domestic Violence Leave	41
7.11	Pay in Lieu of Paid Leave	41
7.12	Paid Leave Donations	41
7.13	Health Insurance	42
7.14	Tax Sheltered Annuities	42
7.15	Flexible Spending Account	42
7.16	Worker's Compensation	42
7.17	Credit Union & Direct Deposit	43
<b>8.0</b>	<b>EMPLOYEE DEVELOPMENT</b>	
8.1	Position Descriptions	44
8.2	Training and Orientation	44
8.3	Individual Education Opportunities	45
8.4	Travel Expenses for Professional Conferences/Workshops	45
8.5	Transfer to Another Department or Work Unit	46

<b>SECTION</b>	<b>INDEX</b>	<b>PG#</b>
<b>9.0</b>	<b>Discipline</b>	
	9.1 First Level Offense	47
	9.2 Second Level Offense	48
	9.3 Third Level Offense	48
<b>10.0</b>	<b>SEPARATION FROM EMPLOYMENT</b>	50
	10.1 Resignation and Termination	50
	10.2 Exit Interview	50
	10.3 Employment References	50
	10.4 Rehiring Former Employees	50
<b>11.0</b>	<b>IN CONCLUSION</b>	50
Attachment	Department of Labor Family & Medical Leave Summary	
Attachment	Bureau of Labor & Industries Oregon Family Leave Act Summary	
<b>12.0</b>	<b>RECEIPT ACKNOWLEDGEMENT</b>	51





# SHANGRI-LA EMPLOYEE HANDBOOK

## 1.0 INTRODUCTION

The policies contained in this handbook are intended to help management operate consistently with all Federal and State laws that govern employment practices in Oregon. This handbook supersedes all previous versions.

### 1.1 Equal Opportunity Employment Revised 6/06; 4/08; 4/11; 7/13

Shangri-La is an Equal Opportunity Employer. Shangri-La believes every employee has the right to work in an environment free from all forms of unlawful discrimination. It is Shangri-La's policy that employment decisions for all applicants and employees will be made without regard to race, color, religion, sex, age, national origin, marital status, sexual orientation, gender identity, disability, veteran status, genetic information or other characteristic protected under state or federal law. This policy applies to all terms, conditions and privileges of employment, including but not limited to hiring, training, placement, employee development, promotion, transfer, compensation, benefits, educational assistance, layoff and recall, social and recreational program, employee facilities, termination and retirement.

### 1.2 Appropriate Support for Individuals served Revised 6/06; 4/08; 7/13

The Individuals served by Shangri-La shall be supported in conformity with pertinent Federal and State statutes and without regard for their race, color, religion, sex, age, national origin, marital status, sexual orientation, gender identity, disability, veteran status, genetic information or other characteristic protected under state or federal law while preserving and ensuring an individual's human rights, dignity, and safety at all times.

Employees and volunteers are never permitted to accept or purchase goods or services from, give or sell goods or services to, or trade and barter goods or services with individuals receiving services from Shangri-La including items that employees or individuals served intend to discard. Employees and volunteers are never permitted to borrow goods, services or money from individuals served nor loan goods, services or money to individuals served. Any exception to this policy must be approved by a Director.

### 1.3 Rights of Individuals Served by Shangri-La Revised 3/03; 6/06; 7/13; 8/14

Shangri-La's envisions a community that accepts all people for their abilities and celebrates their achievements. Shangri-La's mission is to serve people with disabilities and disadvantages so they may recognize and achieve their potential. This mission is to be accomplished in a manner that is respectful of an individual's human dignity and rights.

The value of each employee and stakeholder is directly related to the dignity and respect afforded co-workers, other stakeholders and the persons we serve. In evaluating employee performance, reinforcement of these human rights will be acknowledged.

At the same time, violation of any individual's human rights is grounds for disciplinary action including termination of employment. Such violations may include, but are not limited to, the following examples of misconduct:

### **1.3 Rights of Individuals Served by Shangri-La (Continued)**

1. Any incident of physical, sexual, verbal or emotional abuse or harassment including but not limited to: (a) the use of physical restraint in other than a bona fide emergency or as a previously approved intervention; (b) violating an individual's right to privacy (c) subjecting an individual to ridicule, profanity or intimidation.
2. Financial exploitation including but not limited to theft, inappropriate borrowing or lending or commingling of funds.
3. Use of any other individual's personal property. Removal of an individual's personal property is permitted only when the property is deemed unsafe or when prior authorization has been approved by supervisory personnel.
4. Use of any Shangri-La property for personal benefit that includes, but is not limited to equipment, office supplies, telephones and vehicles
5. Falsification of records or failure to report any incident or safety issue.
6. Breach of confidentiality specific to the condition, treatment and personal status of those we serve.
7. Providing or permitting the use of alcohol without prior Management approval or providing or permitting the use of any non-prescribed, controlled substance on corporate property.
8. Endangering the health or safety of the people we serve or other persons employed by or otherwise affiliated with Shangri-La including neglect of care or supervision of individuals served.

### **1.4 Personnel Policy Handbook; Not a Contract Revised 12/13**

This handbook contains a description of most Shangri-La personnel policies. Shangri-La has a tradition of consistently following its policies and intends to continue to do so. However, this handbook is not a contract between an employee and Shangri-La and it is not a promise or agreement of employment. Shangri-La can change the policies and procedures in this handbook at any time and employees will be bound by those changes from the announced effective date. Continued employment after any such changes does not constitute a binding contract of employment. Shangri-La will give notice of any changes in personnel policies.

Each employee receives the employee handbook upon hire and is required to review the employee handbook prior to reporting to work. Employees sign a statement acknowledging receipt of this handbook.

Shangri-La can terminate employment at any time and employees can resign at any time. No supervisor, manager or representative of Shangri-La, other than the Chief Executive Officer, has the authority to enter into any agreement on behalf of the organization with a person for employment, for any period of time or to make any promises, commitments or representations contrary to this handbook. Further, any such employment agreement or change to the provisions of this handbook, entered into on behalf of Shangri-La by the Chief Executive Officer shall not be enforceable unless the agreement is in writing.

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## **2.0 DEFINITIONS**

### **2.1 Immediate Family Members and Relatives** Revised 12/13

For the purposes of Shangri-La policy immediate family and relatives includes, but is not limited to, an employee's spouse, domestic partner or a person with whom the employee shares a household, and each of these individuals' children, stepchildren, mothers, fathers, stepmothers, stepfathers, brothers, sisters, stepbrothers, stepsisters, grandparents and grandchildren.

### **2.2 Employment of Immediate Family Members and Relatives** Revised 12/13

Immediate family members and relatives of employees are welcome to work at Shangri-La, provided that they are the most qualified applicants available for the particular job opening. Immediate family members and relatives will not be employed under the supervision of a family member or relative and family members and relatives not in supervisory positions will not usually be permitted to work together.

### **2.3 Employee Classification** Revised 12/13

Employees of Shangri-La will be classified as either an "exempt" or "non-exempt" employee.

A non-exempt employee is one who is normally assigned a regular work shift of not more than forty (40) hours per week and whose job calls for overtime payment at a rate of 1 ½ times the regular rate of pay for all hours worked in excess of forty (40) in a work week, as appropriate under state and federal statute.

An exempt employee is one whose duties are primarily executive, administrative or professional and is assigned responsibilities which cannot be restricted to a specific number of hours in a workday or work week. An exempt employee is paid a fixed salary and is exempt from overtime payment.

Employees are informed of their classification as exempt or non-exempt upon hire. If any employee's job changes because of a promotion, transfer or other reason the employee will be informed of any change in exemption classification.

When a salaried employee is initially hired or a current employee changes classification from hourly to salaried, the employee would receive pay through the actual pay date sometimes before verification of days worked. In the event that employment is terminated, the final paycheck may be adjusted to reflect any unpaid time or time already paid. If the amount of the advance in pay exceeds the amount of the final paycheck, accrued paid leave owed to the employee at the time of termination, will be used to repay the balance due, when available.

### **2.4 Employee Status** Revised 6/06; 12/13

Regular Full-time Employee: An employee that is customarily scheduled to work thirty to forty (30 to 40) hours per week on a continuous basis is considered a regular full-time employee. Regular full-time employees are eligible for job benefits as described in other sections of this handbook.

Regular Part-time Employee: An employee that is customarily scheduled to work less than thirty to forty (30 to 40) hours per week on a continuous basis is considered a regular part-time employee. Regular part-time employees are eligible for job benefits as described in other sections of this handbook on a prorated basis, based on the number of regularly scheduled hours worked.

Temporary Employee: Employees working for a limited period of time are classified as temporary employees. Employees may be temporary for up to one-hundred eighty (180) days. Temporary employees may be required to complete specific training and orientation related to their position. Temporary employees are not eligible for any job benefits.

## **2.4 Employee Status (Continued)**

**Relief or On-Call Employee:** Employees with no specified work schedule and no specific number of work hours are considered to be relief or on-call employees. Relief and on-call employees are also required to complete the trial period, orientations and training. Relief and on-call employees are not eligible for any job benefits.

On occasion there may be employment situations within Shangri-La which do not meet the criteria for the type of employee status listed. Anyone offered employment in a status which does not meet the criteria for the types of employee status listed previously will be provided with an explanation of that status prior to beginning employment in that status.

## **2.5 Trial Service Period Revised 6/06; 7/13**

In general newly hired, promoted or rehired employees are on a trial service period when first employed. The trial service period provides the employee the opportunity to be oriented and trained to the position and adjust to work with Shangri-La and provides supervisors the opportunity to determine the employees' suitability for continued employment. Trial service periods are not a guarantee of employment and may be adjusted according to job performance or experience.

- A newly hired or rehired employee on a trial service period is eligible for some job benefits after 30 days. Eligibility for health insurance benefits will vary depending on each employee's particular status and date hired or rehired. Rehired employees returning to work within a one (1) year period may be eligible for benefits not available to a newly hired employee. See section 7.0 in this handbook for additional benefits information.
- An employee on a trial service period as a result of a transfer, promotion or disciplinary action may be eligible to continue or retain job benefits even though on a trial service period.
- All employees are required to work at least two-hundred (200) hours of paid work time prior to the completion of the trial service period. In the event the minimum two-hundred (200) hours has not been worked, the trial service period may be extended in order for the two-hundred (200) hour minimum to be completed.

## **2.6 In Good Standing Revised 6/06**

An employee is considered "In Good Standing" when he/she has:

- Successfully completed and maintained certifications in all mandatory orientation and training, within the time frames established by Shangri-La.
- Attended, or was authorized to be absent from, all required meetings.
- Not subject to disciplinary actions, work plans or other personnel actions that indicate less than satisfactory job performance or work behavior or failure to adhere to Shangri-La policy and procedure during the past six (6) months.

## **2.7 Conflict of Interest** – Revised 6/06; 12/13

Conflict of interest may arise in any situation in which an employee's private interests conflict or raise a reasonable question of potential conflict, with the business of Shangri-La. Conflict of interest may arise in any of the following situations, as well as others not listed. If an employee has any question as to the appropriateness of activities in this regard, the Department Director should be consulted. The Department Director will advise the Chief Executive Officer of potential concerns.

Shangri-La reserves the right to terminate any employee who engages in any act or shall have any interest, direct or indirect, in any business transactions or incurring obligations which is in substantial conflict with the proper discharge of his or her duties. The following areas should be of particular note:

- Business transactions which have any direct or indirect relationship to the employee the employee's family members and are of financial benefit to those parties.
- Accepting gifts, gratuities and favors from other organizations or persons which might reasonably be construed to carry the intent to gain favor with Shangri-La.
- Contributions and gifts to supervisors with the intent to gain favor.
- Use of confidential information for any purpose that is not work related.
- Use of Shangri-La facilities and/or equipment for non-Shangri-La purposes, without a Director's approval and proper compensation when warranted.
- Outside employment.
- Conducting personal enterprises under the guise of conducting Shangri-La business.

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### **3.0 REQUIREMENTS, EXPECTATIONS AND GENERAL INFORMATION**

#### **3.1 Employee Responsibilities**

Employees are expected to support the Vision, Mission and Values of Shangri-La and to conduct themselves in an ethical manner. Employees are also expected to perform their assigned duties in an efficient, satisfactory and acceptable manner which will be determined through periodic job performance evaluations completed by supervisors.

Professional employees and consultants are encouraged to belong to and participate in professional organizations and to be knowledgeable of current information in their profession. Professional employees and consultants are also expected to adhere to the code of ethics officially adopted by their professional organizations.

#### **3.2 Outside Employment Revised 12/13**

Employment outside of and in addition to positions held and jobs performed for Shangri-La, shall not constitute a conflict of interest, interfere with or distract from job performance or the commitments, duties and responsibilities inherent in the individual's employment with Shangri-La.

#### **3.3 Public Relations**

Employees of Shangri-La are encouraged to take special care in dealings with people, whether it is a friendly greeting as you pass an employee in the hall, giving directions to a confused visitor or assisting Individuals served in accessing the community. These simple gestures help make Shangri-La a place where the Individuals served, their families, co-workers, our community and all stakeholders know they are valued and respected.

#### **3.4 Personal Property Revised 6/06**

Employees are responsible for their personal property at all times. Shangri-La is not responsible for personal items lost, stolen or damaged except as required to perform the duties of one's job.

Shangri-La provides policies, procedures and guidelines which may offer opportunities to employees as a result of actions taken by an individual served, to request reimbursement for the cost of repairing or replacing personal property if damaged during the performance of duties, even though reasonable precautions have been taken and policies and procedures have been adhered to. This policy shall not be construed as an assumption of liability by Shangri-La for incidental or consequential damages resulting to an employee or the employee's property from the loss or damage of personal property.

Shangri-La's service and business locations and administrative offices serve many purposes and may have a variety of individuals on premises at different times including employees not normally working at the location, Individuals served, trainees, personnel from other organizations and government agencies, job seekers, vendors and contractors. Consequently, your personal valuables should not be left unattended or unsecured.

Due to the diversity of work settings throughout Shangri-La there is not a standard means to secure personal valuables while working. After you begin work, if a means of securing your personal valuables is not readily apparent, please discuss the matter with your immediate supervisor as soon as possible to avoid any loss of or damage to your personal property.

### **3.5 Dress Code, Appearance and Conduct**

Employees are required to be clean, neat, groomed and dressed for the duties they are to perform. Employees serve as models for the Individuals served by Shangri-La. Halter tops, short shorts, see-through and tight-fitting clothing and clothing in poor repair are not permitted. Dress codes, appearance and conduct requirements may vary according to specific job assignments and may be altered at any time by Shangri-La for reasons which include, but are not limited to, changes in program requirements, business necessity or safety concerns. Profanity and rude behavior are not permitted at any time. Employees failing to adhere to Shangri-La's standards with respect to dress codes, appearance and conduct may be subject to disciplinary actions including termination of employment.

### **3.6 Personal Matters** Revised 12/13

It is very important that personal problems or personal business matters do not negatively affect job performance. If a personal matter interferes with an employee's ability to perform the duties of their assigned position, the employee is advised to meet with their immediate supervisor to determine what alternatives exist, if any, to address and mitigate the issue such as requesting a leave of absence, or seeking out counseling or other supports.

### **3.7 Personal Telephone Use** Revised 6/06; 12/13

Personal use of work telephones is a courtesy permitted by Shangri-La to employees and shall not interfere with job performance unless in an emergency. Any costs associated with the use of Shangri-La telephones by an employee must be reimbursed by the employee.

On occasion employees may need to use a Shangri-La telephone for personal business while working. Although Shangri-La telephones are for business use, Shangri-La does permit limited use of telephones for personal purposes provided that the benefit is not misused. It is Shangri-La's expectation that employees arrange their personal lives in a manner that does not require the need to use Shangri-La business telephones for personal purposes while at work.

The same principles that apply to using Shangri-La land based telephones also apply to the use of Shangri-La issued or privately obtained cellular telephones or other electronic devices used for communication. Use of cellular telephones and other electronic devices for personal purposes while at work is a courtesy permitted by Shangri-La and shall not interfere with job performance unless in an emergency. The expectation is that personal use is limited to what is absolutely urgent and necessary; otherwise it is unacceptable and considered an inappropriate use of paid work time.

If questions arise regarding the appropriate use of Shangri-La or personal telephones or other electronic communication devices while working, it is the employee's responsibility to discuss those questions with their supervisor prior to taking actions that would be in conflict with this policy and result in disciplinary actions.

### **3.8 Personnel Record** Revised 6/06

Each employee's official personnel file is maintained in the Business Office. Employees may have access to their files by request to the Director of Human Resources. Operating portions of the file may be maintained in other locations; however, the originals must be in the employee's official personnel file.

### **3.9 Change of Personal Information**

Employees are expected provide and maintain accurate information in their employment record such as current address, telephone number, name and marital status. Records can be updated through the employee's individual Ultipro account or by contacting human resources personnel for assistance. Contact Business Office personnel to complete a W-4 Form.

### **3.10 Confidential Information** Revised 12/13

All information concerning Individuals served, their families, business records, fellow employees, volunteers and other stakeholders is confidential. This is a basic rule of Shangri-La ethics. Individuals served, their families, employees, volunteers and other stakeholders rely on one another to respect the laws, rules, regulations, policies and practices concerning confidentiality. The growth of technology along with the proliferation of devices for accessing and sharing information makes it even more important to understand that required ethical, legal and policy standards regarding confidentiality and privacy for all stakeholders remains unchanged. Requests for confidential information must be referred to a Director.

### **3.11 Record Keeping**

Record keeping systems in each department are very important. Requirements for maintaining these records will be provided during orientation and training and may also be found in Shangri-La policy and procedure handbooks for each program or department and in position descriptions. Continuity of the records for Individuals served is necessary to insure proper placement, treatment, training and follow-up. Similar records for employees are an important part of the employment history and must also reflect training, performance and significant events during employment. Both the employee and management are responsible for these records.

### **3.12 Tardiness and Absenteeism**

Since the efficient operation of each work unit depends on the employee being on the job and ready to start work at the beginning of assigned shifts, tardiness and/or absenteeism cannot be accepted. A person who must be absent from work is responsible for obtaining approval from his/her supervisor. Should an unexpected emergency arise, supervisors must be notified per the requirements of the position description, leave policies and work unit practices. Employees whose absences from work are unreported for one day may be regarded as having voluntarily resigned. Employees reporting to work tardy may be disciplined. Leave in excess of accumulated benefits are grounds for disciplinary action including termination of employment.

### **3.13 Harassment and Discrimination** Revised 6/06; 4/08; 7/13

**Shangri-La strictly prohibits any form of harassment, sexual or otherwise.**

Sexual Harassment includes, but is not limited to unwelcome sexual advances, requests for sexual favors and all other communication or conduct of a sexual or otherwise offensive nature when:

- Submission to such communication or conduct is made either explicitly or implicitly a term or condition of employment;
- Submission to or rejection of such conduct is used as a basis for decisions affecting an individual's employment;
- Or such communication or conduct has the purpose of affecting or creating an intimidating, hostile or offensive working environment.

Examples of communication or conduct that would violate this policy include but are not limited to, sexually suggestive or explicit comments, jokes or innuendos; sexually orientated posters, cartoons, pictures or drawings, sexually demeaning gestures and expressions, or unwanted touching.

### **3.13 Harassment and Discrimination (Continued)**

#### **Shangri-La strictly prohibits any form of discrimination.**

Discrimination includes but is not limited to communication or conduct that treats anyone unfairly or unlawfully because of his or her race, color, religion, sex, age, national origin, marital status, sexual orientation, gender identity, disability, genetic information or qualified protected veteran status.

Examples of communication or conduct that would violate this policy include but are not limited to, employment decisions based on stereotypes about race, color, age, gender, religion, national origin, marital status, sexual orientation, gender identity, disability or veterans status; disqualifying someone from consideration for employment solely because of pregnancy or disability; the use of ethnic slurs or racial jokes; retaliating against a person who files a complaint of discrimination, participates in an investigation or opposes discriminatory practices.

### **3.14 Reporting a Complaint of Harassment or Discrimination Revised 7/13**

Each member of management is responsible for creating an atmosphere free of discrimination and harassment, sexual or otherwise. Further, employees are responsible for respecting the rights of Individuals served, co-workers, volunteers, and other stakeholders.

Any complaint of harassment or discrimination should be reported to the employee's supervisor or any Shangri-La Director immediately. In the event the supervisor is the offending employee, report the complaint to any Shangri-La Director.

If management determines that an employee has violated the policy appropriate disciplinary action will be initiated.

Shangri-La prohibits any form of retaliation against any employee for filing a complaint in good faith under this policy or for assisting in a complaint investigation.

### **3.15 Electronic and Telephonic Communications Revised 7/13; 8/14**

Shangri-La has established a policy with regard to access and disclosure of all electronic and telephonic communications created, sent, received or stored by Shangri-La employees/volunteers using Shangri-La property and systems. Electronic and telephonic communication systems include electronic-mail (e-mail), voice-mail, computer files, work related files on Shangri-La owned and/or non-Shangri-La owned computers, cellular telephones, tablets, cloud computing or other web based applications or elsewhere, facsimile devices and all other devices and methods for storing, retrieving or transferring electronic, photographic, graphic or audio information. For purposes of simplicity, this policy shall refer to all such systems as "ETC systems" and all messages, documents, voice mail, programs, graphics, recordings, files and information contained on such systems as "electronic information." Any reference in this policy to **authorized personnel** refers to employees of Shangri-La's Information Technology (IT) Department. Shangri-La reserves the right to modify this policy at any time and employees/volunteers will be bound by those changes from the announced effective date.

Shangri-La ETC systems are corporation property and are intended for corporation business only. All information composed, sent, received or stored on Shangri-La ETC systems are and remain the property of Shangri-La. Any information placed on a Shangri-La ETC system shall become the property of Shangri-La. Shangri-La ETC systems shall not be used to distribute, solicit or advertise unauthorized commercial ventures, religious or political causes, outside organizations or other non-related solicitations. For additional information about solicitation, distribution and posting of information using Shangri-La's ETC and other systems, see policy 3.16 in the employee handbook.

### 3.15 Electronic and Telephonic Communications (Continued)

All Shangri-La policies including Sexual Harassment, Discrimination and Equal Opportunity Employment policies apply to all ETC systems. Employees/volunteers shall not use ETC systems in any manner that violates any Shangri-La policy. Examples of ETC systems use that would violate Shangri-La policy include, but are not limited to, creating, sending, receiving or storing any discriminatory, intimidating, hostile, offensive or disruptive information or messages, documents or graphics which contain sexual implications, racial slurs, gender-specific slurs or any other comments that offensively addresses a person's age, race, color, sex, sexual orientation, religious creed, marital status, national origin, sexual orientation, gender identity, disability, veteran status, genetic information, political beliefs or other protected characteristics. Any employee/volunteer, who uses Shangri-La's ETC systems in any manner that violates Shangri-La policy, may be subject to disciplinary actions including termination of employment.

Only Shangri-La Directors' or any employee to whom the Director has personally delegated authority to is authorized to use Shangri-La's ETC systems to send (upload) or receive (download) copyrighted materials, trade secrets, proprietary financial information or similar information, whether owned by Shangri-La, its stakeholders or others. Only **authorized personnel** shall be permitted to install or uninstall any software on Shangri-La ETC systems. For example, this includes, but is not limited to, requiring authorized personnel to install or uninstall any screen savers and other programs on Shangri-La owned computers. For additional information about software or hardware, please refer to the "Software or Hardware Utilization Procedure" in the Policies and Procedures section in SharePoint. Shangri-La reserves and shall exercise its right to permit **authorized personnel** to review, audit, intercept, access and disclose any and all information created, received, sent or stored within any Shangri-La ETC system. Shangri-La may exercise these rights without notice to or the permission of employees/volunteers.

The confidentiality of any information on a Shangri-La ETC system shall not be assumed. Even when information is erased or deleted, it may still be possible to retrieve and read that information. Further, the use of passwords does not guarantee confidentiality. All passwords must be approved by and shall be disclosed to authorized Shangri-La personnel. Shangri-La reserves the right to override and/or change any password. Except for the authorized use of passwords, no employee/volunteer shall encrypt any electronic information without prior approval by Shangri-La.

Shangri-La reserves the right to retrieve and read any information on any ETC system. No other employee or volunteer is authorized to retrieve, disclose, store, read, alter, transfer or print any information to, from or using any Shangri-La ETC systems unless the employee/volunteer is the intended recipient of such information, the supervisor of the intended recipient or is considered an authorized Shangri-La employee as defined by this policy, All ETC systems information shall be treated as confidential information.

No employee/volunteer shall sabotage, by deletion, modification, introduction of a virus or other method, any electronic information on any Shangri-La ETC system. Such conduct may result in the immediate termination of employment.

In addition, Shangri-La may pursue criminal remedies against such an employee/volunteer and take legal action sufficient to compensate Shangri-La for any loss of business or other damages caused by the employee or volunteer.

### **3.15 Electronic and Telephonic Communications (Continued)**

Employees/volunteers are not permitted to use Shangri-La computers for personal use. Employees/volunteers may use Shangri-La Wi-Fi on their personal phones and devices where it is available. Please be aware this may cause computers at some locations to slow down, and the connected Wi-Fi device may need to be turned off or disconnected from the Wi-Fi source at those times.

Any employee/volunteer who discovers a violation of this policy is required to immediately notify his/her direct supervisor, any Director, IT or human resources personnel. Any employee/volunteer who violates this policy or uses Shangri-La ETC systems for improper purposes may be subject to discipline including termination of employment.

Any exception to this policy requires the prior approval of authorized Shangri-La personnel.

### **3.16 Solicitation, Distribution and Posting Revised 6/06; 12/13**

Shangri-La prohibits the solicitation, distribution and posting of materials at Shangri-La owned or operated locations or using Shangri-La electronic or telephonic communications equipment except those materials that are part of Shangri-La sponsored or approved business activities. Solicitation, distribution and posting of materials not obviously connected to Shangri-La sponsored or approved business activity must be approved by a Director who will consider if the request and material is compatible with Shangri-La's Vision, Mission, Values and Strategic Direction.

Employees may not permit non-employees or former employees' access to work areas and work locations except in connection with Shangri-La sponsored or approved business activity or as provided by other policies contained in this handbook including the visitors and photographic and non-photographic identification policy.

Employees may not solicit other employees during work times, except in connection with Shangri-La sponsored or approved business activities.

Except as permitted by law, employees may not distribute literature or other materials of any kind during work times or in any work area at any time except in connection with Shangri-La sponsored or approved business activities.

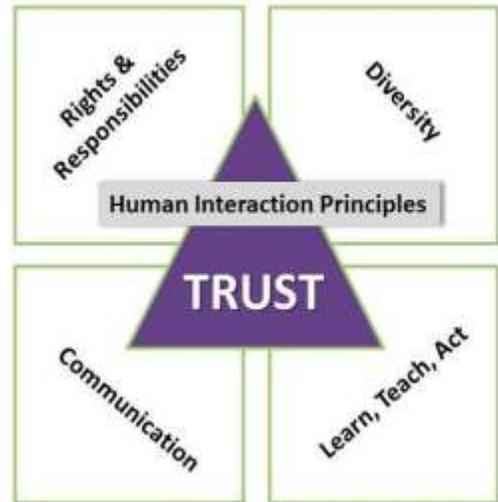
Employees may not post materials or electronic messages or announcements, except in connection with Shangri-La sponsored or approved business activities.

If questions arise regarding solicitation or the distribution and posting of materials, please discuss the matter with a Shangri-La Director.

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**3.17 Human Interaction Principles (HIP)** Revised 12/13; 8/14

Shangri-La **envisions** a community that accepts all people for their abilities and celebrates their achievements. Our **mission** is to serve people with disabilities and disadvantages so they may recognize and achieve their potential. Shangri-La **values** emerge from the five inter-related Human Interaction Principles; a belief that all interaction must occur within a culture of dignity, honesty, and integrity. We expect all interactions will be respectful, mutually beneficial, and motivated by the desire to understand one another. Shangri-La’s Human Interaction Principles (HIP) and Values are:



- *Trust*
- *Diversity*
- *Rights and Responsibilities*
- *Learn, Teach, and Act*
- *Communication*

**Trust Principle (Value: Trust)**

- Demonstrate trustworthiness.
- Take a risk to trust others and expect trust in return.
- Actively build and enhance trust in all relationships.

**Commitment**  
Dedicated, loyal,  
faithful, caring

**Capability**  
Skilled, qualified,  
able, competent



**Consistency**  
Reliable, dependable  
stable, predictable

**Diversity Principle (Value: Personal Focus)**

- Value the uniqueness of all people and recognize everyone views the world differently.
- Seek to understand others point of view, preferences and needs.
- Agree to work with all people.

**Rights and Responsibilities Principle (Value: Choice)**

- Manage myself professionally during all interactions and take personal responsibility for the choices I make.
- Encourage and support others to exercise their rights and to take responsibility for choices they make.
- Expand the Universe of Choice for myself and others.

**Learn, Teach and Act Principle (Value: Continual Growth)**

- Seek opportunities for learning and teaching others.
- Be responsible for my own learning.
- Be actively involved in setting and achieving goals.
- Give and be receptive to feedback.

**Communication Principle (Value: Effective Communication)**

- Communicate respectfully with all people.
- Listen with awareness, openness, and empathy.
- Be honest and direct when I have needs, issues or concerns.
- Participate in resolving issues affecting me.

The Shangri-La community is unified by an organizational **culture** based on “Trust Plus”. The 20 actions and attitudes of “Trust Plus” describe how the services and supports offered are delivered to every customer, in every community where Shangri-La does business.



### **3.18 Issue Resolution Process** Revised 6/06; 7/13

Shangri-La is committed to open and direct communication. Employees are encouraged to interact with each other openly and directly. The aim of the issue resolution process is to encourage employees to resolve conflicts and disagreements, openly, directly and on their own.

- No solution can conflict with present Shangri-La policy, practice or procedure. If the resolution requires changes in policy, practice or procedure, the participants must forward their recommendation for any changes to the appropriate Director for approval. Recommendations will be responded to in writing.
- It is preferred that participants in the issue resolution process mutually agree to a resolution. However, in the event that no resolution can be reached between participants, and particularly if the disagreement interferes with operations, the decision of the Chief Executive Officer is final and may require that some or all parties involved accept certain agreements.

#### **Informal Issue Resolution Process**

- If an employee has a disagreement with any other employee including Management personnel, they should attempt to resolve the matter directly with that person.
- Employees may request assistance from any other employee to help them determine a method for communicating their issues. The assisting employee's role is to help their coworker understand how to communicate the issue, not to communicate for them. The assisting employee is to treat all information confidentially and must not discuss these issues with any other employee.
- Supervisors and Directors are available to provide assistance in these matters and may act as a facilitator at the employee's request. The facilitator's role is not to resolve the issue for participants but rather to foster communication between the participants so that they may resolve the issue.
- In the event resolution is not reached, the Formal Issue Resolution process may be initiated. It is assumed at this point, that all parties have given their best efforts to seek resolution informally and have requested and received assistance from supervisors or directors.

#### **Formal Issue Resolution Process**

- All formal issues shall be submitted in writing to the Director of Human Resources for the Chief Executive Officer's review.
- The Director of Human Resources or designee shall be responsible for investigating the matter.
- The Chief Executive Officer shall prepare a written response after completion of the investigation.
- In the event the employee is not satisfied with the Chief Executive Officer's findings and response, they may initiate the Appeals Process.

#### **Appeals Process**

- All appeals shall occur in a personal meeting with the Chief Executive Officer with all parties concerned. Reasons for the appeal, any additional information relevant to the issue and a list of participants shall be submitted in writing to the Director of Human Resources at the time the appeal is submitted.
- Employees may request an individual confidential meeting, if they believe that it is necessary in order to maintain confidentiality or to have an objective hearing of the issue.
- The appeals process is the final step of the issue resolution process and all decisions of the Chief Executive Officer are final.

### **3.19 Reporting Dishonest, Unethical or Illegal Activity** New 12/13

#### **Introduction**

This policy is intended to encourage and enable employees to raise serious concerns within Shangri-La prior to seeking resolution outside the organization.

#### **General Provisions**

Shangri-La employees are expected to abide by all policies, professional standards and ethics and comply with all applicable laws, rules and regulations in the performance of their duties. It is the responsibility of all employees to report violations or suspected violations of policy, professional standards or ethics or applicable law, rule or regulations in accordance with this policy.

#### **Reporting Violations**

As outlined in the Employee Handbook, Shangri-La encourages informal and formal problem solving using the Issue Resolution Process and Complaint Procedures; however, there may be matters which an employee reasonably believes are substantially more serious that should be addressed by Shangri-La's Board of Directors. Complaints of this nature should be sent to the Board of Directors by emailing the President of the Board at [BoardPresident@shangrilacorp.org](mailto:BoardPresident@shangrilacorp.org).

#### **Handling of Reported Violations**

When possible, the President of the Board of Directors or assigned designee will acknowledge receipt of the report to the sender within five business days of receipt.

#### **Confidentiality**

Reports may be submitted on a confidential basis or may be submitted anonymously. These reports will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation.

#### **No Retaliation**

Employees who in good faith, reports a violation of policy, professional standards or ethics, law, rule or regulation shall not suffer retaliation or adverse employment consequence. Any employee who retaliates against someone who has reported a violation in good faith may be subject to disciplinary action up to and including the termination of employment

#### **Acting in Good Faith**

Anyone filing a complaint concerning a suspected serious violation of policy, professional standards or ethics, law, rule or regulation must be acting in good faith and have reasonable grounds for believing the information reported is accurate and valid. Any allegations not substantiated which prove to have been made maliciously or knowingly to be false will be viewed as a serious offense and may result in disciplinary action including the termination of employment.

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#### **4.0 SAFETY Revised 12/13**

Shangri-La has a long-standing commitment to providing a safe working and service delivery environment. Shangri-La provides resources and systems to ensure employees have what is required to carry out this critical function of their jobs. Maintaining a safe environment is the responsibility of all employees and can be accomplished by:

- Cooperating with all aspects of the safety program.
- Compliance with all training, rules, policies, procedures and practices.
- Reporting any unsafe condition immediately to the immediate supervisor.
- Performing all duties in a safe manner.

#### **4.1 Safety Committee**

Shangri-La has Safety Committees that conducts regularly scheduled meetings. The Committees monitor and evaluate the effectiveness of Shangri-La's safety practices, using strategies developed by the Committees. The Committees advise management and develop recommendations to further enhance the safety of all Shangri-La operations.

#### **4.2 Workplace Violence Revised 6/06; 12/13**

To further Shangri-La's commitment to safety for employees, volunteers, consumers and other stakeholders, Shangri-La has adopted a **Zero Tolerance** policy towards all forms of workplace violence.

#### **Prohibition of Workplace Violence**

Maintaining a safe living, working and service delivery environment is everyone's responsibility and in part can be accomplished by abiding by this and other Shangri-La safety policies, procedures and practices. In general, employees, volunteers, consumers and other stakeholders who conduct themselves in a manner that is respectful of all persons and representative of the standards outlined and communicated in Shangri-La's policies, procedures, job descriptions, trainings, job competency models, job performance evaluations and work behavior reviews are unlikely to violate this policy. Consequently, anyone employed by or otherwise affiliated with Shangri-La who violates this policy or fails to abide by established standards of acceptable conduct may be immediately removed from the workplace and may be subject to disciplinary action, termination from employment, volunteer status or other affiliation with Shangri-La.

At Shangri-La's discretion, any employee conduct that constitutes an act of workplace violence may be reported to appropriate law enforcement authorities. Shangri-La will respond appropriately to incidents of workplace violence where individuals other than employees are concerned. Appropriate action may include reports to law enforcement authorities that may result in criminal charges.

Workplace violence comes in many forms and Shangri-La makes no claim that this policy provides a comprehensive list of all communication or conduct that constitutes an act of workplace violence or a violation of this policy. Accordingly, Shangri-La reserves the right to review each incident on a case-by-case basis. For the purposes of this policy, Shangri-La has adopted the following definitions and guidelines.

## 4.2 Workplace Violence (Continued)

### Defining the Workplace

A workplace is any location, either permanent or temporary, where an employee or volunteer performs any work related duty or activity on behalf of Shangri-La. The workplace includes Shangri-La or privately owned vehicles that are being used in the course of conducting Shangri-La business. The location does not need to be owned or leased by Shangri-La to be considered a workplace.

### Defining Workplace Violence

According to the National Institute for Occupational Safety and Health (NIOSH) workplace violence is any physical assault, threatening behavior or verbal abuse occurring in the workplace. Any person could be the source of workplace violence including strangers, customers, clients, persons served, domestic partners, immediate or extended family members, friends, acquaintances, employees or volunteers.

Examples of communication or conduct that would constitute an act of workplace violence or otherwise violate this policy are as follows:

- Communication or conduct that is offensive, hostile, rude, vulgar, obscene, demeaning, disrespectful, defiant or insubordinate.
- Disorderly communication or conduct such as shouting, name-calling, using profanity, throwing or pushing objects, punching walls or slamming doors.
- Intentional, negligent or reckless communication or conduct including negative gossip of any kind or making or promoting false, malicious or unfounded statements.
- Intentional, negligent or reckless infliction of mental, emotional or physical distress such as threatening telephone calls, bomb threats, unwanted touching, holding and restraint, blocking an exit or entrance, following, bullying, stalking, threatening or harassing another person.
- Intentional, negligent or reckless disregard for the safety of self or others such as creating a safety hazard, reckless driving, destruction of property, ignoring safety policies, procedures, practices or rules.
- Physical assault such as pushing, grabbing, slapping, hitting or other aggressive acts against another person.
- Except as authorized by law, the possession of firearms and other weapons including ammunition and explosives on any premises considered a workplace as defined by this policy including parking lots.

### Defining Levels of Workplace Violence

1. **Level I incidents** include any display of hazardous or threatening behavior like the examples outlined in this policy when **persons and property are safe from immediate harm.**
2. **Level II incidents** include any display of hazardous or threatening behavior like the examples outlined in this policy when **persons or property are in imminent danger.**

At Shangri-La's discretion and without restriction, any incident of workplace violence may be reported to appropriate law enforcement authorities. Level II incidents will likely result in immediate law enforcement attention such as calling 911.

## **4.2 Workplace Violence Continued**

### **Reporting Incidents of Workplace Violence**

Employees and volunteers are required to immediately report any incident of workplace violence to their immediate supervisor or any Shangri-La Director.

Reporting must be in person or by direct telephone contact. Email or voice messages are an insufficient and unacceptable means of reporting a matter considered this serious.

Management personnel first on the scene are required to ensure the safety of themselves and others which may include (1) soliciting additional support from other Shangri-La employees (2) contacting law enforcement or emergency medical assistance and when appropriate (3) completing a Workplace Violence Incident Report to document the basic facts of the incident and ensure that it has been reported.

Shangri-La employees and volunteers are encouraged but not required to report matters that create a potential hazard at work resulting from personal life situations including incidents of stalking, domestic violence and circumstances requiring the use of restraining orders. Shangri-La will make every effort to respect and protect the privacy of those involved.

Employees or volunteers that fail to report incidents of workplace violence will be considered in violation of this policy and such failures to report may result in disciplinary action up to and including the termination of employment or volunteer status.

Shangri-la's goal is to provide safe living, working and service delivery environments and promote open, two-way lines of communication between employees and management to prevent and, when needed, resolve problems or misunderstandings and avoid unnecessary conflict. Employees concerned about workplace conditions or other individuals in the work environment, even if the workplace condition or behavior of the individual has not risen to the level of workplace violence, should discuss these concerns with their immediate supervisor or any Shangri-La Director.

### **Responding To Incidents of Workplace Violence**

Shangri-La provides employees with policies, guidelines and training to prevent workplace violence and, when needed, recognize and respond appropriately to incidents of workplace violence. Shangri-La may provide specific Workplace Violence Incident Response Plans and training for locations with added risk factors. Incident Response Plans are posted at each work location. Employees working at locations that are not Shangri-La owned, leased or operated or working in circumstances that are mobile will receive an individual copy of the appropriate plan for their work situation and personal use.

Shangri-La provides management personnel with a Workplace Violence Incident Response Checklist to use during and after an incident of workplace violence has occurred. The Incident Response Checklist is a basic list of actions to be considered and initiated, if deemed necessary, in order to ensure the safety of all concerned.

### **No Retaliation/Confidentiality**

Shangri-La prohibits any form of retaliation against any employee or volunteer for reporting an incident of workplace violence in good faith under this policy or for assisting in the investigation of an incident and will make every effort to treat all reports confidentially.

#### **4.3 Criminal Background Checks** Revised 6/06

Most jobs with Shangri-La are subject to Federal or State laws, rules and regulations that require employees submit certain personal information for the purpose of conducting a criminal background check. The purpose of the criminal background check is to determine if there is an arrest or conviction that would by law, rule or regulation disqualify the employee from continued employment. Consequently, all employees are required to disclose and report any arrests or convictions for any misdemeanor or felony crime that occurs while employed by Shangri-La. Failure to disclose or report arrests or convictions for misdemeanor or felony crimes that occur while employed by Shangri-La may result in the immediate termination of employment.

#### **4.4 Use of Alcohol or Illegal Drugs** Revised 6/03, 6/06 & 8/11; 12/13

##### **Introduction**

While all people have the right to use prescribed medication as directed by their physicians or over the counter medication according to labeled directions, employees must remain alert, aware, and responsive when using any medication while working and continue to ensure that appropriate supervision, support and training are provided and the health, safety and rights of those served is protected. Employees using medications that prevent them from responding as required or would otherwise prevent them from performing their job duties according to required standards are obligated to disclose that information to the immediate supervisor. Excessive or other use of medications other than as prescribed or advised according to labeled directions is unacceptable and may be in violation of this policy.

##### **Drug Free Work Place**

In accordance with the provisions of the Drug Free Work Place Act of 1988 and to further Shangri-La's commitment to maintaining high standards of employee performance and promoting the health and safety of employees and individuals served, Shangri-La will require a drug free work place for all employees during paid work time or when conducting Shangri-La business, regardless of work location.

##### **Prohibited Conduct**

Employees and volunteers will not manufacture, distribute, dispense, possess, solicit, use or permit the use of alcohol or illegal drugs at any Shangri-La work location including Shangri-La vehicles and personal vehicles being used for Shangri-La business or any equipment being operated in conjunction with Shangri-La business, including during rest or meal breaks.

Employees and volunteers will not report to work if using or under the influence of alcohol or illegal drugs, in any amount. Employees and volunteers who fail to abide by these policies or exhibit any conduct that interferes with the implementation of Shangri-La's Drug Free Work Place Programs, including any refusal to participate, may be subject to disciplinary actions including termination of employment.

##### **Conditions of Employment**

Employees and volunteers must agree to and abide by the terms of this policy.

All applicants who have received an offer of employment will be required to complete drug testing to determine if illegal drugs are present in the body. All applicants must receive a negative result during drug testing, within the time frames required, before any job offers are finalized.

#### **4.4 Use of Alcohol or Illegal Drugs (Continued)**

Applicants refusing to participate in, or cooperate with, the pre-employment drug-testing program will be disqualified from consideration for employment.

Shangri-La may require any employee or volunteer, at any time, to submit to random unannounced, for cause or reasonable suspicion drug testing to determine if illegal drugs are present in the body, in any amount which may impair job performance.

Employees and volunteers refusing to participate in the random testing program for illegal drug use may be subject to immediate termination of employment.

Employees or volunteers testing positive for illegal drug use may be subject to disciplinary actions, including termination of employment.

Employees and volunteers are required to notify Shangri-La, in writing, of any criminal drug statute arrest, conviction or plea of "nolo contendere," (not contested) for a violation occurring in the work place no later than five (5) days after such conviction or plea.

Employees and volunteers are required to notify Shangri-La, in writing, of any DUII arrest, conviction or Diversion agreement no later than five (5) days after such conviction or agreement.

The mere fact that an employee or volunteer has been arrested for, or convicted of, DUII or violating a criminal drug statute or has submitted to a diversion agreement, does not necessarily mean there will be disciplinary actions. Each occurrence shall be reviewed on a case-by-case basis.

#### **Investigation & Discipline**

When an employee or volunteer is suspected of violating this policy, Shangri-La shall conduct a thorough investigation. The investigation may include one or more of the following steps:

- Discussing the subject with the employee or any witness with knowledge of the relevant issues.
- The Chief Executive Officer may require the employee to be tested for use of alcohol or illegal drugs.
- Suspending the employee from his/her work duties with or without pay during investigation.

Depending on the results of the investigation and prior violations of this or other Shangri-La policies, the employee or volunteer may be subject to disciplinary actions, including termination of employment. Disciplinary actions may include one or more of the following:

- Suspension from work duties without pay.
- Loss of merit pay or other pay increases for a specific period of time.
- Loss of promotional opportunities for a specific period of time.
- Required participation in, and successful completion of, an approved substance abuse treatment program.
- A Last Chance Agreement that specifies additional conditions of employment for a specific period of time.
- Termination of employment.

#### **4.4 Use of Alcohol or Illegal Drugs (Continued)**

##### **Drug Free Workplace Awareness Program**

A Drug Free Work Place Awareness Program is available to educate all employees about the effects of using alcohol and illegal drugs and includes the following:

- Publications and printed materials about the effects of using alcohol and illegal drugs, available at Shangri-La's administrative offices.
- Information on any confidential counseling programs available through Shangri-La.
- A list of counseling and treatment programs as described in benefits materials or other community resource materials when applicable. The cost of these programs may or may not be covered in whole or in part by health insurance or other benefits currently provided by Shangri-La. In all cases it is the responsibility of the employee accessing these programs, either as part of a disciplinary action or by personal choice, to pay any costs associated with obtaining information, assessment or treatment.
- Written policies provided during orientation regarding the use of alcohol and illegal drugs.

##### **Notification of Federal Funding Agencies**

The Shangri-La shall notify the appropriate federal funding agency, in writing, within ten (10) days of being notified by an employee or otherwise receiving notice that an employee has been convicted of violating a criminal drug statute while at work.

#### **4.5 In Case of Snow or Other Adverse Weather Conditions**

In the event that snow or other adverse weather conditions occur, all employees are expected to report to work as usual.

If an employee expects to be late or is unable to report to work, Shangri-La policies on Tardiness and Absenteeism shall be followed.

In the event an employee is unable to report to work and it is critical that they report as scheduled, Shangri-La may choose to provide transportation for that employee. Each situation shall be considered on a case-by-case basis.

In the event an employee is unable to report to work and Shangri-La does not offer transportation, paid leave may be used for the absence. If paid leave is not available, employees will not be paid for lost work time.

Employees who are unable to report to their regular work unit but could report to another work unit may be temporarily reassigned.

*See the 'Procedure for Driving during Adverse Weather Conditions' in the Safety Handbook for additional information*

#### **4.6 Children or Visitors in the Work Place** Revised 6/03; 6/06

Childcare can sometimes be a problem that leads to employees calling in sick or wishing to bring their children to the work place. In some positions bringing children to the work place is acceptable, in others it is not. Following are the criteria for all employees to follow when bringing children or visitors to the place of work, either during working or non-working hours.

- Employees MUST have a supervisor's approval PRIOR to bringing children or visitors to the workplace.
- If the employee is on duty and responsible for Individuals served, children or visitors WILL NOT be permitted.
- If the employee making the request is not scheduled to work, the supervisor of that work unit should consider the following when attempting to determine if bringing children or visitors to the workplace is appropriate.
  - ✓ How many employees are scheduled to work?
  - ✓ Is this a frequent request?
  - ✓ How many children or visitors does the employee propose to bring?
  - ✓ How long does the employee propose to have children or visitors at work?
  - ✓ Is the child or visitor ill with a communicable disease?
  - ✓ Is approval of the request in the best interests of individuals served?

Employees may use the Issue Resolution Process as described in this handbook when requests are disapproved.

#### **4.7 Personal Outings Away From The Home Environment**

Any outing, trip or other interaction between employees and individuals served by Shangri-La, away from the home or employment setting and not specifically associated with the individuals support plan, requires prior written approval from the Manager, the Department Director, and the guardian if applicable.

#### **4.8 Photographic & Non-Photographic Identification** Revised 6/06; 7/13

##### **Principle**

In keeping with Shangri-La's continued commitment to provide a safe working and living environment for employees, volunteers, trainees, individuals served and other stakeholders, Shangri-La has established a policy regarding photographic and non-photographic identification for persons employed by or otherwise affiliated with the Shangri-La.

##### **Purpose**

The purpose of the photographic and non-photographic identification policy is to establish a consistent and reliable method for identifying a person's affiliation with Shangri-La as an employee, volunteer, trainee, person served, visitor or other stakeholder.

For purposes of simplicity, this policy shall refer to Shangri-La's photographic and non-photographic identification as photo and non-photo ID.

## **4.8 Photographic & Non-Photographic Identification (Continued)**

### **General Provisions**

All employees, volunteers, trainees, individuals served, and other stakeholders on the premises of Shangri-La owned or operated business and service locations are subject to this policy.

Shangri-La's photo and non-photo ID cards will be issued at no cost to the persons required to use the identification.

Shangri-La issued photo or non-photo ID is intended for the sole use of the authorized cardholder and will only be considered valid when presented by the authorized cardholder.

Any employee, volunteer, trainee, individual served or other stakeholder that uses or permits the use of, a Shangri-La issued photo or non-photo ID for fraudulent purposes will be considered in violation of this policy and may be subject to the immediate termination of employment, volunteer or trainee status or other affiliation with Shangri-La.

Employees, volunteers and trainees are required to carry Shangri-La issued photo or non-photo ID with them at all times while on Shangri-La premises or conducting Shangri-La business and should be prepared to present such ID at any time as verification of their affiliation with Shangri-La. Some Shangri-La locations may require that the Shangri-La issued photo or non-photo ID is worn while on premises.

### **Issuing ID's to New Employees, Volunteers & Trainees**

All new employees and volunteers will be issued a photo ID on or about the first day of employment or volunteer status. All trainees will be issued a non-photo ID while in training status.

### **Temporary Identification Cards for Visitors**

Some Shangri-La locations may require that visitors sign in/out and receive a temporary identification card that should be worn while on premises. The employee, whom the person is visiting, shall be responsible to ensure that the visitor signs in/out, is issued and wears a temporary identification card and returns the temporary identification card prior to leaving the premises.

### **Non-Photo ID Cards**

In general, Shangri-La will no longer issue employees or volunteers identification that does not include a photograph, except in cases when this policy conflicts with religious or other strongly held beliefs, safety considerations or other circumstances that are reasonable grounds to restrict the use of photographic images.

### **Replacement of Shangri-La Issued Photo ID**

There may be times when an employee or volunteer needs to replace or update the photo ID card including replacement of lost or damaged cards.

Employees or volunteers requiring a replacement photo ID for any reason should notify human resources personnel as soon as possible in order to have a replacement photo ID issued.

Trainees who require a replacement of a Shangri-La issued non-photo ID should notify their supervisor

#### **4.8 Photographic & Non-Photographic Identification (Continued)**

##### **Termination of Employment, Volunteer or Trainee Status**

Shangri-La issued photo and non-photo ID is considered Shangri-La property and must be returned when employment, volunteer or trainee status is terminated.

#### **4.9 Use of Shangri-La or Privately Owned Vehicles** Revised 6/03; 6/06; 12/13

Shangri-La shall determine if an employee or volunteer will be authorized to drive Shangri-La or privately owned vehicles during paid work time or when conducting Shangri-La business. This authorization shall occur prior to and continue throughout employment or volunteer service.

Shangri-La reviews the employee's or volunteer's motor vehicle record periodically and determines if an employee's or volunteer's driving history is considered an acceptable risk, a marginally acceptable risk or an entirely unacceptable risk to be insured to drive a Shangri-La or privately owned vehicle for work purposes.

Employees and volunteers that are considered acceptable or marginally acceptable to drive are authorized to operate Shangri-La and privately owned vehicles during paid work time or when conducting Shangri-La business.

The motor vehicle records of employees and volunteers that are considered only marginally acceptable as authorized drivers will be reviewed periodically. Reports of additional accidents, violations or convictions and any suspension of the driver's license may change the employee's or volunteer's authorization status.

Any employee or volunteer that is not authorized to drive Shangri-La or privately owned vehicles during paid work time or when conducting Shangri-La business may not transport the Individuals served by Shangri-La at any time.

***Shangri-La's insurance coverage protects only corporation owned vehicles and does not cover employee or volunteer liability or damage to the employee's or volunteer's private vehicle.*** Employees and volunteers who use private vehicles during paid work time or when conducting Shangri-La business must provide, prior to actual usage, "Proof of Insurance" for the private vehicles used. If driving privately owned vehicles during paid work time or when conducting Shangri-La business is a bona fide job requirement, the "Proof of Insurance" will be requested upon hire or start of volunteer service and must remain up to date throughout employment. The "Proof of Insurance" shall be reviewed on an ongoing basis and annually as part of the job performance evaluation process when driving a privately owned vehicle for work purposes is a condition of employment.

Employees and volunteers that must use a privately owned vehicle as part of their job shall maintain and operate their private vehicle in a manner that ensures the safety of all passengers. Safe operation includes, but is not limited to, the use of seat belts which must be available and in use by the driver and all passengers when operating any vehicle which is used during paid work time or when conducting Shangri-La business.

Any failure on the part of an employee or volunteer to maintain proper automobile insurance coverage on their private vehicle or failure to maintain and operate any vehicle in a manner which reasonably ensures its safe operation during paid work hours or when conducting Shangri-La business may result in disciplinary actions up to and including termination of employment.

#### **4.9 Use of Shangri-La or Privately Owned Vehicles (Continued)**

The motor vehicle records of employees and volunteers will be reviewed periodically regardless of authorization status. All accidents, violations, convictions, suspensions or restrictions of driving privileges that occur while employed by or volunteering for Shangri-La must be reported to the Director of Human Resources within three (3) working days to determine if the driver's authorization should be changed. The mere fact that an employee or volunteer has been involved in a motor vehicle accident, cited for a traffic violation or had their driving privileges suspended or restricted in some way does not mean that the employee or volunteer will necessarily be disciplined or discharged.

In the event that an employee or volunteer cannot be authorized to drive Shangri-La owned vehicles or privately owned vehicles during paid work time or when conducting Shangri-La business and driving is a bona fide occupational or volunteer requirement, the employee or volunteer may be subject to disciplinary action including, but not limited to, suspension, demotion, transfer, reassignment or termination of employment or volunteer service. Employees that cannot be authorized to drive may also be ineligible to apply for transfers and promotions or work voluntary overtime when the job duties involved require driving as a bona fide occupational requirement.

Each employee or volunteer that is not authorized to drive shall be given an opportunity to review the information used in making that determination. Any motor vehicle information considered that the employee believes deserves further consideration will be investigated. Employees and volunteers will be given the opportunity to correct any information they believe is inaccurate. Employee will be notified of any changes in authorization status that effects current or continued employment regardless of the reason for the change.

#### **4.10 Use of Mobile Communication Devices While Driving** Added to handbook 12/13

Oregon law and Shangri-La policy prohibits operating a motor vehicle while using a mobile communication device except as a hands-free device. Even though Shangri-La provides hands free equipment for use with the mobile communication devices issued through the organization, in the interest of safety, Shangri-La continues to discourage the use of mobile communications devices while driving even when operation of the device is hands free. It is Shangri-La's position, that except in emergencies and other limited circumstances, using a mobile communication device while driving is unnecessary to conduct business. Violation of Shangri-La policy or Oregon Law related to the use of a mobile communication device while driving, including texting while driving, will be considered a violation of safety policy and practice resulting in disciplinary action up to and including the termination of employment.

#### **4.11 Tobacco Products** Revised 12/13

The use of tobacco products which includes but is not limited to cigars, cigarettes, e-cigarettes, chew and other smokeless tobacco products, is discouraged by Shangri-La. Tobacco use is not permitted inside any Shangri-La facility, vehicle or in the presence of individuals served. The use of tobacco products is permitted at some locations but not permitted at others based on Oregon Administrative Rules (OAR's) governing the services provided at a particular location. Employees will be notified which standards apply according to the job assignment and work location.

When smoking is permitted, designated areas for tobacco use are situated to be in compliance with Oregon's "Smoke Free Workplace" law and are different for each location. If smoking is permitted at your work location, ask your supervisor for information on the designated area for your work location. When smoking is permitted it is only permitted during breaks and in the areas designated for tobacco use at each work location.

Shangri-La serves people who can be unpredictable or unsteady in their physical responses to situations. Smoking may be dangerous to these people and to the person smoking in the event that aggression, an unexpected hug or a stumble should occur.

#### **4.11 Tobacco Products (Continued)**

Compulsive eating of both food and non-food items (PICA) is a problem experienced by some people with disabilities. Tobacco products and litter can be very dangerous to these people. Authorized receptacles for tobacco waste are the closed containers provided at each designated tobacco use area.

There is now clinical proof that secondary tobacco smoke may be as harmful as the smoke received by the smoker. People with disabilities often have accompanying lung and heart problems; we must respect this physical frailty.

In the event that employees are representing or working for Shangri-La at any other location, smoking is permitted outside and in accordance with this policy. Smoking is not permitted if it detracts from service or job performance or designated smoking areas are not available.

#### **4.12 Health Requirements** – Revised 6/06; 12/13

Tuberculin (TB) screening is required for many employees and Hepatitis B vaccinations are available and encouraged for all employees but not required. These requirements may vary as laws and regulations change. Other tests may be required as deemed necessary.

When required, TB tests must be obtained within seven (7) days of employment. Employees determined to have a positive TB skin test, must obtain a chest x-ray within seventy-two (72) hours. Employees are required to consent to or decline the Hepatitis B vaccination within ten (10) days of employment. Employees that decline Hepatitis B vaccination may change their mind and choose to consent in the future.

Shangri-La pays the cost of TB testing, chest x-rays when advised and Hepatitis B vaccinations.

Failure to complete the above requirements within the time limits indicated may result in disciplinary actions up to and including termination of employment.

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## **5.0 WAGE AND SALARY INFORMATION**

### **5.1 Compensation - Revised 6/06, 3/08; 7/13**

#### **Introduction**

Shangri-La believes in a compensation structure that attracts, retains and motivates high caliber talent in order to ensure Shangri-La's Mission is fulfilled and the organization continues to be a leader in the field.

The compensation policy is intended to provide a framework for the administration of compensation. Job performance is evaluated based on demonstrated skills and achievement of organizational, work unit, and individual goals. In general, pay increases are given to reward competent and consistent job performance. Shangri-La may also offer incentives tied to the achievement of specific goals.

The compensation policy may be reviewed periodically and revised when necessary.

#### **General Provisions**

All employees except those paid sub-minimum wages are subject to this policy.

All pay offers, increases, demotions, promotions, reclassifications, transfers and all other changes affecting payroll status must be recommended by the immediate supervisor and approved by a Director. Written or electronic authorization must be obtained before any change in payroll status will be considered valid.

Any and all changes in compensation, including but not limited to wage increases or decreases are at the sole discretion of Shangri-La.

#### **Compensation Committee**

The Compensation Committee monitors the administration of compensation. The Compensation Committee is comprised of Shangri-La Directors as assigned by the Chief Executive Officer (CEO). The Compensation Committee advises the CEO regarding matters covered by this policy and, in general, acts to ensure that the procedures used for the administration of compensation are applied consistently.

#### **Market Survey**

To remain competitive in the recruitment and retention of employees, a market survey may be conducted to determine how the wages paid for jobs at Shangri-La compare to the wages paid by other businesses that have similar jobs. Due to the unique nature of some jobs, it may be necessary to compare other factors to obtain accurate comparisons of wages including a review of jobs that require similar qualifications even though the actual job performed may be different

#### **Resource Availability**

Contracts for the administration and provision of services are financed through public and private sources. Some contracts, known as cost reimbursement contracts allow Shangri-La to renegotiate contracts periodically to account for the increased costs of providing services including wages. Wages paid for jobs funded by cost reimbursement contracts may experience different frequency and amounts of wage increases or decreases based on contract negotiations.

## **5.1 Compensation (Continued)**

### **Job Ranking & Job Banding**

As a means of comparing jobs within the organization; the compensation committee may rank and group jobs (job banding) using one or more specific factors such as physical and mental demands, job knowledge, level of responsibility, impact, leadership, planning and development. The committee may also rank and band jobs by collecting information through a job analysis questionnaire, a review of the current job description or through interviews with supervisors and other employees. Generally jobs in the same band have same or similar wages and job rankings.

### **Wage Rates**

Each job is assigned a wage rate by the Compensation Committee based on a market survey of comparable jobs in the organization, the business community and the resources available. The wage rate is expressed as a range from lowest to highest rates of pay and is published on the Wage and Advancement Schedule (WAS) for that job. The wage range is expressed as steps and represent the wage that would be paid based on not meeting, meeting or exceeding the hiring requirements for the position. Once hired, this schedule also describes the requirements an employee must meet to advance to the next step and receive a wage increase. When employees receive a wage increase, it will be within the wage limits assigned to the job. The wage and advancement schedule also identifies if wages are paid as a salary or hourly rate, if the position is exempt or non-exempt, and the methods used for evaluating job performance.

### **Establishing Wage Rates for New Jobs**

Wage rates for all new jobs are established by the Compensation Committee using the market survey method described previously, however, other methods may be used as well depending on the availability of market based wage information for any particular job. To request a market survey for a new job, a job description must be completed by the applicable supervisor and Director and forwarded to the Compensation Committee for review.

### **Re-evaluation of Wage Rates for Existing Jobs**

The Compensation Committee may conduct a re-evaluation of existing jobs.

When management personnel or other interested employees believe that a job has changed so substantially that the current job description or market survey is no longer valid, a re-evaluation of that job may be requested. Requests for re-evaluation must be in writing and include a revised job description that accurately reflects the current duties and a detailed explanation of why another wage rate is thought to be more appropriate. Requests for re-evaluation of any job must be accompanied by the recommendation of the applicable supervisor and Director prior to being forwarded to the Compensation Committee for consideration.

The Compensation Committee will normally review requests for re-evaluation within thirty (30) days of receipt provided requests are properly documented. Employees will be notified of all decisions regarding requests for re-evaluation.

## **5.1 Compensation (Continued)**

### **Reclassification of Existing Jobs**

The re-evaluation process may result in jobs being reclassified particularly when a job has been found to have changed so substantially that it will be paid at either a higher or a lower wage rate than previously assigned. Jobs that are reclassified may be ranked and banded differently and assigned a different job title and position description.

### **Pay Increases**

There are generally four reasons pay increases occur:

1. When recommended after completion of a job performance evaluation.
2. When re-evaluation of a job results in reclassification of the job to a higher rate of pay.
3. When an employee is promoted or changes jobs for any reason and the new job is paid a higher wage.
4. As a result of a market adjustment to the wage structure. In general, a market adjustment to wages is the result of changes in what is considered a competitive wage for the job in question. A market adjustment to wages is always contingent on the resources available.

### **Pay Decreases**

There are generally four reasons why pay decreases occur:

1. When an employee is demoted or changes jobs for any reason and the new job is paid a lower wage.
2. When job duties have changed so substantially that re-evaluation determines that the job will be paid at a lower wage rate than previously assigned.
3. When available resources decrease so substantially that it is not possible to pay the wage rate assigned previously.
4. When a market survey demonstrates that wages for a particular job have decreased.

### **New Hire Starting Wage**

Directors are responsible for determining the wage rates of newly hired employees within the limits of the wage and advancement schedule established for that job.

If a newly hired or promoted employee has less than the required qualifications for the job offered, the starting wage may be below the entry level wage established for the job, until the employee has demonstrated that they meet the minimum qualifications.

## **5.1 Compensation (Continued)**

If a newly hired or promoted employee meets the qualifications for the job offered, the starting wage will normally be at the entry level wage established for that job.

The starting wage for a newly hired or promoted employee may exceed the entry level wage if the employee's qualifications are sufficient to justify it and it is in the best interest of the organization to approve a higher starting wage.

The starting wage for a newly hired or promoted employee may not exceed step 2 of the Wage and Advancement Schedule (WAS) without prior approval of the Compensation Committee. When necessary, approval to exceed step 2 may be obtained electronically and must include a decision by at least three committee members. Directors must report the decision to pay wages above step 2 for newly hired or promoted employees at the next Leadership Team meeting.

There may be other factors that affect the decision to hire below, at or above the entry-level wage established for any job. Each director is responsible for maintaining documentation of all exceptions to hiring at other than the entry-level wage for review by the Compensation Committee.

### **Promotion**

A promotion is the act of moving an employee from a job at a lower wage to a different job that is paid a higher wage.

A promoted employee may receive a wage increase as a result of being placed at the entry-level wage for the new job. If the employee's wage already exceeds that amount, the Director is responsible for determining the amount of the wage; which cannot exceed the maximum wage established for the new job and the new hire starting wage criteria described previously.

### **Demotion**

A demotion is the act of moving an employee from a job with a higher wage to a different position with a lower wage.

A demoted employee may receive a pay adjustment that reduces or freezes the wage. The Compensation Committee must approve of any wage freeze or other action that allows an employee to be paid at more than the maximum wage for the current job.

### **Transfer**

A transfer is the reassignment of an employee to the same or similar job at a different work location. Granting or scheduling transfers will be made in the best interest of the Corporation. There are normally no wage adjustments when employees are transferred.

### **Job Performance Evaluations**

Shangri-La's management practice is to provide employees with job performance feedback. Job performance evaluations are completed periodically and are used to summarize and document an employee's job performance during a specific period of time. In general, job performance evaluations are completed during the trial period and then regularly throughout employment. Job performance evaluations may be completed more or less frequently as circumstances warrant.

## **5.2 Time Sheets** Revised 12/13

Employees are expected to complete time sheets daily after completion of the work shift or work day. All hours worked and the work unit must be noted on all time sheets. When working in different work units, separate time sheets must be completed.

Time sheets must be submitted to and approved by the supervisor before being forwarded to the Business Office. Time sheets are due in the Business Office on the day indicated on the time sheet cut-off schedule. Time sheets cut-off schedules are available at each work unit or from the business office.

## **5.3 Paychecks** - Revised 1/13

Shangri-La pays on a bi-weekly basis (every two weeks). Payday is every other Friday. If payday falls on a holiday, paychecks will be available on the banking day prior to the holiday. Paychecks not picked-up within three (3) days may be mailed to the employee's current mailing address on file in the business office.

## **5.4 Payroll Deductions** Revised 7/13

Mandatory and elective deductions are noted on the paycheck and include, but are not limited to, the following:

1. Mandatory deductions are as follows:
  - Social Security & Medicare (F.I.C.A. Taxes)
  - Federal Withholding Taxes
  - State Withholding Taxes
  - Worker's Compensation Insurance
  - Garnishments
2. Elective deductions included but are not limited to the following:
  - Shangri-La's Health and Dental Plans (may include self, dependents and part-time employees depending on current health and dental plans available).
  - 403(b) Deferred Compensation Plan contributions.
  - Direct deposit amounts.
  - Wage Advances.
  - Flexible Spending Account contributions.
  - Voluntary supplemental insurance plan deductions.
  - Other miscellaneous deductions

## **5.5 Advances** - Revised 4/99; 1/11; 1/13; 7/13

Employees may receive an advance payment of wages. The advance amount cannot exceed 75% of gross earnings accumulated for that pay period that have not been paid.

All requests for advances of wages are considered Emergency Draws. Employees who choose to receive an Emergency Draw must complete the Emergency Wage Advance Request form and forward it to the Business Office.

## **5.5 Advances (Continued)**

The following criteria will be used to determine eligibility and approval of Emergency Draws:

- All employees are limited to five (5) Emergency Draws per calendar year. The calendar year begins January 1 and ends December 31 of each year.
- All Emergency Draw requests in excess of five (5) per calendar year will be denied.
- Emergency Draws do not accumulate if not used during the calendar year in which they become available.
- Emergency Draws cannot be transferred from one employee to another.
- All Emergency Draw requests must be in writing on an Emergency Draw Request Form and accompanied by a time sheet that is signed by the supervisor verifying the employee's hours of work. No other supervisory approval is needed to request an Emergency Draw.
- All Emergency Draw requests submitted by 11:00am will be available the same day after 3:00pm. When it is a work day for the business office requests submitted after 11:00am will be available the next working day after 3:00pm. Requests submitted on Friday after 11:00am will not be available after 3:00pm on the first working day for the business office during the following week.

## **5.6 Garnishments**

Shangri-La will comply with its obligations as a garnishee, to remit to the judgment creditor all monies rightfully owed to that creditor under the Writ of Garnishment. Garnishments obviously cause a hardship both on the affected employee and Shangri-La, consequently, Shangri-La urges all employees to manage financial affairs in ways that will avoid the garnishment of their wages.

## **5.7 Correction of Status, Pay or Benefits**

Shangri-La tries to avoid any errors in time records, pay calculations and benefit programs. Errors may occasionally occur or employees may need additional information. Questions about status, pay or benefits should be directed to the Business Office or to the supervisor's attention immediately.

## **5.8 Mileage Reimbursement Revised 7/13**

Shangri-La reimburses employees for approved business mileage while performing job-related duties, when a Shangri-La owned vehicle is not available, per the mileage reimbursement procedure. Requests for mileage and other reimbursement should be submitted on the same day time sheets are due.

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## **6.0 REGULAR WORK PERIODS**

### **6.1 Workday**

The workday is defined as the hours an employee is scheduled to work during a 24-hour period. For pay purposes, hours worked are recorded on the day in which the shift begins.

### **6.2 Workweek**

The workweek begins with the first shift following 12:01 AM on Monday and ends with the last shift worked which has its beginning prior to midnight of the following Sunday.

### **6.3 Regular Employees Working as Relief Staff**

With the supervisor's prior authorization, regular employees may provide relief staffing for the programs or work units to which they are usually assigned, as well as those to which they are not usually assigned. It is Shangri-La's policy, however, to call in workers who are assigned specifically to provide relief staffing before allowing regular full-time employees to work hours that result in overtime pay.

### **6.4 Overtime Revised 6/06; 3/13; 7/13**

Maintaining a safe work and service delivery environment is everyone's responsibility and in part can be accomplished by abiding by Shangri-La's overtime policy. Shangri-La strives to keep overtime to a minimum so no one works excessive and potentially unsafe work hours.

Shangri-La requires that the immediate supervisor or on-call manager, and Program Manager authorize overtime hours before they are worked. Employees that work overtime without first obtaining authorization may be subject to disciplinary action. Some emergency situations may make prior authorization difficult to obtain; in those cases the employee is required to obtain authorization as soon as practical. In no case is an employee to leave a person served by Shangri-La without proper or scheduled supervision, even if remaining at work results in overtime and no authorization has been obtained.

Employee should not work more than:

1. 16 consecutive awake hours in any 24 hour period;
2. 62 awake hours in one week, or
3. 104 awake hours in any two-week period.

Any exception to these limits on work hours must be prior approved by the Program Manager. The Program Manager should consider if additional work hours include a sleeping shift, is related to providing support to a person served that is traveling or constitutes an unexpected emergency.

Employees are expected to monitor the total hours worked and are required to decline additional opportunities that would cause them to exceed these limits.

Overtime pay is one and one-half (1½) times the regular rate of pay for those hours actually worked in excess of forty (40) hours during the workweek. Only non-exempt employees are eligible for overtime. Shangri-La is not obligated to pay overtime unless the actual hours worked exceeds forty (40) hours. Actual hours worked excludes sleep time as part of a companion shift, paid leave and holidays taken during the workweek.

#### **6.4 Overtime (Continued)**

There are some exceptions when determining overtime work hours, even when the actual hours at the work location exceeds forty (40) hours in a week. The Department of Labor authorizes these exceptions related to specialized support services for people with disabilities. Employees will be notified in advance if assigned to a job where these exceptions apply

In general, employees should not be on the work premises when not scheduled to work. Although not considered paid work time, hourly employees may be at work 15 minutes prior to the start of a work shift or 15 minutes after the end of the work shift. Employees may not volunteer time to catch up on, or carry out work duties or related tasks. In most cases employees will not be approved to volunteer personal time when the work or duties involved are same or similar to what the employee is otherwise paid to do during schedule work hours. Employees on premises outside of scheduled work hours are considered visitors and must follow establish procedures for visitors which includes the Manager's prior approval.

#### **6.5 Breaks and Meals Revised 6/06**

During any period in which employees work four (4) hours or the major part of four (4) hours, a break period of fifteen (15) minutes paid will be arranged by the supervisor. A meal period of not less than thirty (30) minutes unpaid will be provided for employees who work six (6) or more hours. For work periods of seven (7) hours or less, but at least six (6) hours, the meal period is to be taken between the second (2<sup>nd</sup>) and fifth (5<sup>th</sup>) hour worked. If the work period is more than seven (7) hours, the meal period must be taken between the third (3<sup>rd</sup>) and sixth (6<sup>th</sup>) hour worked. If the employee is required to remain on duty during the meal period or performs any tasks during this period, this time will be paid. The break period shall be scheduled so that it will not disrupt or interfere with care, support or supervision of persons served.

#### **6.6 Rest Breaks for Breast Feeding or to Express Milk Added 7/13**

Shangri-La provides reasonable rest periods to employees that need to breast feed or express milk for their child. Reasonable rest breaks include at least a thirty (30) minutes for every four (4) hours of work or major portion thereof. Breaks for this purpose are unpaid but may overlap with other legally required meal or rest periods that are paid. If an employee uses a break period for this purpose in whole or in part that is customarily a paid break, that portion of the break to express milk or breast feed time is also paid. Reasonable efforts will be made to provide a private room or location to breast feed or express milk.

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**7.0 EMPLOYEE BENEFITS** Revised 3/03; 3/05; 6/06; 9/11; 7/13; 12/13

The Leadership and Board of Directors of Shangri-La realize the importance of providing a comprehensive benefit program. These programs are an important and substantial part of overall compensation. The following information outlines the benefit programs offered by Shangri-La. Complete information is available in the insurance booklets and benefit summaries provided to employees. That information should be read in its entirety prior to making decisions regarding benefits. Further assistance is also available through the Business Office and Human Resources personnel.

Only regular employees are eligible for benefits. The specific benefits available to eligible employees are described under each category of benefit and are based on the type of work performed, an employee’s status as part or full time and the program or department assignment. Temporary and relief employees are not eligible for any benefits. Shangri-La reserves and will exercise the right to change benefit programs at any time.

**7.1 Holidays** – Revised 9/11; 9/13; 12/13

Regular employees, who have successfully completed all required orientation, training and health requirements or after 30 days, whichever comes first, and are scheduled to work thirty (30) or more hours per week, are eligible to be paid eight (8) hours for each of the days shown as paid holidays. Paid holiday hours will be prorated for regular employees scheduled to work less than thirty (30) hours per week.

The actual days observed as holidays are subject to change and may vary according to job assignment or personal preference, if authorized in advance. Refer to the holiday schedule posted for the applicable year, to determine the date the holiday is observed.

The following schedule lists both the paid and unpaid holidays observed by Shangri-La.

<b>Holidays Observed</b>		<b>All regular employees working 30 or more hours per week except as indicated</b>
New Years Day	(1 day)	8 hours paid each day to all regular employees
Memorial Day	(1 day)	8 hours paid each day to all regular employees
Independence Day	(1 day)	8 hours paid each day to all regular employees
Labor Day	(1 day)	8 hours paid each day to all regular employees except unpaid for Production Workers
Thanksgiving	(2 days)	8 hours paid each day to all regular employees except 2 <sup>nd</sup> day unpaid for Production Workers
Christmas	(2 days)	8 hours paid each day to all regular employees except 2 <sup>nd</sup> day unpaid for Production Workers

**Refer to the current Holiday Schedule for actual dates of paid or unpaid holidays**

**7.2 Paid Leave** – Revised 7/07; 9/11; 7/13; 9/13

The following schedule describes the monthly paid leave accrued by regular Shangri-La employees. Except for production workers, paid leave accrues based on the length of employment, hours worked per pay period and the exempt or non-exempt status of the position.

Regular non-exempt, hourly employees will accrue paid leave hours based on the actual hours worked, up to a maximum of forty (40) hours per week. Overtime work hours are not included when computing paid leave accruals.

**7.2 Paid Leave (Continued)**

Regular exempt, salaried employees will accrue paid leave hours based on the full-time or part-time status of employment. Regular exempt employees scheduled to work less than full time will accrue paid leave hours on a prorated basis.

Regular employees do not accrue paid leave until all orientation, training and health requirements are completed or after 30 days whichever comes first.

Effective July 1, 2007, when determining paid leave accrual rates, former employees rehired by Shangri-La will be given credit for their previous length of service provided the following conditions are met:

- Resigned employment with proper notice.
- “In good standing” at the time of resignation.
- Rehired within one year of the effective date of resignation by the same program or department that employed them at the time of resignation.

All employees continue to accrue paid leave when absent from work, when accrued paid leave or paid holiday time is used during the absence. Employees do not accrue paid leave for unpaid absences.

Months of Employment		0-12 months	13-24 months	25-36 months	37-48 months	49-60 months	61+ months
<b>Production Workers</b>	Factor X ea hr worked	.040816	.040816	.040816	.040816	.040816	.040816
<b>Regular, hourly, non-exempt employees</b>	Factor X ea hr worked	.04615	.0577	.0692	.08077	.0923	.0923
<b>Regular, FT salaried, exempt</b>	Monthly	8.0 hrs	10.0 hrs	12.0 hrs	14.0 hrs	16.0 hrs	18.0 hrs

Table revised: 9/2011

Effective March 31, 2003, the maximum number of paid leave hours that can be accumulated is two-hundred and forty (240). Paid Leave hours in excess of two-hundred and forty (240) will be forfeited (not paid in the form of wages and subtracted from the paid leave balance) upon an annual review on December 31<sup>st</sup> of each year. Acceptable uses of paid leave include both planned and unplanned absences.

**7.3 Planned Absences Revised 7/13**

Planned absences include, but are not limited to vacation, observation of a holiday not listed, pregnancy, parental leave, and scheduled hospitalizations. In order to ensure that a leave request for a planned absence will be given adequate consideration, employees must submit all requests for leave, in writing, to the immediate supervisor using a Shangri-La Leave Request Form or Ultipro electronic leave request notice. Leave requests for planned absences must be submitted as much in advance as possible, allowing a minimum of two (2) weeks notice for absences of more than two (2) days.

**7.4 Unplanned Absences Revised 7/13**

Unplanned absences include, but are not limited to, emergencies, unexpected illness and doctor’s appointments for self or immediate family members, death of an immediate family member and voluntary or required enrollment in a licensed substance abuse treatment program.

Absences for these or similar circumstances require approval from the supervisor, with at least two (2) hours prior notification for day shift positions and four (4) hours prior notification for swing, graveyard and companion shifts. Some work locations have absence notification procedures that are different than those previously described. Employees will be notified in advance if assigned to a work location where different notification procedures apply.

### **7.5 Unpaid Leaves of Absence** Revised 7/13

Any absence from work in excess of accrued paid leave is considered a leave of absence without pay. Employees may request unpaid leaves of absence, by submitting a written request for such leave to the immediate supervisor at least two (2) weeks prior to the start of leave.

If the leave request is caused by an emergency, employees are required to provide notification to the immediate supervisor or director as soon as possible. Failure to obtain timely and proper authorization for an emergency leave may be considered an unexplained absence that may result in disciplinary action including termination of employment.

Although there may be exceptions for medical or religious reasons normally unpaid leave will not be granted until all accrued paid leave has been exhausted. Each request for an exception to this policy will be reviewed on a case by case basis. Reinstatement cannot be guaranteed for employees on unpaid leave and employees will not accrue and may not be eligible for any benefits while on an unpaid leave of absence. Accordingly, the employee must pay all insurance premiums for themselves and dependents while on an unpaid leave of absence unless eligible and approved for leave that require an employer to continue to health insurance benefits during leave.

In general, Shangri-La retains the discretion to grant leave, whether planned or unplanned, paid or unpaid, according to the best interest of the organization consequently, there may be occasions when requests for leave must be denied or postponed. A written approval or denial of the leave requested will be returned to employees within five (5) working days following the supervisor's receipt of the leave request.

### **7.6 Family and Medical and Oregon Family Leave** Revised 6/06; 12/13

Federal and State law requires that Shangri-La notify employees of their rights to request and be granted leave, regardless of Shangri-La policy, if the employee's request for leave qualifies as Family and Medical Leave, Oregon Family Leave and other legally protected absences such as Military or Jury Duty leave. The table on the next page and other information on succeeding pages outline the types of leaves that may be requested, eligibility requirements and other important information. If at any time there are questions regarding these or other leaves, please contact your supervisor or human resources personnel for assistance.

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**Summary of Family and Medical Leave Revised 7/13**

Description	Family and Medical Leave
Eligibility	Employed at least 12 months and worked at least 1250 hours in past 12 months.
Reasons For Leave	<ol style="list-style-type: none"> <li>1. Birth of Child.</li> <li>2. Placement of child for adoption or foster care.</li> <li>3. Serious health condition of employee.</li> <li>4. Serious health condition of employee’s spouse, parent or biological, adopted or foster child.</li> <li>5. Military caregiver and qualifying exigency leave as explained in the Department of Labor Family and Medical Leave poster on last page if this handbook.</li> </ol>
Length of Leave	<p>12 work weeks during any 12-month period.</p> <ol style="list-style-type: none"> <li>1. Intermittent leave, reduced work schedule permitted when leave taken for care of sick family member or employee’s own serious health condition.</li> <li>2. Leave may be taken on intermittent or reduced work schedule basis for birth or adoption of child if employer agrees.</li> <li>3. When spouses work for same employer, leave is limited to a total of 12 weeks when leave is for birth, adoption or foster care of a child or to care for a sick parent.</li> </ol>
Notice	30 days notice if need for leave foreseeable. If unforeseeable, notice required as soon as practicable.
Certification	Employers may require certification from health care provider. Can require second opinion at employer’s expense if validity doubtful. Third opinion is conclusive.
Paid or Unpaid	Unpaid. Shangri-la policy requires employees to exhaust accrued paid leave prior to requesting unpaid leave.
Reinstatement in job upon return to work	Yes
Benefits	Health insurance premiums continue to be paid by Shangri-La for employee only. Employees must pay premiums for family members and dependents and any other voluntary insurance coverage of any kind.

***See Department of Labor poster about Family and Medical Leave on last page for additional details***

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**Summary of Oregon Family Leave Revised 7/13**

Description	Oregon Family Leave
Eligibility	Employed at least 180 days and work an average of 25 or more hours per week. Exception: Reason #1 below only requires employment of 180 days. Reason #6 below only requires 20 or more hours per week, no length of employment criteria.
Reasons For Leave	<ol style="list-style-type: none"> <li>1. To care for an infant, newly adopted or newly placed foster child under 18 years of age or for an adopted or foster child over 18 years of age if incapable of self-care due to mental or physical disability. Leave must be completed within 12 months after birth or placement of the child. Employee is not eligible for this type of leave after the expiration of 12 months after birth or placement of the child.</li> <li>2. Care for a spouse, same sex domestic partner, parent, parent-in-law, biological, adopted or foster child, grandparent or grandchild with a serious health condition.</li> <li>3. To recover from or seek treatment for a serious health condition of the employee.</li> <li>4. To care for a child of the employee who is suffering from an illness, injury or condition that is not serious but requires home care. Employers may refuse to approve this type of leave if another family member is available to take care of the child.</li> <li>5. Illness, injury or condition related to childbirth.</li> <li>6. Military Leave Entitlements as explained in the Bureau of Labor &amp; Industries Oregon Family Leave poster on last page if this handbook.</li> <li>7. Bereavement Leave effective January 1, 2014.</li> </ol>
Length of Leave	<p>12 weeks within any 1-year period. Exceptions:</p> <ol style="list-style-type: none"> <li>1. A female employee who takes 12 wks for reason #1, 2, or 4 above within a 1-yr period may take up to an additional 12 wks for reason #5 in same 1-yr period.</li> <li>2. An employee who takes 12 wks for reason #1 above within a 1-yr period may take up to an additional 12 wks for reason #4 above within the same 1-yr period.</li> <li>3. When 2-family members work for the same employer, they cannot take family leave at the same time unless (a) one employee needs to care for the other employee who is suffering from a serious health condition or (b) one employee needs to care for a child who has a serious health condition while the other employee is also suffering from a serious health condition.</li> <li>4. Intermittent leave may be available per employer's approval for parental leave.</li> <li>5. Military Leave Entitlements as explained in the Bureau of Labor &amp; Industries Oregon Family Leave poster on last page if this handbook</li> <li>6. Eligible employees may request up to two (2) weeks bereavement leave within a 12 month period per death of covered family member; leave must be taken with 60 days of notice of death; multiple deaths of covered family members entitle employees to request up to 2 weeks for each death; family members working for the same employer must be permitted to take leave at the same time. Bereavement leave is credited against the employees 12 weeks of leave under OFLA and is not an additional two weeks for each death.</li> </ol>
Notice	<ol style="list-style-type: none"> <li>1. Thirty (30) day notice if the need for leave is foreseeable. When unforeseeable verbal notice within 24 hrs of leave and written notice within 3 days after employee returns to work. Verbal notice may be given by any other person on behalf of the employee.</li> <li>2. Military Leave Entitlements as explained in the Bureau of Labor &amp; Industries Oregon Family Leave poster on last page if this handbook</li> <li>3. For Bereavement leave employee must provide at least verbal notice of leave within 24 hours of starting leave; employers may require written notice within 3 days.</li> </ol>
Certification	Medical certification may be required prior to leave for reason #2, 3, or 4, above. Medical verification for reason #4 may only be required after employee has taken three (3) days of leave. This type of medical verification is at employer's expense. When leave unforeseeable, medical verification within 15 days. At employer's expense may be required to obtain 2 <sup>nd</sup> and 3 <sup>rd</sup> opinion. Third opinion will be considered final and binding.
Paid or Unpaid	Unpaid. Shangri-La policy requires employees to exhaust accrued paid leave prior to requesting unpaid leave.
Reinstatement	Yes
Benefits	Not required. Employee may pay health insurance continuation for self and family members.

**See Bureau of Labor & Industries Oregon Family Leave poster on last page for additional details**

## **7.8 Jury Duty Leave** Revised 10/04; 6/06; 7/13

All Shangri-La employees are encouraged to serve as jury members or court witnesses. If normally scheduled to work, employees are eligible for leave with pay during those days on active jury duty, less any pay received for serving as a jury member or court witness, subject to the following arrangements:

- The summons to serve on a jury must be shown to your supervisor within twenty-four (24) hours of receipt or next scheduled work shift, whichever comes first.
- Upon completion of jury duty, written verification that the employee served on a jury or was required to remain available to serve on a jury must be presented to the supervisor, along with a record of any pay received while on jury duty.
- Jury duty leave is a paid absence, but the time is not deducted from an employee's paid leave accruals.
- Jury duty leave with pay is limited to a maximum of eighty (80) hours per calendar year. The calendar year begins January 1 and ends December 31 of each year.
- In the event an employees must serve as a jury member or court witness in excess of eighty (80) hours per calendar year, the employee may take additional leave as paid or unpaid leave.

## **7.9 Military Leave** – 6/06; 7/13;11/13

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment to undertake military service or certain types of service in the National Disaster Medical System. The following is a brief summary of an employee's rights under USERRA. Please discuss any questions about leaves of absence covered by USERRA with your supervisor or Human Resources personnel.

- Employers are prohibited from discriminating against past and present members of the Uniformed Services and applicants to the Uniformed Services, and may not deny reemployment, retention in employment, promotion or any benefit of employment to an individual on the basis of his or her membership, application for membership, performance of service, application for service or obligation for service in the Uniformed Services.
- Employees should provide notice of service as much in advance as is reasonable for the circumstances, unless military necessity or other conditions make it impossible to provide notice.
- The maximum cumulative length of absence is five (5) years.
- Under USERRA, no break in employment is considered to have occurred because of military service and no forfeiture of benefits already accrued is permitted.
- Employees are not required to, but may use accumulated paid leave benefits during an eligible absence until exhausted.
- Employees on military leave and their dependents may pay the premiums to continue group health insurance coverage for up to twenty-four (24) months of service. If group health insurance coverage was not continued, the employee and his or her family may re-enter the group health plan upon reemployment.

Oregon Veterans may take paid or unpaid time off on Veterans Day with 21 days prior notice unless leave creates an undue hardship or operational disruption. Veterans may choose an alternative day off if denied leave on Veterans Day.

### **7.10 Domestic Violence Leave** Added 7/13

All employees regardless of hours worked or length of employment may be approved for a reasonable leave of absence to obtain services or treatment relating to or resulting from domestic violence, sexual assault, or stalking whether suffered by the employee or the employee's minor child or dependent. Leave may be taken to seek legal or law enforcement assistance, medical treatment, counseling, attend court proceedings to relocate or take other steps to ensure health and safety.

Leave may be paid or unpaid based on other Shangri-La policy.

The amount of leave available is not defined and may be limited if it creates an undue hardship defined as significant difficulty and expense to the employers business and critical need to have the employee at work.

When available, employers are permitted to request and obtain documentation of the events leading to a leave request for this purpose which may include police reports, medical certification, attorney records or other reasonable documentation. All such documentation will be maintained in a confidential file.

Employees taking leave for the above purposes are protected from retaliation or disciplinary actions based on the use of such leave.

### **7.11 Pay in Lieu of Paid Leave** Revised 3/03; 6/06; 9/11; 1/12; 11/12

Effective January 1, 2012 regular, hourly non-exempt employees in positions *that require replacements when they are absent*, and maintain a balance of at least eighty (80) hours of paid leave, (including sick and vacation hours earned prior to July 1, 1993), may choose to receive pay in the form of wages, while maintaining the required eighty (80) hours balance, multiplied by the employee's current rate of pay.

Effective January 1, 2012 regular, hourly non-exempt employees in positions *that do not require replacements when they are absent*, and maintain a balance of at least eighty (80) hours of paid leave, (including sick and vacation hours earned prior to July 1, 1993), may choose to receive pay in the form of wages for up to forty (40) accrued paid leave hours per calendar year, while maintaining the required eighty (80) hours balance, multiplied by the employee's current rate of pay.

Effective November 1, 2012, regular salaried and exempt employees who maintain a balance of at least eighty (80) hours of paid leave, (including sick and vacation hours earned prior to July 1, 1993), may choose to receive pay in the form of wages for up to forty (40) accrued paid leave hours per calendar year, while maintaining the required eighty (80) hours balance, multiplied by the employee's current rate of pay.

Requests for pay in lieu of Paid Leave can be made on a time sheet or a leave request form and included with regularly scheduled payroll. Payments requested outside of regularly scheduled payroll would be considered an Emergency Draw. Remaining paid leave hours not received as wages will be accumulated and retained for future use.

### **7.12 Paid Leave Donations** Revised 3/03

Regular employees may voluntarily donate a portion of their accrued paid leave, in excess of eighty (80) hours, to co-workers who have unanticipated emergencies which cannot be covered by the co-workers accrued paid leave. Paid leave donations to co-workers may not exceed twelve (12) weeks of paid leave or the actual length of leave, whichever is less. (See Paid Leave Donations Procedure for details)

### **7.13 Health Insurance** – Revised 12/04; 3/05; 6/06; 1/11; 12/13

All regular employees scheduled to work twenty (20) hours or more each week are eligible for health insurance benefits. Regular employees working at least thirty (30) hours per week are eligible for employer paid health insurance benefits. Shangri-La's contribution toward employee health insurance premium is offered on a prorated basis for regular employees working less than thirty (30) hours per week beginning with the plan year January 1, 2014. An eligible employee's health insurance becomes effective no sooner than the first day of the month following sixty (60) days of regular employment.

Shangri-La customarily provides notification of eligibility for health insurance benefits; however, it is the employee's responsibility to contact the Business Office or Human Resources personnel to initiate health insurance benefits when eligibility requirements have been completed.

There are several conditions under which employees may continue health insurance for a limited time upon separation of employment, if payment for the full cost of the insurance premium is received. This information will be available upon separation of employment.

### **7.14 403(b) Deferred Compensation Plan (Retirement)** Revised 12/13

Due to the fact that Shangri-La is a tax-exempt organization as described in section 501(c)(3) of the Internal Revenue Code, employees can contribute a portion of their wages to a 403(b) Deferred Compensation (retirement) Plan. Income taxes on the contributions are deferred until retirement after age 59½, with a 10% penalty for withdrawals before that age. Employees determine and can change the amount of contributions, within limits, set annually by the IRS, which are invested through mutual funds that an employee chooses. A Salary Reduction Agreement is submitted by the employee to the Business Office, after selecting the amount of contribution, where and how it will be invested. Professional advice regarding retirement and investments is strongly advised. Most banks or credit unions have advisors and the ability to establish 403(b) plans.

### **7.15 Flexible Spending Account (FSA)**

All regular employees are eligible to use the Flexible Spending Account Plan. This plan permits regular employees to choose certain "tax free" benefits, in lieu of taxable compensation. Please contact the Business Office or Human Resources for more details.

### **7.16 Worker's Compensation**

Shangri-La maintains full compliance with the State Workers' Compensation Board. All employees are covered by workers' compensation insurance while on the job.

- Employees are required to submit Shangri-La's Occupational Injury Report (OIR) form to the immediate supervisor within twenty-four (24) hours, for any accident or injury that did not require immediate medical attention.
- If immediate medical attention is necessary or becomes necessary later, then a Form 801 is required within twenty-four (24) hours of seeking medical attention. If the employee is not physically able to perform their job duties because of an on-the-job injury, every effort will be made to temporarily modify job duties to enable the employee to return to work as soon as possible. Employees that do not return to work are required to maintain at least weekly contact with their supervisor.
- If an individual served by Shangri-La caused the injury reported on the OIR or Form 801, then the employee should also complete or provide a copy of the Therap GER or other type of Incident Report or Event Record customarily required and completed by the program for this type of incident.

**7.16 Worker's Compensation (Continued)**

- If the employee misses work for more than three (3) calendar days because of an on-the-job injury, he or she may be eligible to receive time loss benefits from Shangri-La's worker's compensation carrier. Each on-the-job injury claim will be reviewed individually to determine eligibility.
- Shangri-La may authorize employees to access their accrued paid leave for any regularly scheduled work hours not worked due to injury and not eligible for time loss benefits.
- In cases where injured workers must draw disability payments, Shangri-La does not make up the difference between disability payments and the employee's pay. For salaried employees, any time-loss benefits will be deducted from their salary to reflect that absence.

**7.17 Credit Union & Direct Deposit**

All Shangri-La employees are eligible to use the Marion-Polk Schools Credit Union services (MAPS).

Direct payroll deposits with MAPS and most banking institutions may be arranged through Shangri-La's Business Office upon request.

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## **8.0 EMPLOYEE DEVELOPMENT**

### **8.1 Position Descriptions**

Position descriptions are available upon request. Upon hire, employees will receive the position description for the job for which they were hired. Occasionally, when a position is temporary or newly developed, the position description may not be available immediately.

### **8.2 Training and Orientation** – Revised 6/06; 7/13

Orientation is scheduled and required for all new employees in order to familiarize them with Shangri-La's Mission, ethics, policies, practices, procedures, responsibilities and the duties of the position.

- Some orientations may be required prior to beginning work or performing job duties.
- All employees will remain “Temporary” until completing mandatory orientations, training and health testing.
- Orientations and trainings are usually scheduled one time each month.
- Relief employees may not be permitted to work until all orientation, training and health testing is completed depending on each employees previous experience and training and the requirements for each work unit.
- Employees are expected to complete all orientation, training and health testing according to the schedules provided when hired. Employee’s failing to complete orientation, training and health testing according to the schedules provided may be subject to disciplinary action up to and including termination of employment.
- Employees will be paid for time involved in orientations and training.

Employees may be required to attend and successfully complete training on an annual basis. Some programs require a minimum number of training hours or annual certification in specific subject areas, others require individual employees or teams attend training to remain current with industry standards and best practices. Employee are expected to meet the training requirements applicable to their position with Shangri-La. Employees that do not meet required training requirements may be subject to disciplinary action including termination of employment.

For some programs or departments this policy may require that Shangri-La offer training in various required subjects annually. This policy also requires all supervisory employees to:

- Communicate the value of the training.
- Make every effort to inform employees of training schedules and times.
- Make every effort to provide alternative coverage to allow attendance at scheduled trainings.

## **8.2 Training and Orientation Continued**

Depending on program or department requirements some mandatory orientations, training and health requirements include, but are not limited to:

- First Aid
- CPR
- Health Services
- TB Tests
- Bloodborne Pathogen Training
- Fatal Four
- Staff Meetings & In-service Trainings
- Safety including Hazard Communications
- Oregon Intervention Systems (OIS)
- Medication Administration
- Mission & Values
- Hepatitis B Vaccination
- Recognizing/Preventing Sexual Harassment, Discrimination and Workplace Violence
- Abuse Reporting
- Confidentiality
- Technology use policy
- Human Interaction Principles

In order to be considered eligible for promotion, transfer or other changes in employment status, employees are expected to be current in all required training and certifications.

- Newly hired employees that may not have had the opportunity to complete all training requirements but are otherwise eligible to seek promotion, transfer or other changes in employment status, will have the opportunity to have the request or application considered.
- Employees who attend training or other education opportunities not provided by Shangri-La are responsible to provide documents of attendance, successful completion and number of hours or credits earned for the training record.
- Each employee is responsible for registering at any orientation or training session.

## **8.3 Individual Educational Opportunities**

Employees are encouraged to attend training and other educational opportunities offered outside of Shangri-La. When such opportunities are directly related to their field of employment, Shangri-La may reimburse the employee for the tuition costs as long as the following criteria are met:

- The employee obtains prior approval from a Director for reimbursement arrangements.
- Job duties and performance are not adversely affected.
- The employee receives the agreed upon grade.
- Maximum reimbursement per employee per course is \$50.00.
- Maximum reimbursement per employee per year is \$100.00.

## **8.4 Travel Expenses for Professional Conferences/Workshops**

Employees may be granted time off to attend professional conferences, seminars, institutes, workshops and meetings with prior approval from supervisors and Directors. Shangri-La may reimburse travel expenses for such conferences per the Mileage Reimbursement policy.

**8.5 Transfer to Another Department or Work Unit** – Revised 6/06; 7/13

Shangri-La encourages employees to apply for other positions within the organization.

- Positions available are advertised as position announcements and usually distributed to employees by email, posted on-line, and at administrative office locations.
- Position announcements typically include the title, hourly wage or salary range, minimum hiring requirements and responsibilities.
- To be eligible to apply for a position within Shangri-La, employees should meet the minimum hiring requirements and be in good standing.
- Any employee applying for another position within Shangri-La must complete an internal application.
- The employee is responsible for monitoring job vacancy notices and for completing and submitting the necessary forms during the stated posting period.
- The employee's supervisor will be contacted as part of a job reference check for any employee who has applied for a posted position or requested a transfer.
- Granting and scheduling transfers will be made in the best interest of Shangri-La and the individuals served.

*The remainder of this page intentionally left blank.*

## **9.0 Discipline – Revised 6/06; 12/13**

Shangri-La has policies, procedures and rules of conduct that apply to all employees. These are necessary to assure a safe, efficient business operation, to assure compliance with public laws, and to protect the well being and rights of all employees and to carry out Shangri-La's Mission.

The following list, which is not all-inclusive, outlines acts and behavior that are not acceptable. Unacceptable work behavior is grounds for disciplinary action including termination of employment.

### **9.1 First Level Offenses**

First level offenses are unacceptable acts and behavior that are subject to disciplinary action. In general the disciplinary action for these types of offenses results in the issuance of warning notices. The purpose of a warning notice is to impress upon an employee the need for corrective action on his or her part.

Due to the nature of the offense, discussions between the supervisor and the employee may occur to allow the employee to correct the situation before it reaches the stage of a warning notice. These discussions are normally documented by a memo that becomes part of the employees personnel file.

If a warning notice is issued, it becomes a part of an employee's employment record and will be considered when evaluating performance, disciplinary actions or when considering an employee's application for promotion or transfer.

Management is responsible for evaluating each case based on its individual facts. Management expressly retains the right to determine the facts that support allegations of wrongdoing against the employee. Examples of first level offenses include, but are not limited to:

- Unauthorized time away from workstation.
- Failure to meet housekeeping responsibilities.
- Use of profanity.
- Failure to adhere to Shangri-La's communication standards.
- Job related traffic violations.
- Leaving the premises without completing a time sheet.
- Failure to take necessary safety precautions or adhere to dress code.
- Lack of attention to job responsibilities including medication administration or documentation errors.
- Failure to follow prescribed work procedures.

## **9.0 Discipline (Continued)**

### **9.2 Second Level Offenses**

Second level offenses include behavior that is of such a nature that violation may result in both a warning notice and disciplinary time off without pay. Repetition of the type of offense usually results in discharge. Examples of second level offense include but are not limited to:

- Failure to follow supervisor's instructions.
- Unauthorized or excessive absence, tardiness or leaving a work shift without adequate notice.
- Obscene, abusive, offensive or disruptive language or behavior.
- Completing a time sheet or other documentation on behalf of another employee or permitting any other person to complete a time sheet or other documentation for self.
- Violation of confidentiality rules or ethical standards.
- Violation of Safety policy, procedure or practice.
- Leaving the premises during working hours without informing supervisor.
- Excessive traffic violations.
- Medication administration or documentation errors.
- Unauthorized use of materials or equipment.
- Consumption of food or beverages of individuals served except when employee is working in a residential setting and is scheduled to provide support services during meal times or is a guest at meals time by invitation of the individual served.
- Posting or removal of notices, signs or writing in any form on bulletin boards or company property without approval.

### **9.3 Third Level Offenses**

Third level offenses include behavior of such a serious nature that a first occurrence will normally warrant discharge. Examples of third level offenses include, but are not limited to:

- Reporting to work when intoxicated or under the influence of alcohol or illegal drugs.
- Falsifying any records such as time sheets, vouchers or reports, including insurance claims, personal absence, illness, timer production records or records and documents regarding any and all services provided to or on behalf of those served by Shangri-La.
- Deliberately damaging, defacing or misusing company property or the property of others.
- Insubordination.

9.3 **Third Level Offenses (Continued)**

- Theft which is defined as the unauthorized use of Corporation or other's services, facilities, property, goods or funds and the possession of Corporation or other's property, goods or funds for personal use.
- Recording on the time sheet of an absent employee or when absent, arranging for any other person to do so for self.
- Unauthorized work hours, either on or off Shangri-La's premises, even when those hours are not claimed as paid work hours.
- Gambling at work.
- Acts of physical violence or any violation of the Workplace Violence Policy.
- Abusive or inappropriate treatment of individuals served.
- Failure to report abuse or inappropriate treatment of Individuals served.
- Immoral or indecent conduct.
- Sleeping during paid working hours.
- Unauthorized possession of explosives, firearms or other dangerous weapons and devices on company property including parking areas.
- Failure to participate in investigations.
- Failure to report an absence without a satisfactory explanation.
- Unauthorized removal of safety locks or tags and any failure to abide by safety policy, practice or procedure
- Threatening, intimidating, coercing or interfering with other employees or supervisors performance of job duties and responsibilities.
- Falsification of employment or personal history data.
- Job abandonment

Regardless of the level of the offense, Shangri-La expressly retains the right to take whatever disciplinary action it deems appropriate in its sole discretion based on the circumstances involved. In addition, the prohibited acts described are merely illustrative of the types of prohibited behaviors. Those lists are not exhaustive. Shangri-La reserves the right to discipline conduct that is not included on those lists.

## **10.0 SEPARATION FROM EMPLOYMENT**

### **10.1 Resignation & Termination** Revised 12/13

If it becomes necessary for an employee to leave Shangri-La it is important to give proper notice. When an employee voluntarily resigns employment, accrued paid leave hours may be forfeited if the employee fails, neglects or refuses to provide at least two (2) weeks written notice of resignation prior to the last day of work. If an employee is terminated for reasons of misconduct he/she may lose all claims to these benefits.

Upon voluntary separation of employment with adequate notice, 100% of unused paid leave, up to a maximum of two-hundred forty (240) hours may be payable at the employees current rate of pay, as separation benefits.

To be in good standing and considered eligible for rehire, a resignation must be submitted in writing at least fourteen (14) calendar days prior to the employee's final workday.

Accrued paid leave may not be used in lieu of working during the notice period unless approved by a Shangri-La Director.

### **10.2 Exit Interview**

Shangri-La is interested in your comments and customarily conducts an exit interview with all employees who are separating employment.

### **10.3 Employment References**

Only those employees authorized by the Chief Executive Officer may release employment information upon request.

All requests for employment information must be forwarded to the Human Resources Department.

The only information Shangri-La will release is dates of employment, positions held and description of the duties performed in those positions. No additional information including the eligibility for rehire will be released.

Separating employees may request a reference from the Chief Executive Officer, who reserves the right to deny such requests if circumstances do not warrant a positive or at least neutral response.

### **10.4 Rehiring Former Employees**

In most cases voluntary or involuntary termination of employment involves a loss of seniority and accumulated benefits. However there are some exceptions when employees return to work within one (1) year of separation from employment. See benefits section 7.0 for details. Returning applicants will be subject to all aspects of Shangri-La's hiring policy, procedure and practice.

## **11.0 CONCLUSION** – Revised 6/06; 7/13

The foregoing pages set out the basic employment policies of Shangri-La as they exist at this time. Shangri-La is a dynamic, growing organization and new challenges and opportunities will mean the need to develop new and modified policies. Our employment policies will be reviewed on a periodic basis to ensure they continue to reflect Shangri-La's Vision, Mission and Values. We encourage questions about the information outlined in the employee handbook or about other aspects of employment and appreciate your continued contributions.



**EMPLOYEE HANDBOOK**

**RECEIPT ACKNOWLEDGMENT**

I, the undersigned, acknowledge receipt of the Shangri-La Employee Handbook.

- I understand that the Employee Handbook outlines Shangri-La's employment policies that apply to all employees.
- I agree to read and become familiar with the contents of the Employee Handbook prior to reporting to work and understand I will be bound by the contents when received.
- If I am receiving the Employee Handbook again, I am receiving it because of changes to the handbook. I agree to read and become familiar with all changes to the handbook and understand I will be bound by those changes when received.
- I agree to refer to and abide by the policies and requirements set forth therein.
- I understand that it is my responsibility to discuss any questions I may have regarding this information with my supervisor.
- It is also understood that this acknowledgement form will be maintained in my personnel file as evidence of having received Shangri-La's most recent edition of the Employee Handbook.

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Employee/Volunteer Signature

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Date

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Please Print Name



# EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

## Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

## Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness\*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.\*

**\*The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

## Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

## Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months\*, and if at least 50 employees are employed by the employer within 75 miles.

**\*Special hours of service eligibility requirements apply to airline flight crew employees.**

## Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and

a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

## Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

## Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

## Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

## Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

## Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

## Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

**FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.**



For additional information:  
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627  
[WWW.WAGEHOUR.DOL.GOV](http://WWW.WAGEHOUR.DOL.GOV)

U.S. Department of Labor | Wage and Hour Division



WHD Publication 1420 · Revised February 2013



Oregon

Brad Avakian, Commissioner



# FAMILY LEAVE ACT

## NOTICE TO EMPLOYERS AND EMPLOYEES

The Oregon Family Leave Act (OFLA) requires employers of 25 or more employees to provide eligible workers with protected leave to care for themselves or family members in cases of death, illness, injury, childbirth and adoption. ORS 659A.150 to 659A.186

### When can an Employee take Family Leave?

- Employees can take family leave for the following reasons:**
- ⇒ **Parental Leave** during the year following the birth of a child or adoption or foster placement of a child under 18, or a child 18 or older if incapable of self-care because of a mental or physical disability. Parental leave includes leave to effectuate the legal process required for foster placement or adoption.
  - ⇒ **Serious health condition leave** for the employee's own serious health condition, or to care for a spouse, parent, child, parent-in-law, grandparent, grandchild or same gender domestic partner with a serious health condition. NOTE: Does not include an employee unable to work due to a compensable Workers Compensation injury.
  - ⇒ **Pregnancy disability leave** (a form of serious health condition leave) taken by a female employee for an incapacity related to pregnancy or childbirth, occurring before or after the birth of the child, or for prenatal care.
  - ⇒ **Sick child leave** taken to care for an employee's child with an illness or injury that requires home care but is not a serious health condition.
  - ⇒ **Bereavement leave** to deal with the death of a family member.
  - ⇒ **Oregon Military Family Leave** is taken by the spouse or same gender domestic partner of a service member who has been called to active duty or notified of an impending call to active duty or is on leave from active duty during a period of military conflict.

### Who is Eligible?

To be eligible for leave, workers must be employed for the 180 day calendar period immediately preceding the leave and have worked at least an average of 25 hours per week during the 180-day period.

**Exception 1:** For parental leave, workers are eligible after being employed for 180 calendar days, without regard to the number of hours worked.

**Exception 2:** For Oregon Military Family Leave, workers are eligible if they have worked at least an average of 20 hours per week, without regard to the duration of employment.

### How much Leave can an Employee take?

- ⇒ Employees are generally entitled to a maximum of 12 weeks of family leave within the employer's 12-month leave year.
- ⇒ A woman using pregnancy disability leave is entitled to 12 additional weeks of leave in the same leave year for any qualifying OFLA purpose.
- ⇒ A man or woman using a full 12 weeks of parental leave is entitled to take up to 12 additional weeks for the purpose of sick child leave.
- ⇒ Employees are entitled to 2 weeks of bereavement leave to be taken within 60 days of the death of a covered family member.
- ⇒ A spouse or same gender domestic partner of a service member is entitled to a total of 14 days of leave per deployment after the military spouse has been notified of an impending call or order to active duty and before deployment and when the military spouse is on leave from deployment.

### What Notice is Required?

Employees are required to give 30 days notice in advance of leave, unless the leave is taken for an emergency. Employers may require that notice is given in writing. In an emergency, employees must give verbal notice within 24 hours of starting a leave.

### Is Family Leave Paid or Unpaid?

Although Family Leave is unpaid, employees are entitled to use any accrued paid vacation, sick or other paid leave.

### How is an Employee's job Protected?

Employers must return employees to their former jobs or to equivalent jobs if the former position no longer exists. However, employees on OFLA leave are still subject to nondiscriminatory employment actions such as layoff or discipline that would have been taken without regard to the employee's leave.

### FOR ADDITIONAL INFORMATION:

Employer Assistance . . .971-673-0824	BOLI
Portland . . . . .971-673-0761	Civil Rights Division
Eugene . . . . .541-686-7623	800 NE Oregon, #1045
Salem . . . . .503-378-3292	Portland, OR 97232
<a href="http://www.oregon.gov/BOLI">www.oregon.gov/BOLI</a>	<a href="mailto:bolita@boli.state.or.us">bolita@boli.state.or.us</a>

**Employees who have been denied available leave, disciplined or retaliated against for requesting or taking leave, or have been denied reinstatement to the same or equivalent position when they returned from leave, may file a complaint with BOLI's Civil Rights Division.**

This is a summary of laws relating to Oregon Family Leave Act. It is not a complete text of the law.

December 2013

**THIS INFORMATION MUST BE POSTED IN A CONSPICUOUS LOCATION**



# Mental Health Housing

## Mental Health Clinician Credentialing - BH

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**PURPOSE:** To ensure that clinicians are credentialed and providing services appropriate to their education and experience and in accordance with Oregon Administrative Rules (OAR).

**POLICY:** Shangri-La Mental Health Programs ensure that clinicians meet the requirements to provide services as Qualified Mental Health Professionals (QMHP) or Qualified Mental Health Associates (QMHA).

### **PROCEDURE:**

1.0 All clinicians/case managers seeking to provide mental health services in Shangri-La mental health programs must be credentialed either as QMHP or QMHA and will provide the required documentation to make such determination.

#### 2.0 Initial Credentialing

- a. A credential file is established for each clinician, documenting the required experience and training to meet standards outlined in the Oregon Administrative Rules (OAR 309-032-0535 (Adults) and OAR 309-032-0960 (Children)). If the individual is not a Licensed Professional Counselor, this documentation is kept in a Credentialing section within their employee file. The credential documentation includes the following:
  - i. Credentialing Checklist signed and dated by the clinical supervisor, a copy of this form is attached in Appendix A
  - ii. Agency application form and/or resume that clearly delineates work experience and education to support the QMHP/A designation
  - iii. Copies of any diplomas and primary source verification with the training institution
  - iv. Criminal background check results
  - v. Copies of licenses, certifications, and certificates of additional coursework or training
  - vi. Check for Medicaid exclusions (OIG check)
  - vii. Relevant Continuing Professional Education courses (CPE certificates)
  - viii. MVBCN Staff Adverse Actions Report Staff Disclosures Form
  - ix. Supporting documentation of required clinician's competencies, copies of the QMHA and QMHP Competencies Check Lists are included in Appendix B.
  - x. Any additional documentation that may be requested or required to show that the clinician meets the standards in the OAR.
- b. The Mental Health Director or designee reviews all documentation and makes the determination that the clinician meets the standards for the QMHP/A designation.
- c. The Credentialing Coordinator will verify the academic degree by and document that on the Credentialing Form.
- d. The completed Credentialing File is returned to the Human Resources Department which maintains custody of the file.

#### 3.0 Re-credentialing

- a. All Mental Health clinicians must complete the MVBCN Staff Adverse Actions Report Staff Disclosure Form every two years and submit it to their supervisor for re-credentialing.

## Mental Health Housing Mental Health Clinician Credentialing - BH

b. Licensed Professional Counselors must also comply with the re-credentialing process described in the Provider Credentialing and Privileging policy (AD-200-505).

### Mental Health Provider Credentialing Checklist

**Employee Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Program** \_\_\_\_\_ **Title** \_\_\_\_\_

**Date of Hire** \_\_\_\_\_

**Supervisor** \_\_\_\_\_

In <input type="checkbox"/> QMHA's or <input type="checkbox"/> QMHP's Credentialing File
<input type="checkbox"/> Current Resume/CV
<input type="checkbox"/> Adjunct Service Provider Form (for MH Counseling Interns and others as appropriate) with Documentation
<input type="checkbox"/> QMHA or QMHP Competencies Certification Form with Documentation
<input type="checkbox"/> Criminal Background Check Results
<input type="checkbox"/> Primary Source Verification of Education
<input type="checkbox"/> Relevant Continuing Professional Education courses (CPE-certificates)
<input type="checkbox"/> MVBCN Staff Adverse Actions Report Staff Disclosure Form
<input type="checkbox"/> Check for Medicaid Exclusions

I have reviewed the provider's credentials for completeness and find the provider qualified to provide mental health services for Shangri-La.

# Mental Health Housing Mental Health Clinician Credentialing - BH

Printed Name and Title \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

## QMHA Credentials & Competencies Checklist

Provider Name \_\_\_\_\_

Date \_\_\_\_\_

### CREDENTIALS

- *This person has the following credentials (check one)*

- A bachelor's degree in a behavioral sciences field
- A combination of at least three years' relevant work, education, training or experience.
- Other (Please attach a completed Adjunct Service Provider form) \_\_\_\_\_

### COMPETENCIES

- *This person demonstrates the following competencies (check all that apply)*

- Communicate effectively
- Understand mental health assessment, treatment and service terminology and apply the concepts
- Provide psychosocial skills development
- Implement interventions prescribed on a Treatment Plan within the scope of his or her practice

### DOCUMENTATION

- *Written demonstrations of the above, as indicated in the following documents are attached.*

- Case service plan
- Session notes, please include at least 3 notes

### HEALTH QUALIFICATION

Have you ever observed or been informed of any physical/mental health, drug or alcohol dependencies or other problems that this person may have that have impaired or could possibly impair ability to exercise patient/client care at Shangri-La?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

Signature below attests that the mental health service provider named above has demonstrated the abovementioned competencies and the documents attached are the work of that provider.

# Mental Health Housing Mental Health Clinician Credentialing - BH

---

Program Manager/Clinical Supervisor (please print)

---

Signature

Date

## QMHP Credentials & Competencies Checklist

Provider Name \_\_\_\_\_

Date \_\_\_\_\_

### CREDENTIALS

- This person has the following credentials (check one)

- Graduate degree in psychology
- Bachelor's degree in nursing and licensed by the State of Oregon
- Graduate degree in social work
- Graduate degree in a behavioral science field
- Graduate degree in recreational, art, or music therapy
- Bachelor's degree in occupational therapy and licensed by the State of Oregon
- Other (Please attach a completed Adjunct Service Provider form) \_\_\_\_\_

### COMPETENCIES

- This person demonstrates the following competencies (check all that apply)

- Identify precipitating events
- Gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts
- Assess family, social and work relationships
- Conduct a mental status examination
- Document a multi-axial DSM diagnosis
- Write and supervise a treatment plan (children); or write and implement or supervise implementation of a treatment plan (adults)
- Conduct a Comprehensive Mental Health Assessment (children); or conduct and document a mental health assessment (adults)
- Provide individual, family, and/or group therapy within the scope of his or her practice (children); or provide mental health treatment and rehabilitative services within the scope of his or her practice (adults).

### DOCUMENTATION

- Written demonstrations of the above, as indicated in the following documents are attached.
  - Mental health assessment
  - Treatment plan
  - Session notes, please include at least 3 notes

### HEALTH QUALIFICATION

Have you ever observed or been informed of any physical/mental health, drug or alcohol dependencies or other problems that this person may have that have impaired or could possibly impair ability to exercise patient/client care at Shangri-La?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

# Mental Health Housing Mental Health Clinician Credentialing - BH

---

If yes, please explain: \_\_\_\_\_

Signature below attests that the mental health service provider named above has demonstrated the abovementioned competencies and the documents attached are the work of that provider.

---

*Program Manager/Clinical Supervisor (please print)*

---

*Signature*

*Date*

## MENTAL HEALTH PROGRAM OVERVIEW

Shangri-La operates 8 Residential Treatment Homes serving 40 individuals with serious mental illness in 5 Counties. Shangri-La's Mental Health Housing program helps the people living in the homes to access resources and learn skills to live as independently as they are able. Services provided include living skills training, planning for success, medication management, connection to community resources, recreation opportunities, health management, and other supports needed to aid in their success.

### Marion County:

- Adams Lane: Adams Lane provides housing to 5 individuals who are under Civil Commitment.
- Via Verde: Via Verde provides housing for 5 individuals under the jurisdiction of the Psychiatric Security Review Board (PSRB).

### Linn County

- Old Oak: Old Oak provides housing for 5 individuals who are under Civil Commitment.
- Casa Rio: Casa Rio provides housing for 5 individuals who are under Civil Commitment

### Benton County

- Sequoia Creek: Sequoia Creek provides housing for 5 individuals who are under Civil Commitment.

### Lane County

- Myers 370 Home: Myers is a 370 Aid and Assist home and provides housing and supports to 5 individuals.
- Danebo: Danebo provides housing and supports for 5 individuals who are under Civil Commitment.

### Lincoln County

- Benton Home: Benton provides housing and supports to 4 individuals who are under Civil Commitment and to 1 individual who is under the jurisdiction of the PSRB.

## CONNECT WITH US



[www.shangrilacorp.org](http://www.shangrilacorp.org)

[www.facebook.com/ShangriLaCorp](https://www.facebook.com/ShangriLaCorp)

[@ShangriLaOregon](https://twitter.com/ShangriLaOregon)

[www.youtube.com/user/ShangriLaCorp](https://www.youtube.com/user/ShangriLaCorp)

Salem  
4080 Reed Road SE  
Suite #150  
Salem, OR 97302  
☎ 503-581-1732

Eugene  
Pearl Buck Center  
3690 W. 1st Ave.  
Eugene, OR 97402  
☎ 541-515-8890

Newport  
141 NW 11th Street  
Newport, OR 97365  
☎ 541-265-4015

Florence  
85188 Hwy 101 S.  
Florence, OR 97349  
☎ 541-997-8028



**309-035-0420**

**Prohibition of Seclusion and Restraints**

No resident will be placed in seclusion. Seclusion is defined as placing an individual in a locked room. Resident rooms have locks that only prevent others from entering, not preventing them from leaving while inside.

The use of restraints (physical, chemical and mechanical) is prohibited. Restraints are defined as the restriction or inhibition of movement, functioning, or behavior of a resident.

**Attachments: NONE**

**Health Systems Division**  
**Home and Community-Based Services**  
**Evidence Package**

**Salmon Run**

**OREGON HEALTH AUTHORITY  
RESIDENTIAL TREATMENT HOME LICENSE**

Name: **Salmon Run RTH**  
Address: **2575 Westgate, Building 1  
Pendleton, Oregon 97801**

License No.: **200033**  
Payment Received: **\$60.00**

**02/10/2016**                      **02/09/2018**  
Effective Date                      Expiration Date

Occupancy: **R-3 Class: 3**  
License Capacity: **5**  
Owner: **ColumbiaCare Services, Inc. #**  
Administrator: **Billings, John**



*[Handwritten Signature]*  
\_\_\_\_\_  
Administrator  
Health Systems Division

HSD 9106 (3/08)

This license is not transferable to any person or address.

**Addictions and Mental Health Division (AMH)  
License Renewal Application  
Residential Treatment Program**

**FACILITY NAME: Salmon Run RTH**

AMH MUST RECEIVE THIS APPLICATION 30 DAYS PRIOR TO THE DATE OF LICENSE EXPIRATION. The applicable renewal fee is required by Oregon Revised Statutes (ORS) 443.415(1). Check or money order made payable to **Oregon Health Authority**.  
*(Government bodies excluded from fee)*

EACH LICENSE IS VALID FOR A TWO (2) YEAR PERIOD AFTER APPROVAL AND DATE OF LICENSURE. A license will be issued to any facility that is in substantial compliance with OAR 309-035-0100 through 309-035-0460.

**Are you changing Administrator at this time?** Yes  No   
If yes, please provide us with the following:  
Administrator Name: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_  
 Resume  Criminal History/Background  Job Description

**Occupancy Rating** R-3

Please submit documentation of Residential Occupancy as determined by Building Codes.

**Ownership Information:** COLUMBIA CARE SERVICES, INC

Has a change occurred during the current license period? Yes  No  If yes, provide the required information and attach any supporting documentation.

Operated by:  State  County  Individual  
 Non-profit  Other(specify) \_\_\_\_\_

If individual, list full name and address:  
n/a  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

If partnership, list each partner having interest in 10% or more (use additional sheets if necessary)

Name	Full Address	%
n/a		

If corporation:

Exact corporate name: COLUMBIACARE SERVICES, INC.
and/or register assumed name: SALMON RUN RTH
Phone Number: (541) 858-8770 Email: SFEVKEL@COLUMBIACARE.ORG

Has the corporation received a certificate of incorporation or a certificate of authority to do business in the State of Oregon from the Corporation Commission?

Yes  No

If yes, quote certificate number: 143975-90

If corporation, list all officers and directors and/or persons owning 10% or more.

Name	Full Address	%
please see attached BOD list.		

**Supporting documentation or information:**

Please respond and/or enclose all required documents and/or information.

● **Policies and Procedures:**

Did you revise your manuals during the current license period?

Yes  No

● **Do you currently have a variance?** Yes  No  If yes, please complete the attached request for variance forms.

During the current licensed period has any facility staff had a sustained allegation of abuse?

Yes  No  If yes, provide us with this information at the on site inspection.

Was there a critical or significant investigation of any type within the program?

Yes  No  If yes, provide us with this information at the on site inspection.

During the current licensed period has any facility staff been convicted of any crime identified in ORS 161.505 through ORS 161.565, during the licensed period?

Yes  No  If yes, please explain below.

**REQUIRED SIGNATURES:**

*The renewal application information submitted for review is true to the best of my knowledge and understanding.*

John L. Billings

*Printed name of Administrator*

John L. Billings

*Signature of Administrator*

Date: 8/31/15

Stacy Furrell, Deputy Director

*Printed name of Licensee and/or authorized individual*

Stacy Furrell

*Signature of Licensee and/or authorized individual*

Date: 8-24-15

## Addictions and Mental Health Division

Please verify the information below, and fill in any changes or corrections in the space to the right of each item.

### FACILITY DEMOGRAPHICS:

Name: Salmon Run RTH  
Address: 2575 Westgate, ~~Building E~~ Building 1  
~~North~~  
City: Pendleton  
State: OR  
Zip: 97801  
County: Umatilla  
Phone (ext): 541-429-8721 ()  
Mailing Address: 3587 Heathrow Way  
Mailing City: Medford  
Mailing State: OR  
Mailing Zip: 97504  
Fax: 541-429-8720  
TTD:  
Provider Name: ColumbiaCare Services, Inc.

### CONTACTS:

Name	Rashell Baker <del>-REMOVE</del>	<u>John Billings</u>
Title	Administrator	<u>Administrator</u>
Phone (Ext) ()		<u>541-429-8721</u>
Cell	541-267-0509	<u>541-969-1119</u>
Email	rbaker@columbiacare.org	<u>jbillings@columbiacare.org</u>

### VARIANCES:

Add: Brett Asmann  
Quality Manager  
503-654-7654  
503-310-4723  
basmann@columbiacare.org

Stacy Ferrell  
Deputy Director  
541-858-8170  
541-660-5696  
sferrell@columbiacare.org



"Promoting the mental health and welfare of individuals  
by developing a progressive regional system of behavioral health  
care facilities and affiliated service programs in collaboration  
with public and private providers of  
social, judicial, and health care services"

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## **COLUMBIACARE SERVICES BOARD OF DIRECTORS LIST 2014-2015**

**Robert C. Beckett, President**  
***October 2011-October 2016***  
1535 Stardust Way  
Medford, Oregon 97504  
Non-profit Administrator  
541/659-8258

**Jean M. Work, Chair**  
***October 2011-October 2016***  
3587 Heathrow Way  
Medford, Oregon 97504  
Retired Employment Services Manager  
541/858-8170

**Mike Curtis, Vice Chair**  
***June 2013-June 2018***  
200 Rene Drive  
Shady Cove, OR 97539  
Retired School Teacher  
541/858-8170

**Estelle Womack, Treasurer**  
***October 2011-October 2016***  
1586 Rogue River Hwy  
Gold Hill, OR 97525  
Retired School Teacher/Administrator  
541/855-2584

**Ginger Swan, Board Member**  
***February 2012-February 2017***  
87220 E. Jupiter Lane  
Bandon, OR 97411  
County Mental Health Administrator  
541/858-8170

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**Jennifer Sewitsky (staff), Board Secretary**

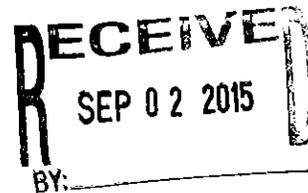
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"Promoting the mental health and welfare of individuals by developing a progressive regional system of behavioral health care facilities and affiliated service programs in collaboration with public and private providers of social, judicial, and health care services"

August 23, 2015

Kim Stubenrauch  
Quality Improvement & Certification Unit  
500 Summer Street NE E86  
Salem, OR 97301-1118

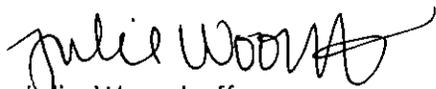


RE: License Renewal Application – Salmon Run RTH

Dear Kim:

Please find enclosed our completed license renewal application for Salmon Run RTH located at 2575 Westgate, Building 1, Pendleton, OR 97801. Also enclosed is a check for the payment of the license fee. Please feel free to contact me with any questions.

Thank you,

  
Julie Woodruff  
Administrative Services Manager



HEALTH SYSTEMS DIVISION

Kate Brown, Governor

Oregon  
**Health**  
Authority

April 5, 2016

500 Summer Street NE, E-86  
Salem, OR 97301-1118  
Voice: 503-945-5763  
Fax: 503-378-8467  
TTY: 800-375-2863  
[www.oregon.gov/OHA/amh](http://www.oregon.gov/OHA/amh)

ColumbiaCare Services, Inc. #  
John Billings, Administrator  
Salmon Run RTH  
3587 Heathrow Way  
Medford, OR 97504

Dear John Billings:

Len Ray, Compliance Specialist(s) for the Health Systems Division (HSD) conducted an inspection on January 21, 2016 of your RTH, located at 2575 Westgate, Building 1, Pendleton, Oregon.

This inspection was completed for the purpose of licensing your RTH under the provisions of applicable Oregon Administrative Rules and Oregon Revised Statutes as referenced in the attached report.

Please review the enclosed report and submit a written Plan of Correction (POC) where indicated. This report is to be submitted with the POC information on the right side of the report. Please submit your POC **within 30 days of receipt of this certified letter.**

Your POC should include the following components:

- Action(s) to be taken to correct the rule violations for each cited deficiency.
- Date corrective action was or will be completed.
- Describe procedures to prevent the violation from reoccurring.
- Describe how administration will ensure the procedures are followed.
- Include supportive documentation for each corrected action.

If the POC is unacceptable for any reason, we will notify you. You are ultimately accountable for your own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of your POC is not made timely.

ColumbiaCare Services, Inc.

April 5, 2016

Page 2

Please be sure to sign and date the first page of the report before returning your POC. Keep a copy of the report for your files and for the required public access.

You will be notified directly by HSD regarding other corrective action that may be required.

If you have questions, please call me at 503-945-9714.

Sincerely,

A handwritten signature in cursive script that reads "Len Ray".

Len Ray, L.C.S.W.  
Compliance Specialist

A handwritten signature in cursive script that reads "LuAnn Meulink".

LuAnn Meulink  
Licensing and Certification Manager

LR/ks

CC: File

DEPARTMENT OF HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ORH361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/21/2016</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SALMON RUN RTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2575 WESTGATE, BLDG E NORTH PENDLETON, OR 97801</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments  On January 21, 2016, Len Ray, compliance specialist for the Oregon Health Authority (OHA), Health Systems Division (HSD), conducted a 2-year inspection of Salmon Run, a residential treatment home located in Pendleton, Oregon. The following report identifies the deficiencies found during the inspection.	C 000		
C 255	<p>OAR 309-035-0330(6) Safety: Evacuation Drills</p> <p>(6) Evacuation Drills. Every resident will participate in an unannounced evacuation drill each month. (See Section 408.12.5 of the Fire Code.)</p> <p>(a) At least once every three months, the drill will be conducted during resident sleeping hours.</p> <p>(b) Drills will be scheduled at different times of the day and on different days of the week with different locations designated as the origin of the fire for drill purposes.</p> <p>(c) Any resident failing to evacuate within the established time limits will be provided with special assistance and a notation made in the resident record.</p> <p>(d) Written evacuation records will be retained for at least three years. They will include documentation, made at the time of the drill, specifying the date and time of the drill, the location designated as the origin of the fire for drill purposes, the names of all individuals and staff present, the amount of time required to evacuate, notes of any difficulties experienced, and the signature of the staff person conducting the drill.</p> <p>This Rule is not met as evidenced by: There were three sleeping hours fire drills conducted annually identified in the evacuation records and according to administrative rule a</p>	C 255		

STATE OF OREGON LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

DEPARTMENT OF HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ORH361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/21/2016</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SALMON RUN RTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2575 WESTGATE, BLDG E NORTH PENDLETON, OR 97801</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 255	Continued From page 1  minimun of quarterly sleeping hour fire drills need to be conducted.	C 255		
C 271	OAR 309-035-0340(2) Sanitation: Surfaces  (2) Surfaces. All floors, walls, ceilings, windows, furniture, and equipment will be kept in good repair, clean, neat and orderly.  This Rule is not met as evidenced by: Room 214 - there were two small holes in the wall - facility administrator stated these would be repaired within 2 weeks from this date.	C 271		
C 337	OAR 309-035-0370(8) Termination of Residency: Disp- Pers Property  (8) Disposition of Personal Property. At the time of termination of residency, the resident will be given a statement of account, any balance of funds held by the RTH and all property held in trust or custody by the RTH. (a) In the event of pending charges (such as long distance phone charges or damage assessments), the program may hold back the amount of funds anticipated to cover the pending charges. Within 30 days after residency is terminated or as soon as pending charges are confirmed, the resident will be provided a final financial statement along with any funds due to the resident. (b) In the case of resident belongings left at the RTH for longer than seven days after termination of residency, the RTH will make a reasonable attempt to contact the resident, guardian (as applicable) and/or other representative of the resident. The RTH must allow the resident, guardian (as applicable) or other representative at least 15 days to make arrangements	C 337		

DEPARTMENT OF HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ORH361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/21/2016</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SALMON RUN RTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2575 WESTGATE, BLDG E NORTH PENDLETON, OR 97801</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 337	<p>Continued From page 2</p> <p>concerning the property. If it is determined that the resident has abandoned the property, the RTH may then dispose of the property. If the property is sold, proceeds of the sale, minus the amount of any expenses incurred and any amounts owed the program by or on behalf of the resident, will be forwarded to the resident or guardian (as applicable).</p> <p>This Rule is not met as evidenced by: In both discharged records reviewed, information relating to funds either owed to the resident or owed to the facility by the resident was missing. There was also no record of a copy of the Medication Administration Record (MAR) provided to the resident upon discharge.</p>	C 337		

*Approved  
MPL, 5/10/16  
KAW*

Plan of Correction  
Salmon Run RTH  
2575 Westgate Pendleton OR  
ColumbiaCare Services

ID prefix	Summary statement of deficiencies	Action taken to correct the rule violation	Program operations to prevent the rule violation	Staff Member Responsible	Evaluation schedule	Date corrective action completed
C255 ✓	There were three sleeping hours fire drills conducted annually identified in the evacuation records and according to administrative rule a minimum of quarterly sleeping hour fire drills need to be conducted.	N/A	Fire drills and follow-up will be scheduled on Outlook with reminders to staff and administrators. Administrative staff will follow up and if not done will assure the drill is completed as scheduled.	Administrator/ Assistant Administrator	Third week of each month.	5/10/16
C271 ✓	This rule is not met as evidenced by room 214 – there were two small holes in the wall – Facility administrator stated these would be repaired within 2 weeks from this date.	Holes in the walls have been repaired as stated.	Periodic inspections of all rooms, with repairs made immediately. PSRB-required random room checks, which are scheduled on Outlook for staff.	Administrator/ Assistant Administrator	Monthly  Weekly	1/31/16
C337 ✓	This rule is not met as evidenced by: In discharge records reviewed, information relating to funds either owed to the resident or owed to the facility by the resident was	These documents were found, and relocated to be with the discharge records.	The discharge summary will be double checked for completion using a check list of necessary information and documentation.	Administrator/ Assistant Administrator	The day prior to the discharge	5/10/16

✓	missing. There was also no record of a copy of the Medication Administration Record provided to the resident upon discharge.					
---	--	--	--	--	--	--

<b>Adopted:</b>	August 12, 2010
<b>Revised:</b>	June 23, 2011, July 2, 2014
<b>Approved By:</b>	Robert C. Beckett, Executive Director
<b>Related Documents:</b>	None

---

**Purpose:**

The purpose of this policy is to ensure that all staff, interns, and students working in ColumbiaCare Services, Inc. (ColumbiaCare) treatment facilities meet the qualifications of Oregon Administrative Rules relevant to their position and billing activities.

**Policy:**

It is the policy of ColumbiaCare that all Clinical Supervisors and Qualified Mental Health Professional (QMHP) staff meet the requirements listed in OAR 309-019-0105 (16)(17)(79), OAR 309-019-0125(2)(3) and OAR 309-019-0130, all Qualified Mental Health Associate (QMHA) staff meet the requirements listed in OAR 309-019-0105(78), all Interns and students meet the requirements listed in OAR 309-019-0105 (49) and all Licensed Medical Practitioner (LMP) staff meet the requirements listed in OAR 309-019-0105 (54).

---

**Procedure:**

1. The Facility Administrator, in conjunction with the ColumbiaCare Administrative Office (HR Department), shall ensure that each hired staff member, intern and student meets the OAR qualifications to suit the needs of the residents in each facility, to fulfill the requirements of their position, and to suit the business needs of ColumbiaCare.
2. Proper documentation shall be required as evidence of staff, intern and student qualifications and credentials. Continued employment shall be contingent upon received verification of such qualifications.

3. Upon the offer of a position, applicants will be screened and cleared through the National Practitioner Data Bank – Healthcare Integrity and Protection Data Bank when applicable.
4. Upon the offer of a position all employees, interns, students and contractors are cleared through OIG & SAMS exclusion lists.
  - a. Thereafter each individual is verified by OIG & SAMS on a monthly basis by the HR Specialist
  - b. The HR Department maintains a monthly tracking log containing the results of each exclusion check.
  - c. If an individual is verified as a match ColumbiaCare will self-report and reassign the employee to a position not affected if appropriate. If reassignment is not appropriate or possible the employment, intern, student or contract relationship will end.
5. Upon the offer of a position, the Facility Administrator shall obtain all necessary information to complete a Criminal background Check and submit completed paperwork to the ColumbiaCare Administrative Office (HR Department).
6. The Facility Administrator shall request and supply to the ColumbiaCare Administrative Office (HR Department) original documentation of education and experience to verify QMHA, QMHP/(Clinical Supervisor), or LMP status. Documentation of education, licensure and experience shall come from primary sources (i.e., former employers, education and licensing institutions) and shall be kept in the employee's personnel file.
7. ColumbiaCare's HR Department will verify through employment verification that all QMHP's responsible for clinical supervision have completed two years of post-graduate clinical experience in a mental health treatment setting.
8. The ColumbiaCare Clinical Director shall review documentation of education, licensure and experience for validity and to ensure that each hired staff, intern and student meets the qualification of QMHA, QMHP, or LMP status, per relevant OAR.
9. ColumbiaCare may use staff, intern or student license information to request additional information via licensing databases as needed.
10. ColumbiaCare requires verification of licensure renewals for all positions that require licensing by a governing board; such as RN, MD, LMP, CNA, LCSW etc....
  - a. The HR Department audits expiration of all licenses on a monthly basis.
  - b. For individual practitioners, ColumbiaCare will follow the Joint Commission Credentialing standards.

- c. Proof of renewal is required on or before the expiration date or the employee will be removed from the position until the requested documentation is received by the HR Department.

# ColumbiaCare Services Inc.

## Policies and Procedures – Salmon Run RTH

**Approved by:** John Billings, Administrator  
**Effective Date:** February 10, 2014

**Policy Title:** Prohibition of Seclusion and Restraints - 309-035-0420

**Purpose:** To ensure the safety and protect the rights of individuals who are admitted to Salmon Run Residential Treatment Home, and ensure compliance with OAR 39-035-0420.

**Policy:** General Prohibition. The use of seclusion or restraints is prohibited in Residential Treatment Homes (RTH).

**Procedure:** Staff will be trained to manage an individual's behavior by applying the principles of Verbal and Physical Intervention training provided by ColumbiaCare Services. Staff will understand that there is a clear pattern of risk involved in working with people with assaultive history.



# CONSENT FOR CONTACT WITH RESIDENT UNDER 18 YEARS

NEW ROADS RTH 2575 WESTGATE, BUILDING 3, PENDLETON, OR 97801 541.276.6330

Name of Youth Under Age 18 \_\_\_\_\_

OAR 413-215-0576 (1) requires that a parent or legal guardian signs a consent that authorizes the residential care home to restrict the youth's contact with persons outside the residential care home; including visits, telephone communication, electronic mail, and postal mail. I hereby consent to restrict the youth named above from contact with the following individual(s) as described below:

Name	Relationship	Phone Number	Phone calls FROM	Phone calls TO	Exchange of mail	Visit at the RTH

\_\_\_\_\_

*Parent/Guardian Signature*

\_\_\_\_\_

*Date*

\_\_\_\_\_

*Staff Signature*

\_\_\_\_\_

*Date*

I,     , agree to the following financial plan, which includes:

- Who will be the payee for my income,
- Whether I will participate in the ColumbiaCare Services (CCS) Money Management Program, and
- How my money will be kept secure at this facility.

**1. Payee for My Income**

*(Initial which option applies)*

\_\_\_\_\_ I am the payee.

\_\_\_\_\_ I agree that ColumbiaCare Services is to be my Representative Payee. ColumbiaCare Services is authorized to contact the Social Security Administration to make arrangements for this to occur. *(Note: This option requires participation in Money Management Program)*

\_\_\_\_\_ I have a Representative Payee. Name:

Address:

Phone:

**2. Participation in Money Management Program**

*(Initial which option applies)*

\_\_\_\_\_ I agree to participate in the CCS Money Management program. I understand and agree that:

- ColumbiaCare Services holds my Personal and Incidental Funds (PIF) for me,
- I will negotiate a budget for spending the PIF with my financial contact person at this residential facility,
- My PIF are to be dispersed according to this budget,
- I will cooperate with my financial contact person in maintaining my funds and benefits,
- ColumbiaCare Services will give me the complete record of my account at my request.

I further understand that I may discontinue participation in the CCS Money Management program at my request. In this event, the following guidelines will apply:

- If ColumbiaCare is acting as my payee, my request to discontinue money management services must be directed to the Social Security Administration office (phone number: 1-800-772-1213). Resources for assistance in this matter can be a Social Security Administration office, a staff member, or Disability Rights Oregon (phone number 503-243-2081)
- If ColumbiaCare is not my payee, my requests to discontinue money management services must be directed in writing to the facility administrator,

and upon receiving this request, the remaining funds in my account will be returned to me.

- If I designate a different payee, I am still responsible for room and board charges each month, as described in my Room and Board Fees Agreement.

I further understand and agree that if I cannot abide by this contract and the obligations described above, ColumbiaCare Services or other parties may contact Social Security Administration and inform them that they do not wish to be Representative Payee for my SSI or SSD any longer. At this point, my money would be sent back to Social Security Administration and it will be my responsibility to work with Social Security Administration in finding a new Representative Payee. If I need additional money management, this will be reviewed with my Case Manager who will be asked to help locate a rep-payee or make other appropriate arrangements.

\_\_\_\_\_ I do not wish to participate in the CCS Money Management program.

**3. How My Money Will Be Kept Secure**

*(Initial which option applies)*

\_\_\_\_\_ I agree to have my money in excess of \$ locked up in the office at this residential facility. This facility will place my money in an envelope separate from the money of other residents, and will keep a record of its disposition. My money will not be used except with my consent as evidenced by my signature and/or initials at any time money is withdrawn from my account. Only the facility staff and administration will have access to my money.

\_\_\_\_\_ I am responsible for keeping my money secure. I will keep my money on my person, or in my lock box that I will keep locked at all times. I understand that by making this choice I am responsible for any loss of my money. I also understand I may request at any time that my money be locked up in the office at this residential facility.

\_\_\_\_\_  
*Resident Signature/ Guardian Signature (if applicable)*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Administrator Signature*

\_\_\_\_\_  
*Date*

**For Staff Use Only - Annual Review**

I have reviewed all of the items listed above with the resident named above:

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**AUTHORIZATION FOR  
MEDIA RELEASE**

**SALMON RUN RTH 2575 WESTGATE, BUILDING 1, PENDLETON, OR, 97801 541.429.8721**

This authorization pertains to:

**Name**

**DOB**

**Address/Phone**

**Purpose(s) for which information is disclosed:** Public promotion, training, advertising, and marketing materials; internal and external publication in print, digital, Internet, and/or multi-media formats.

**Release of My Confidential Information**

1. By initialing next to an item listed here, I hereby give ColumbiaCare Services, Inc. permission to use, for the purpose above, my: \_\_\_\_\_ Name \_\_\_\_\_ photograph \_\_\_\_\_ likeness \_\_\_\_\_ voice
2. I hereby personally and on behalf of me and/or my dependent/child forever release and agree to hold harmless ColumbiaCare Services, Inc., it's employees, agents, successors, and assigns from any liability, claims, actions, damages, demands, or expenses whatsoever by reason of such use.
3. I hereby further release and agree to hold harmless the photographer, his/her representatives, employees or any persons or corporations acting under this permission or authority, or any persons or corporations, for whom he/she might be acting, including any firm publishing and/or distributing the finished product, in whole or in part, from and against any liability as a result of any use that may occur or be produced in the taking, processing or reproduction of the finished product, its publication or distribution.
4. I understand that I will not be compensated for the use of my name, photograph, likeness, and/or voice when used in connection with ColumbiaCare Services, Inc. promotional and informational materials.
5. I fully understand that I have the right to deny ColumbiaCare Services, Inc. to publish photographs, audio, and video recordings of me for training, promotional, news, and other purposes without any negative consequence to myself whatsoever.
6. I fully understand that this Authorization will remain in effect until this consent is withdrawn by me in writing, and that such a withdrawal will only affect materials produced after the date of the withdrawal.

**Term**

This Authorization will remain in effect until the time initialed below from the date of the authorizing signature. **(Initial only one)**

\_\_\_\_\_ As long as the material lasts: This consent will remain in effect for the **life of materials** produced under this Authorization.

\_\_\_\_\_ One-Time/Purpose \_\_\_\_\_  
(Write the one-time event or the purpose above)

**I CONSENT:** I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my confidential information. By my signature, I hereby, knowingly and voluntarily authorize ColumbiaCare Services to use confidential information in the manner described above.

\_\_\_\_\_  
*Client/Guardian Signature*

\_\_\_\_\_  
*Date*

ACKNOWLEDGEMENT OF  
**ORIENTATION TO HOME AND RIGHTS**  
SALMON RUN RTH 2575 WESTGATE, BUILDING 1, PENDLETON, OR, 97801  
541.429.8721

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**Welcome, we are glad to have you here!**

Entering an unknown situation can be both frightening and exciting. We want you to be comfortable here and encourage you to ask questions, including the rules, the schedules and the expectations. We have made the following orientation checklist so we don't forget any important information as we help you adjust. As staff shows you around, please initial the areas that are covered as you learn them; you will receive a copy of this document when it is completed.

\_\_\_\_\_ **Tour of Facility**

**Locations** I have been shown the location of the room I will be in, staff areas, laundry room, bathrooms, living room and activity area, where I may eat food and drinks, the client telephone and information boards and where emergency phone numbers are posted, where to get towels and bathmats.

**Expectations and encouragements** I understand:

- My room I am expected to keep my room clean and presentable.
- Personal hygiene I am encouraged to shower and brush my teeth daily then return personal belongings, grooming items, and, my towel and bathmat to my room so they don't get mixed up with those of other residents. If I do not have necessary personal toiletries, staff may be able to provide them at my request.
- Laundry I am expected to do my own laundry using the washer and dryer. Laundry supplies are available by asking staff. Dirty towels may be placed in the laundry basket or they may be washed with my dirty clothing after use. Sheets may be washed as often as desired; staff encourages that they be changed at least once per week.
- Dress in Common Areas I know that for sanitary purposes I need to wear something on my feet when out of my room, and that I am expected to get dressed every day instead of wearing sleepwear all day.
- No Smoking That I cannot smoke here because State rules do not allow smoking on the facility property or in facility vehicles. I have been shown where the property boundaries are. I understand that I am expected to tell staff when I go off the property to smoke.

\_\_\_\_\_ **Introductions:** I have been introduced to other residents. I have met facility staff and been given information about staff who are not here right now, and their roles in the care and treatment of residents.

\_\_\_\_\_ **Meals and Snacks:** The meal and snack schedule has been explained as follows: . Snacks are available by request unless restricted by physician order. I will talk with the staff member on shift if I wish to have guests join me for a meal, need to miss a meal, would like items not on the menu or to contribute to the menu. I am encouraged to assist with food preparation. I know staff are available to explain how to prepare food. Proper food handling and storage techniques have been explained. I agree to assist with cleaning up after meals.

\_\_\_\_\_ **Daily Schedule:** Staying in a home requires having schedules so all residents and staff can plan their day. Every day is not the same, and schedules may change due to unplanned incidents, weather conditions or other factors. Staff has explained how I can contribute to the schedule or make requests for activities I would like to do. Policies regarding community privileges, transportation, outside appointments, visiting hours and quiet times have been explained. I have had an opportunity to have my questions answered.

**ACKNOWLEDGEMENT OF  
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\_\_\_\_\_ **Emergency Procedures:** The smoke alarm has been set off and I can identify the sound as requiring an emergency exit. Emergency exits have been identified, including doors and windows able to be opened, and I can identify the closest appropriate exit from different locations in the house. I have demonstrated my capability of using another way to exit if necessary because the door to my room is hot. I walked through a simulated fire drill on . I understand I am expected to participate in routine fire drills whenever they occur. I understand that 911 is the local emergency number and I would be able to call them and give the address of the facility, if necessary during an emergency.

In case of fire, would this resident require assistance with exiting? Yes No

\_\_\_\_\_ **Releases of Information:** I, or my parent or guardian, understand(s) the need to have a Release of Information signed for anyone other than ColumbiaCare Services staff, including my emergency contact, the pharmacy, and my primary care physician. I will also need to sign ROI's if I want staff assistance in interactions with personal and professional contacts.

**In addition to the foregoing,** I have reviewed the following documentation with staff and been given a copy of documentation for my use. By my initials below, I acknowledge that each item has been explained and I understand the information therein. If applicable, a copy of the following has also been given to my Guardian.

\_\_\_\_\_ **Informed Consent to Treatment (Non-PSRB)** I understand that this is a voluntary placement, I have had service options explained, and I, or my parent or guardian, agree to receive and participate in mental health treatment services while I live here. I have been informed of the risks and benefits of treatment, and that I, or my parent or guardian, have a right to refuse treatment. I, or my parent or guardian, understand that, if I, or my parent or guardian, refuse mental health treatment at this facility, staff will help me, or my parent or guardian, find another placement which will better meet the kind of treatment and care I, or my parent or guardian, want. I, or my parent or guardian, initialed this form and have been provided with a copy of the Orientation to Home and Your Rights Handout that includes Informed Consent to Treatment information for my records at the time I entered services.

\_\_\_\_\_ **Informed Consent to Treatment (PSRB)** I, or my parent or guardian, understand(s) that participation in treatment not included in my conditional agreement with the P SRB is voluntary and I, or my parent or guardian, agree to receive and participate in these additional mental health treatment services while I live here. I, or my parent or guardian, have had service options explained, have been informed of the risks and benefits of treatment, and that I, or my parent or guardian, have a right to refuse treatment not included in my conditional agreement with the PSRB. I, or my parent or guardian, understand that, if I, or my parent or guardian, refuse this voluntary mental health treatment or mental health treatment mandated by the PSRB at this facility, staff will address my concerns in a collaborative manner to avoid the revocation of my PSRB conditional release. I, or my parent or guardian, initialed this form and have been provided with a copy of the Orientation to Home and Your Rights Handout that includes Informed Consent to Treatment information for my records at the time I entered services.

**Additional Consents** I, or my parent or guardian agree(s) that this facility may do all of the following as described in the ***“Orientation to Home and Your Rights”*** document:

\_\_\_\_\_ Provide routine and emergency medical care, unless restricted or limited in accordance with the creed or tenets of a well-recognized religion or denomination;

**ACKNOWLEDGEMENT OF  
ORIENTATION TO HOME AND RIGHTS**  
SALMON RUN RTH 2575 WESTGATE, BUILDING 1, PENDLETON, OR, 97801  
541.429.8721

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- \_\_\_\_\_ Use this facility's behavior management system;
- \_\_\_\_\_ Restrict the youth's contact with persons outside the residential care agency;
- \_\_\_\_\_ Exclude or limit the youth's possession of personal items;
- \_\_\_\_\_ Impose a dress code; and,
- \_\_\_\_\_ Restrict the youth's participation in recreational or leisure activities in an appropriate manner, consistent with behavior or safety issues.
- \_\_\_\_\_ **Disclosures** I, or my parent or guardian have been informed about personal or room searches and protocols for confiscation of contraband items, including the notification of law enforcement if illegal contraband is discovered. In addition, I understand any written policy or procedure pertaining to program services is available, upon request.
- \_\_\_\_\_ **Fee Agreement and Management of Personal Funds** I understand that I am responsible to pay for room, board and other covered services, long distance phone charges, and co-pays for my medications. I also understand that it is best not to bring large amounts of money into the facility, and that staff will provide a way to lock up money in excess of \$10 in order to protect my resources. I agree to have my personal and incidental funds held by the facility with the understanding that this money will not be used except with my consent as evidenced by my signature and/or initials at any time money is withdrawn from my funds. I understand I am responsible to follow my monthly budget and return receipts for items I purchase.
- \_\_\_\_\_ **Advance Mental Health and Health Directives:** I have been given information on advance health care directives and a mental health declaration. I understand I am able to identify my wishes to be followed in case of illness and appoint someone else to speak for me if needed. Should I desire to complete one or both of these documents, I may ask staff to provide a copy of the form for review and completion after discussion with my loved ones, my personal representative, and my doctor(s). I also understand that staff may not give medical advice, act as a witness to my directives or be appointed as my representative.
- \_\_\_\_\_ **Resident Rights:** I understand I have the rights of other individuals, including the right to privacy and to communicate privately with visitors. I was provided with a copy of the Resident's Bill of Rights listing other rights afforded to residents.
- \_\_\_\_\_ **Mutual Respect, Responsibilities, and Safety:** While living in this facility, I understand that everyone has a responsibility to do their part to keep the house a comfortable place to live and work. I have been provided with a copy of Mutual Respect, Responsibilities, and Safety. I have had an opportunity to discuss this with a staff member and agree that while I am a resident at the facility I will follow this.
- \_\_\_\_\_ **Complaints, Grievances & Appeals:** I understand I have the right to file a grievance regarding incidents while here, or appeal a decision regarding a grievance. I have been provided with a copy of the grievance form and of the Notice of Right to Submit a Complaint/ Grievance or Appeal.
- \_\_\_\_\_ **Abuse Reporting:** While a resident at this facility, I understand I have the right to be free from abuse. In this regard, I have been provided with a copy of the abuse report form as well as abuse reporting information that identifies how to report any concerns of abuse I have. I have discussed this information with a staff member and can ask further questions if needed.

**ACKNOWLEDGEMENT OF  
ORIENTATION TO HOME AND RIGHTS**  
SALMON RUN RTH 2575 WESTGATE, BUILDING 1, PENDLETON, OR, 97801  
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\_\_\_\_\_ **Notice of Privacy Practices:** As required by HIPAA, I have been provided with a copy of the ColumbiaCare Privacy Practices and had them explained to my satisfaction. I understand if I have further questions, I may discuss them with staff or a representative of ColumbiaCare and that these practices ensure the confidentiality of my Protected Health Information.

\_\_\_\_\_ **Relationships with Law Enforcement:** I have been shown the ColumbiaCare policy on relationships with law enforcement personnel that is posted on the bulletin board. I understand that I may not be threatened with law enforcement involvement as a means of behavioral support and that staff will not provide information about me to law enforcement without my consent. However, law enforcement involvement may be an option in certain situations as described in the policy. I am aware that a copy of the policy on Relationships with Law Enforcement will be provided at my request.

\_\_\_\_\_ **Visit and Other Contact with the Youth:** I have provided the names of individuals to whom I given my consent to visit the youth or have indicated the type of contact named individuals may have with the youth.

\_\_\_\_\_ **Youth Participation in Activities:** I consent to the youth's participation in routine activities, recreational events and travel provided by the facility.

By my signature below, I acknowledge that I received the information above.

<i>Resident Signature/ Guardian Signature (if applicable)</i>	<i>Date</i>
<i>Staff Signature</i>	<i>Date</i>

**For Staff Use Only - Annual Review**

I have reviewed all of the items listed above with the resident named above:

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**AUTHORIZATION FOR  
RELEASE OF INFORMATION**

**NEW ROADS RTH 2575 WESTGATE, BUILDING 3, PENDLETON, OR 97801 541.276.6330**

This authorization pertains to:

**Name** **DOB**  
**Address/Phone**

Facility and/or persons, for information to be released, obtained or exchanged with:  
**Name**  
**Address**  
**City, State, Zip**  
**Phone**

Information requested by:  
**Name**  
**Address**  
**City, State, Zip**  
**Phone**

Purpose(s) for which information is disclosed: **To provide a family member or friend information about the about the above named person's welfare.**

**Release of My Highly Confidential Information**

By initialing next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated, if any such information will be used or disclosed pursuant to this Authorization:

- Information about treatment or evaluation of a Mental Illness
- Psychotherapy notes created by a mental health professional
- Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- Information about sexual assault, child abuse, and/or neglect
- Information about drug/alcohol abuse and/or services
- Medical information, laboratory testing and physician's notes and orders
- Financial information: including banking, financial institutions, social security and insurance matters
- Other \_\_\_\_\_

**TERM**

This Authorization will remain in effect until the time initialed below from the date of the authorized signature.

- From the date of this Authorization until 30 days after the date of discharge from services.
- From the date of this Authorization until the \_\_\_\_\_ day of \_\_\_\_\_, 201\_\_\_\_\_.
- Until ColumbiaCare Services fulfills this request.
- Other: \_\_\_\_\_

**AUTHORIZATION FOR  
RELEASE OF INFORMATION**

**NEW ROADS RTH 2575 WESTGATE, BUILDING 3, PENDLETON, OR 97801 541.276.6330**

**PURPOSE**

1. I authorize ColumbiaCare Services to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the specific purpose(s) listed above.
2. I understand that once ColumbiaCare Services discloses my health information to the recipient(s), ColumbiaCare Services cannot guarantee that the recipient(s) will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and Oregon law governing the use of my health information.
3. I understand that ColumbiaCare Services may, directly or indirectly, receive payment from a third party for the cost of providing such records.
4. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason, and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at ColumbiaCare Services.
5. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice or revocation to ColumbiaCare Services' Office at the address listed below. The revocation will be effective immediately upon ColumbiaCare Services' receipt of my written notice, except that the revocation will not have any effect on any action taken by ColumbiaCare Services in reliance on this Authorization before it received my written notice of revocation.
6. I may contact ColumbiaCare Services' Administrative Office by mail at 3587 Heathrow Way, Medford, OR 97504, by telephone at 1 (541) 858-8170.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize ColumbiaCare Services to use or disclose my health information in the manner described above.

\_\_\_\_\_

*Client/Guardian Signature* *Date*

**For Staff Use Only** This is a true copy of the original.

\_\_\_\_\_

*Full Signature of Agency Staff Person making copies* *Date*

**AUTHORIZATION FOR  
RELEASE OF INFORMATION**

**NEW ROADS RTH 2575 WESTGATE, BUILDING 3, PENDLETON, OR 97801 541.276.6330**

***For Staff Use Only - Annual Review***

I have reviewed all of the items listed above with the resident named above:

<i>Staff Initials</i>	<i>Date</i>	<i>Staff Initials</i>	<i>Date</i>	<i>Staff Initials</i>	<i>Date</i>
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# ROOM AND BOARD PAYMENT AGREEMENT

NEW ROADS RTH 2575 WESTGATE, BUILDING 3, PENDLETON, OR 97801  
541.276.6330

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**Individual's Name**

The Total Cost for services in our Residential Facility consists of two charges:

1. Room and Board
2. Service Payment

All or part of the Service Payment is based on your monthly income. The State Of Oregon pays any balance remaining. If your monthly income changes then your monthly charge may change. When there is a change in your income, you will be given a 30-day notice in writing advising you of any change in your Service Payment.

Based on your current income, your finances work out as follows:

**Your Total Monthly Income =** \$ \_\_\_\_\_

**Your Total Monthly Charges =** \$ \_\_\_\_\_

These include:

Room and Board \$ 570

Service Payment \$ \_\_\_\_\_

**Your Personal and Incidental Funds left =** \$ \_\_\_\_\_

Please remember that you will need to use some of your Personal and Incidental Funds to pay Copays for which you are responsible (such as pharmacy, medical, dental and vision services). Unless you have a payee, ColumbiaCare Services will use your Personal and Incidental Funds to pay any Copays that have accrued from the previous month. **This means the Personal and Incidental Funds (PIF) you will have left may be less than the amount shown above (i.e., PIF minus copays).**

If you are mandated to have a payee or chose to have one, ColumbiaCare Services can provide this service free of charge. *(See Financial Plan Agreement form)*

I understand and agree that the monthly Room and Board Payment, the Service Payment, and Copays are my obligation. Also, I understand and agree that, if I don't have a payee, ColumbiaCare Services will use my Personal and Incidental Funds to pay any copays that have accrued from the previous month. This has been explained to me and I am receiving a copy of this agreement.

---

*Resident Signature/ Guardian Signature (if applicable)*

---

*Date*

**ROOM AND BOARD**  
**PAYMENT AGREEMENT**

**NEW ROADS RTH 2575 WESTGATE, BUILDING 3, PENDLETON, OR 97801**  
**541.276.6330**

---

*Administrator Signature*

*Date*

*Individual's Name*

*Pre-Service Conclusion Meeting Date      Admission Date      30-Day Notice Date      Service Conclusion Date      Last Contact Date*

<i>Axis</i>	<i>Diagnosis at Admission</i>	<i>Diagnosis at Service Conclusion</i>
<i>I</i>		
<i>II</i>		
<i>III</i>		
<i>IV</i>		
<i>GAF</i>		

**Type of Service Conclusion or Transfer**

**Reason for Service Conclusion or Transfer**

*Summary Statement Describe the effectiveness of recovery program modalities and progress relative to goals listed in the Individual Services and Support Plan while in service*

**Recovery status at conclusion of services**

**Resilience and strengths identified/developed while in program**

**Prognosis and recommendations for future treatment**

**Transitional Planning** *Document resources identified to assist Individual in accessing recovery and resiliency supports and services. If not needed, specifically note why not needed.*

<i>Service Area</i>	<i>Date Appt. Scheduled</i>
<i>Residential Services</i>	
<i>Mental Health Services</i>	
<i>Medical Services</i>	
<i>Medication Management</i>	
<i>Financial Management</i>	
<i>Case Management</i>	

**SERVICE CONCLUSION SUMMARY**  
SALMON RUN RTH 2575 WESTGATE, BUILDING 1, PENDLETON, OR, 97801  
541.429.8721

**Wellness Plan** Referral information provided, when needed, such as peer supports, cultural resources, meaningful activities; education or training; social opportunities; recovery supports/relapse prevention; exercise/recreation; personal growth opportunities/interests as identified by individual.

_____ Resident Signature/ Guardian Signature (if applicable)	_____ Date
_____ Staff Signature	_____ Date (within 30 days of service conclusion)

**Disposition of medications, property and funds** Describe whether the resident's medication was sent with the resident or destroyed, whether the resident's property was sent with the resident or stored for 15 days prior to disposition, and how the resident's cash at the facility and funds held by CCS were distributed. (please see attach medication and personal property inventories)

**If a transfer**

**Date requested records were sent to receiving provider.** Within 14 days of request .

**Date Service Conclusion Summary was sent to receiving provider.** Within 14 days of request

ACKNOWLEDGEMENT OF  
**OPPORTUNITY TO REGISTER TO VOTE**  
NEW ROADS RTH 2575 WESTGATE, BUILDING 3, PENDLETON, OR 97801  
541.276.6330

---

I understand I have the opportunity to register to vote, and that staff are available to help me to get registered.

---

*Resident Signature/ Guardian Signature (if applicable)*

---

*Date*

---

*Staff Signature*

---

*Date*

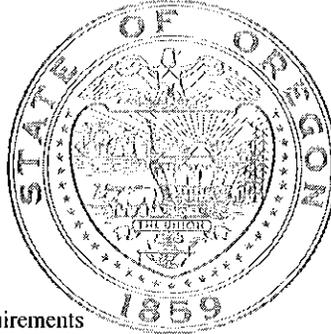
**Health Systems Division**  
**Home and Community-Based Services**  
**Evidence Package**

**New Roads**

**OREGON HEALTH AUTHORITY  
RESIDENTIAL TREATMENT HOME  
LICENSE**

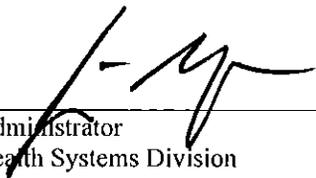
Name: New Roads RTH  
Address: 2575 Westgate  
Pendleton, Oregon 97801

License No.: **200032**  
Payment Received:            \$30.00



<u>2/10/2016</u>	<u>2/9/2018</u>
Effective Date	Expiration Date

Occupancy: SR-3 Class:3  
License Capacity: 5  
Owner: Columbia Care Services, Inc.  
Administrator: Scott Young

  
\_\_\_\_\_  
Administrator  
Health Systems Division

Variance: OAR 309-035-0300 (1,3,4) General Record Requirements

- Conditions:
- OAR 413-215-0046 (1) Children and Families Rights & Grievance Policy
  - OAR 413-215-0056 Policies and Procedures
  - OAR 413-215-0061 (1,4) Personnel
  - OAR 413-215-0541 (5) Safety
  - OAR 413-215-0556 (2,3) Staff Training
  - OAR 413-215-0561 (1,c,2,3) Minimum Staffing Requirements
  - OAR 413-215-0566 (1,2) Separation of Residents
  - OAR 413-215-0576 (1,2,3) Consents, Disclosures, and Authorizations
  - OAR 413-215-0581 (1,4) Information About Children in Placement with the Agency

HSD 9106 (3/08)

This license is not transferable to any person or address.

CW

**Addictions and Mental Health Division (AMH)  
License Renewal Application  
Residential Treatment Program**

**RECEIVED**  
SEP 08 2015  
BY: \_\_\_\_\_

**FACILITY NAME: New Roads**

AMH MUST RECEIVE THIS APPLICATION 30 DAYS PRIOR TO THE DATE OF LICENSE EXPIRATION. The applicable renewal fee is required by Oregon Revised Statutes (ORS) 443.415(1). Check or money order made payable to **Oregon Health Authority**.  
*(Government bodies excluded from fee)*

**EACH LICENSE IS VALID FOR A TWO (2) YEAR PERIOD AFTER APPROVAL AND DATE OF LICENSURE. A license will be issued to any facility that is in substantial compliance with OAR 309-035-0100 through 309-035-0460.**

**Are you changing Administrator at this time?** Yes  No   
If yes, please provide us with the following:  
Administrator Name: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_  
 Resume  Criminal History/Background  Job Description

**Occupancy Rating R-3**

Please submit documentation of Residential Occupancy as determined by Building Codes.

**Ownership Information: COLUMBIACARE SERVICES, INC.**

Has a change occurred during the current license period? Yes  No  If yes, provide the required information and attach any supporting documentation.

Operated by:  State  County  Individual  
 Non-profit  Other(specify) \_\_\_\_\_

If individual, list full name and address:  
N/A  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

If partnership, list each partner having interest in 10% or more (use additional sheets if necessary)

Name	Full Address	%
N/A		

If corporation:

Exact corporate name: COLUMBIACARE SERVICES, INC.
and/or register assumed name: New Roads RTH
Phone Number: (541) 858-8170 Email: Sferrell@columbiacare.org

Has the corporation received a certificate of incorporation or a certificate of authority to do business in the State of Oregon from the Corporation Commission?

Yes  No

If yes, quote certificate number: 143-97590

If corporation, list all officers and directors and/or persons owning 10% or more.

Name	Full Address	%
please see attached BOD list		

**Supporting documentation or information:**

Please respond and/or enclose all required documents and/or information.

● **Policies and Procedures:**

Did you revise your manuals during the current license period?

Yes  No

● **Do you currently have a variance?** Yes  No  If yes, please complete the attached request for variance forms.

During the current licensed period has any facility staff had a sustained allegation of abuse?

Yes  No  If yes, provide us with this information at the on site inspection.

Was there a critical or significant investigation of any type within the program?

Yes  No  If yes, provide us with this information at the on site inspection.

During the current licensed period has any facility staff been convicted of any crime identified in ORS 161.505 through ORS 161.565, during the licensed period?

Yes  No  If yes, please explain below.

**REQUIRED SIGNATURES:**

*The renewal application information submitted for review is true to the best of my knowledge and understanding.*

Scott F. Young

*Printed name of Administrator*

Scott F. Young

*Signature of Administrator*

*Date:* 8/31/15

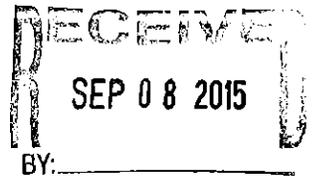
Stacy Ferrell, Deputy Director

*Printed name of Licensee and/or authorized individual*

Stacy Ferrell

*Signature of Licensee and/or authorized individual*

*Date:* 8-24-15



# Addictions and Mental Health Division

BY: \_\_\_\_\_

*Please verify the information below, and fill in any changes or corrections in the space to the right of each item.*

## FACILITY DEMOGRAPHICS:

Name: New Roads \_\_\_\_\_

Address: 2575 Westgate, ~~Building E~~ Building 3 \_\_\_\_\_

City: Pendleton \_\_\_\_\_

State: OR \_\_\_\_\_

Zip: 97801 \_\_\_\_\_

County: Umatilla \_\_\_\_\_

Phone (ext): 541-276-6330 () \_\_\_\_\_

Mailing Address: 3587 Heathrow Way \_\_\_\_\_

Mailing City: Medford \_\_\_\_\_

Mailing State: OR \_\_\_\_\_

Mailing Zip: 97504 \_\_\_\_\_

Fax: 541-276-6295 \_\_\_\_\_

TTD: \_\_\_\_\_

Provider Name: ColumbiaCare Services, Inc. \_\_\_\_\_

## CONTACTS:

② Name Brett Asman \_\_\_\_\_

Title Quality Manager \_\_\_\_\_

Phone (Ext) () 503-654-7654 \_\_\_\_\_

Cell 503-310-4723 \_\_\_\_\_

Email basmann@columbiacare.org \_\_\_\_\_

① Name Scott Young \_\_\_\_\_

Title Administrator \_\_\_\_\_

Phone (Ext) 541-276-6330 () \_\_\_\_\_

Cell 907-209-1755 \_\_\_\_\_

Email syoung@columbiacare.org \_\_\_\_\_

③ Add: stacy Ferrell \_\_\_\_\_

Deputy Director \_\_\_\_\_

541-858-8170 \_\_\_\_\_

541-660-5696 \_\_\_\_\_

Sferrell@columbiacare.org \_\_\_\_\_

## VARIANCES:



"Promoting the mental health and welfare of individuals by developing a progressive regional system of behavioral health care facilities and affiliated service programs in collaboration with public and private providers of social, judicial, and health care services"

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## **COLUMBIACARE SERVICES BOARD OF DIRECTORS LIST 2014-2015**

**Robert C. Beckett, President**  
***October 2011-October 2016***  
1535 Stardust Way  
Medford, Oregon 97504  
Non-profit Administrator  
541/659-8258

**Jean M. Work, Chair**  
***October 2011-October 2016***  
3587 Heathrow Way  
Medford, Oregon 97504  
Retired Employment Services Manager  
541/858-8170

**Mike Curtis, Vice Chair**  
***June 2013-June 2018***  
200 Rene Drive  
Shady Cove, OR 97539  
Retired School Teacher  
541/858-8170

**Estelle Womack, Treasurer**  
***October 2011-October 2016***  
1586 Rogue River Hwy  
Gold Hill, OR 97525  
Retired School Teacher/Administrator  
541/855-2584

**Ginger Swan, Board Member**  
***February 2012-February 2017***  
87220 E. Jupiter Lane  
Bandon, OR 97411  
County Mental Health Administrator  
541/858-8170

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**Jennifer Sewitsky (staff), Board Secretary**

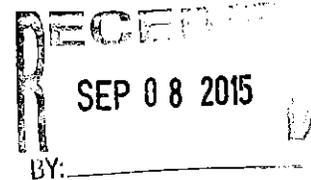
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"Promoting the mental health and welfare of individuals by developing a progressive regional system of behavioral health care facilities and affiliated service programs in collaboration with public and private providers of social, judicial, and health care services"

August 23, 2015

Kim Stubenrauch  
Quality Improvement & Certification Unit  
500 Summer Street NE E86  
Salem, OR 97301-1118



RE: License Renewal Application – New Roads RTH

Dear Kim:

Please find enclosed our completed license renewal application for New Roads RTH located at 2575 Westgate, Building 3, Pendleton, OR 97801. Also enclosed is a check for the payment of the license fee. Please feel free to contact me with any questions.

Thank you,

A handwritten signature in black ink, appearing to read "Julie Woodruff".

Julie Woodruff  
Administrative Services Manager



# Quarterly Safety Check List

Location: New Roads Date of Inspection: 1/15/15 Conducted by: Scott F. Youngs

Item	Circle one
Emergency flashlights work	<input checked="" type="radio"/> Yes or No
Smoke detector test done	<input checked="" type="radio"/> Yes or No
Fire extinguishers checked	<input checked="" type="radio"/> Yes or No
Windows operational	<input checked="" type="radio"/> Yes or No
Window locks in working order	<input checked="" type="radio"/> Yes or No
Sliding glass doors operational	NA <input checked="" type="radio"/> Yes or No
Locks on sliding glass doors in working order	NA <input checked="" type="radio"/> Yes or No
Locks on front and back doors in working order	<input checked="" type="radio"/> Yes or No
Emergency and disaster plans available	<input checked="" type="radio"/> Yes or No
Emergency phone numbers visibly posted	<input checked="" type="radio"/> Yes or No
Safety procedure book available and marked	<input checked="" type="radio"/> Yes or No
Water temperature safe (hot tap 110°-120°)	<input checked="" type="radio"/> Yes or No
Refrigerator temperature safe (33°-45°)	<input checked="" type="radio"/> Yes or No
Freezer temperature accurate (0°)	<input checked="" type="radio"/> Yes or No
Oven cleaned	<input checked="" type="radio"/> Yes or No
Microwave cleaned	<input checked="" type="radio"/> Yes or No
Dryer vent vacuumed	<input checked="" type="radio"/> Yes or No
Extension cords properly stored/used	<input checked="" type="radio"/> Yes or No
Combustible, hazardous, poisonous, toxic materials labeled and stored properly	<input checked="" type="radio"/> Yes or No
Checked for overloaded or unprotected electrical outlets	<input checked="" type="radio"/> Yes or No
Floors clear of trip or slip hazards	<input checked="" type="radio"/> Yes or No
Building clear of potential fire hazards	<input checked="" type="radio"/> Yes or No
Large, heavy objects are stored low	<input checked="" type="radio"/> Yes or No
Knives locked in knife drawer (if applicable)	<input checked="" type="radio"/> Yes or No
Smoking area fire hazards checked	<input checked="" type="radio"/> Yes or No
Filters in heating/laundry room(s) clear	<input checked="" type="radio"/> Yes or No
Checked and addressed safety issues in clients' rooms	<input checked="" type="radio"/> Yes or No
Disaster kit complete and ready	<input checked="" type="radio"/> Yes or No
Medication emergency kit complete and ready	<input checked="" type="radio"/> Yes or No
First aid kit complete and ready	<input checked="" type="radio"/> Yes or No
SDS complete and available	<input checked="" type="radio"/> Yes or No
Emergency flood lights working (if applicable)	<input checked="" type="radio"/> Yes or No
If applicable, check batteries and status of Carbon Monoxide detectors	<input checked="" type="radio"/> Yes or No



### Quarterly Safety Check List Plan of Correction

Location: New Roads  
Inspection Date: 1/15/15  
Completed By: Scott E. Youngs  
Number of Unsafe Items Found: 1

Item	Problem	Correction Plan	Date Corrected
fire extinguisher need check	noticed during <u>1/6</u> drill	fire ext. company called <u>1/7</u> + checked same day by company	1/7/15

### REPORT OF INSPECTION

Inspecting Agency: **Western Automatic Sprinkler Co., Inc.**

Date of this Inspection: 10/09/15 Completed by: Tim Warren

Occupant Business Name: Columbia Care Services

Street Address: 2575 Westgate Billing address if different: 3587 Heathrow Way Medford, OR 97504

City: Pendleton State: OR Zip: 97801

Phone: 541-429-8721 Fax: \_\_\_\_\_

Owner/Designated Representative Name: ~~John Billings~~ Scott F. Young

Position: Administrator Authority to approve work? Y N

Name of supervisory Alarm Company: None Phone: \_\_\_\_\_

Date of last Alarm Inspection: \_\_\_\_\_ Prior Alarm Inspector's name: \_\_\_\_\_

Part 1 - Owner's Section	Y	N
1. Are all fire protection system in service	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. All Prior inspection reports, logs and test data are available for review?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Plans of system on site for review?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Modifications made to systems fully reviewed and documented?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Reports of sprinkler action fully reviewed and documented?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Copy of NFPA # 25 on file?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Weekly logs of inspections required by NFPA # 25 on file?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Is the occupancy and hazard the same as reported on last inspection?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. All deficiencies reported at last inspection corrected?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. MS Data sheets and hazards to inspector removed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
11. Last Backflow test report on site?	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Use separate sheet for additional information as may be needed. All "NO" answers to be fully explained for the above section.

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The owner and/or designated representative acknowledges the responsibility of the operating condition of the component parts at the time of this inspection. It is agreed that the inspection service provided by the contractor as prescribed herein is limited to performing a visual inspection and/or routine testing, and any investigation or unscheduled testing, modification, maintenance, repair, etc., of the component parts is not included as part of the inspection work performed. It is further understood that all information contained herein is provided to the best of the knowledge of the party providing such information.

OWNER/DESIGNATED REPRESENTATIVE: Scott F. Young DATE: 10/19/15

INSPECTOR'S SIGNATURE: Tim Warren DATE: 10/09/15  
 WESTERN AUTOMATIC SPRINKLER CO., INC.

Information on this form covers the minimum requirements of NFPA 25 for fire sprinkler system connected to distribution systems without supplemental tanks or fire pumps.

This inspection is  Annual  Third Year  Fifth Year

Property being inspected: Salmon Run System # 1/ wet

Note: All questions for pertinent system sections to be answered. All "No" answers are to be explained in the comment portion

**Part II - Inspector's Section covering all system types:**

1. Control valves and isolation valves on backflow prevention device:
  - a. In correct (open or closed) position?  Yes  No
  - b. Sealed, locked or supervised and accessible?  Yes  No
2. Sprinkler wrench with spare sprinklers?  Yes  No
3. Fire Department Connections:
  - a. Gauges show normal supply water pressure?  Yes  No
  - b. Free from physical damage?  Yes  No
  - c. Couplings and swivels not damaged and rotate smoothly?  Yes  No
  - d. Plugs or caps in place and undamaged?  Yes  No
  - e. Gaskets in place and good conditions?  Yes  No
  - f. Identification sign(s) in place?  Yes  No
  - g. Check valve is not leaking?  Yes  No
  - h. Drip check, automatic drain valve in place and operating properly?  Yes  No
4. Hydraulic nameplate, if provided, securely attached to riser?  Yes  No
5. Proper number and type of spare sprinklers?
  - a. Visible Sprinklers
    1. Free from corrosion?  Yes  No
    2. Free of obstruction to spray pattern?  Yes  No
    3. Free of foreign materials including paint?  Yes  No
    4. Free of physical damage?  Yes  No
  - b. Visible pipe
    1. In good condition?  Yes  No
    2. Free of mechanical damage and not leaking?  Yes  No
    3. No external corrosion?  Yes  No
    4. Properly aligned?  Yes  No
    5. No external loads?  Yes  No
  - c. Visible pipe hangers and seismic braces not damaged or loose?  Yes  No
6. If sprinkler(s) have been replaced, were they proper replacements?  Yes  No
7. If any of the following were discovered, was an obstruction investigation conducted and the system flushed?
  - a. Heavy discoloration of water during drain test or plugging of inspectors test connection?  Yes  No
  - b. Plugging of sprinklers found during activation or alteration?  Yes  No
  - c. System has not been out of service for an extended period of service (grater than one year)?  Yes  No
  - d. System is believed to not contain sodium silicate?  Yes  No
  - e. Operating stem of all OS&Y valves show lubrication completely closed and reopened?  Yes  No
  - f. Obstructive materials discharged during waterflow tests?  Yes  No
  - g. Was yard piping or surrounding public mains flushed following new installation or repairs done?  Yes  No
  - h. Is there a record maintained of broken public main in the area by some authority?  Yes  No
  - i. Fire sprinkler additions, modification, changes, etc meet installation requirements per sate, city?  Yes  No
8. Are all sprinklers in service dated 1920 or later?  Yes  No
9. Fast Response sprinklers in service for less than 20 years? If no test sample now and every 10 years.  Yes  No
10. Standard sprinklers less than 50 years old?  Yes  No
11. All control valves operated through full range and returned to normal position?  Yes  No
12. Did facility lack remodeling, addition, modifications?  Yes  No
13. Gauges checked against calibrated gauge or replaced within 5 years  Yes  No
14. Main Drain Test Static 105 Residual 90 Final Reading 105

**Part III - System Type**

Answer only the questions pertaining to the system being inspected i.e Dry Pipe, Wet, Pre-Action-Deluge

**15. Dry Pipe System**

- a. Enclosures around dry-pipe valve maintaining a minimum of 40°F?  Yes  No
- b. Gauges on dry system in good conditions and showing normal air and water pressure?  Yes  No
- c. Air leaks in dry pipe system resulting in air pressure loss more than 10psi/week repaired?  Yes  No
- d. Dry pipe system being maintained in dry conditions?  Yes  No
- e. Free from physical damage?  Yes  No
- f. Trim valves in appropriate (open or closed) position?  Yes  No
- g. No leakage from intermediate chamber?  Yes  No
- h. Interior of pipe in dry pipe system which passes through freezer free of ice blockage?  Yes  No





This inspection is  Annual  Third Year  Fifth Year

Property being inspected: New Roads System # 2 Wet

Note: All questions for pertinent system sections to be answered. All "No" answers are to be explained in the comment portion

**Part II - Inspector's Section covering all system types:**

- 1. Control valves and isolation valves on backflow prevention device:
  - a. In correct (open or closed) position?  Yes  No
  - b. Sealed, locked or supervised and accessible?  Yes  No
- 2. Sprinkler wrench with spare sprinklers?  Yes  No
- 3. Fire Department Connections:
  - a. Gauges show normal supply water pressure?  Yes  No
  - b. Free from physical damage?  Yes  No
  - c. Couplings and swivels not damaged and rotate smoothly?  Yes  No
  - d. Plugs or caps in place and undamaged?  Yes  No
  - e. Gaskets in place and good conditions?  Yes  No
  - f. Identification sign(s) in place?  Yes  No
  - g. Check valve is not leaking?  Yes  No
  - h. Drip check, automatic drain valve in place and operating properly?  Yes  No
- 4. Hydraulic nameplate, if provided, securely attached to riser?  Yes  No
- 5. Proper number and type of spare sprinklers?
  - a. Visible Sprinklers
    - 1. Free from corrosion?  Yes  No
    - 2. Free of obstruction to spray pattern?  Yes  No
    - 3. Free of foreign materials including paint?  Yes  No
    - 4. Free of physical damage?  Yes  No
  - b. Visible pipe
    - 1. In good condition?  Yes  No
    - 2. Free of mechanical damage and not leaking?  Yes  No
    - 3. No external corrosion?  Yes  No
    - 4. Properly aligned?  Yes  No
    - 5. No external loads?  Yes  No
  - c. Visible pipe hangers and seismic braces not damaged or loose?  Yes  No
- 6. If sprinkler(s) have been replaced, were they proper replacements?  Yes  No
- 7. If any of the following were discovered, was an obstruction investigation conducted and the system flushed?
  - a. Heavy discoloration of water during drain test or plugging of inspectors test connection?  Yes  No
  - b. Plugging of sprinklers found during activation or alteration?  Yes  No
  - c. System has not been out of service for an extended period of service (grater than one year)?  Yes  No
  - d. System is believed to not contain sodium silicate?  Yes  No
  - e. Operating stem of all OS&Y valves show lubrication completely closed and reopened?  Yes  No
  - f. Obstructive materials discharged during waterflow tests?  Yes  No
  - g. Was yard piping or surrounding public mains flushed following new installation or repairs done?  Yes  No
  - h. Is there a record maintained of broken public main in the area by some authority?
    - i. Fire sprinkler additions, modification, changes, etc meet installation requirements per state, city?  Yes  No
- 8. Are all sprinklers in service dated 1920 or later?  Yes  No
- 9. Fast Response sprinklers in service for less than 20 years? If no test sample now and every 10 years.  Yes  No
- 10. Standard sprinklers less than 50 years old?  Yes  No
- 11. All control valves operated through full range and returned to normal position?  Yes  No
- 12. Did facility lack remodeling, addition, modifications?  Yes  No
- 13. Gauges checked against calibrated gauge or replaced within 5 years  Yes  No

14. Main Drain Test Static 95 Residual 75 Final Reading 95

**Part III - System Type**

Answer only the questions pertaining to the system being inspected i.e Dry Pipe, Wet, Pre-Action-Deluge

- 15. Dry Pipe System  Yes  No
  - a. Enclosures around dry-pipe valve maintaining a minimum of 40°F?  Yes  No
  - b. Gauges on dry system in good conditions and showing normal air and water pressure?  Yes  No
  - c. Air leaks in dry pipe system resulting in air pressure loss more than 10psi/week repaired?  Yes  No
  - d. Dry pipe system being maintained in dry conditions?  Yes  No
  - e. Free from physical damage?  Yes  No
  - f. Trim valves in appropriate (open or closed) position?  Yes  No
  - g. No leakage from intermediate chamber?  Yes  No
  - h. Interior of pipe in dry pipe system which passes through freezer free of ice blockage?  Yes  No



Part IV Comments (Any "No" answers, test failures or other problems found with the sprinkler system must be explained here or attached excluding No answers for system type)

Inspectors test is in adjacent bld.

**Part V - Inspector's Information**

Company: Western Automatic Sprinkler Co., Inc.

Address: 1403 N Monroe  
La Grande, OR 97850  
(541) 963-0492

I state that the information on this form is correct at the time and place of my inspection, and that all equipment tested at this time was left in operation condition upon completion of this inspection except as noted in Part IV of this report.

Signature of Inspector: \_\_\_\_\_

Date: 10-09-2015

INSPECTION AND TESTING FORM

DATE: 10-6-15  
 TIME: 5:15 pm

SERVICE ORGANIZATION

Name: Smith Security LLC  
 Address: PO Box 83 Pendleton OR 97801  
 Representative: Dan Smith  
 License No.: 2921 LEA 30-11706 LCB 205947  
 Telephone: 541-276-4847

PROPERTY NAME (USER)

Name: New Roads  
 Address: 2575 Westgate Bldg 3 Pendleton  
 Owner Contact: Heather  
 Telephone: 541-276-6330

MONITORING ENTITY

Contact: N/A  
 Telephone: N/A  
 Monitoring Account Ref. No.: N/A

APPROVING AGENCY

Contact: Pendleton Fire / City of Pendleton  
 Telephone: 541-276-1442

TYPE TRANSMISSION

- McCulloh
- Multiplex
- Digital
- Reverse Priority
- RF
- Other (Specify) LOCAL ONLY

SERVICE

- Weekly
- Monthly
- Quarterly
- Semiannually
- Annually
- Other (Specify) \_\_\_\_\_

Control Unit Manufacturer: Silent Knight  
 Circuit Styles: B  
 Number of Circuits: 7  
 Software Rev.: N/A  
 Last Date System Had Any Service Performed: N/A  
 Last Date that Any Software or Configuration Was Revised: N/A

Model No.: SK-4

ALARM-INITIATING DEVICES AND CIRCUIT INFORMATION

Quantity	Circuit Style
<u>1</u>	<u>B</u>
<u>0</u>	<u>N/A</u>
<u>1</u>	<u>B</u>
<u>2</u>	<u>B</u>
<u>0</u>	<u>N/A</u>
<u>1</u>	<u>B</u>
<u>1</u>	<u>B</u>
<u>N/A</u>	<u>N/A</u>

- Manual Fire Alarm Boxes
- Ion Detectors
- Photo Detectors
- Duct Detectors
- Heat Detectors
- Waterflow Switches
- Supervisory Switches
- Other (Specify): \_\_\_\_\_

Alarm verification feature is disabled  enabled \_\_\_\_\_

(NFPA Inspection and Testing, 1 of 4)

FIGURE 10.6.2.3 Example of an Inspection and Testing Form.

**ALARM NOTIFICATION APPLIANCES AND CIRCUIT INFORMATION**

<p>Quantity</p> <p><u>1</u></p> <p><u>N/A</u></p> <p><u>✓</u></p>	<p>Circuit Style</p> <p><u>B</u></p> <p><u>B</u></p> <p><u>N/A</u></p> <p><u>✓</u></p>	<p>Bells</p> <p>Horns <u>Stroke</u></p> <p>Chimes</p> <p>Strobes</p> <p>Speakers</p> <p>Other (Specify): _____</p>
---	--	--

No. of alarm notification appliance circuits: \_\_\_\_\_

Are circuits monitored for integrity?  Yes  No

**SUPERVISORY SIGNAL-INITIATING DEVICES AND CIRCUIT INFORMATION**

<p>Quantity</p> <p><u>N/A</u></p> <p><u>✓</u></p>	<p>Circuit Style</p> <p><u>N/A</u></p> <p><u>✓</u></p>	<p>Building Temp.</p> <p>Site Water Temp.</p> <p>Site Water Level</p> <p>Fire Pump Power</p> <p>Fire Pump Running</p> <p>Fire Pump Auto Position</p> <p>Fire Pump or Pump Controller Trouble</p> <p>Fire Pump Running</p> <p>Generator In Auto Position</p> <p>Generator or Controller Trouble</p> <p>Switch Transfer</p> <p>Generator Engine Running</p> <p>Other: _____</p>
---	--	---

**SIGNALING LINE CIRCUITS**

Quantity and style of signaling line circuits connected to system (see NFPA 72, Table 6.6.1):

Quantity 0 Style(s) N/A

**SYSTEM POWER SUPPLIES**

(a) Primary (Main): Nominal Voltage 120 VAC Amps 20

Overcurrent Protection: Type Breaker Amps 20

Location (of Primary Supply Panelboard): Electrical / RACP Room (outside end)

Disconnecting Means Location: Panel F #39

(b) Secondary (Standby): 12V x 2 Storage Battery: Amp-Hr. Rating 7ah x 2

Calculated capacity to operate system, in hours: \_\_\_\_\_ 24 \_\_\_\_\_ 60

Location of fuel storage: N/A Engine-driven generator dedicated to fire alarm system: \_\_\_\_\_

**TYPE BATTERY**

Dry Cell

Nickel-Cadmium

Sealed Lead-Acid

Lead-Acid

Other (Specify): \_\_\_\_\_

(c) Emergency or standby system used as a backup to primary power supply, instead of using a secondary power supply:

N/A Emergency system described in NFPA 70, Article 700

✓ Legally required standby described in NFPA 70, Article 701

✓ Optional standby system described in NFPA 70, Article 702, which also meets the performance requirements of Article 700 or 701.

(NFPA Inspection and Testing, 2 of 4)

FIGURE 10.6.2.3 Continued

PRIOR TO ANY TESTING				
NOTIFICATIONS ARE MADE	Yes	No	Who	Time
Monitoring Entity <i>N/A</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
Building Occupants	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>All</i>	<i>5:15</i>
Building Management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>Heather</i>	<i>5:15</i>
Other (Specify) <i>Pandletan Fire</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<i>7:20</i>
AHJ Notified of Any Impairments	<input checked="" type="checkbox"/>	<input type="checkbox"/>		

SYSTEM TESTS AND INSPECTIONS			
TYPE	Visual	Functional	Comments
Control Unit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Interface Equipment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Lamps/LEDS	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Fuses <i>N/A</i>	<input type="checkbox"/>	<input type="checkbox"/>	
Primary Power Supply	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Trouble Signals	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Disconnect Switches <i>N/A</i>	<input type="checkbox"/>	<input type="checkbox"/>	
Ground-Fault Monitoring <i>N/A</i>	<input type="checkbox"/>	<input type="checkbox"/>	

SECONDARY POWER			
TYPE	Visual	Functional	Comments
Battery Condition	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<i>dated 3/14</i>
Load Voltage		<input checked="" type="checkbox"/>	
Discharge Test		<input type="checkbox"/>	
Charger Test		<input checked="" type="checkbox"/>	
Specific Gravity		<input type="checkbox"/>	

TRANSIENT SUPPRESSORS <i>N/A</i>	<input type="checkbox"/>		
REMOTE ANNUNCIATORS	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
NOTIFICATION APPLIANCES			
Audible	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Visible	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Speakers <i>N/A</i>	<input type="checkbox"/>	<input type="checkbox"/>	
Voice Clarity <i>N/A</i>		<input type="checkbox"/>	

INITIATING AND SUPERVISORY DEVICE TESTS AND INSPECTIONS							
Loc. & S/N	Device Type	Visual Check	Functional Test	Factory Setting	Measured Setting	Pass	Fail
<i>panel</i>	<i>Smoke Detector</i>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
<i>panel</i>	<i>Pull Station</i>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
<i>viser room</i>	<i>Tamper</i>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
<i>viser room</i>	<i>WF</i>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
<i>E &amp; W</i>	<i>Dust Detectors</i>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

Comments: *Actual WF test to be done by Sprinkler Co.*

(NFPA Inspection and Testing, 3 of 4)

FIGURE 10.6.2.3 Continued

EMERGENCY COMMUNICATIONS EQUIPMENT		Visual	Functional	Comments
Phone Set	N/A	<input type="checkbox"/>	<input type="checkbox"/>	
Phone Jacks	N/A	<input type="checkbox"/>	<input type="checkbox"/>	
Off-Hook Indicator	N/A	<input type="checkbox"/>	<input type="checkbox"/>	
Amplifier(s)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	
Tone Generator(s)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	
Call-in Signal	N/A	<input type="checkbox"/>	<input type="checkbox"/>	
System Performance		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	

INTERFACE EQUIPMENT	Visual	Device Operation	Simulated Operation
(Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SPECIAL HAZARD SYSTEMS	Visual	Device Operation	Simulated Operation
(Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Special Procedures: \_\_\_\_\_

Comments: \_\_\_\_\_

SUPERVISING STATION MONITORING	Yes	No	Time	Comments
Alarm Signal	<input type="checkbox"/>	<input type="checkbox"/>		
Alarm Restoration	<input type="checkbox"/>	<input type="checkbox"/>		
Trouble Signal	<input type="checkbox"/>	<input type="checkbox"/>		
Supervisory Signal	<input type="checkbox"/>	<input type="checkbox"/>		
Supervisory Restoration	<input type="checkbox"/>	<input type="checkbox"/>		

NOTIFICATIONS THAT TESTING IS COMPLETE	Yes	No	Who	Time
Building Management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Heather	
Monitoring Agency	<input type="checkbox"/>	<input type="checkbox"/>		
Building Occupants	<input checked="" type="checkbox"/>	<input type="checkbox"/>	All	
Other (Specify) <i>pendleton Fire &amp; Court Dispatch</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Kevin	6:00pm

The following did not operate correctly: \_\_\_\_\_

System restored to normal operation: Date: *10-6-15* Time: *6:15pm*

THIS TESTING WAS PERFORMED IN ACCORDANCE WITH APPLICABLE NFPA STANDARDS.

Name of Inspector: *Dan Smith* Date: *10-6-15* Time: *6:20pm*

Signature: \_\_\_\_\_

Name of Owner or Representative: *Heather Smidt*

Date: *10/6/15* Time: *6:08pm*

Signature: *Heather Smidt*

(NFPA Inspection and Testing, 4 of 4)

FIGURE 10.6.2.3 Continued



State of Oregon  
Office of State Fire Marshal  
4760 Portland Rd NE  
Salem, Oregon 97305-1760

**Fire and Life Safety  
Inspection**  
**Notice and Order of Correction**

201508070923

Inspection Date: 9/9/2015

Inspection Reason: Scheduled

Business Name and Address:  
New Roads  
2575 Westgate Bldg F  
Pendleton OR 97801

Inspection Type:  
Inspection Business License

Responsible Party:

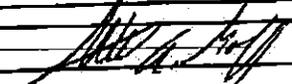
County: Umatilla

The State Fire Marshal is authorized to enforce laws and rules pertaining to fire and life safety in accordance with Oregon Revised Statutes, Chapters 476, 479, and 480. Entry and inspection of the building(s) or premises was made in accordance with ORS 476.070/150. Failure to correct the following fire safety violations may result in legal action as defined under ORS 479.170.

Violation Code	Deficiency(s) Requiring Correction and/or Action	Compliance Date	Abatement Date
901.6.2	Annual test records for the fire alarm and fire protection sprinkler system were not available at time of inspection.	11/9/2015	

The full text of codes cited above is available through the Oregon State Fire Marshal's website:  
[http://www.oregon.gov/osp/SFM/pages/codes\\_2\\_new.aspx](http://www.oregon.gov/osp/SFM/pages/codes_2_new.aspx)

**Inspection Notes**

Deputy State Fire Marshal: Scott Goff 

You have the right to appeal this order (ORS 479.180). To initiate an appeal contact the individual who issued this order.

OREGON OFFICE OF STATE FIRE MARSHAL  
4760 Portland Road NE, Salem, OR 97305

LICENSED FACILITIES REFERRAL  
FOR FIRE SAFETY INSPECTION

**ALL INFORMATION MUST BE COMPLETED FOR FORM TO BE PROCESSED**

**Licensing Agency Information**

Date: 8/3/15 Licensing Contact Name: Carrie Wouda  
Licensing Agency Name: OHA/AMH  
Agency Address: 500 Summer St NE B86  
City/Zip: Salem 97301 Phone #: 503-945-8866

RECEIVED

(Occupancy Type Defined on Reverse)

Residential Care (SR)  Treatment Home  
Assisted Living Facility (SR)   
Please indicate the number of clients 5  
Health Care Facility (I-2)   
Children's Residential Facility or  
Day Treatment Facility (L):

Adult Foster Home (R-3): \*\* AUG 06 2015  
Date of Licensing Agency On-Site Inspection of Adult  
Foster Home \*\*: STATE FIRE MARSHAL  
\*\*Describe the area(s) of concern \_\_\_\_\_

\*\*\*FOR CHILD CARE FACILITIES\*\*\*  
Day Care Center (E):   
Day Care Facility (I-4):   
Increase # of Occupants   
Original # of children \_\_\_\_\_ # increased to \_\_\_\_\_

**Facility Information (To be Completed by Owner/Manager)**

Name of Facility: New Roads  
Street Address: 2575 Westgate Bldg F City: Jendleton  
Zip: 97801 County: Union Nearest Cross St. (if known): \_\_\_\_\_  
Provider/Manager: Scott Young Phone #: 541-276-6330  
License Expiration Date: 2/9/16 # Residents/Children/Capacity: 5  
Reason for Referral:  
 New Facility/New License  Renewal of Licensed Facility  
 Other (Explain): \_\_\_\_\_

**To Be Completed By DEPUTY/INSPECTOR**

Name of Deputy/Inspector: Scott A. Goff  
Inspecting Agency: OSFM (Please Print) Inspection Date: 9/9/15  
Phone #: (541) 276-4676 Fire Inspection #: 201508070923

- APPROVED for occupancy (no deficiencies noted).
- APPROVED with corrections listed on fire inspection notice.
- NOT APPROVED until all deficiencies are corrected. Refer to fire inspection notice.

Deputy/Inspector Signature: [Signature]

Distribution: White-Provider Yellow-OSFM, Salem Green-District Deputy/Local Inspector Pink-Licensing Agency  
NOTE: All previous copies of this form are invalid. FLS/Form/PM Inspection/Masks/FM Insp Request (3/05) MSC 210 (3/03)

Goff 8/6/15

FIRE EVACUATION DRILL CHECK SHEET

OAR 309-035-0130(6),(7),(8),(9)&(13) / 0330(6),(7),(8),(9)&(13)

Program: New Roads Licensing Period: 2-10-14 to 2/9/16

	Date of Drill	Time (A.M. or P.M.)	Night Drill (11 pm to 6 am)	Location Of Mock Fire	Other Monthly Inspections			
					Smoke Detectors or Alarm	Window Operation Blockage	Exit Door Egress Blockage	Emergency Lights
1	1/26/16	3 pm	<input type="checkbox"/>	east wing	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2	12/21/15	2 pm	<input type="checkbox"/>	west exit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3	11/13/15	10:15 am	<input type="checkbox"/>	Kitchen	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4	10/18/15	11:15 am	<input type="checkbox"/>	east ball office	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5	9/17/15	9:50 pm	<input type="checkbox"/>	east hall	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6	8/14/15	6:02 am	<input checked="" type="checkbox"/>	Admin office	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7	7/9/15	2:03 pm	<input type="checkbox"/>	front door of D	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8	6/24/15	8 pm	<input type="checkbox"/>	front exit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9	5/3/15	10 am	<input type="checkbox"/>	kitchen	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
10	4/9/15	8 pm	<input type="checkbox"/>	NO LOCATION	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
11	3/12/15	9 am	<input type="checkbox"/>	staff office	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
12	2/17/15	8 am	<input type="checkbox"/>	patio door	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
13	1/6/15	11:35 am	<input checked="" type="checkbox"/>	dining room	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
14	12/20/15	4:45 pm	<input type="checkbox"/>	west exit door	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
15	11/12/14	9 am	<input type="checkbox"/>	east door	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
16	10/31/14	9 pm	<input type="checkbox"/>	east door	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
17	9/24/14	7 am	<input type="checkbox"/>	living room	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
18	8/22/14	5 pm	<input type="checkbox"/>	patio door	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
19	7/31/14	3:48 pm	<input type="checkbox"/>	front door	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
20	6/19/14	10 am	<input type="checkbox"/>	east exit door	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
21	5/14/14	4 pm	<input type="checkbox"/>	patio exit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
22	4/12/14	9 pm	<input type="checkbox"/>	hall living room	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
23	3/8/14	10 pm	<input type="checkbox"/>	front door	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
24	2/12/14	10:10 am	<input type="checkbox"/>	kitchen	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

**NEED OVERNIGHT DRILLS - MISSING SEVERAL**



# CONSENT FOR CONTACT WITH RESIDENT UNDER 18 YEARS

NEW ROADS RTH 2575 WESTGATE, BUILDING 3, PENDLETON, OR 97801 541.276.6330

Name of Youth Under Age 18 \_\_\_\_\_

OAR 413-215-0576 (1) requires that a parent or legal guardian signs a consent that authorizes the residential care home to restrict the youth's contact with persons outside the residential care home; including visits, telephone communication, electronic mail, and postal mail. I hereby consent to restrict the youth named above from contact with the following individual(s) as described below:

Name	Relationship	Phone Number	Phone calls FROM	Phone calls TO	Exchange of mail	Visit at the RTH

\_\_\_\_\_ *Parent/Guardian Signature*

\_\_\_\_\_ *Date*

\_\_\_\_\_ *Staff Signature*

\_\_\_\_\_ *Date*

I,       , agree to the following financial plan, which includes:

- Who will be the payee for my income,
- Whether I will participate in the ColumbiaCare Services (CCS) Money Management Program, and
- How my money will be kept secure at this facility.

**1. Payee for My Income**

*(Initial which option applies)*

\_\_\_\_\_ I am the payee.

\_\_\_\_\_ I agree that ColumbiaCare Services is to be my Representative Payee. ColumbiaCare Services is authorized to contact the Social Security Administration to make arrangements for this to occur. *(Note: This option requires participation in Money Management Program)*

\_\_\_\_\_ I have a Representative Payee. Name:

Address:

Phone:

**2. Participation in Money Management Program**

*(Initial which option applies)*

\_\_\_\_\_ I agree to participate in the CCS Money Management program. I understand and agree that:

- ColumbiaCare Services holds my Personal and Incidental Funds (PIF) for me,
- I will negotiate a budget for spending the PIF with my financial contact person at this residential facility,
- My PIF are to be dispersed according to this budget,
- I will cooperate with my financial contact person in maintaining my funds and benefits,
- ColumbiaCare Services will give me the complete record of my account at my request.

I further understand that I may discontinue participation in the CCS Money Management program at my request. In this event, the following guidelines will apply:

- If ColumbiaCare is acting as my payee, my request to discontinue money management services must be directed to the Social Security Administration office (phone number: 1-800-772-1213). Resources for assistance in this matter can be a Social Security Administration office, a staff member, or Disability Rights Oregon (phone number 503-243-2081)
- If ColumbiaCare is not my payee, my requests to discontinue money management services must be directed in writing to the facility administrator,

and upon receiving this request, the remaining funds in my account will be returned to me.

- If I designate a different payee, I am still responsible for room and board charges each month, as described in my Room and Board Fees Agreement.

I further understand and agree that if I cannot abide by this contract and the obligations described above, ColumbiaCare Services or other parties may contact Social Security Administration and inform them that they do not wish to be Representative Payee for my SSI or SSD any longer. At this point, my money would be sent back to Social Security Administration and it will be my responsibility to work with Social Security Administration in finding a new Representative Payee. If I need additional money management, this will be reviewed with my Case Manager who will be asked to help locate a rep-payee or make other appropriate arrangements.

\_\_\_\_\_ I do not wish to participate in the CCS Money Management program.

**3. How My Money Will Be Kept Secure**

*(Initial which option applies)*

\_\_\_\_\_ I agree to have my money in excess of \$ locked up in the office at this residential facility. This facility will place my money in an envelope separate from the money of other residents, and will keep a record of its disposition. My money will not be used except with my consent as evidenced by my signature and/or initials at any time money is withdrawn from my account. Only the facility staff and administration will have access to my money.

\_\_\_\_\_ I am responsible for keeping my money secure. I will keep my money on my person, or in my lock box that I will keep locked at all times. I understand that by making this choice I am responsible for any loss of my money. I also understand I may request at any time that my money be locked up in the office at this residential facility.

\_\_\_\_\_  
*Resident Signature/ Guardian Signature (if applicable)*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Administrator Signature*

\_\_\_\_\_  
*Date*

**For Staff Use Only - Annual Review**

I have reviewed all of the items listed above with the resident named above:

_____ <i>Staff Initials</i>	_____ <i>Date</i>	_____ <i>Staff Initials</i>	_____ <i>Date</i>	_____ <i>Staff Initials</i>	_____ <i>Date</i>
_____ <i>Staff Initials</i>	_____ <i>Date</i>	_____ <i>Staff Initials</i>	_____ <i>Date</i>	_____ <i>Staff Initials</i>	_____ <i>Date</i>
_____ <i>Staff Initials</i>	_____ <i>Date</i>	_____ <i>Staff Initials</i>	_____ <i>Date</i>	_____ <i>Staff Initials</i>	_____ <i>Date</i>



**AUTHORIZATION FOR  
MEDIA RELEASE**

**SALMON RUN RTH 2575 WESTGATE, BUILDING 1, PENDLETON, OR, 97801 541.429.8721**

This authorization pertains to:

**Name**

**DOB**

**Address/Phone**

**Purpose(s) for which information is disclosed:** Public promotion, training, advertising, and marketing materials; internal and external publication in print, digital, Internet, and/or multi-media formats.

**Release of My Confidential Information**

1. By initialing next to an item listed here, I hereby give ColumbiaCare Services, Inc. permission to use, for the purpose above, my: \_\_\_\_\_ Name \_\_\_\_\_ photograph \_\_\_\_\_ likeness \_\_\_\_\_ voice
2. I hereby personally and on behalf of me and/or my dependent/child forever release and agree to hold harmless ColumbiaCare Services, Inc., it's employees, agents, successors, and assigns from any liability, claims, actions, damages, demands, or expenses whatsoever by reason of such use.
3. I hereby further release and agree to hold harmless the photographer, his/her representatives, employees or any persons or corporations acting under this permission or authority, or any persons or corporations, for whom he/she might be acting, including any firm publishing and/or distributing the finished product, in whole or in part, from and against any liability as a result of any use that may occur or be produced in the taking, processing or reproduction of the finished product, its publication or distribution.
4. I understand that I will not be compensated for the use of my name, photograph, likeness, and/or voice when used in connection with ColumbiaCare Services, Inc. promotional and informational materials.
5. I fully understand that I have the right to deny ColumbiaCare Services, Inc. to publish photographs, audio, and video recordings of me for training, promotional, news, and other purposes without any negative consequence to myself whatsoever.
6. I fully understand that this Authorization will remain in effect until this consent is withdrawn by me in writing, and that such a withdrawal will only affect materials produced after the date of the withdrawal.

**Term**

This Authorization will remain in effect until the time initialed below from the date of the authorizing signature. **(Initial only one)**

\_\_\_\_\_ As long as the material lasts: This consent will remain in effect for the **life of materials** produced under this Authorization.

\_\_\_\_\_ One-Time/Purpose \_\_\_\_\_  
(Write the one-time event or the purpose above)

**I CONSENT:** I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my confidential information. By my signature, I hereby, knowingly and voluntarily authorize ColumbiaCare Services to use confidential information in the manner described above.

\_\_\_\_\_  
*Client/Guardian Signature*

\_\_\_\_\_  
*Date*

ACKNOWLEDGEMENT OF  
**ORIENTATION TO HOME AND RIGHTS**  
SALMON RUN RTH 2575 WESTGATE, BUILDING 1, PENDLETON, OR, 97801  
541.429.8721

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***Welcome, we are glad to have you here!***

Entering an unknown situation can be both frightening and exciting. We want you to be comfortable here and encourage you to ask questions, including the rules, the schedules and the expectations. We have made the following orientation checklist so we don't forget any important information as we help you adjust. As staff shows you around, please initial the areas that are covered as you learn them; you will receive a copy of this document when it is completed.

\_\_\_\_\_ **Tour of Facility**

***Locations*** I have been shown the location of the room I will be in, staff areas, laundry room, bathrooms, living room and activity area, where I may eat food and drinks, the client telephone and information boards and where emergency phone numbers are posted, where to get towels and bathmats.

***Expectations and encouragements*** I understand:

- My room I am expected to keep my room clean and presentable.
- Personal hygiene I am encouraged to shower and brush my teeth daily then return personal belongings, grooming items, and, my towel and bathmat to my room so they don't get mixed up with those of other residents. If I do not have necessary personal toiletries, staff may be able to provide them at my request.
- Laundry I am expected to do my own laundry using the washer and dryer. Laundry supplies are available by asking staff. Dirty towels may be placed in the laundry basket or they may be washed with my dirty clothing after use. Sheets may be washed as often as desired; staff encourages that they be changed at least once per week.
- Dress in Common Areas I know that for sanitary purposes I need to wear something on my feet when out of my room, and that I am expected to get dressed every day instead of wearing sleepwear all day.
- No Smoking That I cannot smoke here because State rules do not allow smoking on the facility property or in facility vehicles. I have been shown where the property boundaries are. I understand that I am expected to tell staff when I go off the property to smoke.

\_\_\_\_\_ ***Introductions:*** I have been introduced to other residents. I have met facility staff and been given information about staff who are not here right now, and their roles in the care and treatment of residents.

\_\_\_\_\_ ***Meals and Snacks:*** The meal and snack schedule has been explained as follows: . Snacks are available by request unless restricted by physician order. I will talk with the staff member on shift if I wish to have guests join me for a meal, need to miss a meal, would like items not on the menu or to contribute to the menu. I am encouraged to assist with food preparation. I know staff are available to explain how to prepare food. Proper food handling and storage techniques have been explained. I agree to assist with cleaning up after meals.

\_\_\_\_\_ ***Daily Schedule:*** Staying in a home requires having schedules so all residents and staff can plan their day. Every day is not the same, and schedules may change due to unplanned incidents, weather conditions or other factors. Staff has explained how I can contribute to the schedule or make requests for activities I would like to do. Policies regarding community privileges, transportation, outside appointments, visiting hours and quiet times have been explained. I have had an opportunity to have my questions answered.

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\_\_\_\_\_ **Emergency Procedures:** The smoke alarm has been set off and I can identify the sound as requiring an emergency exit. Emergency exits have been identified, including doors and windows able to be opened, and I can identify the closest appropriate exit from different locations in the house. I have demonstrated my capability of using another way to exit if necessary because the door to my room is hot. I walked through a simulated fire drill on . I understand I am expected to participate in routine fire drills whenever they occur. I understand that 911 is the local emergency number and I would be able to call them and give the address of the facility, if necessary during an emergency.

In case of fire, would this resident require assistance with exiting? Yes No

\_\_\_\_\_ **Releases of Information:** I, or my parent or guardian, understand(s) the need to have a Release of Information signed for anyone other than ColumbiaCare Services staff, including my emergency contact, the pharmacy, and my primary care physician. I will also need to sign ROI's if I want staff assistance in interactions with personal and professional contacts.

**In addition to the foregoing,** I have reviewed the following documentation with staff and been given a copy of documentation for my use. By my initials below, I acknowledge that each item has been explained and I understand the information therein. If applicable, a copy of the following has also been given to my Guardian.

\_\_\_\_\_ **Informed Consent to Treatment (Non-PSRB)** I understand that this is a voluntary placement, I have had service options explained, and I, or my parent or guardian, agree to receive and participate in mental health treatment services while I live here. I have been informed of the risks and benefits of treatment, and that I, or my parent or guardian, have a right to refuse treatment. I, or my parent or guardian, understand that, if I, or my parent or guardian, refuse mental health treatment at this facility, staff will help me, or my parent or guardian, find another placement which will better meet the kind of treatment and care I, or my parent or guardian, want. I, or my parent or guardian, initialed this form and have been provided with a copy of the Orientation to Home and Your Rights Handout that includes Informed Consent to Treatment information for my records at the time I entered services.

\_\_\_\_\_ **Informed Consent to Treatment (PSRB)** I, or my parent or guardian, understand(s) that participation in treatment not included in my conditional agreement with the P SRB is voluntary and I, or my parent or guardian, agree to receive and participate in these additional mental health treatment services while I live here. I, or my parent or guardian, have had service options explained, have been informed of the risks and benefits of treatment, and that I, or my parent or guardian, have a right to refuse treatment not included in my conditional agreement with the PSRB. I, or my parent or guardian, understand that, if I, or my parent or guardian, refuse this voluntary mental health treatment or mental health treatment mandated by the PSRB at this facility, staff will address my concerns in a collaborative manner to avoid the revocation of my PSRB conditional release. I, or my parent or guardian, initialed this form and have been provided with a copy of the Orientation to Home and Your Rights Handout that includes Informed Consent to Treatment information for my records at the time I entered services.

**Additional Consents** I, or my parent or guardian agree(s) that this facility may do all of the following as described in the ***“Orientation to Home and Your Rights”*** document:

\_\_\_\_\_ Provide routine and emergency medical care, unless restricted or limited in accordance with the creed or tenets of a well-recognized religion or denomination;

**ACKNOWLEDGEMENT OF  
ORIENTATION TO HOME AND RIGHTS**  
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- \_\_\_\_\_ Use this facility's behavior management system;
- \_\_\_\_\_ Restrict the youth's contact with persons outside the residential care agency;
- \_\_\_\_\_ Exclude or limit the youth's possession of personal items;
- \_\_\_\_\_ Impose a dress code; and,
- \_\_\_\_\_ Restrict the youth's participation in recreational or leisure activities in an appropriate manner, consistent with behavior or safety issues.
- \_\_\_\_\_ **Disclosures** I, or my parent or guardian have been informed about personal or room searches and protocols for confiscation of contraband items, including the notification of law enforcement if illegal contraband is discovered. In addition, I understand any written policy or procedure pertaining to program services is available, upon request.
- \_\_\_\_\_ **Fee Agreement and Management of Personal Funds** I understand that I am responsible to pay for room, board and other covered services, long distance phone charges, and co-pays for my medications. I also understand that it is best not to bring large amounts of money into the facility, and that staff will provide a way to lock up money in excess of \$10 in order to protect my resources. I agree to have my personal and incidental funds held by the facility with the understanding that this money will not be used except with my consent as evidenced by my signature and/or initials at any time money is withdrawn from my funds. I understand I am responsible to follow my monthly budget and return receipts for items I purchase.
- \_\_\_\_\_ **Advance Mental Health and Health Directives:** I have been given information on advance health care directives and a mental health declaration. I understand I am able to identify my wishes to be followed in case of illness and appoint someone else to speak for me if needed. Should I desire to complete one or both of these documents, I may ask staff to provide a copy of the form for review and completion after discussion with my loved ones, my personal representative, and my doctor(s). I also understand that staff may not give medical advice, act as a witness to my directives or be appointed as my representative.
- \_\_\_\_\_ **Resident Rights:** I understand I have the rights of other individuals, including the right to privacy and to communicate privately with visitors. I was provided with a copy of the Resident's Bill of Rights listing other rights afforded to residents.
- \_\_\_\_\_ **Mutual Respect, Responsibilities, and Safety:** While living in this facility, I understand that everyone has a responsibility to do their part to keep the house a comfortable place to live and work. I have been provided with a copy of Mutual Respect, Responsibilities, and Safety. I have had an opportunity to discuss this with a staff member and agree that while I am a resident at the facility I will follow this.
- \_\_\_\_\_ **Complaints, Grievances & Appeals:** I understand I have the right to file a grievance regarding incidents while here, or appeal a decision regarding a grievance. I have been provided with a copy of the grievance form and of the Notice of Right to Submit a Complaint/ Grievance or Appeal.
- \_\_\_\_\_ **Abuse Reporting:** While a resident at this facility, I understand I have the right to be free from abuse. In this regard, I have been provided with a copy of the abuse report form as well as abuse reporting information that identifies how to report any concerns of abuse I have. I have discussed this information with a staff member and can ask further questions if needed.

**ACKNOWLEDGEMENT OF  
ORIENTATION TO HOME AND RIGHTS**  
SALMON RUN RTH 2575 WESTGATE, BUILDING 1, PENDLETON, OR, 97801  
541.429.8721

\_\_\_\_\_ **Notice of Privacy Practices:** As required by HIPAA, I have been provided with a copy of the ColumbiaCare Privacy Practices and had them explained to my satisfaction. I understand if I have further questions, I may discuss them with staff or a representative of ColumbiaCare and that these practices ensure the confidentiality of my Protected Health Information.

\_\_\_\_\_ **Relationships with Law Enforcement:** I have been shown the ColumbiaCare policy on relationships with law enforcement personnel that is posted on the bulletin board. I understand that I may not be threatened with law enforcement involvement as a means of behavioral support and that staff will not provide information about me to law enforcement without my consent. However, law enforcement involvement may be an option in certain situations as described in the policy. I am aware that a copy of the policy on Relationships with Law Enforcement will be provided at my request.

\_\_\_\_\_ **Visit and Other Contact with the Youth:** I have provided the names of individuals to whom I given my consent to visit the youth or have indicated the type of contact named individuals may have with the youth.

\_\_\_\_\_ **Youth Participation in Activities:** I consent to the youth's participation in routine activities, recreational events and travel provided by the facility.

By my signature below, I acknowledge that I received the information above.

<i>Resident Signature/ Guardian Signature (if applicable)</i>	<i>Date</i>
<i>Staff Signature</i>	<i>Date</i>

**For Staff Use Only - Annual Review**

I have reviewed all of the items listed above with the resident named above:

<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border-top: 1px solid black; text-align: center; padding-top: 5px;"><i>Staff Initials</i></td> <td style="width: 50%; border-top: 1px solid black; text-align: center; padding-top: 5px;"><i>Date</i></td> </tr> <tr> <td style="border-top: 1px solid black; text-align: center; padding-top: 5px;"><i>Staff Initials</i></td> <td style="border-top: 1px solid black; text-align: center; padding-top: 5px;"><i>Date</i></td> </tr> <tr> <td style="border-top: 1px solid black; text-align: center; padding-top: 5px;"><i>Staff Initials</i></td> <td style="border-top: 1px solid black; text-align: center; padding-top: 5px;"><i>Date</i></td> </tr> </table>	<i>Staff Initials</i>	<i>Date</i>	<i>Staff Initials</i>	<i>Date</i>	<i>Staff Initials</i>	<i>Date</i>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border-top: 1px solid black; text-align: center; padding-top: 5px;"><i>Staff Initials</i></td> <td style="width: 50%; border-top: 1px solid black; text-align: center; padding-top: 5px;"><i>Date</i></td> </tr> <tr> <td style="border-top: 1px solid black; text-align: center; padding-top: 5px;"><i>Staff Initials</i></td> <td style="border-top: 1px solid black; text-align: center; padding-top: 5px;"><i>Date</i></td> </tr> <tr> <td style="border-top: 1px solid black; text-align: center; padding-top: 5px;"><i>Staff Initials</i></td> <td style="border-top: 1px solid black; text-align: center; padding-top: 5px;"><i>Date</i></td> </tr> </table>	<i>Staff Initials</i>	<i>Date</i>	<i>Staff Initials</i>	<i>Date</i>	<i>Staff Initials</i>	<i>Date</i>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border-top: 1px solid black; text-align: center; padding-top: 5px;"><i>Staff Initials</i></td> <td style="width: 50%; border-top: 1px solid black; text-align: center; padding-top: 5px;"><i>Date</i></td> </tr> <tr> <td style="border-top: 1px solid black; text-align: center; padding-top: 5px;"><i>Staff Initials</i></td> <td style="border-top: 1px solid black; text-align: center; padding-top: 5px;"><i>Date</i></td> </tr> <tr> <td style="border-top: 1px solid black; text-align: center; padding-top: 5px;"><i>Staff Initials</i></td> <td style="border-top: 1px solid black; text-align: center; padding-top: 5px;"><i>Date</i></td> </tr> </table>	<i>Staff Initials</i>	<i>Date</i>	<i>Staff Initials</i>	<i>Date</i>	<i>Staff Initials</i>	<i>Date</i>
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**AUTHORIZATION FOR  
RELEASE OF INFORMATION**

**NEW ROADS RTH 2575 WESTGATE, BUILDING 3, PENDLETON, OR 97801 541.276.6330**

This authorization pertains to:

**Name** **DOB**  
**Address/Phone**

Facility and/or persons, for information to be released, obtained or exchanged with:  
**Name**  
**Address**  
**City, State, Zip**  
**Phone**

Information requested by:  
**Name**  
**Address**  
**City, State, Zip**  
**Phone**

Purpose(s) for which information is disclosed: **To provide a family member or friend information about the about the above named person's welfare.**

**Release of My Highly Confidential Information**

By initialing next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated, if any such information will be used or disclosed pursuant to this Authorization:

- Information about treatment or evaluation of a Mental Illness
- Psychotherapy notes created by a mental health professional
- Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- Information about sexual assault, child abuse, and/or neglect
- Information about drug/alcohol abuse and/or services
- Medical information, laboratory testing and physician's notes and orders
- Financial information: including banking, financial institutions, social security and insurance matters
- Other \_\_\_\_\_

**TERM**

This Authorization will remain in effect until the time initialed below from the date of the authorized signature.

- From the date of this Authorization until 30 days after the date of discharge from services.
- From the date of this Authorization until the \_\_\_\_\_ day of \_\_\_\_\_, 201\_\_\_\_\_.
- Until ColumbiaCare Services fulfills this request.
- Other: \_\_\_\_\_

**AUTHORIZATION FOR  
RELEASE OF INFORMATION**

**NEW ROADS RTH 2575 WESTGATE, BUILDING 3, PENDLETON, OR 97801 541.276.6330**

**PURPOSE**

1. I authorize ColumbiaCare Services to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the specific purpose(s) listed above.
2. I understand that once ColumbiaCare Services discloses my health information to the recipient(s), ColumbiaCare Services cannot guarantee that the recipient(s) will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and Oregon law governing the use of my health information.
3. I understand that ColumbiaCare Services may, directly or indirectly, receive payment from a third party for the cost of providing such records.
4. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason, and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at ColumbiaCare Services.
5. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice or revocation to ColumbiaCare Services' Office at the address listed below. The revocation will be effective immediately upon ColumbiaCare Services' receipt of my written notice, except that the revocation will not have any effect on any action taken by ColumbiaCare Services in reliance on this Authorization before it received my written notice of revocation.
6. I may contact ColumbiaCare Services' Administrative Office by mail at 3587 Heathrow Way, Medford, OR 97504, by telephone at 1 (541) 858-8170.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize ColumbiaCare Services to use or disclose my health information in the manner described above.

\_\_\_\_\_

*Client/Guardian Signature* *Date*

**For Staff Use Only** This is a true copy of the original.

\_\_\_\_\_

*Full Signature of Agency Staff Person making copies* *Date*

**AUTHORIZATION FOR  
RELEASE OF INFORMATION**

**NEW ROADS RTH 2575 WESTGATE, BUILDING 3, PENDLETON, OR 97801 541.276.6330**

***For Staff Use Only - Annual Review***

I have reviewed all of the items listed above with the resident named above:

<i>Staff Initials</i>	<i>Date</i>	<i>Staff Initials</i>	<i>Date</i>	<i>Staff Initials</i>	<i>Date</i>
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# ROOM AND BOARD PAYMENT AGREEMENT

NEW ROADS RTH 2575 WESTGATE, BUILDING 3, PENDLETON, OR 97801  
541.276.6330

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**Individual's Name**

The Total Cost for services in our Residential Facility consists of two charges:

1. Room and Board
2. Service Payment

All or part of the Service Payment is based on your monthly income. The State Of Oregon pays any balance remaining. If your monthly income changes then your monthly charge may change. When there is a change in your income, you will be given a 30-day notice in writing advising you of any change in your Service Payment.

Based on your current income, your finances work out as follows:

**Your Total Monthly Income =** \$ \_\_\_\_\_

**Your Total Monthly Charges =** \$ \_\_\_\_\_

These include:

Room and Board \$ 570

Service Payment \$ \_\_\_\_\_

**Your Personal and Incidental Funds left =** \$ \_\_\_\_\_

Please remember that you will need to use some of your Personal and Incidental Funds to pay Copays for which you are responsible (such as pharmacy, medical, dental and vision services). Unless you have a payee, ColumbiaCare Services will use your Personal and Incidental Funds to pay any Copays that have accrued from the previous month. **This means the Personal and Incidental Funds (PIF) you will have left may be less than the amount shown above (i.e., PIF minus copays).**

If you are mandated to have a payee or chose to have one, ColumbiaCare Services can provide this service free of charge. *(See Financial Plan Agreement form)*

I understand and agree that the monthly Room and Board Payment, the Service Payment, and Copays are my obligation. Also, I understand and agree that, if I don't have a payee, ColumbiaCare Services will use my Personal and Incidental Funds to pay any copays that have accrued from the previous month. This has been explained to me and I am receiving a copy of this agreement.

---

*Resident Signature/ Guardian Signature (if applicable)*

---

*Date*

**ROOM AND BOARD  
PAYMENT AGREEMENT**

**NEW ROADS RTH 2575 WESTGATE, BUILDING 3, PENDLETON, OR 97801  
541.276.6330**

---

*Administrator Signature*

*Date*

*Individual's Name*

*Pre-Service Conclusion Meeting Date      Admission Date      30-Day Notice Date      Service Conclusion Date      Last Contact Date*

<i>Axis</i>	<i>Diagnosis at Admission</i>	<i>Diagnosis at Service Conclusion</i>
<i>I</i>		
<i>II</i>		
<i>III</i>		
<i>IV</i>		
<i>GAF</i>		

**Type of Service Conclusion or Transfer**

**Reason for Service Conclusion or Transfer**

*Summary Statement Describe the effectiveness of recovery program modalities and progress relative to goals listed in the Individual Services and Support Plan while in service*

**Recovery status at conclusion of services**

**Resilience and strengths identified/developed while in program**

**Prognosis and recommendations for future treatment**

**Transitional Planning** *Document resources identified to assist Individual in accessing recovery and resiliency supports and services. If not needed, specifically note why not needed.*

<i>Service Area</i>	<i>Date Appt. Scheduled</i>
<i>Residential Services</i>	
<i>Mental Health Services</i>	
<i>Medical Services</i>	
<i>Medication Management</i>	
<i>Financial Management</i>	
<i>Case Management</i>	

**SERVICE CONCLUSION SUMMARY**  
SALMON RUN RTH 2575 WESTGATE, BUILDING 1, PENDLETON, OR, 97801  
541.429.8721

**Wellness Plan** Referral information provided, when needed, such as peer supports, cultural resources, meaningful activities; education or training; social opportunities; recovery supports/relapse prevention; exercise/recreation; personal growth opportunities/interests as identified by individual.

\_\_\_\_\_  
Resident Signature/ Guardian Signature (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date  
(within 30 days of service conclusion)

**Disposition of medications, property and funds** Describe whether the resident's medication was sent with the resident or destroyed, whether the resident's property was sent with the resident or stored for 15 days prior to disposition, and how the resident's cash at the facility and funds held by CCS were distributed. (please see attach medication and personal property inventories)

**If a transfer**

Date requested records were sent to receiving provider. Within 14 days of request .

Date Service Conclusion Summary was sent to receiving provider. Within 14 days of request

Form#	File in Section	Content Review/Update	Thin from chart	Reviewed/Revised	Archive for
12.2	12.2	Never	Never	1/15/2016	7 years

ACKNOWLEDGEMENT OF  
**OPPORTUNITY TO REGISTER TO VOTE**  
NEW ROADS RTH 2575 WESTGATE, BUILDING 3, PENDLETON, OR 97801  
541.276.6330

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I understand I have the opportunity to register to vote, and that staff are available to help me to get registered.

---

*Resident Signature/ Guardian Signature (if applicable)*

---

*Date*

---

*Staff Signature*

---

*Date*