ABUSE INVESTIGATION
AND PROTECTIVE SERVICES REPORT

July 6, 2017

SUBJECT **Office of Adult Abuse Prevention and Investigation Report Number:** [redacted]

Multnomah County: [redacted]

Alleged victim: [redacted]

Provider: Legacy Unity Behavioral Health
1225 NE 2nd Ave
Portland OR 97232
503 944 8000

Provider type: Psychiatric Hospital

Accused: 1225 NE 2nd Ave
Portland OR 97232
503 944 8000

Incident date: 05/17/17
Location: 1225 NE 2nd Ave; Portland OR 97232

Investigator: Shawin Khan, MA

ALLEGATION

It is alleged that Unity Behavioral Health neglected [redacted] by failing to adequately assess [redacted] and prematurely discharging [redacted], thereby giving [redacted] an opportunity to attempt an almost successful suicide attempt in violation of OAR 943-045-0260(1) (b)[1].

[1] OAR 943-045-0260(1)(b) defines "Neglect" as " the active or passive withholding of services necessary to maintain the health and well-being of an adult, which leads to physical harm of an adult. "Services" include but are not limited to the provision of food, clothing, medicine, housing, medical services, assistance with bathing or personal hygiene, or any other services essential to the well-being of the adult."

PROTECTIVE SERVICES

[redacted]

INVESTIGATION PROCESS

[redacted]

[redacted]

SITE VISIT

[redacted]

WITNESSES INTERVIEWED	TITLE	DATE/TIME
[redacted]		
[redacted]		
[redacted]		
[redacted]		

WITNESS STATEMENTS

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

ADDITIONAL INVESTIGATION / INFORMATION

EVIDENCE, DOCUMENTS AND EXHIBITS

[redacted]

[redacted]

[redacted]

INVESTIGATION SUMMARY

[redacted]

[2] OAR 943-045-0260(1)(b) defines "Neglect" as " the active or passive withholding of services necessary to maintain the health and well-being of an adult, which leads to physical harm of an adult. "Services" include but are not limited to the provision of food, clothing, medicine, housing, medical services, assistance with bathing or personal hygiene, or any other services essential to the well-being of the adult."

[redacted]

CONCLUSION

The allegation that Unity Behavioral health neglected [redacted] by failing to adequately assess [redacted] and prematurely discharging [redacted] thereby giving [redacted] an opportunity to attempt an almost successful suicide attempt in violation of OAR 943-045-0260(1)(b)[3] NOT SUBSTANTIATED.

During [redacted] first hospitalization at Unity, from 04/28/17-05/17/18, [redacted] was seen and assessed frequently. Although [redacted] stated [redacted] "know[s] how to play the game" and "I know what to say" it appears Unity staff's assessment of [redacted] was accurate. Both [redacted] stated that initially [redacted] was angry and had suicidal ideation, but that over time, [redacted] mood and outlook improved, although [redacted] had predictable "ups and downs." [redacted] had made a very serious attempt and had chronic suicide ideation, but [redacted] could not legally or ethically be held as a prophylactic measure. When given disagreeable choices, [redacted] statements were

[3] OAR 943-045-0260(1)(b) defines "Neglect" as " the active or passive withholding of services necessary to maintain the health and well-being of an adult, which leads to physical harm of an adult. "Services" include but are not limited to the provision of food, clothing, medicine, housing, medical services, assistance with bathing or personal hygiene, or any other services essential to the well-being of the adult."

inconsistent and placed Unity in a double bind. When informed a shelter bed was available, [redacted] said "I've already seen where the Rescue Mission is and I've seen the bridge. It makes me want to go splat." [redacted] was then asked if [redacted] was feeling actively suicidal and [redacted] replied, it was a "passing thought" and contracted for safety. [redacted] behaviors and actions were both taken into account in assessing [redacted] The appropriateness of Unity's decision to discharge [redacted] on 05/17/17 was indirectly reaffirmed by [redacted] [redacted] was aware of [redacted]s 2 recent suicide attempts: the [redacted] and the [redacted], yet [redacted] did not recommend a commitment hearing but instead opted for a 14 day diversion.

REQUIRED ACTIONS

The allegation is not substantiated. There are no required actions.

DISTRIBUTION

1. A copy of the full report will be sent to the Office of Adult Abuse Prevention and Investigation Abuse Investigations Coordinator. OIT will forward report to OSH/AMH-MH Licensing.

2. A copy of the redacted summary, conclusions and required actions portion of this report will be sent to Unity Behavioral Health

Submitted by: _____
Shawin Khan, MA Adult Abuse Investigator

Reviewed and Redacted by: Joan Rice RN, Quality Manager Digitally signed by Joan Rice RN, Quality Manager Date: 2018.06.08 08:15:55 -07'00'
Joan Rice, RN, MHASD Quality Manager – original signed 7.07.2017 version could not be electronically redacted.

Approved by: _____
Karla Kerstner, MS, LPC Office of Adult Abuse Prevention and Investigation Abuse Investigations Coordinator