



## KATRINA FOLEY

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December 10, 2021

**Sent via US and electronic mail**

Michelle.Baass@dhcs.ca.gov

Michelle Baass, Director  
State Department of Health Care Services  
Department of Health Care Services  
P.O. Box 997413, MS 0000  
Sacramento, CA 95899-7413

Re: Concerns about DHCS Enforcement of State Regulations for Licensed Facilities

Dear Ms. Baass:

I'm writing to request information related to the Department of Health Care Service's (DHCS) enforcement procedures to ensure that licensed drug and alcohol facilities comply with regulations and protect the health and safety of patients in recovery.

For more than a decade, I've advocated for regulatory reforms to protect patients from abusive, profit-mill-style detox and sober living home operators that do more harm to patients than help. The types of regulatory reforms that I and others have advocated for seek to prevent tragedies like the death of 23-year-old Richard Lehr from happening. All of us have a family member who have struggled with addiction. This is an issue that we take very seriously and want to ensure that families have access to safe and medically appropriate treatment.

***Gratitude Lodge:***

Thank you for your response to my letter, but you failed to address the important concerns that I raised. Moreover, the public record requests that your office sent over—including the Biennial License Report and the Death Investigative Report—raise more doubts about Gratitude Lodge's ability to comply with regulations and to ensure the health and safety of patients in recovery. Due to the substantiated negligence demonstrated by this facility, the lack of meaningful enforcement of state regulations is unacceptable.

According to the Biennial License Report, Gratitude Lodge was cited for eight deficiencies. While the date of review is redacted, the report appears to have been published on August 19, 2021 (eight days prior to the death of Mr. Lehr). The violations indicate the negligent conduct practiced by this program, including the failure to maintain appropriate personnel files,

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admission agreements, and resident health screenings. (DHCS, Biennial License Report: Gratitude Lodge, August 2021, p. 1-3).

The facility was also deficient in complying with the requirement that the “licensee shall develop, maintain, and implement an ongoing training program for all staff.” (DHCS, Biennial License Report: Gratitude Lodge, August 2021, p. 1-3). Adequate training is fundamental to the program’s ability to ensure the health and safety of those in detox. To supervise patients in detox, staff should have the competency to deal with difficult situations, including the negative psychological effects that patients experience while in detox. If the staff member responsible for monitoring Mr. Lehr had the proper training, it’s possible that they could have been better equipped to respond to his reported hallucinations and actions on that tragic night. Please provide my office evidence that the facility has implemented an ongoing training program and that all staff have participated in the necessary training to carry out their duties to supervise patients in detox.

The failure of the facility to comply with even the most basic requirements raises questions about the level of meaningful enforcement actions taken by DHCS. Please provide evidence of the corrective actions taken by the facility in response to the deficiencies cited in the Biennial License Report.

More than half of the content in the Death Investigative Report is redacted. This makes it difficult to understand what steps were taken by DHCS in response to this incident. The report indicates that deficiency that the “program failed to refer Decedent to a higher level of care” is substantiated. (DHCS, Death Investigative Report: Gratitude Lodge, p. 22). However, the report redacts almost the entire section of the summary describing why the program was deficient. As a result, it’s unclear to me what this deficiency means and how DHCS responded to it. Please provide the basis for the significant redactions or produce the full report immediately.

It shouldn’t take a tragedy to have investigators from your agency inspect facilities more than once every two years. Allocating enforcement resources at the local level would improve patient outcomes and ease neighbors’ anxieties. As Costa Mesa Councilwoman and Mayor, I supported Assemblywoman Quirk-Silva’s Assembly Bill 572 to create a pilot program to have a DHCS Compliance Analyst in Orange County. The City of Costa Mesa even agreed to house and pay for the inspector to serve Orange County. Your office and the industry defeated this reasonable bill. I urge you to re-visit this proposal.

I am concerned that Gratitude Lodge lacks the policies, protocols, and procedures in place to ensure the health and safety of patients in recovery. Even without the redactions, the Death Investigative Report is insufficient to respond to the death. I urge you to conduct a more comprehensive report that goes beyond the substantiated deficiencies identified and addresses the systemic problems that explain *why* these deficiencies have existed. Please provide all documents related to applications, complaints, inspections, investigations, and written verification of compliance since 2014. I would like to know if any of these deficiencies have

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been identified prior to the 2021 report. DHCS should review how its prior actions and procedures could have improved the facility's ability to supervise patients in detox. Part of this review should include analysis of outcomes related to residential detox facilities, including rates of hospitalization and death.

***Dahlia House and Carnation House:***

This week I became aware of a March 2020 investigative report concerning allegations about two licensed facilities on Dahlia Street. The substantiated allegations raised by an investigator in DHCS are troubling, especially considering that many of these deficiencies were identified by DHCS in previous biennial reviews. The 2020 reports raise questions about the health and safety of patients in both of these facilities. In addition, I'm concerned that these two facilities have repeatedly failed to make timely corrective actions in response to the deficiencies raised by DHCS. Repeated deficiencies raise serious questions about the DHCS enforcement efforts to ensure that all facilities comply with regulations. Please explain the previous enforcement actions by DHCS to address these deficiencies and help me understand why the DHCS compliance efforts were insufficient.

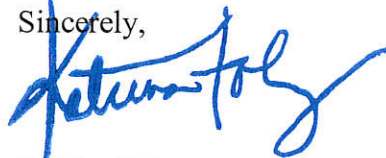
***Questions About Department's Enforcement Procedures:***

I have significant questions about DHCS's ability to enforce regulations concerning licensed alcohol and drug treatment facilities that are critical to ensuring the health and safety of patients in recovery. I am concerned that there is a pattern in which identified deficiencies are not being meaningfully addressed. The current regulatory approach is not working. Please identify improvements to internal DHCS procedures that will provide better regulatory oversight of licensed drug and alcohol treatment facilities.

I look forward to Monday's Assembly Accountability and Administrative Review Committee hearing, and I hope that you can provide answers and a plan to address these concerns moving forward. The Department of Health Care Services needs a paradigm shift that provides better enforcement to protect the health and safety of patients in recovery.

Thank you for your time and consideration of the questions and concerns I am raising. Please contact my office to discuss these issues further.

Sincerely,



Katrina Foley  
Orange County Supervisor

cc:

Dave Min, State Senator – 37<sup>th</sup> District

Cottie Petrie-Norris, State Assemblywoman – 74<sup>th</sup> District

Sharon Quirk-Silva, Chair – Orange County Homelessness & Mental Health Services Committee

Jim Wood, Chair – Assembly Committee on Health

Richard Pan, Chair – Senate Committee on Health

Scott Wiener, Chair – Select Committee on Mental Health & Addiction

Newport Beach City Council

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