DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Clinical Standards and Quality
Survey & Operations Group
Division of SF/Seattle Survey & Enforcement

May 22, 2025

Administrator
Oregon State Hospital Distinct Part
2600 Center Street Ne
Salem, OR 97301-2682

Re: Medicare Provider Number 384008
Intakes OR00056397/OR00056508/OR00056560/OR00056645/
OR00056689/OR00056691/OR00056693/OR00056695/OR00056696/
OR00056700/OR00056715

Dear Administrator:

Previously in a letter dated May 6, 2025, CMS issued a 23-Day Termination based on the findings of a complaint survey conducted on April 29, 2025. An Immediate Jeopardy (IJ) situation was found on March 31, 2025. The IJ situation was not abated by the exit of the survey. The CMS 23-Day Termination informed you that the hospital's Medicare provider agreement could be terminated by May 29, 2025, if the IJ situation was not removed. On May 12, 2025, the IJ situation was removed. With this notice, CMS is extending the hospital's termination date.

A survey conducted by the Oregon Health Authority at Oregon State Hospital Distinct Part on April 30, 2025, found that the facility was not in substantial compliance with the following Conditions of Participation (CoPs) for hospitals.

42 C.F.R. § 482.12 Governing Body
42 C.F.R. § 482.13 Patient Rights
42 C.F.R. § 482.60 Special Provisions for Psychiatric Hospitals

A listing of all deficiencies found is enclosed (Form CMS-2567, Statement of Deficiencies and Plan of Correction).

When a hospital is found to be out of compliance with the CoPs, a determination must be made that the facility no longer meets the requirements for participation as a provider or supplier of services in the Medicare program. Such a determination has been made in the case of Oregon State Hospital Distinct Part and accordingly, the Medicare agreement between Oregon State Hospital Distinct Part and CMS is being terminated.

The date on which the Medicare agreement terminates is August 4, 2025.

The Medicare program will not make payment for services furnished to patients who are admitted on or after August 4, 2025. For inpatients admitted prior to August 4, 2025, payment may continue to be made for a maximum of 30 days of inpatient services furnished on or after August 4, 2025. Termination can only be averted by correction of the deficiencies, through submission of an acceptable plan of correction (PoC) and subsequent verification of compliance by the state agency. The Form CMS 2567 with your POC, dated and signed by your facility's authorized representative must be submitted to the state agency no later than June 2, 2025. Please indicate your corrective actions on the right side of the Form CMS-2567 in the column labeled "Provider Plan of Correction", and list the corresponding deficiency number in the column to its left, labeled "ID Prefix Tag". Additionally, indicate your anticipated completion dates in the column labeled "Completion Date".

An acceptable PoC must contain the following elements:

1. The plan for correcting each specific deficiency cited;
2. The plan for improving the processes that led to the deficiency cited, including how the hospital is addressing improvements in its systems in order to prevent the likelihood of recurrence of the deficient practice;
3. The procedure for implementing the PoC, if found acceptable, for each deficiency cited;
4. A completion date for correction of each deficiency cited;
5. The monitoring and tracking procedures that will be implemented to ensure that the PoC is effective and that the specific deficiency(ies) cited remain corrected and in compliance with the regulatory requirements; and
6. The title of the person(s) responsible for implementing the acceptable PoC.

Copies of the Form CMS-2567, including copies containing the facility's PoC, are releasable to the public in accordance with the provisions of Section 1864(a) of the Act and 42 CFR 401.133(a). As such, the PoC should not contain personal identifiers, such as patient names, and you may wish to avoid the use of staff names. It must, however, be specific as to what corrective action the hospital will take to achieve compliance, as indicated above.

Your facility will be revisited to verify necessary corrections. If CMS determines that the reasons for termination remain, you will be so informed in writing, including the effective date of termination. If corrections have been made and your facility is in substantial compliance, the termination procedures will be halted, and you will be notified in writing.

If your Medicare agreement is terminated and you wish to be readmitted to the program, you must demonstrate to the state agency and CMS that you are able to maintain compliance. Readmission to the program will not be approved until CMS is reasonably assured that you are able to sustain compliance.

If you have any questions regarding this matter, please contact the Seattle Location at CMS_RO10_CEB@cms.hhs.gov to the ATTN: Rosanna Angeldones.

Sincerely,

RAngeldones

Rosanna Angeldones
Health Insurance Specialist
Acute & Continuing Care Branch
Centers for Medicare & Medicaid Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	384008	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL DISTINCT PART	**2600 CENTER STREET NE SALEM, OR 97301**

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A 000	INITIAL COMMENTS This report reflects the findings of an unannounced, onsite Federal Immediate Jeopardy (IJ) investigation survey at the OSH-Salem main campus for complaints OR56560, OR56508, and OR56397 that was initiated on 03/26/2025. The investigation was extended in response to 16 additional complaints received during the survey by the SA, Oregon Health Authority, Healthcare Regulation and Quality Improvement section. The allegations for those were incorporated into the following complaint intakes: OR56645, OR56689, OR56691, OR56693, OR56695, OR56696, OR56700, and OR56715. The survey exit conference was conducted on 04/30/2025. During the survey it was determined that two IJ situations existed. Refer to Tags A-093 under the Governing Body CoP and Tag A-175 under the Patient's Rights CoP for the details of the IJs and their removal on 05/12/2025, after the survey exit date. The findings from the survey that follow in this report reflected that the allegations in the complaints were substantiated and Condition-level deficiencies under the following CoPs were identified: * CFR 482.12 - CoP: Governing Body * CFR 482.13 - CoP: Patient's Rights * CFR 482.60 - CoP: Special Provisions for Psychiatric Hospitals The cumulative effect of the systemic failures that resulted in those Condition-level deficiencies represents a limited capacity on the part of the hospital to provide safe and adequate care.	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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* Hospital departments & hospital level-of-care units referenced in this report may include:
LH2 - Lighthouse 2 unit at OSH-Salem
AN2 - Anchors 2 unit at OSH-Salem

* Hospital staff referenced throughout this report may include:
AAG - Assistant Attorney General
CM - Care Manager
CMD - Clinic Medical Doctor
CMO or Sup/CMO - Chief Medical Officer
CN - Charge Nurse
CNO - Chief Nursing Officer
CoM - Chief of Medicine
COP - Chief of Psychiatry
CS - Compliance Specialist
DCMO - Deputy Chief Medical Officer
DCMOA - Director of the Chief Medical Office Administration
DCNO or DCN - Deputy Chief Nursing Officer
DFSO - Director of Facility & Support Operations
DHR - Director of Human Resources
DMNO - Deputy Medical Nursing Officer/Clinic Manager
DNS - Director of Nursing
DO - Doctor of Osteopathic Medicine
DOIM or IRSID - Director of Incident Management
DOS or DSS - Director of Security
DS or DSup - Deputy Superintendent
DSC - Director of Standards and Compliance
DQM or DOQ - Director of Quality Management
EMT - Emergency Medical Technician
IRSII - IRSI Investigator
JCA - Junction City Adminstrator
LIP - Licensed Independent Practitioner
LPN - Licensed Practical Nurse

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MA - Medical Assistant
MCD - Medical Clinic Director
MD - medical doctor, physician
MHT - Mental Health Technician
MHT - Mental Health Therapist
MOD - Medical Physician on Duty
NM - Nurse Manager
NP - Nurse Practitioner
OHAD/GB - OHA Director/OSH Governing Body
OS2 - Office Specialist 2
OSHS - OSH Superintendent, Administrator OSH
PI - Performance Improvement
POD - Psychiatrist On Duty
PsychSup - Psychiatry Supervisor
RN - Registered Nurse
SC/OPA3 - Standards and Compliance OPA3
SE/OPA2 - Staff Education, OPA2
SP(H) - Supervising Psychiatrist (Harbors)
TDM - Training and Development Manager
UA - Unit Administrator

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* Abbreviations and acronyms used in this report may include:
~ - approximately
& - and
1:1 - one to one constant supervision
ADLs - Activities of Daily Living
AED - Automated External Defibrillator
AM - Morning
Ambu bag - Artificial Manual Breathing Unit bag
aprx/approx - approximately
AROM - Active Range of Motion
BLS - Basic Life Support
BP - blood pressure
CFR - Code of Federal Regulations
CMS - Federal Centers for Medicare and Medicaid Services
c/o - complaints of

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cont/con't - continue or continued
CoP - Condition of Participation
CPR - Cardiopulmonary Resuscitation
CT - Computed Tomography
DME - Durable Medical Equipment
ECT - Electroconvulsive therapy
e.g. - for example
EHR - Electronic Health Record
eMAR - electronic Medication Administration Record
EMS - Emergency Medical Services
EOC - Environment of Care
ES - Enhanced Supervision
ES 1:1 / medical - Enhanced Supervision with constant one to one supervision/ for medical reasons
EVS - Environmental Services
FWW - front-wheeled walker
HR - Human Resources
ID/CC - unknown
IDT - Interdisciplinary Treatment Team
IJ - Immediate Jeopardy
IM - Intramuscular injection
IMBU - Intramuscular injection back-up
JC - Junction City
JC - Joint Commission, the hospital's accreditation organization
L - litre
LIP - Licensed Independent Practitioner
MP - Medical Precautions
MRI - Magnetic Resonance Imaging
NA or N/A - Not Applicable
NC - nasal cannula
Neuro - neurological
NM - Nurse Manager
NP - Nurse Practitioner
O2 sat/spO2 - oxygen saturation
OARs - Oregon Administrative Rules
OHA - Oregon Health Authority

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OHSU - Oregon Health & Sciences University
OSH - Oregon State Hospital, Salem and Junction City
OT - Occupational Therapy
P - pulse
PL - Program Lead
PM - Evening/Night
PM - Program Manager
PMHNP - Psychiatric Mental Health Nurse Practitioner
PNM - Program Nurse Manager
P&P, PP - policy(ies) and procedure(s)
PEN - as needed
Pt, pt - patient
Q/q - every
R - respirations
RCA - Root Cause Analysis, a problem-solving method used to identify the underlying causes of faults or problems.
re/re: - regarding
SA - The CMS designated State Agency responsible for enforcement of the Federal hospital regulations. In Oregon that is the Public Health Division office of Health Care Regulation and Quality Improvement within the Oregon Health Authority.
SBA - stand-by assist
[sic] - In a quote reflects the language, spelling or punctuation is recorded as in the original document.
Side room - seclusion room
SHED - Salem Hospital Emergency Department
SOAP - format for medical documentation: Subjective, Objective, Assessment, and Plan
S&R - Seclusion and Restraint
T - temperature
TCP - Treatment Care Plan
TCPA - Treatment Care Plan Addendum
Tx - Treatment

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A 000	Continued From page 5 US - Ultrasound VS/VSS - Vital Signs/Vital Signs Stable WNL - Within Normal Limits X/x - times **********	A 000		
A 022	LICENSURE OF HOSPITAL CFR(s): 482.11(b) The hospital must be - o Licensed; or o Approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing hospitals. This STANDARD is not met as evidenced by: ********** Based on interview, review of P&Ps and review of other documentation it was determined that the hospital failed to ensure it was in compliance with applicable State laws and rules related to hospital licensing and radiology services. Hospital licensing OAR 333-500-0032 requires that psychiatric hospitals have available on-site or through contract radiology services and have radiology staff on-site or on-call 24/7. Hospital licensing OAR 333-520-0040 requires that all hospitals have on-site or contract radiology services that support the hospital's medical and other services, are available on a timely basis, and have on-site or in-house radiology staff available 24/7. The hospital failed to comply as follows: * The hospital failed to ensure available radiology services and radiology staff were on-site or on-call 24/7 and the hospital transported patients to another hospital for radiology services when radiology staff were not scheduled or otherwise	A 022		

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A 022	Continued From page 6 available. Findings include: 1. Refer to the findings cited at Tag A-529 under CFR 482.26(a) - Scope of Radiologic Services that reflects the hospital failed to ensure available radiology services and radiology staff were on-site or on-call 24/7 and the hospital transported patients to another hospital for radiology services when radiology staff were not scheduled or otherwise available. **********	A 022		
A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: ********** Based on observation, review of video recordings, interviews, review of incident and medical record documentation for 17 of 17 patients [redacted] review of OSH internal investigation documentation, review of training documentation for 4 of 5 LIPs (MD A, DO B, MD N and MD O) and 23 of 23 Direct Care nursing staff (RN C, RN D, RN E, RN F, RN G, RN R, RN T, RN U, RN W, RN Z, RN AA, RN EE, LPN H, LPN P, LPN Y, MHT J, MHT S, MHT Q, MHT V, MHT X, MHT BB, MHT CC, and MHT	A 043		

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A 043	Continued From page 7 DD), review of training curriculum and training media, review of governing body and medical staff bylaws, and review of P&Ps it was determined that the governing body of the hospital was not organized or effective and failed to ensure that the hospital operated in accordance with current and complete governing body bylaws, medical staff bylaws and rules and regulations, and medical staff and hospital P&Ps that ensured patients received safe and appropriate care in the hospital. The failures potentially contributed to [redacted] and created the likelihood of harm to other patients. The cumulative effect of these systemic failures resulted in this Condition-level deficiency that represents a limited capacity on the part of the hospital to provide safe and adequate care. The failures included [redacted]. On 03/31/2025 the hospital was notified that an IJ situation had been determined to exist. Refer to Tag A-093 for the details of the IJ identification, IJ notification, IJ Removal Plan approval, and IJ Removal Plan Verification Visits. A third IJ Removal Plan Verification Visit was conducted on 05/12/2025 and the IJ was determined to be removed. Findings include:	A 043		

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A 043	Continued From page 8 1. The hospital's Governing Body Bylaws dated 04/22/2020 were unclear, incomplete and not current. A Preamble, and Articles 1, 2, 3, and 11 as described below were the extent of the bylaws: *Article 1 of the bylaws stated "The Governing Body is the Director of the Oregon Health Authority (OHA). The Director of the Oregon Health Authority promulgates Administrative Rules and Management Directives to establish policies and procedures." *Article 2 of the bylaws stated "The Superintendent is appointed by The Governing Body (ORS 179.331). The Governing Body authorizes the Superintendent to make final decisions on behalf of the Governing Body regarding granting applications for membership or clinical privileges or granting renewal of MAPHS membership or clinical privileges." *Article 3 of the bylaws was titled "Responsibilities of the Govering [sic] Body." The article stated, "The Governing Body of the Oregon State Hospital shall be responsible for the operation of the facility, the selection of the medical staff and the quality of care rendered in the facility." - The responsibilities listed did not include all of the responsibilities of the governing body specified by the hospital CFRs and OARs. For example: CFR 482.12(a)(10) requires that "The governing body must consult directly with the individual assigned the responsibility for the organization and conduct of the hospital's medical staff, or his or her designee. At a minimum, this direct consultation must occur periodically throughout the fiscal or calendar year and include discussion of matters related to the quality of medical care provided to patients of the hospital." There were no provisions for this direct consultation in the bylaws. -Further, the bylaws did not contain specific	A 043		

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A 043	Continued From page 9	A 043		

information about how the governing body would ensure its responsibilities for those that were listed.
*Article 11 followed Article 3 and was titled "Adoption of the governing body bylaws." A handwritten entry recorded on the last page was of a partial date "2/21 (Revised)" with no indication of what was revised, and underneath were the illegible and undated initials of one individual.

2. Refer to the findings cited under this CoP, CFR 481.12 (a)(4) - Standard: Governing body approval of medical staff bylaws and rules and regulations. Those findings reflected the medical staff bylaws and rules and regulations were not current, clear, or complete, and had not been approved by the governing body that was in place at the start of this investigation (Tag A-048).

3. Refer to the findings cited under this CoP, CFR 482.12(f)(2) - Standard: Emergency Services. Those findings reflect that provisions for timely and appropriate medical emergency response for patients in seclusion were not fully developed and implemented. The hospital's failures potentially contributed to [redacted] and created the likelihood of harm to other patients (Tag A-093).

4. Refer to Tag A-115, CFR 482.13 - CoP: Patient's Right. The hospital failed to ensure patients were informed of their health status (Tag A-131). The hospital failed to ensure the provision of care in a safe setting (Tag A-144). The hospital failed to ensure patients' rights to be free from seclusion and restraint (Tag A-154). The hospital failed to ensure patients in seclusion were monitored and observed to ensure their safety

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A 043	Continued From page 10	A 043		

(Tag A-175). The hospital failed to ensure staff training related to seclusion and restraint was conducted appropriately (Tag A-199 and Tag A-206).

5. Refer to Tag A-1600, CFR 482.60 - CoP: Special Provisions for Psychiatric Hospitals. Those findings reflect that he hospital failed to comply with all CoPs specified in CFRs 482.1 through 482.23 and CFRs 482.25 through 482.57 (Tag A-1605).

6. Unsolicited, numerous department, program, and unit medical staff and leaders came forward to speak to the surveyors. Those staff provided permission for the concerns they shared to be used in the survey report. To ensure as much as possible the protection of the identity of those staff, specific interview dates and times are not provided in this report. The concerns that were shared included, but were not limited to:
* [redacted], and other sentinel events that included patient deaths and serious patient harm that were investigated by the SA during the past two years, [redacted], resulted after numerous warnings and problems were brought to the attention of hospital executive leadership by department, program, and unit leaders. Those concerns were largely ignored and dismissed. There were multiple reports that it is was specifically the OSHS/CMO who responded in those ways.
* During the SA's investigation of the prior incidents referenced above, staff were coached as to what and what not to say to surveyors. After the hospital was found back in compliance with the CoPs, a number of corrective actions and monitoring activities were discontinued, and processes returned to pre-investigation status.

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A 043	Continued From page 11 * Another example of the overuse of seclusion and challenge of releasing patients from seclusion was [redacted] who was admitted to the hospital in early 2025 in seclusion and restraints. Although RNs assessed the patient to be ready for release from seclusion within two days and released the patient, the patient's LIPs expressed anger about that decision and insisted that the RNs needed to keep patients in seclusion until they consulted with the provider, contrary to hospital policy. * Operational and communication systems involving hospital departments, programs, and units are fragmented, broken, or non-existent. * Patients are sicker and more medically complex than patients in prior years. * Medical staff and clinical P&Ps are out of date. * Medical clinic communication with the patient units is lacking. Clinic scheduling of patient appointments and visits is disorganized and not efficient. * Documentation and diagnostic testing results from patient specialty visits and consultations to providers in the community outside of the hospital are not communicated to inpatient units, nor incorporated into the patient's medical record timely. * Psychology and social work needs of patients are not responded to timely or not met. For example psychology behavioral plans are not developed and updated as needed. Clinical notes are not written as required. * There are no standards for medical clinical documentation & corrective action plans developed in response to the last SA investigation to address some of those issues did not continue. * Patient care and clinical failures or gaps are not reported to or addressed by the medical staff and the existing peer review processes are not	A 043		

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A 043	Continued From page 12 capturing the problems. * Medical staff who provided direct care of patients for whom sentinel events occurred have been involved in the hospital's investigations of those events. That has created barriers to impartial and objective investigation and decision-making regarding deficient practices and corrective actions. * There is an empathy problem and staff do not know how to interact with patients to provide for a therapeutic milieu. * Modeling and coaching of therapeutic interactions with patients, attempted in real time by experienced trainers, have often been dismissed and rejected by unit leaders and other hospital staff. [redacted]. * Staff training is primarily in the form of attestations that a policy and procedure has been read. Staff are numb to attestations. * Training is insufficient in both content and in-person teaching. * The newest, least experienced, and most under-trained staff are assigned to the Anchors and Lighthouse units in the Harbors Program where the patients with the highest acuity reside. **********	A 043		
A 048	MEDICAL STAFF - BYLAWS AND RULES CFR(s): 482.12(a)(4) [The governing body must] approve medical staff bylaws and other medical staff rules and regulations. This STANDARD is not met as evidenced by: ********** Based on interview, review of medical staff bylaws, and review of policies and procedures it was determined the Governing Body failed to	A 048		

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ensure the medical staff operated under current and approved medical staff bylaws, that medical staff rules and regulations had been developed and approved, and that the medical department and medical clinic policies and procedures were fully developed, approved, current, and implemented.

Findings include:

1. The "Oregon State Hospital Medical And Allied Health Professional Staff Bylaws" were reviewed. The cover page reflected "Approved and adopted on: January 30th, 2020." The approval signature page contained four signature and date blocks to indicate approval by the four individuals listed. Those were:
* "President, Medical and Allied Health profession Staff Oregon State Hospital, 2019"
* "Chief Medical Officer"
* "Superintendent"
* "Director of Oregon Health Authority"

The four individuals listed were no longer at OSH or were not in the position assigned to their name. The spaces for signatures and dates for each of those individuals to reflect approval of the bylaws were blank.

2. The "Oregon State Hospital Medical And Allied Health Professional Staff Bylaws" included Article10.8 for the "Bylaws Committee." That article required "The Bylaws Committee shall meet as often as necessary at the call of its chair but at least annually ..." and "The duties of the Bylaws Committee shall include: (a) conducting a biennial review of the staff bylaws; (b) submitting recommendations to the Executive Committee for changes in these documents as necessary to

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A 048	Continued From page 14 reflect current staff practices ..." There was no evidence to reflect that the bylaws had been reviewed at least every two years since January 2020. The Bylaws were not annotated with the date of last review and initialed or signed by the responsible person(s). 3. The Bylaws referenced "Medical And Allied Health Professional Staff" (MAHPS) "rules and regulations" 13 times. For example: * In the Preamble, Item 4 stated that the organization shall "establish and maintain rules and regulations for self-governance of the [MAHPS]." * Article 2.4 included that the MAHPS membership constituted agreement to "abide by the MAHPS bylaws, rules and regulations, and administrative memoranda." * Article 3.1 included that applicants for MAHPS membership agree to "comply with the ... bylaws and rules and regulations as they exist and as they may be modified." * "Rules and regulations" were also referenced under Articles 3.4; 3.6; 4.1; 4.5; 6.4; 10.4; and 11.3. There were no MAHPS rules and regulations provided. In an email received from the DSC on 04/10/2025 at 1224 they stated in regard to the request for MAHPS rules and regulations that "We have written protocols for each department." 4. Article 2.12 of the Bylaws titled "Chief Medical Officer and Directors of Clinical Disciplines" included "Roles and Responsibilities" identified at (a) through (n). For example: "(g) coordinate and integrate interdepartmental and intradepartmental services;" and "(h) develop and implement	A 048		

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policies and procedures that guide and support the provision of care, treatment, and services." Article 5 of the Bylaws included a statement that stated, "Additional requirements for completing a medical history and physical examination are found in the Medical Department Policies and Procedures and the Medical Clinic Policies and Procedures."

5.a. All Medical Department and Medical Clinic policies and procedures were requested. There were 15 "Medical Department Protocols" provided of which 12 had been last reviewed or approved between 02/04/2015 and 03/16/2020. There were 21 "Medical Clinic Protocols" provided of which 18 had been last reviewed or approved on 10/07/2016. Several of those (at least eight) were not related to medical staff practice and were related instead to department and clinic operations such as hours, funding for services, scheduling of patient appointments, and equipment use or maintenance.

5.b. "Medical Department Protocol: 1.009" was titled "Medical Care of Patients" and was dated 02/24/2015. There was no evidence of review of the protocol since that date more than 10 years ago. The protocol included direction that "The MOD shall also be available for telephone consultation with the OSH-Portland POD ..." The OSH-Portland campus was closed on 03/31/2015.

5.c. The "Medical Clinic Protocol: X.XXX [sic]" for "Approval of Medical Services, Devices, and Procedures" had an approval date of "XXXXXX [sic]." The "Revision History" at the end of the protocol reflected it had last been reviewed on 10/07/2016. It was not clear that the protocol had

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A 048	Continued From page 16	A 048		

been approved or that 2016 practices were still current.

5.d. The "Medical Clinic Protocol: X.XXX [sic]" for "Minor Surgery" had an approval date of 10/07/2016. The protocol was not surgical procedure specific and contained unclear information. The generic protocol written as "one-size fits all" did not ensure the provision of safe and appropriate "minor surgery" care for patients. For example:
*Under "Definitions" it reflected "'Minor Surgery' for the purposes of this protocol includes, but is not limited to: I and D of abscesses, matrix, punch biopsies, and skin tag removal." The scope of surgical procedures allowed to be performed in the medical clinic was not specified.
* Under Section A for "Equipment" was listed "Any electrical equipment needed." There was no indication as to what specific "electrical equipment" was needed for each different type of procedure performed.
*Under the "Equipment" section it listed "Sterile instruments, as needed." There was no indication as to what specific "sterile instruments" were needed for each different type of procedure performed.
* Under the "Equipment" section it listed "Hydrogen Peroxide" and "Antiseptic solution for washing skin" and "Formalin" and "Betadine swabs" and "Alcohol prep pads." The list was not procedure specific. It was unclear what "antiseptic solution" was to be used. It was unclear if those five solutions were all to be used for each minor surgical procedure.
*Under the "Equipment" section it listed "Injectable lidocaine" and "Anesthetic, per M.D." It was unclear what types of "anesthetic" were allowed to be administered to patients in this

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A 048	Continued From page 17 medical clinic that was not part of a general hospital. * Under Section B for "Method/Description" it included "Obtain any medications or solutions that will be required during the procedures." It was unclear what "medications or solutions" were required for each type of procedure performed. * The "Method/Description" reflected "Use masks, goggles and gowns for the physician and staff if there is a potential of splatter or contamination by body substances." * The "Method/Description" reflected "Position the patient according to type and location or surgery performed." It was unclear what the positioning requirements were for each type and location of surgery performed. * The "Method/Description" reflected "Sanitize after surgery a. With gloves on, after the patient leaves, sanitize reusable instruments and supplies, dispose of disposable, clean and prepare room. B. Clean all instruments for sterilization, sterilize, and return them to proper storage area. C. Wash hands." There were no specific instructions for "sanitizing" and "cleaning" and "sterilizing" instruments and supplies. *The protocol also stated, "Clinic Protocol, National Patient Safety Goals, will be adhered to as applicable." However, it was unclear what National Patient Safety Goals from 2016 were being referred to, what "as applicable" meant, and whether those were still current in 2025. Further, There were no other policy and procedure references at the end of this protocol and there was no indication that the hospital's Infection Preventionist had been involved in the development of the protocol to ensure appropriate and effective infection prevention practices during invasive procedures and during	A 048		

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A 048	Continued From page 18 the processing of instruments and supplies. 5.e. The "Medical Department Protocol: 1.002" was titled "Orders" and was dated 03/02/2020. Under Section B were listed "Required Orders" that included "6. Seclusion and Restraint - must use the Seclusion & Restraint order form." Under the "References" section at the end of the protocol it reflected "Policy and Procedure 6.003, Seclusion or Restraint Process." *Review of the P&P "6.003 ... Seclusion and Restraint" dated 02/12/2024 revealed it contained no reference to a "Seclusion & Restraint order form." *The "Policy Attachment Procedures B: Restraint or Seclusion Orders and Assessment by Physician/Nurse Practitioner ... 6.003" dated 02/12/2024 contained no reference to a "Seclusion & Restraint order form." 5.f. The "Radiology Department" Policy and Procedure "PL1.00 ... Radiology Department Hours" was dated as last revised 05/13/2013. The space for "Approved By: was blank. The document reflected "The radiology technologist is on duty from 7:30 AM to 4:30 PM, Monday through Friday. If a radiographic exam is needed outside these hours, the OSH staff have two options: [although three options were listed] 1. Salem Hospital [address] 2. Salem Hospital MRI/CT Center [address] 3. The patient may be sent to the Salem Hospital Emergency room for the necessary exam." That was the entirety of the Policy and Procedure. *During interview with the Deputy Medical Nursing Officer on 04/11/20225 beginning at 1000 they stated that the hospital currently has one Xray technician and that person works 4, 10-hour shifts. The current hours of operation are	A 048		

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A 048	Continued From page 19 generally Tuesday through Friday 0630 to 1700. After hours, and at other times the Xray tech is not available such as for leave, the hospital uses a portable Xray company or sends the patient to Salem Health hospital. This current practice was not reflected the the Radiology Department P&P. *There were four other "Radiology Department" P&Ps provided (PL4.00, PL 6.00, PL 13.00 and PL 14.00). Those were each last reviewed or revised on 05/13/2013. The DMNO confirmed that the Radiology P&Ps were not current. *During interview, the DMNO also stated that the hospital did not have a functioning Xray machine for more than a year prior to December 2022. All Xray needs during that time were carried out by third-party Xray suppliers or by Salem Health hospital. 5.g. There were no policies, procedures, or protocols for the use and management of a sufficient oxygen supply for those patients who required oxygen and for use during medical emergency responses. **********	A 048		
A 093	EMERGENCY SERVICES CFR(s): 482.12(f)(2) If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate. This STANDARD is not met as evidenced by: ********** Based on observation, review of video recordings, interviews, review of incident and medical record documentation for 2 of 2 patients	A 093		

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A 093	Continued From page 20 [redacted]), review of OSH internal investigation documentation, review of training documentation for 4 of 5 LIPs (MD A, DO B, MD N and MD O) and 23 of 23 Direct Care nursing staff (RN C, RN D, RN E, RN F, RN G, RN R, RN T, RN U, RN W, RN Z, RN AA, RN EE, LPN H, LPN P, LPN Y, MHT J, MHT S, MHT Q, MHT V, MHT X, MHT BB, MHT CC, and MHT DD), review of training curriculum and training media, and review of P&Ps and other hospital protocols it was determined that the governing body of the hospital failed to fully develop and implement P&Ps that ensured that patients received care in a safe setting, including timely and appropriate medical emergency response. The hospital's failures potentially contributed to harm and death of one patient and created the likelihood of harm to other patients. [redacted]	A 093		

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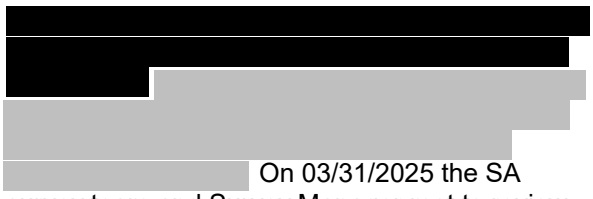

On 03/31/2025 the SA survey team and Survey Manager met to review possible IJ for Tag A-093. On 03/31/2025 IJ was called and hospital leadership staff were presented with the IJ template. Between 04/02/2025 and 04/07/2025 the hospital submitted four versions of the IJ Removal Plan for Tag A-093. The fifth version of the IJ Removal Plan was submitted on 04/08/2025, and was approved with an implementation date of

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04/11/2025. On 04/14/2025 an onsite IJ Removal Plan Verification Visit was conducted. The hospital was notified on 04/15/2025 that it was determined the hospital had not fully implemented the IJ Removal Plan. On 04/17/2025 the hospital submitted an IJ Removal Plan Update Amendment and on 04/18/2025 they sent an email to confirm they would be ready for a Verification Visit on or after 04/22/2025. The IJ Removal Plan Update Amendment was approved. On 04/24/2025 a second onsite IJ Removal Plan Verification Visit was conducted. The hospital was notified on 04/25/2025 that it was determined the hospital had not fully implemented the IJ Removal Plan. The survey team conducted the survey exit conference on 04/30/2025. On 05/06/2025 CMS issued the IJ CMS 2567 report to the hospital with the 23-Day Termination letter. On 05/07/2025 the hospital submitted the signed IJ CMS 2567 with the previously approved IJ Removal Plan Update Amendment and a new implementation date of 05/06/2025. On 05/12/2025 the third onsite IJ Removal Plan Verification Visit was conducted. After conferring with the Survey Manager on the afternoon of 05/12/2025 the survey team notified the hospital that it was determined the IJ Removal Plan had been fully implemented and that the recommendation to CMS was that the IJ for Tag A-093 was removed.

Findings include:

1.a. During interviews on 03/26/2025 beginning at ~ 1045, again at ~1145, and at ~ 1345 hospital staff that included the DS, CNO, DCNO, DSC, DQM, DOIM, DOS, DHR, and others [redacted]. The

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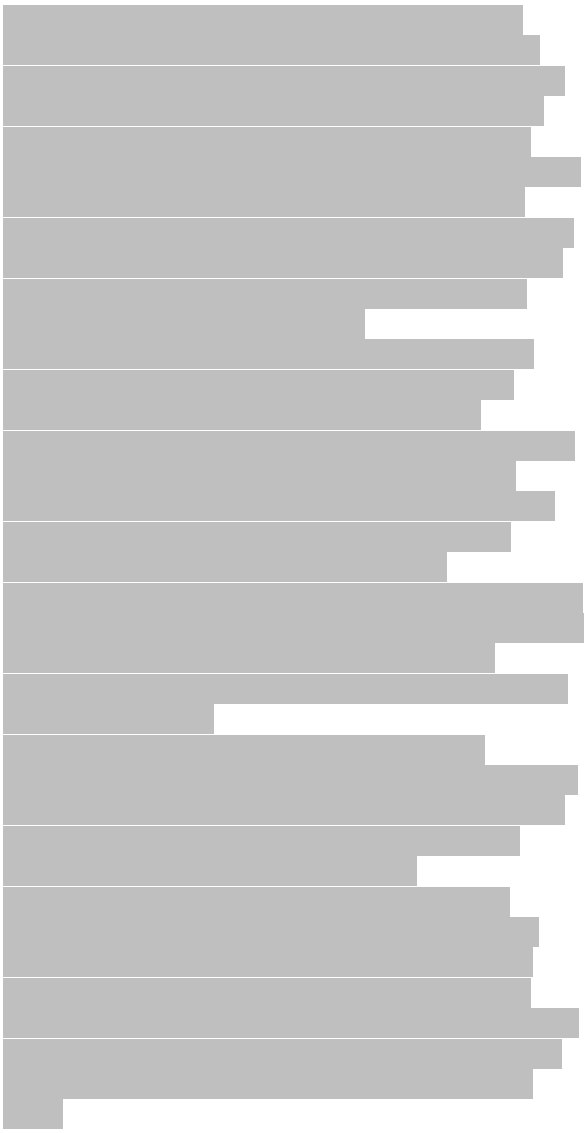
A 093	Continued From page 23 following information was provided during those sessions:	A 093		



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[redacted]

1.b. The policy titled "Code Blue Medical Emergency" dated as last approved on 06/24/2024 including the following information and requirements: "[OSH] will provide immediate response to any medical emergency that presents anywhere on campus ... If the situation appears to be life threatening or life altering to the person, staff must call a Code Blue ... A physician, nurse practitioner (NP), or registered nurse (RN) must assess the person to determine whether an emergency medical condition exists and determine whether they need additional emergency care ... Once initiated, staff must continue CPR until authorized to terminate CPR by an OSH physician, responding community paramedic, or when the person recovers from cardiac arrest ... Definitions ... 'Code Blue' means a request for immediate response to any apparent emergency medical condition that could be either potentially life threatening or life altering ... 'Emergency medical condition ... means: 1. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in - a. Placing the health of the individual ... in serious jeopardy; b. Serious impairment to bodily functions; or c. Serious

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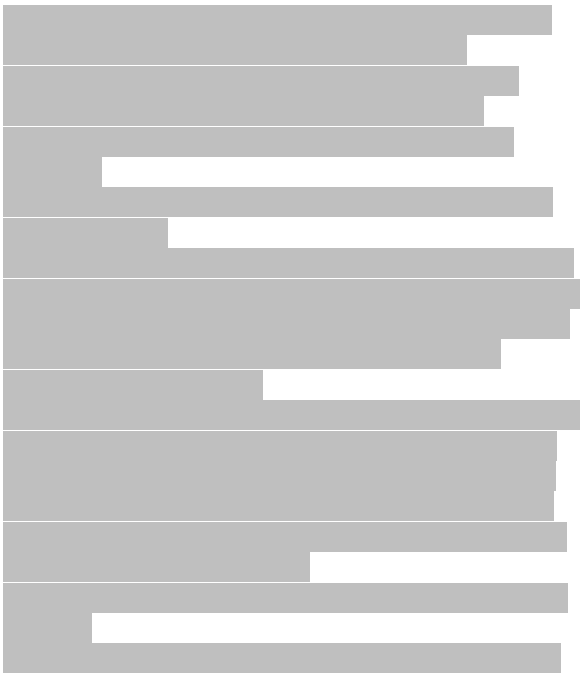
A 093	Continued From page 25 dysfunction of any bodily organ or part ..." The Code Blue "Policy Attachment - Procedures A: Code Blue Medical Emergency Response" dated as last approved 06/24/2024 included the following: The "First Responder" duties included "1. If a person appears to be experiencing an emergency medical condition, evaluation the situation, do not leave the person. 2. Call for 'Code Blue', if needed ... 3. Request staff bring the emergency medical equipment. 4. Initiate emergency medical intervention(s) within the responder's scope of practice or training." The "Physician/NP/RN" duties included "1. Assess the person to determine whether they are experiencing an emergency medical condition."	A 093		



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A 093	Continued From page 28	A 093		

[redacted]

1.e. During interview on 03/26/2025 beginning at ~ 1045 with staff that included the CNO, DCNO, DSC, DQM, DOS, DHR, and others the following information about the hospital's actions [redacted] was that "significant"

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A 093	Continued From page 29 resources for Code Blue and emergency response systems had been approved. Seven new position for Code Blue RNs had been approved and three RNs had been hired. During interview on 03/28/2025 beginning at ~ 1150 with the DCMO and others the DCMO stated that [redacted] There was no indication that the likelihood of serious injury, serious harm, or death for other patients in locked seclusion had been removed while the underlying systems' problems were identified and long-term corrective actions developed and implemented. 1.f. The policy titled "Code Blue Medical Emergency" dated as last approved on 06/24/2024 included the requirement that "Code Blue incidents must be reviewed by the Code Blue team and the Chief of Medicine (COM) to determine opportunities for systemic improvements. This review must include a	A 093		

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completed 'Code Blue Review Form' which must be securely stored and retained for 3 years by the Code Blue Team." The policy did not ensure that the Code Blue Flowsheet was maintained as part of the patient's medical record as required for documentation of all aspects of care and services provided during a patients hospital encounter.

The policy included a "Policy Attachment Procedures A" that specified that the "Recorder" was responsible to "1. Complete the Code Blue Flowsheet: a. Give the white copy to responding EMTs or emergency department. b. File the yellow copy in the patient ' s medical record or give it to the person if they are not a patient. c. Send the pink copy to the [Chief of Medicine]." There was no other information regarding the completion of the flowsheet and it was not clear what was meant "give the white copy to ... emergency department" when this psychiatric hospital did not have an emergency department.

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2. Review of an IRF regarding [redacted] with incident date [redacted]/2025 reflected "... MHT was standing at the patient's room and reported that [patient] fell but did not witness the fall. Observed patient on the floor of the entrance to the bathroom. Assessed patient for head injury, no apparent head injury. Patient asked for assistance, awaited for more staff to assist. Assisted patient back to [their] feet and onto [the] bed. Patient did not appear to be in any pain ... Code blue called during 3rd hourly Neuro assessment, patient's O2 Sats ranging from 88%-91% ... Immediate Action(s) ... Code blue called, given Narcan and 2L of O2, Sats increased ... continue to monitor SpO2, SpO2 96% on 2L O2 ..." The "Document immediate actions taken:" section reflected "... code blue called on 3rd hourly assessment as patient was hard to wake and [oxygen] was in the lower range

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A 093	Continued From page 32 88-91% ... Oxygen provided: concerns over availability of O2. Initially 2 liters ordered however order changed to 1 liter due to lack of available oxygen. Reported that there was no available oxygen, PNM reports that they found 5 full containers on the empty rack and over 30 empty cannisters [sic] ..." 3. Observations of the hospital's oxygen storage area near Sally Port 6 with DMNO, DSC and other hospital staff on 04/08/2025 at 1450 revealed: * An entry door leading to an oxygen storage area. * Inside the oxygen storage area to the right of the entry door, approximately 19 portable oxygen tanks were observed in a storage rack. On the wall above the oxygen tanks, "FULL" and an arrow pointing downward toward the tanks in red paint was observed. * Inside the oxygen storage area to the left of the entry door, approximately 14 portable oxygen tanks were observed in or near a storage rack. On the wall above the oxygen tanks, "EMPTY" and an arrow pointing downward toward the tanks in black paint was observed. * A binder was observed in the oxygen storage area. The cover read "Log Book: O2 tanks. Signature required ... with credentials please ... Please leave the pen ... Use cart to transport Oxygen tanks". The binder contained instructions titled "Grab 'n Go Portable Oxygen System" that included information about oxygen set up, delivery and safety considerations. The binder also included an oxygen tracking sheet. 4. During interview with the DMNO on 04/08/2025 at the time of the observations in finding 2 in this tag, the DMNO stated:	A 093		

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* Oxygen tanks are kept with code carts on patient units. When a tank is empty, "unit staff" are responsible for bringing the empty tank to the oxygen storage area and replacing it with a full tank.
* The oxygen supply room near Sally Port 6 has a backup supply of 23 full oxygen tanks. When the backup supply drops below 50% or gets down to 11 tanks "we re-order more".
* Medical Clinic "Outside Scheduler" staff are responsible for making sure oxygen is available in the hospital when needed. They check the supply of oxygen in the oxygen supply room once a week. They also check the gauges on the oxygen tanks to make sure they are full.
* The DMNO stated there was "a recent issue where we got pretty low [on oxygen]". The DMNO stated they did not have any further information about the issue.

5. The P&P titled "Oxygen Therapy" dated approved 05/15/2023 and last reviewed 01/04/2021 was reviewed. The P&P was not fully developed as it did not include the hospital's current practice regarding Medical Clinic "Outside Scheduler" staff checking the hospital's oxygen tank supply and gauges to make sure they were available and full as described in Finding 4 in this tag.

6. Review of a "Standard Work Instructions" titled "Portable Oxygen Tank Management" with revision date 04/04/2025 reflected:
* "Goal ... Delineate roles and responsibilities of portable oxygen tank management."
* "Purpose ... Improve understanding of portable oxygen tank management."
* "Who ... Outside Scheduling staff ... What ... Review and document O2 tank supply weekly on

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A 093	Continued From page 34 the Salem campus." * "Who ... Outside Scheduling staff ... What ... OSH Salem campus will have a max supply of portable oxygen tanks not to exceed 23 tanks (one for each unit minus BY1 - who has access to wall oxygen)." * "Who ... Outside Scheduling staff ... What ... OSH Junction City campus will have a max supply will be 12 tanks (current maximum capacity). OSH Junction City campus medical clinic will notify the Outside Scheduling office when reordering is needed." * "Who ... Outside Scheduling staff ... What ... Oxygen tanks will be reordered when the total supply drops below 50%. Standard for JC and Salem." * "End of Process" The P&P was not fully developed as it did not include all stated practices described and observed. For example, it did not include: * That Medical Clinic "Outside Scheduler" staff would check oxygen tank gauges to make sure they were full as described in Finding 4 above. * Information about designated spaces for full and empty oxygen tanks in the oxygen storage room as described in Finding 3 above. 7.a. The P&P titled, "Staff Training and Development ... Policy: 9.002" dated: April 23, 2024" was reviewed and reflected: * "Oregon State Hospital (OSH) provides staff with education and training ... to promote the acquisition of knowledge and skills while employed at OSH ... This policy applies to all staff." * "Training provided by OSH must meet applicable state and federal regulations. When required by policy or regulations, staff must	A 093		

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demonstrate competency before a training is considered complete."
* "All staff must complete annual training as indicated in Attachment A and as required by state, federal, or other regulations. OSH Executive Team must approve trainings before they are designated as mandatory unless the training is required by regulation."
* "Staff must complete mandatory training within the designated time period as required by policy, regulation or by the OSH Executive Team."
* "Training directed by this policy must be documented in the OSH-designated learning management system, Human Resources, supervisory, or Complementary Personnel Database (CPD) files."
* "Oregon State Hospital (OSH) follows all applicable regulations, including federal and state statutes and rules; Oregon Department of Administrative Services (DAS), Shared Services, and Oregon Health Authority (OHA) policies; and relevant accreditation standards. Such regulations supersede the provisions of this policy unless this policy is more restrictive."
* "Staff who fail to comply with this policy or related policy attachments or protocols may be subject to disciplinary action, up to and including dismissal."
* "Definitions ... 'Staff' includes employees, volunteers, trainees, interns, contractors, vendors, and other state employees assigned to work at Oregon State Hospital (OSH)."

7.b. The P&P titled, "Attachment A ... Annual Mandatory Training ... Policy Number: 9.002" dated "November 25, 2024" was reviewed and reflected:
* A three-column table with the following headers, Training Title, Required Staff, and Due Date,

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listed the following training requirements:
- "OHA - OSH Online: [YEAR] Annual Education - Code Blue ... All staff ... December 31 [Year]"
- "Code Blue Drill ... Nursing ... Twice Annually"
- "OSH American Heart Association (AHA) BLS CPR ... Staff according to OSH Policy 9.001 ... Annually for Nursing or staff working overtime for Nursing Every 2 years for non-Nursing staff".

8. A document titled "Nurse Staffing Plan-Salem Campus" dated "June 4, 2024" was reviewed and reflected:
* "Definitions ... 'Agency staff' means nursing staff who are contracted from external staffing agencies to meet staffing needs that cannot otherwise be met by available OSH employees ... 'Nursing staff' means a Registered Nurse (RN), Licensed Practical Nurse (LPN), and Mental Health Therapy (MHT) staff."
* "Nurse Staff Position Requirements and Qualifications ... Staff who fail to maintain required qualifications will not be allowed to work on patient care units ... Failure to maintain required qualifications may result in disciplinary action. Nursing staff qualifications are documented and maintained in their credentialing file which is maintained by Nursing Administration."
* Two tables, each with three columns titled: Position, Requirements and Authorized Work Location contained the following information for RNs, LPNs, and MHTs ... Requirements and Work location, respectively: "Annual Competencies ... All programs".
* "Nursing Staff Trainings and Competencies ... The training and competencies identified below apply to all units and levels of care at the Oregon State Hospital ... If trainings are not completed in the required time window, the employee will be

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scheduled time off the unit to complete the required trainings. Staff will not be allowed to work on the patient care units until all required competencies are in compliance ... Failure to complete the necessary competencies and maintain position requirements within the allotted time windows may result in disciplinary action."
* "Training and competency completion is documented within the Workday Learning Module. Required annual competency verification and documentation is kept in the employee credentialing file and maintained and stored by Nursing Administration."
* "New Employee Orientation (NEO) Required Trainings ... for All Nursing Staff ... Code Blue ... NEO Trainings are only required for staff hired after January 1, 2020. These are in addition to the annual competency requirements."

9. The P&P titled, "Contracted ... Nursing Staff ... Protocol: 2.010" dated "October 2, 2023" was reviewed and reflected:
* "The purpose of this protocol is to describe the expectations and procedures related to the use of contracted (agency) nursing staff at Oregon State Hospital (OSH)."
* "Agency nursing staff meet the same minimum qualifications and requirements for credentialing as hospital-employed nursing staff working in equivalent positions."
* "Agency nursing staff must adhere to all OSH policies, procedures, and protocols."
* "Staff in the above-named department who fail to comply with this protocol may be subject to disciplinary action, up to and including dismissal."

10.a. The P&P titled, "Basic Life Support ... Cardiopulmonary Resuscitation ... Training and Certification ... Policy: 9.001" dated 06/28/2023

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was reviewed and reflected:
* "This policy established Oregon State Hospital (OSH) procedures and requirements for Basic Life Support (BLS) Cardiopulmonary Resuscitation (CPR) certification for staff ... This policy applies to all staff."
* " ... OSH designates staff who must maintain BLS CPR certification appropriate to their position."
* "All staff working in the capacity of one of the positions listed in Attachment A of this policy (including overtime shifts) must maintain AHA BLS CPR certification."
* "Employees listed in Attachment A are responsible for maintaining their own certification and must avoid any lapse in certification."
* "Supervisors are responsible for verifying staff compliance with this policy at performance reviews."
* "Staff who fail to comply with this policy or related policy attachments or protocols may be subject to disciplinary action, up to and including dismissal."
* "'Staff' includes employees, volunteers, trainees, interns, contractors, vendors, and other state employees assigned to work at Oregon State Hospital (OSH)."

10.b. The P&P titled, "Attachment A ... Required BLS CPR Certification List ... Policy: 9.001" dated 06/28/2023 was reviewed and reflected:
* "Clinical ... Physician Specialist ..."
* "Nursing ... Nurse Practitioner ... Psychiatric Mental Health Nurse Practitioner ..."

11.a. The P&P titled, "Policy: 8.038 ... Code Blue Medical Emergency" dated "June 24, 2024" was reviewed and reflected:
* "Oregon State Hospital (OSH) will provide

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immediate response to any medical emergency that presents anywhere on campus and requires a coordinated team effort by staff trained in American Heart Association Health Care Provider Basic Life Support cardiopulmonary resuscitation (CPR) and first aid. In accordance with OSH licensing requirements, OSH will offer reasonable basic life safety emergency response to stabilize the person, if possible, and transfer their care to an acute-care facility when needed ... This policy applies to all staff, including employees, volunteers, trainees, interns, contractors, vendors, and other state employees assigned to work at OSH."
* "A physician, nurse practitioner (NP), or registered nurse (RN) must assess the person to determine whether an emergency medical condition exists and determine whether they need additional emergency care."
* "Staff listed in Attachment A must complete Code Blue training annually."
* "Mental Health Registered Nurses, Licensed Practical Nurses, and Mental Health Therapy classifications are required to complete Code Blue drills twice annually."
* "Staff who fails to comply with this policy or related procedures may be subject to disciplinary action, up to and including dismissal."
* "Definitions ... 'Staff' includes employees, volunteers, trainees, interns, contractors, vendors, and other state employees assigned to work at Oregon State Hospital (OSH)."

11.b. The P&P titled, "Attachment A ... Code Blue Training List ... Policy: 8.038" dated "June 24, 2024" was reviewed and reflected:
* "In accordance with OSH Policy 8.038, every employee working in the capacity of one of the positions listed below must complete Code Blue

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A 093	Continued From page 40 training annually". * "Nursing ... Mental Health Registered Nurse ... Mental Health Supervising Registered Nurse ... MHT1 ... MHT2 ... MHTT ... Nurse Manager ... Any employee working in a RN license-required or LPN license-required position". * "Clinical ... Nurse Practitioner ... Physician, Primary Care ... Physician, Psychiatrist ... Supervising Physician ... Clinical Psychologist 1& 2 ..." 12.a. During interview and review of training documentation, including Medical Staff education/training records with the DSC, CS, SE/OPA2, DHR, and other hospital staff on 03/31/2025 beginning at 1315, hospital staff provided the following information: * Regarding MD A, with hire date of 01/31/2017, training/education records reflected there were no Annual Code Blue trainings documented for 2021, 2022, 2023, or 2024. Documentation reflected: - A "Policy Review - 8.038 Code Blue ... Updates (04/09/2025)" was completed on 04/09/2025. - A "Policy Review - 8.038 Code Blue" was completed on 11/17/2024. - The most recent Code Blue "classroom training" was completed on "06/03/2015". * Regarding Medical DO B, with hire date 01/28/2013, and [redacted], training/education records reflected there were no Annual Code Blue trainings documented since 2015. Documentation reflected: - A "Policy Review - 8.038 Code Blue ... Updates (04/09/2025)" was completed on 04/10/2025. - A "Policy Review - 8.038 Code Blue" on 06/24/2024 was "Not Started".	A 093		

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A 093	Continued From page 41 - A "Policy Review - 8.038 Code Blue" on 05/09/2024 was "Not Started". - The most recent Code Blue "classroom training" was completed on "05/29/2015". * Regarding Medical MD N, with hire date 09/14/2020, training/education records reflected there were no Annual Code Blue trainings documented for 2021, 2022, 2023, or 2024. Documentation reflected: - A "Policy Review - 8.038 Code Blue ... Updates (04/09/2025)" was "Not Started" as of 04/10/2025, 11 working days after the start of the survey. - A "Policy Review - 8.038 Code Blue" on was completed on 06/25/2024. - A "Policy Review - 8.038 Code Blue" on was completed on 06/04/2024. - An "Annual Code Blue ... Online Training" was completed on "09/17/2020". - Additionally, training records for MD N reflected that their BLS certification expired on 03/15/2025, and MD N was still providing direct care to patients. * Regarding Medical MD O, with hire date 07/06/2009, training/education records reflected there were no Annual Code Blue trainings documented for 2021, 2022, 2023, or 2024. Documentation reflected: - A "Policy Review - 8.038 Code Blue ... Updates (04/09/2025)" was completed on 04/09/2025. - A "Policy Review - 8.038 Code Blue" on was completed on 07/31/2024. - A "Policy Review - 8.038 Code Blue" on was completed on 05/15/2024. - An "Annual Code Blue ... Online Training" was completed on "10/01/2020". - The most recent Code Blue "classroom training"	A 093		

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A 093	Continued From page 42 was completed on "05/29/2015". 12.b. Nursing staff Annual Code Blue training records related to nursing staff requirements were not complete for all direct care staff. Review of employee training documentation reflected the following: * Agency RN D, with hire dates 04/04/2022 and 10/23/2023, reflected one but not two Code Blue training drills for 2024, as required by hospital policy. * Regarding RN F, an agency RN with hire date 12/11/2023, [redacted], training/education records reflected Annual Code Blue trainings were not completed every year as required. Documentation reflected: - An "Online: 2025 Annual Education-Code Blue" was completed on "02/28/2025". - A "Policy Review - 8.038 Code Blue" was completed on 07/01/2024. - A "Policy Review - 8.038 Code Blue" was completed on 05/27/2024. - An "Online: 2023 Annual Education-Code Blue" was completed on "12/15/2023". * RN U, a regular full-time staff with hire date 08/08/2008, reflected no evidence of Code Blue training drills for 2024 as required by hospital policy. * Agency RN Z with hire date 09/27/2021, reflected no evidence of Code Blue training drills for 2024 as required by hospital policy. * LPN P, a regular full-time staff with hire date 10/09/2023, reflected one but not two Code Blue training drills for 2024, as required by hospital policy. * LPN Y, a regular full-time staff member with hire date 07/25/2022, reflected one but not two Code Blue training drills for 2024, as required by	A 093		

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A 093	Continued From page 43 hospital policy. Additionally, a medical emergency assessment test was not available for review and had not been retained in the Workday Learning Module or in the employee credentialing file per policy. * MHT CC, a regular full-time staff member with hire date 04/08/2019, reflected one but not two Code Blue training drills for 2024, as required by hospital policy. * There was no evidence of two Code Blue training drills for 2024 as required by policy for the following five other regular direct care staff: - RN W with hire date 12/12/2016. - RN EE with hire date 12/04/2017. - MHT X with hire date 04/06/2020. - MHT BB with hire date 01/22/2024. - MHT DD with hire date 07/31/2023. The hospital failed to provide safe care [redacted] The hospital's failure to provide safe care included a lack of trained direct care clinical staff [redacted] which included DO B and at least one agency RN F, both of whom had not completed Annual Code Blue trainings as required by hospital P&Ps. Refer to Findings 12.a. and 12.b, staff competency records, and Finding 11.a., the Code Blue Emergency P&P that reflected, "Staff listed in Attachment A must complete Code Blue training annually ..." and Finding 11.b., "Attachment A ... positions listed below must complete Code Blue training annually ... Nursing ... MHT[s] ... Any employee working in a RN license-required or LPN license-required position ... Clinical ... Nurse Practitioner ... Physician, Primary Care ... Physician, Psychiatrist ... Supervising Physician ... Clinical Psychologist 1& 2 ..." Additionally, four of five LIPs responsible for	A 093		

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A 093	Continued From page 44 assessing "the person to determine whether an emergency medical condition exists and determine whether they need additional emergency care" as required by the Code Blue P&P, Finding 11.a., had not completed annual Code Blue training for greater than four years, and DO B, [redacted], had not completed Code Blue training for almost 10 years. Additionally, 16 direct care staff, including the LIPs, RNs (agency and regular staff), and MHTs did not have up-to-date Code Blue training, and were still providing direct care to patients contrary to hospital P&Ps, which reflected, "If trainings are not completed in the required time window, the employee will be scheduled time off the unit to complete the required trainings. Staff will not be allowed to work on the patient care units until all required competencies are in compliance ...", refer to Finding 8, Nurse Staffing Plan. Refer also to Findings 7.a., 9., 10.a., and 11.a., "Staff who fail to comply ... may be subject to disciplinary action, up to and including dismissal." Leadership failed to fully implement training P&Ps, and failed to verify compliance with CPR and BLS requirements as directed by hospital P&Ps, and allowed a provider with an expired CPR certification, MD N, to provide direct care to patients. Refer to Finding 10.a, Required CPR Certification P&P, "Supervisors are responsible for verifying staff compliance with this policy at performance reviews ... [and] Staff who fail to comply with this policy or related policy attachments or protocols may be subject to disciplinary action, up to and including dismissal." 12.c. Findings 12.a and 12.b. were confirmed at the time of the training review by the SE/OPA2.	A 093		

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12.d. An email from the COP to the CS on 04/10/2025, confirmed that MD N had been "actively working" at the hospital with an expired CPR certification since 03/15/2025.

12.e. An email dated 04/11/2025 from the DCMOA reflected, "[MD N's] BLS/CPR certification expired on 3/15/25 and [they] is currently scheduled to re-certify on 4/15/25 ..."one month after the expiration date.

12.f. There were no training records for First Aid for any of the direct care nurses, as the hospital did not provided First Aid training specific to patients who were secluded or restrained.

13.a. The hospital failed to provide training for Seclusion and Restraint that adhered to hospital P&Ps. The curriculum provided did not reflect training for First Aid specific to a restrained or secluded patient as required by CFR 482.13(f)(2)(vii). For example:

13.b. The P&P titled, "Use of Seclusion Room Bathroom ... Protocol: 2.220" dated "August 1, 2023" was reviewed and refelcted:
* "The purpose of this protocol is to give nursing staff at Oregon State Hospital (OSH) directions regarding the safety monitoring required when a patient uses the Seclusion Room bathroom."
* "When a patient is in locked seclusion, the door to the bathroom may be either locked or unlocked based on the assessment of the Register Nurse (RN) regarding the patient's ability to safely utilize the bathroom."
* "When a patient is utilizing the unlocked Seclusion Room (e.g., for Voluntary Movement Restriction [VMR]) and is not under direct observation, the door to the bathroom must be

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A 093	Continued From page 46 locked." 13.c. The P&P titled, "Policy: 6.003 ... Seclusion and Restraint" dated "February 12, 2024" was reviewed and reflected: * Purpose And Applicability ... Oregon State Hospital (OSH) is committed to supporting a patient's right to be free from inappropriate seclusion or restraint while protecting the physical safety of patients, staff, and others ... This policy applies to all staff, including employees, volunteers, trainees, interns, contractors, vendors, and other state employees assigned to work at OSH." * "Seclusion or restraint may only be used when clinically justified by a behavioral emergency (as defined in this policy) when other interventions have been determined to be ineffective. When used, restrictive interventions must be discontinued as soon as possible." * "Unless safety demands immediate physical response, staff must first consider non-restrictive interventions such as engagement, disengagement, offering a therapeutic item or medication to aid with calming or symptom management, verbal redirection, asking the patient to remove themselves from the milieu or an RN offering Voluntary Movement Restriction, calling for a show of concern, or other de-escalation to prevent a situation from escalating to the point of using seclusion or restraint." * "Staff must apply the least restrictive interventions incrementally and no more than what is necessary to safely manage the behavioral emergency ... Seclusion or restraint may not be used as a substitute for an activity or treatment,or as a means of coercion, discipline,	A 093		

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A 093	Continued From page 47 convenience, or retaliation by staff ... Chemical restraint may not be used at any time." * "... if efforts such as de-escalation, disengagement, or evasion are not possible or fail and a patient is engaging in physical aggression imminently directed at another person, trained staff may act in self-defense or immediate defense of another person if reasonably necessary to prevent harm to that person. This includes but is not limited to ... Before the arrival of a physician/NP or RN, staff may manually restrain the patient or seclude the patient by preventing the patient from physically leaving any room. (Note: Staff may not direct the patient to walk to a designated seclusion room or initiate mechanical restraint. These require the authorization of an RN, NP, or physician.) ... This temporary restrictive intervention may only continue until a RN, NP,or physician is notified, assesses, and provides direction about continuation or discontinuation of the restrictive intervention(s)." * "A face-to-face assessment must be conducted by a physician/NP within one hour of the initiation of a seclusion or restraint event per Procedures B ... If a Physician or NP is unavailable to complete the assessment, a trained Nurse Manager, Program Nurse Manager, or Program Lead RN may be delegated to conduct the assessment per Procedures B." * "OSH follows all applicable regulations, including federal and state statutes and rules; Oregon Department of Administrative Services (DAS), Shared Services, and Oregon Health Authority (OHA) policies; and relevant accreditation standards. Such regulations supersede the provisions of this policy unless this policy is more restrictive." * "Staff who fail to comply with this policy or	A 093		

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A 093	Continued From page 48	A 093		

related policy attachments or protocols may be subject to disciplinary action, up to and including dismissal."
* "Definitions ... 'Behavioral emergency' in this policy means a situation in which ... the patient presents an imminent danger of harm to self or others (as defined in this policy), and ... nonphysical interventions are not viable, and ... safety concerns require an immediate physical response."
* "'Chemical restraint' means a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition."
"'De-escalation skill set' in this policy includes interpersonal communication and conflict resolution skills to de-escalate a potentially dangerous situation without using seclusion or restraint and to develop or maintain a positive relationship with the person(s) involved."
* "'Imminent danger of harm' in this policy means a substantial likelihood of immediate physical harm to the patient or others, an immediate and substantial likelihood of significant property damage, or an immediate and serious disruption of the activities of other patients in the area."

13.d. The P&P titled "Procedures B ... Restraint or Seclusion Orders and Assessment by Physician/Nurse Practitioner ... Policy: 6.003" dated "February 12, 2024" was reviewed and reflected:
* "Implementing a more restrictive intervention (e.g., moving a patient from seclusion to mechanical restraint or adding a chest strap to a patient in mechanical restraint) requires a ... face-to-face assessment by a physician/NP."

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A 093	Continued From page 49 * "All manual restraints require ... [a] face-to-face assessment by a physician/NP ... If the manual restraint occurs after the patient is already in seclusion or mechanical restraint ... a new face-to-face assessment by the physician/NP is required." * "Orders following initiation of seclusion or mechanical restraint ... Following a face-to-face assessment, the physician/NP may order continued seclusion or mechanical restraint if indicated. This order may not exceed three hours and begins at the time that the previous telephone order expires, irrespective of the time that the face-to-face order is written ... If the physician/NP is present and conducts a face-to-face assessment during the process of seclusion or mechanical restraint, the initial order may not exceed four hours." * "Subsequent orders if [sic] seclusion or restraint continues after the initial four hours ... If four hours have passed since initiation of the restrictive intervention (or since the previous face-to-face assessment by the physician/NP, for events lasting longer than eight hours), the RN must contact the physician/NP to obtain a telephone order to continue seclusion or restraint ... If eight hours have passed since initiation of the restrictive intervention or since the previous face-to-face assessment by a physician/NP, an order for continued seclusion or mechanical restraint must be written by a physician/NP following a new face-to-face assessment ... A physician/NP may conduct a face-to-face assessment and write a new order earlier than eight hours since initiation of the restrictive intervention or the previous face-to-face assessment. In such cases, if seclusion or restraint continues to be required four hours after that face-to-face assessment was conducted, the	A 093		

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A 093	Continued From page 50 RN must obtain a telephone order to continue seclusion or restraint." * "A physician/NP must conduct a face-to-face assessment of the patient within one hour of the initiation of seclusion or any kind of restraint, including manual restraint ... If the Psychiatrist on Duty (POD) is not able to complete the assessment within one hour they may assign this duty to a Nurse Manager (NM), Program Nurse Manager (PNM), or Program Lead RN (PL) who has been trained and deemed competent ... The NM/PNM/PL must conduct the face-to-face assessment within one hour after seclusion or restraint is initiated; then ... The NM/PNM/PL must immediately call the POD to discuss the assessment, the need for other interventions or treatment, and the need to continue or discontinue seclusion or restraint. The NM/PNM/PL must document the assessment and discussion with the POD ... The POD must conduct a face-to-face assessment no later than two hours after the initiation of seclusion or mechanical restraint. If continued seclusion or mechanical restraint is indicated, the order may not exceed two hours, and begins when the second telephone order expires, irrespective of the time that the face-to-face order is written." * "The physician/NP must document the following in a progress note no later than the end of their work shift: 1. The time they conducted the face-to-face assessment ... The patient's condition or symptom(s) and specific behavior(s) that justified using the intervention ... The restrictive intervention used and the patient's response to the intervention ... Patient quotes from the interview during the in-person interaction or an explanation as to why the patient was unable to participate in a discussion ... A summary of the patient's relevant history related	A 093		

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to the current behavior and mental status, including documentation of any patient injury during the event ... The circumstances around any expired orders, if applicable ... The plan to reduce the intervention; and ... Any consultation obtained during the restrictive event."

13.e. The P&P titled, "Attachment D ... Training Requirements ... Policy: 6.003" dated "February 12, 2024" was reviewed and reflected:
* "Oregon State Hospital (OSH) will provide training to staff about restrictive interventions which meets regulatory requirements and as directed by OSH's Education Department ... All staff with direct patient care responsibilities and any other staff involved in the use of seclusion or restraint must receive ongoing training and demonstrate competency and understanding of the following ... OSH philosophy, goals, and policies regarding the use of seclusion or restraint ... Cardiopulmonary resuscitation (CPR); and ... First aid techniques."
* "Designated Nurse Managers/PNMs/Program Leads must be trained once every two years and demonstrate competency to complete the one-hour face-to-face assessment on behalf of the Physician/NP as described in OSH Policy 6.003, "Seclusion or Restraint". Training must also include content to ... Evaluate the patient's immediate situation ... The patient's reaction to the intervention ... The patient's medical and behavioral condition (including a complete review of systems assessment, behavioral assessment, review and assessment of the patient's history, medications, most recent lab results, etc.), and ... The need to continue or terminate the restraint or seclusion."

The P&Ps on Seclusion and Restraint contained

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A 093	Continued From page 52 unclear and inaccurate information about Face-to-Face assessments and First Aid training required. For example, on 04/10/2025, documentation of Face-to-Face training was requested for RNs who performed Face-to-Face assessments from the sample list of RNs selected for record review as the P&P for Seclusion and Restraints reflected, "If a Physician or NP is unavailable to complete the assessment, a trained Nurse Manager, Program Nurse Manager, or Program Lead RN may be delegated to conduct the assessment ..." refer to Findings 13.c. and 13.d., Seclusion and Restraint P&Ps, and 7.e. training requirements for S&R. However, during communication about the P&Ps for Seclusion and Restraint related to the practice of Face-to-Face assessments by nurses, the DSC reported to the survey team that Face-to-Face assessments by nursing staff only occur on the Junction City campus, and not on the Salem campus. The DSC further acknowledged in an email dated 04/23/2025 that "We understand that this is in policy. Our current practice in Salem is to only have providers do face-to-face. OSH has it in policy for NMs PNMs and PLs to cover in Junction City because the amount of staffing to support Junction City is different. We are in the process of updating our policy to better reflect this." Refer also to Finding 15.b., Slide 27 S&R training that discusses Face-to-Face training and does not distinguish between campuses. Also refer to Findings 15.a., 15.b. and 15.c. regarding S&R training curriculum and the lack of specific First Aid training as described in hospital policy "Training Requirements ... Policy: 6.003", Finding 13.e., "All staff with direct patient care responsibilities ... involved in the use of seclusion or restraint must receive ongoing training and demonstrate competency and understanding of ...	A 093		

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First aid techniques."

14.a. The P&P titled, "Enhanced Supervision ... Policy: 6.010" dated "February 28, 2024" was reviewed and reflected:
* "This policy establishes guidelines for enhanced supervision at Oregon State Hospital (OSH) ... by minimizing the occurrence of aggressive, suicidal, or self destructive behavior ... This policy applies to all OSH staff."
* "The least intrusive means of providing effective treatment must be used, with the goal of helping patients regain the ability to maintain safety toward self and others without the need for an increased staff presence."
* "Any limitation to a patient's rights must be clinically justified ..."
* "'1:1 supervision' means a staff member must be assigned to monitor a patient ' s location and activities at all times. The assigned staff member must maintain constant visual contact and consistent physical proximity, as well as verbal contact while the patient is awake, within parameters specified by the ... order and as described on the Intervention Card. The psychiatrist or PMHNP must specify additional parameters, as appropriate, in the order."

14.a. The P&P titled, "Staff Responsibilities ... Policy: 6.010" dated "February 28, 2024" was reviewed and reflected:
* "Additional considerations for staff assigned to 1:1 supervision ... Staff must continuously visualize the head, neck, and hands of any patient on 1:1 suicide/self-harm supervision, including during patient use of bathroom and shower ... Staff must remain approximately two (2) arm lengths from the patient (in the doorway if the patient is in their bedroom) unless the

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supervision order or acute safety considerations require otherwise ... Staff must provide their attention to the patient and direct other patients to be assisted by other available staff ..."

15.a. A document titled, "Safe Together for Nurses Facilitation Guide" updated "1.31.2025" was reviewed and reflected:
* "Learning Objective ... By the end of the lesson, learners develop a sense of welcome and support by peers and instructors through discussion and perspective sharing."
* "Learning Objective ... During group discussion and application, learners develop confidence in assessing restraints to improve safety and effectiveness of restraints ... After participating in downgrade, learners compare options to increase safety when team [sic] move from restraints to seclusion."
* "Share a quick overview of the tasks you are going to accomplish (restraint assessment, 5-point restraint, downgrade, and shields)."
* "Only a provider or RN may authorize a restrictive intervention, least restrictive options attempted first, etc. (Policy 6.003)"
* "RN/LPN must supervise staff actions in person during application of restraints. LPNs can do so because application of restraints is a focused assessment. Assess and correct staff positioning as needed. Ensure no direct pressure on patient's joints, spine, face, neck. Assess your staff safety as well - look for signs of needing to be switched out. Pain, fatigue, stress. Assess patient breathing, circulation, skin integrity, injuries."
* "Mechanical Restraints Applied ... Assess all four points, counterclockwise. Keep observations to yourself. Coach observes processes used to assess (two finger method still being used, etc.) Nurses demonstrate proficiency by using proper

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assessment techniques and by pointing out errors in restraint application, as well as proper methods for correcting improper restraint placement. Wrist restraints: ask staff to lift pt's hand so license can view gap between pts skin and the restraint. Goal is to see no light through the gap. Safely contain pt's hand; grab locking mechanism strap and slowly twist the soft restraint. It should move slightly, if not, it is too tight. Ankle restraints: ask staff holding pt's leg to allow license to see through any gap between the restraint and the skin. There should be no light showing through. Nurses should assess the tightness of the waist belt as the fifth point of restraint. Using a flat hand, pointing toward the head of the patient, starting at the patient's hip and moving inward, ensuring that its seatbelt tight. Check for contraband prior to exiting the room. Talking point: What is allowed in seclusion? Shoes - RN discretion, pedal pulse considerations, ability to use heels to dig in, etc. Who can offer the wedge? What other reasons would we use the wedge?"
* "Upgrade to 5 Point - Chest Strap ... Reason for upgrade? Risks? Requires a separate order unless it is complete prior to closing the seclusion room door, in which case it can be added to the initial order. If occurring after the door has been shut, an RN or LPN can call for the order and the upgrade can occur after the call is made ... Reasons? (Rocking, thrashing, self-harm.) Process: After RN assesses need for chest strap, nurse assesses placement, lining the strap up with the slot directly aligned with the patient's eyes and ears. Placement of the chest strap is above the nipple line. The label on the strap must be centered on the chest."
* The facilitation guide described the physical process of employing the 5 point restraint, similar

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to the talking points outlined in the previous technical description of the four-point restraints above.
* "Downgrade" Similarly, the talking points contained a technical description of the process.
* "Most Restrictive Downgrade". Similarly, the talking points contained a technical description of the process, including how to remove the bed from the Seclusion room. The description then stated, "... remove the restraints buckle side first. When finished with this step, they [staff] will step back and all arm staff to assist pt to the bathroom, or to a sitting or lying position. When it is safe to do so, all staff exit the room. The two staff touching the patient or holding the bathroom door closed exit last and the seclusion room door is then locked. Downgrade can be straight from restraints to milieu. In this instance, procedures will be much less restrictive."
* "Shields ... Learning Objectives ... During hard shield discussion, learners review procedures to understand roles and responsibilities when using the safety device ... After soft shield discussion, learners identify changes to accommodate use of soft shields to decrease chance of injury."
* "Hard Shield ... Item vs. weapon verbiage Code Purple Roles: Provider, RN, Shield Lead -Discuss Responsibilities of each, required collaboration between the three. Requirements to be a Shield Lead -Only Security and TSO currently. 4 Hour Annual, quarterly etc. Risks of Shield Use: Patient? Staff? The Planning Process -Considerations? (Secluding Patient, Verbal De-escalation, Pursuing Least Restrictive) Appropriateness? (age, trauma/abuse history, medical/psychiatric condition). Overview -Provide a quick example, from real experience or hypothetical, of what that planning process might look like. Documentation required of each role

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A 093	Continued From page 57 -Manual Restraint order (Provider), Incident Reports (All staff involved except Provider), Progress Note detailing least restrictive attempts (RN), S & R required documentation (RN). The incident report filled out by hard shield lead must be done whether shield was deployed or not, and must contain who requested the hard shield, the reason for retrieving it, and whether security was notified." This was followed by a review of debriefing, after action review and administrative follow up on the use of the shield. * "Soft Shields ... Soft Shield Requirements (RN approval removed) - 'any behavioral emergency where there are conditions of dangerous behavior and means of harm' and agreement between both staff capturing arms. We still also require the team and plan; we do not use them in emergent situations. Following code green with soft shield deployment, RN must document in a progress note the less restrictive interventions attempted and why they were unsuccessful. IRs should be filled out by all involved if it is a reportable incident (staff or patient injury, etc.). IRs are also encouraged when soft shields are deployed in successful interventions as support to illustrate why we have them as a safety tool." * "Wrap Up ... Cover any questions ..." The Facilitation Guide failed to provide emphasize the use of "least restrictive interventions" and mention of "First Aid" techniques were non-existent. For example, it was unclear from the Facilitation Guide whether "... least restrictive options attempted first, etc. (Policy 6.003)" actually covered the policy or whether other interventions such as "... engagement, disengagement, offering a therapeutic item or medication to aid with calming or symptom management, verbal redirection,	A 093		

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asking the patient to remove themselves from the milieu or an RN offering Voluntary Movement Restriction, calling for a show of concern, or other de-escalation to prevent a situation from escalating to the point of using seclusion or restraint..." as reflected in the hospital's P&P 6.003, were discussed or practiced. Further, the Facilitation Guide did not include any mention of First Aid for patients in distress or injured, and only addressed patient injuries in the following sentence, "Assess patient breathing, circulation, skin integrity, injuries."

15.b. A 46-slide power point titled, "S&R for Nursing Licenses" dated "4.3.25" was reviewed and reflected:
* Slide 2 notes discussed the course objectives, "We will be asking judgement questions and provide scenarios to provide for open discussion ... The goal is to have open discussions about assessments and how people view safety, what imminent harm is to them, and how to utilize least restrictive options. The goal of this class is to cover material to provide a space to become more comfortable with what is expected of licenses, and to protect staff, and patients from harm."
* Slide 3 noted, "Decisions ... Are seclusion or restraints needed ... Is an upgrade or downgrade needed and was it completed ... What other options are available for the patient that are least restrictive".
* Slide 4 noted, "RNs must justify why an S&R is needed and assess ... Documentation is required".
* Slide 5 listed documentation times for tasks such as obtaining orders, completion of forms and assessments.
* Slide 10 noted, "No direct pressure may be

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A 093	Continued From page 59 placed on the patient's joints, spinal column, neck, or eyes, mouth or nose, per OSH policy 6.003 ... A nurse needs to assess pt. breathing, circulation, skin integrity, injuries, etc. Assess, adjust, and provide care as needed." * Slide 11 described downgrading a patient from restraints to Seclusion. It reflected, "After the nurse has assessed for safety, the team will enter the seclusion room ... Arms on arms, legs on legs, shadowing the limbs or providing light contact as needed ... The RN will verbally walk the patient through the process of downgrading ... Downgrading to seclusion ... The arm staff on the opposite side will sit next to the patient and gently hook the patient's arm ... When the patient is ready, allow a full minute for blood circulation and ensure the patient is not dizzy and to prevent falls, help them stand up regaining balance ... Lead will make sure everything is out of the room ... Lead or RN will ask the patient what they would like to do so the arms staff can leave the room safely ... We can ask the patient to go into the bathroom, sit, orlie down ... Do not ask a patient to kneel. If a patient chooses to kneel remind them, they do not have to kneel and document in a Progress Note ... Arm staff will maintain contact and assist the patient into a sitting or lying position, or into the bathroom, verify they have a clear exit, and then exit the room." * Slide 13 included updated changes to the power point which were added during the survey and will not be considered as part of the training review. * Slide 17 was titled "Care of patient in the side room". * Slide 18 reflected, "Nurses are required per OARs to obtain an order ahead of time when able, and per the nursing act to know if they can restrain a patient when it is not for imminent harm, such as medication administration/IMBU ...	A 093		

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Restrictive events increase the potential of injury and trauma to both patients and staff ... Is the forced medication really needed? This is up to the practitioner to decide ... Even if there is an IMBU order in the eMar ... This order is for the medication, not for restraining a pt."
* Slide 19 presented scenarios for offering least restrictive options for a "Disruptive Milieu", that included "Naked Patient ... Racial Slurs ... [and] Masturbating in milieu".
* Slide 20 titled, "Enhanced Supervision" and reflected, "The staff's focus is and should only be the 1:1/patient".
* Slide 22 noted the following about VMR, "The seclusion room bathroom door must always be locked while the patient remains unsupervised."
* Slides 23 - 41 were focused on documentation that included but limited to: monitoring and reporting forms, data entry, and shift-to-shift communication.
* Slide 26 included a form titled, "Additional Considerations". This form had one line about patient injuries under the section titled "The RN Assessment of the Patient in S&R includes" and then "1. respiration, skin color, injuries".
* Slide 27 reflected, "If a trained RN is completing the initial face-to-face within the first hour, treat the RN as if they are a practitioner that can't write orders ... If continuation of S&R is needed a floor nurse must get an additional 1 hr order from the practitioner".
* Slide 29 included a form titled, "Emergency Seclusion or Restraint Entry Note" and a section for "Least Restrictive Methods Offered/Utilized Prior to Restrictive Event". This was followed by 10 check boxes, one of which included "Other" for freehand text. Options included: 1:1 Counseling, Problem Solving, Limit Setting, PRN medications, Disengaged, Given Space, patient's room, quite

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space, and Diversionary activity. Presenter notes included, Be specific on least restrictive methods attempted, interventions used, and what led to the restraint or seclusion".
* Slide 40 reflected the following as an example of a Seclusion event in a "Unit Nursing Shift to Shift" report, "Pt became argumentative prior to going to breakfast. He was educated that he needed to change his shirt due to it being ripped. Pt began to yell, threaten staff, and postured at staff. Staff went hands on using Safe Containment at 0754. Pt continued to struggle against staff and had difficulty with being safe. Pt was placed in S&R, provider notified, PRN medications administered, pt. let put of S&R at 1134. Pt stated he wanted to go to his room to rest and be left alone. Lunch was taken to him in his room. Pt stayed in his room for the remainder of the shift."
* Slide 41 included a form titled, "Seclusion and S&R Event Audit". The audit did not include whether the least restrictive interventions were employed.
* Slide 43 described justifications for "hands on". This included the following, "Can staff go hands on, even if a patient is not swinging? OSH is teaching least restrictive, but this is where RN assessment comes in ... What is the safest option for staff and patients? Imminent harm ... Do the patient's actions pose a safety threat to themselves, staff, or other patients? Is yelling a safety threat? Milieu disruption - annoying or a safety concern? Is there property damage or does damaged property pose a safety concern, not a concern for the property, but for safety of staff, the patient, or other patients ... Imminent harm (self/others). We have time and property is just property. Property can be replaced. It is when use of an item becomes a means to perform

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A 093	Continued From page 62 harm to others or significant self-harm that it is considered imminent harm ... Unless there is excessive property damage." The power point presentation included unclear information, some of which was not supported by hospital P&Ps. For example, Slide 40 provided an example of shift to shift communication that described a patient seclusion for behavior that did not meet the hospital's clinical justification of a "behavioral emergency" or its provision that "Seclusion or restraint may not be used as a substitute for an activity or treatment, or as a means of coercion, discipline, convenience, or retaliation by staff ..." Refer to Finding 13.c, the Seclusion and Restraint policy, 6.003. The severity of the patient's behaviors described in the example were, "Pt began to yell, threaten staff, and postured at staff." This behavior did not meet the policy definition of a "Behavioral emergency" which defined a behavioral emergency as "a situation in which ... the patient presents an imminent danger of harm to self or others". Further, after "Staff went hands on" and secluded the patient, "PRN medications [were] administered." Hospital P&Ps reflected that "Chemical restraint may not be used at any time." Refer again to Finding 13.c, the S&R P&P. The presentation also included a slide about Face-to-Face Assessments by nurses (Slide 27) and did not call out that this practice only occurred on the Junction City campus, refer to Findings 13.c, 13.d, and 13.e. the S&R P&P and training requirements. There was no First Aid training addressed in the presentation and only a brief mention of assessing patients for injuries, "A nurse needs to assess pt. breathing, circulation, skin integrity, injuries, etc." on slide 10, and "The RN Assessment of the Patient in S&R includes ...	A 093		

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respiration, skin color, injuries" on slide 26. The training failed to provide first aid techniques as described in the hospital's P&P, "Training Requirements ... Policy: 6.003", Finding 13.e., "All staff with direct patient care responsibilities ... involved in the use of seclusion or restraint must receive ongoing training and demonstrate competency and understanding of ... First aid techniques." Lastly, presentation focused mainly on hands on, restraint and seclusion techniques, as well as documentation of the event; there were 18 of 46 slides devoted to documentation alone. It was unclear whether the hospital emphasized the importance of other, less restrictive interventions be tried and documented, or whether alternatives were considered and determined to be insufficient and documented. For example, slide 41 included a leadership audit document that did not verify whether other, least restrictive interventions were utilized prior to S&R.

15.c. A 17-slide power point titled, "Safe Together for Licenses Refresher" last updated "4-2025" was reviewed and reflected:
* Slide 1, presenter notes reflected, "Learning Objectives: LO 1: By the end of the lesson, learners develop a sense of welcome and support by peers and instructors through discussion and perspective sharing".
* Slide 4 titled, "Actual Code Green Event" included video review with the following introduction, "We are going to watch an actual code green event that went very well." Notes also included:
- "Patient is on a 1:1 enhanced supervision, there is a PNM (on left of screen) and 2 MHTs (one on the 1:1 enhanced observation and one on Milieu Management)."
- "There are not clear black and white answers for

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A 093	Continued From page 64 many of these points (although there are some clearly WRONG things)" - "... 15.19.34 ... discuss ... (specifically position staff is in [bent at waist with head in patient's midriff] ... " - "... 15.19.38, discuss arm placement on shoulder (PNM puts hand on right shoulder of patient rather than in proper placement)" - "... 15.20.00 What would we put for " ...description of patient behavior leading to a more restrictive intervention and patient's response? What less restrictive options were offered after initial restrictive intervention?" - "... 15.20.44 This is a great time to bring up the contraband check on the Entry Note, did they do one? (No)" - "***Make sure to summarize that this was a GOOD code. It was handled quickly and efficiently, and staff supported each other well.***" - "Discuss use of side room Bathroom: Should it remain locked? This is dependent on RN assessment. If patient has a high risk of self-harm, the door should remain locked. If the patient is at risk for self-harm, there must be a safety plan documented in the hourly RN assessment. If no assessment is completed by RN regarding bathroom use, default is to leave it locked. RN is also to assess if side room is clean ... " * Slide 14 was titled "Care of patient in the seclusion room" and presenter notes reflected, "Review only, this is covered filling out of flow sheet during code green review portion ... Assess the patient. Don't go into the seclusion room alone." There was no mention of assessing the patient for injuries. The training presentation was very brief and lacked First Aid training. Although the	A 093		

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presentation notes discussed several concerns with the video portion of the presentation, other policy concerns were not addressed. Refer to Finding 15.d. below, review of the training video that was used for both power point presentations and S&R trainings.

15.d. A video titled, "Video for Safe Together for Licenses 2025" was reviewed and reflected:
* The video was tagged, "AN3-E-Hall (G01-3E) COR 2024-09-10 15.19.34.648".
* At "00:00" the video reflected a patient in a blue shirt, khaki pants and bare feet sitting in a chair directly across from two staff members, who were talking with another staff member who was standing approximately three feet behind the seated patient. None of the staff were engaged with the patient or looking at them.
* At "00:05" the patient suddenly stood up and raised their right hand in a fist and attempted to hit a staff member who was standing across the hall. The staff member ducked, and it was unclear whether the left hand of the patient made contact with the staff member. The right hand did not make contact.
* At "00:06" the other two staff members had hands on the patient's shoulders and a manual restraint had been initiated.
* At "00:07" the staff member who was the target of the patient aggression moved clear of the patient and the other two staff members began to gain control of the patient.
* At "00:10" a staff member has a hand on the back of the patient's neck, and the second staff member had control of the patient's arm. They both have the patient against the wall. The staff who was the target of the attack moved behind the patient and attempted to take control of the second arm.

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A 093	Continued From page 66 * At "00:13" three other staff members arrived, and the targeted staff moved back. The other two staff have gained full control of the patient's arms. The patient did not appear to be struggling. * At "00:31" the patient was removed from the wall and staff walked the patient down the hall to the seclusion room. The patient was not observed to be struggling against the hold. * At "01:04" one of the staff members holding the patient's arm was seen turning back, with their face turned toward the patient's head, and speaking with another staff member who was walking behind the escorted the patient. * At "01:13" the staff escorts had the patient face the wall down the hall from the seclusion room while the bed was being removed. Patient has still not been observed struggling. * At "01:51" the Seclusion room bathroom was unlocked. * At "02:08" staff held open the bathroom door while an escorting staff released the patient's left arm. The second staff escort was in the bathroom doorway and out of camera view with the patient. * At "02:12" the two other staff quickly exit the bathroom doorway and the staff who released the left arm closed the bathroom door behind the patient with patient inside the bathroom. * At "02:16" all staff exited the Seclusion room, and the door was closed. The video ended at "02:19" with the patient still inside the bathroom. The S&R event depicted in the video failed to demonstrate a clinical justification for the use of seclusion in a cooperative patient who exhibited aggressive behavior. The video further demonstrated the direct care staff and leadership's failure to implement the hospital's S&R P&Ps, as well as following and implementing the P&P for Enhanced Supervision.	A 093		

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For example, the patient was on ES 1:1, as described in Finding 15.c., however, the staff supervising the patient was engaged in conversation with another MHT and a PNM. The PNM failed to demonstrate leadership by engaging in conversation with a staff who was on a ES 1:1, contrary to policy and the PowerPoint training presentation in Finding 15.b., slide 20, which reflected, "The staff's focus is and should only be the 1:1/patient". This was not called out in Finding 15.c., review of the video as a learning tool. Additionally, when the staff began the "hands on" event, the PNM briefly placed their hand on the patient's neck, contrary to the hospital's training as described in Finding 15.b., slide 10 which noted, "No direct pressure may be placed on the patient's joints, spinal column, neck ... per OSH policy 6.003." The review of the video in Finding 15.d., did not address the PNM's hand on the patient's neck, but described it as "PNM puts hand on right shoulder of patient ". More importantly, after the aggressive behavior, the patient was escorted by two staff members using a manual hold technique, however, the patient was not seen struggling against the staff escorts. It was was unclear whether Seclusion was the correct intervention for the patient at that time, or whether the seclusion was being used as punishment for the aggression toward staff, contrary to hospital policy, 6.003 in Finding 13.c.

16.a. During interview and review of training documentation with the DSC, CS, SE/OPA2, DHR, and other hospital staff on 03/31/2025 beginning at 1315, the SE/OPA2 confirmed that First Aid training specific to Seclusion and Restraint (Safe Together) was not offered. They stated that nurses, by training, already had the skills neccessary to render first aid to a patient in

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A 093	Continued From page 68 the event of an injury while in seclusion or restraint. 16.b. An email to the TDM on 04/11/2025, the TDM was asked whether First Aid education was offered in the "Safe Together" classes. The TDM responded on 04/11/2025 at 1647, "Safe together does not cover that. It is my understanding that we have CPR for all staff through LDD we do not have standardized, first aid training in addition to that as far as I know. The reasoning that I have heard was that every MHT is working under the license of a nurse who has more training than basic first aid therefore it's covered." **********	A 093		
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: ********** Based on observation, review of video recordings, interviews, review of incident and medical record documentation for 17 of 17 patients (Patients [redacted]), review of OSH internal investigation documentation, review of training documentation for 23 of 23 Direct Care nursing staff (RN C, RN D, RN E, RN F, RN G, RN R, RN T, RN U, RN W, RN Z, RN AA, RN EE, LPN H, LPN P, LPN Y, MHT J, MHT S, MHT Q, MHT V, MHT X, MHT BB, MHT CC, and MHT DD), review of training curriculum and training media, and review of P&Ps it was determined that the hospital failed to fully develop and implement P&Ps that ensured patients' rights were protected	A 115		

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A 115	Continued From page 69 and promoted. The hospital's failures potentially contributed to [redacted] and created the likelihood of harm to other patients. The cumulative effect of these systemic failures resulted in this Condition-level deficiency that represents a limited capacity on the part of the hospital to provide safe and adequate care. [redacted]. On 03/31/2025 the hospital was notified that an IJ situation had been determined to exist. Refer to Tag A-093 for the details of the IJ identification, IJ notification, IJ Removal Plan approval, and IJ Removal Plan Verification Visits. A third IJ Removal Plan Verification Visit was conducted on 05/12/2025 and the IJ was determined to be removed. Findings include: 1. Refer to the findings cited under this CoP, CFR 482.13(b) - Standard: Exercise of Rights. Those findings reflect the hospital failed to inform a patient of their health status in a timely manner and failed to have system to ensure that for all patients (Tag A-131). 2. Refer to the findings cited under this CoP, CFR 482.13(c) - Standard: Privacy and Safety. Those findings reflect the hospital failed to ensure the provision of care setting (Tag A-144).	A 115		

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A 115	Continued From page 70 3. Refer to the findings cited under this CoP, CFR 482.13(e) - Standard: Restraint or seclusion. The hospital failed to ensure patients' rights to be free from seclusion and restraint (Tag A-154). 4. Refer to the findings cited under this CoP, CFR 482.13(e) - Standard: Restraint or seclusion. The hospital failed to ensure that patients in seclusion and restraint were monitored and observed to ensure their safety (Tag A-175). 5. Refer to the findings cited under this CoP, CFR 482.13(f) - Standard: Restraint or seclusion. The hospital failed to ensure that training related to seclusion and restraint was conducted appropriately (Tag A-199 and Tag A-206). **********	A 115		
A 131	PATIENT RIGHTS: INFORMED CONSENT CFR(s): 482.13(b)(2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: ********** Based on interview, review of incident documentation for 1 of 1 patient ( ), and review of other documentation it was determined	A 131		

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A 131	Continued From page 71 the hospital failed to fully develop and implement clearly written policies and procedures to ensure the patient's right to be informed of their health status. Results of outpatient testing completed were not provided to the patient in a timely manner. 1. Incident report with "Incident ID" "[redacted]" reflected "[redacted]/2025, [redacted] went to an outside medical appointment at Salem Health for an ultrasound. On [redacted]/2025, [redacted] became verbally upset, stating that it has been two weeks since Salem Health sent the results of [their] ultrasound to OSH, and [they have] not been notified of the results. [redacted] had called Salem Health to check on the status of [their] appointment. [NM] then walked to the medical clinic, and asked the staff if they had the results of the ultrasound, and they were able to immediately print me off the results. [NM] immediately notified [redacted] of the results, and [they] remained agitated that no one has let [them] know for the past two weeks. [NM] reviewed [redacted] Avatar chart, lab results, progress notes, client health maintenance, and [redacted]] blue chart, and there was no documentation of the results of [their] ultrasound anywhere." 2. During interview with DMNO on 04/08/2025 starting at 1400 they provided the following information regarding the process for how patients that had outpatient testing receive results: *The process is to have the medical clinic MD notify the patient by going to the unit or making an appointment for the patient to come to the clinic. *The MD is supposed to document an "MD General Note" in Avatar that they gave the patient	A 131		

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the results or any other meeting with a patient.
*This is not a new process and the only issue was results being sent to email instead of the medical clinic receiving a fax.
*There are no policies and procedures describing the process.

3. An undated document titled "Clinic communication from units survey" reflected:
*"It is public knowledge that when a patient has a medical concern or request to call the medical clinic. The provider, after they view the results, schedules an appointment with MA."
*"The below are the results from a survey sent to Trails, Crossroads, Bridges, Pathways NM & UAs."
*Question: "Is this your understanding of the process (make appointment with the provider to obtain results)? If so, how is it working?"
"A. This is not my understanding of the process. I have worked on many units."
"B. No, each provider that I have worked with seems to have a different understanding of what the process is and how they would personally like things to work. I have worked here for 14 years and there has never been a clear process with the clinic. Many times, clinic processes will be decided within the clinic, but not communicated to the units. I would also like to point out, if the unit is unaware that procedural results have been received, how would they know to make a follow-up appointment."
"C. While making an appointment to review results makes sense and would be ideal this only works if the results are sent to the unit so they know results are in to make an appointment. Also there's the challenge that covering providers may not be willing/able to review results with patients and defer to regular provider ..."

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A 131	Continued From page 73 "D. During monthly meetings with providers, the provider will review the recent results sometimes, like if they are for medication levels or ones they have ordered. If not, I am not sure how the patients are notified." "E. For years it has involved calling the clinic over and over again, trying to contact the providers directly, typically unsuccessfully. Leaving messages only sometimes receiving a response." "F. It is hard to get our patients in to see a provider in the clinic and I don't think they schedule appts to review ... the lab results." "G. It was not my understanding that it's the responsibility of the unit to schedule a follow-up appointment with the med clinic provider to review results. A hospital-wide communication sharing a med clinic process update would be helpful." *Question: "Is there a process? Is it working?" "A. It is not working." "B. There is no process ..." "C. There isn't a standard process." "D. Current state, result is being printed on unit printer, RN put it in the unit provider box, Unit provider review, sign and OS2 filling them. If it is urgent, RN notify provider immediately ... Medical provider goes over result with patient ..." "E. Whatever the process is, it does not work." **********	A 131		
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: ********** Based on observation, interview, review of video recordings, review of incident and medical record	A 144		

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A 144	Continued From page 74 documentation for 17 of 17 patients ([redacted]), and review of P&Ps it was determined that the hospital failed to fully develop and implement P&Ps that ensured each patient's right to receive care in a safe setting. The hospital's failures included: [redacted] * Failure to observe and monitor patients in seclusion to prevent the presence of contraband, prohibited items, and the alteration of items in the seclusion room that could be used for patient self-harm or as potential weapons. * Failure to ensure that patients without behaviors and physician's orders for locked seclusion were not subject to locked seclusion. [redacted] was accidentally locked into a seclusion room overnight, and no provisions to prevent recurrence were planned. * Failure to ensure that oxygen was readily available for medical emergencies. * Failure to provide for the vision and optometry needs of patients to ensure patient safety. * Failure to provide safe and appropriate care that prevented patient injury and harm. The hospital	A 144		

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failed to provide necessary DME to prevent injury during seizures.
* Failure to timely assess and reassess patients who were on Enhanced Supervision to ensure patient safety for medical issues and concerns.
* Failure to thoroughly assess and reassess patients after falls, and to implement corrective actions to prevent recurrence.
* Failure to ensure that complex patients with medical comorbidities were assessed timely and monitored by a medical physician 24 hours a day, seven days a week.
* Failure to ensure medical documentation was accurate, timely and available for other clinical staff providing direct care to patients with medical comorbidities.

Findings include:

1. [redacted].

2. For [redacted] refer to the findings under Tag A-175 that reflect the lack of safe and appropriate care in locked seclusion.

3. For [redacted] refer to the findings under Tag A-154 that reflect this patient who had no behaviors or orders that required locked seclusion was "accidentally" locked in a seclusion room for several hours overnight.

4. [redacted] had a fall in a seclusion room on [redacted]2025 at 2221. The Falls Assessment dated and signed on [redacted]/2025 at 0422 was incorrectly completed and failed to capture relevant information to inform the fall risk score. The

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history of falls was recorded as "No"; and the number of medication classifications contributing to fall risk was recorded as "0." However, the patient had a fall [redacted]/2025; and they were on at least four medications that could increase fall risk.

5. [redacted] had access to the bathroom in the locked seclusion room and was allowed to engage in the unsafe behaviors of standing on the toilet and covering the monitoring camera with wet toilet paper. The 1:1 staff assigned to the seclusion room anteroom documented on the "Emergency Seclusion or Restraint Flowsheet" for [redacted]/2025 during the 1400 hour that the patient "Placed toilet paper on camera placing an abundance of toilet paper in toilet and continuously flushing ... wet toilet paper and is trying to cover cameras ... standing on toilet. Hitting head on door and punching face."

6. [redacted] was allowed to possess unsafe items that created a risk for harm to themselves and others. The 1:1 staff assigned to the seclusion room anteroom documented on the "Emergency Seclusion or Restraint Flowsheet" for [redacted]/2025 at 0645 that the patient was "using a spoon as a knife and stabbing the [anteroom] window ... using spoon to puncture mattress." A progress note signed by an RN later that same day, on [redacted]/2025 at 1555, reflected that "Patient remains in locked seclusion ... Staff ... removed a broken plastic spoon and a urinal handle that had been broken off the urinal."

7. [redacted] was allowed to possess altered items in the seclusion room that they used for self-harm, or that had potential for harm to self and others. On [redacted]/2025 at 1600 incident

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documentation reflected that the patient had an "altered patient toothbrush ... used by [redacted] to self harm on their arm." On [redacted]/2025 at ~ 0900 multiple incident reports reflected that the patient had a "white cylindrical object with a pointed end and [they] struck the metal bathroom counter with force. The object did not bend or break." The incident documentation described the object as a patient pen that had been wrapped in multiple layers of paper and soaked in an unknown brown substance that created a rigid cylindrical object with a pointed end.

8. Refer to the findings cited at Tag A-0093 under CFR 482.12(f)(2) Emergency Services that reflect the hospital failed to develop and implement P&Ps that ensured oxygen was readily available for medical emergencies, including for [redacted].

9.a. Review of an IRF regarding [redacted] with incident date [redacted]/2025 reflected "... patient approached myself and MHT's during Lead viability rounds, complained of bleeding on the center/parietal side of [their] head. Observed what seemed to be dried up blood of unknown origin ... Brought patient to the exam room ... assessed and cleaned area, unit provider notified ... Observed mild redness and tenderness on the surrounding tissue. Observed dark and dried blood and scabbing ... Patient reports pain from area upon palpation. Patient was alert and oriented X 4 ... Continues on fall protocol for possible unwitnessed seizure/fall on previous shift ... Patient to be referred to medical clinic for follow up on wound care."

9.b. In an email regarding [redacted] sent to Physician K from a DNS, the DNS wrote "I wanted to bring up a situation that I am hoping to

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A 144	Continued From page 78 be able to get a solution to. [redacted]. Please let me know if this is an option that we could provide or if anyone has any other thoughts on how we could expedite any solutions. 9.c. The response to the DNS' email in finding 3 from Physician K dated [redacted]/2025 at 1109 reflected only "[redacted]." 9.d. During interview with the DMNO on 04/08/2025 beginning at 1330 regarding the Medical Clinic's optometry services, the DMNO stated that the "wait list is quite lengthy" and "it could take up to 8-10 weeks to get an appointment." 9.e. Review of Medical Clinic optometry services P&Ps reflected they were outdated and did not ensure current optometry needs of patients would	A 144		

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A 144	Continued From page 79 be met. Examples included: 9.f. The P&P titled "Optometry Clinic" dated last revised 12/02/2011 and last reviewed 10/07/2016 reflected: * "Scheduling appointments in the Eye Clinic Appointment Book on Tuesday and Thursday mornings ... Follow-up intra-ocular pressure checks, eye infections, or other non-exam appointments can be scheduled as well generally in the 10:30 a.m. slot ... Schedule repairs, dispensing and adjustments as the clinic schedule allows ... Call the unit the day before the appointment to verify." * "Ordering ... When the exam is complete, check the patient's exam form to see if glasses were prescribed ... If glasses were not prescribed, file the form ... If there is a prescription indicated, determine whether the patient is requesting any non-medically necessary options ... Patients are typically entitled to one pair of glasses with frames and lenses per year. Exceptions can be made at the discretion of the interdisciplinary treatment team or social worker on a case-by-case basis." * "Dispensing ... When the glasses come in, place the glasses in the correct tray and call the unit to arrange for pick-up ..." The P&P had not been reviewed or revised in nearly 10 years and did not ensure current needs of patients would be met. 9.g. The P&P titled "Optometry Funds" dated last revised 05/13/2013 and last reviewed 10/07/2016 was reviewed. The P&P had not been reviewed or revised in nearly 10 years and did not ensure current optometry needs of patients would be met.	A 144		

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A 144	Continued From page 80 10.a. [redacted] the hospital failed to ensure [redacted] was provided in a timely manner. 10.b. Incident review form with "Incident Report Number [redacted]" for [redacted] reflected that on [redacted]/2025 "During the top of the 1500 hour, patient approached [staff member] and MHT's during Lead viability rounds, complained of bleeding on [redacted] of [their] head. Observed what seemed to be dried up blood of unknown origin. Patient reported that [they noticed] this when [they were] combing [their] hair. Brought patient to the exam room and [RN] assessed and cleaned area, unit provider notified ... Continues on fall protocol for possible unwitnessed seizure/fall on previous shift. Patient has been compliant with Neurological assessments. Assessments within normal range." "Document immediate actions taken: Wound Asseded [sic], Unit Provider notified, Med clinic notified [redacted], Patient all ready [sic] on Close Observation [redacted] 10.c. During interview with DMNO on 04/08/2025 starting at 1326 they provided the following information regarding the process for obtaining DME: *There is a new process. Staff on the units used to order equipment but now the order is faxed to the medical clinic. *If it is in stock, the item is delivered such as an arm sling. *If the item is not stocked the CM takes the order and works with the MD to find the right item on the vendor website. An order to the vendor is placed. Usually takes 1-2 weeks to get the item. *A product risk assessment is completed. When	A 144		

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the item arrives, it is taken to the unit by the CM with the Risk Mitigation Form completed by the safety department that describes unit recommendations for potential patient specific self-harm or harm to others.
*The CM completes teaching with the patient and staff, including the Lead RN and Unit Manager. The CM documents to close the loop, in Avatar, who was educated and who received the item.
*There is no policy for this process currently. It is still being built.

11.a. There were no clear provisions for two-way hand-held Siyata radios to ensure the radios are maintained, checked out or tracked on each unit. The hospital had not developed or implemented a policy for assigning, distributing, or maintaining the radios.

11.b. During interview with FL3 CN on 04/08/25 starting at 1500 the following information was received: The following staff should have a radio on their shift; an MHT if transporting patients; MHT in an anteroom watching a seclusion patient and any staff going outside the unit with a patient or patients.

11.c. During interview with DCNO on 04/08/2025 at 1506 they stated there is no process for assigning, distributing, or maintaining the radios. Staff "grab them as they need them" and nobody is assigned to make sure they are charged. They also stated that because CMS came, OSH was allowed to order radios for each unit's anteroom.
12. Refer to Tag A-450 for Patients [redacted] that reflected the following failures for those patients:
* Failure to provide safe and appropriate care that prevented patient injury and harm. The hospital

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A 144	Continued From page 82 failed to provide necessary DME for [redacted] * Failure to timely assess and reassess patients who were on Enhanced Supervision for medical issues and concerns. * Failure to thoroughly assess and reassess patients after falls, and to implement corrective actions to prevent recurrence. * Failure to ensure medical documentation was accurate, timely and available for other clinical staff providing direct care to patients with medical comorbidities. * Failure to ensure that complex patients with medical comorbidities were assessed timely and monitored by a medical physician 24 hours a day, seven days a week. **********	A 144		
A 154	USE OF RESTRAINT OR SECLUSION CFR(s): 482.13(e) Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. This STANDARD is not met as evidenced by: ********** Based on interview, review of incident and medical record documentation for 9 of 9 patients (Patients [redacted]), review of training documentation for 23 of 23 nursing staff (RN C, RN D, RN E, RN F, RN G, RN R, RN	A 154		

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A 154	Continued From page 83 T, RN U, RN W, RN Z, RN AA, RN EE, LPN H, LPN P, LPN Y, MHT J, MHT S, MHT Q, MHT V, MHT X, MHT BB, MHT CC, and MHT DD), review of training curriculum and media, and review of P&Ps it was determined that the hospital failed to ensure patients' rights to be from seclusion or restraint, that restraint or seclusion was imposed only to ensure the immediate physical safety of the patient or others, and that when imposed it was discontinued at the earliest possible time. The hospital's failures related to patients in seclusion or restraint included: * [redacted]'s right to be free from seclusion was grievously violated when they were "accidentally" locked into a seclusion room overnight, and no provisions to prevent recurrence were planned. [redacted] * Documentation of justification for locked seclusion, observation and monitoring, and RN assessment for other patients in long-term seclusion was unclear and inconsistent. * Patients in seclusion were allowed to possess contraband. * Staff did not always exhibit behaviors that demonstrated understanding of the gravity of	A 154		

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A 154	Continued From page 84 seclusion events, and it was not always clear that locked seclusion or the application of mechanical restraint was not a form of discipline, punishment, retaliation, or convenience. * Failure to develop and implement clearly written, effective policies, procedures, and staff training that ensured patient safety and security, and safety of others during seclusion events. * Failure to ensure training curriculum for Seclusion and Restraint was in accordance with hospital P&Ps and offered First Aid as required by CMS regulations. Findings include: 1.a. Review of incident documentation for [redacted] reflected that on [redacted]/2025 at 0530 on the LH3 unit the "[seclusion room] that was unlocked with patient resting in it was locked without staff knowing. Thus restricting patient without orders ... RN unlocked [seclusion room] door as soon as it was discovered to have been locked by accedent [sic] ... [redacted] slept through the shift with no notable observed behavioral or medical issues. Patient attempted to leave [seclusion room] at 0535 and found the door had been locked sometime during the shift. Immediate Action(s) RN unlocked the [seclusion room] door for patient at 0540. RN reported incident to PNM and OD." 1.b. On [redacted]/2025 at 0740 an RN signed a progress note that reflected "1:1 BP [sic] maintained this shift. Received patient in unlocked side room. Patient slept through the shift with no notable observed behavioral or medical issues. Patient attempted to leave side room at 0535 and found the door had been locked sometime during the shift. RN unlocked the side room door for patient at 0540. Slept 6+	A 154		

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A 154	Continued From page 85 hours." 1.c. On [redacted]/2025 at 1612 a DO signed a psychiatry note that reflected "The patient was seen with the treatment team today. On multiple occasions, [the patient's] responses were initially relevant and reality based before becoming illogical and disorganized ..." The note contained no reference that reflected [redacted] had spent the night in a locked seclusion room. The DO's notes signed on [redacted]/2025 at 0826 and [redacted]/2025 at 1531 also lacked reference to the seclusion room. 1.d. [redacted]'s Treatment Care Plans and Treatment Care Plan Addendums were reviewed: * [redacted]'s Treatment Care Plan signed on [redacted]/2025 at 0832 lacked reference to the patient use of unlocked seclusion room for "resting." * [redacted]'s Treatment Care Plan signed on [redacted]/2025 at 1432, after the patient's right to be free from seclusion was violated, included no reference to that incident and no provisions to ensure it did not recur. The plan of care stated, "Diarrhea - [redacted] is experiencing diarrhea multiple times daily ... [In their] room multiple pieces of clothing contaminated with fecal matter scattered on the floor as well as fecal matter spots on the bed frame and floor. When out of [their] room, the patient had been sitting in the common areas, including on tables and counters, in clothing contaminate with feces. Additionally, [they have] not maintained personal or hand hygiene and has been reported to remain in soiled clothing for prolonged periods of time ... the patient's room was moved to the unlocked side room as means of limiting contamination of the common areas, potential exposure to	A 154		

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infection, and biohazard risk. The patient was also placed on 1:1 observation to assist in prompting [them] to maintain hand hygiene and to change from soiled clothing."
* Treatment Care Plan Addendums dated [redacted]/2024, [redacted]/2024, [redacted]/2024, [redacted]/2024, [redacted]/2024, [redacted]/2025, [redacted]/2025, [redacted]/2025, [redacted]/2025, and [redacted]/2025 all lacked any indication that the patient was "moved to the unlocked [seclusion room]."
* The plans of care and plan of care addendums failed to identify when this significant plan of care change had been made; failed to describe a clear plan for use of the seclusion room as the patient's room including the use of furniture, a bed, and patient belongings; and failed to ensure there was a plan to prevent the patient from being inadvertently locked in the seclusion room. Once the incident had occurred on [redacted]/2025 the plan of care and addendums failed to address that incident and further failed to include plans to prevent recurrence.

1.e. Review of the "Unit Patient Census and Status Flowsheet" rounding record dated 02/18/2025 for the hours of 0000 to 0600 reflected for [redacted] that their status at the top of each hour was "S." The flowsheet "Key" specified that "S = Seclusion Room (Locked or Unlocked)." There was no documentation on the record to reflect whether the seclusion room was required to be locked or unlocked, nor documentation to reflect whether the seclusion room was actually locked or unlocked at each of those checks.

1.f. An OSH internal email from the LH3 Unit Administrator to the staff assigned to 1:1 observation of [redacted] in the unlocked

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A 154	Continued From page 87 seclusion room was dated [redacted]/2025 at 1606. It stated "This is a follow-up to our conversation we had regarding the incident of the Unintended Locked [seclusion room] Door on Monday, [redacted]/25 at 2243. I shared that on Video we can see you open the [seclusion room] Door for [redacted], [they go] and [lay] down, you say something to [them], then you close the door and lock it and return to the Ante Room to continue the 1:1 Observation. [redacted] attempted to exit the room on Tuesday, [redacted]25 at 0530 but the door was locked. The [night RN] unlocked the door and submitted the Incident Report, which led me to watch the Video. You admittedly said you did not even realized you had locked the door until I explained the event, step by step, then you pictured in your mind the exact moment when you locked the door. You shared that you 'remembered that you opened the door for [redacted] and left your keys in the door while holding the door open for [them] then after closing it you turned the key to lock, just in habit, then returned to the Ante Room'. You shared that 'you were very sorry and that you will make sure that this will not happen again'. I assured you that mistakes happen, but we can only fix them if people are willing to admit to them so that we can figure out where the breakdown occurred. Again, you do not have to share this with anyone of your coworkers, but I will be sure to follow-up with the [night shift] to assure that the SSM [Unit Safety and Security Management] Checks are getting done correctly. From 2300-0500, the SSM Checks were scheduled and done. However, none of which caught the fact that the [seclusion room] Door was locked. So this was also a systems breakdown, as this should have been caught shortly after it had happened."	A 154		

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A 154	Continued From page 88 1.g. Incident review documentation dated [redacted]/2025 and untimed reflected "[redacted] is currently using the unlocked seclusion room due to medical issues. Pt. is currently on a 1:1 medical. Pt. had been in the unlocked seclusion and then came out and sat in the hallway. At approximately 2243 Pt. returned to seclusion room. Staff locked the seclusion room after patient entered. Pt. slept until approximately 5:45 and tried to exit the seclusion room and found it locked. Staff unlocked the door and Pt. exited. Viability checks were performed through Ante room window. 1:1 staff had constant visual of Pt. It appears that staff (out of habit) locked the door after the pt. entered." The documentation reflected the following investigation and outcome: * "Immediate actions taken:" were documented as only "Pt seclusion room unlocked" and "Interview/ Education with staff." * In the section for "Select all contributing factors identified during this review" the only boxes checked were under the heading of "Human Factors" and were "Distraction/Interruptions" and "Procedures not followed." Factors not identified as contributing included "Communication Factors" and "Environmental Factors" and "Management/Supervisory/Workforce Factors" and "Task/Process Factors" and "Team Factors." * For "How did you investigate those factors?" was listed "Staff interview" and "Document review" and "Video review." * "Immediate Actions Reviewed" was checked and the question "Were actions appropriate to provide added patient or staff safety?" was answered "Yes." * For "What additional actions were taken in response to this incident in order to resolve the incident and prevent reoccurrence?" The only action identified was "Event documented in	A 154		

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A 154	Continued From page 89 [electronic health record]." * For "Safety and Risk Mitigation" the only action was "Staff education." There was no indication that policies, procedures, processes, communication, and other systems had been evaluated to identify gaps that led to the patient being inappropriately locked in seclusion. The incident investigation did not include that there were other staff also assigned to the 1:1 observation of [redacted] during the night after the staff person who had locked the patient in the seclusion room and that none of those staff identified that the seclusion room was locked. [redacted]'s right to be free from seclusion was violated for several hours and there were no corrective actions taken to ensure that did not recur for that patient or for other patients who may use the seclusion rooms voluntarily. 1.h. In response to the request for a hospital policy and procedure "that addresses use of a seclusion room to replace the patient's regular inpatient room" the DSC stated in an email received on [redacted]/2025 at 1157 that "We don't have an OSH policy or protocol that addresses using the Seclusion Room in lieu of the patient's bedroom." 2. For Patients [redacted] refer to the findings identified under Tag A-175 that reflect the seclusion and restraint occurrences, events, and incidents for those patients. 3. Throughout the survey it was noted that staff used the term "side room" in place of "seclusion room" frequently during interviews and interactions, in medical record documentation, and in training materials. It was unclear why the	A 154		

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A 154	Continued From page 90 hospital chose to use "side room" when policies and procedures and protocols used the term "seclusion room." The use of "side room" verbiage may have eliminated the stigma of a "seclusion room" and as a result downplayed the significance of patients' rights to be free from seclusion. That language may have contributed to the overuse of seclusion, the use of long-term seclusion, and the lack of staff and patient recognition and awareness that when patients were in those rooms their rights were potentially being violated. The absence of understanding the critical patients' rights significance of the use of seclusion and restraint, and the inherent risks to patient safety, may have potentially contributed to the lack of staff attention to their duties and responsibilities to those patients. 4. Regarding lack of staff training specific to seclusion and restraint refer to Tag A-199 and Tag A-206. **********	A 154		
A 175	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(10) The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy. This STANDARD is not met as evidenced by: ********** Based on review of video recordings, interviews, review of incident and medical record documentation for 8 of 8 patients who were in locked seclusion (Patient	A 175		

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A 175	Continued From page 91 , review of OSH internal investigation documentation, and review of P&Ps and other hospital protocols it was determined that the hospital failed to fully develop and implement P&Ps that ensured each patient's right to receive care in a safe setting and to be treated with dignity and respect, including to provide for ongoing monitoring and assessment of the patient, and appropriate staff response, when seclusion or restraint had been imposed. The hospital's failures potentially contributed to and created the likelihood of harm to patients. The failures for patients in seclusion included: * Failure to prevent staff distractions and ensure staff assigned to the seclusion room anteroom for 1:1 observation provided constant observation and monitoring of patients. . * . * Failures of RN and LIP staff to maintain situational awareness of patients' activities in the seclusion room bathroom and to lock the seclusion room bathroom door	A 175		

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A 175	Continued From page 92 [redacted]. * Failure to prevent the presence of contraband, prohibited items, and the alteration of items in the seclusion room that could be used for patient self-harm or as potential weapons for [redacted] patients. * Failures of nursing and LIP staff to monitor the seclusion room and bathroom EOC and intervene timely for [redacted] patients to ensure floors, walls, and surfaces for patients were free of feces, urine, vomit, other bodily fluids, garbage, food, and contraband that created an increased risk for falls, infection, and self-harm while in seclusion. * Failure to develop coordinated plans in advance for [redacted] patients in seclusion to respond to falls and incidents, self-harm behaviors, unsafe and unsanitary conditions in the EOC, and the use of physical restraints. [redacted] * Failures of 1:1 staff and RN staff to clearly and accurately document [redacted] seclusion and restraint occurrences, including observation, monitoring, response, and assessment of their condition and behaviors, and the application and discontinuation of mechanical restraints, on the "Emergency Seclusion or Restraint Flowsheets" and in progress notes [redacted]. *Failure to ensure that [redacted]	A 175		

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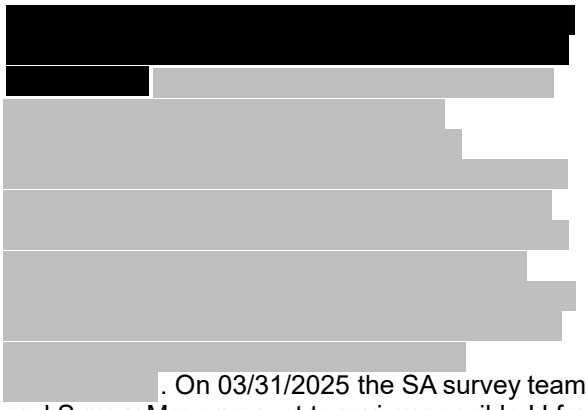
A 175	Continued From page 93 patients were provided with, or offered, aspects of patient care such food and fluids, mobility and ROM, and toileting, and that their physical condition and extremities were monitored and assessed during the additional application of 4-point mechanical restraints while they were in locked seclusion.  . On 03/31/2025 the SA survey team and Survey Manager met to review possible IJ for Tag A-175. On 03/31/2025 IJ was called and hospital leadership staff were presented with the IJ template. Between 04/02/2025 and 04/07/2025 the hospital submitted four versions of the IJ Removal Plan for Tag A-175. The fifth version of the IJ Removal Plan was submitted on 04/08/2025, and was approved with an implementation date of 04/11/2025. On 04/14/2025 an onsite IJ Removal Plan Verification Visit was conducted. The hospital was notified on 04/15/2025 that it was determined the hospital had not fully implemented the IJ Removal Plan. On 04/17/2025 the hospital submitted an IJ Removal Plan Update Amendment and on 04/18/2025 they sent an email to confirm they would be ready for a Verification Visit on or after 04/22/2025. The IJ Removal Plan Update	A 175		

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A 175	Continued From page 94	A 175		

Amendment was approved. On 04/24/2025 a second onsite IJ Removal Plan Verification Visit was conducted. The hospital was notified on 04/25/2025 that it was determined the hospital had not fully implemented the IJ Removal Plan. The survey team conducted the survey exit conference on 04/30/2025. On 05/06/2025 CMS issued the IJ CMS 2567 report to the hospital with the 23-Day Termination letter. On 05/07/2025 the hospital submitted the signed IJ CMS 2567 with the previously approved IJ Removal Plan Update Amendment and a new implementation date of 05/06/2025. On 05/12/2025 the third onsite IJ Removal Plan Verification Visit was conducted. After conferring with the Survey Manager on the afternoon of 05/12/2025 the survey team notified the hospital that it was determined the IJ Removal Plan had been fully implemented and that the recommendation to CMS was that the IJ for Tag A-175 was removed.

Findings include:

1.a. The policy titled "Seclusion and Restraint" dated as approved 02/12/2024 was reviewed. It included the following:
* "Seclusion or restraint may only be used when clinically justified by a behavioral emergency (as defined in this policy) when other interventions have been determined to be ineffective. When used, restrictive interventions must be discontinued as soon as possible."
* "Staff must protect a patient's dignity and protect them from self-injury or injury by others while in seclusion or restraint."
* "The bathroom door may remain unlocked or locked per RN direction or assessment."
* "Before a patient is placed in seclusion or mechanical restraint, a nurse must evaluate the

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patient in person to determine what items they have in their possession. The nurse may allow the patient to keep or to be given an object considered to be safe if the object assists the patient to deescalate, or if the removal of the object would further escalate the patient. 1. Contraband items must be removed from a patient's possession during a restrictive event. 2. Other items may be removed only if there is an imminent safety concern as evaluated by a nurse, psychiatrist, or PMHNP."
* "Patients in seclusion or restraint must be continuously monitored. 1. The RN may delegate continuous monitoring and 15-minute checks to trained, qualified staff. 2. Staff must continuously, directly watch one patient at a time and monitor their agitation, aggression, and physical status. 3. A patient's environment while in seclusion or restraint must be made as comfortable as reasonably possible to aid in reregulation (e.g., elevating the patient's head, providing a blanket or pillow)."
* The "Restrictive Intervention Tasks Timeline" attachment to the policy directed staff to "Throughout the entire event: Continuously monitor, contact RN as needed."

1.b. The policy titled "Use of Seclusion Room Bathroom" dated as approved 08/01/2023 was reviewed. It included the following:
* "The purpose of this protocol is to give nursing staff at Oregon State Hospital (OSH) directions regarding the safety monitoring required when a patient uses the Seclusion Room bathroom."
* "Due to the unavailability of adequate ligature-resistant door hinges and closure devices, doors to Seclusion Room bathrooms present a safety risk that requires mitigation through direct observation."

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A 175	Continued From page 96 * "When a patient is in locked seclusion, the door to the bathroom may be either locked or unlocked based on the assessment of the Register [sic] Nurse (RN) regarding the patient's ability to safely utilize the bathroom. If the door is unlocked: 1. staff must continue required observations if the patient accesses the bathroom ..." 1.c. The policy titled "Restrictive Event Documentation and Reporting" dated as approved 07/22/2024 was reviewed. It included the following: * "The use of any restrictive intervention as defined in OSH policy 6.003, "Seclusion and Restraints" must be closely monitored, documented, and reported." * "Assigned nursing staff must continuously monitor the patient, verbally check-in with the patient when indicated, and document the patient's status utilizing the Emergency Seclusion or Restraint Flowsheet. a. The patient's levels of agitation, aggression, and physical status must be monitored and documented within, but no later than, every 15 minutes. i. For the patient's physical status, staff must monitor their breathing, their comfort level, whether the patient is hot or cold, if they have any numbness or tingling in their hands or feet (if in restraints), and if there are any new signs or complaints of injury. ii. All observations and responses that are unexpected or out of the norm require intervention (within the staff 's scope and training) and notification to the RN. iii. Upon notification of any of the above, the RN must assess the patient and document their assessment on the flowsheet or in a progress note in the patient's EHR	A 175		

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A 175	Continued From page 97 b. The patient's needs for nutrition, hydration, elimination, and exercise must be monitored, met, and documented at least every two hours. c. Throughout the seclusion or restraint event, as appropriate, nursing staff must attempt to complete a review with the patient of the criteria for release, as determined by the RN. Staff must document all attempts to review criteria for release, along with the patient's response, on the flowsheet. d. Patient status, including any attempted review of release criteria, along with the patient's response, must be reported to oncoming monitoring staff. 4. The RN must assess and document the patient's overall status at least once every 60 minutes. This assessment and documentation must include: a. the patient's mental status; b. the patient's physical health and comfort; c. the patient's current risk to harm self or others; d. a determination of whether or not the patient is ready for release, or to be moved to a less-restrictive intervention; e. a review with the patient of the criteria for release and the patient's response; f. patient's level of cooperation; g. a review of the monitoring and care provided and documented by assigned nursing staff; and h. a plan to address any patient needs that have not been met. Note - When documenting hourly status checks of a patient who is not ready for release, the RN must address any instances from the past hour when the patient was rated as 0-1 for Agitation and 0 for Aggression on the same 15 minute check. 1.d. The policy titled "Enhanced Supervision"	A 175		

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A 175	Continued From page 98 dated as approved 01/15/2025 was reviewed. It included a "Policy Attachment - Procedures B: Supervision Practices" also dated 01/15/2025 that included the following: "Supervision During Episodes of Seclusion or Restraint 1. During any episode of seclusion or restraint patients must be supervised at the level of 1:1, irrespective of their supervision order before the seclusion or restraint episode occurred." 2.a. During interviews on 03/26/2025 beginning at ~ 1045, again at ~1145, and at ~ 1345 hospital staff that included the DS, CNO, DCNO, DSC, DQM, DOIM, DOS, DHR, and others confirmed [redacted]. The following information was provided during those sessions: * [redacted]. * All patients in seclusion are assigned a 1:1 staff person who is to observe and monitor the patient continuously through the seclusion room anteroom windows. * [redacted]. * [redacted].	A 175		

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A 175	Continued From page 100	A 175		

[redacted]

2.b. [redacted]

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A 175	Continued From page 101 * . . 2.c. * *	A 175		

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A 175	Continued From page 102	A 175		

[redacted]

2.d. During interview on 03/26/2025 beginning at ~ 1045 with staff that included the CNO, DCNO, DSC, DQM, DOS, DHR, and others, information about the hospital's actions in response to [redacted] was provided and included:
* There were preliminary investigation activities started the night of [redacted]2025 after leadership staff were notified of [redacted].
* On [redacted]/2025 the investigation was begun and immediate corrective actions taken.
* A seclusion and restraint consult team was immediately implemented to address patients who were in seclusion for more than 24 hours.
* Rounding of all seclusion room anterooms was done to identify and correct issues with visibility through the anteroom windows that was limited by papers, signs, and equipment that blocked some of the view.
* An evaluation of camera views in the seclusion rooms and seclusion room bathrooms was conducted and no issues were identified.
* It was unclear whether 1:1 staff in the anteroom had been carrying a hand-held two way radio.
* Staff support was provided.
* Notifications to CMS, the JC, and other agencies were made.
* Review of the patient's medical record was

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A 175	Continued From page 103 conducted. * Extensive video review [redacted] was conducted. * Eleven staff, that included unit staff [redacted] were interviewed. [redacted] * Five multi-disciplinary "response teams" were developed [redacted] 2.e. Video recording [redacted] was reviewed on 03/27/2025 beginning at 1447. During interview staff stated video of this view [redacted] had not been reviewed by hospital staff. [redacted]	A 175		

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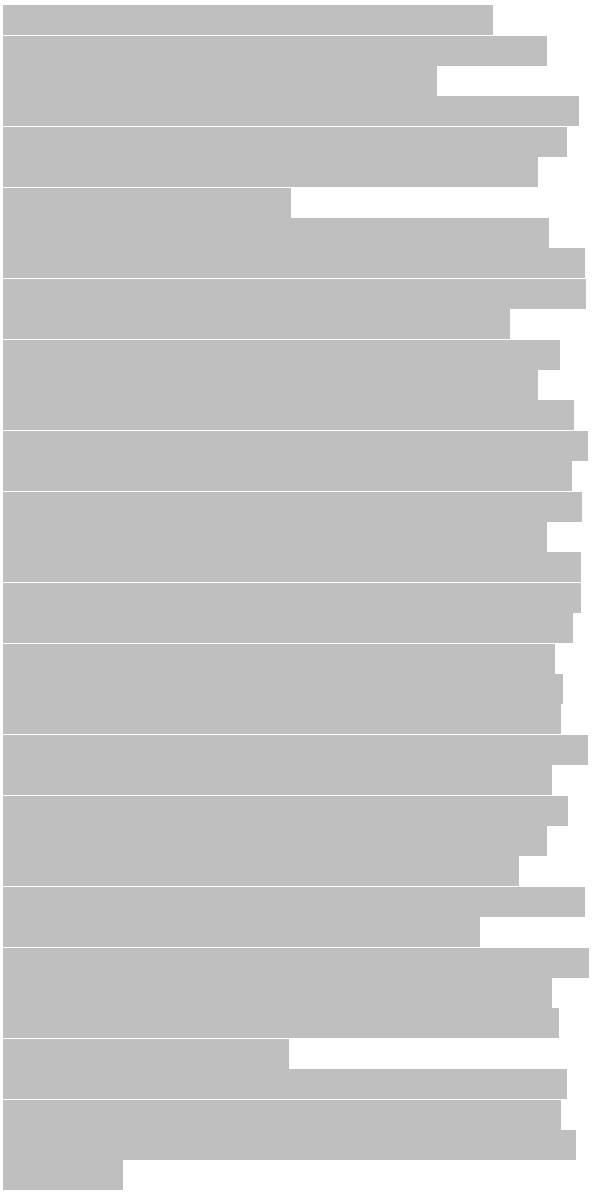

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A 175	Continued From page 105	A 175		

[redacted]

2.f. During interview on 03/28/2025 beginning at ~ 1035 with numerous staff that included the DCNO, DSC, DOIM, DS, COP, and many others,

[redacted] There was no assurance that patients in locked seclusion, with bathroom doors locked or unlocked, would be continuously observed to ensure falls and other incidents were immediately reported and responded to, and that the likelihood of serious injury, serious harm, or death for other patients in locked seclusion had been removed while the

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A 175	Continued From page 106 complex underlying systems' problems were identified and long-term corrective actions developed and implemented. 2.g. Review of hospital investigation documentation reflected that [redacted]	A 175		

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[redacted]

The interview revealed that [redacted]

[redacted]

2.h. Review of hospital investigation documentation information reflected that [redacted]

[redacted]

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL DISTINCT PART	**2600 CENTER STREET NE SALEM, OR 97301**

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A 175	Continued From page 108	A 175		

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A 175	Continued From page 109	A 175		

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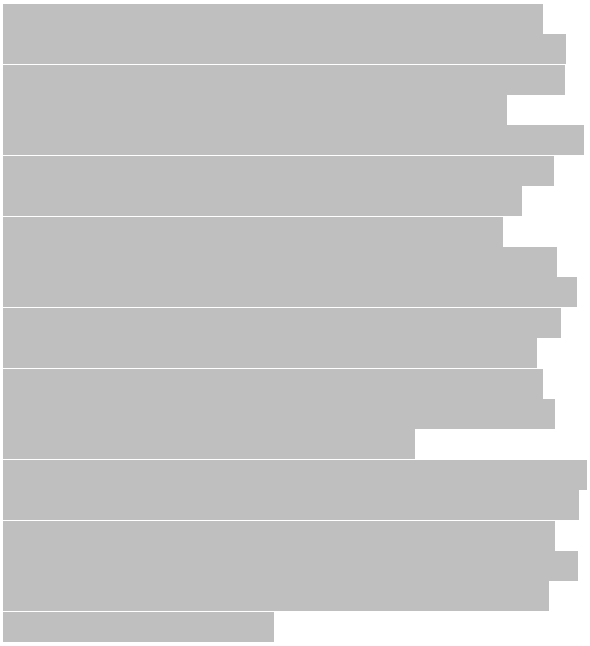
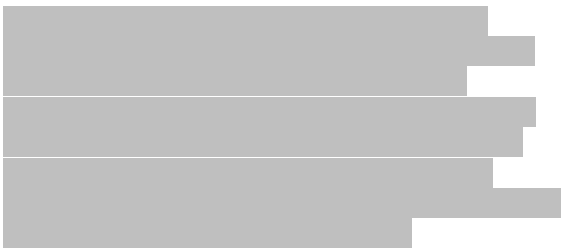
A 175	Continued From page 110	A 175		

*Incident documentation reflected that on





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A 175	Continued From page 111	A 175		

* During interview on 03/27/2025 at ~ 1040 with the DOQ, DSC, and DCNO they stated that staff had "unfettered access" to outside lines on the anteroom desk telephone, and to the internet on the computers in the anterooms. They reported that all computers and keyboards were removed from seclusion rooms the day of the interview, on 03/27/2025, and that just the monitors remained in the rooms on which the seclusion room camera views could be seen.

*There was no reference to staff use of personal cell phones during 1:1 seclusion room observation assignments [redacted] Hospital staff were asked if the use of personal cell phones during 1:1 seclusion observation assignments was allowed. They stated that staff were not allowed to have personal cell phones while on duty.

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A 175	Continued From page 112 Review of the "Protocol" titled "Use of Personal Portable Electronic Devices" that was dated 03/03/2025 revealed the requirement that "Staff may not access or interact with [personal portable electronic devices] while on assignment in a patient care role or while working on a patient living unit ... All non-hospital issued [personal portable electronic devices] must be turned off or set on silent mode and safely stored, preferably in the employee's locker, during the work shift ... If the employee chooses to carry their [personal portable electronic device] on their person, the following rules apply ...The device ... must not be visible to a patient ... The staff member must not answer, or otherwise interact with, the device in a primary patient care area or in the presence of patients ... staff member must not leave a patient care assignment to answer ... without ensuring adequate coverage during the staff's absence ... 'Personal portable electronic devices ...' include, but are not limited to: cellular phones, hand-held computers, book viewers, music players, games ..." The "Protocol" was unclear as it contained clear language that prohibited "access" to and "interaction with" personal cell phones and other personal electronic devices, and it also included language reflecting a preference that staff store those in their lockers, and allowed staff to "choose to carry" those. There was no indication of any system to ensure staff did not use personal portable electronic devices during their patient care assignments, including when assigned to 1:1 observation for patients in seclusion.	A 175		

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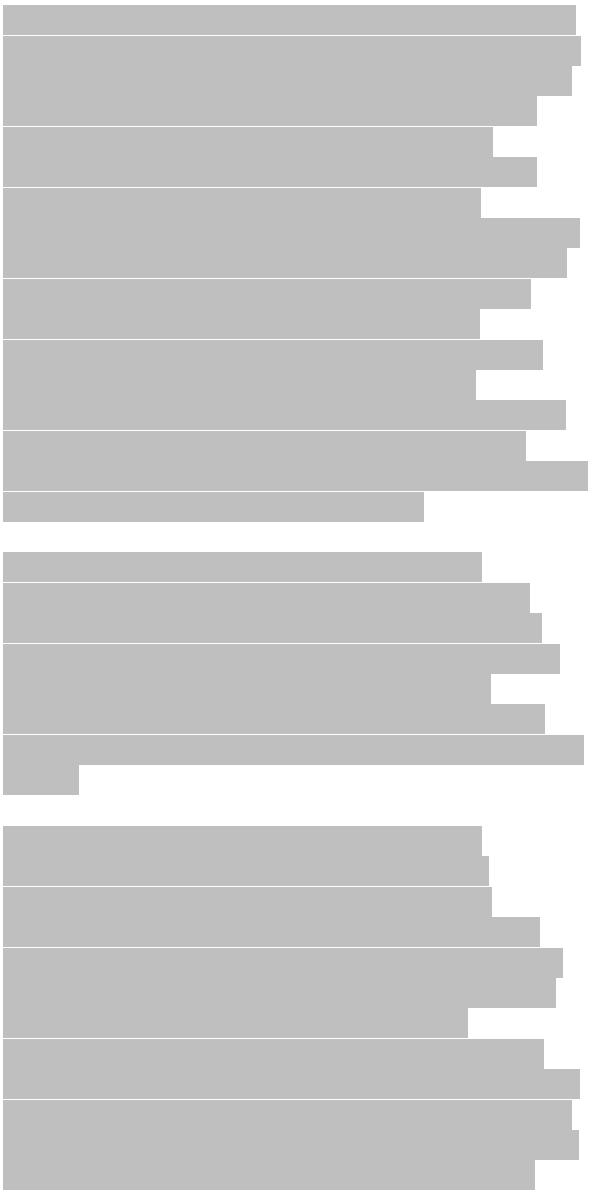
A 175	Continued From page 113	A 175		



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A 175	Continued From page 114	A 175		

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A 175	Continued From page 115	A 175		

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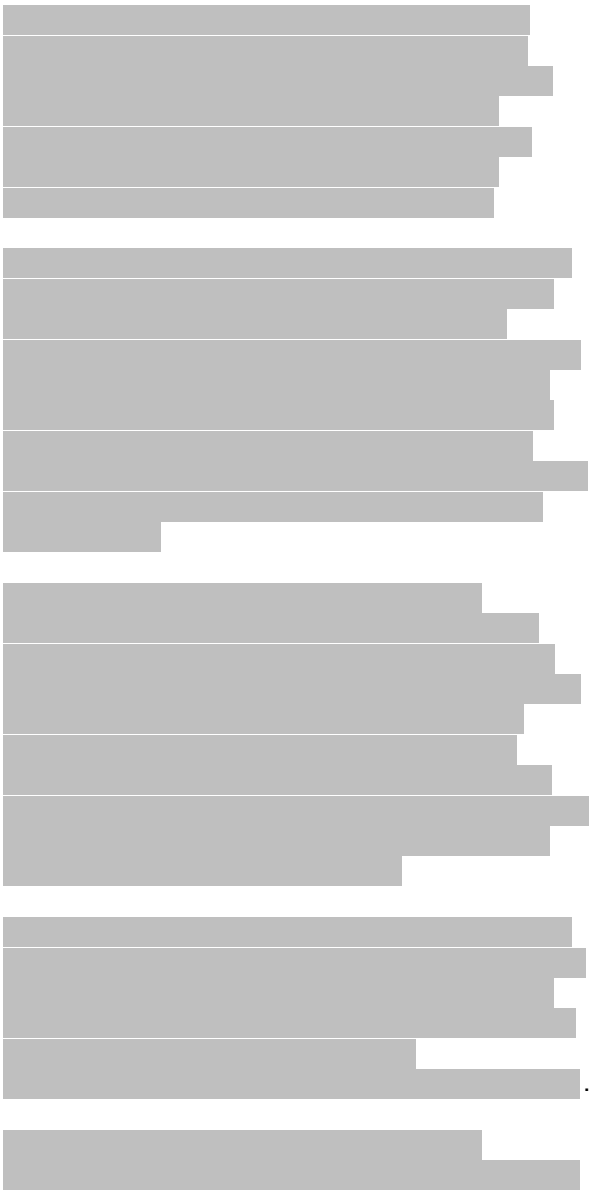
A 175	Continued From page 116	A 175		



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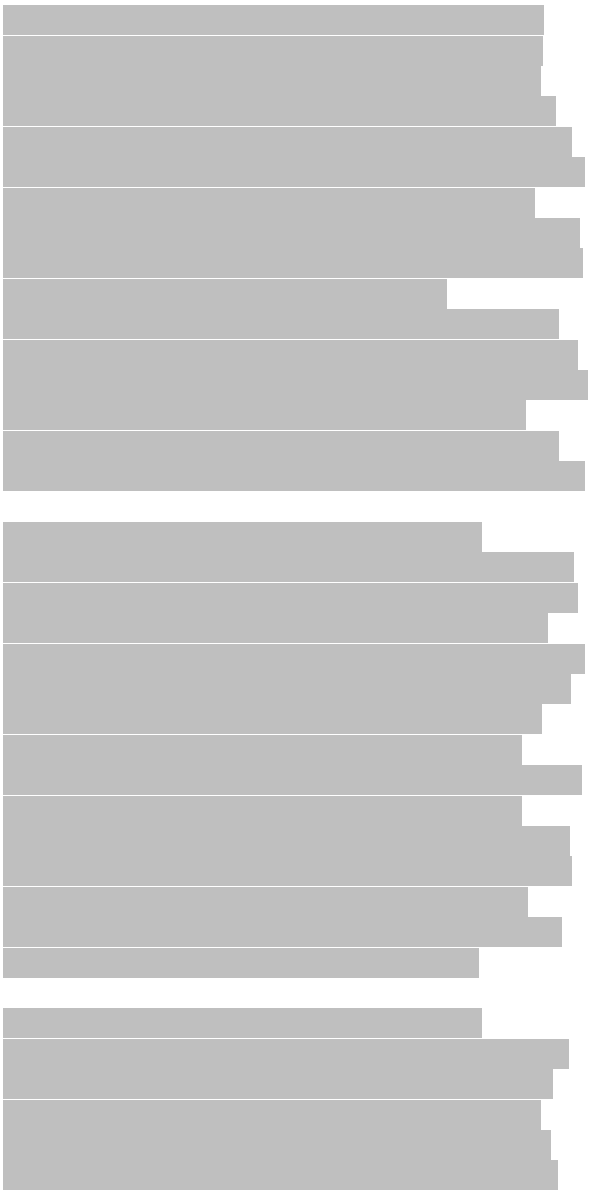
A 175	Continued From page 117	A 175		



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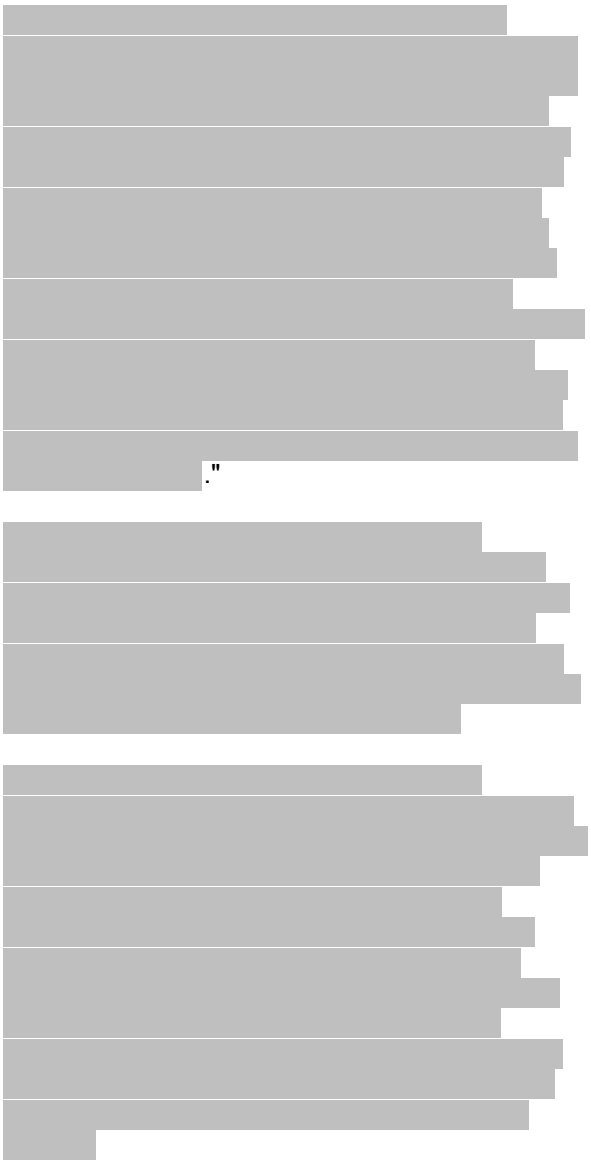

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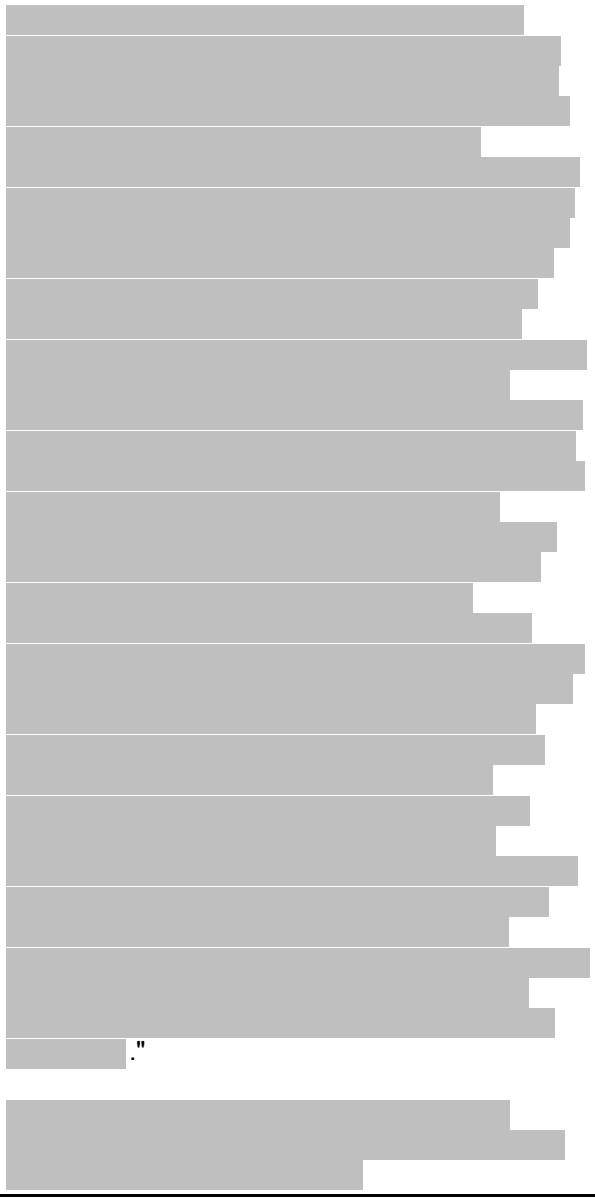
A 175	Continued From page 120	A 175		



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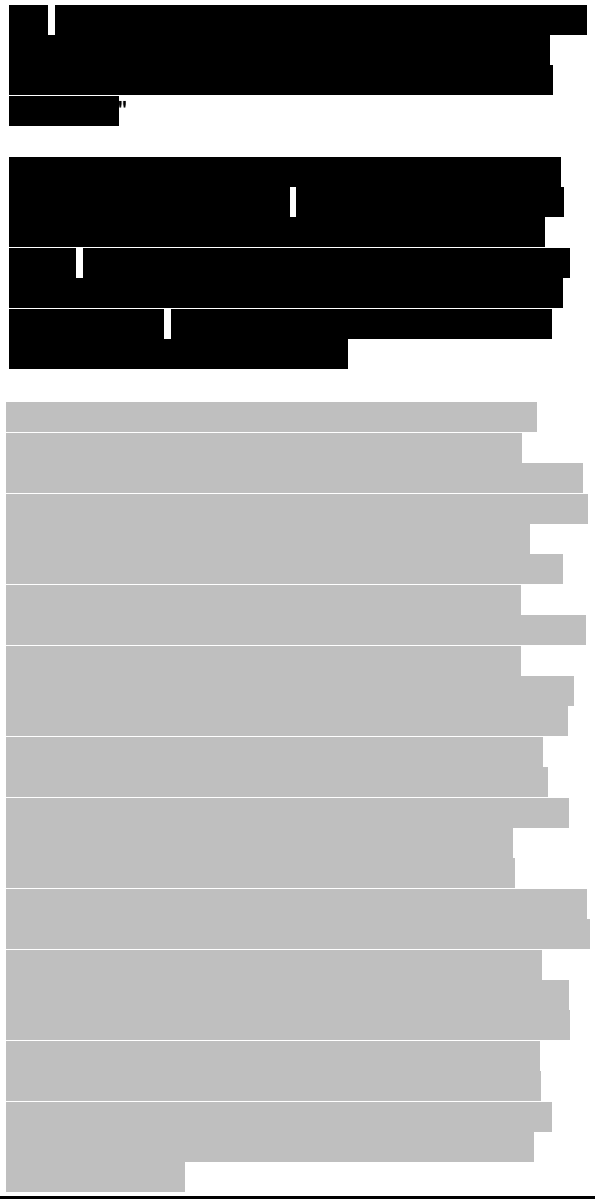
A 175	Continued From page 122	A 175		



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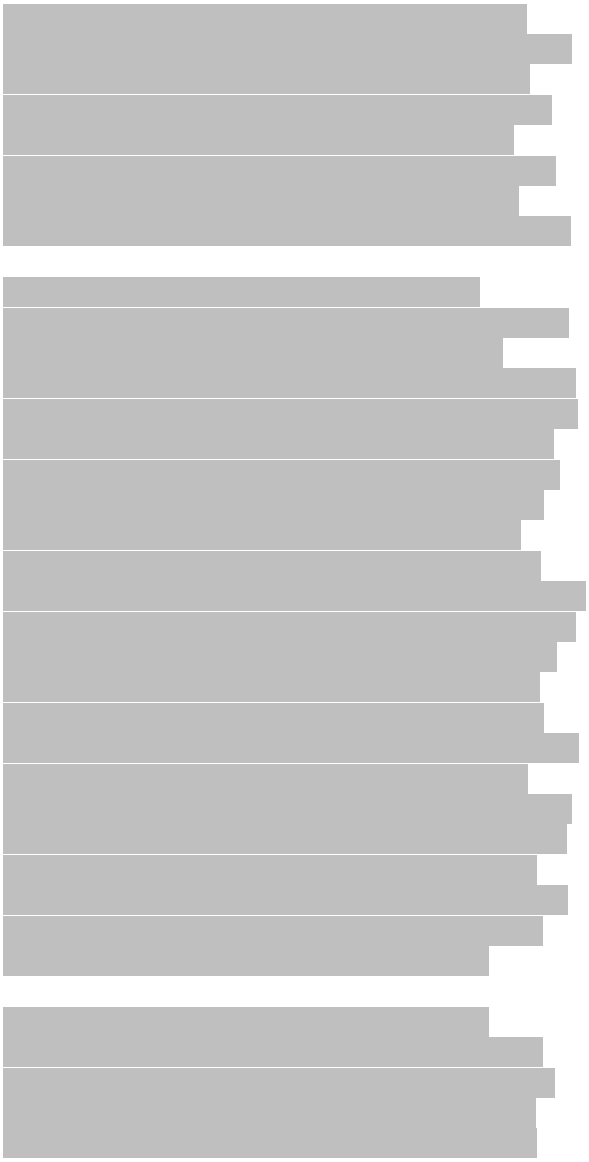

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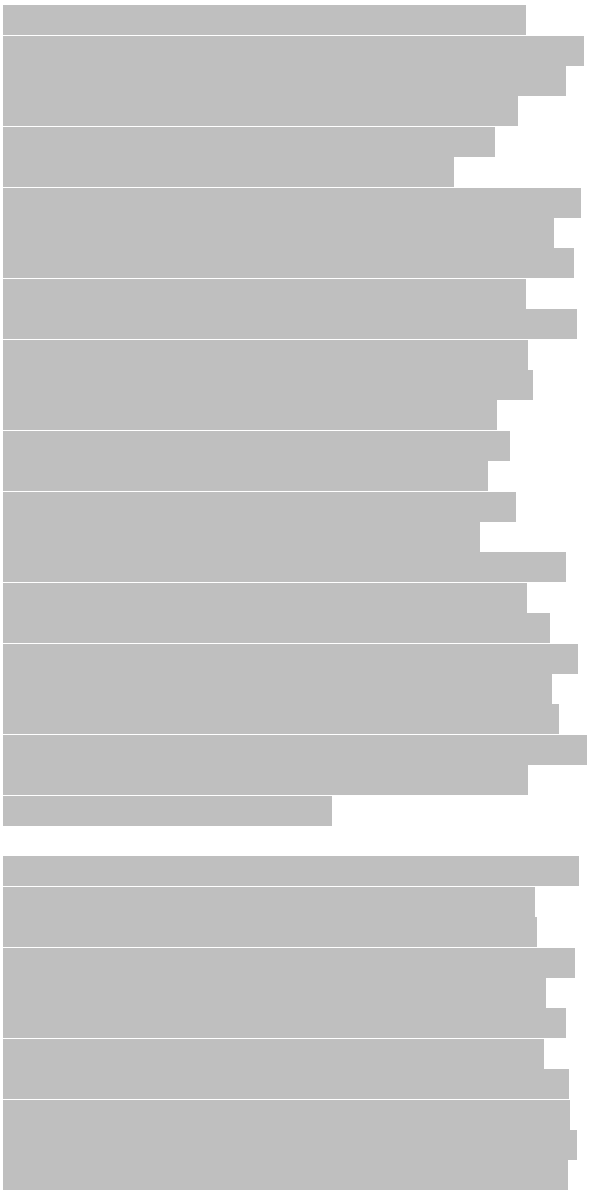

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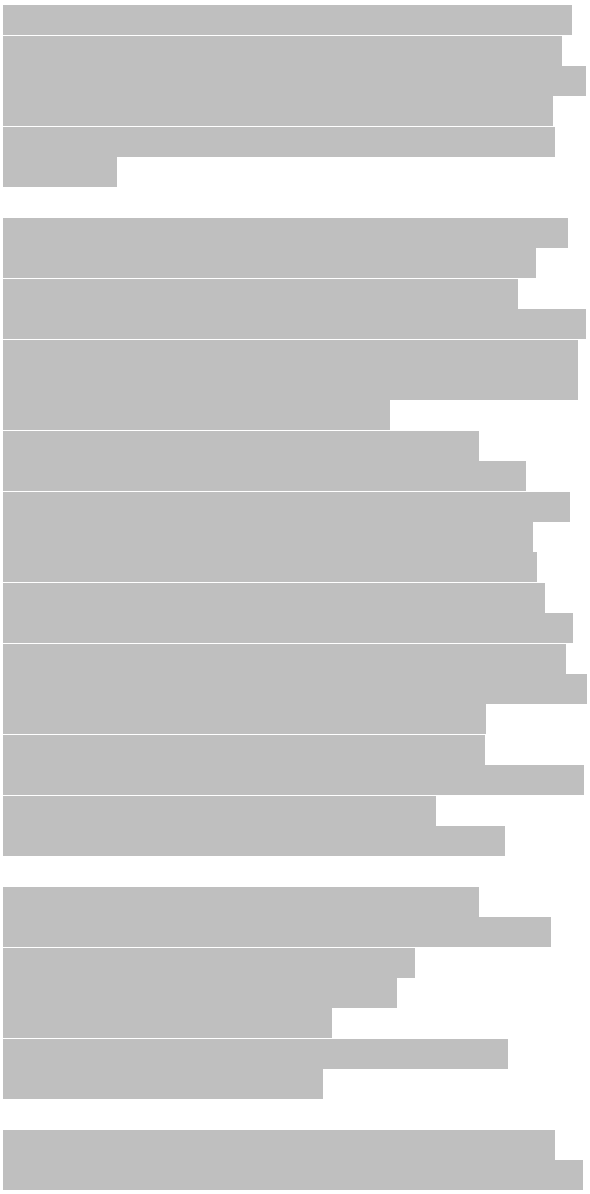
A 175	Continued From page 126	A 175		



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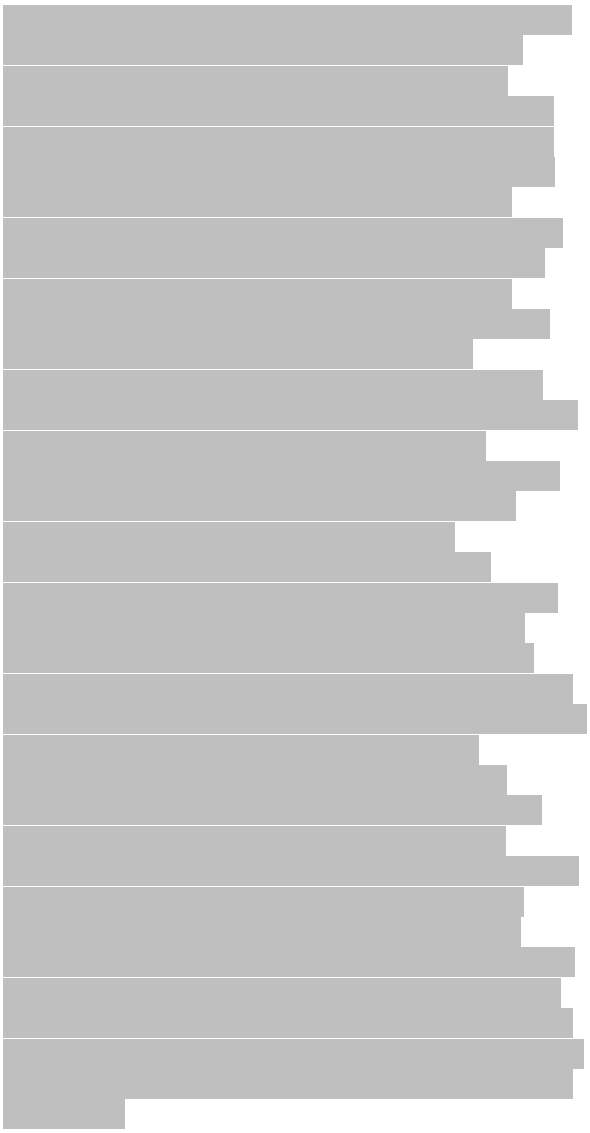
A 175	Continued From page 127 [redacted]	A 175		



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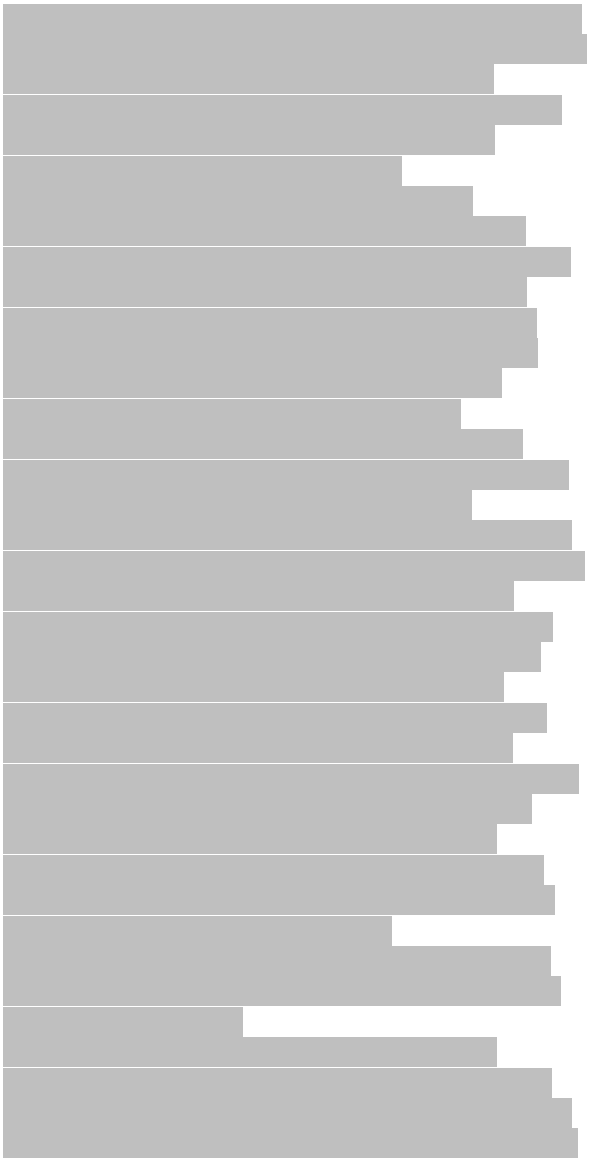

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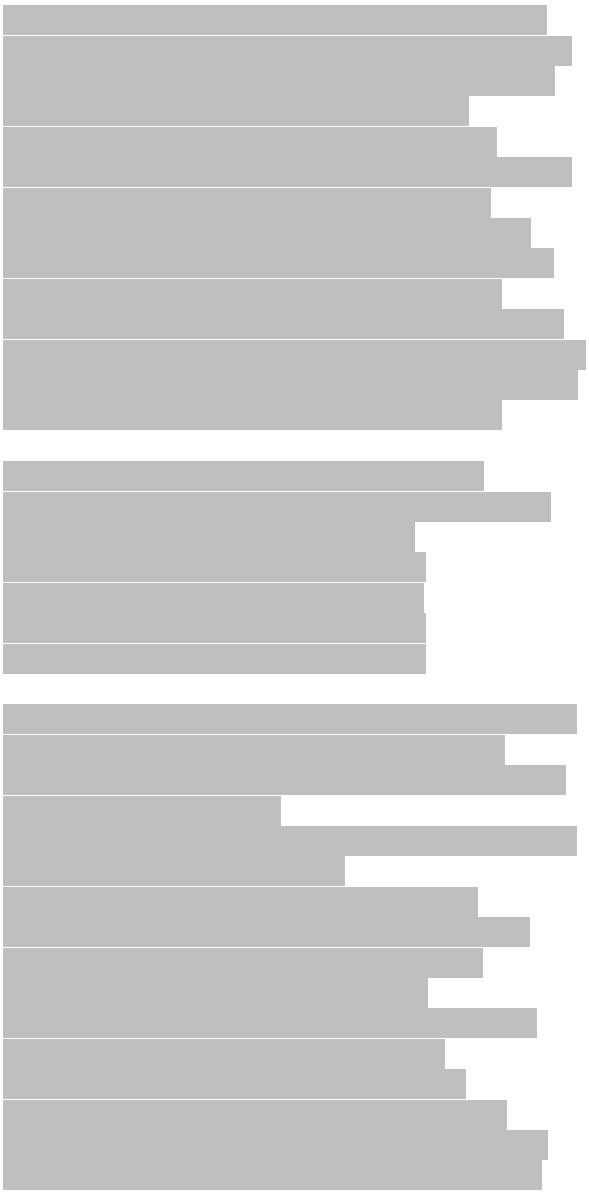
A 175	Continued From page 129	A 175		



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	384008	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL DISTINCT PART	**2600 CENTER STREET NE SALEM, OR 97301**

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A 175	Continued From page 130	A 175		

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A 175	Continued From page 131	A 175		

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A 175	Continued From page 132	A 175		

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A 175	Continued From page 133	A 175		

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A 175	Continued From page 134	A 175		

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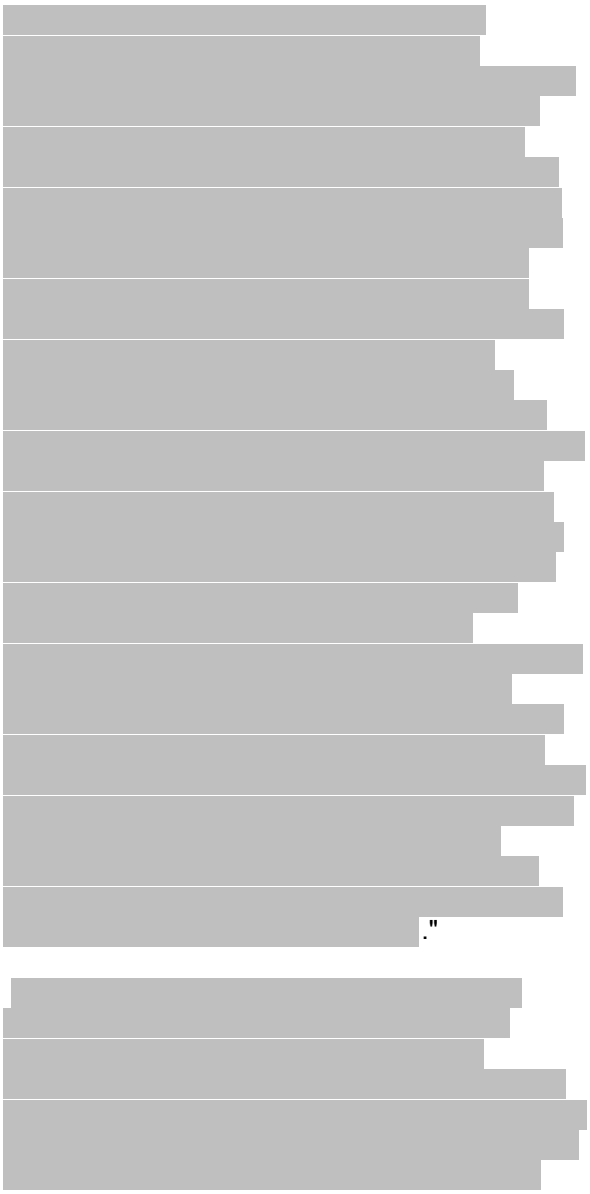
A 175	Continued From page 135	A 175		



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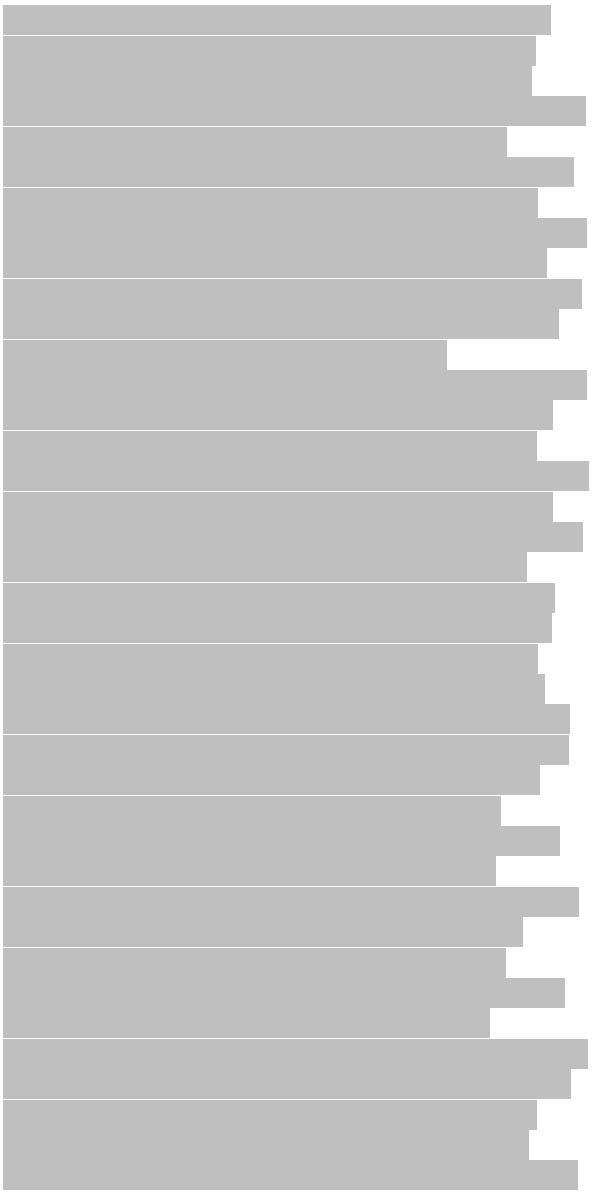
A 175	Continued From page 136	A 175		



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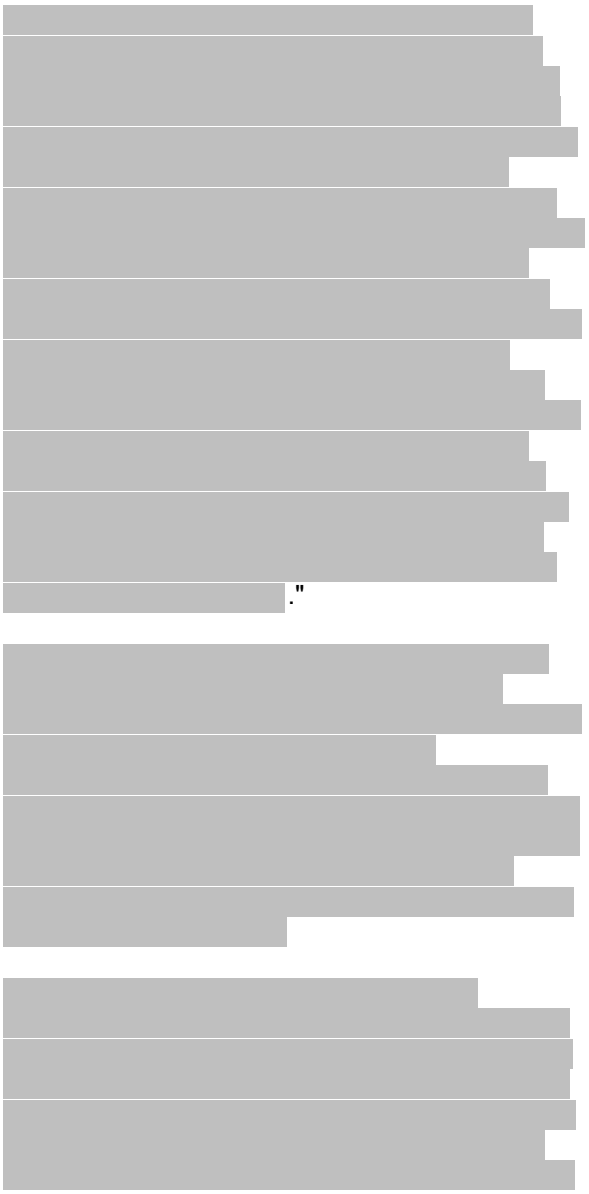
A 175	Continued From page 137	A 175		



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A 175	Continued From page 138	A 175		

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A 175	Continued From page 139	A 175		

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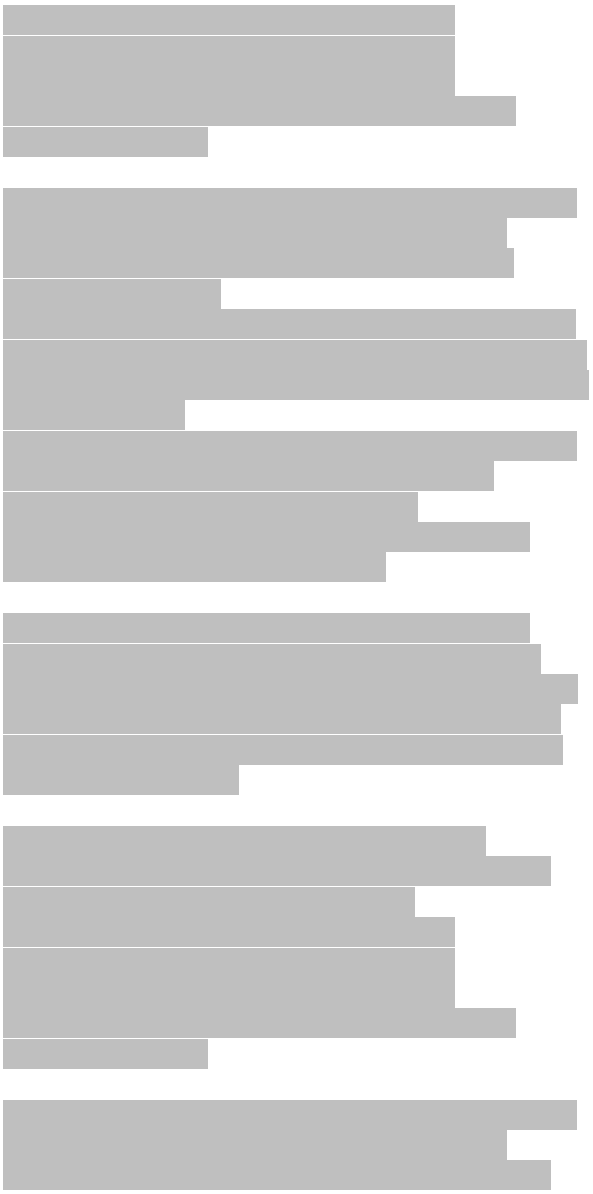
A 175	Continued From page 140	A 175		



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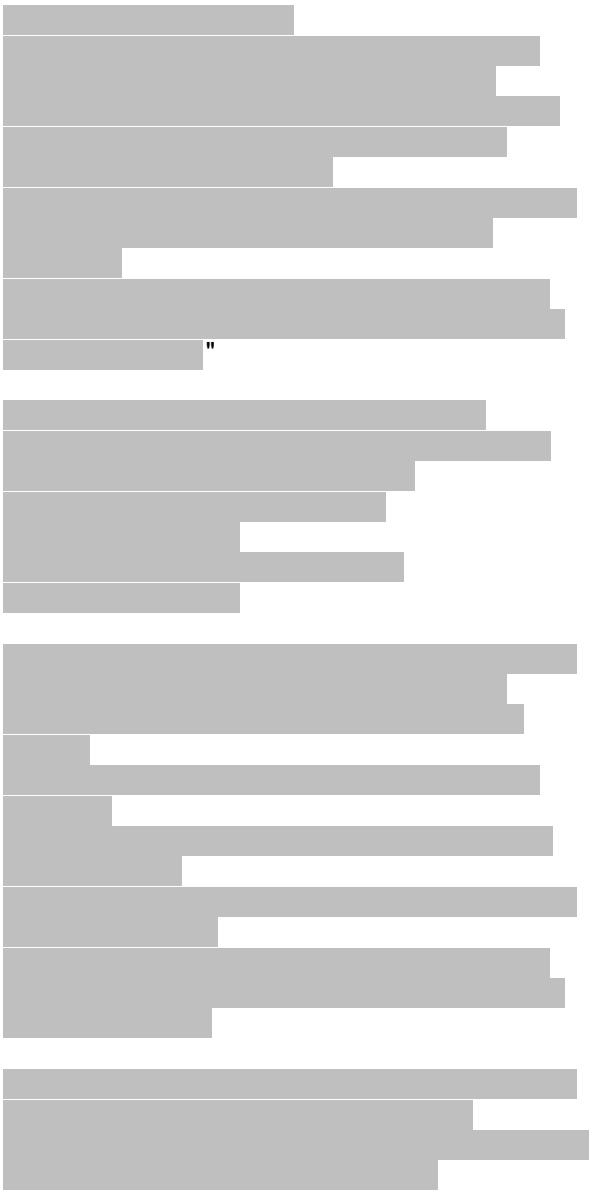
A 175	Continued From page 141	A 175		



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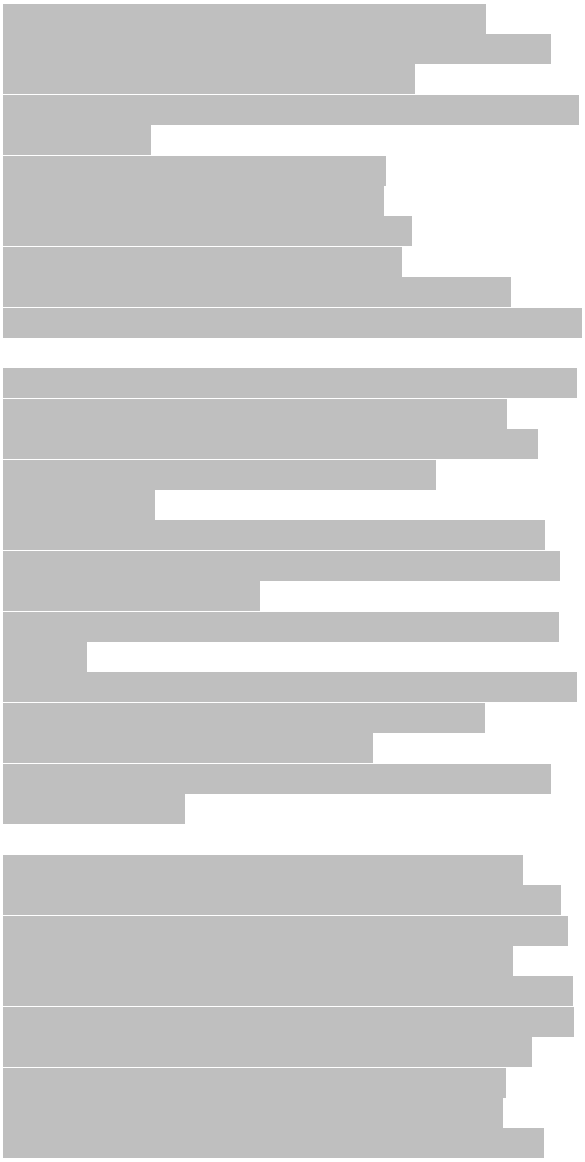
A 175	Continued From page 142	A 175		



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A 175	Continued From page 143	A 175		

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A 175	Continued From page 144	A 175		

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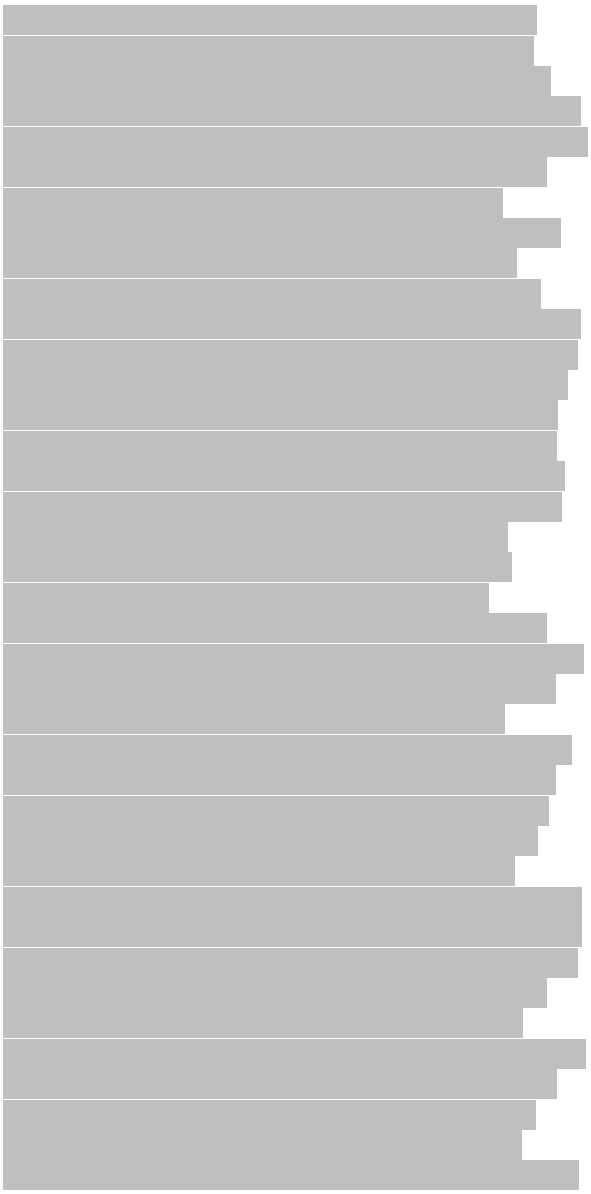
A 175	Continued From page 145	A 175		



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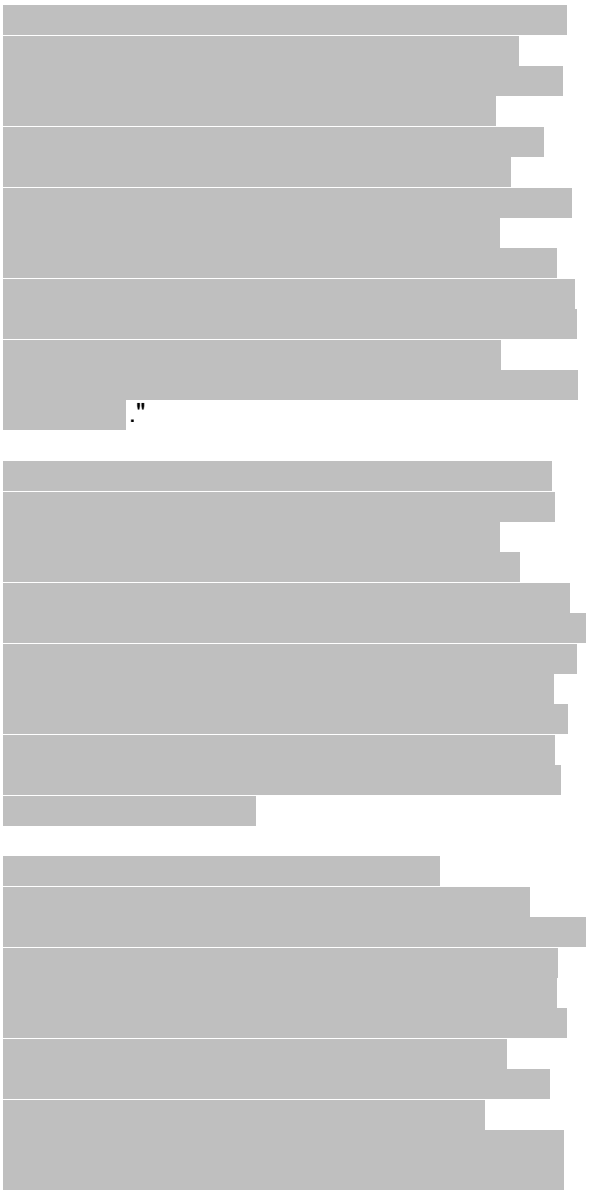

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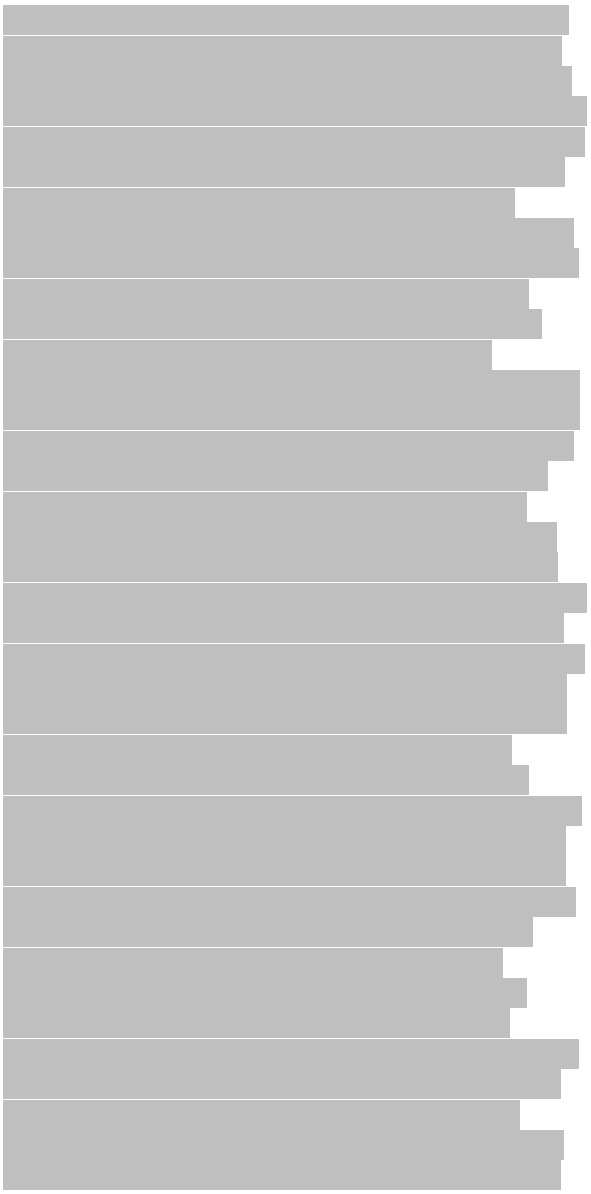

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A 175	Continued From page 148	A 175		

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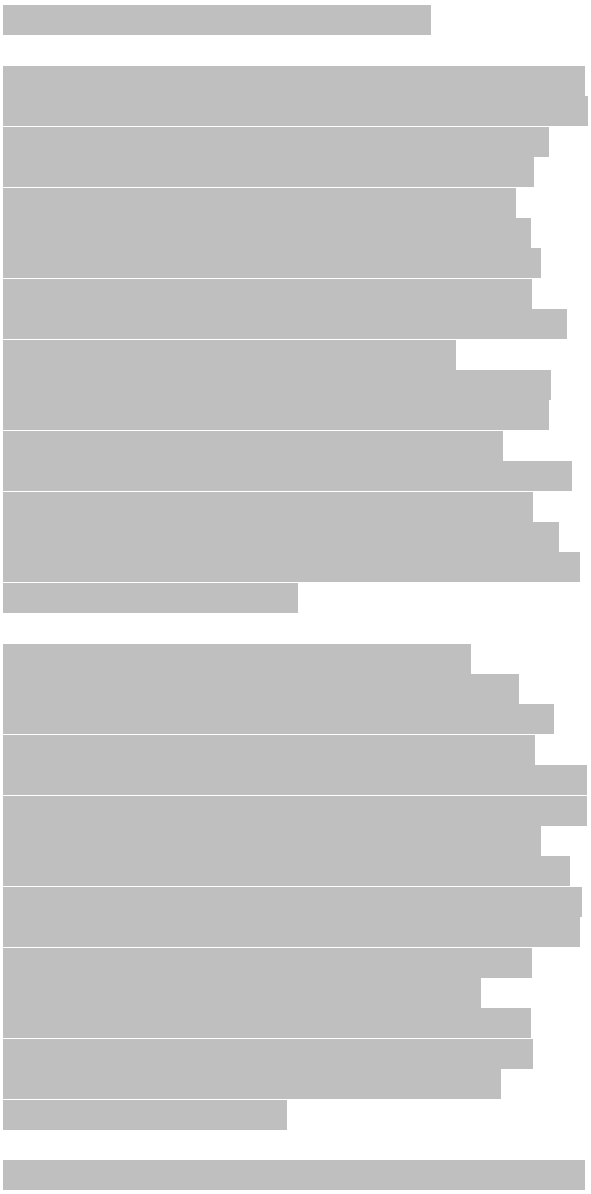

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A 175	Continued From page 150	A 175		

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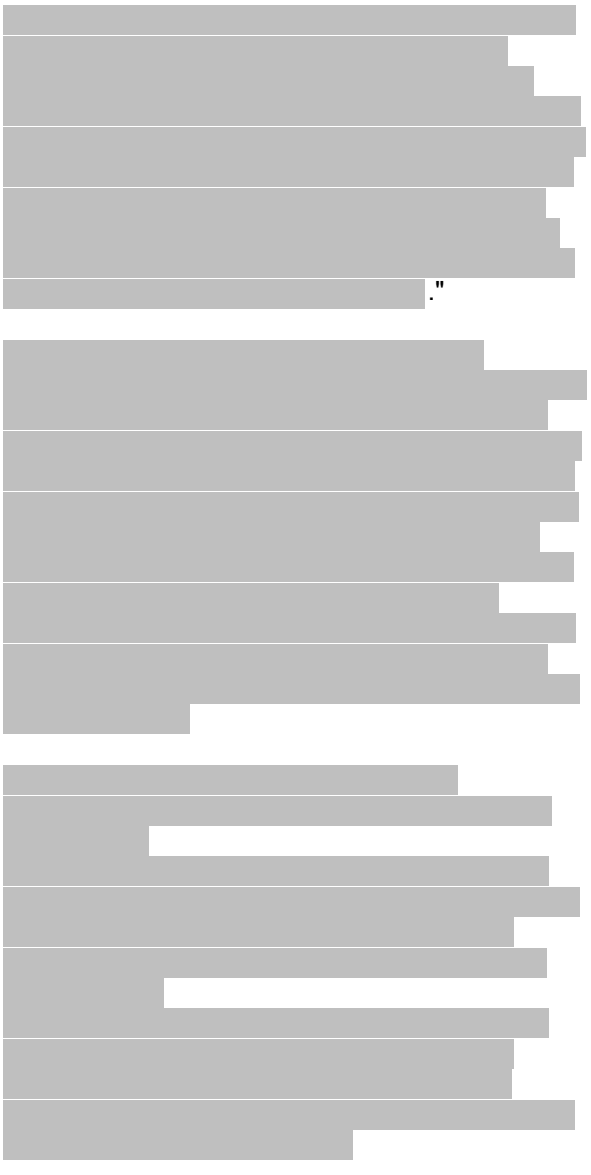

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A 175	Continued From page 152	A 175		

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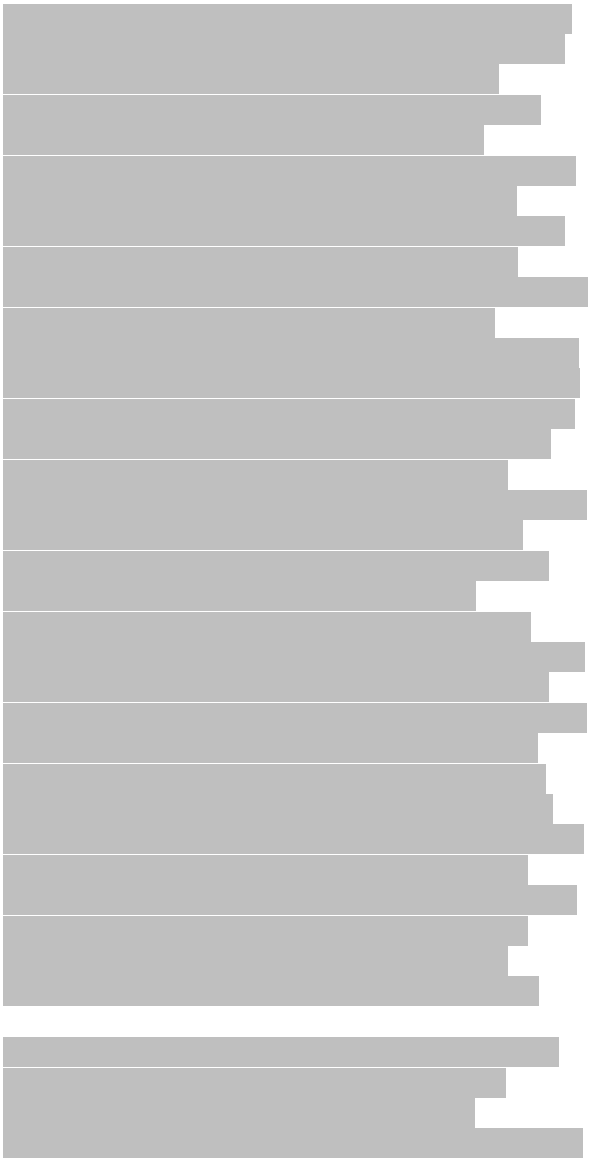

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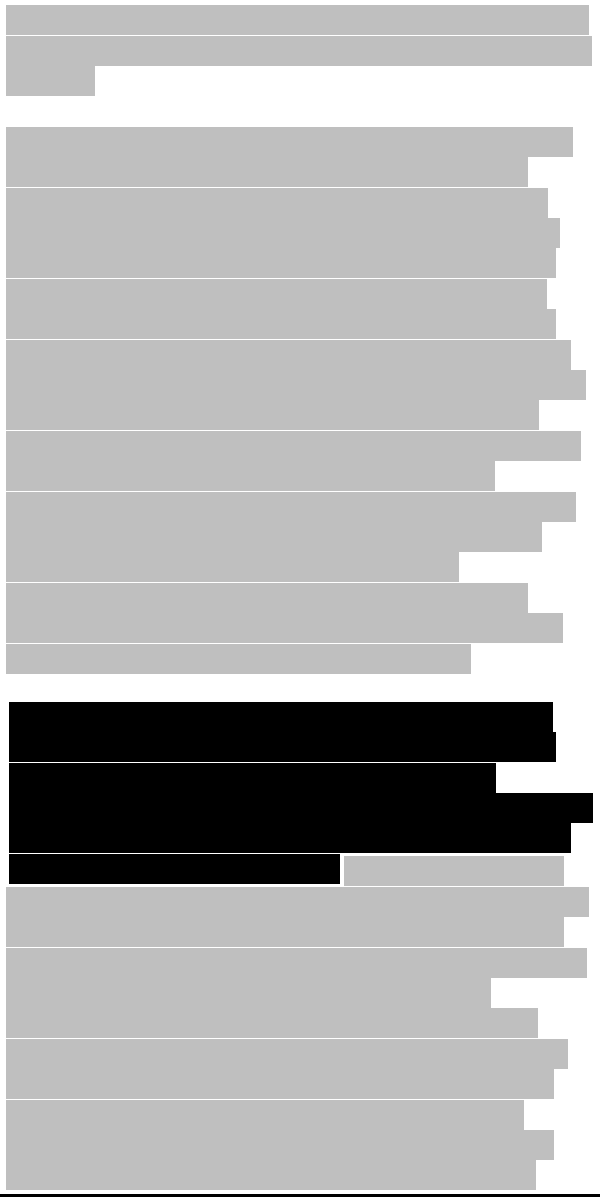

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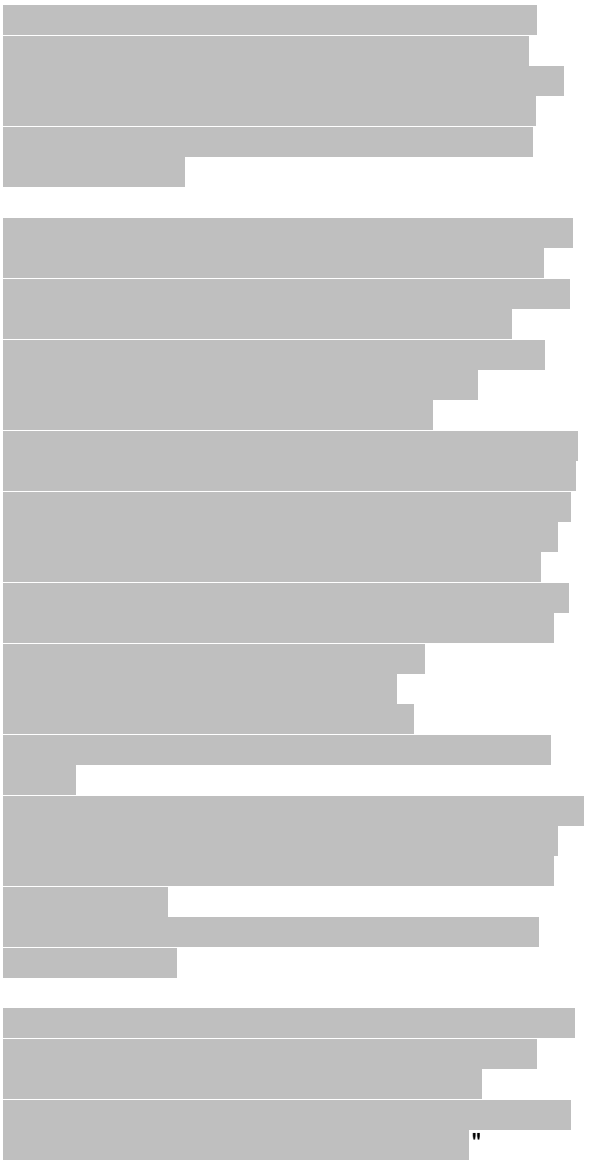

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A 175	Continued From page 164 [redacted] 2.n. Patients [redacted] had also experienced long-term seclusion episodes since [redacted] 2024. [redacted] related to the lack of clear and complete documentation on "Emergency Seclusion or Restraint Flowsheets," were found for those patients in their medical records. 2.o. Refer to Tag A-144 that further reflects that the provision of safe care for other patients in seclusion was not ensured: * For [redacted] who had falls in seclusion. * For [redacted] who accessed the cameras in the seclusion room bathroom and covered them with wet toilet paper. * For [redacted] who had a fall in seclusion, made a ligature from their shirt, was allowed to possess a spoon to puncture the bed mattress, and possessed a broken plastic spoon and broken urinal handle, both with sharp edges. * For [redacted] who was allowed to possess an altered patient toothbrush that they used for self-harm, and a patient pen wrapped in multiple layers of paper soaked in unknown substance that created a rigid cylindrical object with a pointed end. **********	A 175		
A 199	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(f)(2) Training content. The hospital must require appropriate staff to have education, training, and	A 199		

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A 199	Continued From page 165 demonstrated knowledge based on the specific needs of the patient population in at least the following: (i) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion. This STANDARD is not met as evidenced by: ********** Based on interviews, observations (training video), training curriculum, P&Ps, and other documentation, it was determined that the hospital failed to fully develop and implement training techniques to identify, prevent and manage patients' aggressive behaviors in accordance with policies and procedures to ensure patients' rights to receive safe care by trained staff. Findings include: 1. Refer to Tag A-093, Findings 13.a. through 16.b., for review of P&Ps and Seclusion and Restraint training curriculum. **********	A 199		
A 206	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(f)(2)(vii) [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:] (vii) The use of first aid techniques and certification in the use of cardiopulmonary	A 206		

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A 206	Continued From page 166 resuscitation, including required periodic recertification. This STANDARD is not met as evidenced by: ********** Based on email communications, review of training records for 4 of 5 LIPs (MD A, DO B, MD N and MD O) and 23 of 23 Direct Care nursing staff (RN C, RN D, RN E, RN F, RN G, RN R, RN T, RN U, RN W, RN Z, RN AA, RN EE, LPN H, LPN P, LPN Y, MHT J, MHT S, MHT Q, MHT V, MHT X, MHT BB, MHT CC, and MHT DD), review of training curriculum and training media, and review of P&Ps and other hospital protocols it was determined that the governing body of the hospital failed to fully develop and implement P&Ps that ensured that patients received care in a safe setting, including timely and appropriate medical emergency response. It was determined that hospital staff failed to complete training in First Aid techniques specific to patients in Seclusion and Restraints in accordance with policies and procedures to ensure patients' rights to receive safe care by trained staff. Findings include: 1. Refer to Tag A-093, Findings 13.a. through 16.b., for review of hospital training curriculum. **********	A 206		
A 450	MEDICAL RECORD SERVICES CFR(s): 482.24(c)(1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and	A 450		

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A 450	Continued From page 167 procedures. This STANDARD is not met as evidenced by: ********** Based on interviews, review of P&Ps, medical record documentation for 8 of 8 patients (Patients [redacted]), and other documentation, it was determined that the hospital failed to ensure that electronic and handwritten medical record entries were accurate, complete, dated, timed, and authenticated in the following areas: * Fall Risk Assessments, reassessments and dcoumentation were not completed in accordance with hospital P&Ps. * Medical ES 1:1 assessments and reassessments for justification of ES 1:1 continuation documentation was not completed in accordance with hospital P&Ps, and orders were not entered timely. * Treatment Care Plans did not contain complete and accurate information and Addendums were incomplete and were not incorporated into the patient's TCPs in accordance with P&Ps. * Medical record documentation for medically complex patients was not timely, was incomplete or nonexistent and was not available for direct care staff providing clinical care. Medical record documentation was not completed in accordance with hospital P&Ps. Findings include: 1. A P&P titled, "On-Duty Physician ... Protocol: 1.011" dated September 5, 2024, was reviewed and reflected: * "Oregon State Hospital provides physician coverage 24 hours daily to care for hospitalized patients ... During regular business hours, the	A 450		

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A 450	Continued From page 168 medical ... needs of OSH patients are attended to by Psychiatrists/Psychiatric Mental Health Nurse Practitioners (PMHNPs) and Primary Care Practitioners ... On-duty Physicians provide coverage during night, weekend, and observed holidays, as well as times when regular physicians/PMHNPs are unavailable." * "The POD and MOD, when on campus, must respond to see a patient on a unit when requested by the nursing staff or by another physician/nurse practitioner." * "POD-Specific Duties ... Respond to all medical emergencies, including falls requiring a physician assessment ... This includes notifying the MOD of the medical emergency, the interventions that have been undertaken (including describing the physical exam you have performed), and requesting their advice in the further management of the patient. Such conversation will be documented by the POD ... Personally assess any patient in seclusion or restraint ... Assess patients as necessary for medical symptoms or enhanced supervision." * "MOD-Specific Duties ... Respond to all medical emergencies when on site ... Round in person on all gero-psych units on weekends and holidays." 2.a. A P&P titled, "Medical Clinic Provider Documentation Standards ... Protocol: 1.017" dated March 14, 2024, was reviewed and reflected: * "Purpose Create a standard for workplace documentation and timeliness for completion of Notes." * "After provider evaluates patient, a SOAP note will be completed in electronic health record." * "Note will be written expeditiously as defined below ... Establish care visit to be done within two weeks of admission: 72 hours ... Non-urgent	A 450		

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stable chronic conditions/Health maintenance: 72 hours ... Urgent or Same-day Visit: 24 hours ... Emergency Visit: Immediately following visit, at the latest end of clinic day".
* "Staff in the above-named department who fail to comply with this protocol may be subject to disciplinary action, up to and including dismissal."
* Definitions for "SOAP Note ... Staff ... Urgent Visit ... Establish Care Visit ... Emergency Visit" were included in the policy. There was no definition for "Non-urgent stable chronic conditions/Health maintenance".

2.b. A P&P titled, "Clinical Documentation ... Policy: 6.045" dated March 9, 2023, was reviewed and reflected:
* "A patient's medical record is systematic documentation about a patient's condition, care, and treatment. Clinical documentation chronicles information about patients and their medical history; their responses to care, treatment, and services; and progress towards treatment goals. It is maintained for purposes of communication, accountability, and coordination of care and services."
* "This policy establishes clinical documentation requirements, processes, and style guide information. This policy also describes draft note reports as found in the electronic health record (EHR)."
* "This policy applies to all staff."
* "Staff must complete and document required assessments as indicated by applicable regulations, discipline-specific standards of practice, and department protocols."
* "Staff must document clinical findings and observations about patients' response to treatment and their progress towards treatment plan goals generally on the date of

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A 450	Continued From page 170 service/observation. If staff cannot document on date of service, the entry must be labeled as a late entry per this policy." * "Staff are responsible for the accuracy and necessity of their documentation." * "Staff must document with their own unique electronic medical record log-in. They may not share their log-in information with anyone else." * "Staff must clearly identify when care has been rendered by another person. They may not document an entry for another staff member." * "Every document filed in the paper medical record must include, at minimum, the patient's first and last name and medical record number on both front and back of the form." * "All EHR draft status entries must be finalized within 48 hours of initiating the entry. Staff should follow Procedures A to process draft documents." * "The Doctor of Medicine or osteopathy responsible for the care of the patient, Nursing, and Social Work must document progress notes at least weekly for the first 2 months and at least one a month thereafter; and ... All disciplines significantly involved in active treatment modalities must document progress notes per frequency of services provided and as necessary as determined by the condition of the patient (i.e., as indicated per acuity of clinical presentation)." * "Late Entries ... It is expected that staff document notes on the date of service/observation. However, extenuating circumstances may prevent this from happening on occasion. Any progress note or group note not finalized on the date of service/observation must be identified as a late entry ... Late entries must be clearly identified at the beginning of the entry and reference the actual date and time of the service provided, observation, and/or event." * "Staff who fail to comply with this policy or	A 450		

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related policy attachments or protocols may be subject to disciplinary action, up to and including dismissal."

3.a. A P&P titled, "Fall Risk Assessment ... Protocol: 2.200" dated December 1, 2023, was reviewed and reflected:
* "The purpose of this protocol is to give directions to nursing staff at Oregon State Hospital (OSH) regarding assessing a patient's risk of falling, as well as maintaining the safety of a patient who is at risk for falls."
* "Within four hours of admission or transfer from one campus to another (i.e., an inter-campus transfer), the admitting or receiving Registered Nurse (RN) must assess and document the patient's fall risk using the Fall Risk Assessment."
* "The RN must use the information in the Scoring section to convert the numeric Total Score into a one-word description of the patient's assessed fall risk (No, Low, Moderate, High) and then select the corresponding Risk Level radio button."
* "The RN must complete another Fall Risk Assessment between Day 6 and Day 10 following admission or campus-to-campus (i.e., inter-campus) transfer, even if the patient received a score of "No" or "Low" on the initial assessment."
* "Throughout the remainder of the patient's hospitalization, the RN must reassess and document the patient's fall risk level using the Fall Risk Assessment ..."
* "Based on the patient's most recently assessed fall risk level, the RN must reassess the patient as follows. [sic]
a. Risk Level "No" (score of 0 - 24 points)- reassess in 12 months.
b. Risk Level "Low" (score of 25-49 points) -

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reassess in six months.
c. Risk Level "Moderate" (score of 50-74 points)- reassess in 90 days.
d. Risk Level "High" (score of 75-120 points)- reassess in 60 days."
* "Note - Any change to the patient's assessed fall risk level will change the timeline for the next reassessment."
* "The RN must reassess the patient's fall risk following any significant change in their mental status or treatment interventions which the RN reasonably expects will increase or decrease their fall risk."
* "The RN must reassess the patient's fall risk after any actual or suspected fall."
* "The RN must notify the practitioner (psychiatrist on duty [POD] after-hours) of any changes to the patient's assessed fall risk ... The manner and timing of this notification is at the RN's discretion, depending on the severity of the change and the implications for the patient's safety."
* "This notification must be documented in the patient's EHR."
* "As noted previously, following completion of the Fall Risk Assessment ... for any other reason, the RN must perform all required follow-up actions ... Ensure the immediate safety of the patient ... Communicate pertinent fall risk level data and required safety measures to nursing staff ... and to others ... Report pertinent findings to the practitioner (POD after-hours) ... Provide education to the patient ... regarding their fall risk, interventions in place to help maintain their safety, and ways they can help themselves be safe. Patient education ... must be documented in a progress note in the EHR ... Develop and document a nursing plan of care addressing the patient's fall risk."
* "For a current patient, do one of the following ...

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A 450	Continued From page 173 Utilize the Treatment Care Plan Addendum (TCPA) form to either document the new nursing plan of care or, if applicable, to amend an existing Treatment Care Plan (TCP) related to falls ... Meet with the patient's Interdisciplinary Treatment Team (IDT) and incorporate the issue into the patient's TCP, provided that the IDT is immediately available to do so." * "Staff in the above-named department who fail to comply with this protocol may be subject to disciplinary action, up to and including dismissal." 3.b. A P&P titled, "Post-Fall Assessment and Monitoring ... Protocol: 2.205" dated June 15, 2023, was reviewed and reflected: * "The purpose of this protocol is to give directions to nursing staff at Oregon State Hospital (OSH) regarding assessing and monitoring a patient following an actual or suspected fall." * "If a patient is found on the ground, or if other factors suggest that a fall may have occurred, nursing staff must investigate in an effort to determine what happened. In the absence of evidence suggesting otherwise, staff must assume a fall has occurred." * "Patient falls (actual or suspected) ... Nursing staff present must complete the following actions. [sic] ... At least one staff must remain with the patient until released by a Register Nurse (RN) ... Immediately report the fall to an RN ... Provide assistance to the RN during the assessment, treatment, and movement of the patient, as indicated and requested ... Call a 'Code Blue' ... if it appears warranted." * "The RN must complete the following actions, not necessarily in the order provided ... Ensure that at least one staff remains with the patient ... The RN completing the assessment may count	A 450		

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A 450	Continued From page 174 as the remaining staff ... Do not release the remaining staff until an assessment is completed and either ... the RN determines that the patient's condition is stable and does not require this level of supervision; or ... the patient leaves the care of the RN for transportation to an acute care facility." * "For all falls ... it is expected that the RN will assess the patient at the scene of the fall, whether or not this requires the RN to leave their primary work assignment location." * "Assess the patient's vital signs and pain ..." * "Assess the patient's neurological status ..." * "If a reliable reporter states that the patient hit their head, the patient's neurological status must be assessed. This assessment is required even if there is no observable sign of a head injury." * "If there was no reliable reporter present, and so it cannot be positively determined that the patient did not hit their head, the patient's neurological status must be assessed." * "If a reliable reporter states that the patient did not head their head, the RN is not required to assess the patient's neurological status, although the RN may choose to do so, based on their clinical judgment." * "Neurological assessment findings must be documented in a progress note in the patient's EHR by the person who performed the assessment, prior to the end of the shift during which it was performed." * "Additional required RN actions for all falls, regardless of location ... explain to the patient the timeline and rationale for ongoing post-fall assessment and monitoring to encourage compliance ... Notify the practitioner (psychiatrist on duty [POD] after-hours) of pertinent findings from the post-fall assessment. The manner and timing of this notification is at the RN's discretion, depending on the urgency of the situation ... If the	A 450		

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A 450	Continued From page 175 patient is on anticoagulation therapy, this information must be included ... If the RN suspects the patient has sustained a significant injury, which requires medical intervention beyond first aid, this information must be included in the notification ... If the RN feels that a face-to-face assessment of the patient by the practitioner is warranted, the RN must include this request in the notification." * "Whether or not a system template provides a specific area for the information, post-fall assessment documentation must include ... the circumstances of the fall, including any known or suspected contributing factors ... that continuous staff supervision was provided post-fall ... assessment findings, including whether findings reflect a change from the patient's baseline (specific vital sign results do not need to be recorded in the progress note, unless indicated for clarity or comparison purposes) ... care provided, including risk mitigation actions taken and safety measures implemented ... recommendations for further care, monitoring, or environmental adjustments, as applicable ... notifications made (e.g., practitioner, anti-coagulation pharmacist, guardian), including attempts ... patient education provided, along with patient's response; and ... initiation of Alert Charting." * "Following the initial RN post-fall assessment of the patient, the nurse must complete the following patient monitoring and indicated actions ... If it is known that the patient did hit their head, or if it is not known whether or not the patient hit their head, assess vital signs and neurological status ... at least once every hour for the next four hours (i.e., more four times);[sic] and then ... at least once every four hours for the next 16 hours (i.e., four more times) ... Notify the lead RN of any	A 450		

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A 450	Continued From page 176 significant changes, as applicable. ... Notify the practitioner (POD after-hours) of any significant changes ... Document the assessment(s) in a nursing progress note immediately following completion. For documentation purposes, the cadence of required patient monitoring following the initial post-fall assessment is referred to as the 'Fall Protocol'." * "Following any actual or suspected patient fall, the RN must reassess the patient's fall [sic] Risk Level using the OSH Fall Risk Assessment and complete all indicated actions." * "Staff in the above-named department who fail to comply with this protocol may be subject to disciplinary action, up to and including dismissal." 3.c. A document titled "Attachment C Post-Fall Checklist" dated "6/2023" was reviewed and reflected: * "Assess for Injuries and Provide 1st Aid" * "Call 'Code Blue' (if applicable)" * "Assess VS (T, P, R, BP, 02 Sat) and Pain (if within scope of practice) Person Who Assessed Must Document". * "Assess Neuro Status if Hit Head or Unknown" * "Notify Practitioner (POD after-hours) of ALL Falls, Include Anticoagulant Tx Info". * "Document Fall in Nursing Progress Note" * "Complete Fall Risk Assessment" * "Create a Treatment Care Plan Addendum to Address Newly Identified Conditions (if applicable)" * "ALL Nursing Staff Who Witness a Fall Must Complete an Incident Report" * "If Patient Did Not Hit Head ... Assess and Document VS 8 hours x 3". * "If Patient Did Hit Head or Unknown ... Assess and Document VS and Neuro Status Hourly x 4 ... Then every 4 hours x 4 ... Document	A 450		

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Assessments Upon Completion in Avatar Using Nursing Progress Note and Templates".

3.d. A P&P titled, "Fall Prevention Program: Fall Risk Assessment and Management ... Policy: 6.046" dated November 5, 2021, was reviewed and reflected:
* " ... OSH will establish a patient fall risk assessment and management process to address individual patient needs and mitigate safety risks."
* "In this policy, a fall means a sudden, independent movement to the ground or lower surface that is unintentional, uncontrolled, or involuntary. It may be witnessed or not witnessed, with or without injury. A fall resulting from an aggressive interaction with another individual is not included in this definition. (NOTE: although fall monitoring processes would apply, such falls are reported separately.)"
* "A patient who falls must be appropriately assessed, evaluated, and monitored per procedures attached to this policy and Nursing Services Department processes."
* "This policy applies to all staff, including employees, volunteers, trainees, interns, contractors, vendors, and other state employees assigned to work at OSH. Staff who fail to comply with this policy or related procedures may be subject to disciplinary action, up to and including dismissal."

3.e. A P&P titled, "Fall Risk Assessment and Reassessment ... Policy Number 6.046" dated November 10, 2021, was reviewed and reflected:
* "Patient falls (actual or suspected) inside the secure perimeter (on- and off-unit) ... Nursing staff present must complete the following actions ... At least one staff must remain with the patient

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A 450	Continued From page 178 until released by a Register Nurse (RN)." * "Immediately report the fall to an RN ... Do not leave the patient alone to make this notification." * "Until the patient is assessed by the RN, make every effort to maintain the patient in their current position, while reassuring the patient that they are safe and that additional help is coming ... If the patient insists on moving, maintain the patient's safety as much as possible by assisting the patient to their desired position, while continuing to discourage further movement ... While waiting for the RN and throughout the post-fall assessment, remain aware of the immediate environment and takes steps to mitigate any identified risks, whether environmental, physical, or related to other patients ... Prior to the arrival of the RN, and depending on the patient's status and staff availability (there must always be at least one staff with the patient), retrieve needed equipment (including writing materials) and obtain a full set of vital signs (temperature, pulse, blood pressure, respirations, and oxygen saturation via pulse oximetry), and assess for pain if within scope of practice, with results to be provided to the RN on their arrival. (Vital signs and pain rating must be documented in the patient's electronic health record [EHR] by the person who collected them, prior to the end of the shift during which they were collected ... Provide assistance to the RN during the assessment, treatment, and movement of the patient, as indicated and requested ... Call a 'Code Blue', per OSH policy 8.038, 'Code Blue Medical Emergency', if it appears warranted." * "The RN must complete the following actions, not necessarily in the order provided ... Ensure that at least one staff remains with the patient ... The RN completing the assessment may count as the remaining staff ... Do not release the	A 450		

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remaining staff until an assessment is completed and either: the RN determines that the patient's condition is stable and does not require this level of supervision; or ... the patient leaves the care of the RN for transportation to an acute care facility."
* "Assess the patient for injuries ... For all falls within the secure perimeter, it is expected that the RN will assess the patient at the scene of the fall, whether or not this requires the RN to leave their primary work assignment location."

4.a. A P&P titled, "Patient Care ... Enhanced Supervision ... Policy: 6.010" dated February 28, 2024, was reviewed and reflected:
* "This policy establishes guidelines for enhanced supervision at Oregon State Hospital ... This policy applies to all OSH staff."
* "The Psychiatrist or Psychiatric Mental Health Nurse Practitioner ... using clinical input from other members of the ... IDT ... must determine the type and level of enhanced supervision necessary to safeguard patients and staff. The IDT must collaboratively plan and implement therapeutic interventions to address dangerous, self-destructive, and or suicidal behavior, or needs associated with medical illness."
* "Any limitation to a patient's rights must be clinically justified, explained to the patient, and documented in the patient's medical record."
* "Staff who fail to comply with this policy or related policy attachments or protocols may be subject to disciplinary action, up to and including dismissal."
* "Enhanced supervision is careful monitoring and/or intervention characterized by types that indicate the primary behavior or condition and levels that describe the frequency with which staff contact the supervised patient ... Medical Supervision provides enhanced monitoring and

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supervision for patients who are medically ill; to prevent patients with medical conditions from inadvertently harming themselves; or to ensure protection of medical equipment or safe delivery of necessary medical treatment."

4.b. A P&P titled, "Staff Responsibilities for Enhanced Supervision ... Policy: 6.010" dated February 28, 2024, was reviewed and reflected:
* "Patient Education About Enhanced Supervision ... Unless clinically contraindicated, the psychiatrist or PMHNP, nurse, or a designee must explain the type and level of enhanced supervision to the patient, describe both the staff and the patient's responsibilities, and provide the patient education handout to the patient ... The person who provides education to the patient about enhanced supervision must document this in a progress note, including an assessment of the patient's understanding of what they have been told."
* "Review of Enhanced Supervision ... This review must include review of the Enhanced Supervision Flow Sheets completed since the previous day ... Following this reevaluation, if the IDT members determine that no change to the enhanced supervision is indicated, a note must be written by one of the following IDT members: psychiatrist or PMHNP, psychologist, or any nurse. The note must address the following ... the rationale for ongoing supervision ... effectiveness of existing interventions ... changes made to the event Intervention Card, if any."
* "The psychiatrist or PMHNP must conduct a face-to-face assessment and write the above note under either of the following circumstances ... at least once every five (5) days following the initiation of 1:1 supervision ... When the IDT determines that a significant change to the

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A 450	Continued From page 181 enhanced supervision order may be indicated." * "Initiation of enhanced supervision ... Medical supervision may be ordered following face-to-face assessment or in consultation with the nurse. The psychiatrist or PMHNP or medical physician must personally evaluate the patient if there is a question about the type and level of supervision, or any other relevant therapeutic interventions to be utilized. If a personal evaluation is necessary, the findings must be documented in a progress note. * "Reassessment of enhanced supervision ... If any patient is started on enhanced supervision by a covering psychiatrist, PMHNP, or designee, the patient must be reassessed by the attending psychiatrist or PMHNP the next business day, with the assessment documented in a progress note." * "If a patient remains on 1:1 supervision for five (5) consecutive days following the previous face-to-face assessment, the attending or covering psychiatrist or PMHNP or medical physician (in the case of medical supervision) must personally reassess the patient. This assessment must be documented in a progress note. If supervision continues to be deemed appropriate, a rationale for ongoing supervision and interventions to help the patient become safe must be documented." * "If a patient is on 1:1 supervision for 14 consecutive days, the attending or covering psychiatrist or PMHNP or medical physician (in the case of medical supervision) must inform the supervisor and Chief of Psychiatry, Chief Medical Officer ... or their designee. This discussion must include review of the treatment provided to the patient, and the patient's progress towards safety. The practitioner must document this discussion (including rationale for ongoing supervision,	A 450		

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alternatives considered, and any change in interventions provided based on supervisor review) in a progress note. This must be repeated at each consecutive 14 days. Their patient remains on 1:1 supervision."

5.a. During a review of 8 of 8 patient medical records [redacted]) on 04/10/2025 beginning at 10:05 with the CS, SP(H), SC/OPA3, and others, information provided indicated that nursing staff failed to follow assessment and reassessment protocols after patient falls, and update TCPs using the TCP Addendum form per policy. For example:

5.b. Regarding [redacted] medical record documentation:
* A Fall Risk Assessment (FRA) written by an OSH RN on [redacted]/2025 at 14:23 included the following: "Type of Assessment: [redacted] ... History of Fall (a fall occurred within last 3 months): Yes ... Vision: Patient reported [redacted] has difficulty seeing without glasses ... ADLS ... Patient able to maintain balance during shower and dress after shower. No unsafe behaviors noted. Patient does have history of seizures and has fallen several time [sic] injuring [themselves] to include some facial fractures ... Clinical Justification Summary: Patient has multiple recorded falls related to seizures. [redacted] Clinically indicated risk level "Moderate".

* "Patient Progress Notes" written by an OSH RN on [redacted]/2025 at 10:47 included the following: "Time of Fall Protocol Assessment: 1010 ... Location of Fall: Pt room ... Client Activity

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A 450	Continued From page 183 Prior/During Fall: [redacted] had just left the IDT room and returned to [their] room where [they] had a seizure ... Fall was unwitnessed by staff, so neuro checks initiated. Neuro assessment WNL ... Seizure activity is consistent with [redacted] reports of ongoing seizures. Close Medical precautions initiated ..." * A Fall Risk Assessment (FRA) written by an OSH RN on [redacted]/2025 at 12:44 PM included the following: "Type of Assessment: Other ... Reason for Assessment: Post seizure involving unwitnessed fall ... Qualifying active medical problems ... Uncorrected vision changes ... Vision: Patient reported that [redacted] has difficulty seeing without glasses ... ADLS ... Patient able to maintain balance during shower and dress after shower. No unsafe behaviors noted. Patient does have history of seizures and has fallen several times injuring [themself] to include some facial fractures ... Clinical Justification Summary: Patient has known seizure disorder with an extensive history of falls resulting from seizures ... " Clinically indicated risk level "Moderate". * "Patient Progress Notes" written by an OSH RN on [redacted]/2025 at 16:58 included the following: "Met with RN, TCPS, and unit psychologist briefly this morning to talk about ... initial goals and plan ... A few moments later, pt's roommate alerted staff that [they] found [redacted] on the floor of their room seizing "for about five seconds." Nurses arrived to assess [redacted], who was sitting up on the floor near ... bathroom ... VS were stable ... pulse remains elevated at baseline. [redacted] reported being a bit tired and appeared disoriented. Staff provided reassurance, assessed for injury, which [redacted]	A 450		

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A 450	Continued From page 184 [redacted] denied, and promoted rest. Neuro assessments initiated since fall was unwitnessed and were WNL throughout the shift. Psych and medical providers notified. Close Medical Precautions initiated at 1030. Order to obtain [redacted] is in process. Around 1500 [redacted] approached RN and said "I had a seizure this morning and I didn't even realize it was coming. I hate those types of seizures." RN offered therapeutic listening and reassurance. [redacted] again denied pain from the fall ..." * "Patient Progress Notes" written by an OSH RN on [redacted]/2025 at 18:14 included the following: "Time of Fall Protocol Assessment: 1725 ... Nursing actions taken, if any, with patient response: Will continue to monitor, patient in agreement to allow RN to complete Neuro assessments ... Provider and RN notification, as indicated: NA ... List of Behaviors: Medical/Physical, Fall Protocol". * "Patient Progress Notes" written by an OSH RN on [redacted]/2025 at 19:49 included the following: "Behavior/Observation Narrative: Maintained on close observation MP for safety concerns. During the top of the 1500 hour, patient approached myself and MHT's during Lead viability rounds, complained of bleeding on [redacted] [their] head. Observed what seemed to be dried up blood of unknown origin. Patient reported that [they] noticed this when [they were] combing [their] hair. Brought patient to the exam room and ... RN assessed and cleaned area, unit provider notified. I assessed area during the 1800 hour. Observed mild redness and tenderness on the surrounding tissue. Observed dark and dried blood and scabbing on 1" X .5" asymmetrical wound. Patient reports pain from area upon	A 450		

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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) COMPLETION DATE
A 450	Continued From page 185 palpation. Patient was alert and oriented X 4 throughout the shift. Continues on fall protocol for possible unwitnessed seizure/fall on previous shift. Patient has been compliant with Neurological assessments. Assessments within normal range. Patient to be referred to medical clinic for follow up on wound care." * "Patient Progress Notes" written by an OSH RN on [redacted]/2025 at 21:42 reflected the following: "Behavior/Observation Narrative: Time of Fall Protocol Assessment: 2130 Assessment findings ... Elevated pulse 109, all other VS within normal range, refused to allow me to assess ... pupils/eye movement. Pt responded to simple commands, asked ... to smile and ... did so. Speech clear, reported feeling tingling in ... right foot, foot strength equal/full. Significant changes from prior assessments, if any: tingling in ... right foot ... Nursing actions take, if any, with patient response: Patient refused to open eyes but appeared to be asleep prior to assessment, attempted to encourage patient [redacted] provided validation and understanding ... Provider and RN notification, as indicated: NA". * A "Patient Progress Notes" written by an DO B on [redacted]/2025 at 23:05 was reviewed and reflected: "ID/CC/Subjective: [redacted]/25, 2241 ... met with patient this afternoon in south hall consult room for apprx 20 minutes or so. we discussed [their] two seizures in past two days, [their] depakote level ... and the decision to increase [their] depakote today ... also discussed possible addition of klonopin if we cannot get [their] seizures nuder [sic] better control with high depakote dose and while [they] remains on [their] zonisamime [sic] ... pt is convinced the seroquel	A 450		

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A 450	Continued From page 186 has been a good med for [them] and has not increased [their] seizure frequency ... this morning i discussed via text messages with [CoM] the above med changes and [they] agreed. for now we'll just increase depakote and hold off on adding klonopin for now. [Surveyor Note: all lower-case words are as they appeared in the original text.] ... VITAL SIGNS ..." - "[redacted]/25 12:55, T: 96.7 F ... P: 108 ... R: 18 ... BP: 123/83 ... spO2: 99 %" - "[redacted]/25 13:25, T: 97.7 F ... P: 111 ... R: 16 ... BP: 129/78 ... spO2: 98 %" - "[redacted]/25 11:38, T: 97.8 F ... P: 116 ... R: 18 ... BP: 131/81 ... spO2: 98 %" - "[redacted]/25 10:14, T: 97.7 F ... P: 115 ... BP: 139/85 ... spO2: 96 %" - "[redacted]/25 17:25, T: 97.5 F ... P: 87 ... R: 14 ... BP: 113/72 ... spO2: 100 %" - "[redacted]/25 21:34, T: 97.7 F ... P: 109 ... R: 12 ... BP: 129/83 ... spO2: 98 %" - "[redacted]/25 03:15, P: 70 ... R: 14 ... BP: 121/69 ... spO2: 97 %" - "[redacted]/25 09:39, T: 97.5 F ... P: 106 ... R: 20 ... BP: 122/79 ... spO2: 100 %" - "Assessment/Plan: ... re seizures, has had 2 in last 2 days in context of somewhat low depakote level ... increased today ... will cont zonisamide ... consider adding klonopin in near future if necessary vs maximizing ... zonisamide dose ... which we could also consider if necessary ... also, pt ... placed on close medical obs a couple days ago because of the frequency of seizures at this time ... psychosis appears stable. PLAN: cont seroquel ... [redacted] ... is on 3X the amount of seroquel now vs then, however, and perhaps we can get ... seizures under better control also. will cont to assess over time whether this is	A 450		

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A 450	Continued From page 187 improving or likely to improve ... re suicide risk: appears low at this time over the short term. pt has indicated ... mood is stable and ... does not feel depressed nor experiencing any suicidal thinking nor wishing [they were] dead ... violence risk currently appears to be low ... dc plan: [redacted] or reaches eoc." [Surveyor Note: all lower-case words are as they appeared in the original text.] * "Patient Progress Notes" written by an OSH PMHNP on [redacted]/2025 at 12:40 included the following: "ID/CC/Subjective: [redacted] had a seizure this morning about 11:29 am, which was reported by ... roommate to staff. Staff timed it for approximately 2 minutes and 46 seconds. [They were] postictal when I arrived and was unable to respond verbally for nearly 30 minutes until [they were] ready to lie down in bed. There was blood noted on ... pillow and RN thought that [they] saw blood from ... mouth but ... was not able to follow simple directives to open ... mouth to let us assess. [Patient] remains on close medical observation." * "Patient Progress Notes" written by an OSH RN on [redacted]/2025 at 13:14 included the following: "Time of Fall: 1128 ... Location of Fall: Patient's bathroom. [Their] legs were in the bathroom and upper body was in [their] room ... Description of Fall if Known: Pt was found lying on floor of [their] bathroom and upper body was in [their] room in a prone position and actively seizing ... Describe Any Injuries: approximate 1 inch irregular abrasion noted [redacted] scant amount of blood noted on pillow that was placed under [their] head which appeared to come from the inside of [their] mouth since no visible injury was noted outside of [their] mouth/lips. Will assess	A 450		

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A 450	Continued From page 188 when out of post ictal [sic] phase ... Neurological Assessment ... VS obtained ... PERRLA/ 3mm ... List of Behaviors: Medical/Physical, Fall, Fall Protocol". * A Fall Risk Assessment (FRA) written by an OSH RN on [redacted]/2025 at 13:25 included the following: "Type of Assessment: Other ... Reason for Assessment: patient fell during seizure activity ... Qualifying active medical problems ... Uncorrected vision changes ... Vision: Patient reported [redacted] has difficulty seeing without glasses ... ADLS ... Patient able to maintain balance during shower and dress after shower. No unsafe behaviors noted. Patient does have history of seizures and has fallen several times injuring himself to include some facial fractures ... Clinical Justification Summary: "Clinical Justification Summary: Despite being compliant with current medication regimen for seizures, pt has fallen twice since day of admission [redacted]/25." ... Clinically indicated risk level "Moderate". * "Patient Progress Notes" written by an OSH RN on [redacted]/2025 at 17:00 included the following: "Behavior/Observation Narrative: At 1340 neuro check, [redacted] reported that [they] had bitten [their] tongue in the back on the right side. [redacted] also reported some left elbow soreness. Med Clinic contacted and medical provider saw [them] on the unit at 1600." * "Patient Progress Notes" written by an OSH RN on [redacted]/2025 at 21:14 included the following: "Patient was seen by Dr. ... from med clinic at about 1605 and placed ... on medical 1:1 due to seizures and risk of falls. [redacted] was moved from room ... into ... with access to the bathroom	A 450		

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A 450	Continued From page 189 close to room door. No seizures noted, neuro checks unremarkable." * A document titled, "Enhanced Supervision Active Order Details" with an "Order Start Date/Time: [redacted]/25 1909" was reviewed and reflected ...Order End Date/Time: [redacted]/26 19:08 ... Order Duration: 365 ... Order Text: Around the clock. On and off the unit. Staff to remain within visual and comfortable speaking distance. Use discretion re: appropriate distance to meet patient needs at the moment ... Patient can attend Treatment Mall, Visits, Religious Services, Cafeteria and Quad. Patient may keep all property ... Describe Reason: Primary Behavior(s) of concern: fall risk". * "Patient Progress Notes" written by the DCMO on [redacted]/2025 at 00:15 included the following: "Late entry for 3.25.25 Cross cover note ... Saw [redacted] in [their] room with staff present to assess [redacted] after [their] seizure earlier in the day. [redacted] does not recall having the seizure but the seizure episode was witnessed by [their] roommate ... [redacted] bit ... tongue during the event and also had a laceration on ... head (likely from falling). [redacted] denies any headaches, changes in vision, shortness of breath, chest pain, feeling fatigued, or any paresthesias ... Ordered Medical 1:1 until reassessment with regular medical provider ... Will message medical clinic RN case manager to follow up on the order for ... soft helmet ... VITAL SIGNS ..." - "[redacted]/25 12:55, T: 96.7 F ... P: 108 ... R: 18 ... BP: 123/83 ... spO2: 99 %" - "[redacted]/25 13:25, T: 97.7 F ... P: 111 ... R: 16 ... BP: 129/78 ... spO2: 98 %" - "[redacted]/25 11:38, T: 97.8 F ... P: 116 ... R: 18 ...	A 450		

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A 450	Continued From page 190 BP: 131/81 ... spO2: 98 %" - "[redacted]/25 10:14, T: 97.7 F ... P: 115 ... BP: 139/85 ... spO2: 96 %" - "[redacted]/25 17:25, T: 97.5 F ... P: 87 ... R: 14 ... BP: 113/72 ... spO2: 100 %" - "[redacted]/25 21:34, T: 97.7 F ... P: 109 ... R: 12 ... BP: 129/83 ... spO2: 98 %" - "[redacted]/25 03:15, P: 70 ... R: 14 ... BP: 121/69 ... spO2: 97 %" - "[redacted]/25 09:39, T: 97.5 F ... P: 106 ... R: 20 ... BP: 122/79 ... spO2: 100 %" - "[redacted]/25 11:10, T: 98.0 F ... P: 111 ... R: 16 ... BP: 120/75 ... spO2: 99 %" - "[redacted]/25 02:15, T: 97.7 F ... P: 77 ... R: 16 ... BP: 113/68 ... spO2: 97 %" - "[redacted]/25 11:40, T: 98.0 F ... P: 126 ... BP: 131/96 ... spO2: 96 %" ..." - "[redacted]/25 12:40, P: 111 ... spO2: 96 %" - "[redacted]/25 13:40, T: 97.5 F ... P: 96 ... BP: 116/83 ... spO2: 96 %" - "[redacted]/25 14:45, T: 97.0 F ... P: 99 ... BP: 117/74 ... spO2: 100 %" - "[redacted]/25 18:55, T: 97.3 F ... P: 104 ... R: 16 ... BP: 118/72 ... spO2: 97 %" - "[redacted]/25 06:25, T: 98.0 F ... P: 79 ... R: 14 ... BP: 107/70 ... spO2: 98 % ... **End of Note**" * "Patient Progress Notes" written by an OSH PMHNP on [redacted]/2025 at 13:52 included the following: "[redacted] was raised from a close observation to 1:1 medical status per medical department after ... last seizure. [They have] since changed rooms where ... now has a room [by themselves] with staff members available to monitor ... safety. Mats were located by the PET team to place on the floor near ... bed ... [redacted] informed me [redacted] I have made several	A 450		

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A 450	Continued From page 191 attempts today [redacted] The nurse supervisor stated that they are making attempts to locate [redacted] which may need to be ordered. Another note, it was discussed today that [redacted] is a low-risk for falls, even though [they] ... had 3 seizures over the past couple of weeks which have resulted in 2 head abrasions. The team does not agree with the computed risk and have made safety plans that will help eliminate further injury from falls that occur with seizure activity-namely the fall mat, ordering a [redacted] 1:1 medical observation. [redacted] understands all of the proposed plans and agrees with them. [They] verbalized appreciation to staff." * "Patient Progress Notes" written by an OSH PMHNP on [redacted]/2025 at 16:23 included the following: "ID/CC/Subjective: [redacted]/25-1600 [redacted]	A 450		

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A 450	Continued From page 192	A 450		

* "Patient Progress Notes" written by an OSH RN on [redacted]2025 at 1627 included the following: "Behavior/Observation Narrative: Pt remains on 1:1 medical ... Pt did not demonstrate any seizure like activity nor have any seizure episodes during shift ... At 1645, med clinic delivered [redacted] for pt use. Pt was provided [redacted] pt states 'It feels good'. Pt observed to be pacing unit [redacted]"

Provider notes were not timely, were incomplete and failed to document justification for ES 1:1 medical for [redacted]. For example, no provider reassessment notes were provided for the justification of continuing [redacted]'s ES 1:1 medical every 5 days as required by policy. Specifically, there were no reassessment notes provided for [redacted]/2025, [redacted]/2025, or [redacted]/2025, the dates when a reassessment was due. The hospital failed to document the "effectiveness of existing interventions to reduce or eliminate those symptoms or behaviors which require enhanced supervision" as required by policy 6.010, Procedures A, Staff Responsibilities. Furthermore, [redacted]'s EHR lacked a 14-day reassessment of the need to continue the ES 1:1 medical progress notes documenting leadership notification, discussions of "rationale for ongoing supervision, [or] alternatives considered" as required in policy, and which "must be repeated at each consecutive 14 days their patient remains on 1:1 supervision."

The hospital's clinical staff failed to fully implement fall P&Ps and failed to document nursing assessments in a timely manner per the hospitals P&Ps. Nursing staff failed to fully

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A 450	Continued From page 193 document FRAs "immediately" after the assessments as required by policy. For example, the fall on [redacted]/2025 was noted to have occurred at "10:10" and the FRA assessment was time stamped at "12:44", two and a half hours after the fall. Additionally, nursing progress notes were unclear as to whether [redacted] had a second fall at "17:25", or whether that encounter was a continuation of the fall and neurological assessments protocol. There were no progress notes indicating that vital signs and neurological assessments occurred "Hourly x4". For instance, the unwitnessed fall occurred at 10:10 and per protocol, neurological assessments and vital signs were due at: ~1100, 1200, 1300 and 1400, and then every 4 hours x4 afterwards; ~ 1800, 2200, 0200 and 0600. Only four sets of vital signs were documented after the fall on that shift: 1014,1725, 2134, and 0315. Only 4 neurological assessments were noted in nursing progress notes and two of those notes alluded to "assessments" being within normal limits but failed to document the times or observations of those assessments. Additional examples include: - [redacted]/2025: The Patient Progress note on [redacted]/2025 at 1949 reflected that the patient would be referred to the "medical clinic for follow up on wound care." However, [redacted] was seen by an LIP on [redacted]/2025, and the patient's wounds were not assessed at that time. Patient's wounds were not assessed by an LIP until [redacted]/2025, 6 days after a provider had been notified of the wounds. Additionally, it was unclear how many neurological assessments were conducted after the [redacted]/2025 fall, or at what time those assessments were determined to be "within normal range." The progress note at 2142 reflected "significant changes from prior assessment", however, the RN did not notify the	A 450		

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A 450	Continued From page 194 POD/MOD per policy. Refer to Finding 3.b., "Post-Fall Assessment and Monitoring ... Protocol: 2.205". - [redacted]/2025: A provider assessment occurred at 2241 ~36h after [redacted]'s fall on [redacted]/2025 and ~ 31 hours after the unit nurse notified a provider. The DO progress note did not discuss the fall or any fall related injuries as noted in the [redacted]/2025 RN Progress Notes. - On [redacted]/2025: [redacted] was noted to have fallen at "11:28" and the FRA assessment was time stamped at "13:14", ~ two hours after the fall. Further, it was unclear whether the information "pt has fallen twice" included the fall for this FRA, or whether two falls had occurred prior to this FRA. Nursing Progress notes on [redacted]/2025 failed to demonstrate that vital signs and neurological assessments occurred "Hourly x4" per the fall assessment protocol 2.205. For example, the RN note at 1700 documented a "1340 neuro check" for an unwitnessed 1128 fall, two hours and 10 minutes after the documented fall. Additionally, the RN Progress note at 2114 failed to document the times that "neuro checks [were] unremarkable", or whether the 2114 note was the documentation of the 2130 neuro check. For instance, the unwitnessed fall occurred at 11:28 and per protocol, neurological assessments were due at: ~1230, 1330, 1430, 1530, and then every 4 hours x4 afterwards; ~ 1930, 2330, 0330 and 0730. Only five sets of vital signs were documented after the fall on that shift: 1140,1240, 1340, 1445, and 1855. The only neurological assessment was documented at 1942. Nursing progress notes did not reflect that vital signs or neurological assessments were completed and documented "in a nursing progress note immediately following completion." A PMHNP assessment was documented at "12:40",	A 450		

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A 450	Continued From page 195	A 450		

however, the progress note does not clearly state whether a neurological assessment was conducted at that time. There were no "Nursing Fall Notes by Patient" provided.
- On [redacted]/2025: The DCMO's note at 0015 note did not specify the time of service for the late entry as required by the hospital's policy, "Clinical Documentation ... 6.045" which reflected, "reference the actual date and time of the service provided, observation, and/or event."

5.c. During a follow up medical record review with the CS, SP(H), SC/OPA3 on [redacted]/2025 beginning at 1005, Finding 5.b. was confirmed. The SP(H) acknowledged that there were no LIP notes justifying the continuation of the ES 1:1 medical. When asked to "pull up" LIP progress notes for the medical justification, the SP(H) stated, "It doesn't pull up. I don't see one."

5.d. Regarding the availability of Durable Medical Equipment for [redacted]:
* [redacted] a previously admitted patient with a known fall risk who required specialized Durable Medical Equipment (DME) and glasses was [redacted]'s [redacted] FRA also reflected "Clinically indicated risk level "Moderate", and that "Patient does have history of seizures and has fallen several times injuring [themselves] to include some facial fractures ... Patient has multiple recorded falls related to seizures. [redacted] However, despite the known fall risk and previously documented "facial fracture" injuries due to falls, [redacted] during which time [redacted] suffered two documented falls, and possibly three, which resulted in patient injury.

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A 450	Continued From page 196 * An email string provided to the surveyors reflected the following information: * "On [redacted], Director of Nursing, sent an email to [CoM] @ 8:13am ... Good Morning, I wanted to bring up a situation that I am hoping to be able to get a solution to. [OSH Unit]3 has a patient [redacted] who has a known seizure disorder. [Patient] has had a few seizures since coming to OSH ... We are working ... on [redacted] interventions to keep [them] safe when ... seizures occur but one thing that [redacted] [patient] [redacted] mentioned were that [patient] needs glasses and that potentially the lack of appropriate glasses can be triggering ... seizures. [redacted] I was wondering if it is possible to expedite a optometry appointment for [patient] so that [they] can potentially have less seizures and prepare for [their] evaluation. At this point [patient] is saying that [they] can't read anything or concentrate. We attempted readers but those weren't successful and caused [patient] to have an increase in auras. Please let me know if this is an option that we could provide or if anyone has any other thoughts on how we could expedite any solutions. [DNS]" *An email dated [redacted]/2025 at 1109 from the CoM to the DNS in response to their email reflected: * "Subject: Re: Expedited optometry appointment?" * "I do not know if any glasses corrected vision need that triggers seizures. [redacted] 5. e. A document that contained a follow up email from the DCN to the DNS dated [redacted]/2025 at 252 reflected:	A 450		

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A 450	Continued From page 197 * "Just to confirm, you still have been unable to get an appointment correct?" * The document included a note on the last page which reflected, "[redacted]: patient has yet to be seen and still does not have glasses. [Their] apt [sic] is not until [redacted]." This was [redacted] days after the patient was admitted. 5.f. [redacted]'s Treatment Care Plans: * [redacted]'s TCP dated [redacted]/2025 was reviewed and reflected: "Reason for Review ... 10 Day TCP Review ... Plan Started: [redacted]/2025 ... Did the patient participate in the development of this plan?: No ... Plan Type: Scheduled Review ... Problems listed included" - "Encounter for competency evaluation" - "Seizure disorder" - "Long Term Goal" ... [redacted] will be free from injury from seizures over the next 6 months ... Feedback from me: ... 'I've got scars from falling' reports it has been a while since [redacted] - Eleven interventions were listed, including "Nursing staff will remove glasses if possible ... Start Date: [redacted]/2025". - "Electronically signed by ... PMHNP on [redacted]/2025 at 10:59 AM". * A 2-page document titled, "Oregon State Hospital Treatment Care Plan Addendum" dated [redacted]/2025, had [redacted]'s first and last name handwritten at the top of the first page and lacked a patient DOB. It was reviewed and reflected: - The form lacked an "Addressograph Label"	A 450		

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A 450	Continued From page 198 affixed to either page 1 or page 2 of the document as required by policy. - The form lacked a medical record number as required by policy. - On the first page of the document the "Problem" section had a box with an "X" next to "From current TCP-Date:" and the space following this date was blank. - The section "Goal (Long Term) had a box with an "X" next to "From current TCP" and for "Target Date:" was "Pt will be free of injury from seizure". There was no target date written. - The section "Short-Term Goals" had a box with an "X" next to "From current TCP" and for "Target Date:" was "follow all recommendations of medical clinic to manage seizure disorder". There was no target date written. - Under the section "Services/Interventions and Frequency/Duration" was: "1. Enhanced Supervision 1:1 medical due to seizures [sic] Follow intervention card [sic] 2. Fall mats placed on either side of bed". Also in this section with darker and thicker ink was "3. Note time seizure begins monitor length of time with stop-watch I provided or pt clipboard". The initials next to this entry were illegible. - A printed staff name with signature was at the bottom of page one and was dated "[redacted]/25" at "1:03" and there were no identifying credentials associated with the name/signature. - Under the staff signature was a line for patient comments, signature, whether the patient understood and agreed to the addendum, as well as a date line. These areas were all blank. - The second page lacked [redacted]'s first and last name and did not include the patient's medical record number as required by policy. - At the top of the second page was a section that reflected: "If patient is unwilling or unable to	A 450		

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A 450	Continued From page 199 participate in this TCP addendum or refuses to sign, provide comment and sign below. Comment: Agreed to 1:1 as making him feel safer agreed to mats on the side of bed". This was followed by a "Staff Printed Name ... Staff Signature ... Date ... [and] Time". It was signed by the same staff who filled out the first page and was dated "[redacted]/25". It did not reflect the timing of the seizures, stopwatch or patient's clipboard. - A line followed with "Guardian notified of addendum Yes ... No ... N/A" and N/A had an "X" next to it. Date and Time were blank. - "After Completion, scan & send electronically to IDT members". The information under this section was blank, and included: - "IDT Reconciliation with Treatment Care Plan ... Approved and Added to TCP ... Yes ... No ... If yes, Date ... Time ..." - "Comments (If not approved, provide reason)" - "MD/PMHNP Printed Name" - "MD/PMHNP Signature ... Date ... Time ... " - "RN Printed Name" - "RN Signature ... Reviewed by IDT Date ... Time ..." * [redacted]'s TCP dated 03/27/2025 was reviewed and reflected: "Reason for Review ... amendment: Enhanced supervision ... Plan Started: [redacted]/2025 ... Did the patient participate in the development of this plan?: No ... Plan Type: Unscheduled Review ... Problems listed included" - "Encounter for competency evaluation" - "Seizure Disorder: [redacted] has a long history of seizures. [redacted], [redacted] has had 3 seizures, 2 of which resulted in striking [their] head. [They] have been provided with [redacted] and was placed on enhanced supervision 1:1 Medical ... Feedback from me: ... requested [redacted]	A 450		

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A 450	Continued From page 200 - "Changes we are making ... Enhanced Supervision 1:1 [redacted] will request a medical bed". - "Long Term Goal" ... [redacted] will be free from injury from seizures over the next 6 months". - "Electronically signed by: ... [DO B] on [redacted]/2025 at 10:58 AM" * [redacted]'s TCP dated [redacted]/2025 was reviewed and reflected: "Reason for Review ... amendment ... Plan Started: [redacted]/2025 ... Did the patient participate in the development of this plan?: No ... Plan Type: Unscheduled Review ... Problems listed included" - "Encounter for competency evaluation" - "Seizure Disorder: [redacted] has a long history of seizures. [redacted] has had 3 seizures, 2 of which resulted in striking [their] head. [They] have been provided with [redacted] and was placed on enhanced supervision 1:1 Medical. [Their] Nightstand [sic] and Bed [sic] were removed, [their] mattress was placed on the floor with fall mats beside it all to mitigated [sic] risk of injury from falls ... Feedback from me: ... did not participate - amendment". - "Changes we are making ... removed nightstand and be [sic] mattress on the floor fall mats beside mattress". - "Long Term Goal" ... [redacted] will be free from injury from seizures over the next 6 months". - "Electronically signed by: ... [DO B] on [redacted]/2025 at 10:59 AM" [redacted]'s TCPs did not contain all elements as required by policy, contained inaccurate information, and did not clearly reflect when interventions began. For example, the falls were not listed as a separate TCP problem although [redacted] had a history of injuries from falls and	A 450		

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A 450	Continued From page 201 had suffered two known falls, and possibly three falls with injuries since admission. Additionally, the TCP dated [redacted]/2025 incorrectly noted: "[redacted] has been provided with [redacted]" although EHR documentation clearly reflected that [redacted] did not receive [redacted] until [redacted]/2025 at 1645, one full day after the [redacted]/2025 TCP had "started", refer to Finding 5.b., RN Progress Note dated [redacted]/2025 at 1627. Under the intervention section of the seizure disorder "problem" the ES Medical 1:1 start date was listed as "[redacted]/2025" when the actual order date was [redacted]/2025 at 1909. The TCP dated [redacted]/2025, reflected that nursing would remove [redacted]'s glasses, when the [redacted] FRA reflected that patient [redacted] "has difficulty seeing without glasses." Refer to Finding 5.b., FRA dated [redacted] Further, this vision concern from the [redacted] FRA was not listed as one of [redacted]'s medical problems on their TCP. Additionally, the TCPA form was incomplete and did not contain all patient identifiers as required by the hospital's documentation policy. It was unclear when the patient agreed to the TCP addendum interventions listed on page one. For example, staff who filled out the second page comments for [redacted] who was "unwilling or unable to participate in this TCP addendum or refuses to sign ..." dated their comments on [redacted]/2025, one day prior to the MD assessment and order for Enhanced Supervision 1:1 Medical, three days prior to the information noted on page one on [redacted]/2025, and three days prior to the PMHNP education as documented in the progress note below on [redacted]/2025 at 1352. Additionally, the added information on page one was initialed by an unknown person, was not dated, and was not included in the comments on page two. Further, it was unclear whether IDT	A 450		

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A 450	Continued From page 202 involvement was solicited as LIP signature lines on the TCP Addendum were left blank and undated. Refer to Finding 3.a., the Fall Risk Assessment P&P, 2.200, which reflected, "Meet with the patient's Interdisciplinary Treatment Team ... and incorporate the issue into the patient's TCP". 5.g. During a follow up medical record review with CS, SC/OPA3, and SP(H) on 04/10/2025 beginning at 1005, Finding 5.f. was confirmed. The SP(H) was asked to show where [redacted]'s TCP addressed falls. The SP(H) confirmed that falls were only mentioned under the listed "Seizure Disorder" problem. Further, when asked to confirm whether [redacted] had [redacted] on [redacted]/2025 as reflected on the TCP of the same date, the CS confirmed that it was incorrect. 6. Regarding [redacted]: the hospital failed to provide radiological services for a medical patient 24/7, and medical x-ray was not available for 2 days. Two LIPs noted radiological services were not available until from [redacted]/2025 through [redacted]/2025. * "Patient Progress Notes" written by an OSH PMHNP on [redacted]/2025 at 1639 included the following: "ID/CC/Subjective: Status update" [:] - "On [redacted]/25, RN reported, 'It was reported that the patient has a tea colored urine, stomach pain, no blood in the urine, no burning sensation, and a little lethargic. Vital signs taken ... patient has a soft abdomen, and not distended. Patient states 'feeling not good', 'my stomach feels pretty swollen and I'm a little dizzy', ' I haven't poop [sic] since I came here' ... Updated the medical on call provider through voicemail ... The provider went to see the patient on the unit and will order some	A 450		

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A 450	Continued From page 203 medications...'". - "On [redacted]/25, RN wrote, 'Staff reports brown colored urine, reddish-brown clots. States 6/10 pain near anus and lower intestines. Vitals taken ... Replied 'yes' when asked if ... had frequent urges of urination. UA ordered by on-call.'" - "On [redacted]/25, RN wrote, 'Pt screaming around 0850 ... C/O pain in lower abdominal area, states ... is having a miscarriage. Admission lab draw results are negative for pregnancy. Pt had episode of incontinence, including feces ... PRN meds given. Pt has long history of constipation ... pt continued to c/o pain. PRN Tylenol given ... Multiple attempts were made by different staff to have pt sit on toilet to try and have a BM ... Med clinic called and stated they are aware of a long history of constipation, pt has poor history of giving accurate accounts of medical issues. Will continue to monitor patient.'" - "S: PMHNP met with pt in ... room with 2 RNs present. Pt ... reported 10/10 rectal pain and 5/10 bladder pain. Pt allowed PMHNP to assess, no hemorrhoids visualized, no impaired skin integrity. Stool visible at rectal opening. With regards to bladder pain: pt denies urinary urgency, frequency or pain upon urination, but reports 5/10 bladder pain ... continues to be incontinent intermittently, chux pad placed on bed, pt remains on close obs ... Per RN report, pt has had approximately two small BMs today ... RN noted that it is difficult to determine presence of distention and bloating due to large abdominal girth. Per RN, bowel tones audible right lower quadrant, barely audible in right upper, none heard anywhere left upper or lower. Upon palpation: firm in bilateral lower quadrants. Pt has not been noted with emesis ... PMHNP notified clinic FNP via TEAMS and completed consult with information highlighted above. FNP ... asked	A 450		

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A 450	Continued From page 204 about possible imaging at ED due to unavailability of imaging at OSH until [redacted]/25. After further discussion, FNP asked for staff to continue to monitor; PMHNP asked RNs to notify OD if pt's presentation worsens and/or unable to produce BM following mag citrate." * "Patient Progress Notes" written by an OSH NP on [redacted]/2025 at 1757 included the following: - "Subjective: Patient reported to unit nurse 10/10 rectal pain (no hemorrhoids) and bladder pain 5/10. Upon unit nurse assessment, patient has soft abdomen, not distended. Denies blood in urine, or dysuria ... Notify MOD for worsening symptoms: fever, chills, rectal bleeding, vomiting. XR imaging is not available until Thursday. Consider referring to SHED for abdominal XR if symptoms persists or worsen." The PMHNP progress notes were not timely and failed to include all information as required by hospital policy. For example, PMHNP notes did not specify the times of service for entries dated [redacted]/2025, [redacted]/2025, and [redacted]/2025 as required by the hospital's policy, "Clinical Documentation ... 6.045" which reflected, "reference the actual date and time of the service provided, observation, and/or event." Therefore, it was unclear documentation whether "physician coverage" was provided "24 hours daily to care for hospitalized patients ... During regular business hours," or whether [redacted] was "attended to by Psychiatrists/Psychiatric Mental Health Nurse Practitioners (PMHNPs) and Primary Care Practitioners" in accordance with the hospital's policy. It was not clear whether a POD, MOD, MD or PMHNP was available to "respond to see a patient on a unit when requested by the nursing staff". The EHR for	A 450		

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A 450	Continued From page 205 [redacted] demonstrated that [redacted] experienced significant complaints of abdominal pain for 3 days prior to an assessment by a medical doctor or PMHNP. Additionally, the "S" (Subjective) documentation did not clearly identify for which encounter the PMHNP conducted an assessment, times when nursing staff noted the abnormal urine on [redacted]/2025 and [redacted]/2025 were omitted in the PHMHNP progress notes, and so it was unclear whether the time of day, i.e., after hours vs. business hours, was a factor in the delayed assessment. 7.a. Regarding [redacted]'s medical record documentation: * A Fall Risk Assessment (FRA) written by an OSH RN on [redacted]/2025 at 1207 included the following: "Type of Assessment: Other ... Reason for Assessment: Post fall on [redacted]/25 ... History of Falls (a fall occurred within last 3 months): Yes ... Vision: previous assessment: Optometry appt scheduled for [redacted] ... Transfers: Ambulates slowly, shuffling gait ... Medication Use: [redacted] has been adherent with taking ... schedule medications ... Mobility/Gait: Unsteady/Weak ... Mobility: short steps, ambulates slowly ... ADLS ... at times wearing socks when ambulating, encourage ... to wear appropriate footwear ... Risk Level: Moderate". * A Fall Risk Assessment (FRA) written by an OSH RN on [redacted]/2025 at 1619 included the following: "Type of Assessment: Other ... Reason for Assessment: Patient fell ... History of Falls (a fall occurred within last 3 months): Yes ... Vision: previous assessment: Optometry appt scheduled for [redacted] ... Transfers: Ambulates slowly, shuffling gait ... Medication Use: [redacted] has been	A 450		

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A 450	Continued From page 206	A 450		

adherent with taking ... schedule medications ... Mobility/Gait: Unsteady/Weak ... Mobility: short steps, ambulates slowly ... ADLS ... at times wearing socks when ambulating, encourage ... to wear appropriate footwear ... Risk Level: Moderate".

* "Nursing Fall Notes by Patient" written by an OSH RN on [redacted]/2025 at 0357 reflected the following:
- "2235 VS obtained, T-98.2 P-110 R-16 BP-121/87 SpO2 91-92% on RA. Sternal rub was performed to arouse patient, alert but continues to have difficulty keeping his eyes open. PNM notified about patient's current status. 0010 patient awoke on ... own while myself and ... LPN entered the room. Patient unable to form words and attempting to speak with a raspy voice. VS obtained, T-98.2 P-114 R-16 BP-129/92 SpO2 92%. OD notified, order obtained to hold the remainder of ... HS medications for over sedation and since patient is unable to comply with PO meds. During 0100 rounds, I was walking around with staff performing my Lead viability checks and an MHT called for my assistance ... MHT was standing at patient's room and reported that [patient] fell but did not witness the fall. Observed patient on the floor of the entrance to the bathroom. Assessed patient for head injury, no apparent head injury. Patient asked for assistance, awaited for more staff to assist. Assisted patient back to ... feet and onto ... bed. Patient did not appear to be in any pain as we manually assisted ... back to ... bed. OD/ PNM notified. Fall protocol initiated, fall risk assessment completed, patient is now at high risk. Assessed head, no signs of head injury."
- "Time of Fall: 0100-0105".
- "Neurologic Assessment if Hit Head: 0110 - Did

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A 450	Continued From page 207 not appear to have any head injury, unknown if hit head, Neuro check completed, VS obtained T-97.8 P-122 R-20 BP-132/89 SpO2-95% on RA, PERRL and unable to assess accomodation[sic], slurred speech, has had difficulty with speech since [redacted]/25 afternoon administration of Suboxone, A+O X 2 to person, place, full/equal grip strength bilateral upper extremities, diminished/weak strength bilateral lower extremities". -"Time of Fall Protocol Assessment: 0210". - "Assessment ... Asleep during assessment, difficult to wake, sternal rub awoke patient ... Significant changes from prior assessments ... diminished SpO2 91% on RA, no significant changes from presentation throughout previous shift and the start of NOC shift ... Nursing actions take [sic] ... Continue to monitor ... Will notify OD for any significant changes". * "Patient Progress Notes" written by the Sup/CMO on [redacted]/2025 at 0407 reflected the following: - "Code blue called at 0315. Pt awoke briefly earlier and attempted to get up to the bathroom, fell (unwitnessed). RN reports fall risk elevated to high on reassessment, neuro checks WNL except what cannot be evaluated due to sedation. Pt too sedated to take HS meds, and O2 sats dropping to low 90s by 0030. Per RN, O2 sat dropped below 90% on room air, so code blue called. Pt placed on O2 2L by NC by RN." - "Assessment/Plan: Sedation most likely cause of drop in O2 sat, given shallow breathing. O2 sat improved with 2L by NC. Pulse mildly elevated but steady, consistent with readings earlier in the evening. Administered Narcan 4 mg intranasally x1, given that increased sedation began after Suboxone dose yesterday, without observable	A 450		

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change.
- continue O2 2L by NC
- 1:1 medical supervision to monitor O2 sat and safety with ligature (cannula)
- if pt declines any further, send to Salem Hospital ED. Pt to be seen by medical OD tomorrow."

* "Nursing Fall Notes by Patient" written by an OSH RN on [redacted]/2025 at 0450 reflected the following:
- "Time of Fall Protocol Assessment: 0310".
- "Assessment findings ... SpO2 88-91% RA, Code blue called, patient barely responsive, aroused by a firm sternal/chest rub, patient not responsive to verbal commands ... Significant changes from prior assessments, if any: see above ... Nursing actions take [sic] ... Code blue called, 2L oxygen administered, Narcan administered. Patient placed on 1:1 medical precautions, continue to monitor pulse/oxygen saturation. Continue fall protocol. Plan is to continue to monitor and report any changes in presentation to [Sup/CMO]. Provider and RN notification, as indicated: [Sup/CMO] present, PNM present ..."

* "Nursing Fall Notes by Patient" written by an OSH RN on [redacted]/2025 at 1418 reflected the following:
- "Throughout the swing shift and Noc shift [redacted] seemed overly sedated. First dose of Suboxone given during day shift of [redacted]/25. Throughout the day sedation continued. Staff found [redacted] had fell in ... room and was lying on the ground around approx 0100 and hourly neuro checks initiated. During the 0300 hour neuro check [redacted] oxygen saturation was floating between 88 and 91. We decided to call a code blue due to the low O2

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sats. All other vitals within normal limits. Code blue called, Suboxone was discontinued, Nacran administered, and administered 2L of o2 [sic] via nasal canula. O2 sats bumped up to 96-97 on o2. [redacted] was placed on a 1:1 medical for falls and ... over sedation. During the 0400 hour, LPN was on rounds and was flagged by the 1:1 to assist. Upon arrival [redacted] was trying to get out of ... bed. [Patient] had urinated the bed and was very weak when trying to assist [them] up in bed. MHT and LPN were able to successfully change ... soiled clothing and linens. Applied antislip socks and assisted [them] back to ... bed."

* "Patient Progress Notes" written by an the MCD on [redacted]/2025 at 1434 and finalized on [redacted]/2025, reflected the following:
- "Late Note ... ON CALL NOTE CODE BLUE FOLLOW UP".
- "Subjective: Patient was evaluated on the unit in [their] room with nursing staff present and 1:1. Received a telephone call from POD ... regarding flowers three patient this morning to follow up on patient after code blue ... On [redacted]/25 patient seemed overly sedated throughout the day per nursing staff after first dose of Suboxone 2 mg sublingual had been given at noon ... was then was found on the floor of ... room around 1 o'clock which initiated hourly neuro- checks. Around 3 o'clock a code blue was called due to low oxygen saturation and 2 L of oxygen was administered via nasal cannula which was able to improve [their] saturation up to 97%. Then naloxone/Narcan 4 mg nasal spray was administered at 322 due to decreased arousal and oversedation of medication effects. Continue to have decreased arousal at bedside requiring physical touch and repeated verbal commands

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A 450	Continued From page 210 before patient responded. When ... oxygen was removed ... oxygen saturation on room air drops to 88%. Advised staff to replace the oxygen via nasal cannula at 1 L which improves stats up to 97%. Patient remained stable at 97% during my physical examination. Patient reports feeling a little bit tired. Denies any further positive review of symptoms ..." * "Nursing Fall Notes by Patient" written by an OSH RN on [redacted]/2025 at 1620 reflected the following: - "Time of Fall Protocol Assessment: 1610". - "Assessment ... All VS and brief Neuro assessment within normal range, Clear speech, responds to verbal commands, asked to smile and [redacted] gave me a big smile, PERRLA, full and equal grip strength in upper extremities, full and equal strength in lower extremities ... Nursing actions take [sic] ... Will continue to monitor and assess per policy". - A Fall Risk Assessment (FRA) written by an OSH RN on [redacted]/2025 at 1525 included the following: "Type of Assessment: Other ... Reason for Assessment: Fall ... History of Falls (a fall occurred within last 3 months): Yes ... Vision: States ... has 'blind spots', often squinting; optometry appt scheduled for 6/26 ... Transfers: Ambulates slowly, shuffling gait, stumbles at times ... Medication Use: Patient took Suboxone ... earlier in the day of the fall ... Mobility/Gait: Unsteady/Weak ... Behaviors: Patient often insists ... is fully capable of taking the stairs despite gait disturbance and elevator-only order ... stumbles and catches [themselves] on walls ... Environment ... struggles with keeping belongings tidy. Sleeps with numerous blankets ... has been seen getting tangled in when getting	A 450		

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A 450	Continued From page 211 out of bed ... ADLS ... at times wearing only socks when ambulating and insists on wearing oversized sandals ... Risk Level: High". The hospital failed to document nursing FRAs in a timely manner in accordance with hospital policy. A fall was noted on [redacted]/2025, however a FRA assessment was not documented until 03/06/2025 and did not include the time of the fall. Further, a "Nursing Fall Notes by Patient" progress note was not provided for the [redacted]/2025 fall. A FRA after [redacted]/2025 fall was not provided by the hospital and documentation of the [redacted]/2025 0500 hourly neuro checks, as well as the 0900, 1300, 1700 then 2200 neuro checks were not provided. 7.b. [redacted]'s Treatment Care Plans: * A 2-page document titled, "Oregon State Hospital Treatment Care Plan Addendum" had [redacted]'s first and last name printed at the top along with their MRN. A DOB was not noted. It was reviewed and reflected: - The form lacked an "Addressograph Label" affixed to either page 1 or page 2 of the document as required by policy. - On the first page of the document the "Problem" section had a box with an "X" next to "New", and under this was noted: "Pt experienced an unwitnessed fall in bathroom without head injury. Pt currently a high fall risk, risk score of 75 on fall screening. 1:1 initiated. Date identified: [redacted]/2025 Status: [was blank]" - The section "Goal (Long Term) had a box with an "X" next to "From current TCP" and for "Target Date:" was blank. - The section "Short-Term Goals" had a box with an "X" next to "From current TCP" and the	A 450		

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A 450	Continued From page 212 "Target Date:" was blank. - Under the section "Services/Interventions and Frequency/Duration" was: "Nursing staff will assure [redacted] to ask for assistance prior to attempting to stand and will further inform staff when experiencing any weakness and/or dizziness". - A printed RN name with signature was at the bottom of page one and was dated "[redacted]/25" at 0500". - Under the staff signature was a line for patient comments, signature, whether the patient understood and agreed to the addendum, as well as a date line. These areas were all blank. - The second page lacked [redacted]s first and last name and did not include the patient's medical record number as required by policy. - At the top of the second page was a section that reflected: "If patient is unwilling or unable to participate in this TCP addendum or refuses to sign, provide comment and sign below. Comment:", which was blank. This was followed by a "Staff Printed Name ... Staff Signature ... Date ... [and] Time". This section too was blank. - A line followed with "Guardian notified of addendum Yes ... No ... N/A" and all were blank. - "After Completion, scan & send electronically to IDT members". The information under this section was blank, and included: - "IDT Reconciliation with Treatment Care Plan ... Approved and Added to TCP ... Yes ... No ... If yes, Date ... Time ..." - "Comments (If not approved, provide reason)" - "MD/PMHNP Printed Name" - "MD/PMHNP Signature ... Date ... Time ... " - "RN Printed Name" - "RN Signature ... Reviewed by IDT Date ... Time ..."	A 450		

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A 450	Continued From page 213 The TCPA form was incomplete and did not contain all patient identifiers as required by the hospital's documentation policy. It was unclear when the patient agreed to the TCP addendum interventions listed on page one. For example, the form had no patient signature, and the second page comments for [redacted] who was "unwilling or unable to participate in this TCP addendum or refuses to sign ..." was blank. Further, it was unclear whether IDT involvement was solicited as LIP signature lines on the TCP Addendum were left blank and undated. Refer to Finding 3.a., the Fall Risk Assessment P&P, 2.200, which reflected, "Meet with the patient's Interdisciplinary Treatment Team ... and incorporate the issue into the patient's TCP". 8.a. Regarding [redacted]'s medical record documentation: * A Fall Risk Assessment (FRA) written by an OSH RN on [redacted]2025 at 1329 included the following: "Type of Assessment: Admission ... History of Falls (a fall occurred within last 3 months): Yes ... Vision: Pt experiences difficulty with seeing objects and signs ... Transfers: Pt appears impulsive, requires 2 person assist with transfers Pt utilizing wheel chair for ambulating ... Mobility/Gait: Impaired: Requires assistance/supervision ... Mobility: Requires supervision ... ADLS ... Requires total assist with ADLs ... Risk Level: High". - "Electronically Signed by: [an OSH RN] on [redacted]/2025 at 01:29 PM PDT Author" - "Date Appended: [redacted]/2025 at 10:11 AM ... Document submitted under [an OSH RN] in error; assessment completed and documented by [a second OSH RN] ... Electronically Signed by: [the second OSH RN] on [redacted]/2025 at 10:11 AM ... Appended Author".	A 450		

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A 450	Continued From page 214 * A "Psychiatric Admission Assessment" by an OSH PMHNP dated [redacted]/2025 at 1903 reflected the following: - "Assessment (include reasoning for suicide/violence risk assessment) ... [Patient] is at high risk for falls as ... had a fall in [redacted] in which [they] hit [their] head resulted in [redacted] subdural hematomas. Due to this fall risk ... has been placed on 1:1 Medical Precautions." * A "Patient Progress Notes" written by an OSH MD dated [redacted]/2025 at 1244 reflected the following: - "[redacted] - "[Patient] is at high risk for falls as ... had a fall in [redacted] in which [they] hit [their] head [sic] resulted in [redacted] subdural hematomas. Due to this fall risk, [patient] has been placed on 1: 1 Medical Precautions." [redacted] * A Fall Risk Assessment (FRA) written by an OSH RN on [redacted]/2025 at 1409 included the following: "Type of Assessment: 10-day ... History of Falls (a fall occurred within last 3 months): Yes ... Vision: Pt experiences difficulty with seeing objects and signs ... Transfers: Pt appears impulsive. Requires 1p SBA with transfers. Uses	A 450		

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A 450	Continued From page 215 FWW for mobility on unit and wheelchair for longer distances off unit ... Mobility/Gait: Impaired: Requires assistance/supervision ... Mobility: Requires supervision and use of adaptive devices ... ADLS ... Requires staff assist with ADLs ... Risk Level: High". * A "Patient Progress Notes" by an OSH MD dated [redacted]/2025 at 1338 reflected the following: - "Late entries for [redacted]/25, [redacted]/25, [redacted]/25". - "S On [redacted]/25 writer met with patient in ... room with staff present. [Patient] was lying in bed with ... wheelchair in the corner. On [redacted]/25, observed [redacted] using ... walker to in the halls for ... OT sessions. On [redacted]/25, [patient] was sitting comfortably in the milieu. [Patient] used ... walker to ambulate from ... room to the milieu. No current complaints." - "O General: no acute distress, well appearing, cooperative, pleasant HEENT: normocephalic atraumatic sclera anicteric, no conjunctival injection, PERRL, EOMI no nystagmus, lids normal. Nares without exudate. Moist oral mucosa, uvula midline. Heart: S1, S2 heard, no murmurs, rubs or gallops Lungs: equal excursion bilaterally, no accessory muscle usage, speaking in full sentences, CTA bilaterally Abdomen: ,softnormal [sic] active bowel sounds present, non-distended, non-tender, no rebound/guarding/rigidity Neck: AROM Extremities: Moves all. Uses wheelchair and walker for ambulation. No calf tenderness, noncyanotic, no pedal edema appreciated,] [sic] Integumentary: warm, dry, intact, good skin turgor". - "A/P Medical 1:1 Justification [redacted] [They are] ... progressively increasing ... endurance using ... walker. 1:1 is still needed because ... at	A 450		

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A 450	Continued From page 216 risk for a fall Appreciate OT, SLP, and Dietitian recs ... Discussed assessment and treatment care plan with unit nurses ... VITAL SIGNS ..." - "[redacted]25 11:30, T: 97.2 F ... P: 79 ... R: 15 ... BP: 125/87 ... spO2: 97 %" - "[redacted]/25 12:00, T: 97.2 F ... P: 79 ... R: 15 ... BP: 125/87 ... spO2: 97 %" - "[redacted]/25 16:13, T: 97.9 F ... P: 94 ... R: 18 ... BP: 106/73 ... spO2: 94 %" - "[redacted]/25 11:15, T: 97.1 F ... P: 66 ... R: 18 ... BP: 109/73 ... spO2: 94 %" - "[redacted]/25 15:00, P: 68 ... R: 16 ... spO2: 97 %" - "[redacted]/25 11:01, T: 97.8 F ... P: 72 ... R: 16 ... BP: 113/69 ... spO2: 94 %" - "[redacted]/25 07:15, T: 97.3 F ... P: 68 ... R: 18 ... BP: 118/79 ... spO2: 96 %" * A "Patient Progress Notes" written by am OSH MD dated [redacted]/2025 at 0936 reflected the following: - "ASSESSMENT & PLAN ... Enhanced Precautions: Changed to 1: 1 Medical for fall risk during day and swing shift & Close Medical during noc shift ... Discharge ... back home with outpatient follow-up [redacted] The DCMO's progress notes were not timely and failed to include all information as required by hospital policy. For example, the DCMO notes dated [redacted]/2025 did not specify the times of service for the late entries as required by the hospital's policy, "Clinical Documentation ... 6.045" which reflected, "reference the actual date and time of the service provided, observation, and/or event." Therefore, it was unclear for which encounter the general "O" was written. Additionally, progress notes reflecting the justifications for the continuation of the ES 1:1 medical were required every 5 days after initiation	A 450		

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A 450	Continued From page 217 of the order: [redacted]/2025, [redacted]/2025, and [redacted]/2025. Although the DCMO note reflected, "A/P Medical 1:1 Justification ... 1:1 is still needed because [they are] ... at risk for a fall," the note did not clearly reflect on which encounter date and time the assessment for continued ES 1:1 medical was conducted. Furthermore, [redacted]'s EHR lacked a 14-day reassessment of the need to continue the ES 1:1 medical progress notes documenting leadership notification, discussions of "rationale for ongoing supervision, [or] alternatives considered" as required in policy, and which "must be repeated at each consecutive 14 days their patient remains on 1:1 supervision" which was required on [redacted]/2025. The progress notes were unclear as to the date(s) and time(s) the MD "Discussed assessment and treatment care plan with unit nurses". Additionally, the MD progress note dated [redacted]/2025 failed to provide a rational for [redacted]'s change in ES 1:1 medical parameters from 24 hours around the clock to "Close Medical" during NOC shift in accordance with hospital policy. Policy 6.010, Procedures A, staff responsibilities reflected, "Patient assessment ... and rationale for ... change of enhanced supervision orders must be documented in a progress note". A separate Progress Note documenting whether a "Patient assessment," as required by policy when ES is changed or modified, was not provided. There was no documentation in [redacted]'s EHR that they received ECT treatments. Nursing staff failed to fully implement the hospital policy, Clinical Documentation Policy: 6.045. For example, the FRA dated [redacted]/2025 at 1329, reflected that findings were documented under another RN's name and EHR account login credentials. The error was not discovered or	A 450		

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A 450	Continued From page 218 corrected for ~ 8 days. 8.b. An email sent on [redacted]/2025 at 1005 from the MCD to the DCMO reflected, "The following Medical 1:1 notes are overdue ... [redacted] was due on [redacted]/25 ... Please complete notes as soon as possible." 8.c. Emails dated [redacted]/2025 at 1806 and provided to the surveyors during the survey confirmed Finding 8.a.: - "Today to [MCD and DCMO) ... Good morning. In [CoM's] absence, [Sup/CMO] mentioned that you were covering ... [redacted] ... [redacted] for catatonia and head injury due to significant falls. [They have] been on a medical 1:1 since admission. I let [CoM] know there were no notes from the clinic and [they] said [they] would let you know. we [sic] checked today and there are still no notes. can [sic] we get some notes into [redacted] chart please? ... [MCD]: Thank you for letting me know." - "To [PsychSup] related to my 1:1 audit on Sunday ... [redacted] ... I went back to [redacted]; [redacted] no medical notes, no notes re 1:1 ... ". 8.d. During a follow up medical record review with CS, SC/OPA3, and SP(H) on [redacted]/2025 beginning at 1005, Finding 8.a. was confirmed. The SP(H) stated "I don't see a note on [redacted]/[25]" regarding reassessment for ES 1:1 medical. 8.e. [redacted]'s Treatment Care Plans: * [redacted]'s TCP dated [redacted]/2025 at 1613 was reviewed and reflected: -"Reason for Review ... 10 Day Review ... Plan Started: [redacted]/2025 ... Plan Type: Initial Review ... Did the patient participate in the development of	A 450		

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this plan?: Yes ... My understanding of why I am here ... [redacted] ... Problems listed included"
- "Catatonia ... Feedback from my team: [redacted] for treatment of catatonia, [redacted]"
- "Fall Prevention. Fall Risk: High ([redacted]/25) ... Feedback from my team: [redacted] is at high risk for falls ... has not fallen at OSH, but ... reports 2 serious falls prior to hospitalization ... Interventions ... Enhanced supervision to help avoid falls and to prevent a fall/injury ..."
- "Osteoarthritis involving multiple joints on both sides of body".
- "Medical: Heart disease. Hypertension, hyperlipidemia, and obstructive sleep apnea ... Followed and managed by OSH Medical Clinic providers."
- "Electronically signed by: ... MD on [redacted]/2025" at 1629.

[redacted]'s TCP dated [redacted]/2025 further confirmed that [redacted]

9. Regarding [redacted]'s medical record documentation:
* On [redacted]/2025 an email sent at 1005 from the MCD to the DCMO reflected, "The following Medical 1:1 notes are overdue ... [redacted] was due on [redacted]/25 ... Please complete notes as soon as possible."

* On [redacted]/2025, the first day of the survey, an email string provided to surveyors reflected the following information:
- "Today [[redacted]/2025] ... To [PsychSup] related to my 1:1 audit on Sunday:

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A 450	Continued From page 220 [redacted] ES for 68 days; last note re medical 1:1 was 3/9 - fall risk and limited mobility; seems like we should have it more closely related to the actual medical needs and feeding tube and what contributes to fall risk ... [OSH Unit]1 and [OSH Unit]2 have been giving a lot of info to [PsychSup] and [Unit DNS]. But it seems like these concerns are going no where ..." * On [redacted]/2025 a "Patient Progress Notes" with the same date written by the DCMO at 0615 was provided, one day after MD notes were requested by the surveyor. These were reviewed and reflected: - "Late entries for [redacted].25, [redacted].25, [redacted]25 with update in Plan on [redacted].25". - "S" On[:] ... [redacted].25 saw and assessed [redacted] in ... room with staff present. [Patient] is making progress is communicating, moving from 'yes' or 'no' replies to using short sentences to express himself. [Patient] notes the PT session helping increase ... range of motion and also expressed ... increased need to rest after ... sessions." - "[redacted].25 Nurses reported soft, loose stools." - "On [redacted].25 saw and assessed [redacted] on the unit with staff present. [Patient] was seated comfortably in ... wheelchair in the TV room. Writer noted improvement in maintaining control of the special spoon utensil while eating dinner the previous the previous evening. [Patient] is able to express ... thoughts more clearly and states ... is feeling better. Denies having any current complaints." - "On [redacted].2025 writer briefly saw and interacted with [redacted] in the milieu. [Patient] was reading the newspaper and shared how much [they] enjoyed March Madness (college basketball finals), [sic]"	A 450		

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A 450	Continued From page 221 - "O" [:] ... On [redacted].25 Gen No acute distress ... HEENT: normocephalic atraumatic sclera anicteric, no conjunctival injection, moist oral mucosa, nares without exudate ... CV: regular rate and rhythm ... Lungs: clear to auscultation, no wheezes, rhonchi , or crackles ... Abd: soft, nontender in all quadrants, Jtube in place ... Musk: contracted lower extremities and upper extremities. Upper extremities able to partially passively extend, hands able to lightly grasp." - "On [redacted].25 Gen No acute distress ... Lungs: clear equal excursion bilaterally, no accessory muscle usage, unlabored respirations ... Abd: soft, nontender in all quadrants, Jtube in place". - "On [redacted].25 Gen No acute distress, cooperative ... HEENT: normocephalic atraumatic sclera anicteric, no conjunctival injection, moist oral mucosa, nares without exudate, decreased ptyalism, appreciable , nontender, right submandibular lymph node, no longer able to appreciate left submandibular nodule ... CV: regular rate and rhythm ... Lungs: clear equal excursion bilaterally, no accessory muscle usage, speaking in full sentences slowly, CTA Bilaterally ... Abd: soft, nontender in all quadrants, Jtube in place ... Musk: contracted lower extremities and upper extremities with improved range of motion (increased range of flexion and extension of the upper extremities, able to lift flex legs at the hips while seated). Hand grip improving". - "A/P"[:] ... [redacted].25 1:1 medical supervision is still needed due to limited mobility of the patient. Appreciate the recs from PT/OT/SLP/Dietitian/Wound Care teams HTN well controlled with amlodipine 5mg daily". - "[redacted].26 Loose/ soft stools Dc'd Miralax, lactulose Ordered daily Lactobacillus capsules for gut biome protection". - "[redacted].25 Submandibular nodules ... [redacted]/25 U/S	A 450		

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A 450	Continued From page 222 of neck / submandibular area result revealed bilateral large reactive level I submandibular nodules ... Ordered referral to ENT to assess with biopsy. 1:1 medical supervision is still needed due to fall risk". - "[redacted].25 Hours for 1:1 medical supervision adjusted for day and swing shift, when [Patient 18] is normally awake and out of bed for fall risk. Ordered close medical for overnight hours 10pm-7am the following morning. Orders for q2hrs, turning if patient is in bed is still in place ... Appreciate the recs from PT/OT/SLP/Dietitian/Wound Care teams Discussed assessments and treatment care plans with unit nurses." The MD progress notes were not timely or thorough, and failed to include all information as required by hospital policy. For example: - MD notes did not specify the times of service for encounters dated [redacted]/2025, [redacted]/2025, [redacted]/2025 and [redacted]/2025 as required by the hospital's policy, "Clinical Documentation ... 6.045" which reflected, "reference the actual date and time of the service provided, observation, and/or event." Therefore, it was unclear whether "physician coverage" was provided "24 hours daily to care for hospitalized patients ... During regular business hours," or whether a POD, MOD, MD or PMHNP was available to "respond to see a patient on a unit when requested by the nursing staff" after hours. The assessment of the "Jtube" did not include additional assessment information of the site such as skin integrity issues, or signs of infection, redness, swelling, or discharge, and only included "Jtube in place". - MD notes for the [redacted]/2025 encounter were written 25 days after the MD assessment, and notes for the [redacted]/2025 encounter were written	A 450		

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A 450	Continued From page 223 16 days after the MD assessment; neither were available for the clinical staff providing direct care for the patient well outside 72 hours. Hospital policy 1.017, "Provider Documentation Standards" reflected, "After provider evaluates patient, a SOAP note will be completed in electronic health record ... Note will be written expeditiously as defined below ... Non-urgent stable chronic conditions/Health maintenance: 72 hours". - MD reassessment notes justifying the continuation of [redacted]'s ES 1:1 medical were not thorough or completed as required by policy. Specifically, [redacted] had been on ES 1:1 medical for 68 days, however, per the email dated [redacted]/2025, a reassessment for ES 1:1 medical was overdue on [redacted]/2025. Using that date, the five-day reassessments for ES 1:1 medical would then be due [redacted]/2025, [redacted]/2025, and [redacted]/2025; and a 14-day reassessment would have been due [redacted]/2025. The hospital failed to document the "effectiveness of existing interventions to reduce or eliminate those symptoms or behaviors which require enhanced supervision" as required by policy 6.010, Procedures A, Staff Responsibilities. Furthermore, [redacted]'s EHR lacked a 14-day reassessment of the need to continue the ES 1:1 medical progress notes documenting leadership notification, discussions of "rationale for ongoing supervision, [or] alternatives considered" as required in policy, and which "must be repeated at each consecutive 14 days their patient remains on 1:1 supervision." The progress notes for the ES 1:1 medical modification on the entry dated "[redacted].25" did not contain an assessment or rationale for the modification as required by policy, 6.010 "Procedures A ... Staff Responsibilities." The policy reflected the	A 450		

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A 450	Continued From page 224 following when "discontinuation or change" of ES occurs: "Patient assessment ... and rationale for discontinuation or change of enhanced supervision orders must be documented in a progress note." It was inferred from the [redacted]/2025 email that the above examples, beginning on [redacted]/2025, were a reflection of the documentation which occurred throughout the 68 days on which [redacted] had ES 1:1 medical ordered. 10.a. Regarding [redacted]'s medical record documentation: * On [redacted]/2025 at 1458 the surveyor requested [redacted]'s "medical provider notes for ES Medical 1:1 justification for falls. ([redacted]/20250[sic]-present)" via email. No MD notes were provided. * On [redacted]/2025 at 1220 the surveyor again requested [redacted]'s "medical provider notes for ES Medical 1:1 justification for falls. ([redacted]/20250[sic]-present)" via email. * On [redacted]/2025 at 1415, the DSC provided the following response, "uploaded into the Onedrive". * The only document uploaded to the "Onedrive" was a document titled, "Client Profile - Single Order Detail". It was reviewed and reflected, "Order Date ... Time ... [redacted]/2025 10:45 ... Order Type: Enhanced Supervision ... Order Description: 1:1 Medical ... Order Text: Around the clock. On and off the unit. Staff to remain within visual and comfortable speaking distance. Use discretion re: appropriate distance to meet patient needs at the moment ... Special/Additional Instructions: Patient can attend Treatment Mall, Visits, Religious Services, Cafeteria and Quad. Patient may keep all property ... Reason: Primary Behavior(s) of concern: uses a wheelchair and is a significant fall risk, particularly given	A 450		

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neurocognitive disorder and limited problem solving ... Start Date/Time: [redacted]/2025 10:45 ... Stop Date/Time: [redacted]/2026 10:44 ... Last Update ... [MD name] ... [redacted]/2025 10:25 ... Last Action Taken: Discontinue ... "
* No MD progress notes were provided for the time period [redacted]/2025 through [redacted]/2025 as requested by the surveyor.

10.b. An email dated [redacted]/2025 at 1806 and provided to the surveyors the first day of the survey reflected the following information:
* "Today [[redacted]/2025] To [PsychSup] related to my 1:1 audit on Sunday ... [redacted]; ES for 34 days; 4 MIs 2017-2024; last note i [sic] saw was from [CMD] 3/11 and the 1:1 is related to ambulation ... [OSH Unit]1 and [OSH Unit]2 have been giving a lot of info to [PsychSup] and [Unit DNS]. But it seems like these concerns are going no where ..."

The MD progress notes were not timely or thorough, and failed to include all information as required by hospital policy. For example:
- There were no MD notes provided for [redacted] and it was unclear whether "physician coverage" was provided "24 hours daily to care for hospitalized patients ... During regular business hours," or whether a POD, MOD, MD or PMHNP was available to "respond to see a patient on a unit when requested by the nursing staff" after hours. Hospital policy 1.017, "Provider Documentation Standards" reflected, "After provider evaluates patient, a SOAP note will be completed in electronic health record ... Note will be written expeditiously as defined below ... Non-urgent stable chronic conditions/Health maintenance: 72 hours". Therefore, because of the lack of clinical documentation, it was unclear

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A 450	Continued From page 226 whether [redacted] was thoroughly evaluated, or whether their chronic medical conditions were being monitored by a medical provider. - Provider reassessment notes justifying the continuation of [redacted]'s ES 1:1 medical were not provided. [redacted] had been on ES 1:1 medical for 34 days, however, per the email dated [redacted]/2025, the last provider notes about reassessment for ES 1:1 medical were on [redacted]/2025. Using that date, the five-day reassessments for ES 1:1 medical would then have been due [redacted]/2025 and [redacted]/2025; and a 14-day reassessment would have been due [redacted]/2025, the day the ES 1:1 medical was discontinued. The hospital failed to document the "effectiveness of existing interventions to reduce or eliminate those symptoms or behaviors which require enhanced supervision" as required by policy 6.010, Procedures A, Staff Responsibilities. Furthermore, the hospital failed to provide documentation that [redacted]'s 14-day reassessments that justified the continuation of ES 1:1 medical progress were completed. Lastly, the hospital's policy reflected the following when "discontinuation or change" of ES occurs: "Patient assessment ... and rationale for discontinuation or change of enhanced supervision orders must be documented in a progress note" and no provider progress notes were provided to substantiate the change in supervision. 11.a. Regarding [redacted]'s medical record documentation: * An email sent on [redacted]/2025 at 1005 from the MCD to the above DCMO reflected, "The following Medical 1:1 notes are overdue ... [redacted] was due on [redacted]/25" ... Please complete notes as soon as possible." * On [redacted]/2025 at 1458 the surveyor requested	A 450		

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A 450	Continued From page 227 [redacted]'s "medical provider notes for ES Medical 1:1 justification for falls. ([beginning] [redacted]/2025)" via email. No MD notes were provided. * On [redacted]/2025 at 1220 the surveyor requested [redacted]'s "medical provider notes for ES Medical 1:1 justification for falls. ([beginning] [redacted]/2025)" a second time via email. * On [redacted]/2025 at 1415, the DSC provided the following response, "uploaded into the Onedrive". 11.b. "Patient Progress Notes" written by the DCMO dated [redacted]/2025 at 0945, a day after the notes had been requested, reflected: * "Notes Field: Late entries for [redacted]/25, [redacted]/25, [redacted]/25,[redacted]/25, [redacted]/25, [redacted]/25". * "S"[:] ... 3/12/25 Still complains of constipation, does not consistently use medications for bowel regimen." - "[redacted]/25 [redacted] is scheduled to have ... sleep study tonight. Reports improvement of ... lower back pain following [their] bilateral medial branch block ... last month." - "On [redacted]/25 Reported increased cloudiness of urine. Requested to extend order for Robitussin. Nursing also requested aid to increase [redacted] ability to wash feet during ... baths. No longer complains of constipation." - "On [redacted]/25 Requested to have left leg wound assessed because [they are] concerned it is worsening." - "[redacted]/25 Discussed antibiotic change with [Patient 20]." - "[redacted]/25 Assessed [them] in the morning following spilling a cup of hot water (while preparing tea) on [their] person the previous evening." * "O"[:] ... [redacted]/25 Gen No acute distress,cooperative [sic] ... Heart: S1, S2 heard,	A 450		

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A 450	Continued From page 228 no murmurs,rubs [sic] or gallops ... Lungs: equal excursion bilaterally, no accessory muscle usage, CTA bilaterally ... LE: uses wheel chair for ambulation. Moves all. No calf tenderness, noncyanotic". - "On [redacted]25 Gen No acute distress ... Resp: decreased bs on left lower lobe, no crackles, rhonchi audible ... Abd: lower abdominal (suprapubic) tenderness". - "[redacted]/25 Gen No acute distress, cooperative Ext: left leg wound appears to have normal granulation tissue, nonerythematous, still tender on palpation, no swelling or induration or discharge." - "[redacted]/25 Gen No acute distress ... Abd: soft, mild tenderness and erythematous area roughly 2inches by 1 inch at the level of the umbilicus, no bullous formation ... Ext:B/L LE 1-2+ edema; left foot: tender on palpation on the medial half of the dorsal surface of the foot, normal skin appearance". - "[redacted] CXR Results: mild left lower lobe pneumonia vs atelectasis". * "A/P"[:] ... [redacted]/25 Type 2 DM Although [Patient 20's] recent A1C ... was 6.3 , in the pre-diabetes range, [they] had a random glucose reading of 221 ... [redacted]/25. Initiated Trulicity 0.75mg sq weekly for Type 2 DM and possible weight loss effects". - "[redacted]/25 ... Constipation Continue to encourage bowel regimen, had declined much of the medications ordered and have many PRNs to accommodate when ... agrees to some. Mineral oil enema q daily, prn Magnesium citrate (grape flavored) q daily prn Senna 7.2 mg bid Miralax BID Lactobacillus capsule for gut biome health 1:1 Justification for fall risk". - "[redacted]/25 1:1 Medical supervision order adjusted from round the clock to only on day and swing	A 450		

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A 450	Continued From page 229	A 450		

shift, with close medical supervision during the NOC shift. Encourage [redacted] to use walker when ... is in ... room and especially when navigating in ... private bathroom".
- "[redacted]/25 Ordered long washing device to aid with patient's ability to wash ... own feet during baths (encourage independent ADL) Ordered UA for increased uring [sic] cloudiness, currently on titrofurantoin prophylaxis and cranberry capsules Ordered cxr , she continues to complain of cough at night".
- "[redacted]/25 Left leg wound Provided reassurance that wound is healing appropriately."
- "[redacted]/25 UTI Initiated Septra DS BID on [redacted]/25 and switched to cefepime 1g IM TID on [redacted]/25 once C&S results showed that the organism Klebsiella pneumoniae was resistant to Septra and susceptible to cefepime. Ordered Benadryl 25 mg initially twice a day, then increased to three times a day to be coadminstered with antibiotics due to patient report of pruitus with septra and concern for pruritus with cefepime. Seasonal allergies Continue zyrtec10mg po daily Possible pna vs atelectasis Both septra and cefepime ordered for the UTI provide coverage".
- "[redacted]/25 Discussed the antibiotic change described above with [redacted]".
- "[redacted]/25 1st degree burns on dorsum of left foot and left abdomen at the level of umbilicus Pt spilled cup containing hot water (in preparation for making tea) the previous evening on self. There are no skin changes noted on left foot, but pt reports tenderness on palpation of the dorsal area. Left abdomen noted to have a erythematous area roughly 2inches by 1 inch at the level of the umbilicus Silvadene was initiated by MOD overnight and writer will continue order and adjust order to apply to affected areas on both foot and abdomen. Will continue to monitor.

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A 450	Continued From page 230 Discussed assessment and treatment care plans with unit nurses." * On [redacted]/2025 at 0917, the hospital uploaded a document for [redacted] titled, "Enhanced Supervision Active Order Details." It was reviewed and reflected, "Enhanced Supervision Order: 1:1 Medical ... Order Start Date/Time: [redacted]/25 10:43 ... Order End Date/Time: [redacted]/26 10:45 ... Order Text: From 07:00am to 21:59pm only. On unit when not in ... room and off the unit. To use walker while in ... room and restroom. Staff to remain within visual and comfortable speaking distance. Use discretion re: appropriate distance to meet patient needs at the moment. Will be on close observation from 22:00 to 06:59. On and off the unit. Staff to remain within visual and comfortable speaking distance. Use discretion re: appropriate distance to meet patient needs at the moment ... Special/Additional Instructions: Patient can attend Treatment Mall, Visits, Religious Services, Cafeteria and Quad. Patient may keep all property. Describe Reason: Primary Behavior(s) of concern: [this was blank]." - A second, separate order for "Close Medical" was also included. - It was unclear whether an order for ES 1:1 medical had been entered per policy. The only 1:1 order provided was written on [redacted]/2025 and included the modified order times which, according to the DCMO's progress notes, were updated on [redacted]/2025, 20 days prior to the order date. The hospital failed to follow its policy on "Late" entries. For example, four dated entries were not identified as "Late" and did not align with policy 6.045, "Clinical Documentation" which reflected "Late entries must be clearly identified at the	A 450		

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A 450	Continued From page 231 beginning of the entry and reference the actual date and time of the service provided, observation, and/or event." These dates were: [redacted]/2025, [redacted]/2025, [redacted]/2025, and [redacted][no year]. The notes were not completed within the hospital policy timelines. Policy 1.017, "Provider Documentation Standards" reflected, "After provider evaluates patient, a SOAP note will be completed in electronic health record ... Note will be written expeditiously as defined below ... Non-urgent stable chronic conditions/Health maintenance: 72 hours". Therefore, it was unclear whether [redacted]'s chronic health issues had been thoroughly evaluated, or whether their chronic medical conditions were being consistently monitored by a medical provider, and those assessments available for clinical staff providing direct care to the patient. For example, the [redacted]/2025 note was entered 45 days after the encounter. The [redacted]/2025 note was entered 17 days after the encounter. Both of these notes were well outside the 72 hour timeline as required by policy. The hospital failed to follow its policy on clinical documentation. None of the 10 entries on [redacted]/2025, [redacted]/2025, [redacted]/2025, [redacted]/2025, [redacted]2025, [redacted]/2025, [redacted]/2025, "[redacted]", [redacted]2025, or [redacted]/2025 had times of encounters. Some of the dated entries from the "SOA/P" format did not align with each other. For example: - There were 6 entries under the "S" narrative dated: [redacted]/2025, [redacted]/2025, [redacted]/2025, [redacted]/2025, [redacted]/2025, and [redacted]/2025; - There were 5 entries under the "O" narrative dated: [redacted]/25, [redacted]/25, [redacted]/25, [redacted]/25, and [redacted]"[no year]; and - There were 8 entries under the "A/P" narrative	A 450		

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A 450	Continued From page 232 dated: [redacted]/2025, [redacted]/2025, [redacted]/2025, [redacted]/2025, [redacted]/2025, [redacted]/2025, [redacted]/2025, and [redacted]/2025. - The "A/P" narrative dated "[redacted]25" reflected a medication that was "switched ... on [redacted]/25", 5 days after that entry. The DCMO's progress notes were not timely or thorough, and failed to include all information as required by hospital policy. For example, there were no physician notes provided for [redacted] until [redacted]/2025 and those notes were entered that same morning at 09:45. Based on that note and the order dated "[redacted]/25", it was unclear how it was determined that an ES 1:1 medical reassessment was due on "[redacted]25", or whether "physician coverage" was provided "24 hours daily to care for hospitalized patients ... During regular business hours," or whether a POD, MOD, MD or PMHNP was available to "respond to see a patient on a unit when requested by the nursing staff" after hours. For example, [redacted] sustained a burn from hot tea on [redacted]/2025, however the MD note from [redacted]/2025 did not reflect an assessment of the burn and the MD assessment of the burn did not occur until [redacted]/2024. The times of the encounters were not noted on either of these entries and it was unclear when [redacted]s burns were assessed, on which shift, how long they had waited to have those burns assessed by a medical provider, or whether a provider was available to assess the patient after the incident. Additionally, Provider reassessment notes justifying the continuation of [redacted]'s ES 1:1 medical were not completed as required by policy. As of [redacted]/2025, the date of the email reminder to the DCMO, [redacted] had been on	A 450		

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A 450	Continued From page 233 ES 1:1 medical for at least 12 days, since [redacted]/2025, the first time the DCMO noted "1:1 Justification for fall risk" in their notes. Using that date, the five-day reassessments for [redacted]'s ES 1:1 medical would have been due [redacted]/2025, [redacted]/2025, [redacted]2025, [redacted]/2025, [redacted]/2025, and [redacted]/2025. Fourteen-day reassessments would have been due [redacted]/2025 and [redacted]/2025. The hospital failed to document the "effectiveness of existing interventions to reduce or eliminate those symptoms or behaviors which require enhanced supervision" for [redacted]'s ES 1:1 medical as required by policy 6.010, Procedures A, Staff Responsibilities. Furthermore, the hospital failed to provide documentation that [redacted]'s 14-day reassessments justifying the continuation of ES 1:1 medical progress were completed. Lastly, the hospital's policy reflected the following when "discontinuation or change" of ES occurs: "Patient assessment ... and rationale for discontinuation or change of enhanced supervision orders must be documented in a progress note" and although the DCMO's progress notes on [redacted]/2025 documented a modification, an order for that modification was not entered until [redacted]/2025, 20 days after the modification, and the progress note was not entered until [redacted]/2025, 17 days after the modification. Therefore, it is unclear whether clinical staff providing direct care for [redacted] were aware of the ES 1:1 medical order, the order's parameters, or the updated changes made on [redacted]/2025. 12.a. Regarding [redacted]'s medical record documentation: * MD notes were requested for [redacted]'s ES medical 1:1 on [redacted]/2025. No MD notes were provided.	A 450		

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A 450	Continued From page 234 * A document titled, "Treatment Care Plan" dated [redacted]/2025 reflected: [redacted] ... Plan Name: 30 Day Review ... Patient Did Not participate [was checked] ... Problem Statement ... Fall Prevention. Fall Risk: Moderate ([redacted]/25). [redacted] reported a fall on [redacted]/25, unwitnessed by staff, no injury. [Patient] reported feeling dizzy or light-headed ... has had some medication changes; staff will continue to monitor." - "Intervention ... MD to meet with [redacted] to follow up after fall, and review medications and how they may affect gait ... How long/often ... 1+ times, as indicated x 30 days ... Staff Responsible: DCMO". - "Other things that are important to my health ... Substance Use: Alcohol use disorder, severe ... Medical: Cataract." - "Reviewed by ... [MD] - Final Approver (Accepted) On [redacted]/2025 At 8:40". * A Fall Risk Assessment (FRA) written by an OSH RN on [redacted]/2025 at 1636 included the following: "Type of Assessment: Other ... Reason for Assessment: fall [redacted]/25 ... Qualifying active medical problems ... Arthritis ... Anemia ... Seizure disorder, Uncorrected vision changes, Other ... Vision: Patient reports need for glasses ... has glasses, but inconsistent with wearing them ... reports that glasses do not help with feelings of dizziness ... ADLS ... Independent ... Select Risk Level "Moderate". * An email requesting [redacted]s medical documentation was sent to the DSC on [redacted]/2025 at 1229, " ... it would be appreciated if notes from the latest complaint patient could also be uploaded." The DSC responded at 1302, "No MD progress notes." * An email requesting [redacted]'s ES 1:1 medical order was sent to the DSC on [redacted]/2025 at	A 450		

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A 450	Continued From page 235 1659, "I know there were no MD notes, but was there an order for 1:1 medical ES?" The DSC responded on [redacted]/2025 at 1024, "-no active orders for 1:1 medical ES". The hospital failed to fully implement its P&P and failed to provide "physician coverage 24 hours daily to care for hospitalized patients ... During regular business hours, the medical ... needs of OSH patients are attended to by Psychiatrists/Psychiatric Mental Health Nurse Practitioners (PMHNPs) and Primary Care Practitioners" as described in the hospital policy, "On-Duty Physician ... Protocol: 1.011", refer to Finding 1. There were no notes that indicated the patient was assessed by a medical provider after the fall as described in the TCP after the [redacted]/2025 fall. It was unclear whether [redacted] was placed on an ES 1:1 medical as no order was provided and there were no medical notes provided. The hospital failed to fully implement interventions as described on [redacted]'s TCP and all medical conditions as listed on the [redacted]/2025 FRA were not identified. Although [redacted] was admitted [redacted] with medical issues and an identified Fall Risk of "Moderate", medical notes had not been documented in the patient's EHR. **********	A 450		
A 529	SCOPE OF RADIOLOGIC SERVICES CFR(s): 482.26(a) [§482.26 Condition of Participation: Radiologic Services The hospital must maintain, or have available, diagnostic radiologic services...]	A 529		

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A 529	Continued From page 236 §482.26(a) Standard: Radiologic Services The hospital must maintain, or have available, radiologic services according to the needs of the patients. This STANDARD is not met as evidenced by: ********** Based on interview, review of P&Ps and review of other documentation it was determined that the hospital failed to develop and maintain documentation of the hospital's radiological services. Radiological and other P&Ps were outdated and did not reflect the hospital's current scope and complexity of radiological services. Findings include: 1. The following information was provided during an interview with the DMNO on 04/08/2025 beginning at 1330: * The hospital got a new Xray machine two years ago. * The hospital currently provides Xray services onsite four days per week, from 6:30 AM to 5:00 PM, Tuesday through Friday. The hospital has no Xray services available outside those days and hours. If a patient needs an Xray outside of those days and hours, they are sent to the ED at another hospital for their Xray. * If the Xray technician is sick or otherwise off work, the hospital has a contract with a third party Xray technician who comes to the hospital and performs Xray services. * The hospital does not provide any other imaging services. If a patient needs an MRI, US or other imaging service they are sent to the ED at another hospital for those. 2. The following information was provided during	A 529		

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follow-up interview with the DMNO on 04/11/20225 beginning at 1000:
* The hospital currently has one Xray technician and that person works 4, 10-hour shifts. The current hours of operation are generally Tuesday through Friday 6:30 am to 5:00 pm. After hours, and at other times the Xray tech is not available such as for leave, the hospital uses a portable Xray company or sends the patient to Salem Health hospital.
* The P&P "Radiology Department Hours" dated as last revised 05/13/2013 was provided and reflected "The radiology technologist is on duty from 7:30 AM to 4:30 PM, Monday through Friday. It a radiographic exam is needed outside these hours, the OSH staff have two options: 1. Salem Hospital ... 2. Salem Hospital MRI/CT Center ... 3. The patient may be sent to the Salem Hospital Emergency room for the necessary exam." That was the extent of the P&P and it did not reflect the current hours and operations described.

3. There were four other "Radiology Department" P&Ps provided. Those were:
* "Department Staffing - Radiological Technologist II" dated last reviewed 05/13/2013 and last revised 12/02/2011.
* "Patient Care in the Radiology Department" dated last reviewed 05/13/2013 and last revised 12/03/2012.
* "Staff Safety in the Radiology Department" dated last reviewed 12/02/2011 and last revised 05/13/2013.
* "Radiology Department Compliance With Regulatory Bodies" dated last reviewed 12/02/2011 and last revised 05/13/2013.
None of those included the hospital's current radiology hours or operations and they had not

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been reviewed or revised for more than ten years.
* The DMNO confirmed that the radiology P&Ps were not current.

4. The following additional P&Ps were provided regarding imaging scope of services and operations, including but not limited to those provided by the hospital, type of imaging conducted onsite, number of machines, hours of operation, radiology technician staffing, and radiologist coverage for reading/interpreting Xrays:
* "Outside Medical Services" dated approved 07/01/2024.
* "Transfer of Patient to an Acute Care Facility" dated approved 01/06/2025.
* "Approval of Medical Services, Devices, and Procedures." Page 1 reflected the P&P was dated "XXXXXX" and the "Revision History" on page 6 reflected it was last revised 09/03/2015 and last reviewed 10/07/2016.
* "Medical Referrals Outside OSH", "Protocol: X.XXX" dated last revised 07/09/2013 and last reviewed 10/07/2016.
* "Patient Care", "Protocol: X.XXX" dated last reviewed 06/23/2015 and last revised 10/07/2016.

The additional P&Ps provided were outdated and none included the hospital's current radiology scope, complexity and hours and operation.

5. Review of the hospital's organizational chart titled "Oregon State Hospital - Peter Courtney Salem Campus Organizational Structure" dated "Last Updated 2/24/25 for March 2025" reflected it did not include imaging or radiologic services.

7. In an email dated 04/09/2025 at 1508 regarding the P&Ps in Finding 4 in this tag, the

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A 529	Continued From page 239 DSC confirmed there were no further P&Ps that depicted the hospital's current scope and complexity of radiologic services. The DSC wrote "Those would be the documents that we have." No further description or P&Ps regarding imaging services were provided. **********	A 529		
A1600	Special Provisions for Psychiatric Hospitals CFR(s): 482.60 Special Provisions Applying to Psychiatric Hospitals - Psychiatric hospitals must... This CONDITION is not met as evidenced by: ********** Based on observation, review of video recordings, interviews, review of incident and medical record documentation for 17 of 17 patients (Patients [redacted]), review of OSH internal investigation documentation, review of training documentation for 4 of 5 LIPs (MD A, DO B, MD N and MD O) and 23 of 23 Direct Care nursing staff (RN C, RN D, RN E, RN F, RN G, RN R, RN T, RN U, RN W, RN Z, RN AA, RN EE, LPN H, LPN P, LPN Y, MHT J, MHT S, MHT Q, MHT V, MHT X, MHT BB, MHT CC, and MHT DD), review of training curriculum and training media, review of governing body and medical staff bylaws, and review of P&Ps it was determined that the governing body failed to ensure the hospital complied with the special provisions that applied to psychiatric hospitals. The failures potentially contributed to [redacted] and created the likelihood of harm to other patients: Findings include:	A1600		

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A1600	Continued From page 240 1. Refer to the findings under this CoP, CFR 482.60 - CoP: Special Provisions Applying to Psychiatric Hospitals. The governing body failed to ensure the hospital complied with all applicable CoPs for hospitals as the CoPs for Governing Body and Patient's Rights were determined to be out of compliance (Tag A-1605). **********	A1600		
A1605	Meet Hospital CoPs CFR(s): 482.60(b) [Psychiatric hospitals must] Meet the Conditions of Participation specified in§§482.1 through 482.23 and §§482.25 through 482.57; This STANDARD is not met as evidenced by: ********** Based on observation, review of video recordings, interviews, review of incident and medical record documentation for 17 of 17 patients (Patients [redacted]), review of OSH internal investigation documentation, review of training documentation for 4 of 5 LIPs (MD A, DO B, MD N and MD O) and 23 of 23 Direct Care nursing staff (RN C, RN D, RN E, RN F, RN G, RN R, RN T, RN U, RN W, RN Z, RN AA, RN EE, LPN H, LPN P, LPN Y, MHT J, MHT S, MHT Q, MHT V, MHT X, MHT BB, MHT CC, and MHT DD), review of training curriculum and training media, review of governing body and medical staff bylaws, and review of P&Ps it was determined that governing body failed to ensure the hospital complied with all CoPs specified in CFR 482.1 through CFR 482.23 and CFR 482.25 through CFR 482.57 as the following CoPs were determined to be out of compliance. The failures potentially contributed to [redacted] and created the likelihood of harm to	A1605		

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A1605	Continued From page 241 [redacted] patients: * CFR 482.12 - CoP: Governing Body * CFR 482.13 - CoP: Patient's Rights Findings include: 1. Refer to Tag A-043, CFR 481.12 - CoP: Governing body. Governing body bylaws were not current and complete. Medical staff bylaws and rules and regulations were not current, clear, or complete, and had not been approved by the governing body that was in place at the start of this investigation (Tag A-048). Provisions for timely and appropriate medical emergency response for patients in seclusion were not fully developed and implemented (Tag A-093). 2. Refer to Tag A-115, CFR 482.13 - CoP: Patient's Right. The hospital failed to ensure patients were informed of their health status (Tag A-131). The hospital failed to ensure the provision of care in a safe setting (Tag A-144). The hospital failed to ensure patients' rights to be free from seclusion and restraint (Tag A-154). The hospital failed to ensure patients in seclusion were monitored and observed to ensure their safety (Tag A-175). The hospital failed to ensure staff training related to seclusion and restraint was conducted appropriately (Tag A-199 and Tag A-206). **********	A1605		