Oregon State Hospital CMS Findings Response

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 _____	R-C 08/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon State Hospital Distinct Part	**2600 Center Street NE Salem, OR 97301**

To: State Licensing Agency, mailbox.hclc@dhsoha.state.or.us
Jennifer Andrews-Burke
Karyn Thrapp

CC: Pat Allen, Dolores Matteucci, Karen Jamieson, Sara Walker, Derek Wehr, Nicole Mobley, Tom Anhalt, Amber Shoebridge

Re: Opportunity to Correct

Please find enclosed our completed Plan of Correction along with the signed first page of Form CMS-2567 (02-99).

The completed plan outlines corrective actions Oregon State Hospital has identified through clinical, operational, and administrative review. Corrections address deficiencies through process improvement, process creation, policy revision, and outcome measures at the local and leadership level. This plan will ensure services are meeting quality standards for review by the governing body as will be documented in our QAPI plan (reference PoC Tag 0263).

Dolores Matteucci, the OSH superintendent, is responsible for implementing the entirety of this plan.

We look forward to meeting the Conditions of Participation and resuming deemed status.

Sincerely,

Dolly Matteucci (she, her, hers)
Oregon State Hospital
Superintendent – CEO
Desk: 503-945-2850
Cell: 503-309-7287
DOLORES.MATTEUCCI@dhsoha.state.or.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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**

(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 000}	INITIAL COMMENTS	{A 000}		

This report reflects the findings of an unannounced, onsite Federal revisit survey conducted on both the OSH-Junction City campus and the OSH-Salem main campus. The survey was initiated on 07/26/2022 and concluded on 08/01/2022. The revisit survey resulted from Condition-level deficiencies identified during a complaint investigation survey (OR33352) conducted on the OSH-Junction City campus that was completed on 01/17/2022.

Although OSH-Salem and OSH-Junction City are Medicare certified as one hospital, the hospital on the OSH-Junction City campus is separately licensed from the hospital at the OSH-Salem main campus as the distance from the OSH-Salem main campus exceeds the State licensing requirements for a State hospital satellite location which is 35 miles. The OSH Salem and Junction City campuses include 25 HLOC, or Hospital Level-of Care units and several non-hospital SRTF, or Secure Residential Treatment Facility units. The SRTF units are not licensed and Medicare certified as part of the hospital and are not subject to oversight by the CMS State Agency.

In the written Plan of Correction submitted in response to the Statement of Deficiencies report that resulted from the original complaint investigation the hospital attested the deficiencies would be corrected by 07/06/2022.

During the revisit survey the hospital was evaluated for implementation of its Plan of Correction and for return to compliance with the Conditions of Participation. Surveyors made

Attached Plan of Correction for:

- Fed - A - 0043 - 482.12 - Governing Body
- Fed - A - 0115 - 482.13 - Patient Rights
- Fed - A - 0118 - 482.13(a)(2) - Patient Rights: Grievances
- Fed - A - 0122 - 482.13(a)(2)(ii) - Patient Rights: Grievance Review Time Frames
- Fed - A - 0123 - 482.13(a)(2)(iii) - Patient Rights: Notice of Grievance Decision
- Fed - A - 0144 - 482.13(c)(2) - Patient Rights: Care in Safe Setting
- Fed - A - 0145 - 482.13(c)(3) - Patient Rights: Free from Abuse/Harassment
- Fed - A - 0263 - 482.21 – QAPI
- Fed - A - 0286 - 482.21(a), (c)(2), (e)(3) - Patient Safety
- Fed - A - 0385 - 482.23 - Nursing Services
- Fed - A - 0395 - 482.23(b)(3) - RN Supervision of Nursing Care
- Fed - A - 0405 - 482.23(c)(1), (c)(1)(i), (c)(2) – Administration of Drugs
- Fed - A - 0438 - 482.24(b) - Form & Retention of Records
- Fed - A - 0700 - 482.41 - Physical Environment
- Fed - A - 0701 - 482.41(a) - Maintenance of Physical Plant
- Fed - A - 0750 - 482.42(a)(3) - Infection Control Surveillance, Prevention

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

Oregon State Hospital CMS Findings Response

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Oregon State Hospital Distinct Part	**2600 Center Street NE Salem, OR 97301**

Glossary of Terms

Administrative Directive

"Administrative Directive" is a document authorized and issued by the Superintendent or designee to establish, supplement, augment, and/or clarify operating policies, procedures, and/or protocols. Administrative directives supersede policy and are effective until the affected referenced document is updated or until otherwise rescinded.

Charter

"Charter" is a document that defines roles, responsibilities, composition, and protocols of a team.

Code Green

"Code Green" means bringing together a group of staff to respond to an immediate behavioral emergency.

Code Green Drills

"Code Green Drills" are opportunities for our staff to practice their behavioral emergency response skills including some de-escalation skills and hands on techniques.

Computerized Maintenance Management System (CMMS)

"Computerized Maintenance Management System (CMMS)" is the OSH work order system.

Continuous Rounds, Census, and Milieu Management (RCM)

"Continuous Rounds, Census, and Milieu Management (RCM)" means the assignment of dedicated direct care Nursing or Treatment Services staff to continuously move through and monitor all patient care areas of a unit or treatment mall for the dual purposes of verifying patients' status and whereabouts and ensuring a safe and therapeutic physical environment (ex: ensuring doors are secured and no potential ligatures are present in the environment). This is documented on a standardized form generated from the electronic health record to be specific to the patient unit or treatment area. Documentation is completed three times hourly, 24 hours a day, 7 days a week.

Oregon State Hospital CMS Findings Response

Direct Care Staff

"Direct Care Staff" refers to staff whose primary job function is to work directly with patients. This includes staff from Nursing, Treatment Services, Psychiatry, Psychology, Social Work, Treatment Care Plan Specialists and Peer Recovery Specialists.

Environment of Care (EOC)

"Environment of Care (EOC)" is the physical environment of each OSH campus.

Environment of Care Cross Functional Work Team (CFWT)

"Environment of Care Cross Functional Work Team (CFWT)" is a multidisciplinary work team that reviews standards and Environment of Care and life safety element of performance's monthly and reports to the EOC Committee.

Hospital Level of Care (HLOC)

"Hospital Level of Care (HLOC)" for Oregon State Hospital purposes, an inpatient psychiatric setting which provides medical, behavioral, and nursing services not available in residential or other outpatient settings. At Oregon State Hospital, HLOC units are:

- Junction City Campus: Mountain 1, Mountain 2, and Mountain 3
    - Meadows 1 is currently under a temporary license waiver granted by OHA Public Health Division. This previous administrative space has been modified for temporary use to meet urgent critical needs as a non-certified/deemed temporary space serving a single patient with exceptional needs. The use of this temporary space for HLOC allows staff to use evasion to address the patient's aggression rather than seclusion and restraint, which would be necessary if the patient was placed on a traditional unit. OSH is working on a long-term transition plan for this patient.
- Salem Campus: Anchor 1, Anchor 2, Anchor 3, Bird 1, Bird 2, Bird 3, Butterfly 1, Butterfly 2, Butterfly 3, Flower 1, Flower 2, Flower 3, Leaf 1, Leaf 2, Leaf 3, Lighthouse 1, Lighthouse 2, Lighthouse 3, Tree 1, Tree 2, and Tree 3

Interdisciplinary Team (IDT)

"Interdisciplinary Team (IDT)" is group that includes the patient, their guardian or representative and other persons important to the patient if applicable, treatment care plan specialist (TCPS), and other clinicians responsible for specialized active treatment, as appropriate. The IDT is responsible to coordinate planning and oversight of a patient's care and treatment.

Oregon State Hospital CMS Findings Response

Level of Care (LOC)

"Level of Care (LOC)" is the range of available services provided from the most integrated setting to the most restrictive and most intensive in an inpatient setting.

Patient Environment and Safety Surveillance (PESS)

"Patient Environment and Safety Surveillance (PESS)" refers to a unit and treatment mall process that includes a checklist to ensure environment is being surveyed for patient safety.

OSH CMS compliance team

"OSH CMS compliance team" is a team developed to ensure the Plan of Correction developed in response to the CMS survey is effective and sustaining on both campuses. This will be accomplished by reviewing audit compliance & assigning follow up actions (as needed). The membership of this team will include representation from both campuses: JC Campus Administrator, Compliance Specialist, Director of Quality Management, Treatment Mall Manager, Director of Safety & Security, Deputy Chief Nursing Officer, Program Director and a Performance Improvement analyst.

Outings

"Outings" means anytime a patient is under staff supervision while outside the secure perimeter or off an OSH campus.

Patient Environment Safety Surveillance (PESS)

"PESS" is a process where Unit Administrators and Unit Safety Specialists use a checklist to monitor environmental safety items such as:

- Environment in good repair (including signs, badge readers, etc.)
- Unobstructed pathways
- Patient rooms free of garbage, food, fluids, dirty laundry visible
- Environment free of ligatures and contraband/prohibited items (including items which have been modified in such a way that they become potential weapons/ligatures)
- Furniture and shower curtain in good repair

Product Risk Assessment

"Product Risk Assessment" is a method of evaluating a product or product features which may cause or contribute to physical harm, injury, or death of a patient. Providing a level of risk and mitigation recommendations.

Oregon State Hospital CMS Findings Response

Program Director

"Program Director" is an individual with appropriate professional qualifications and experience who is designated to manage the operation of a program.

Program Executive Team (PET)

"Program Executive Team (PET)" refers to a program team who are responsible for ensuring the effective and efficient functioning of the clinical processes within the program.

Residential Treatment Facility (RTF)

"Residential Treatment Facility (RTF)" means a facility that provides, for six or more individuals with mental, emotional, or behavioral disturbances or alcohol or drug dependence, residential care and treatment in one or more buildings on contiguous properties.

Restrictive Events

"Restrictive Events" are an event that uses seclusion or another type of restraint.

Restraint

"Restraint" is defined by Centers for Medicare and Medicaid (CMS) in 42 CFR § 482.13(e) as any manual method (including a physical escort), physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or 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.

Safe Together Training

"Safe Together Training" is OSH's training for response to behavioral crisis. Includes relationship-building, verbal de-escalation, assault prevention, and procedures for manual and mechanical restraint to minimize injury.

Sample Size

The actual number of events that will be sampled are calculated each month by a Data Analyst based on number of incidents occurring, specifically for each audit plan. The number of events needed to be audited in each random sample will be calculated based on the statistical standard of a 95% confidence interval with a +/-5% margin of error.

Secure Residential Treatment Facility (SRTF)

"Secure Residential Treatment facility (SRTF)" is defined as a program licensed by OHA to provide services on a 24-hour basis for six to sixteen individuals with mental, emotional or behavior disturbances or alcohol or drug dependence. An SRTF is approved by OHA to restrict an individual's exit from the setting through the use of approved locking devices on individual exit doors, gates or other closures.

Seclusion

"Seclusion" is defined by CMS in 42 CFR § 482.13(e) as the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior in a behavioral emergency.

Standard Work

"Standard Work" is a performance improvement tool used to provide detailed representation and documentation of the most efficient process as it is known today. It breaks down current state work into the elements and characteristics needed to understand and perform a process repeatedly.

Sundry Item

"Sundry items" for the purposes of OSH's nursing protocol means those personal care and hygiene products, whether medicated or non-medicated, which OSH has determined do not require a practitioner order to administer, which are not required to be stored in the automatic dispensing cabinet or medication room, and which nursing staff may independently provide to patients in single-use amounts. Sundry items include, but are not limited to, anti-dandruff shampoos, moisturizing lotions, and sunscreen. (Although it may be used by a patient more than once, a bar of soap is a single-use amount for the purposes of this definition.)

Treatment Care Plan (TCP)

"Treatment Care Plan (TCP)" is an individualized treatment plan of care for patients.

Treatment Care Plan Checklist

"Treatment Care Plan Checklist" is a reference document for teams to use which clearly describes all required elements of a patient treatment care plan.

Trip Slip

"Trip Slip" refers to the form completed anytime a patient leaves the secure perimeter. It includes details around the location of the trip, which patients are attending, which staff are supervising patients, assessment of patients and approval process for the trip.

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Oregon State Hospital Distinct Part	**2600 Center Street NE Salem, OR 97301**

CMS Training Response Plan

CMS Training Response Plan

"CMS Training Response Plan" refers to trainings and Administrative Directives issued in Plan of Correction.

- Required staff are defined in specific deficiency Plan of Correction.
  Staff will have two weeks to complete trainings and Administrative Directive attestations by November 7, 2022.
  Note: this is specific to staff who have been scheduled to work during this time period. Staff members not scheduled to work will be given time to complete trainings within 14 days of return to work.
- Training records will be pulled by the Learning and Development Department and provided to Quality Management to develop a report for managers.
- After the initial training period, Quality Management will provide a report to managers and program/department leaders every week until training compliance is 100%.

Stratified target for completion of trainings:

% of Staff Required	Actions Required to Reach 100% Target
100% of staff required	No action required
If 80-99% of staff required have completed trainings and AD attestation, then:	Managers will schedule time for staff members who are working to complete training. For staff members not at work, managers will provide time for training within 14 days of the staff return to work consistently.
If fewer than 80% of staff required have completed trainings and AD attestation, then:	Program/department leader will develop an action plan with managers to prioritize staff training for staff who are actively working (i.e. not on leave).

Ongoing monitoring:

- New Employee Orientation and Onboarding- 100% of staff must complete these trainings within 6 weeks. Additional time will be provided in the event a staff member is out on unplanned leave. Staff and managers are required to schedule "make-up" days, if necessary, within six weeks.
- Annual training- 85%* of staff required must complete annual trainings every calendar year. When staff return to work after leave of absence, they will be scheduled for training within 14 days of returning to work. Use stratified target above.
  Note: this is due to established patterns of staff on leave of absence and therefore unavailable to complete training. Goal of training compliance is always 100% for staff required who are actively working

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Oregon State Hospital Distinct Part	**2600 Center Street NE Salem, OR 97301**

Fed – A – 0043 – 482.12 – Governing Body A-0043

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference PoC Tags: A-0115, A-0263, A-0385, A-0700, A-0750

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Oregon State Hospital Distinct Part	**2600 Center Street NE Salem, OR 97301**

Fed - A - 0115 - 482.13 - Patient Rights

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference PoC Tags: A-0118, A-0122, A-0123, A-0144, A-0145

Oregon State Hospital CMS Findings Response

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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**

Fed - A - 0118 - 482.13(a)(2) - Patient Rights: Grievances

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference PoC Tags: A-0122, A-0123
- The OSH Grievance Policy (7.006) will be updated to:
  - Provide that a Grievance Committee will review and respond to all grievances, as delegated by OSH's Governing Body, and requires a Grievance Committee to provide written responses to the grievant within seven days of the hospital receiving the grievance. Written responses will be either a Determination of an Ineligible Issue Form or the Grievance Response Form.
  - Define ineligible grievances and quality grievance investigation
  - Revise forms
- Staff on the Grievance Committee are required to complete initial and annual grievance training. Training includes timeliness, completion, quality investigation and quality of written responses.
- The OSH Ombuds review grievances to determine if policy is being followed related to timeliness, completion, quality of investigation, and quality of written responses. OSH Ombuds notifies Grievance Committee and Program Director when policy is not being followed. This notification includes reminders related to policy requirements and provides feedback focused on timeliness, completion, quality of investigation, and quality of written response.

2: List procedures/process for implementing the acceptable plan of correction for each deficiency cited:

- The OSH Ombuds office is revising the Determination of an Ineligible Issue Form (Attachment B to Patient Grievances Policy 7.006) to include patient acknowledgement of receipt of this form as the written response.
- The OSH Ombuds office and OSH Learning and Development Department created an initial and annual web-based grievance training to be accessible to Grievance Committee members.
- The OSH Ombuds support staff on the Grievance Committee in complying with the grievance process through maintenance of a patient grievance intranet page and communication with individual staff.

3: What monitoring and tracking procedures will be used to ensure the plan of correction is effective?

- The OSH Learning and Development office and department managers will track staff on the Grievance Committee completion of the initial and annual web-based grievance training with a target of 100% compliance.
- Audit to ensure patients who file grievances (eligible or ineligible) are receiving a written response.
    - Audit performed by OSH Ombuds office
    - Sample size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in "Sample Size" in the glossary
    - Compliance target: 90%
    - Auditing will occur based on OSH CMS Compliance Audit Step Down Guidelines listed below
    - Audit findings will be reported to the OSH CMS Compliance Team
- Audit to ensure patient grievances are reviewed by a Grievance Committee and meet timeline requirements.
    - Audit performed by OSH Ombuds office
    - Sample size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in "Sample Size" in the glossary
    - Compliance target: 90%
    - Auditing will occur based on OSH CMS Compliance Audit Step Down Guidelines listed below
    - Audit findings will be reported to the OSH CMS Compliance Team
- Qualitative audit of grievance responses to ensure they align with policy as defined in OSH policy 7.006 Patient Grievances.
    - Audit performed by OSH Ombuds office
    - Sample size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in "Sample Size" in the glossary
    - Compliance target: 90%
    - Auditing will occur based on OSH CMS Compliance Audit Step Down Guidelines listed below
    - Audit findings will be reported to the OSH CMS Compliance Team
- OSH CMS Compliance Audit Step Down Guidelines
    - The intensity of the audits will be as follows:
    - Level One
        - Audit on a monthly basis.
        - This level of auditing will continue until compliance reaches 90% for four consecutive months, at which point the auditing intensity can move to Level Two.
    - Level Two
        - Audit on a quarterly basis.
        - If, during Level Two auditing, compliance drops below 90%, audit intensity will revert to Level One.
        - This level of auditing will continue until 90% compliance is maintained for four quarters (one year), at which point the auditing intensity can move to Level Three.
    - Level Three
        - Audit on an annual basis.
        - If, during Level Three auditing, compliance drops below 90%, audit intensity will revert to Level Two.

- This level of auditing will continue until the OSH Executive Team determines that auditing is no longer required for the specific corrective action.

4: Date of completion for correcting deficiency cited: October 31, 2022.

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Fed - A - 0122 - 482.13(a)(2)(ii) - Patient Rights: Grievance Review Time Frames

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference PoC Tag: A-0118

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Fed - A - 0123 - 482.13(a)(2)(iii) - Patient Rights: Notice of Grievance Decision

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference PoC Tag: A-0118

Fed - A - 0123 - 482.13(a)(2)(iii) - Patient Rights: Notice of Grievance Decision

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Oregon State Hospital Distinct Part	**2600 Center Street NE Salem, OR 97301**

Fed - A - 0144 - 482.13(c)(2) - Patient Rights: Care in Safe Setting

CORRECTING THE DEFICIENCY

I. Investigation of Incidents to identify causes and to plan and implement corrective actions to prevent recurrences for the affected patient and other patients.

1: List the Plan of Correction for specific deficiency cited:

- Reviewed current policies and protocols pertaining to investigation of incidents, and determined no changes were needed at this time.
- Train IDT members and all managers to identify contributing causes of incidents using investigative strategies and to identify appropriate corrective actions to address the immediate problem and long-term solutions to prevent recurrence in the future.
- Update the Incident Response Form to include documentation of investigative strategies, immediate corrective actions, and steps to avoid recurrence.
- Develop tracking system to identify repeat incidents within program or unit.

2: List procedures/process for implementing the acceptable plan of correction for each deficiency cited:

- Develop training to include investigative strategies and corrective actions.
- Provide training to IDT members and all managers on investigative strategies and corrective actions.

3: What monitoring and tracking procedures will be used to ensure the plan of correction is effective?

- Reference CMS Training Response Plan
- Perform an audit on the Incident Review Process Form – confirm completeness of the form and each Incident Response affiliated with the form is present.
  - Audit performed by Quality Management office.
  - Sample size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in “Sample Size” in the glossary.
  - Compliance target: 90%

- Auditing will occur based on OSH CMS Compliance Audit Step Down Guidelines below.
- Audit findings will be reported to the OSH CMS Compliance Team
  - OSH CMS Compliance Audit Step Down Guidelines
    - The intensity of the audits will be as follows:
    - Level One
      - Audit on a monthly basis
      - This level of auditing will continue until compliance reaches 90% for four consecutive months, at which point the auditing intensity can move to Level Two
    - Level Two
      - Audit on a quarterly basis
      - If, during Level Two auditing, compliance drops below 90%, audit intensity will revert to Level One
      - This level of auditing will continue until 90% compliance is maintained for four quarters (one year)
    - Level Three
      - Audit on an annual basis
      - If, during Level Three auditing, compliance drops below 90%, audit intensity will revert to Level Two
      - This level of auditing will continue until the OSH Executive Team determines that auditing is no longer required for the specific corrective action

4: Date of completion for correcting deficiency cited: November 07, 2022**.**

II. Patient supervision and prevention of patient elopement during off-campus activities.

1: List the Plan of Correction for specific deficiency cited:

- Clinical Administrative Debrief Meeting (CADM) process requires CADM review following all incidents of Unauthorized Leave during off-campus activities, including those which are not considered sentinel events.
  - CADM will perform a root cause analysis and develop counter measures for future prevention.
- Amended administrative directive to modify policy 6.006, "On-Grounds and Off-Grounds Outings" to:
  - Add requirement that each trip slip identifies a group leader who is responsible for the pre- and post- trip meeting and documentation for each outing. This will clarify staff roles related to patient supervision on outings.
  - Add requirement that new trip slips must be generated at least 24 hours before a trip (except urgent medical/legal/discharge.) This will help prevent elopement by allowing appropriate time for assessment and planning by staff.
  - Add requirement that a search of patient (including confirmation of amount of money patient is carrying) is conducted *prior* to departure for approved on-grounds and off-grounds trips. This will prevent elopement by allowing the staff to screen for possession of items that may be used to aid

in elopement.

- Train all current staff who supervise patients on outings to amended administrative directive to modify policy 6.006, "On-Grounds and Off-Grounds Outings."
- Develop a system template in electronic health record to document core elements of the pre-trip meeting. This prevents elopement by ensuring staff and patients have reviewed expectations together and is documented.
- Develop a system template in electronic health records to document post-trip debrief. This prevents elopement by documenting if patients are following expectations during outings.

2: List procedures/process for implementing the acceptable plan of correction for each deficiency cited:

- Update trip slip database to include:
  - Check box to check each patient in and out before and after each outing.
  - Check box to identify group lead for each outing.
- Add template into electronic health record for pre-trip and post-trip meeting documentation.
  - Develop training on how to document pre-trip and post-trip meeting.
- Update outings training to include:
  - All additions to the Administrative Directive.
- Staff will read and acknowledge amended Administrative Directive modifying policy 6.006, "On-Grounds and Off- Grounds Outings."

3: What monitoring and tracking procedures will be used to ensure the plan of correction is effective?

- Reference CMS Training Response Plan
- Monitoring: Chief Treatment Fidelity Analyst will coordinate monthly with Discipline Chiefs and Treatment Mall Managers to accompany outings for direct observation of staff compliance with policy requirements for outings on an ongoing basis.
- Audit processes related to pre-trip and post-trip group notes.
  - Audit performed by Chief Treatment Fidelity Analyst
  - Audit findings will be reported to the OSH CMS Compliance Team
  - Sample size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in "Sample Size" in the glossary.
  - Compliance target: 90%.
  - Auditing will occur based on OSH CMS Compliance Audit Step Down Guidelines below
    - OSH CMS Compliance Audit Step Down Guidelines
      - The intensity of the audits will be as follows:
      - Level One
        - Audit on a monthly basis.
        - This level of auditing will continue until compliance reaches 90% for four consecutive months, at which point the auditing intensity can move to Level Two.
      - Level Two

        - Audit on a quarterly basis.
        - If, during Level Two auditing, compliance drops below 90%, audit intensity will revert to Level One.
        - This level of auditing will continue until 90% compliance is maintained for four quarters (one year).
    - Level Three
        - Audit on an annual basis.
        - If, during Level Three auditing, compliance drops below 90%, audit intensity will revert to Level Two.
        - This level of auditing will continue until the OSH Executive Team determines that auditing is no longer required for the specific corrective action.
- Audit processes related to trip slip completion for outings.
    - Audit performed by Chief Treatment Fidelity Analyst.
    - Audit findings will be reported to the OSH CMS Compliance Team.
    - Sample size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in "Sample Size" in the glossary.
    - Compliance target: 90%.
    - Auditing will occur based on OSH CMS Compliance Audit Step Down Guidelines below.
        - OSH CMS Compliance Audit Step Down Guidelines
            - The intensity of the audits will be as follows:
            - Level One
                - Audit on a monthly basis.
                - This level of auditing will continue until compliance reaches 90% for four consecutive months, at which point the auditing intensity can move to Level Two.
            - Level Two
                - Audit on a quarterly basis.
                - If, during Level Two auditing, compliance drops below 90%, audit intensity will revert to Level One.
                - This level of auditing will continue until 90% compliance is maintained for four quarters (one year).
            - Level Three
                - Audit on an annual basis.
                - If, during Level Three auditing, compliance drops below 90%, audit intensity will revert to Level Two.
                - This level of auditing will continue until the OSH Executive Team determines that auditing is no longer required for the specific corrective action.

4: Date of completion for correcting deficiency cited: November 07, 2022.

III. Patient supervision and prevention of patient elopement and entry into unauthorized areas during on-

campus activities.

1: List the Plan of Correction for specific deficiency cited:

- Policy 6.024 "Transportation and Supervision Ratios" was updated on 9/16/2022 to clarify patient supervision requirements during on campus activities.
- Provide training to all staff related to door closure to prevent patient elopement and entry into unauthorized areas.
- Security Staff check doors daily and submit work orders for repairs as necessary to prevent patient entry into unauthorized areas from unsecure doors.
- Update nursing protocol 2.090 "Medication Storage and Security" to include that medication room windows must remain closed unless staff are actively engaging with patient.

2: List procedures/process for implementing the acceptable plan of correction for each deficiency cited:

- Develop training on verifying closure of doors behind you when transporting patients.
- Staff will read Policy 6.024 "Transportation and Supervision Ratios."
- All staff will complete training related to door closure to prevent patient elopement and entry into unauthorized areas.
- RN/LPN will read and acknowledge updated nursing protocol 2.090 "Medication Storage and Security."

3: What monitoring and tracking procedures will be used to ensure the plan of correction is effective?

- Reference CMS Training Response Plan
- Monitoring: Director of Security will monitor Security staff are checking high-risk doors during security rounds on a weekly basis for four months.

4: Date of completion for correcting deficiency cited: November 07, 2022.

IV. Patient supervision and prevention of patient access to contraband, unsafe and prohibited items that can be used for SA, SH, or harm to others.

1: List the Plan of Correction for specific deficiency cited:

- Reference PoC Tags: A-0701
- Modified OAR Chapter 309, Division 102 to:
    - Update definition of packages and mail
    - Allow OSH staff to open packages except for legal mail and journalist mail/communication
    - Allow OSH staff to return to sender or dispose of unapproved packages
    - Restrict patients to purchasing items only from the OSH Market or OSH ordering system
- Created process to approve packages to be received
- Created new ordering mechanisms for patients to obtain property that include unit and program oversight. This ensures only items assessed as safe and compliant with OSH policy enter the Environment of Care (EOC) and ensures property limits are maintained.
- Conducted unit resets where security and unit staff went through each patient room to remove

prohibited items, potential ligatures and other disallowed items from patients' living spaces. This supports the removal of contraband, unsafe and prohibited items creating a new baseline of items in patient care areas. Unit resets allow staff to supervise patients in their environments with less clutter.

- Patients are searched upon re-entry into the secure perimeter from an outing. This is to verify that patients are not bringing any contraband or prohibited items into the secure perimeter.
- Retrained MHTs, LPNs, RNs, Nurse Managers and Unit Administrators on nursing protocol 2.020 "Continuous Rounds, Census, Milieu (RCM) Management" which includes the requirement for surveillance of unit environment three times an hour and removal of prohibited items, elimination of ligature risks, and verification of items in use which are allowed and have ligature risk mitigation plans in place. This action is intended to support staff following protocols which keeps prohibited items out of the unit environment. Additionally, the actions required by this protocol represent one way that patients are continually supervised while on the unit.
- Updated policy 8.024 "Tool & Sharp Security." This addresses the concern of contraband in patient rooms, unsafe and prohibited items, and the supervision of patients and environment.
- Update Administrative Directive for policies 8.044 "Contraband and Prohibited Items" and 8.037 "Patient Property and Valuables."
    - Modify the patient property/item access list to prevent access to unsafe and prohibited items and to clarify what items are allowed.
    - Establish property limits to support patient supervision and prevention of patient access to contraband, unsafe and prohibited items that can be used for suicide attempts, self-harm, or harm to others.
- Support appropriate patient supervision, retrain nursing and clinical staff on policy 6.010 "Enhanced Supervision" with particular emphasis on
    - Intervention cards to provide appropriate patient supervision.
    - Nursing supervision of patients with Enhanced Supervision orders with and without an intervention card.
- Developed unit and treatment mall protocol to monitor patient safety, infection control measures, and EOC on a weekly basis. This protocol is referred to as the Patient Environment Safety Surveillance (PESS). The checklist requires staff to verify environmental safety items.
- Issued administrative directive to modify policy 8.009, "OSH Safety Programs" to:
    - Implement PESS on 9/7/2022, to assess the physical environment on patient care units and in treatment mall spaces on a weekly basis.
    - Direct unit and treatment mall managers locating hazards found in the physical environment must document findings, and
    - Complete any work order to fix broken items, and
    - Ensure Incident Reports are completed for any physical damage within the environment from a critical incident or upon discovery during inspections within the patient unit or treatment mall area, and

- Report any safety concerns to the OSH Safety Team and Facilities.

2: List procedures/process for implementing the acceptable plan of correction for each deficiency cited:

- Staff will read and acknowledge Administrative Directive modifying policies 8.044 "Contraband and Prohibited Items" and 8.037 "Patient Property and Valuables."
- Continue to complete PESS weekly on all units and treatment malls.
- Create and provide training on policy 6.010 "Enhanced Supervision."

3: What monitoring and tracking procedures will be used to ensure the plan of correction is effective?

- Reference CMS Training Response Plan
- Audit RCM form for completion
  - Audit performed by Quality Management office
  - Sample size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in "Sample Size" in the glossary.
  - Compliance target: 90%.
  - Audit on a monthly basis until compliance reaches 90% for four consecutive months.
  - Audit findings will be reported to the OSH CMS Compliance Team
- Monitoring: The Clinical Nurse Advisor will round on a weekly basis on the units for four months to directly observe staff completing RCM and interview them on their understanding of their role. After the fourth month, Nurse Executive Cabinet will review and determine a schedule for maintaining ongoing compliance thereafter.
- Monitoring: The Treatment Services managers will round on a weekly basis on the treatment malls for four months to directly observe staff completing RCM and interview them on their understanding of their role. After the fourth month, Director of Treatment Services and Director of Treatment Mall will review and determine a schedule for maintaining ongoing compliance thereafter.
- Audit the PESS for completion
  - Audit performed by Quality Management office
  - Sample size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in "Sample Size" in the glossary.
  - Compliance target: 90%.
  - Auditing will occur based on OSH CMS Compliance Audit Step Down Guidelines below
    - OSH CMS Compliance Audit Step Down Guidelines
      - The intensity of the audits will be as follows:
      - Level One
        - Audit on a monthly basis.
        - This level of auditing will continue until compliance reaches 90% for four consecutive months, at which point the auditing intensity can move to Level Two.
      - Level Two
        - Audit on a quarterly basis.
        - If, during Level Two auditing, compliance drops below 90%, audit intensity will

revert to Level One.
- This level of auditing will continue until 90% compliance is maintained for four quarters (one year).

- Level Three
  - Audit on an annual basis.
  - If, during Level Three auditing, compliance drops below 90%, audit intensity will revert to Level Two.
  - This level of auditing will continue until the OSH Executive Team determines that auditing is no longer required for the specific corrective action.
- Audit findings will be reported to the OSH CMS Compliance Team

- Perform quarterly audits of adherence to purchasing procedures for all patient Market inventory for one year, then reassess frequency of audits.
  - Audit performed by Quality Management office
  - Audit findings will be reported to the OSH CMS Compliance Team

4: Date of completion for correcting deficiency cited: November 07, 2022.

V. Supervision and prevention of other unsafe conditions in the indoor and outdoor EOC.

Ref. A-0144 III and A-701

VI. Hospital leadership monitoring of the EOC, and of staff practices to ensure a safe EOC.

1: List the Plan of Correction for specific deficiency cited:

- OSH implemented the OSH CMS compliance team to ensure the Plan of Correction developed in response to the CMS survey is effective and sustaining on both campuses. OSH's Plan of Correction ensures the EOC is safe for staff and patients.

2: List procedures/process for implementing the acceptable plan of correction for each deficiency cited:

- OSH CMS compliance team monitors audits to OSH's Plan of Correction.
- OSH CMS compliance team assigns actions and makes decisions based on the results on audits to OSH's Plan of Correction.

3: What monitoring and tracking procedures will be used to ensure the plan of correction is effective?

- Audit results of the Plan of Correction will be monitored by the superintendent monthly.
- OSH CMS compliance team will continue to audit until the OSH Leadership Governance Committee is chartered and the OSH Executive Team determines the OSH CMS compliance team is no longer required.

4: Date of completion for correcting deficiency cited: November 07, 2022.

Oregon State Hospital CMS Findings Response

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 _____	**R-C 08/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon State Hospital Distinct Part	**2600 Center Street NE Salem, OR 97301**

Fed - A - 0145 - 482.13(c)(3) - Patient Rights: Free from Abuse/Harassment

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference PoC Tag: A-0144

Oregon State Hospital CMS Findings Response

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 _____	R-C 08/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon State Hospital Distinct Part	**2600 Center Street NE Salem, OR 97301**

Fed - A - 0263 - 482.21 – QAPI

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference PoC Tags: A-0115, A-0286, A-385, A-700, A-750

Oregon State Hospital CMS Findings Response

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 _____	R-C 08/01/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
Oregon State Hospital Distinct Part		**2600 Center Street NE Salem, OR 97301**	
Fed - A - 0286 - 482.21(a), (c)(2), (e)(3) - Patient Safety			

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference PoC Tags: A-0144, A-0145

Fed - A - 0286 - 482.21(a), (c)(2), (e)(3) - Patient Safety

Oregon State Hospital CMS Findings Response

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 _____	R-C 08/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon State Hospital Distinct Part	**2600 Center Street NE Salem, OR 97301**

Fed - A - 0385 - 482.23 - Nursing Services

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference PoC Tags: A-0115, A-0395, A-0405

Oregon State Hospital CMS Findings Response

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 _____	R-C 08/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon State Hospital Distinct Part	**2600 Center Street Salem, OR 97301**

Fed - A - 0395 - 482.23(b)(3) - RN Supervision of Nursing Care

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference PoC Tags: A-0144, A-0145

Fed - A - 0395 - 482.23(b)(3) - RN Supervision of Nursing Care

Oregon State Hospital CMS Findings Response

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 _____	R-C 08/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon State Hospital Distinct Part	**2600 Center Street NE Salem, OR 97301**

Fed - A - 0405 - 482.23(c)(1), (c)(1)(i), (c)(2) – Administration of Drugs

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference PoC Tags: A-0144
- Update nursing protocol 2.060, "Medication Administration" to define the approved device and method for opening a capsule when necessary, including any cleaning and/or disposal requirements for the approved device.
- Update nursing protocol 2.060, "Medication Administration" to define circumstances when topical treatments may be self-administered without requiring direct observation by RN/LPN. This includes sundry items as identified in nursing protocol 2.042, "Medical Treatment Supplies and Sundry Items" and when a physician has ordered a prescribed medication to be administered without direct observation.
- Update pharmacy protocol 13.001, "Medication Crush Policy," to require substituting a therapeutically similar crushable tablet, whenever possible, before filling an open capsule medication for administration.

2: List procedures/process for implementing the acceptable plan of correction for each deficiency cited:

- Retrain RNs and LPNs on the nursing protocol 2.060, "Medication Administration."
- Retrain pharmacists on pharmacy protocol 13.001, "Medication Crush Policy."

3: What monitoring and tracking procedures will be used to ensure the plan of correction is effective?

- Reference CMS Training Response Plan
- Pharmacy will perform unannounced weekly monitoring and document compliance of requirements of medication passes. Monitoring will occur on both day and swing shift on an ongoing basis. The medication passes monitored will be determined randomly using a tool provided by Data and Analysis.

4: Date of completion for correcting deficiency cited: September 30, 2022

Oregon State Hospital CMS Findings Response

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 _____	**R-C 08/01/2022**
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 0700 - 482.41 - Physical Environment			

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference PoC Tags: A-0115, A-0701, A-0750

Oregon State Hospital CMS Findings Summary

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 _____	R-C 08/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon State Hospital Distinct Part	**2600 Center Street NE Salem, OR 97301**

Fed - A - 0701 - 482.41(a) - Maintenance of Physical Plant

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference PoC Tag: A-0144, A-0750
- Reviewed current policies and protocols that pertain to the maintaining the hospital, and no changes were needed at this time.
- OSH implemented PESS across both campuses. The PESS ensures all hazards and risks are identified and mitigated in patient living areas including treatment mall. The goal of this program is to ensure patient safety and infection prevention standards are met. When areas do not meet standards set forth by policy or PESS standard work, the following will occur to mitigate deficiencies noted:
    - Work orders submitted to correct deficiencies
    - Items of concerns removed
    - Infection prevention measures taken
- The existing PESS will be updated to include identification of floors, walls, and other surfaces in patient living areas (including treatment mall) in disrepair or unclean with dirt, debris, grime, and mold/mildew. This update will include weekly review of unit and treatment mall kitchenettes.
- Develop standard work for staff completing the PESS to communicate weekly with unit EVS staff to collaborate on completing priority work needs. This will ensure when floors, walls and other surfaces have excessive build-up of dirt, debris, grime and mold/mildew, they are being addressed as high priority.
- Develop nursing standard work for regular cleaning of kitchenette areas.
- Develop standard work for bushes, shrubs and tree pruning to maintain a safe physical environment. This will address outdoor spaces not currently evaluated in Environment of Care (EOC) rounds. Maintenance of this standard will be audited as part of the ongoing EOC rounds.
- To ensure OSH's system for evaluating the risks and hazards in the physical environment is complete and comprehensive, the hospital will
    - Identify each process and team that reviews the EOC (whether that be weekly, monthly, bi-annually and annually)

- Determine if gaps exist in existing processes
- If necessary, develop strategy to eliminate gaps in environmental risk evaluation methods

2: List procedures/process for implementing the acceptable plan of correction for each deficiency cited:

- Train staff who complete PESS to the new aspects of the audit, including
  - new audit points
  - standard evaluation criteria for audit points
  - standard work for weekly communication with EVS staff
- Train unit nursing staff (RN, LPN, MHT) on new standard work for cleaning kitchenettes.
- Communicate new standard work for pruning shrubs, trees and bushes with Facilities Department staff and Vocational Services who are responsible for grounds maintenance.

3: What monitoring and tracking procedures will be used to ensure the plan of correction is effective?

- Reference CMS Training Response Plan
- Audit the PESS for completion. Auditing will occur based on OSH CMS Compliance Audit Step Down Guidelines below.
  - OSH CMS Compliance Audit Step Down Guidelines
    - The intensity of the audits will be as follows:
    - Level One
      - Audit on a monthly basis.
      - This level of auditing will continue until compliance reaches 90% for four consecutive months, at which point the auditing intensity can move to Level Two.
    - Level Two
      - Audit on a quarterly basis.
      - If, during Level Two auditing, compliance drops below 90%, audit intensity will revert to Level One.
      - This level of auditing will continue until 90% compliance is maintained for four quarters (one year).
    - Level Three
      - Audit on an annual basis.
      - If, during Level Three auditing, compliance drops below 90%, audit intensity will revert to Level Two.
      - This level of auditing will continue until the OSH Executive Team determines that auditing is no longer required for the specific corrective action.

4: Date of completion for correcting deficiency cited: November 07, 2022**.**

Oregon State Hospital CMS Findings Response

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 _____	R-C 08/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon State Hospital Distinct Part	**2600 Center Street NE Salem, OR 97301**

Fed - A - 0750 - 482.42(a)(3) - Infection Control Surveillance, Prevention

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference PoC Tags: A-0144, A-701
- Provide patients with covered laundry baskets to keep their dirty laundry separate from clean linens.
- Provide patient communication on room expectations related to storage of dirty laundry and clean clothing, clarifying that clean, folded clothing and linens are to be stored in room wardrobe, dirty laundry is to be stored in the covered laundry baskets that have been provided, and that other locations in a patient's EOC are not appropriate for storage of dirty or clean laundry.
- Address concern for personal care items that are not marked, unclear to whom they belong, and to prevent cross contamination the following actions will be or have been taken:
    - each patient received a shower caddy labelled with their name
    - develop and communicate standard work for new patients to receive shower caddy with their name labeled on it
    - issue an Administrative Directive for storage requirements for patients' personal care items and labeling the patient's name on personal care items, and labels for items that contain contents such as lotion, gels, shampoos, and including when those items expire, if applicable
    - train nursing staff on new Administrative Directive concerning storage of personal hygiene items
    - communicate to patients the expectation that all personal hygiene items that belong to them are stored in their caddy
    - add shower caddy labeling, personal care storage and labeling to the room expectations and the PESS
- Address hand washing sinks in non-working order, a communication will be sent to all OSH staff as a reminder to submit a work order to have repairs completed by OSH Facilities Department. It will include instructions for submission of work order in the communication.
- Update standard work for EOC rounds to include checking expirations dates of handwashing supplies and removing and replacing expired items if found.
- Reviewed current policies and protocols pertaining to maintaining a clean environment and determined to update protocols and polices (through Administrative Directives) as detailed below.

- Address sundry items (such as creams, lotion, gels, liquids, and powders) that are un-identified, unclear ownership and unclear if they were allowed or were prohibited items. The OSH Nursing Services protocol 2.042 “Medical Treatment Supplies and Sundry Items” will be updated to include:
    - Instructions to label single use items provided to patients with the name of the item, initials of the patient to whom it was given and the date the item is to be discarded.
    - The standard number of days a single-use sundry item can be kept by patients before nursing staff are instructed to throw them away when found during environmental monitoring.
    - A revised “attachment A” that will detail which sundry items are allowed to be possessed by patients.
    - Use of a standard container for a sundry item, when appropriate.
- Updated Administrative Directive 6.047 “Patient Food” to not allow food in patient room, with exception for patients in medical isolation.
- Update OSH Infection Prevention Administrative Directive 2.001 “Infection Prevention Program and protocol 1.010 “Infection Prevention Program” to allow for removal of items from patient rooms which could pose an infection risk. This includes removal of food, fluids except water, soiled clothes or linens, sundry items past the expiration date.
- Update Food and Nutrition Services protocol 310 “Dating of Food” to ensure all food containers are labeled with contents and expiration date.

2: List procedures/process for implementing the acceptable plan of correction for each deficiency cited:

- Provide covers for laundry baskets to each patient.
- Label laundry basket as “dirty” laundry.
- Create and distribute patient communication on room expectations related to storage of dirty laundry and clean clothing.
- Train MHT/MHTT, LPN/RN, Nurse Manager/Unit Administrator on protocol 2.042 “Medical Treatment Supplies and Sundry Items.”
- Train MHT/MHTT, LPN/RN, Nurse Manager/Unit Administrator on Administrative Directive 6.047 “Patient Food.”
- Train MHT/MHTT, LPN/RN, Nurse Manager/Unit Administrator on Administrative Directive 2.001 “Infection Prevention Program and protocol 1.010 “Infection Prevention Program.”
- Train Food and Nutrition Services staff on protocol 310 “Dating of Food.”
- Create and distribute patient communication related to use and cleanliness of hygiene caddy.
- Train unit-based management, mall-based management, and their supervisors on additions added to the PESS.
- Train Facilities staff to new expectation of EOC rounds.

3: What monitoring and tracking procedures will be used to ensure the plan of correction is effective?

- Reference CMS Training Response Plan
- Direct Care Nursing and Treatment Service staff perform PESS weekly. Take corrective action in the moment.
- Audit the PESS for completion
    - Audit performed by Quality Management office
    - Sample size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in “Sample Size” in the glossary.

- Compliance target: 90%.
- Auditing will occur based on OSH CMS Compliance Audit Step Down Guidelines below
  - OSH CMS Compliance Audit Step Down Guidelines
    - The intensity of the audits will be as follows:
    - Level One
      - Audit on a monthly basis.
      - This level of auditing will continue until compliance reaches 90% for four consecutive months, at which point the auditing intensity can move to Level Two.
    - Level Two
      - Audit on a quarterly basis.
      - If, during Level Two auditing, compliance drops below 90%, audit intensity will revert to Level One.
      - This level of auditing will continue until 90% compliance is maintained for four quarters (one year).
    - Level Three
      - Audit on an annual basis.
      - If, during Level Three auditing, compliance drops below 90%, audit intensity will revert to Level Two.
      - This level of auditing will continue until the OSH Executive Team determines that auditing is no longer required for the specific corrective action.
- Audit findings will be reported to the OSH CMS Compliance Team

4: Date of completion for correcting deficiency cited: November 07, 2022.