DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS 400
Seattle, WA 98104

San Francisco & Seattle Survey & Enforcement Division

May 5, 2022

Administrator
Oregon State Hospital Junction City
29398 Recovery Way
Junction City, OR 97448

Re: CMS Certification Number:
Conditions of Participation Not Met
Removed Deemed Status
90-day Termination Track

Dear Administrator:

On January 17, 2022, the Oregon Health Authority (State survey agency) completed a complaint survey at your facility. The deficiencies cited limit the capacity of Oregon State Hospital Junction City to furnish services of an adequate level and quality. The deficiencies identified are as follows and are listed on the enclosed Statement of Deficiencies and Plan of Correction (Form CMS - 2567).

Fed - A - 0020 - 482.11 - Compliance With Laws
Fed - A - 0022 - 482.11(b) - Licensure Of Hospital
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 - 0438 - 482.24(b) - Form And 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
Fed - A - 1640 - 482.61(c)(1) - Treatment Plan

To participate as a provider of services in the Medicare and Medicaid Programs, a facility must meet all of the Conditions of Participation established by the Secretary of Health and Human Services. When a facility is found to be out of compliance with the Medicare Conditions of Participation, The Social Security Act Section 1866(b) authorizes the Secretary to terminate a facility's Medicare provider agreement because the facility no longer meets the requirements for participation as a provider of services in the Medicare program. 42 CFR § 489.53 authorizes the Centers for Medicare and Medicaid Services to terminate Medicare provider agreements when a provider no longer meets the Conditions of Participation.

This letter is to inform you the Centers for Medicare and Medicaid Services (CMS) has determined that Oregon State Hospital Junction City no longer meets the conditions for participation as a provider of services in the Medicare program established under Title XVIII of the Social Security Act. Consequently, Oregon State Hospital Junction City's participation in the Medicare program may be terminated on 08/03/2022 if deficiencies have not been corrected.

Your deemed status with TJC is removed and you are placed under the State's survey jurisdiction. Your deemed status will be restored when you get back in
substantial compliance with Medicare regulatory requirements. The finding that the Oregon State Hospital Junction City is not in compliance with the Conditions of Participation does not affect your facility's TJC accreditation, its Medicare payments, or its current status as a participating provider in the Medicare program. However, you are required to submit an acceptable plan of correction regarding these deficiencies. After the approved plan of correction has been implemented, and we have found that all of the Medicare Conditions of Participation are met, we will discontinue the state's survey jurisdiction. A copy of this letter is being forwarded to TJC and the Department Of Human Services.

PENDING TERMINATION AND OPPORTUNITY TO CORRECT

To avoid termination action and notice to the public, within 10 calendar days of the date of this letter, you must submit your completed plan of correction. Please use the space provided on the 2567, or use the format of your choice, for your plan of correction, If more space is needed you can attach additional pages that are appropriately identified with the facility name, survey date and deficiency you are addressing.

Please send your plan of correction to (1) the State Survey Agency and (2) to CMS to the attention of Jennifer Andrews-Burke at:

CMS_RO10_CEB@cms.hhs.gov

An acceptable plan of correction, which includes acceptable completion dates, must contain the following elements:

- Plan of Correction for each specific deficiency cited.
- Procedure/process for implementing the acceptable plan of correction for each deficiency cited.
- Monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements.

- Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice.

- A completion date for correction of each deficiency cited.

- The plan must include the individual responsible for implementing the acceptable plan of correction with signature and title.

If you have any questions please contact me via e-mail to CMS_RO10_CEB@cms.hhs.gov. Attention: Jennifer Andrews-Burke

Sincerely,

Jennifer Andrews-Burke

Jennifer Andrews-Burke, Sr Health Insurance Specialist
Acute & Continuing Care Branch
Centers for Medicare & Medicaid Services
San Francisco & Seattle

cc: Oregon Health Authority
The Joint Commission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 complaint investigation survey for complaint OR33352 that was initiated on 12/13/2021 and completed on 01/17/2022.

The complaint involved a patient at OSH's 75-bed, Medicare certified, off-campus hospital inpatient Federal satellite location in Junction City, Oregon. The OSH-Junction City campus is approximately 65 miles, and one hour and 15 minutes drive time, from the OSH-Salem campus. The hospital on the OSH-Junction City campus is separately licensed from the hospital at the OSH-Salem campus as the distance from the OSH-Salem campus exceeds the State licensing requirements for a State hospital satellite location which is 35 miles. The investigation was conducted at the OSH-Junction City campus.

The hospital was evaluated for compliance with the Condition of Participation for Patient's Rights, CFR 482.13.

The findings from this survey that follow in this report reflected that the allegation in the complaint was substantiated and Condition-Level deficiencies under the following CoPs were identified:

* CFR 482.11 - CoP: Compliance with Federal, State and Local Laws
* CFR 482.12 - CoP: Governing Body
* CFR 482.13 - CoP: Patient's Rights
* CFR 482.21 - CoP: Quality Assessment and Performance Improvement

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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	Continued From page 1	A 000		

* CFR 482.23 - CoP: Nursing Services
* CFR 482.41 - CoP: Physical Environment

Reviews and interviews referenced in this report were conducted with leadership, quality, clinical, program and other staff, onsite/in-person and virtually, that included:

DCNO-JC - Deputy Chief Nursing Office OSH-JC
DON-JC - Director of Nursing Services OSH-JC
DS-JC - Director of Security OSH-JC
PD-JC - Program Director OSH-JC
SCS - Standards and Compliance Specialist III OSH-JC
TCPS - Treatment Care Plan Specialist OSH-JC
TMM - Treatment Mall Manager OSH-JC

CFO/COO - Chief of Operations OSH
CMO - Chief Medical Officer OSH
CNO - Chief Nursing Officer OSH
DCFO/COO - Deputy Chief of Operations OSH
DCO - Deputy Chief of Operations OSH
DSC - Director of Standards and Compliance OSH
DQM - Director of Quality Management OSH
MD&A - Manager of Data and Analysis OSH
OQMI - Office of Quality Management Investigator OSH
OSH DS - Deputy Superintendent OSH
OSH Superintendent - Administrator OSH

Abbreviations and acronyms used throughout this report include:
@ - at
# - number
1:1 - one-to-one observation
AC - Activities Coordinator
c/o - complains of
CDC - Centers for Disease Control

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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	Continued From page 2	A 000		

CEO - Chief Executive Officer
CFR - Code of Federal Regulations
CIR - Critical Incident Review
CIRP - Critical Incident Review ?
CLERC - not known
CMS - Federal Centers for Medicare and Medicaid Services
comm - communication(s)
CoP - Condition of Participation
d/t - due to
DC- discontinue
DHS- Oregon Department of Human Services
DND - Do Not Distribute
e.g. - for example
EOC - Environment of Care
FYI - For your information
GEI - Guilty Except for Insanity
HCP - Health Care Personnel
HCRQI - Health Care Regulation and Quality Improvement
HR - Human Resources
ICU - Intensive Care Unit
IDT - Interdisciplinary Team
IP - in-patient
IP - Infection Preventionist
LIP - Licensed Independent Practitioner
LPN - Licensed Practical Nurse
MD - medical doctor, physician
mg - milligrams
MHT - Mental Health Technician/Therapist
MN - Mountain unit
NM - Nurse Manager
NMI - Notice of Mental Illness
NP - Nurse Practitioner
OAR - Oregon Administrative Rule
OHA - Oregon Health Authority
Omnicell - An electronic medication management system device
OQM - OSH Office of Quality Management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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	Continued From page 3	A 000		

OSH - Oregon State Hospital
OSH-JC - Oregon State Hospital in Junction City, Oregon
OSH-JC Mountain units - OSH-JC licensed hospital inpatient units
OSH-Salem - Oregon State Hospital in Salem, Oregon
OSP - Oregon State Police
OTIS - DHS/OHA Office of Training, Investigation and Safety
P&P, PP - policy(ies) and procedure(s)
PERA - Physical Environment Risk Assessment
PET - Program Executive Team
PHD - OHA Public Health Division
PRN - as needed
PSRB - Psychiatric Security Review Boards
pt - patient
QAPI - Quality Assessment and Performance Improvement
Q15 - every 15 minutes
r/t - related to
RCA - Root Cause Analysis
RCM - Rounds, Census, Milieu
RN - Registered Nurse
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.
SA - suicide attempt
SH - self harm
SI - suicidal ideation
(sic) - In a quote reflects the language, spelling or punctuation is recorded as in the original document.
SOM - CMS State Operations Manual
SRTF - Secure Residential Treatment Facility
Sup - supervisor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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	Continued From page 4 TCP - Treatment Care Plan TMM - Treatment Mall Manager TX - treatment TXM - Treatment Mall Manager VAH - visual and auditory hallucinations w/ - with	A 000		
A 020	COMPLIANCE WITH LAWS CFR(s): 482.11 Compliance with Federal, State and Local Laws This CONDITION is not met as evidenced by: Based on interviews, review of the organizational chart, review of incident logs, and review of QAPI documentation it was determined that the hospital failed to ensure it complied with all State laws and rules that pertained to hospital licensure and organization. The hospital's leadership, incident reporting and management, and QAPI systems were combined with that of OSH-Salem, a separately licensed hospital, and that of non-hospital licensed SRTFs on each campus that are licensed by another agency. The co-mingling of those systems resulted in a lack of clear leadership, and a lack of clear and accurate information pertaining to the hospital's patient care safety operations and outcomes. This Condition-level deficiency represents a limited capacity on the part of the hospital to provide safe and adequate care. Findings include: 1. Refer to the findings cited at Tag A22 under CFR 482.11(b) - Standard: Licensure of Hospital. 2. Refer to the findings cited at Tag A145 under	A 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 020	Continued From page 5 CFR 482.13(c) - Standard: Privacy and Safety. 3. Refer to the findings cited at Tag A286 under CFR 482.21(a), (c)(2), (e)(3) - Standard: Patient Safety.	A 020		
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 and review of organizational and QAPI documentation it was determined that the 75-bed hospital at OSH-JC failed to ensure it complied with State hospital licensing requirements. Although the hospital at OSH-JC shared Federal Medicare certification with the hospital at OSH-Salem campus, the hospital at OSH-JC exceeded the distance requirements for a State licensed hospital satellite location and therefore was required to independently comply with State licensing rules. Hospital leadership and organizational systems were not independently maintained for this separately State licensed hospital. Findings include: 1. The definition for a hospital "Satellite" at OAR 333-500-0010(46) "means a building or part of a building owned or leased by a hospital, and operated by a hospital in a geographically separate location from the hospital, with a separate physical address from the hospital but	A 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 022	Continued From page 6 that is within 35 miles from the hospital ..." The OSH-JC campus is approximately 65 miles, and one hour and 15 minutes drive time, from the OSH-Salem campus and was not approved as a hospital satellite location for State licensing purposes. The hospital at OSH-JC was separately licensed as a hospital on 03/10/2015 as it demonstrated provisions for independent compliance with the State licensing requirements for hospitals. 2. OAR 333-505-0010(1) and (3), "Administrator," requires that "Each hospital shall employ or contract with a chief executive officer (CEO) or administrator who is responsible for the operation of the hospital and hospital based services in a manner commensurate with the authority conferred by the governing body, supports the delivery of high quality hospital care and services and ensures compliance with all hospital policies and applicable state and federal laws and regulations. In determining the appropriate number of facilities for which a CEO or administrator is responsible, the governing body of the hospital or health system should consider distance between hospitals and the size and complexity of each facility ... The hospital shall notify the Division, in writing, of the voluntary or involuntary termination of the CEO or administrator as well as the appointment of a new CEO or administrator." During interview with clinical and program leaders on 12/13/2021 @ 1530 they stated that the hospital at OSH-JC no longer had an onsite administrator and at the time of the survey entrance that the PD-JC was in charge. They indicated that OSH executive leadership staff	A 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 022	Continued From page 7	A 022		

offices were located at the OSH-Salem campus, approximately 65 miles from OSH-JC.

During interview with clinical and program leaders on 12/14/2021 @ 1445 staff stated that the most recent OSH-JC administrator, who had been onsite full-time, had "retired" in December of 2020 and the OSH-JC "administrator position had been eliminated." Staff described the current onsite leadership at OSH-JC as being "shared" by three clinical and program leaders.

Review of SA hospital licensing records for 2020 reflected that the OSH-JC "administrator" at that time had not been the individual identified by staff during the 12/13/2021 and 12/14/2021 interviews above and there was no indication in the records that he/she had been appointed or had retired. Rather, the licensing records submitted by OSH-JC reflected the OSH-JC administrator was the OSH-Salem administrator.

3. OAR 333-505-0030(2), "Organization, Hospital Policies," requires that "A hospital shall adopt and maintain clearly written definitions of its organization, authority, responsibility and relationships."

Beginning at the time of the survey entrance there were repeated requests for an organizational chart the delineated the OSH-JC leadership and reporting structure. None was provided until 01/13/2022.

An OSH internal email provided on 01/13/2022 was dated 11/18/2020 @ 1400 and included the following information:
* "The following email is for all staff on the OSH both the Junction City and Salem campuses from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 022	Continued From page 8 the [OSH Superintendent]. * The retirement of the [OSH-JC Deputy Superintendent] was "upcoming." * "OSH Realignment Plan for Junction City Campus Effective, Jan. 1, 2020 (sic): Instead of a deputy superintendent, Junction City Campus leaders will report to their respective OSH Executive Team members and department directors: - The Junction City program director will report to the OSH deputy superintendent (one for both campuses). - The Junction City deputy chief nursing officer will report to the OSH chief nursing officer. - The Junction City associate chiefs (Psychiatry, Psychology, Social Work, and Treatment Services) will report to their associated OSH discipline chiefs. - The Junction City treatment mall manager will report to the OSH treatment mall director. - The Junction City security director will report to the OSH safety and security director. - Junction City facilities, environmental and food and nutrition services managers will report to their OSH department directors within OSH Operations. - Junction City's two safety specialists will report to the OSH safety and emergency preparedness manager." * "Please see the new OSH organizational chart for more information ... We understand this will be a big shift for the Junction City Campus community ... A key component of this plan is also a stronger OSH leadership presence on the Junction City Campus, both virtually and in-person once the pandemic passes ...". The undated, "Oregon State Hospital Superintendent Org Chart" attached to the email	A 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 022	Continued From page 9	A 022		

did not distinguish the leadership and reporting structure for the OSH-JC campus as separate from the OSH-Salem campus and further, did not distinguish the leadership and reporting structure for the licensed hospital on either campus from the non-hospital licensed SRTFs on both campuses. For example:
* Unspecified "Program Directors" for a number of "programs" were identified as direct reports to the "Deputy Superintendent," who was identified as a direct report to the OSH "Superintendent." The listed "programs" were not specified as hospital, SRTF or other types. Those included generically "Junction City."
* Generically, "Salem and Junction City Campuses ... Nursing Direct Care ... Medicine ... Pharmacy ... Psychiatry ... Psychology ... Social Work ... Treatment Services" were identified as direct reports to the "Chief of Nursing" and "Chief Medical Officer," who were identified as direct reports to the OSH "Superintendent."
* Generically, "Facilities and Support Operations" and "Safety & Security" for "Salem and Junction City Campuses," and "Quality Management," were identified as direct reports to the "CFO/COO," who was identified as a direct report to the OSH "Superintendent."

During interview on 01/13/2022 @ 1245 the OSH Superintendent confirmed that the OSH executive team that included the OSH DS, the OSH CNO, the OSH CMO and the OSH CFO/COO were located in offices at the OSH-Salem campus and that there was no administrator or "deputy superintendent" or other executive leadership staff located onsite at OSH-JC. He/she confirmed that there had been an onsite administrator at OSH-JC who had retired and that when that occurred there had been a "re-alignment" of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 022	Continued From page 10 OSH-JC and OSH-Salem leadership structure. He/she also indicated that executive leadership staff had planned to conduct "routine rounds twice a month" at OSH-JC, however, those had not occurred consistently during the Covid-19 pandemic. 4. OAR 333-505-0060(1) and (2), "Quality Assessment and Performance Improvement" requires that "The governing body of a hospital must ensure that there is an effective, written, facility-wide quality assessment and performance improvement program to evaluate and monitor the quality and appropriateness of patient care ... All organized services related to patient care, including services furnished by a contractor, must be evaluated." Refer to the findings cited at Tag A263 under CFR 482.21 - CoP: Quality Assessment and Performance Improvement that reflected the QAPI data and documentation for the hospital at OSH-JC was not clearly differentiated from the hospital at OSH-Salem campus.	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 observations, interviews, review of incident and medical record documentation for 36	A 043		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 043	Continued From page 11	A 043		

of 37 OSH-JC patients (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36 and 37), review of P&Ps, review of PERA documentation and review of other documentation it was determined that the governing body failed to ensure the provision of safe and appropriate care to patients in the hospital in a manner that complied with all Conditions of Participation.

This Condition-level deficiency represents a limited capacity on the part of the hospital to provide safe and adequate care.

Findings include:

1. Refer to the findings cited at Tag A22 under CFR 482.11(b) - Standard: Licensure of Hospital.

2. Refer to the findings cited at Tag A115 under CFR 482.13 - CoP: Patient's Rights.

3. Refer to the findings cited at Tag A263 under CFR 482.21 - CoP: Quality Assessment and Performance Improvement.

4. Refer to the findings cited at Tag A385 under CFR 482.23 - CoP: Nursing Services.

5. Refer to the findings cited at Tag A438 under CFR 482.24(b) - Standard: Form and Retention of Records.

6. Refer to the findings cited at Tag A700 under CFR 482.41 - CoP: Physical Environment.

7. Refer to the findings cited at Tag A750 under CFR 482.42(a) - Standard: Infection Control

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 043	Continued From page 12 Program. 8. Refer to the findings cited at Tag A1640 under CFR 482.61(c)(1) - Standard: Treatment Plan.	A 043		
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 observations, interviews, review of incident and medical record documentation for 36 of 37 OSH-JC patients (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36 and 37), review of P&Ps, review of PERA documentation and review of other documentation it was determined that the hospital failed to fully develop and implement P&Ps that recognized and protected each patient's right to provision of care in a safe setting. Those failures resulted in actual and potential physical and psychological harm to patients. This Condition-level deficiency represents a limited capacity on the part of the hospital to provide safe and adequate care. Findings include: 1. Refer to the findings cited at Tags A144 and A145 under CFR 482.13(c) - Standard: Privacy and Safety. 2. Refer also to the findings cited at Tags A118, A122 and A123 under CFR 482.13(a)(2) - Standard: Patient Grievances	A 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 118	PATIENT RIGHTS: GRIEVANCES CFR(s): 482.13(a)(2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. This STANDARD is not met as evidenced by: Based on review of grievance documentation for 1 of 1 patient reviewed for grievances (Patient 7) it was determined that the hospital failed to ensure patients' rights were recognized, protected, and promoted in regards to grievance response, investigation and documentation: * Responses to and investigations of patient grievances were not clear, complete or timely. * A written grievance notice that contained the required elements including the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion was not provided for each grievance submitted. Findings include: 1. Refer to the grievance findings for Patient 7 cited at Tags A122 and A123 under CFR 482.13(a)(2) - Standard: Patient Grievances.	A 118		
A 122	PATIENT RIGHTS: GRIEVANCE REVIEW TIME FRAMES CFR(s): 482.13(a)(2)(ii) At a minimum: The grievance process must specify time frames for review of the grievance and the provision of a response. This STANDARD is not met as evidenced by: Based on review of grievance documentation for 1 of 1 patient reviewed for grievances (Patient 7)	A 122		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 122	Continued From page 14 it was determined that the hospital failed to ensure patients' rights were recognized, protected, and promoted in regards to timeliness of grievance review and response. Findings include: 1. Refer to the findings related to grievances submitted by Patient 7 on 07/04/2021, 09/25/2021, 11/12/2021 and 11/18/2021 that are cited at Tag A144 under CFR 482.13(c) - Standard: Privacy and Safety.	A 122		
A 123	PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION CFR(s): 482.13(a)(2)(iii) At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This STANDARD is not met as evidenced by: Based on review of grievance documentation for 1 of 1 patient reviewed for grievances (Patient 7) it was determined that the hospital failed to ensure patients' rights were recognized, protected, and promoted in regards to the written grievance notice to patients or their representatives. Findings include: 1. Refer to the findings related to grievances submitted by Patient 7 on 07/04/2021,	A 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 123	Continued From page 15 09/25/2021, 11/12/2021 and 11/18/2021 that are cited at Tag A144 under CFR 482.13(c) - Standard: Privacy and Safety.	A 123		
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 observations, interviews, review of incident and medical record documentation for 36 of 37 OSH-JC patients (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36 and 37), review of P&Ps, review of PERA documentation and review of other documentation 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 to provide adequate observation, supervision and other preventive measures and precautions created an unsafe EOC that resulted in actual and potential physical, mental or emotional harm to patients and included: * Failure to prevent elopement of patients during off-campus activities. * Failure to maintain accountability for patients during on-campus activities off the secure unit. * Failure to prevent patient entry into unauthorized areas. * Failure to prevent patient to patient sexual contact and sexual assault. * Failure to prevent patient to patient physical altercations. * Failure to prevent patient suicide attempts and self-harm with contraband, unsafe and prohibited items.	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 16	A 144		

* Failure to prevent other unsafe conditions in the physical environment.
* Staff responses to incidents failed to include investigations to identify causes and to plan and implement corrective actions to prevent recurrence for the affected patient and other patients.

This Condition-level deficiency represents a limited capacity on the part of the hospital to provide safe and adequate care.

Findings include:

A. Following are findings related to an unsafe EOC as result of failures to prevent elopement of patients during off-campus activities, to maintain accountability for patients during on-campus activities off the secure unit, and to prevent patient entry into unauthorized areas:

1.a. P&Ps related to the prevention of elopement and unsupervised access to unauthorized areas included:

1.b. The P&P titled "Unauthorized Leave" dated as 03/22/2021 reflected that "In this policy, unauthorized leave means a patient leaves the confines of the assigned unit or secure perimeter without authorization, or leaves the supervision of staff while on the grounds of OSH or during authorized supervised travel in the community. A patient who walks away from their responsible party or who overstays an off-ground pass is also considered to be on unauthorized leave."

This P&P was specific to steps and processes following a successful patient elopement from the facility, a secure unit or during an off-grounds

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 17	A 144		

outing. The P&P did not address steps to prevent elopement or "unauthorized leave."

1.c. The P&P titled "On-grounds and Off-grounds Movement" dated as 03/22/2021 reflected that "All movement outside the secure perimeter, including on-grounds and off-grounds activities and discharges, requires a trip slip ... 'Trip slip' refers to the form completed any time a patient leaves the secure perimeter." All procedures and directions on the seven-page P&P were not clear. For example:

* "Escorting staff are responsible for the following on the day of the outing. 1. Before leaving, escorting staff must gather the patient, trip slip, and any necessary belongings for the outing. a. Escorting staff must print and distribute a copy of the trip slip to every staff member participating in the outing, to the appropriate treatment mall or unit, and to Security when exiting the secure perimeter. b. Before leaving, staff in charge of the outing must hold a meeting with the patient and other staff to discuss staff roles, patient needs, goals, rules, behavioral expectations, and commitments. c. Any changes or additions made before the outing to the itinerary or patient list must be revised by staff to reflect the change or addition. Copies of the revised trip slip must be printed and distributed as directed above ... Escorting staff must provide a copy of the trip slip to Security before exiting the secure perimeter."

* "While outside the secure perimeter, staff must follow security guidelines described in this policy. A peer or 'buddy' system' is not an acceptable substitution for staff security responsibilities ... 2. During an outing, patient badges must be kept with staff on the staff member's person ... 3. Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 18	A 144		

must verify that patients remain within 'line of sight' and within speaking distance of staff members. This means staff must maintain consistent visual contact with patients and be able to communicate using a normal speaking voice. 4. When escorting, staff must vary spacing in the group and verify one staff member is at the rear of the group ... 6. After verifying the restroom does not contain potential risks or alternative exits, staff must continuously observe the restroom door the entire time patients are inside."

* "Attachment A ... B. Before the patient may go on the outing, the [TMM] must approve a mall-based outing ... 2. Before approving the trip slip, the appropriate manager must complete the form sections regarding unit or mall acuity, appropriate staff-to-patient ratios, destination appropriateness, and whether staff pairing with the patient is appropriate ... C. The [RN] must verify safety and security for the unit and patient on the day of the outing ... 3. The RN must perform the clinical screen to assess the patient's mental status and any concerns or safety issues that could affect the outing."

The P&P did not clearly define expectations about all aspects of recreational off-grounds outings. For example:
* It was not clear how far in advance of the outing clinical assessments and approvals for patient attendance must occur.
* It was not clear how far in advance changes in patient attendance were allowed once the Trip Slip had been approved.
* It did not specify what the "rules, behavioral expectations, and commitments" were that were to be discussed during a pre-outing meeting.
* It did not include provisions to assess patients

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 19	A 144		

for possession of cell phones that were prohibited on outings.
* It was not clear what aspects of pre-outing activities were to be documented and where.
* It was not clear whether the driver of the vehicle for the outing was also one of the staff responsible for supervising patients, and not clear how staff to patient ratios were to be maintained while one staff person was driving and was unable to respond to problems or behaviors if those occurred in the vehicle.
* It was not clear how staff to patient ratios would be met in public restroom facilities in all instances. For example: On an outing approved for a ratio of two staff to four patients, in the case where a staff person needed to use the restroom that would leave one staff person responsible for supervision of four patients. In the case where one patient used the restroom in a multi-stall facility that would leave three patients outside of the restroom to be supervised by the second staff person.
* It did not clearly specify how staff were to "vary spacing" during the outing.
* It included no provisions or criteria for discontinuing the outing in the presence of concerning patient behaviors or other problems that may arise.

1.d. The P&P titled "Transportation Ratios and Escorting Patients" dated as 05/14/2021 reflected that it "... establishes transportation ratios and staff escorting expectations during transports within OSH's secure perimeter to maintain a safe environment."
* "Transportation ratios are not considered to be to (sic) supervision ratios for activities in areas such as a plaza or quad, or during therapeutic groups off-unit, or for other similar reasons."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 20 * "Minimum staff-to-patient transportation ratios inside the secure perimeter ... are ... [on inpatient units] ... one staff for groups of two to five patients (1:5), and two staff for groups of six to ten patients (2:10)." * "Staff escorting patients ... are responsible to take appropriate precautions to maintain a safe environment, such as securing doors and observing patient activity during transport." * "If a patient without appropriate privileges is found unescorted, the staff person who finds them becomes responsible for the patient and must immediately escort them to their unit." 1.e. The P&P titled "Continuous Rounds, Census, and Milieu (RCM) Management" dated as 11/01/2019 included the following: * "Staff assigned to RCM duties must verify the presence and viability of each patient on the unit at least once per hour, at random intervals (within 10 minutes before or after the top of each hour)." * "If at any time a patient's presence cannot be verified, the following must occur ..." * "RCM staff must maintain awareness of the location and status of all patients assigned to the unit, including knowing if and when individual patients are off-unit." * "Document patent movement on and off the unit which occurs outside of the hourly checks ... If only a single patient or a small group of patients leave or return to the unit ... If a large group of patients leave or return to the unit (for example in relation to Treatment Mall or a meal) ..." * "Unit staff must complete hand-off communication with Treatment Mall staff whenever patients move from a unit to a Treatment Mall and whenever patients move from a Treatment Mall back to a unit."	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 21	A 144		

2.a. The medical record for Patient 7 reflected that he/she was admitted to OSH-JC on 06/04/2020 and that he/she had eloped on 12/02/2021 during an off-grounds outing and had not been located as of the start date of this survey on 12/13/2021. The record included the following information:

2.a.i. A court document titled "Judgement upon Finding of Guilty Except for Insanity and Placement under PSRB" reflected that Patient 7 was "placed under the jurisdiction of the Psychiatric Security Review Board for care, custody and treatment for a maximum period of time not to exceed 5 years; and ... committed to the custody of the state mental hospital ..." The order was signed on 03/30/2020.

2.a.ii. A Progress Note dated 12/02/2021 at 1412 by an MHT reflected that "During dayshift [Patient 7] pace (sic) the halls. [He/she] when (sic) on a on ground walk with Treatment mall as well as an outing. He attend (sic) lunch of (sic) the unit."

2.a.iii. A Progress Note dated 12/02/2021 at 1738 written by an MHT reflected that Patient 7 had approached the MHT at approximately 0910 to ask to go on the Urban Hike scheduled for that day at 1300. Patient 7 "was reminded that the group was full as it already had 4 peers assigned that had committed to attend the group for that day and [he/she] could be looked at as an alternate for the next time the group met. [Patient 7] then asked who else led the group and if this writer was a co-lead and not the lead ... at approximately 1030 this writer was informed that [Patient 7] had contacted the groups (sic) second Co-Lead and talked about the outing. [Patient 7] had been added and approved to the outing trip

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 22	A 144		

slip at around 1230 with IDT and Nursing staff approval as [he/she] was able to talk a peer into not attending the group, the group left the facility at 1305, [Patient 7] and a peer were asked by staff to use the restroom prior to leaving the facility as public restrooms are few in the community ... at approximately 1340 the group arrived at their destination ... [Patient 7] immediately asked to use the restroom as the vehicle pulled into the parking stall ... [Patient 7] begun (sic) to walk in front of the group and creating short gaps of 10 to 12 feet ... clients were once again reminded by staff to remain together. [Patient 7] would create gaps between [him/herself] and the group ... one staff led the group with three clients while one remained behind walking close to [Patient 7]. [Patient 7] begun (sic) to run ... [he/she] left the group at a fast run heading East bound from the 5th street market Provisions store parking lot and headed East bound direction til staff lost sight of him. Local police and OSH-JC facility were promptly notified."

2.a.iv. A Group Note dated 12/02/2021 at 2005 written by the AC reflected that "This morning [Patient 7] attended the Mindful Activity group that took place in the sensory quad at 09:05 ... [patient] approached me and walk (sic) along side and began making conversation ... [He/she] discussed being added to the Urban Hiking group. I replied to [patient] that I could possible add [him/her] to group as an alternate and seek approval. I also let [him/her know I did have a unit drive today with [his/her] unit if [he/she] wanted to check in with the unit staff for that. [Patient 7] said [he/she] didn't just want to do a drive, that [he/she] liked getting out and walking or hiking around like [he/she] done (sic) before with me. I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 23	A 144		

... let [him/her] know at this time I didn't have any space today that I was aware of. [He/she] asked more about if all the clients were going today ... [He/she] continued to ask about group and whether others attend regularly ... At 11:00 when I arrived on the unit preparing to leave for another outing, [Patient 7] approached me to say one of the clients declined to [go on Urban Hike] so [he/she] was hoping to go ... I then discussed the decline of today's group with [Patient 38 who had declined] and [he/she] replied [Patient 7] asked [him/her] if [he/she] could skip the outing today so [Patient 7] could go. I reported to RN on unit what [Patient 38] said. Unit RN approved the trip slip following manager approval. [TMM] was notified by email [his/her] approval was not showing up and other manager was requested for approval. [Patient 7] was approved for outing today by [his/her] unit RN just before leaving unit for outing and after unit peer declined to attend. [Patient 7], along with group peers and staff, entered vehicle and I collected name badges from all clients and placed them in backpack to be carried during duration of outing."

The note continued and described a stop at a coffee drive-through prior to arriving at the hike destination that reflected that "While waiting at drive through, [Patient 7] asked how long it was going to take, as we were 4th in line for the drive up window. I sensed [he/she] may be concerned about the time, and I reflected back asking [Patient 7] if [he/she] was concerned we would have enough time to do our walk. [Patient 7] said [he/she] just wanted to make sure we could walk around without running out of time ... when arriving [Patient 7] asked if a bathroom would be available while stating [he/she] needed to use the bathroom, and even though before leaving unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 24	A 144		

[he/she] stated [he/she] had used the restroom ... Other staff went into bathroom following [Patient 7] and other [patient] ... Group left bathroom and began walking ... I noticed [Patient 7] getting farther ahead of group about 8 or 10 feet, I said to all of the group, 'Just a reminder we all need to stay close together as a group' ... Group then began walking towards the market and [Patient 7] remained at back of group with other staff, as we arrived to the holiday tree area ... I began hearing other staff yelling my name ..." The note reflected that the AC did not see Patient 7 again but that the other staff person and the patients informed him/her that Patient 7 had "run" and the other staff person had "lost line of sight" and that Patient 7 remained on "unauthorized leave" at the time this note was written.

2.a.v. A Progress Note dated 12/02/2021 at 1531 written after the elopement by an RN reflected that "When I spoke with [Patient 7] today, [he/she] held a linear conversation, was calm and polite. [His/her] behavior appeared baseline. [He/she] follows staff's directions and follows the unit expectations ... medication complaint. [Patient 7] participated in an on grounds walk during the 1000 hour and there were no issues reported. [He/she] has participated in multiple walks and outings with no reported concerns ... I spoke with [LIP] about the possibility of adding [him/her] to the group which [he/she] approved. I emailed each group leads to see if this was a possibility. In the afternoon I was informed that [Patient 7] was added to the trip slip which I approved."

There was no documentation by the RN related to the report he/she had received prior to the outing, that Patient 7 had talked another patient out of going on the outing at last minute so that he/she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 25	A 144		

could go on the outing instead.

Further, the RN's note contained inaccurate information about the patient's participation on an "on grounds walk during the 1000 hour" on 12/02/2021 as reflected in the following group note written on 12/07/2021 at 0823.

2.a.vi. A Group Note dated 12/07/2021 at 0823 was written by an MHT for "On Grounds Walk ... Date of Group Service ... 12/2/2021." The note reflected that "[Patient 7] was approved to attend the on grounds walk but was excused from the walk due to being on another pass on the mall."

That group note also contradicted the MHT note referenced earlier in this finding that was written on 12/02/2021 at 1412 and reflected that "During dayshift [Patient 7] ... when (sic) on a on ground walk ... as well as an outing."

2.a.vii. A "Personal Property - Non - Clothing Items Stored on Unit" form included the following entry: "Nokia 106 cell phone & [charger] 11/8/21" with a staff person's initials. A second similar form reflected a "Phone Sim Card" was added to the patient's personal property on "11/13," followed by another staff person's initials. There was no other documentation about the phone.

2.a.viii. An "OSH Cell Phone Agreement" form was signed and dated by Patient 7 on 11/10/2021, two days after the cell phone had been added to the patient's property. A space for "IDT approval" contained the following notation: "Verbal approval from [LIP] 11/12/21 1635 [RN's name]."

The form included the following stipulations for the patient:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 26 * "1. Patients must obtain IDT authorization for the cell phone prior to obtaining the cell phone." * "2. Cell phones must be purchased through OSH approved vendors only. Cell phones must only be capable of sending and receiving voice and text. No camera, internet access or other function will be allowed." * "3. Cell phones must be minutes-style only through use of minutes cards. No calling plans, individual or otherwise are allowed for the phones." * "4. Cell phones are not to be taken to the treatment mall. No cell phones on any staff supervised on- or off-grounds activities, unless there is prior approval, on a case-by-case basis." * "10. All cell phones will be recorded on the patient's property sheets along with the corresponding phone identification, serial number and phone number." Documentation in the record did not clearly reflect that the stipulations identified in the agreement under numbers 1, 2, 3, 4, and 10 had been met for Patient 7. 2.a.ix. Review of Patient 7's IDT treatment plan dated 11/15/2021 revealed it contained no documentation of goals and interventions related to off-campus outings and the patient's possession and use of a cell phone. 2.a.x. A "Risk Review - Forensic" form for Patient 7 reflected the "Date of Risk Review" was 06/29/2021. The form reflected that "Off-Grounds" privileges for staff to patient ratio of 2:1 had been requested and "approved 6/29/2021." The form also reflected that "Off-Grounds" privileges for staff to patient ratio of 2:4 had been requested and "approved	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 27	A 144		

6/29/2021."

This discrepancy was confirmed during interview with leadership, clinical and program staff that included the DCNO-JC, the PD-JC, the TMM and a Psychiatrist on 12/14/2021 beginning @ 1000.

2.b. A "Trip Slip for Departure" form reflected that an "on grounds walk ..." was scheduled for 12/02/2021 at 1000. The form listed four patients that included Patient 7 and a notation next to each of the four names reflected "Approval" for the trip. The form had the word "Cancelled" printed over the top of the trip description in a red, large, bold font. A noted reflected "Cancelled Note all clients declined on grounds walk" and "Cancelled [Reason] Cancelled by Patient."

During interview with leadership, clinical and program staff on 12/14/2021 beginning @ 1430 the TMM confirmed that the 12/02/2021 on grounds walk had been cancelled.

2.c. A "Trip Slip for Departure" form reflected that an "Urban hike and community reintegration going to 5th street market ..." was scheduled for 12/02/2021 at 1300. It identified two "Escorting Staff" as an AC and an MHT. The form listed five patients that included Patient 7. A notation next to Patient 7 and three other patients' names reflected "Approval" for the trip. A notation next to the fifth name reflected "Declined" for the trip. There was no indication on the form when those approvals occurred and there was no reason documented for the patient who declined.

2.d. Medical record documentation for Patient 38, the patient who declined the trip on 12/02/2021, was provided in form of a Group Note dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 28	A 144		

12/02/2021 at 1206, written within an hour prior to the Urban Hike departure. There was no documentation related to the Urban Hike outing that the patient had "declined" and none to reflect that staff had talked to Patient 38 about the circumstances that led to his/her decision to decline the off grounds outing.

During interview on 12/14/2021 beginning @ 1430 staff confirmed that the Group Note was the only note written for Patient 38 on 12/02/2021 and there were no other group notes or nursing progress notes, including late entries, written for that day.

2.e. Incident documentation for Patient 7's elopement was reviewed. It contained similar documentation to the 12/02/2021 medical record progress notes written at 1738 and 2005 that were referred to earlier in these findings. In addition, a report written for the incident date and time of 12/02/2021 @ 1408 reflected that "At approximately 1406 [Patient 7] ran away from the group as the group was in an off grounds outing to the Eugene 5th Street market area parking lot. Client had been advised several times by staff that the group was to stay together and client continued to create gaps in the group by creating distance between himself and the group. The group had turned left to enter a covered area and client ran away from the group headed East at a fast run. Staff called out [his/her] name and maintained line of sight until [he/she] was not visible while notifying second staff of the incident. "

2.e.i. Additional incident documentation dated 12/02/2021 reflected that on 12/02/2021 @ 1530 staff were directed to "conduct a Room Search of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 29	A 144		

[Patient 7's room] ... The purpose of the search was to locate the client's phone and any information about [Patient 7] absconding from [his/her] trip ... The search was able to find a blue book of resources with a page torn out of Portland area food kitchens and two envelopes addressed to Colorado. The phone was never located."

2.e.ii. An OQM form identified for this incident reflected "Leadership Directives: Level II Investigation: [OQM staff] 12/3/21 ... [Patient 7], GEI, was on an outing in the community in Eugene, Oregon. [Patient 7] was reported to have run from staff resulting in an unauthorized leave. Law enforcement was notified along with Comm Center. Patient was still at large at the time of this document (1115, 12/3/21)."

2.e.iii. A document titled "December 2, 2021 Timeline" reflected a number of notifications and communications and that on 12/02/2021 at 1450 an "incident report" was generated. However, there was no information on the timeline that reflected that an investigation into how this elopement was allowed to occur had been conducted or initiated as of the start date of this survey, 12/13/2021. There was additionally no information that reflected any changes to practices regarding off-site outings had been made to mitigate recurrence until an investigation was completed and long-term corrective actions planned and implemented.

2.f. A "Junction City outings" document reflected that 21 "off grounds" outings had occurred from 12/03/2021, the date of Patient 7's elopement, through the date of this survey on 12/14/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 30	A 144		

2.f.i. Documents titled "Trip Slips for Departure" included 14 "Trip Slips" for off grounds outings to destinations other than medical or health related purposes. There were six of those outings on which there was more than one patient and those were:
* On 12/05/2021 @ 0945 w/ four patients
* On 12/06/2021 @ 1300 w/ four patients, for which the AC present during Patient 7's elopement was assigned.
* On 12/07/2021 @ 1400 w/ four patients
* On 12/08/2021 @ 1400 w/ three patients
* On 12/09/2021 @ 1305 w/ three patients, for which the MHT and AC who were present during Patient 7's elopement were assigned.
* On 12/09/2021 @ 1510 w/ four patients

2.g. During interview with staff that included the DCNO-JC, DON-JC, the PD-JC and the TMM on 12/14/2021 @ 1155 they provided the following information:
* Patient 7 had a cell phone on his/her personal property list.
* It could not be found after the elopement.
* Patients are not searched or asked about their phones before they leave the unit for the treatment mall or outings or other off-unit destinations.
* Regarding where Patient 7 obtained the phone, whether through an approved vendor, the response was "good question."

2.h. During interview with staff present during the outing on 12/15/2021 beginning @ 1035 the details and information contained in the medical record and incident documentation were reviewed and confirmed. Regarding Patient 7's cell phone, staff stated they had no knowledge that Patient 7 had a cell phone on the outing. It was also

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 31	A 144		

disclosed that staff didn't check the patient and didn't ask the patient about a cell phone prior to leaving the facility or during the outing, and that this interview was the first time the cell phone questions had come up since the elopement

2.i. During interview with staff that included the DCNO-JC and the PD-JC on 12/14/2021 @ 1525 regarding the hospital's follow-up and investigation of the elopement the following information was provided:
* OSH-JC staff stated that the investigation was managed by staff at OSH-Salem and the status of an investigation was not known.
* OSH-JC staff had not been directed by OSH Executive Team to make any changes to practices around outings.
* Off-grounds outings had continued without changes since the 12/02/2021 elopement.
* The MHT and AC responsible for the 12/02/2021 outing had continued to be assigned to off-grounds outings.

2.j. In an email from the DQM received on 01/17/2022 @ 2020, 46 days after Patient 7's elopement, information provided included the following:
* "Follow up activity" in response to Patient 7's elopement "occurred immediately" and "efforts are still underway."
* On 12/02/2021 @ 1823 the OSH Superintendent sent an email to all staff. That email reflected "To all OSH Staff, I am writing to notify you that a patient is currently on unauthorized leave. The person, [Patient 7], is a patient on the Junction City Campus. [Patient 7] was last seen at about 2:07 p.m. at the 5th Street Public Market in Eugene, where [he/she] was on a group outing. [He/she] ran away from the group

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 32	A 144		

and left the immediate area. The hospital has notified both state and local law enforcement, and they are now conducting a search for the missing patient. We have issued a news release to state media organizations, asking for anyone having information leading to whereabouts of [Patient 7] to call the Oregon State Police at [phone number]. I will keep you apprised as more information becomes available."
* On 12/03/2021 the DQM assigned an internal investigation.
* On 12/03/2021 applicable documents for Patient 7 were gathered and review and discussion begun with the OSH Superintendent and other leadership staff.
* As result of the review "... an opportunity for performance improvement ..." was identified related to the ways that Patient 7 went about securing him/herself a place on the outing. "... many of which were concerning. This was to be considered in any upcoming outings and would be formalized as an action item upon completion of the systems investigation and report."
* A medication review was requested "in order to identify any potential decompensation concerns that should be shared with law enforcement during the course of the ongoing search."
* A meeting was held "to review the notification and warrant process across parties and determine any immediate opportunity for improvements and/or consistency."
* On 12/13/2021 the DQM "verbally instructed the [OQM] investigator to pause the internal investigation due to [CMS SA Surveyor] arrival. The intent was to avoid a conflict or interference with [the CMS SA] investigation."
* On 12/22/2021 the DQM "instructed the investigator resume the investigation as there did not appear to be any conflict with [the CMS SA]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 33	A 144		

investigation."

There was no other documentation provided of investigation, identified opportunities for improvement or actions taken or planned to prevent another elopement.

The 12/13/2021 action described in the email to discontinue the hospital's internal investigation had not been discussed with the surveyor during the survey and was contradictory to CMS survey practice. It is the expectation that providers maintain continuous compliance with all requirements regardless of parallel investigations by other agencies, including the CMS SA.

2.k. In an email received on 12/29/2021 @ 1212 from the PD-JC he/she reported that that Patient 7 had been found in a coastal Oregon town on 12/27/2021, 25 days after he/she had eloped, and had been returned to OSH-Salem.

2.l. Findings related to Patient 7's elopement during a supervised off-grounds outing reflected failures on the part of the hospital that included:
* Failure to maintain situational awareness and conduct assessment related to the patient's behaviors that allowed him/her to orchestrate the last minute off-grounds outing change.
* Failure to adhere to P&Ps regarding pre-outing meetings that were to include discussion of rules and behavioral expectations.
* Failure to maintain situational awareness and conduct assessment related to the patient's concerns about time, rest room use and his/her continued creation of gaps and distance from the group.
* Failure by nursing and MHT staff to document accurate progress notes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 34	A 144		

* Failure to actively investigate the elopement and to take immediate actions to prevent recurrence during an investigation.

As of 01/17/2022 no changes to practices had been made to prevent recurrence and protect patients during the investigation such as the temporary suspension of recreational off-grounds outings, or not approving changes within a specified time prior to an outing to ensure time for complete and appropriate assessment.

3.a. Multiple other incidents, and grievances, that reflected an unsafe EOC and actual and potential physical, mental or emotional harm for Patient 7 prior to his/her elopement included the following:

3.b. A "Patient Grievance" form noted as received on 07/06/2021 was signed and dated by Patient 7 on 07/04/2021. It reflected "I don't feel safe with [Patient 5] on the unit as the situation currently stands. Something significant should be done like a security constant or move [Patient 5] to a higher security unit."

There was no documentation of investigation of the reason the patient felt unsafe and what "situation" that involved Patient 5 he/she was referring to.

A "Patient Grievance Response" form dated 07/13/2021 reflected under "Response/Information," only: "The concerns expressed in this grievance have naturally resolved due to administration changes on the unit. The hospital staff continue to prioritize safety and encourage [Patient 7] to immediately let staff know when [he/she] feels unsafe - at any time." In response to the question on the form "Are you

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 35	A 144		

satisfied with the response?" the box next to "No" was checked and Patient 7 signed and dated the form on 07/13/2021.

It was not clear what "administration changes" referred to or why that would "naturally resolve" the concerns in the grievance. There were no other signatures on the form and although two staff members' names were on the form it was not clear if either of them was the author of the form or what their position/title/roles were at the hospital.

3.c. Incident documentation for Patient 7 reflected that on 08/14/2021 @ 1235 staff "found a pill on the floor against the wall in the west hall about 3 feet to the left of room M3534. [Staff] believe the pill belongs to [Patient 7]. [His/her] room is located across from where the pill was found. The Pill is orange, has a diameter of just over half a centimeter, and has the marking 'BRX 1'."

There was no documentation of an investigation, to include evaluation of medication administration practices in order to determine how and why the patient's medication was found on the floor next to his/her room.

In emails received on 01/11/2022 @ 1005 and 01/12/2022 @ 1047 OSH staff confirmed there was no additional documentation related to this incident.

3.d. A "Patient Grievance" form noted as received on 09/27/2021 was signed and dated by Patient 7 on 09/25/2021 and reflected "[Patient] erased my chalkboard art 10 minutes after I put it up. [He/she] continues to harass and disrespect clients ... continuance of belligerent behavior ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 36	A 144		

"A "Patient Grievance Response" form dated 10/11/2021, 14 days after receipt of the written grievance, reflected under "Response/Information," only: "'I feel as safe as I did before this was ever even an issue.' Peer [name] has been moved to the Salem campus and [Patient 7's] concerns have been alleviated." Patient 7 indicated he/she was "satisfied with the response" and signed and dated the form on 10/11/2021.

Although the response indicated the other patient had been moved off the unit, it was not clear what the patient meant by "I feel as safe as I did before this ..." and there was no indication that staff had followed up on that statement to investigate further. There were no other signatures on the form and although five staff members' names were on the form it was not clear if any of them was the author of the form or what their position/title/roles were at the hospital.

3.e. Documentation for Patient 7 on a "Comm Log [Report]" reflected that on 10/15/2021 @ 1518 he/she "was found to be off of the secure unit and alone on [Treatment Mall 1], I asked [him/her] where staff was and [he/she said] 'they should be here to get me soon.' I notified access that I would escort the patient back to [his/her] unit."

An OQM report reflected "On [10/15/2021] OSH security found [Patient 7] alone on the Treatment Mall ..." A note on the report dated 10/20/2021 reflected "Request response from [unit NM]: How did this occur? If failure occurred under different department send the response request to appropriate department/discipline."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 37	A 144		

An email from OQM staff to another OSH staff person was dated 10/28/2021 @ 1307. It reflected "Critical Incident Review is requesting information related to an incident of a patient found unsupervised on 10-15-21. I have attached the incident information to this email. If this event is something that would not fall under your supervision roll (sic) can you please point me in the right direction? Please answer the following: 1. How did this event occur? 2. Has mitigation has (sic) been implemented to prevent future re-occurrence? A. If so, what strategy has been implemented? Please respond no later than 11-8-21."

A second email from an OSH staff person to OQM was dated 10/28/2021 @ 1314 and reflected only "I will get this done. I was gone that day, but I will speak to my staff and get the story. Thanks."

In an email received on 01/13/2022 @ 1052 OSH staff confirmed there was no other documentation related to this incident.

3.f. Incident documentation reflected that on 11/10/2021 @ 0850 Patient 7 was unexpectedly hit by Patient 29 "several times, contacting the right orbital area and knocking [him/her] down. [Patient 7] attempted to protect [him/herself] while supine on the ground. [Patient 29] did not respond to the verbal intervention of staff and continued to aggress until staff was able to reach [him/her] and place [him/her] into a manual restraint ... [Patient 29] indicated that [he/she] would assault [Patient 7] again ... [Patient 7] had minor abrasions and redness to the right orbital area as well as his right elbow."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 38 There was no documentation of an investigation of this incident to prevent recurrence. In an email received on 01/11/2022 @ 1107 OSH staff confirmed that there was no documentation of an investigation. 3.g. Two "Patient Grievance" forms, one dated 11/12/2021 and the other dated 11/18/2021, were each signed by Patient 7 and reflected the patient's grievances that specifically named staff persons were "demeaning ... rude ... condescending ... dismissive ... inappropriate staff behavior ... gaslighting/mental health stigma." The forms were dated as received on 11/16/2021 and 11/19/2021 respectively. There was no documentation of an investigation or response to those concerns and allegations. 3.h. Patient 7 had been left unsupervised, alleged he/she had been verbally abused and harassed and disrespected by both patients and staff, stated he/she felt unsafe, and had been injured by another patient. It would not be unreasonable to conclude that those experiences may have contributed to Patient 7 acquiring a cell-phone, and to the planning and successful execution of his/her elopement from OSH-JC during an off-campus outing. 4.a. Multiple and repeated incidents that reflected an unsafe EOC and potential harm for Patient 2 were reviewed and included the following: 4.b. Incident documentation for Patient 2 reflected that on 02/05/2021 @ 1043 he/she "requested prn medications. NM turned to pull medications	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 39	A 144		

from the Omnicell and heard a noise. [He/she] turned to find [Patient 2] had crawled through the [medication room] window and was standing in the med room."

4.c. A month later, for the second time incident documentation for Patient 2 reflected that on 03/09/2021 @ 1717 he/she "climbed into the medication room via the window ... [Patient 2] came to the med window for ... medication ... climbed through the med window. The med window was open, as this RN was taking medications from the Omnicell ..."

4.d. Incident documentation for Patient 2 reflected that on 03/10/2021 @ 1532 he/she "was walking down the hall, and then walked into the chart room as the door was closing, after a staff had just walked in."

4.e. Medical record documentation for Patient 2 reflected that on 06/28/2021 @ 1651 an LPN wrote that "During lunch at dining, [Patient 2] made [his/her] way through the treatment mall/dining hallway doorway unwitnessed and unauthorized ... When it was time to go back to the unit, [Patient 2] was not with the group. [He/she] was located back on the unit."

An OQM report for the incident on 06/28/2021 @ "Lunch?" included a note that reflected "Leadership Directives: [OQM staff] - Video Review [OQM staff] 7/2/21."

OQM investigation documentation dated 07/14/2021 reflected that "On 6-28-21, it was reported ... that [Patient 2] had made [his/her] way from lunch to [his/her] Mountain 1 Unit without staff escort. I was assigned a video

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 40	A 144		

review in an attempt to identify any system failures that may have contributed in [his/her] ability to make it from lunch, through the Downtown Treatment Mall, and back onto [his/her] unit without escort by staff. In review of the video it was learned that a door did not close fully after staff passed through, and staff did not watch to ensure the door secured. This resulted in the patient being able to gain access from the Valley Dining hallway to the Downtown Treatment Mall. Once on the mall the patient went to the door of the Mountain 1 Activity room where [he/she] ... a staff member let the patient back onto the unit ... [Patient 2] was found by staff to have made it back to [his/her] unit from lunch without a staff escort as required."

The report included the following "Findings:"
* "Staff passed through the door between the Downtown Treatment Mall and the Valley Dining hallway. The door remained slightly ajar and staff failed to ensure it was fully secure before leaving the door. As a result, [Patient 2] was able to move between the Valley Dining hallway and the Downtown Treatment Mall hallway through the unsecured door ..."
* "The physical design of OSH Junction City Campus is known to result in air pressure variations that prevent doors from closing fully."
* "The issues have previously been identify as preventing doors from closing fully and determined that corrections were cost prohibitive."
* "Signage, and staff education at OSH Junction City Campus are utilized to educate staff on the need to ensure doors are fully closed after passing through.
* "During my review of OSH policy, no policy could be located defining an expectation of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 41	A 144		

staff to ensure doors close and secure behind them when they are not escorting patients. OSH policy does list an expectation of staff to ensure doors are closed when they are escorting patients (OSH Policy 6.024)."

The report concluded with a summary of the evidence that supported the "Findings" listed above and included video review that began at "12:40:48" when the patient was in the hallway outside of the dining room: "12:40:48: A [staff member] accessed the doorway between Valley Dining hallway and the Downtown TX mall. The staff member did not look back to see the door did not fully secure. 12:41:10: [Patient 2] approached the door above and passed through it after looking through window between the two hallways ..."

Although there was an investigation of this incident and significant staff and physical environment failures related to door security were identified, the investigation and findings did not address patient supervision and staffs' situational awareness while the patient was off his/her unit. For example:
* There was no video or information related to the patient's movement inside the dining room and from the dining room into the hallway.
* It was not clear whether Patient 2 was supervised while he/she was in the dining room and as he/she moved into the hallway outside of the dining room.
* It was not clear whether Patient 2 should have been supervised while he/she was in the dining room and in the hallway outside the dining room.
* There was no information to reflect whether supervision, situational awareness, and staff-to-patient ratios in the dining room and in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 42	A 144		

hallway had been appropriate.

In addition, there was no documentation provided that reflected that corrective actions to prevent recurrence for Patient 2 and other patients had been planned or implemented as result of the investigation.

In an email received on 01/13/2022 @ 1052 OSH staff confirmed there was no additional information.

4.f. Medical record documentation for Patient 2 reflected that on 06/28/2021 @ 2031 an LPN wrote that "Today, [Patient 2] had three incidents where [he/she] entered places that [he/she] was not supposed to. At approximately 1715, [Patient 2] followed one of the unit LPN's (sic) into the med room and closed the door behind [him/herself] before the LPN could grab it ... Approximately 45 minutes later [Patient 2] entered the unit chart room."

There was no documentation to reflect investigation of how and why Patient 2 was allowed to enter the med room and later the chart room, including no evidence that staffs' door security practices were evaluated, and no evidence of a plan or actions to prevent recurrence. This was a repeat of an incident that had occurred on 03/10/2021.

In an email received on 01/13/2022 @ 1052 OSH staff confirmed there was no additional information.

4.g. Medical record documentation for Patient 2 reflected that on 06/29/2021 @ 1600 an LPN wrote that Patient 2 was "... restricted to the unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 43	A 144		

this shift due to entering non-client areas multiple times during swing shift on 6/28. During the morning medication pass, a [peer] was standing at the med window. [Patient 2] pushed [him/her] aside and climbed through the window ... and entered the med room."

There was no documentation to reflect investigation of how and why Patient 2 was allowed to enter the medication room through a window for the third time and no evidence of a plan or actions to prevent recurrence. This was a repeat of incidents that had occurred on 02/05/2021 and 03/09/2021.

In an email received on 01/13/2022 @ 1052 OSH staff confirmed there was no additional information.

4.h. Incident documentation for Patient 2 reflected that on 07/22/2021 @ 1640 he/she "climbed into the kitchenette window ... until [he/she] had completely climbed over the door and was standing in the kitchenette."

In an email received on 01/11/2022 @ 0931 OSH staff confirmed there was no additional information

4.i. Incident documentation for Patient 2 reflected that on 08/05/2021 @ 1840 he/she was observed "climbing into the medroom (sic) through the open window ... [Staff] held onto [his/her clothing] to try and keep [him/her] from climbing through, but then let go, as we could see that this was not going to have any affect. [Patient 2] proceeded to climb through the window, then walked straight over to the door, opened it and walked out ... There was not a nurse or LPN in the med room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 44	A 144		

while [Patient 2] was climbing into it. I do not know if someone left the window open or if it was not latched and [Patient 2] slid it open."

There was no documentation to reflect investigation of how and why Patient 2 was allowed to enter the medication room through an open window for the fourth time, including evaluation of why the medication room window was open with no staff present, and no evidence of a plan or actions to prevent recurrence. This was a repeat of incidents that had occurred on 02/05/2021, 03/09/2021 and 06/29/2021.

In an email received on 01/11/2022 @ 1005 OSH staff confirmed there was no additional information.

4.j. Incident documentation for Patient 2 reflected that on 08/19/2021 @ 1545 "Two pink/white capsules found in [Patient 2's] room."

There was no documentation to reflect investigation of how and why medications were found in the room of Patient 2 who had repeatedly been allowed to enter the medication room.

In emails received on 01/11/2022 @ 1005 and on 01/12/2022 @ 1047 OSH staff confirmed there was no additional information.

5. Incident documentation for Patient 11 reflected that on 07/28/2021 @ 1500 "Client using fitness equipment. Staff in hallway walking or pacing or standing while client and sharps/equipment unattended for period of at least several minutes. Staff not observing client. Staff previously notified of expectation to be in room observing client and equipment/sharps. TXM manager previously

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 45	A 144		

notified. I believe staff is not fitness trained."

In emails received on 01/11/2022 @ 0931 and on 01/12/2022 @ 1046 OSH staff confirmed there was no additional documentation.

6. Incident documentation for Patient 8 reflected that on 08/09/2021 "At approximately 1650, our unit left the mountain quad and [Patient 8] was in the bathroom for roughly 20 minutes prior. Staff counted the number of clients, but miscounted and left [Patient 8] unsupervised in the bathroom. At 1651 once I arrived on the unit, I turned back around immediately to do a quad sweep and found [Patient 8] still in the bathroom. I instantly transported [Patient 8] back to the unit. We arrived approximately 1652 to the unit."

An OQM form for this incident reflected "Leadership Directives: Close- T and T ... [OQM staff] 8/11/21 ... The [documentation] states the patient was in the quad for about 1 minute while unsupervised."

There was no investigation as to how and why the patient was in the bathroom for twenty minutes, was "miscounted" and left unsupervised.

In an email received on 01/13/2022 @ 1052 OSH staff confirmed there was no additional documentation.

7. Incident documentation for Patient 12 reflected that on 08/10/2021 @ 1700 Patient 12 was observed "coming out of [Patient 4's] room. [Patient 12] slowly shut [Patient 4's] door and looked up noticing this LPN watching [him/her]. The client walked at what appeared to be a fast pace and looked at the ground as [he/she] walked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 46	A 144		

past this LPN ... This LPN notified other unit staff to keep an I (sic) eye on the client for unauthorized entry and possible dating behaviors."

There was no evidence of an investigation to determine how Patient 12 was allowed to be in Patient 4's room, including to determine why Patient 12 was in Patient 4's room.

Refer to Finding C.19. that follows in this Tag that reflects incident documentation for Patient 4 on 05/05/2021 where there were findings of numerous contraband and prohibited times including Pruno, for which there were no investigation or corrective actions planned or implemented to prevent recurrence.

Further, during interview on 12/21/2021 @ 1630 OSH staff confirmed the patient's Treatment Plan dated 08/26/2021 contained no reference to intrusive or "dating behaviors."

8. Incident documentation for Patient 3 and Patient 22 reflected that on 10/09/2021 @ 1020 "... I received a call from a security staff member alerting me that two clients were alone in the café area near the market who were off unit for visiting. Security called due to one of the clients being a Mountain 2 client. I advised security that Mountain 1 staff were supposed to be monitoring the clients during their visiting time."

An OQM report dated 01/04/2022 for the 10/09/2021 incident reflected that "... two patients were left unattended in the [OSH-JC] cafeteria during visitation. This event was assigned as a video review." The report reflected the following "Findings:"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 47 * "Visitation was being conducted and one of the groups was in the air court while another was in the interior cafeteria area. A single staff member was in the air court monitoring the visitation." * "OSH Policy 8.026 requires that two staff be assigned for visitation in [OSH-JC]." * "Additionally, a Superintendent directive dated 9-29-2021 was in effect at the time. Per the directive visitation locations were subject to the direction of the Security Manager who would decide if visitation would take place indoors or outdoors depending on weather. This was implemented as a Covid-19 precautionary measure. The directive did not allow for visitation in both locations." * "The groups should have been in the same area for visualization of both visitations at the same time. As a result, [Patient 22] was left unattended in the Cafeteria area for approximately 1 minute and 28 seconds before security contacted [him/her]." * "... one of the patients was in the air court and the other was in the cafeteria area. I found staff were always with the patient in the air court. The patient in the inside cafeteria area was left unattended." An internal email from OQM staff to another OSH staff and the JCDON dated 01/04/2022 @ 1302 reflected "Hello, Critical Incident Review has issued the following: Directive: 1. Send FYI to NM of MN1 and MN2 (See attached report). Response requested: No." During interview with leadership, quality, clinical and program staff on 01/11/2021 beginning @ 1130 OQM staff confirmed that there was no documentation of actions planned or taken to prevent recurrence in response to the	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 48	A 144		

investigation findings. The DQM stated that he/she "does not send [the investigation report] to NMs with an expectation that they do something."

In an email received on 01/11/2022 @ 1035 OSH staff confirmed there was no additional documentation.

9. Incident documentation for Patient 26, Patient 27 and Patient 28 reflected that on 10/25/2021 @ 1400 during an off-grounds outing at an "Orchard" a "Client needed to use the restroom and [the AC] pointed client to a (sic) area that there was no visibility as it was a good distance away and the [restroom entrance] was on the backside of the building. I said I was going with client and [the AC] stayed behind with the two other clients. I tried to stay where I could still see the group while waiting for client to come out of the restroom but there was zero visibility of [the AC] and the rest of the group. There were two other stops on this outing to a Starbucks drive through on HWY 99 in Junction City and a bathroom stop for two clients at a (sic) outhouse at a winery ..."

There was no evidence that this concern about failure to supervise patients had been investigated to prevent recurrence of opportunities for potential elopement. The AC referred to in this documentation was the AC present on the off-grounds outing during which Patient 7 eloped five weeks later on 12/02/2021

In emails received on 01/11/2022 @ 1035 and 01/12/2022 @ 1047 OSH staff confirmed there was no additional documentation.

10. Incident documentation for Patient 30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 49	A 144		

reflected that on 11/21/2021 @ 1700 the "Bathrooms not checked, PT (sic) left in dinning (sic) Hall ... During the 1700 hour I was standing in the hallway watching our unit at dinner, [Patient 30] came from Mn2 DR running towards the double doors, I asked [Patient 30] what was going on and [he/she] stated [his/her] staff forgot to check the bathroims (sic) and left [him/her]. [Patient 30] said [he/she] thought they were coming back, few minutes passed, (sic) I walked [Patient 30] toards (sic) the mn (sic) side of the hospital, we met up with the staff, were (sic) [Patient 30] and myself reminded the staff they need to check the bathrooms."

An OQM report reflected for the incident on 11/21/2021 @ 1700 that "On the above date and time, [Patient 30] was left in one of the restrooms in the the (sic) MN2 dinging (sic) room area. [Patient 30] was seen running past a staff member and when asked what was going on [he/she] said [he/she] thought staff would return for him. Staff walked [Patient 30] back to MN2. Staff were reminded to check the restrooms."

A note on the report reflected "Leadership Directives: Track and Trend FYI to NM of MN2 ... [OQM staff] 12-1-21."

An internal email from OQM to the DON-JC dated as sent on 12/02/2021 @ 1259 reflected only: "Hello, Critical Incident Review has directed the attached be set to you as an FYI. No response is required for this event. Please feel free to contact Director of Quality Management ... should you have any questions. Please see the attached document for your review."

There was no documentation of investigation into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 50	A 144		

how the patient was allowed to be unsupervised off the unit and no documentation of corrective actions planned and taken to prevent recurrence. Although documentation reflected "[Patient 30] and myself reminded the staff they need to check the bathrooms," it is the responsibility and obligation of the hospital, and not the patient, to implement corrective actions.

In an email received on 01/13/2022 @ 1052 OQM staff confirmed there was no additional information.

****

B. Following are findings related to an unsafe EOC as result of failures to prevent patient to patient sexual contact, including sexual assault, and patient to patient physical altercations:

11. Documentation for Patient 8 on a "Comm Log [Report]" reflected that on 07/04/2021 "It was reported to (sic) that [Patient 8] had allegedly been sexually assaulted during the night by [his/her] roommate. the on-call doctor [physician name] was notified and responded to the unit to interview [Patient 8]. It was decided by [physician] that [Patient 8] needed to go to [SHRB] via non emergent transport, for a complete medical evaluation or forensic evaluation and treatment."

Incident documentation for Patient 8 reflected that on 07/04/2021 @ 0915 Patient 8 had "Exhibited Patient Behavior(s): sexual contact" and that at 0954 security staff "were dispatched to assist on MN2 with maintaining the secure area and seizure of bedding and clothing from alleged victim [Patient 8] from [his/her] (sic) room ... At approximately 1156hrs (sic) [security staff] entered [Patient 8's] room to seize all bedding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 51	A 144		

and clothing. At 1209 hrs patient door was resecured and evidence tape was placed on patient door. [Security staff] took patients belongings and bedding to the Security evidence room and lodged all recovered items into locker #2. Nothing more to report."

Incident documentation also reflected that when the on-call physician arrived on the unit he/she spoke with the "Unit Manager" and another RN "regarding our protocol for this type of event. We went over the Policy 8.019 Staff Response to Alleged Criminal Acts and Contraband." The documentation reflected that subsequently Patient 8 was transported to SHRB for examination.

An OQM report for the alleged sexual assault reflected that "On 7/4/21 [Patient 8] told staff [he/she] was sexually assaulted by [his/her] roommate, [patient name], on 7/2 or 7/3 while [he/she] was sleeping. [Patient 8] provided details to support [his/her] allegations. Security met with the patient. [Patient 8's] roommate was moved to another room. Evidence was collected and the room was secured as a crime scene. [Patient 8] was taken to [SHRB] for a rape kit. OSP was notified." An entry at the top of the report reflected "Leadership Directives: Close [OQM staff initials] 7-7-21"

During interview with leadership, quality, clinical and program staff on 12/21/2021 @ 1545 OQM staff confirmed that the hospital "closed" the incident and sent it for a criminal, law enforcement investigation. The DQM further verified that the hospital had not done an investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 52	A 144		

During the interview the DCNO-JC stated that the clinical team did follow-up for Patient 8 and moved his/her roommate to another room. However, he/she confirmed that the roommate was moved to another room on the same unit as Patient 8. The DCNO-JC also stated that he/she did not know whether Patient 8's roommate had ever been interviewed or the allegation discussed with him/her.

The PD-JC stated that that once an incident is turned over to law enforcement, they "leave it to [law enforcement]." He/she further stated that as of the date of this survey the hospital did not know the outcome of the criminal, law-enforcement investigation.

In an email received on 01/11/2022 @ 0931 OQM staff confirmed that "None of the [incident reports for this sexual assault] were screened into Critical Incident Review therefore there is no related CIR screening document."

As of the date of this survey there was no documentation provided to reflect that the hospital had conducted a non-criminal investigation of the alleged sexual assault to identify how this was allowed to occur, to identify failures that may have contributed and to identify corrective actions to prevent recurrence for Patient 8 and for other patients.

12.a. Incident documentation by an RN for Patient 16 reflected that on 09/07/2021 @ 0615 another patient reported to the RN that Patient 16 and Patient 17 "are having sex on the unit." The RN wrote "I asked how [he/she] knew, and [he/she] replied, 'I have talked to both [Patient 17] and [Patient 16] and they told me about it.' I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 53	A 144		

asked if either person talked about being raped or assaulted and [he/she] replied in a manner that indicated that it was consensual. I reported this to the other RNs on the unit to decide the right course of action. It was decided to move clients from being roommates." The report reflected the RN "spoke" to Patient 16 and an MHT2 "spoke" to Patient 17 and both patients confirmed they were having sex and both reported the sex was consensual.

There was no related incident documentation generated for Patient 17.

During review and interview with leadership, quality, clinical and program staff on 12/21/2021 @ 1005 the following information was provided:
* There was no investigation of the incident "because we don't preclude people from having sexual contact."
* The policy was to "discourage" sexual contact and "confirm whether it is consensual."
* All Incident reports were distributed by email for review and follow-up to multiple distribution lists for "teams" and individuals including the unit team, the treatment team members, the Director of Security and IP staff.
* For sexual contact cases incident reports were distributed by email to a "Do Not Distribute" (DND) email list. However, the IP staff were not on the "DND" list.
* There was a "Master Distribution List" for email distribution that IP staff was on, however, security staff was not on that list.
* There are "challenges maintaining distribution lists" to be current and complete.
* The DCNO-JC stated that the treatment team met every day and reviewed incident reports during those meetings. However, he/she stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 54	A 144		

that there was no documentation of those meetings and the review was "not recorded in any way and it was not expected that they have a note for this specific incident."

12.b. Review of Patient 16's medical record revealed the following documentation:
* On 09/16/2021 @ 1510, nine days after the sexual contact, a NP progress note reflected that Patient 16 was "seen today in clinic to follow up on recent report of consensual sexual contact with client and peer ... [Patient 16] reported the sexual congress with a [same sex] peer was consensual on both parts, (sic) and consisted of oral intercourse only. [He/she] declined to provide additional details but did express concern about [his/her] exposure to STI/HIV or other communicable disease ... Risk of sexually transmitted disease: STI/HIV, HEP B/C, GC/CT, Syphilis ordered - results pending."

There was no other information in the note related to the sexual contact and the results of the laboratory testing ordered on 09/16/2021 for Patient 16 was not provided as requested.
* A 14-page "TCP Treatment Plan" dated as "created" on 09/20/2021 @ 1135 was electronically signed by the "Author" on 09/20/201 and by a physician as the "Final Approver" on 09/22/2021. The first problem identified on the plan was "Abnormal sexual behavior" and indicated Patient 16 was "not approved for Internet access due to misuse of privileges to view child pornography ..." Under that problem a note reflected that Patient 16 "was found to have had sexual relations with previous roommate, and admitted to such when approached ..."

The second problem on the plan was "Cognitive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 55	A 144		

Ability: [Patient 16] was adjudicated Guilty Except for Insanity on 11/21/11. [He/she] was sentenced to three consecutive sentences of 20 years each under the PSRB ... struggles with rules and authority at times, is prone to black and white thinking, prone to embarrassment, inability to effectively express feelings, neurodevelopment and cognitive diagnoses ... Impaired cognitive ability."

Except for the treatment plan note above, there were no other references related to sexual contact with other patients nor any information that reflected that this vulnerable, psychiatric patient was competent to give consent or had the judgement to discern whether another patient was safe to engage in sexual contact with.

12.c. Review of Patient 17's medical record revealed the following documentation:
* On 09/08/2021 @ 1136 an MHT progress note reflected "This is a late entry from 9/7/21 ... concerns that were mention (sic) in morning report about [Patient 17] and roommate having physical relationship which includes sexual activity ... [MHT] stated 'I am concerned for you and your safety ... I just wanted to make sure you are in a safe environment and not getting forced into things that make you feel uncomfortable ... [MHT] mention (sic) to [Patient 17] that [he/she] is moving into a different room because we can't be having physical relationships with peers, it's for everyones (sic) safety." There was no other related documentation in the note.

* An 11-page "TCP Treatment Plan" dated as "created" on 09/10/2021 @ 1412 was electronically signed by the "Author" and by a physician as the "Final Approver" on 09/10/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 56	A 144		

Although the treatment plan was created three days after the sexual contact was reported, there were no problems or references on the treatment plan related to sexual contact with other patients nor any information that reflected that this vulnerable, psychiatric patient was competent to give consent or had the judgement to discern whether another patient was safe to engage in sexual contact with.

13. In the cases of Patient 8, Patient 8's roommate, Patient 16 and Patient 17 there was no evidence of clear and complete investigations by the hospital of the sexual contact and alleged sexual assault. The hospital is responsible to ensure that patients receive care in a safe environment and are free from abuse and neglect, including sexual abuse. The hospital is obligated to protect patients, particularly vulnerable populations such as psychiatric patients, from unsafe situations such as unprotected sex with other patients. Patients 8, Patient 8's roommate, Patient 16 and Patient 17 are all victims of the neglect by staff that allowed these unsafe situations to occur. It was not evident that the hospital investigated these cases to identify how and why these situations were allowed to occur and to identify correction actions to prevent recurrence for the patients involved and for other patients.

14.a. Incident documentation reflected that Patient 5 was involved in physical altercations with other patients on multiple occasions that resulted in physical harm included:

14.b. On 06/27/2021 @ 1430 while off the unit in the library Patient 5 hit Patient 37 "in the face multiple times ... appeared to be unprovoked.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 57	A 144		

Staff initiated physical hold with [Patient 5], and [he/she] walked to seclusion." The documentation reflected that Patient 37 "... sustained injuries; a split lower lip, shallow abrasions whose pattern resembled fingernail scratch marks on [his/her] right cheek, and small ecchymotic areas at [his/her] left temple/lateral eyebrow ... [Patient 37] was escorted by security and MHT staff and was taken to the ED."

There was no documentation of an investigation, including whether staff were actively supervising, monitoring and situationally aware of the patients' movements and behaviors in the library. There was no evidence of plans to prevent recurrence for these patients and other patients.

In an email dated 01/11/2022 @ 0926 hospital staff wrote that the incident was not "screened into Critical Incident Review therefore there is no related CIR screening document" and there was no additional information.

14.c. Eight days later, on 07/05/2021 @ 1948 incident documentation reflected that "Staff heard clients in activity room shouting 'fight, fight' and immediately went to the area. Patient 5 and Patient 9 were fighting in the treatment hallway." The report reflected that "Staff attempted to separate the clients ... [Patient 5] made provocative comments to [Patient 9], staff were unable to hold them apart and they resumed fighting. More staff arrived and the clients were separated ... [Patient 9] had physical injuries, a laceration to [his/her] left eyebrow and a laceration to the inside of [his/her] lower lip ... [Patient 9] stated that [he/she] would be safe as long as [Patient 5] was not present on the unit. The on-call MD examined [Patient 9's] injuries

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 58	A 144		

and an order was received to send [him/her] to the emergency department."

According to the incident documentation staff responded to the altercation because they "heard" clients shouting. There was no documentation of an investigation, including where staff were when they "heard" the clients, what the patients' observation orders were, and whether staff should have been present in the space and actively supervising, monitoring and situationally aware of the patients' movements and behaviors in the "activity room" and "treatment hallway." Particularly when at least one patient with a history of involvement in physical altercations was in that space. There was no evidence of plans to prevent recurrence for those patients and other patients

In an email dated 01/11/2022 @ 0931 hospital staff wrote that the incident was not "screened into Critical Incident Review therefore there is no related CIR screening document."

In an email dated 01/12/2022 @ 1046 copies of eight progress notes from Patient 9's medical record were provided. Those described staff responses to this incident but contained no documentation of an investigation as described in this finding.

14.d. Two days later, on 07/07/2021 @ "12:55 AM" incident documentation for Patient 5 reflected that during an encounter with a patient about the rings that patient was wearing, Patient 5 "hit [his/her] peer in the face. The peers chair fell sideways onto the floor. [Patient 5] then began to punch [his/her] peer repeatedly in the head, [Patient 5] also kicked [him/her] in the head and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 59	A 144		

in the side of [his/her] stomach. A code green was called ... [Patient 5] continued to assault [the other patient.] When staff arrived on the unit to assist with safe containment [Patient 5] stopped assaulting [his/her] peer ... [Patient 5] walked to the side room ... the sideroom door was locked at 0058."

There was no documentation of an investigation, including whether staff were actively supervising, monitoring and situationally aware of Patient 5's movements and behaviors. Particularly when Patient 5 had a history of physically assaulting at least two other patients who sustained injuries in the previous 11 days. There was no evidence of plans to prevent recurrence for those patients and other patients.

In an email dated 01/11/2022 @ 0931 hospital staff wrote that the incident was not "screened into Critical Incident Review therefore there is no related CIR screening document."

In an email dated 01/12/2022 @ 1046 copies of four progress notes from Patient 5's medical were provided. Those four progress notes were written on 06/29/2021, 07/03/2021 and 07/04/2021, several days prior to this incident that occurred on 07/07/2021.

14.e. In addition to the patients who were injured during the altercations described above, Patient 5 was also a victim of the hospital's failure to provide supervision and other interventions to prevent his/her behaviors. Those failures resulted in the use of physical restraint and locked seclusion for Patient 5 and also placed Patient 5 at risk for injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 60 15. Similar findings were identified in relation to incident documentation for a physical altercation between Patient 17 and Patient 18 on 09/25/2021 @ 1603. ********** C. Following are findings related to an unsafe EOC as result of failures to prevent contraband, unsafe and prohibited items, and failures to prevent other unsafe conditions in the physical environment: 16.a. P&Ps related to the prevention of unsafe and prohibited items and areas in the POC included: 16.b. The P&P titled "Contraband and Prohibited Items" dated as 12/18/2017 included the following: * "[OSH] will provide a safe treatment environment where items considered to be prohibited are restricted, and items considered to be contraband are not allowed on OSH property unless exempted in this policy." * "Contraband is forbidden at all times on OSH property, including in patient-care areas, with exceptions indicated in this policy." * "Prohibited items are not allowed in patient possession in areas specified on the 'Prohibited Items' lists (Attachment A)." * "Prohibited items list exceptions for a patient may be made based on the interdisciplinary treatment team's (IDT) clinical assessment." * "Prohibited items lists are not all-inclusive. The Superintendent or designee may deny an item that is not on the list and that is deemed to be a safety or security risk.". * "HCP may transport items considered to be prohibited and listed in Attachment B in	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 61	A 144		

patient-care areas. The item(s) must be in secure possession at all times."
* "Items listed in Attachment B may not be used in patient-care areas."
* "Exceptions to this policy include circumstances where a patient uses a prohibited item as listed on Attachment A while under staff supervision.
* "Unless indicated otherwise, this policy supersedes all other OSH prohibited item or contraband policies or procedures.
* "'Contraband'" means any item that is not permitted on OSH grounds. Contraband includes, but is not limited to: 1. weapons, controlled substances, cannabis and products containing cannabis, drug paraphernalia, illegal substances, lighters or incendiary devices, explosives, and escape devices; 2. any substance or article that is likely to cause harm to patients or others; 3. any substance or article that violates facility infection control requirements; or 4. any substance or article that is otherwise illegal."
* "'Prohibited item' means an item that has been determined to be potentially detrimental by the PET for patients at a particular level of care. A prohibited item is not permitted to be in patient possession with exceptions indicated in this policy."

"ATTACHMENT A ...
Tier 0 Prohibited Items - All hospital level of care patient-care areas ...
o Aerosol spray cans or bottles
o Alcohol
o Any chargers, electronics cords, power strips, surge protectors, extension cords, plug or outlet adapters not approved or issued by OSH
o Cameras or recording devices of any kind ...
o Cash exceeding $30.00 ...
o Clothesline, cables, cords, or rope longer than

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 62	A 144		

12 inches
o Clothing with drug, alcohol, gang, or overtly violent content
o Duct tape
o Any electronic device not approved per OSH policy ...
o Glass, mirror, or ceramic items
o Items that are broken or altered from their original, intended use
o Keys other than those issued by OSH and not stored in accordance with OSH Policy ...
o Lighters, matches, incendiary devices, or flammable liquids
o Media not allowed per OSH Policy ... including pornography and "NC-17" or "X" rated movies
o Pantyhose, knee-high hose, and long socks
o Plastic bags or plastic wrap
o Prescription or over-the-counter drugs, herbal supplements, or other supplements ...
o Any item associated with illicit drug use
o Tattooing, piercing, or cutting devices
o Toxic glues, paint, alcohol-based products, thinner, or solvents
o Valuables and identification documents not stored in accordance with OSH Policy ..."

"The following items are prohibited on hospital level-of-care units ...
o Chargers, electronics cords, power strips, surge protectors, extension cords, plug or outlet adapters not approved or issued by OSH
o Clothesline, cables, cords, rope, scarves, or straps longer than 12 inches
o Computers (personal)
o Electric personal fans
o Metal, wood, or plastic clothes hangers
o Metal combs or brushes
o Razor blades (exception: disposable razors checked in or out for up to one hour, or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 63	A 144		

supervised by staff)
o Shoelaces
o Television (personal)"

"Additional prohibited items are assigned Tier Level 1 to Tier Level 3, and are associated with individual units."

"Tier 1 Prohibited Items - Units: [Three hospital units on OSH-JC campus & 10 units on OSH-Salem campus] - All items listed in Tier 0 unless specific clarification included below, and
o Any product in which alcohol is listed as one of the first two ingredients
o Can openers, can parts, cans
o Clipboards or notebooks with metal
o Clothing hangers
o Clothing with chains or spikes, or torn clothing, except factory distressed
o Foil, tin, and aluminum except pre-packaged food wrapping
o French press coffee makers
o Incense
o Purses or bags with strap(s)
o Rulers with metal parts
o Safety pins and tacks
o Scarves, including bandanas
o Sports equipment, unless approved by Program Executive Team"

"Tier 1 items allowed only with IDT approval and/or HCP supervision and check-out
o Belts
o Clothing with camouflage prints or hunting-related images
o Hair dryer, flat iron, curling iron
o Hair dye (exceptions include hair dye applied by OSH hairdresser after IDT approval)
o Heavy or metal-toed boots

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 64 o Neckties o Perfume cologne, body spray, scented lotions, and aromatherapy products o Personal hygiene products not issued by OSH including, but not limited to: Fixodent; dental floss; electric razors, shavers, trimmers; nail files; or clippers o Scissors, including safety scissors o Sewing or craft needles, knitting needles, or crochet hooks o String, twine, thread, loose wire, or yarn longer than 12 inches in length o Stringed instruments o Suspenders o Tea, coffee not issued by OSH" "Tier 2 Prohibited Items - Units: [No units on OSH-JC campus & five units on OSH-Salem campus] - All items listed in Tier 0 and Tier 1, unless specific clarification added below, and o Buckles o Bobby pins o Discs (e.g., CDs, DVDs, games) o Gum o Videotapes and cassettes" "Tier 3 Prohibited Items - Units: [No units on OSH-JC campus & six units on OSH-Salem campus] - All items listed in Tier 0, Tier 1, and Tier 2 unless specific clarification added below, and o Alarm clock radios o Bras with underwire o Brimmed hats (exception: "beanies") o Cargo or carpenter pants o Hardback books o Hooded shirts o Jewelry, excluding wedding bands or engagement rings	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 65 o Metal hair accessories (including barrettes, bobby pins, etc.) o Pens and pencils (exception: OSH-issued flex pens) o Powders such as nondairy creamers not issued by OSH o Radios (exception: OSH-issued radios) o Reading lamps o Staples o Zippers longer than normal on pants or jeans, and zippered coats" "ATTACHMENT B Health Care Personnel Prohibited Items - The following items may be transported through patient care areas under secure possession of health care personnel (HCP), and must be stored in a secure, non-patient-care area (such as a break room or staff locker) as indicated in OSH Policy ... These items may not be used in patient-care areas, even under the secure possession of HCP: o glass, mirror or ceramic items; o plastic bags or plastic wrap; o personal toiletries (e.g., hair brushes, soaps, perfumes, deodorant, toothpaste, toothbrush, Aerosolized products); o personal electronic devices not issued by OSH (e.g., cellphones, radios, MP3 players, cameras, or recording devices of any kind); o prescription or over-the-counter drugs, herbs or supplements except for medically-necessary products which must be immediately available on a person as specified by a physician note as indicated in OSH Policy ... o metal or glass containers; and o utensils for meals."	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 66	A 144		

The P&P attachments of prohibited items that had exclusions for various units across the OSH-Salem and OSH-JC campuses and not for others was confusing and unclear. For example: The Attachment A prohibited items and Tier 1 list included cords longer than 12 inches and safety pins, However the Tier 3 list of items that were not excluded on the hospital units included "jewelry."

During interview with leadership, quality, clinical and program staff on 12/21/2021 beginning @ 1655 it was confirmed that the "Tier 2" and "Tier 3" prohibited items were allowed on the OSH-JC hospital units.

16.c. The P&P titled "Tool and Sharp Security" dated as 04/01/2019 included the following: "At [OSH] a patient has the right to receive care in a safe setting as directed by 42 [CFR] 482.13(c)(2). Therefore, at OSH, any instrument designed for repair, craft, personal hygiene, culinary use, or any other instrument which has a high probability of being used as a weapon against self or others or as an escape devise must be closely monitored." The P&P described procedures for secure storage, inventory and sign-out systems for such items on treatment units and treatment areas.

The P&P also required that "[HCP], including inmate workers, are responsible to follow this policy and monitor the location and appropriate patient use of tools and sharps. It was unclear who "inmate workers" were as the term "inmate" generally refers to a person confined in a prison. It was also unclear why those workers were made to be responsible for monitoring the location and appropriate use of tools and sharps by patients.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 67	A 144		

16.d. The P&P titled "Electronic Devices and Internet Access for Patients" dated as 12/17/2017 included the following:
* "[OSH] supports reasonable patient use of cell phones, computers, tablets, gaming devices, (i.e., 'electronic devices') and the internet within parameters established in this policy ... this policy must be read in conjunction with OSH [P&P] Contraband and Prohibited Items and OSH [P&P] regarding patient access to media."
* "Electronic devices used by a patient must be OSH-approved or OSH-issued."
* "Cell phones may only be capable of sending and receiving voice calls or text messaging, but not of sending or receiving photographs or videos. No camera, internet access, or other function will be allowed."
* "Computer an internet use must be in support of, and may not interfere with, treatment at OSH."
* "Gaming devices allowable under this policy may only be used as outlined in the permission grid."
* "USB storage devices may be used as storage for data only and may not contain software."

16.e. The P&P titled "Media Access for Patients" dated as 03/23/2018 included the following:
* "None of the following may be displayed in any area of OSH: 1. media which meets the definition of pornographic material in this policy; 2. media which overtly promotes criminal, violent, or self-destructive behavior; 3. media which overtly expresses hatred on the basis of race, religion, national origin, or sexual orientation; or 4. media rated "NC-17", "X", "MA", or equivalent rating systems."
* "'Media' in this policy means visual or audio content or material and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 68	A 144		

communication channels through which news, entertainment, education, data, or other messages are distributed. Media includes but is not limited to photos, newspapers, magazines, videos, television, music, and radio.
* "'Pornographic material' means media which displays sexually-explicit behavior or activities."
* "Individual patient guidelines on acceptable media must be developed in consultation with the patient's [IDT] including, when necessary, the Sexual Offender Treatment Program."
* "A civilly committed or voluntarily admitted patient ... may access media rated "Mature" (M) or "adult only" (AO) or the equivalent movie rating "restricted" (R) ..."

The P&P was not clear. For example: It did not clearly describe what "displayed in any area" meant. It was not clear if it meant that those listed items were not allowed on the premises of the facility at all, or that those listed items were allowed in patient rooms as long as they were not "displayed" on the walls or in open view for others to see.

In addition, it stated that media with certain ratings was not allowed, yet it later reflected that some patients would be able to view media with those ratings. The rating descriptions of NC-17, X, MA, M, AO, R were not all defined and were not used consistently throughout, therefore, it was unclear.

16.f. The ten-page P&P titled "Patient Property and Valuables: Handling and Storage" dated as 02/13/2015 specified specific units by name on the OSH-Salem campus but did not reference the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 69	A 144		

OSH-JC campus or the hospital units on the OSH-JC campus. Therefore, it was not clear which parts of the P&P were applicable to the OSH-JC hospital units. However, the P&P included, but were not limited to the following:
* "[OSH] strives to protect the rights of each patient, safeguard property entrusted to its safekeeping, and maintain a safe living and working environment."
* "Unit Storage: Personal possessions must be neatly stored on the unit in the patient's wardrobe, nightstand, or desk."
* "Food items may only be stored in specified containers in unit kitchenettes or in other identified secured unit storage spaces."
* "Excess property that negatively impacts the health or safety of patients may be stored as listed below ..."
* "Small Storage: driver's license and vehicle keys; identified ... credit cards ..."
* "Large Storage: Clothing or larger items ... Due to health and safety issues, certain items may not be kept in large property storage including, but not limited to: food and other perishable items, tobacco, combustibles (e.g., alcohol, perfume, cigarettes, matches, lighters), and excessive paper. These items must be disposed of ..."

16.g. Other P&Ps reviewed included provisions for identification of contraband and prohibited items and for management of those to prevent those items from coming into the possession of patients. Those included:

* The P&P titled "Mail and Packages for Patients" dated as 09/28/2018.
* The P&P titled "Patient Screenings from Outings or Trips" dated as 03/12/2019.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 70	A 144		

17. Incident documentation for Patient 1 reflected that on 01/06/2021 @ 1415 the following items were found in his/her room; "food, multiple hair ties, string attached to a book, a plastic sleeve from a small puzzle and a metal ring ... a drawn picture of a male subject hanging from a noose."

The report reflected that the items were removed from patient's possession however, there was no indication of an investigation to determine how he/she had possession of those items and how the hospital planned to prevent recurrence for Patient 1 and for other patients.

18.a. Incident documentation for Patient 3 reflected that on 02/17/2021 @ 2250 he/she "made a ligature tying 4 friendship bracelets together to form a 27-inch rope ... patient was not seriously hurt ... [Patient 3] handed [staff] the bracelet rope and told [staff] [he/she] attempted to choke [him/herself] while lying in [his/her] bed ... voices ... were telling [him/her] to kill [him/herself] ... [Patient 3's] neck area which appeared to be red but had not broken the skin ..."

The report reflected that the "rope" was removed from the patient's possession. However, there was no indication that the patient's room had been searched for other items he/she could self-harm with. Further, there was no documentation of investigation related to how and why the patient was able to obtain multiple bracelets to fasten together to form a "rope" to harm him/herself and no evidence of corrective actions or plans to prevent recurrence for Patient 3 and for other patients.

18.b. Twenty-nine days later, incident documentation for Patient 3 reflected that on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 71	A 144		

03/19/2021 @ 2130 his/her roommate reported that Patient 3 "had taken pills and needed staff assistance. [Patient 3] reported saving pills from various day/swing/PRN Tylenol over the last 14 days from 3/5/21, and had swallowed 50-60 pills (Atenolol, Pepcid, Prozac, Latuda, Topamax, Docusate) ... ambulance ordered emergent ... arrived at [Acute Hospital] at 2255. Admitted to ICU ..."

18.c. Incident documentation for Patient 3 reflected that on 03/20/2021 @ 1335, the day after the patient ingested the pills, staff conducted a room search of Patient 3's room. The following items were found: "around 6-7 pills/medication (tylenol (sic), some gel capsuls (sic) and some unknown pills), numerous ball point pens, a packet of Wiggle Eyes that had staples in the packaging, a pack of gum (EXTRA Polar Ice) and some food items (a peanut butter packet and 2 packets of graham crackers ... The pills/medication were found ... inside a sock ..."

It was unclear why the room search for unsafe items did not occur until 16 hours after Patient 3's suicide attempt, when there was another patient who occupied the room and who was at risk of self-harm from known unsafe and prohibited items. Further, it was unclear why the documentation did not provide specific information about the number of pills or number of pens found.

18.d. A "Summary Report" of an investigation dated 05/24/2021 reflected that Patient 3 returned to OSH-JC on 03/21/2021 at 1300 and was placed on 1:1 suicide precautions.

The investigation summary identified multiple

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 72	A 144		

failures that included, but were not limited to: suicide risk assessment, observation orders, documentation, leadership, clinical guidance, staff competency, IDT function, communication, compliance with unspecified policies and protocols.

The report included action plans in three areas. Those plans were identified as "Suicide Risk Screening" training, "Guilty except for Insanity (GEI) Jurisdictional Training," a leadership meeting on 05/20/2021 to "Review historical efforts to address [IDT] functioning and dynamics" and "Leadership presence and rounding ... at [OSH-JC]" beginning "June 2021."

The investigation summary report did not address how and why Patient 3 was allowed to have "50-60 pills" in his/her possession to use to attempt suicide. For example: there was no evidence that nursing staff medication administration practices had been evaluated or that medication control and security practices had been evaluated.

Additionally, there was no investigation related to how Patient 3 had possession of the other items removed from his/her room and why the room had not been searched for 16 hours when staff had knowledge that Patient 3 had possession of unsafe items. This created an unsafe environment for Patient 3's roommate.

There was no documentation to reflect how the hospital planned to prevent recurrence of prohibited and unsafe items in patient rooms.

18.e. During review and interview with leadership, quality, clinical and program staff on 12/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 73	A 144		

@ 1530 the DQM confirmed that there was no information related to how Patient 3 was allowed to possess four bracelets to form a ligature and how he/she was able to hoard 50 to 60 pills to ingest. He/she further confirmed that no related corrective action items had been planned or implemented.

19. Incident documentation for Patient 4 reflected that on 05/05/2021 @ 1135 the following items were found in his/her room: "10.5 tabs of 325 mg Tylenol, 3 capsules of Benadryl 50 mg were found on [Patient 4 him/herself]. 1 bag of Pruno, 3 Seltzer bottles full of Pruno, various condiment food packets, 1 bottle of honey, night time tea bags, 1 condom, sugar packets, 2 Tazo tea packets, 2 jelly packets, 1 cube of butter, 1 Stash tea packet and 1 Jenga block were found in the room and them photographed and removed for disposal."

Review of the CDC website on 03/10/2022 revealed the following information about "Pruno:"

"Pruno: A Recipe for Botulism ... quick way to make a kind of homemade alcohol that goes by many different names, including pruno, hooch, brew, prison wine, and buck ... It can give you botulism, a life-threatening illness ... Botulism is a rare but serious illness caused by a toxin (poison) that attacks the body's nerves and can lead to paralysis and death. Because the disease can paralyze the muscles used in breathing, people can die soon after symptoms first appear. Even those who get medical treatment right away may be paralyzed and hooked up to a ventilator (breathing machine) for many weeks. One way people get botulism is by eating or drinking something that has the toxin in it ... after making

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 74	A 144		

and drinking pruno ... anyone who drinks this kind of alcohol is at risk ... When people make pruno, they usually ferment fruit, sugar, water, and other common ingredients for several days in a sealed plastic bag. Making alcohol this way can cause botulism germs to make toxin (poison). The toxin is what makes you sick ... If you make pruno, you put yourself and anyone who drinks it in danger of getting botulism. The alcohol in your drink won't destroy the toxin (make it harmless). The only way to be sure you don't get botulism from pruno is to not drink it ... batches of pruno that gave people botulism used at least one of these ingredients: o Potatoes o Honey o Food from bulging cans ... if you [drink pruno] and you have symptoms of botulism, get medical help immediately ... Some of the symptoms of botulism are: o Double vision o Blurred vision o Drooping eyelids o Slurred speech o Difficulty swallowing o A thick-feeling tongue o Dry mouth o Muscle weakness ... o Difficulty breathing o Paralysis (can't move your body)."

Online recipes for pruno reflected that it can be made with ingredients such as: fruit, sugar, honey, ketchup and bread. The recipes also reflected techniques for brewing in plastic bags, or in bottles using a condom over the bottle opening "with a small hole pricked in it as a release valve of sorts." They also indicated that for fermentation "5 - 7 days is a pretty standard length of time but the more time the better."

The incident documentation reflected that the items were removed from patient's possession however, there was no indication of an investigation to determine how he/she had possession of medications, bags, and bottles, and how he/she was allowed to make and store a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 75	A 144		

"homemade alcohol" that carried the risk of botulism and could lead to paralysis or death.

During interview with leadership, quality, clinical and program staff on 12/20/2021 @ 1615 OQM staff confirmed there had been no investigation and stated that the OQM would not conduct investigations of "nuisance contraband" and "medications are reviewed by someone else." The DQM stated that "For sure, we would not have investigated how a patient had Tylenol or Benadryl in their room." It was further confirmed by staff present that there had been no investigation related to how the patient was allowed to have possession of the medications in his/her room.

It was unclear what the criteria was for "nuisance contraband" and whether potentially deadly "pruno" and the items known to make "pruno" were considered "nuisance contraband.

There was no documentation to reflect how the hospital planned to prevent recurrence of prohibited and unsafe items in patient rooms.

20. Incident documentation for Patient 12 and Patient 36 reflected that on 08/19/2021 @ 1545 "Suspected pruno found in [Patient 12 and Patient 36's] room."

The report reflected that the "pruno" was removed from the patients' possession however, there was no indication of an investigation to determine how the patients had been allowed to make "suspected pruno" and what type of containers the "pruno" was found in. There was no documentation to reflect how the hospital planned to prevent patients from making and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 76 possessing this dangerous "homemade alcohol." In an email dated 01/12/2022 @ 1047 hospital staff wrote there was "no additional documentation" in relation to this incident. 21.a. Incident documentation for Patient 23 reflected that on 10/16/2021 @ 1630 Patient 23 was found in his/her room with bleeding from his/her forearms and that staff found "... a black pen with part of the tip broke off with blood on the end of it sitting (sic) on the bed next to [his/her] right leg." The report reflected that the item was removed from the patients' possession however, there was no indication of an investigation to determine how the patient had been allowed to have possession of the item used for self-harm and how the hospital planned to prevent recurrence. In an email dated 01/12/2022 @ 1047 hospital staff wrote there was "no additional documentation" in relation to this incident. 21.b. An RN progress note in Patient 23's medical record dated 10/25/2021 @ 2148 reflected "On Enhanced Supervision?: Yes ... remains on unobtrusive suicide supervision ... came out of [his/her] room around 1715 with hair bleach and blue hair dye running into [his/her] eyes. Staff helped [him/her] get it out of [his/her] eyes and [he/she] was supposed to be rinsing it out of [his/her] hair in the shower. [He/she] then went back into [his/her] room and put more blue dye on [his/her] hair with [his/her] bare hands which got all over hands, face, and neck ..." Reason for Enhanced Supervision: Suicide."	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 77	A 144		

An LPN progress note in Patient 23's medical record dated 10/25/2021 @ 2238 reflected "On Enhanced Supervision?: No ... came out of [his/her] room walking carefully and [his/her] hands were noticeably shaking and [he/she] had a milky blue liquid streaming down [his/her] face from [his/her] hair ... [he/she] said, 'It's burning'. The smell of ammonia was strong, a towel was grabbed to start wiping the drips when [he/she] announced, 'It's burning my eyes'. [He/she] was immediately taken to the nearby sink where staff assisted [him/her] in flushing the chemicals out of [his/her] eyes ... [Patient 23's] bathroom had bold blue dye splattered from the sink to the toilet, the water in the toilet appeared to be similar to the color of the toilet water on an airplane ..."

Incident documentation for Patient 23 reflected that on 10/25/2021 @ 1730 "Hazardous chemicals ... Hair coloring kit given to client from their personal belongings that included hair bleach with unknown developer strength and blue hair color. Client came out of [his/her] room with the bleach all over [his/her] hands and hair and complaining of [his/her] eyes burning as bleach was also in [his/her] eyes and the smell of ammonia was very strong ... I told staff we needed to get the hair dye kit out of his room because that there would be more product in clients hair dying kit ... client gave over two paper bags of product and one with writing on the outside stating '[Patient 23] 8/12 Hairdresser.'"

There was no documentation of investigation to reflect how the patient was allowed to keep in his/her possession "two paper bags" of chemical product that he/she was able to harm him/herself with, how he/she was able to use those products without staff supervision and how the hospital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 78	A 144		

planned to prevent recurrence of such hazardous chemicals in patient rooms.

Further the RN and LPN documentation contained contradictory information regarding Patient 23's "enhanced supervision" status.

During interview with leadership, quality, clinical and program staff on 01/11/2022 beginning @ 1430 staff confirmed the findings and no additional information was provided.

22. Incident documentation for Patient 5 reflected that on 06/10/2021 @ 1107 "... observed 'four broken fork tines' floating in the toilet of [Patient 5's] room ... last week on 6/2/21 ... a similar broken spoon/fork had been found in [Patient 5's] possession as well ... When we got to [Patient 5's] room [he/she] went in and retrieved a broken fork. The fork was a harder plastic one from the dining hall, the top prongs were broken off. I took possession of the fork ... It was decided that since [Patient 5] handed over the item, they wanted to give him some trust, so they were not wanting to search his room." The report reflected that security staff removed the altered fork from the patient's possession. . Security cleared and I lodged the broken fork into prohibited property." No other documentation.

There was no documentation to reflect how the patient was allowed to possess a broken and altered fork that was of "harder plastic" and that could be used as a weapon to harm self or others, eight days after a similar broken utensil had been found in the patient's possession. There was no documentation to reflect how the hospital planned to prevent patients from possessing such unsafe items.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 79	A 144		

In an email dated 01/11/2022 @ 0926 staff confirmed that there was no additional information related to this incident.

23. Incident documentation for Patient 6 reflected that on 06/26/2021 @ 1340 and LPN was alerted by another patient that "... the frame housing unit phone list by the male (sic) phone on the unit had been tampered with. The phone list had a cover of clear plastic that someone had torn loose, breaking a chunk of plastic - odd shaped - about 6 inches by 4 inches by 1/8th inch thick that was missing. On the paper under the missing plastic were two very small drops of bright red stain that looked like blood ... [Patient 6] volunteered that inside [his/her] shorts [he/she] had another quarter that [he/she] had not shown staff that was sharpened on the end. [Patient 6] stated [he/she] had sharpened the quarter to use as a screwdriver in order to dismantle the seclusion room if [he/she] were placed in seclusion again. [He/she] relinquished this to staff ... [Patient 6] disclosed ... that the missing shard of plastic was hidden in [his/her] bathroom ... [staff] found the shard of plastic in [Patient 6's bathroom] trash can."

There was no documentation to reflect how the patient was allowed to possess an altered coin to be used as a tool, how he/she altered it, and how he/she was able to tamper with the plastic cover undetected. There was no documentation to reflect how the hospital planned to prevent patients from possessing such unsafe items.

In an email dated 01/11/2022 @ 0926 staff confirmed that there was no additional information related to this incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 80 24. Incident documentation for Patient 13 reflected that on 08/21/2021 @ 1200 Patient 13 "... wanted to attend computer lab ... asked to stop at the personal property room for [his/her] auxilary (sic) cord to connect [his/her] headophones (sic) to the computer ... [he/she] asked me to hand [him/her his/her] personal property box. I did and [he/she] removed [auxiliary cord] and then rummaged through other items in the box ... took [him/her] to the computer lab. At 1230, I escorted [him/her] from the computer lab back to the unit and saw [him/her] place a USB cable that I had not seen [him/her] remove as well as [the auxiliary cord] in his property room (sic). It was later reported that [Patient 13] had had (sic) a long USB cable, which [he/she] had used to connect [his/her] MP3 player to the computer [he/she] was using, and it appeared that [he/she] was trying to download files from the internet." Progress notes in Patient 13's medical record dated 08/21/2021 @1541 and 08/21/2021 @ 1806 contained similar information. There was no documentation to reflect an investigation of how the patient was able to access prohibited items that included such considerations as to whether the practice of allowing patients to retrieve items from personal property boxes was allowed, or whether the staff supervision of the patient at that time was adequate. In an email dated 01/11/2022 @ 1005 staff confirmed that there was no additional information related to this incident.	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 81	A 144		

25. Incident documentation for Patient 15 reflected that on 08/30/2021 at 1855 staff noted that "[Patient 15] had not returned the electric razor blade that [he/she] had checked out earlier in the day, around 1400, ... and that [Patient 15] had a history of being 'defiant' and withholding items ... the electric razor blade was located inside of [Patient 15's] pillowcase, at about 1948 ... 3 round blades inside of the razor head ... NM took possession of the razor and the blades ..."

There was no documentation to reflect an investigation of how the patient was able to use prohibited "razor blades" without staff supervision, particularly when Patient 15 had been assessed to have a history of "withholding items," and how he/she was able to retain possession of this unsafe item for approximately six hours, placing [Patient 15] and others at risk. There was no documentation to reflect how the hospital planned to prevent patients from possessing such unsafe items.

Progress notes in Patient 15's medical record dated 08/21/2021 @ 1335 and 08/21/2021 @ 2120 contained similar information.

In an email dated 01/11/2022 @ 1005 staff confirmed that there was no additional information related to this incident.

26. Incident documentation for Patient 32 reflected that on 12/01/2021 @ 0854 a "Cleaning chemical found in patient room ... [Patient 32] brought a bottle of enzymatic luster cream to RN at 0854 and handed it to RN after coming from [his/her] room ... When asked where it was found, [Patient 32] smiled and declined to identify where it came from."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 82 There was no documentation to reflect an investigation of how the patient was able to have a hazardous and prohibited cleaning product in his/her possession and no documentation to reflect how the hospital planned to prevent patients from possessing such unsafe items. During review and interview with leadership, quality, clinical and program staff on 01/11/2022 beginning @ 1430 it was confirmed that there was "no known follow-up," including in the patient's medical record. 27. Incident documentation for Patient 10 reflected that on 09/13/2021 @ 1035 the following items were found in his/her room: "... $1.75 over the allotted $30 dollars clients are allowed to have on them. Food items, three draw strings in pants and an unknown crystal substance in some disintegrated paper was found ... a used match and cigarette butt that appeared to be very old ... the crystal substance was taken to be tested. A test of the substance showed no reaction to being methamphetamine." There was no documentation to reflect an investigation of how the patient was able to have those items in his/her possession and how the hospital planned to prevent patients from possessing those. During interview with leadership, quality, clinical and program staff on 12/21/2021 beginning @ 1130 the PD-JC stated that he/she was not sure whether there had been an investigation, including related to the draw strings found in the patient's pants.	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 83	A 144		

In an email dated 01/11/2022 @ 1012 staff confirmed that there was no additional information related to this incident.

28. Incident documentation for Patient 19 reflected that on 10/01/2021 @ 0840 "... SD Card's, DVD Player and MP3 Player's (sic) (Personal and Unit) ... 1 intact magazine containing 2 plus pages of Marijuana paraphernalia, 40 miscellaneous magazine pages containing nudity, sexual positions, the illusion of intercourse and penetration, and alcohol advertisements. Also, found 13 computer printed pages of explicit photographs, containing nudity, sexual positions, intercourse and penetration." The report reflected those items were removed from the patient's possession.

Review of medical record progress notes included a psychiatrist note dated 10/01/2021 @ 1552 that reflected Patient 19 was "procuring pornographic materials through other clients." An RN progress note dated 10/01/2021 @ 1748 reflected that Patient 19 informed staff that "'another client is printing off pictures and selling them to people on the unit.'" An MHT progress note dated 10/04/2021 @ 2326 reflected that Patient 19 told the MHT that "'staff took my MP3 player ... there was child pornography on it.'"

There was no documentation to reflect an investigation of how Patient 19 was allowed to have possession of the prohibited items, how he/she was able to obtain, or purchase prohibited and illegal materials from other patients and how the hospital planned to prevent those activities.

In an email dated 01/11/2022 @ 1035 staff confirmed that there was no additional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 84	A 144		

information related to this incident.

29.a. Incident documentation for Patient 20 reflected that on 10/04/2021 @ 0830 the following items were found in his/her room: "a unrated DVD ... CD Master ... Speaker ... Sony Walkman ... Extra OSH badges of the client ... glitter glue bottles, black sharpie and folder with pornographic drawings and images."

There was no documentation to reflect an investigation of how Patient 20 was allowed to have possession of the prohibited items and how the hospital planned to prevent recurrence.

During interview with leadership, quality, clinical and program staff on 12/21/2021 beginning @ 1510 the PD-JC confirmed that P&Ps prohibited pornographic items. The DCNO-JC stated that there was not a documented investigation related to how the patient was allowed to have the prohibited items and that no changes to practices had been made as result of those items being found. The DCNO-JC also confirmed that Patient 20's treatment plan did not allow for the patient to have sexually explicit materials and images.

29.b. Sixteen days later, incident documentation for Patient 20 reflected that on 10/20/2021 @ 1245 the following items were found in his/her room: "Pornographic images and a hard plastic fork from Lake Dining were taken from [the patient's] room."

There was no documentation to reflect an investigation of how the patient was allowed to have possession of the prohibited items and how the hospital planned to prevent recurrence.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 85	A 144		

During interview with leadership, quality, clinical and program staff on 01/11/2022 beginning @ 1430 staff stated that the forks used in the dining room were "hard plastic ... washed and reused ... not breakable." Staff also confirmed that it was easy for patients to take and conceal the forks and utensils from the dining room.

In an email from staff received on 01/12/2022 @ 1349 staff confirmed that there was no investigation documentation.

29.c. Incident documentation for Patient 20 reflected that on 11/27/2021 @ 2045 "... the MHT staffing computer lab, noticed [Patient 20] pull a long auxiliary cord out of the inside of his coat. It is not a cord [he/she] checked out of the property room and it is not accounted for on the sharps sheet. It is red and approximately 50 inches long ... [Patient 20] said it came with headphones [he/she] got from [his/her] last market order ..."

An OQM form for this incident included a note dated 12/01/2021 that reflected "Leadership Directives: Level II: [OQM staff], contact [other staff] to identify who (sic) clears JC market items. Identify if we have the headphones in the store. Send to CLERC as FYI to include what is being done by QM investigators."

An attached internal email from OQM staff to other hospital staff dated 12/02/2021 @ 1406 reflected "... Critical Incident Review has directed the attached information be sent to CLERC as an FYI. Additionally, Quality Management will be conducting a Level II investigation into this event under the following scope: Identify who is conducting approvals of items in the JC market. Identify if the referenced headphone with 50" cord

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 86	A 144		

is provided through JC market and if so, reach out to market management regarding the item. Please let [OQM staff] know if you have any questions or have additional information that may be of assistance in this matter."

In an email from OSH staff dated 01/11/2022 @ 1107 OSH staff confirmed that there was no other documentation to reflect that the investigation of how Patient 20 was allowed to have the prohibited item had been completed, and none to reflect how the hospital planned to prevent recurrence.

During interview with leadership, quality, clinical and program staff on 01/11/2022 beginning @ 1430 OQM staff confirmed that no immediate actions had been taken and the case was "still active." No additional information was provided.

30. Incident documentation for Patient 21 reflected that on 10/07/2021 @ 1415 staff "... saw clearly visible tweezers in patient room - on [his/her] table - that were not on the sharps count and not accounted for in the patient's belongings inventory."

There was no documentation to reflect an investigation of how the patient was allowed to have possession of the prohibited item and how the hospital planned to prevent recurrence.

In an email dated 01/12/2022 @ 1047 hospital staff confirmed there was no "No additional documentation" related to this incident.

31. Incident documentation for Patent 17 reflected that on 10/20/2021 @ 1245 in the patient's "... property bin we found 4 pills. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 87	A 144		

pills were taken to the Pharmacy to be identified and disposed of."

There was no documentation to reflect an investigation of how "pills" were allowed to be stored in the patient's personal property bin. Particularly when incident documentation for Patient 13 in the findings above revealed a practice that allowed patients to go through their personal property bins on their own and without adequate supervision.

In emails dated 01/11/2021 @ 1035 and 01/12/2022 @ 1047 hospital staff confirmed there was no "No additional documentation" related to this incident.

32. Incident documentation for Patient 24 reflected that on 10/20/2021 @ 1245 a "Long white shoe sting (sic) found inside one of [his/her] shoes ..."

There was no documentation to reflect an investigation of how the patient was allowed to have possession of the prohibited item and how the hospital planned to prevent recurrence.

In an email dated 01/12/2022 @ 1047 hospital staff confirmed there was no "No additional documentation" related to this incident.

33. Incident documentation for EOC-i reflected that on 06/12/2021 @ 1135 "... a 'wet floor' sign was left unattended on the Mountain 2 aircourt for an unknown amount of time; possibly left from yesterday's EVS staff. This was an item that is considered a ligature risk and safety concern to be left unattended. It was retrieved at the same time of this report and appeared to be intact and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 88	A 144		

unaltered."

There was no documentation to reflect an investigation of how this item was left unattended and how the hospital planned to prevent recurrence.

34. Incident documentation for EOC-ii reflected that on 06/22/2021 @ 1800 it was reported that on 06/10/2021 "palette knives" used in art therapy "... were missing from the cabinet ... conducted a search without results ... additional searches were made ... [staff person] voiced [his/her] concern for patient safety regarding the knoves (sic) ... [another staff person] responded with 'Don't worry - I'm sure the patients don't have them ... we have no logs so noone (sic) even knows they were here.' [Staff person] states [he/she] asked to write an incident report on June 16 but was instructed not to by [another staff person] ... asked at the end of the day on the 21st what security plan was and was told ... not yet filed report or spoken to security ... asked about cameras in room 2339 ... inquired about video feed viewing to check for palette knives ... that had been denied by security ... At this time, the locaiton (sic) of these palette knives is unknown"

In an email dated 01/11/2022 @ 0926 staff confirmed there was no additional information related to palette knives reported to be missing.

35. Incident documentation for EOC-iii reflected that on 08/03/2021 @ 1020 "While on an on-grounds walk, a client found a thin purple marker with a small bic lighter taped to it with packing tape. The client pointed it out with [his/her] foot and I picked it up and put it in my pocket. Upon returning the building, I gave it to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 89	A 144		

my manager and security was called to come get the contraband item."

In an email dated 01/11/2022 @ 1005 staff confirmed there was no additional information related to this unsafe and prohibited item found on hospital grounds.

36. Incident documentation for Patient 14 reflected that on 08/16/2021 @ 1300 in the first floor outdoor "Air Court" the "gauge steel fence broke at the bottom and left side of the framed enclosure, causing a security/safety concern ... [Patient 14] was leaning against the enclosure and had kicked the enclosure, causing the bottom of the enclosure to break loose from the steel frame ... did not kick the enclosure with a lot a (sic) force ... The gauge steel fence broke free at the bottom and left side of the frame. The edges are rusted and sharp ... Air Court ... secured until the damage can be repaired."

There was no documentation of an investigation to identify how the fencing was able to be broken with little force, no evidence that the rest of the fencing in that air court and throughout the hospital had been evaluated for strength and integrity and no documentation related to how the hospital planned to prevent recurrence.

In an email dated 01/12/2022 @ 1047 staff provided two medical record notes for Patient 14 however, neither of those included an investigation as described above.

37. Incident documentation for EOC-iv reflected that on 08/19/2021 @ 1545 staff "reported a DVD charger missing from the property room. The sharps count last accounted for the missing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 90	A 144		

charger on Aug 15, 2021 and it was reported missing on August 19, 2021 ... search was completed ... The charger was not located during the search ... The missing charger was later found to be issued to a MN1 client who is at Riverbend Hospital recovering from surgery."

An OQM form for this incident that summarized this incident also included a note dated 08/30/2021 that reflected "Email NM and ask questions listed in narrative below ... Was OSH and Riverbend staff aware the cord was with the patient? Do the sharps count forms list the correct documentation and disposition of items, and how often are checks being done?"

An attached internal email between OSH staff dated 09/21/2021 @ 1616 reflected "Critical Incident Review has request (sic) answers to the following questions at (sic) they relate to critical incident ... (Attached). Was OSH and Riverbend staff aware the cord was with the patient? Do the sharps count forms list the correct documentation and disposition of items? How often are checks being done? Please respond by 9-30-21."

There was no documentation to reflect that those questions were answered. There was no documentation to reflect that an investigation as to why this item had been missing for four days before it was reported missing had been completed and how the hospital planned to prevent recurrence.

In an email dated 01/12/2022 @ 1047 hospital staff wrote there was "no additional documentation" in relation to this incident.

38. Incident documentation for EOC-v reflected

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 91	A 144		

that on 09/01/2021 @ 1600 "a contraband item found ... staff turned over a nickel with a sharphened (sic) edge ... found on the floor in the hallway of MN1 on 8/15/2021, but they did not know at what time it was found."

There was no documentation to reflect an investigation related to how this altered coin, known to be used by patients as a screwdriver, had been allowed on the unit, and further no investigation related to why this item had not been reported on the date it was found, 16 days prior to the report, when an investigation may have been more successful.

In an email dated 01/11/2022 @ 1005 hospital staff confirmed there was no additional documentation.

39. Incident documentation for Patient 33 reflected that on 12/06/2021 @ 1907 another patient "reported to me seeing [Patient 33] throw a pill into a trash after taking HS meds. I went through the trash and found a 200 mg Clozaril ... I confronted [Patient 33] about the incident. [He/she] states the pill fell out of the cup into the trash while [he/she] was taking [his/her] meds so [he/she] just left it there, and agreed to take another one."

There was no documentation of an investigation of nursing staff medication administration practices that allowed Patient 33 to have unsupervised possession of the medication in the medication cup and no information to reflect how the hospital planned to prevent recurrence.

Standards of practice for medication administration require that the nursing staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 92	A 144		

member who prepared the medication observe the patient ingest the medication to ensure the "rights of medication administration" that "include right patient, right drug, right time, right route, and right dose." The National Institute of Health website reviewed on 03/15/2022 reflected that "These rights are critical for nurses ... The essential environmental conditions conducive to safe medication practices ... (d) the right to have policies on safe medication administration; (e) the right to administer medications safely and to identify problems in the system; and (f) the right to stop, think, and be vigilant when administering medications."

40. Incident documentation for Patient 34 reflected that on 12/10/2021 @ 1615 the following items were found in Patient 34's room: "... Eighty Dollars Fifty-two cents ... baseball cap with a metal clasp ... black beanie with a hole in the seam ... black metal jewelry box was discovered, which the bottom had been pulled out of and modified in such a way that an item could be hidden in the box ... sixty-eight isopropyl alcohol wipes ... Three small plastic bags ...excess of food including approximately a dozen large cookies and a large summer sausage ... food ... contraband was removed from the client's room ..."

There was no documentation to reflect investigation of how the patient was allowed to have these items in his/her possession and how the hospital planned to prevent recurrence.

41.a. Similar findings related to lack of investigation and planning of actions to prevent recurrence were reviewed for the following incidents:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 93 41.b. EOC-vi on 09/11/2021 @ 0851 related to missing electronic device auxiliary cords In an email from OSH-JC received on 01/12/2022 @ 1047 staff confirmed there was no additional documentation. 41.c. Patient 31 on 11/24/2021 @ 1530 related to his/her possession of a medication cup while in seclusion that he/she broke and used to strike out at staff. During interview with leadership, quality, clinical and program staff on 01/11/2022 beginning @ 1430 it was confirmed that there was no documentation of actions planned to prevent recurrence. 41.d. EOC-vii on 11/19/2021 @ 1448 related to an 18-inch copper wire found in the milieu that "... could have been fashioned into a garrote." 41.e. EOC-viii on 12/10/2021 @ 2100 related to a missing screw from a door stop on the unit. 41.f. Patient 35 on 12/10/2021 @ 1900 related to the patient's possession of "a red thumb drive." 41.g. EOC-ix on 12/11/2021 @ 2152 related to an IDT room door found unlocked. 41.h. EOC-x on 12/14/2021 @ 0900 related to a computer lab door found unlocked. 42.a. During tour of the hospital with the PD-JC on 12/13/2021 beginning @ approximately 1800 observations on the Mountain 1 unit included the following:	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 94	A 144		

* Multiple patient rooms were observed from the hallway to have an inordinate and excessive number of items strewn on beds, floors and surfaces in a cluttered and disorganized manner that was not consistent with the "Patient Property and Valuables: Handling and Storage" P&P identified previously in this Tag.

* Decorative "mardi-gras" type face masks were observed affixed to two patient room doors. The masks were constructed of hard plastic material and had sharp and pointed edges.

42.b. During tour of the hospital with the PD-JC on 12/15/2021 beginning @ 1440 observations on the Mountain 2 and Mountain 3 units, and in common areas included the following:

* Multiple patient rooms were observed from the hallway to have an inordinate and excessive number of items strewn on beds, floors, and surfaces in a cluttered and disorganized manner.

* Signs affixed to room doors that identified the room use were observed to be designed with raised, individual letters constructed from a thick, rigid plastic material. Numerous letters from signs were observed to be broken or missing. Those letters had the potential to be used for self-harm or harm to others. For example:
-A "LAUNDRY" room sign was missing the U and N.
-A "STORAGE" room, M3530, was missing the S, T, O, and half of the G.
-A "CLIENT RESTROOM SHOWER" room, M3524, was missing the C, L, S, and half of the H.
-A "LAUNDRY" room, M2531, was missing the U.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 95	A 144		

43.a. During the tour of the hospital on 12/13/2021 identified in the finding above, @ 1808 a patient was observed to walk off the secure Mountain 1 unit carrying a long, orange electronics device auxiliary cord and enter the computer room. The PD-JC stated at the time of the observation there was a system for patients to check-out prohibited items for uses such as in the computer room.

43.b. On the day following the observation a Mountain 1 "Sharps + Ligatures" form with entries dated "12/12" to "12/14" was reviewed. Ten of 25 entries on the form contained omissions and incomplete entries and reflected that not all items checked out had been returned. For example:

* The "Time In" and staff "Initials" spaces were blank for the following items checked out by three different patients:
- A "nose trimmer" checked out on "12/12" @ 1105.
- A "vest" checked out on "12/[illegible]" @ 0814.
- A "belt" checked out on "12/14" @ 1004.
- A "gloves & [illegible]" checked out on "12/14" @ 1004.
- A "speaker cord" and "receiver cord" checked out on "12/14" @ 1030.

There was no documentation that those items had been returned at the time the form was provided for review on 12/14/2021 @ 1430.

* The "Time In" and staff "Initials" spaces for "gloves" checked out on "12/12" @ 1500 had not been completed and only "returned" was written across those fields.
* The "Time Out" and "Initials" spaces for "toenail clippers" checked out on "12/13" were blank and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 144	Continued From page 96 the "Time In" space had only "returned" written in it. * The "Time Out" and "Initials" spaces for "toe & nail clippers" checked out to another patient on "12/13" were blank and the "Time In" space had only a checkmark in it. * The "Time In" space for a "razor personal" checked out on "12/13" @ 1910 only had "returned" written in it. There was no documentation to reflect how long those patients had possession of those prohibited items.	A 144		
A 145	PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT CFR(s): 482.13(c)(3) The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on observations, interviews, review of incident and medical record documentation for 36 of 37 OSH-JC patients (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36 and 37), review of P&Ps, review of PERA documentation and review of other documentation it was determined that the hospital failed to fully develop and implement clear P&Ps that ensured each patient's right to be free from all forms of abuse and neglect. Identification of, investigations of, and response to, allegations of abuse, and incidents that reflected potential neglect that resulted in actual and potential patient harm, were not clear, complete, and accurate to ensure those incidents	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 97	A 145		

and events did not recur.

The CMS Interpretive Guidelines for this requirement at CFR 482.13(c)(3) reflects "Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish. This includes staff neglect or indifference to infliction of injury or intimidation of one patient by another. Neglect, for the purpose of this requirement, is considered a form of abuse and is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."

Further, the CMS Interpretive Guidelines reflect those components necessary for effective abuse protection include, but are not limited to:
o Prevent.
o Identify. The hospital creates and maintains a proactive approach to identify events and occurrences that may constitute or contribute to abuse and neglect.
o Investigate. The hospital ensures, in a timely and thorough manner, objective investigation of all allegations of abuse, neglect or mistreatment.
o Report/Respond. The hospital must assure that any incidents of abuse, neglect or harassment are reported and analyzed, and the appropriate corrective, remedial or disciplinary action occurs, in accordance with applicable local, State, or Federal law.

This Condition-level deficiency represents a limited capacity on the part of the hospital to provide safe and adequate care.

Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 98 1.a. The P&P titled "Patient Abuse or Mistreatment Allegation Reporting" dated as 05/05/2021 included the following: * "'Abuse or mistreatment' means any act or absence of action toward a patient by staff inconsistent with prescribed treatment and care and falls within the definitions of abuse ..." * "'Neglect, such as failure to provide the care, supervision or services necessary to maintain the physical and mental health of a patient that may result in physical harm or significant emotional harm to the patient ... the failure of staff to make a reasonable effort to protect a patient from abuse; or withholding of services necessary to maintain the health and well-being of a patient which leads to physical harm of the patient." * "'Physical abuse ... Any physical injury by other than accidental means or that appears to be at variance with the explanation given for the injury ... Willful infliction of physical pain or injury ..." * "'Sexual abuse or mistreatment' such as sexual harassment; sexual exploitation or inappropriate exposure to sexually explicit language or material; any sexual contact between staff and a patient; failure to discourage sexual advances by a patient; or any sexual contact that is achieved through force, trickery, threat or coercion ..." * "'Verbal abuse or mistreatment' such as threat of significant physical or emotional harm to the patient through use of yelling, ridicule, harassment, coercion, threats, mental cruelty, inappropriate sexual comments, intimidation, cursing, foul language or other forms of communication which are derogatory or disrespectful of the patient; remarks intended to provoke a negative response by the patient ..." * "...abuse or mistreatment conduct is prohibited at OSH and includes, but not limited to: abandonment ... physical harm to a patient	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 99	A 145		

caused by other than accidental means ... willful infliction of physical pain or injury ... neglect ... verbal abuse or mistreatment ... condoning abuse or mistreatment ..."
* "Abuse and mistreatment allegations will be investigated by the Office of Training, Investigation, and Safety (OTIS) (sic) All categories of prohibited conduct allegations will be examined as part of the OTIS investigation."
* "After a report of alleged abuse has been made, the following steps must be completed to enhance the investigation and protect patients: The Superintendent or their designee will implement protective measures as appropriate ...

1.b. The P&P titled "Incident Reporting" dated 03/27/2017 included the following:
* "[OSH HCP] must accurately report incidents in accordance with this policy. In response OSH must conduct thorough investigations, prepare reports showing the tracking and trending of data, and implement and monitor corrective or preventive actions."
* "Every HCP who witnesses a reportable incident as defined in this policy must promptly report the incident in the OSH incident reporting system when possible."
* "A reported incident which falls within established criteria will be investigated by the Critical Incident Review Panel as indicated in the committee charter."
* "Reportable incident" was defined as "any occurrence involving:
1. physical aggression on members or visitors, regardless of injury;
2. bodily injury to patients whether the injury is considered minor, moderate, or severe;
3. patient self-harm, including suicide attempt, with or without injury;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 100	A 145		

4. patient falls ...
5. sexual contact between patients or with a patient;
6. patient choking when attempting to swallow;
7. unanticipated patient death;
8. security problems and crime or suspicious events including, but not limited to: property loss or intentional damage, contraband or patient possession of prohibited items, substance abuse by a patient, and unauthorized leave or significant attempt of unauthorized leave;
9. environment of care issues including, but not limited to the presence of hazardous material, utility or systems failure, medical equipment failures, emergency preparedness issues and safety issues;
10. laboratory issues ...
11. medication errors not associated with a patient, including narcotic count variances or medication found outside the medication administration process."

Although the P&P included "Policy" and "Definitions" components, there were no procedure components in the document, including steps for staff to take in response to the incident beyond reporting in the incident reporting system. Further, there were no procedures for how investigations of incidents to prevent recurrence were to occur for those that did not fall "within established criteria" for "Critical Incident Review Panel" investigation and who was to conduct those.

1.c. In relation to response to contraband the P&P titled "Staff Response to Alleged Criminal Acts and Contraband" dated as 05/01/2015 reflected the following:
* "All [OSH] employees are responsible for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 101	A 145		

protecting patient and staff by reporting and responding to alleged criminal acts and observations of contraband being introduced into the organization as directed in this policy."
* "Contraband" was defined as "any controlled substance, drug paraphernalia, unauthorized currency, or any other article which by statute, rule, order, or the state institution's policies, is prohibited from being in a patient's possession, and the use of which could endanger the safety or security of the institution."
* "The following must occur for the confiscation, control and disposition of contraband: All contraband which may be part of an illegal act must be retained in is existing condition and turned over to OSP or other investigating authority ... If immediate police response is expected, a weapon should be left alone in the secured crime scene ... All other items considered contraband must be turned over to the Security Department."
* A memo on OSH letterhead dated 11/17/2021 was attached to the P&P and referenced the P&P by title and number. It included P&P clarification that indicated that "Contraband is considered a criminal act when a person purposefully supplies contraband to a patient or when a patient knowingly makes, obtains, or possesses contraband as defined in OSH policy."

The P&P lacked information related to investigations that included, for example: How patients in the secure facility would have come to be in possession of such contraband items, what systems to prevent contraband items in the secure facility had failed and what actions would be taken to prevent recurrence.

A secure, psychiatric hospital or unit must be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 102	A 145		

responsible to have systems in place that do not allow patients access to contraband, and unsafe and prohibited items for the protection of themselves and others. Allowing patients access to those items creates an unsafe EOC and is neglect.

1.d. In relation to response to sexual assault the P&P titled "Staff Response to Alleged Criminal Acts and Contraband" dated as 05/01/2015 included the following:
* "All [OSH] employees are responsible for protecting patient and staff by reporting and responding to alleged criminal acts and observations of contraband being introduced into the organization as directed in this policy."
* "Criminal acts or crimes" are as defined in the [ORS] and [OARs]."
* "Sexual assault" was defined as "any unwanted sexual contact."
* "If the report or allegation includes any information that patient abuse as occurred at OSH, an immediate report to the Superintendent and to the Office of Adult Abuse Prevention and Investigations is required ..."
* "An incident report must also be completed ..."
* "If the alleged victim, patient or staff prefers to file a police report independently and requests staff assistance, staff must provide the victim with the [OSP] phone number."
* "In the event an alleged criminal act is determined to have occurred, the following steps must be taken: Staff must contact the Security Department ... The Security Department must in turn report the incident to the appropriate law enforcement agency, fire department, or medical response personnel ... Staff must ensure that scenes related to alleged criminal acts are secured, and evidence is preserved and not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 103	A 145		

destroyed ... The scene of the alleged criminal act must remain secured and undisturbed until released by OSP or the Superintendent ... Whenever practical, involved staff or patient should not be interviewed by anyone except a police agency representative ... Staff must make every reasonable effort to provide emotional support to the victim."

The P&P was not clear or complete. For example:
* It did not include provisions for protection of the patient who was assaulted and separation from the patient who was alleged to have committed the assault.
* It was not clear what was a "criminal act," how staff were to know that, and who would decide that.
* It did not include provisions related to the hospital's responsibility to immediately protect the patient, mitigate further incidents, conduct an investigation separate from any criminal investigation, identify whether hospital failures contributed to the incident, and develop and implement corrective actions to prevent recurrence.

1.e. The P&P titled "Sexual Activity Between Patients" dated as 03/27/2017 reflected the following:
* "Oregon State Hospital (OSH) has the responsibility to take reasonable steps to discourage sexual contact between patients and to direct appropriate follow-up actions if sexual contact or sexual assault occurs."
* "When a patient or [HCP] alleges that sexual contact between patients occurred, HCP must: 1. notify the patient's [psychiatric LIP] or the Physician Officer of the Day ... 2. submit an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 104 incident report for each suspected or confirmed sexual contact incident ... 3. notify the Infection Prevention and Employee Health Department ... 4. report the incident to the Security Department." * "The interdisciplinary treatment team must review and address the sexual contact Incident ..." * "HCP must follow OSH Policy and Procedure 8.019, "Staff Response to Alleged Criminal Acts and Contraband," when responding to an allegation of sexual assault. * "HCP must provide education to patients and family members or legal representatives about this policy." * "'Sexual assault' means an incident of sexual contact between patients where criminal activity is alleged to have occurred as defined by Oregon Criminal Code, including, but not limited to, non-consensual sexual intercourse or penetration, and those acts involving an alleged victim who lacks capacity to consent to a sexual act." * "'Sexual contact' means any touching of the sexual or other intimate parts of a person or causing such person to touch the sexual or other intimate parts of the actor for the purpose of arousing or gratifying the sexual desire of either party." There was no other information or direction in the P&P related to response and investigation by staff. 1.f. A document titled "Critical Incident Investigation Operating Procedure ... Incident Screening" dated as 05/18/2021 reflected: * "Objective ... Establish a standardized process for incident screening by Critical Incident Investigators for CIR leadership."	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 105 * The following were defined: - "Abuse of Illegal Substance ... - Atypical Seclusion or Restraint Event ... - Choking with Injury or Medical Intervention ... - Illegal Item Possession ... Items in this category include any item that possession alone is prosecutable under Oregon Statute and which pose a risk to the safety and security of the OSH facilities, patients, and staff. This category does not include nuisance contraband, small amounts of tobacco or items that have been deemed by the report writer as having a potential of creating risk without an established intent by the possessor. - Medication Diversion: The intentional and/or planned concealing, smuggling, transferring or sale of prescribed medications for inappropriate use by the prescribed user or others. - Missed Code Blue ... - Patient to Patient or Patient to Staff Assault with Serious Injury to Patient or Staff: Any assault by a patient toward another patient or an OSH staff member where an injury is sustained as a direct result of the assault and that injury is serious enough in nature to require specialized medical procedures above and beyond basic first aid ... - Reasonable Suspicion ... - Serious Crime: Any crime that would be classified as a felony under Oregon Statute or any person-to-person crime classified under Oregon Statue as a Class A Misdemeanor. This category does not include alleged criminal acts from a non-patient toward a non-patient. - Serious Patient Injury ... - Serious Self-Harm ... - Serious Suicide Attempt ... - Serious System Failure .... - Sexual Contact ... The touching of the sexual or	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 106	A 145		

other intimate parts of a person or causing such person to touch the sexual or other intimate parts of the actor for the purpose of arousing or gratifying the sexual desire of either party.
- Unattended/ Wandering Patient: An event of a patient within the secured perimeter of OSH, which requires the patient to be under supervision and no supervision was present.
- Unauthorized Leave (UL) or Significant Attempt: An event of a patient making a significant and intentional attempt toward, or successful attempt of, leaving the custody of OSH prior to discharge ... on grounds ... off grounds ...
- Unexpected Patient Death ..."

The following was reflected in the P&P:
* "OSH Critical Incident Investigators are tasked with the screening of critical incidents listed in the Critical Incident Review (CIR) Critical Incident Grid for Level 2 Incidents (See attachment A). In addition to the Level 2 Incidents on attachment A of this procedure, OSH Critical Incident Investigators are tasked with the screening of incidents involving; unexpected patient deaths, unattended/wandering patients, sexual contact, missed code blue events, and medication diversion. Investigators will present screenings to OSH CIR Leadership for decision making purposes and investigation assignments. CIR leadership will determine follow-up assignments to include, but not limited to critical incident investigations, referral to hospital disciplines, the tracking and trending of data, or additional investigator assignments such a document reviews, video pulls, or video reviews. CIR leadership may also decline to accept the screening on the grounds the screened incident does not rise to the level of a critical incident or close the event without further assignments if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 107	A 145		

satisfied with the information already known."

* "For screening purposes sexual contact incidents are screened based on physical sexual contact without the need to identify intent during the screening phase. In the event of reported sexual contact occurs involving patients only; the investigator will use available documentation to determine if the act was consensual. Any alleged sexual contact by staff toward patients qualifies as a sexual contact event. In the event of consensual sexual contact between patients, critical incident investigators are to verify the ability of the patient to give consent. If a patient has a guardian over him/her, the patient is not able to legally provide consent. If consent is able to be determined, and it is clear system failures did not contribute to the sexual contact and that direct care clinical staff are aware of the sexual contact, the incident may be closed by the critical incident investigator with documentation of the above on the critical incident screening document. In the event of a reported sexual contact by brief, potentially accidental contact by a patient toward a staff member where there is no complaint the contact was intentional, the investigator may screen the incident out."

* "OSH Critical Incident Investigators will screen Incident Reports, Communication Log Entries, Nursing Reports and Medical reports to identify potential reportable events. Patient records, unit management staff, and OSH security video (when authorized) may be used to help the investigator in determining if there is reasonable suspicion an event falls within reporting criteria for CIR Leadership referral. The purpose of the screening process is to identify if there is reasonable suspicion an event meets the definition of one or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 108	A 145		

more of the categories listed as a Level II incident on the attached CIR Critical Incident Grid."

1.g. "Attachment A", a one-page document titled "CIRP Critical Incident Grid" that was referenced in the P&P in 1.f. above was dated 05/18/2021 and reflected the following:

* For "Minor/Significant or 'Near Miss'" incidents the "Level of Review" was "Leadership review and follow-up as necessary" and the "Turnaround" time was "2 Business Days." Those incidents were listed as:
"Non-injury patient altercations
Choking without injury
Property loss/theft or intentional damage
Contraband
Minor patient injury
Substance abuse by patient"

* For "Serious/Critical" incidents the "Level of Review" was "OSH Investigations conduct full Critical Incident Review" and the "Turnaround" time was "10 Business Days." Those incidents were listed as:
"Illegal item possession
Abuse of illegal substance
Atypical seclusion or restraint event
Choking with Medical Intervention
Patient-patient or patient-staff assault with serious injury to patient or staff
Serious self-harm
Serious suicide attempt
Serious patient injury
UL or significant attempt
Serious crime
Serious system failure"

* For "Sentinel" incidents the "Level of Review"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 109	A 145		

was "Superintendent or Designee initiates full interdisciplinary review" and the "Turnaround" time was "As Directed." Those incidents were listed as:
"The Joint Commission Sentinel Event"

On the grid it was unclear how "Minor/Significant" and "Serious/Critical" were defined and there was no information that described the "Leadership review and follow-up as necessary" and "full Critical Incident Review." Further the types of incidents listed on the "Grid" did not clearly align with those identified in other P&Ps described in this finding.

In addition, for the "Minor/Significant or 'Near Miss'" incidents the response was reflected as "Leadership review and follow-up as necessary." It was not clear what the leadership review and follow-up consisted of and did not provide assurance that those incidents that also reflected potential patient neglect would be investigated to identify corrective actions to prevent recurrence.

1.h. A document titled "Critical Incident Investigation Operating Procedure ... Scope of Investigations" dated as 05/18/2021 reflected:
* "Critical Incident Investigations are limited in scope to the identification of system failures."
* "Critical Incident Review (CIR)" was defined as "a formal process in the review of suspected and identified critical incidents directly impacting the operations of the Oregon State Hospital and/or the clients it serves to identify any necessary improvements in an attempt to prevent similar events in the future."
* "Personnel Issues" was defined as "those events where policy or procedures are in place but not adhered to by an individual."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 110 * "During the course of a system investigation the Investigator may use, but is not limited to, available patient records, hospital documentation, written policies and procedures, video ... witness and subject interviews, and outside investigation documentation to aid in the identification of system failures." * "OSH Investigators are not charged with investigating personnel issues that may have contributed to a critical incident. In the event a critical incident was the result of personnel issues the Investigator is to provide notification to the Director of Quality Management about describing how the critical incident did not result from a system failure and recommend the closure of the investigation. The request for case closure, and authorization to close the case, will be placed in the electronic case file." * "It is the charge of Critical Incident Investigator to contact the responsible program director during an investigation and notify them of critical system failures when the failure has a direct impact on life or safety of any person and immediate attention could prevent future failures. The investigator will document the communication of such reports in the investigation report along with any action that have been taken to prevent future failures." 1.i. The P&P titled "Sentinel Events and Root Cause Analyses" dated 05/11/2016 included the following: * "OSH will review each adverse patient event which involves a patient committed to OSH and which meets criteria for a Sentinel Event ... * "Any time a Sentinel Event occurs, or when otherwise directed by the Superintendent for serious incidents that do not meet the definition of a Sentinel Event, OSH must complete a thorough	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 111	A 145		

and credible [RCA], implement improvements to reduce risk, and monitor the effectiveness of the improvements as part of its ongoing performance improvement efforts."
* "'Adverse patient event' for the purposes of this policy means an event where a patient may be injured including, but not limited to:
1. an unanticipated death ...
2. a suicide of any patient ...
3. an elopement (unauthorized leave) resulting in a related death (suicide or homicide), or major loss of function or severe temporary harm to the patient;
4. a fall resulting in death or major permanent loss of function as result of the injuries sustained in the fall;
5. an abduction;
6. a rape, assault, or homicide that occurs while a patient is committed to OSH; or
7. an identified case of unanticipated death or major permanent loss of function associated with a health care-associated infection, assault, homicide, or other crime."
* "'Sentinel Event' means an unexpected occurrence involving death, permanent harm, severe temporary harm, or serious risk thereof. The phrase 'or the risk thereof' includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome."
* "The Superintendent must determine the action to be taken in response to an adverse patient event, including whether a RCA is required ... A RCA assigned by the Superintendent must be completed within 45 calendar days ... At the completion of a RCA, an action plan must be generated that identifies strategies to reduce the risk of similar events occurring in the future ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 112	A 145		

The P&P contained no information related to immediate mitigation strategies to prevent recurrence and protect patients during the duration of the RCA process and the implementation of corrective actions which could take up to 45 days.

2.a. During interview on 12/13/2021 at 1710 leadership, clinical and program staff provided the following information:
* Incidents were generally entered into a hospital-wide, electronic incident reporting system.
* Incidents involving alleged staff to patient abuse were entered into a separate electronic system and were not included in the incident reporting system.
* All incident reporting activity was managed by staff at the OSH - Salem campus and any investigations determined to be needed were conducted by OQMIs, whose offices were located at the Salem campus.

2.b. During interview with leadership, quality, clinical and program staff on 12/14/2021 at 1550 the DQM provided the following information:
* Every day OQMIs review the incident reports submitted electronically, they review other electronic communication systems, and "If they see something that meets criteria" they bring to a weekly OQM meeting for review to determine what follow-up would be indicated.
* OQM investigations were conducted for sentinel events, and for critical incidents that met criteria.

2.c. In response to requests for a log of hospital patient incident/events at the OSH-JC campus from which a sample could be selected for review of incident/event investigations and follow-up, on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 113	A 145		

12/14/2021 and 12/15/2021 OSH staff provided multiple log iterations that upon review were determined not to be complete or accurate. For example: The log included the non-hospital, separately licensed SRTF facility incidents; The log erroneously identified dates and types of incidents for the wrong patients; The log did not specify the type or nature of incident for many entries.

2.d. During interview with leadership, quality, clinical and program staff on 12/15/2021 beginning @ 1530, the DQM and OQMI provided the following information about incident logs and investigations:
* The incident logs provided to the surveyor in response to the request on the survey needs list did not include all incidents at OSH-JC campus. There were entries on the log for which the campus/location had not been identified and those were not included in the log provided.
* "Any incident report that doesn't have a location will not be on the [incident log]. This is a fault of the database."
* If the surveyor wanted a log of all incidents at OSH-JC, staff would need to run a log of all incidents on both the OSH-Salem and OSH-JC campus.
* The incident reporting "database was built before OSH-JC was built" and therefore didn't allow for entries of accurate patient locations, including that it still referenced an OSH-Portland campus that was closed in March of 2015.
* All incident reports for OSH-JC and OSH-Salem were electronically reviewed daily by OQM staff who work on the OSH-Salem campus and that "critical incidents" of sexual contact, wandering, and injuries that require more than first aid are "pulled" for investigation by the OQM staff who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 114	A 145		

work on the OSH-Salem campus.
*OQM staff did not investigate or follow-up on incidents that did not meet the criteria to be pulled for investigation.

2.e. During further interview with leadership, quality, clinical and program staff on 12/16/20201 beginning @ approximately 1000 the DQM and MD&A provided the following information:
* They confirmed that the organization maintained an incident log for OSH-JC that was combined with the incident log for OSH-Salem.
* The log was also combined with the non-hospital, separately licensed SRTF facility that was on the same campus and in the same building as the hospital.
* The log "doesn't capture every incident."
* It was known that the "data system doesn't meet the needs."
* In relation to the inaccurate logs provided to the surveyor earlier as requested on the survey needs list, they decided to filter out what they thought was wanted and did not confirm with the surveyor.
* They confirmed that the incident log did not ensure an accurate accounting of the incidents/events that occurred at OSH-JC.
* They electronically demonstrated the complete electronic version of the full log that was observed to consist of approximately 166 columns that aligned with the rows for each incident entered. When a sample was printed, the log consisted of 14 letter sized pieces of paper in landscape orientation taped together.

3. Review of the complete electronic version of the final incident logs provided on 12/16/2021 revealed the following:
* The log for the month of June 2021 reflected

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 115	A 145		

there were 83 incidents entered after staff "filtered" out OSH-Salem campus and non-hospital SRTF incidents. Of those 83 incidents there were 37 incident entries identified for hospital patients at OSH-JC and 44 entries where the location/campus of the incident was blank and not specified for either OSH-JC or OSH-Salem.
* Similarly, on the log for July 2021 there were 70 incidents of which 35 were for hospital patients at OSH-JC and 35 entries did not specify the incident location/campus.
* On the log for August 2021 there were 65 incidents of which 32 were for hospital patients at OSH-JC and 33 entries did not specify the incident location/campus.
* On the log for September 2021 there were 54 incidents of which 28 were for hospital patients at OSH-JC and 24 entries did not specify the incident location/campus.
* On the log for October 2021 there were 89 incidents of which 50 were for hospital patients at OSH-JC and 37 entries did not specify the incident location/campus.
* On the log for November 2021 there were 105 incidents of which 46 were for hospital patients at OSH-JC and 56 entries did not specify the incident location/campus.

There was a lack of assurance that the last version of the logs provided as described in this finding completely and accurately identified all incidents/events for tracking and investigation.

4. Refer to the incident/event findings cited under Tag A144, CFR 482.13(c)(2), CoP Patient's Rights - Standard: Right to safe care. Those findings reflect the hospital's failure to ensure investigations of incidents/events that reflected

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 145	Continued From page 116 potential neglect were clear, complete, and accurate to prevent recurrence for those patients who experienced actual and potential harm, and for other patients.	A 145		
A 263	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on observations, interviews, review of incident and medical record documentation for 36 of 37 OSH-JC patients (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36 and 37), review of P&Ps, review of PERA documentation and review of other documentation it was determined that the hospital failed to ensure that the QAPI program was effective to ensure the provision of safe and appropriate care to patients in the hospital.	A 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 263	Continued From page 117 This Condition-level deficiency represents a limited capacity on the part of the hospital to provide safe and adequate care. Findings include: 1. Refer to the findings cited at Tag A286 under CFR 482.21(a), (c)(2), (e)(3) - Standard: Patient Safety. 2. Refer to the findings cited at Tag A115 under CFR 482.13 - CoP: Patient's Rights.	A 263		
A 286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are	A 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 286	Continued From page 118	A 286		

established.
This STANDARD is not met as evidenced by:
Based on observations, interviews, review of incident and medical record documentation for 36 of 37 OSH-JC patients (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36 and 37), review of P&Ps, review of PERA documentation and review of other documentation it was determined that the hospital failed to ensure that incidents and adverse patient events were clearly identified, tracked, investigated and analyzed. Further, the hospital failed to plan and implement corrective actions to prevent recurrence of those, to promote learning throughout the hospital, and to establish clear expectations for patient safety.

Findings include:

1. Refer to the findings cited at Tags A144 and A145 under CFR 482.13(c) - Standard: Privacy and Safety.

2.a. Review of QAPI documentation titled "OSH Performance System Quarterly Performance Review" dated 11/02/2021 revealed that data for 12 measures were documented for the period of the second quarter of 2020 through the third quarter of 2021 for "Junction City" and were related to the following:
* "Manual Restraints"
* "Mechanical Restraints"
* "Seclusion"
* "Patient to Patient Aggression"
* "Falls"
* "Patient Treatment Participation"

Graph data for those measures was described as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 286	Continued From page 119	A 286		

for "Junction City" and did not differentiate between the 75-bed hospital on the OSH-JC campus and the separately licensed non-hospital SRTF facility on the same campus and in the same building as the hospital.

2.b. Data for other measures included on the "Quarterly Performance Review" that were documented for the period of the second quarter of 2020 through the third quarter of 2021 for "Oregon State Hospital" included the following:
* "Staff Training"
* "Informed Consent Duration"
* "Fire Drills"
* "Monthly Safety Checklist"
* "Admission Package Completion"
* "Med variance"

Data for those measures was described as for "Oregon State Hospital" and did not differentiate between the seperately licensed 75-bed hospital on the OSH-JC campus and the OSH-Salem campus.

3. Other QAPI data and documentation reviewed was not clear or accurate. For example:

* Data on a "Medication Variance Trends Report" for the numbers of types of errors and the percentages of those types of errors for the period of November 2020 through October 2021 did not differentiate between the hospital on the OSH-JC campus and the hospital on the OSH-Salem campus.

* A "Fall Trends Report ... High Risk Patient Fall Events ... Non-High Risk Patient Fall Events ..." for October 2021 reflected that there were "0.00" falls on each of the three OSH-JC hospital units.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 286	Continued From page 120 However, review of the October incident/event log reflected that there were at least three patient falls on those units that occurred on 10/12/2021, 10/25/2021 and 10/31/2021. * Data for "Percent of All Fall Events with Reported Moderate or Severe Injury by Month" for the period of November 2019 through October 2021 did not differentiate between the hospital on the OSH-JC campus and the hospital on the OSH-Salem campus. * Data on the "Utilization Trends Report" for the period of November 2019 through October 2021 did not differentiate between the hospital on the OSH-JC campus and the hospital on the OSH-Salem campus. 4. Review of the "Oregon State Hospital Performance Management" plan for 2021 revealed no provisions to distinguish QAPI activity and data between the two separately licensed hospital at OSH-Salem campus and OSH-JC campus. 5. During review and interview with leadership, quality, clinical and program staff on 01/13/2022 beginning @ 0950 staff confirmed that data identified in the findings for this Tag was reflective of both hospitals on the OSH-Salem campus and the OSH-JC campus combined, or of both the licensed hospital units and the non-hospital licensed SRTF units combined.	A 286		
A 385	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services.	A 385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 385	Continued From page 121 The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observations, interviews, review of incident and medical record documentation for 36 of 37 OSH-JC patients (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36 and 37), review of P&Ps, review of PERA documentation and review of other documentation it was determined that the hospital failed to ensure that nursing services were organized and managed to ensure the provision of safe and appropriate care to each patient in the hospital. This Condition-level deficiency represents a limited capacity on the part of the hospital to provide safe and adequate care. Findings include: 1. Refer to the findings cited at Tag A395 under CFR 482.23(b)(3) - Standard: RN Supervision of Nursing Care. 2. Refer to the findings cited at Tag A115 under CFR 482.13 - CoP: Patient's Rights.	A 385		
A 395	RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on observations, interviews, review of incident and medical record documentation for 36	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 395	Continued From page 122 of 37 OSH-JC patients (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36 and 37), review of P&Ps, review of PERA documentation and review of other documentation it was determined that the RNs failed to supervise the nursing care for each patient to ensure the provision of safe and appropriate care. Findings include: 1. Refer to the findings cited at Tags A144 and A145 under CFR 482.13(c) - Standard: Privacy and Safety.	A 395		
A 438	FORM AND RETENTION OF RECORDS CFR(s): 482.24(b) The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. This STANDARD is not met as evidenced by: Based on review of medical records for 1 of 1 patient (Patient 7) it was determined that the hospital failed to ensure that medical record entries were promptly written and filed in patients' record to ensure they were accessible to other care providers when needed for patient assessment, decision-making and planning the patient's care. Findings include:	A 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 438	Continued From page 123	A 438		

1. The closed medical record for Patient 7 was reviewed. The patient's record was closed as result of having successfully eloped from the facility on 12/02/2021. The medical record included the following documents and entries written between two days to 33 days after the care and services had been provided. None of the documents and entries below were identified as late entries.

* A Group Note with service date of 11/04/2021 at 0900 was written and signed on 12/07/2021 at 1151, 33 days after the group encounter.
* A Group Note with service date of 11/21/2021 at an unspecified time was written and signed on 12/04/2021 at 1315.
* A Group Note with service date of 11/23/2021 at an unspecified time was written and signed on 12/02/2021 at 1330.
* A Group Note with service date of 11/24/2021 at an unspecified time was written and signed on 12/02/2021 at 1241.
* A Group Note with service date of 11/28/2021 at an unspecified time was written and signed on 12/04/2021 at 1712.
* A Group Note with service date of 11/28/2021 at an unspecified time was written and signed on 12/05/2021 at 1309.
* A Group Note with service date of 11/29/2021 at 1400 was written and signed on 12/02/2021 at 1106.
* A Group Note with service date of 11/30/2021 at 1300 was written and signed on 12/02/2021 at 0850.
* A Group Note with service date of 11/30/2021 at 1400 was written and signed on 12/06/2021 at 1103.
* A Group Note with service date of 11/30/2021 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 438	Continued From page 124 an unspecified time was written and signed on 12/02/2021 at 1332. * A Group Note with service date of 11/30/2021 at an unspecified time was written and signed on 12/06/2021 at 1035. * A General Note for "November 2021" was written and signed on 12/10/2021 at 1156. * A Group Note with service date of 12/01/2021 at 1300 was written and signed on 12/03/2021 at 1513. * A Group Note with service date of 12/02/2021 at an unspecified time was written and signed on 12/07/2021 at 0823.	A 438		
A 700	PHYSICAL ENVIRONMENT CFR(s): 482.41 The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based on observations, interviews, review of incident and medical record documentation for 36 of 37 OSH-JC patients (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36 and 37), review of P&Ps, review of PERA documentation and review of other documentation it was determined that the hospital failed to develop and maintain the EOC in a manner that ensured the provision of safe and appropriate care to patients in the hospital. This Condition-level deficiency represents a limited capacity on the part of the hospital to provide safe and adequate care.	A 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 700	Continued From page 125 Findings include: 1. Refer to the findings cited at Tag A701 under CFR 482.41(a) - Standard: Maintenance of Physical Plant. 2. Refer to the findings cited at Tag A115 under CFR 482.13 - CoP: Patient's Rights.	A 700		
A 701	MAINTENANCE OF PHYSICAL PLANT CFR(s): 482.41(a) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observations, interviews, review of incident and medical record documentation for 36 of 37 OSH-JC patients (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36 and 37), review of P&Ps, review of PERA documentation and review of other documentation it was determined that the hospital failed to maintain the EOC, and to identify and mitigate hazards and risks, to ensure the safety and well-being of patients in the hospital. Findings include: 1. Refer to the findings cited at Tags A144 and A145 under CFR 482.13(c) - Standard: Privacy and Safety. 2.a. The "Annual Environmental & Suicide Risk Assessment (ESRA) - 2020-21" dated 02/19/2021 was reviewed. It reflected that "The following areas and units were assessed, and the	A 701		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 701	Continued From page 126	A 701		

established Room Risk Levels were verified based on the accessibility of the room by patients and the items present in the room ... Treatment Malls ... [OSH-JC Mountain] ... [OSH-JC Mountain Units 1-3] ... Outdoor Quads/Areas ... [OSH-JC Mountain] ... Patient areas listed above were assessed for physical safety and ligature risks for patients. While this assessment is accomplished annually, OSH currently has several processes in place for continued assessment of physical safety and ligature risks to patients ... During this assessment each room was assessed for current use and if appropriate room risk level currently identified matches the current use, and if any actions to mitigate risk to patients were required ... Dining ... [OSH-JC] ..."

Although the assessment stated that "items present in the room" were included in the assessment, there was no indication that all items in patient rooms and in the EOC, including, but not limited to, patients' personal belongings, food items, linens, room signs, art hanging on patient room doors, utensils in the dining room, unsafe items that patients were allowed to check-out and use without supervision, and other items identified in the findings in this report had been included in the assessment to ensure the safety of all patients.

2.b. An untitled spreadsheet table provided with the risk assessment listed EOC and safety related requests made by staff beginning 04/27/2021 and through 12/06/2021. There were no entries related to assessment of items in the EOC including, but not limited to, personal belongings in patient rooms, food, linens, room signs, paper and art covering patient room doors, utensils in the dining room and other items in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 701	Continued From page 127	A 701		

EOC identified in the findings in this Tag.

3. Twenty-six "Safety Monthly Inspection Checklist" forms completed for distinct units and treatment areas beginning July 2021 and through November 2021 were reviewed.

Eighteen of the 26 forms had a "Revision" date of 03/01/2019 printed at the bottom of the form while eight of the forms had a "Revision" date of 04/01/2021. It was unclear whether revisions to the form on 04/01/2021 had impact on the checklist items.

Verbiage on the two-page forms reflected "Monthly safety inspections of patient care units ... are required to ensure a safe environment for staff, patients and visitors ..." The forms did not include spaces or sections related to items in the EOC identified in the findings in this Tag.

Further, documentation did not reflect timely follow-up of all items noted as "Non-Compliant." For example: Checklists for OSH-JC Mountain 1 patient unit reflected that the "Fire Drill Coordinator Kit accessible & complete" was "Non-Compliant" for the monthly inspections conducted on 07/03/2021, 08/01/2021, 09/04/2021 and 11/07/2021.

4. During tour of the hospital with the PD-JC on 12/15/2021 beginning @ 1440 observations on the Mountain 2 unit and in common areas included the following:
* Hallway ceiling tiles on Mountain 2 were observed to be warped and did not lay flush to the ceiling tile frame.
* Ceiling tiles in the hallway outside of the patient dining room were observed to have water stains.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 750	INFECTION CONTROL SURVEILLANCE, PREVENTION CFR(s): 482.42(a)(3) The infection prevention and control program includes surveillance, prevention, and control of HAIs, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities; and This STANDARD is not met as evidenced by: Based on observations, interviews, review of incident and medical record documentation for 36 of 37 OSH-JC patients (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36 and 37), review of P&Ps and review of other documentation it was determined that the hospital failed to ensure the infection prevention and control program included surveillance, prevention and control to ensure the safety and well-being of patients. Findings include: 1. Refer to the applicable findings cited at Tags A144 and A145 under CFR 482.13(c) - Standard: Privacy and Safety. 2.a. During tour of the hospital with the PD-JC on 12/13/2021 beginning @ approximately 1800 observations on the Mountain 1 unit included the following: * Multiple patient rooms were observed from the hallway to have an inordinate and excessive number of items strewn on beds, floors and surfaces in a cluttered and disorganized manner that rendered the floor and surfaces in those rooms not readily cleanable. * A household type plastic laundry basket with	A 750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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 750	Continued From page 129 large openings on all four sides and with no cover was placed on the floor underneath a sink in the hallway. The basket contained unfolded and crumpled towels and linens as if they had been used. 2.b. During tour of the hospital with the PD-JC on 12/15/2021 beginning @ 1440 observations on the Mountain 2 and Mountain 3 units, and in common areas included the following: * Multiple patient rooms were observed from the hallway to have an inordinate and excessive number of items strewn on beds, floors and surfaces in a cluttered and disorganized manner that rendered the floor and surfaces in those rooms not readily cleanable. * A brown paper bag was placed on the floor in the hallway under the Mountain 2 medication room window and overflowed with garbage. Items observed on the top of the contents of the bag included multiple used face masks, used drinking cups and an empty Kleenex box. * Purell Hand Sanitizer dispenser affixed to hallway wall, with "M3-39" handwritten on it, did not contain any hand sanitizer. * Purell Hand Sanitizer dispenser affixed to hallway wall, with "LC-86" handwritten on it, did not contain any hand sanitizer.	A 750		
A1640	Treatment Plan CFR(s): 482.61(c)(1) Standard Treatment Plan Each patient must have an individualized, comprehensive treatment plan based on an inventory of the patient's strengths and disabilities. This STANDARD is not met as evidenced by:	A1640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ORST0592	A. BUILDING _____ B. WING _____	C 01/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL JUNCTION CITY	29398 RECOVERY WAY JUNCTION CITY, OR 97448

(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
A1640	Continued From page 130 Based on interviews and review of incident and medical record documentation for 5 of 5 patients whose treatment plan was reviewed (Patients 7, 12, 16, 17 and 20) it was determined that the hospital failed to ensure that an individualized and comprehensive treatment plan was developed and followed for each patient. Findings include: 1. Refer to the treatment plan findings for Patients 7, 12, 16, 17, 20 cited at Tag A144 under CFR 482.13(c) - Standard: Privacy and Safety.	A1640		