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December 11, 2023

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

Re: CMS Certification Number 384008  
Conditions of Participation Not Met  
90 Day Termination Track  
Removal of Deemed Status

Dear Administrator:

Section 1865 of the Social Security Act (the Act) and Centers for Medicare & Medicaid Services (CMS) regulations provide that a provider or supplier accredited by a CMS-approved Medicare accreditation program of the Joint Commission will be "deemed" to meet all of the Medicare Conditions of Participation (CoPs) for hospitals. In accordance with Section 1864 of the Act State Survey Agencies may conduct at CMS's direction surveys of deemed status providers/suppliers on a selective sampling basis, in response to a substantial allegation of noncompliance, or when CMS determines a full survey is required after a substantial allegation survey identifies substantial noncompliance. CMS uses such surveys as a means of validating the accrediting organization's survey and accreditation process.

A survey conducted by the Oregon Health Authority at Oregon State Hospital Distinct Part on October 5, 2023 found that the facility was not in substantial compliance with the following CoPs for hospitals.

Fed - A - 0043 - 482.12 - Governing Body  
Fed - A - 0115 - 482.13 - Patient Rights  
Fed - A - 0263 - 482.21 - Qapi

As a result, effective December 11, 2023 your deemed status has been removed and survey jurisdiction has been transferred to the Oregon Health Authority.

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

During this same visit, the state agency identified an Immediate Jeopardy situation which was declared on September 15, 2023 and subsequently abated September 28, 2023.

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

The date on which the Medicare agreement terminates is March 10, 2024.

The Medicare program will not make payment for services furnished to patients who are admitted on or after March 10, 2024. For inpatients admitted prior to March 10, 2024, payment may continue to be made for a maximum of 30 days of inpatient services furnished on or after March 10, 2024.

Termination can only be averted by correction of the deficiencies, through submission of an acceptable plan of correction (PoC) and subsequent verification of compliance by the state agency. The Form CMS 2567 with your POC, dated and signed by your facility's authorized representative must be submitted to Oregon Health Authority no later than December 21, 2023. Please indicate your corrective actions on the right side of the Form CMS-2567 in the column labeled "Provider Plan of Correction", and list the corresponding deficiency number in the column to its left, labeled "ID Prefix Tag". Additionally, indicate your anticipated completion dates in the column labeled "Completion Date".

An acceptable PoC must contain the following elements:

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

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

Your facility will be revisited to verify necessary corrections. If CMS determines that the reasons for termination remain, you will be so informed in writing, including the effective date of termination. If

corrections have been made and your facility is in substantial compliance, the termination procedures will be halted, and you will be notified in writing.

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

If you have any questions regarding this matter, please contact the Seattle Location at [CMS\\_RO10\\_CEB@cms.hhs.gov](mailto:CMS_RO10_CEB@cms.hhs.gov) to the ATTN: Valerie Vajda.

Sincerely,

*Valerie Vajda*

Valerie Vajda  
Sr. Health Insurance Specialist  
Acute & Continuing Care Branch  
Centers for Medicare & Medicaid Services

Enclosures: CMS Form-2567 Statement of Deficiencies

CC: State Survey Agency  
Accrediting Organization

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>384008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/05/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>OREGON STATE HOSPITAL DISTINCT PART</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2600 CENTER STREET NE SALEM, OR 97301</b>		
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A 000	<p><b>INITIAL COMMENTS</b></p> <p>This CMS 2567 report reflects the findings of an unannounced, onsite Federal complaint survey initiated on 09/12/2023 and concluded offsite thereafter on 10/05/2023.</p> <p>Federal complaint OR44708 was investigated. The allegation related to the hospital's failure to provide adequate supervision and interventions during a patient transport that resulted in a patient elopement was substantiated. The allegation related to the hospital's failure to ensure appropriate restraint use, was unable to be substantiated due to insufficient evidence.</p> <p>During the survey, SA surveyor findings confirmed that, on 08/30/2023 during night hours, a psychiatric patient charged with multiple serious violent crimes and prior convictions gained control of a hospital transport vehicle and eloped from the hospital less than 12 hours after admission. Hospital staff were returning the patient to the hospital from a supervised medical outing when staff left the vehicle keys in the ignition unattended. Staff exited the vehicle, and the patient, who was still in the vehicle and in STRs, accessed the vehicle keys and sped away at speeds of up to 100 mph. The patient was found several days later in a muddy slough and taken to a hospital for medical treatment. The patient had made statements to hospital staff about escaping prior to this elopement incident. The hospital had not developed policies and procedures, nor trained staff, about actions staff should take to prevent this incident from occurring. The survey findings further reflected that the hospital had initiated an investigation in response to the incident and had identified some</p>	A 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 000	Continued From page 1 practice gaps and started some corrective actions. However, it had not completed its investigation, and it had not implemented immediate corrective actions to mitigate the possibility of recurrence for other patients while the internal investigation was in process and while long-term corrective actions were determined, planned, and implemented. The following survey actions were taken as result of those findings: * On 09/15/2023 at ~ 1200, the surveyor conducted a meeting with the SA Survey Manager to review the findings for potential IJ as survey findings revealed that no actions had been taken to prevent patients requiring similar secure transport and supervision for medical outings from accessing transport vehicle keys and eloping. The hospital's failure to fully cooperate slowed this IJ determination but did not impact the underlining recommendation. The surveyor drafted a CMS IJ template. * On 09/15/2023 at ~ 1240, the draft IJ template was reviewed by the SA Survey Manager. * On 09/15/2023 at ~ 1400, the surveyor presented the completed IJ template to the hospital Superintendent, COO/CFO, CMO and other hospital leadership and gave instructions regarding removal of the IJ. * On 09/19/2023 at ~ 1235, the DSC and other hospital leadership presented the surveyor with an IJ removal plan. The surveyor reviewed the IJ removal plan with the SA Survey Manager and determined it was unacceptable. * On 09/19/2023 at 1415, the DSC and other hospital leadership were informed the IJ removal plan was not acceptable. * On 09/19/2023 at ~ 1815, the DQM and other hospital leadership presented the surveyor with a second IJ removal plan that included, but was not	A 000			

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A 000	Continued From page 2 limited to: - "OSH will use specialized secure vehicles to provide secure medical transports to all justice-involved patients who use STRs ... vehicles have a built-in secure protective barrier between the front and rear passenger areas ... similar to those used in law enforcement vehicles ... With this barrier in place, a patient will be unable to access the driver's area of the vehicle from the seats in the rear of the vehicle." - "OSH will use secure vehicle sally ports at both OSH campuses for entry and exit of all secure medical transports for justice-involved patients ... A secure vehicle sally port is an enclosed garage that a vehicle can drive into, providing a secure location for patients to enter and exit vehicles ..." - "OSH Security staff were directed to maintain control of the vehicle keys at all times during a transport ... OSH is updating a protocol with detailed instructions on the use of secure vehicle sally ports for secure medical transports, which includes utilization of ... departure and arrival checklists ..." - "OSH is ... developing a new protocol for maintaining control of secure vehicle keys ..." - "OSH has four secure vehicles and are using those vehicles for all secure medical transports of justice-involved patients ..." - "OSH ordered a new key securement clip which will be attached to the secure vehicle keys ..." - "A departure trip checklist will be utilized for all trips with justice-involved patients requiring STRs ... The departure checklist includes ... STRs have been applied appropriately ... presence of securement clip on the vehicle keys ... Security staff and patient are exiting through Sally Port 8 in Salem, or Sally Port 2A in Junction City ... verify vehicle license plate (to ensure it is one of the four secure vehicles with barrier installed) ..."	A 000			

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A 000	<p>Continued From page 3</p> <p>Verification of training records for security staff providing transport ..."</p> <p>- "If any of the departure and arrival safety-measures are not in place, the secure medical transport will not proceed until this issue is addressed ..."</p> <p>* On 09/21/2023 at ~ 1325, The second IJ removal plan with an implementation date of 09/27/2023 was reviewed by the surveyor and SA Survey Manager and determined to be acceptable.</p> <p>* On 09/21/2023 at ~ 1605, the DQM and other hospital leadership were informed the second IJ removal plan was approved.</p> <p>* On 09/28/2023 at ~ 1630, the surveyor determined through observations, interviews and document review that the actions contained in the approved IJ removal plan had been implemented, and that information was reported to the SA Survey Manager.</p> <p>* On 09/28/2023 at ~ 1645, the surveyor informed the DQM that the SA recommended the IJ removal plan had been implemented and the IJ removed.</p> <p>Although the IJ was verified to have been removed, deficient practice with Condition-level findings remained under:</p> <p>* CFR 482.12 - Condition of Participation: Governing Body.</p> <p>* CFR 482.13 - Condition of Participation: Patient's Rights.</p> <p>* CFR 482.21 - Condition of Participation: Quality Assessment and Performance Improvement Program.</p> <p>The following abbreviations, acronyms, and definitions may be used in this report:</p>	A 000			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 000	Continued From page 4 & - and ~ - approximately % - percent ADTS - Associate Director of Training and Support Department Approx - Approximately BHS2 - Behavioral Health Specialist 2 CFO - Chief Financial Officer CFR - Code of Federal Regulations CMO - Chief Medical Officer CMS - Centers for Medicare & Medicaid Services CNO - Chief Nurse Officer COO - Chief Operations Officer COP - Medicare Condition of Participation CS3 - Compliance Specialist 3 Derm - Dermatology DMV - Department of Motor Vehicles DQM - Director of Quality Management DS - Director of Security DSC - Director of Standards and Compliance DTS - Director of Training and Support Department ED - Emergency Department EDP - Extremely Dangerous Persons Emerg - Emergency ER - Emergency Room FAQ - Frequently Asked Questions GEI - Guilty Except for Insanity HCP - Health Care Personnel HLOC - Hospital Level of Care IDT - Interdisciplinary Treatment Team IFU - Instructions for Use IJ - Immediate Jeopardy iLearn - Education computer program IR - Incident Review JC - Oregon State Hospital - Junction City Law enforcement - Local and state police, sheriffs, federal law enforcement agents, and other deputies charged with	A 000			



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A 000	Continued From page 5 enforcing the law LEMC - Legacy Emanuel Medical Center LPN - Licensed Practical Nurse MCS - Marion County Sheriff Meds - Medications MH RN - Mental Health Registered Nurse MHST - Mental Health Security Tech MHT - Mental Health Tech MIRS - Manager of Incident Reporting System MRI - Magnetic Resonance Imaging MST - Manager of Security Transport N/A - Not applicable NEO - New Employee Orientation NP - Nurse Practitioner OBS - Observation OD - Overdose ORS - Oregon Revised Statutes OSH - Oregon State Hospital OSH - JC - Oregon State Hospital - Junction City campus OSH - Salem - Oregon State Hospital - Salem campus OSHA - Occupational Safety and Health Administration OT - Occupational Therapist OTIS - Office of Training, Investigations, and Safety P&P - Policy and procedure PCU - Patient Care Unit PM - Preventive Maintenance QAPI - Quality Assessment & Performance Improvement Quetiapine - An antipsychotic medication Priv, Privile, Privileg - Privilege R - Restraint RCM - Rounds and Census Milieu RN - Registered Nurse S - Seclusion S&R - Seclusion & Restraint	A 000			

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A 000	Continued From page 6 SA - State Agency SaO2 - Oxygen saturation of arterial blood Sally Port - Secure controlled building entry SC - Standards and Compliance Secure Vehicle Sally Port - An enclosed garage that a vehicle can drive into, providing a secure location for patients to enter and exit vehicles SMS - Security Manager Salem Campus SOS2 - Security Operations Supervisor 2 SP - Supervising Psychiatrist s/s - Signs and symptoms STRs - Secure Transport Restraints, metal wrist restraints attached to a waist band, and may include ankle cuffs connected by an additional band in conjunction with waist restraints TCP - Treatment Care Plan TCST - Training Coordinator Security and Transport TMHA - Transport Mental Health Aide TV - Television Tx - Treatment Unauthorized Leave - Patient leaves the confines of the assigned unit or secure perimeter without authorization; patient leaves the supervision of staff while on hospital grounds or during authorized supervised travel in the community; or patient walks away from their responsible party.	A 000			
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	A 043			

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A 043	Continued From page 7 governing body ...  This CONDITION is not met as evidenced by: Based on observation, interviews, review of medical record and incident documentation for 9 of 11 patients (Patients 1, 2, 3, 4, 5, 7, 8, 9 and 10), documentation in 1 of 1 medical record reviewed for restraint and seclusion (Patient 8), review of incident and medical record documentation for 3 of 3 patients reviewed for nursing services (Patients 3, 8, and 9), review of off grounds transport documentation for 9 of 9 patients (Patients 9, 10, 11, 12, 13, 14, 15, 16 and 17), review of staff education/training records for 11 of 11 staff (Employees 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11), review of staff education/training materials, review of manufacturer's instructions for STRs, review of hospital P&Ps, and review of other documentation, it was determined that the hospital 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 A115 under CFR 482.13 - CoP: Patient's Rights.  2. Refer to the findings cited at Tag A263 under CFR 482.21 - CoP: Quality Assessment and Performance Improvement.	A 043			
A 115	PATIENT RIGHTS CFR(s): 482.13	A 115			

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A 115	Continued From page 8  A hospital must protect and promote each patient's rights.  This CONDITION is not met as evidenced by: Based on observation, interviews, review of medical record and incident documentation for 9 of 11 patients (Patients 1, 2, 3, 4, 5, 7, 8, 9 and 10), documentation in 1 of 1 medical record reviewed for restraint and seclusion (Patient 8), review of incident and medical record documentation for 3 of 3 patients reviewed for nursing services (Patients 3, 8, and 9), review of off grounds transport documentation for 9 of 9 patients (Patients 9, 10, 11, 12, 13, 14, 15, 16 and 17), review of staff education/training records for 11 of 11 staff (Employees 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11), review of staff education/training materials, review of manufacturer's instructions for STRs, review of hospital P&Ps, and review of other documentation, it was determined that: * The hospital failed to ensure each patient's right to receive care in a safe setting and freedom from all forms of abuse and neglect. * The hospital failed to ensure alternatives or less restrictive interventions to restraints and seclusion had been attempted and determined ineffective, and were clearly documented. * The hospital failed to ensure hospital staff involved in restraint/seclusion and STR implementation were trained and had demonstrated competencies. * The hospital failed to ensure STRs applied by hospital staff were maintained in accordance with manufacturer's IFUs to ensure safe working order.  This Condition-level deficiency represents a limited capacity on the part of the hospital to	A 115			

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A 115	Continued From page 9 provide safe and adequate care.  Refer to Tag A000 at the beginning of this SOD report for IJ identification, notification, removal plan approval, and verification of removal.  Findings include:  1. Refer to the findings cited at Tag A144 under this CoP, CFR 482.13(c)(2) - Standard: Care in a Safe Setting.  2. Refer to the findings cited at Tag A145 under this CoP, CFR 482.13(c)(3) - Standard: Freedom from Abuse.  3. Refer to the findings cited at Tags A164 and A186 under this CoP, CFR 482.13(e)(2) - Standard: Restraint or seclusion: Less Restrictive Interventions.  4. Refer to the findings cited at Tag A196 under this CoP, CFR 482.13(f)(1) - Standard: Restraint or seclusion: Staff Training Requirements.  5. Refer to the findings cited at Tag A395, CFR 482.23(b)(3) - Standard: Staffing and Delivery of Care: Nursing Supervision.  6. Refer to the findings cited at Tag A724, CFR 482.41(d)(2) - Standard: Facilities. Supplies and Equipment Maintenance.	A 115			
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:	A 144			

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A 144	Continued From page 10 Based on observation, interviews, review of medical record and incident documentation for 9 of 11 patients (Patients 1, 2, 3, 4, 5, 7, 8, 9 and 10), review of off grounds transport documentation for 9 of 9 patients (Patients 9, 10, 11, 12, 13, 14, 15, 16 and 17), review of staff education/training records for 11 of 11 staff (Employees 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11), review of staff education/training materials, review of manufacturer's instructions for STRs, review of hospital P&Ps, and review of other documentation, it was determined the hospital failed to fully develop and implement P&Ps to ensure each patient's right to receive care in a safe setting in the following areas: * Failure to prevent elopement of justice-involved patients during secure transport in hospital vehicles while under supervision of hospital staff. * Failure to develop and implement clearly written, effective policies, procedures, and staff training that ensured patient safety and security, and safety of others during transport and trips involving justice-involved patients while under supervision of hospital staff, including: - Departure and arrival procedures. - Management and control of hospital transport vehicle keys. - Application and management of STRs applied by hospital staff; and management and control of STR keys. - Patient supervision and monitoring. * Failure to prevent patients who did not require transport with STRs, from having STRs applied by hospital staff and incurring injuries. * Failure to ensure STRs applied by hospital staff had been maintained to ensure safe working order in accordance with manufacturer's IFUs. * Failure to ensure staff responses to patient incidents included timely, clear and complete	A 144			

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A 144	<p>Continued From page 11</p> <p>investigations to identify causes and to plan and implement corrective actions to prevent recurrence for the affected patients and others. Incidents include but are not limited to failure to prevent patients from entering unauthorized areas through secure doors; failure to ensure staff closed and locked doors to secure areas; elopement attempts; exit seeking behaviors; and STR related incidents.</p> <p>Patient 11, a psychiatric patient charged with multiple serious violent crimes and prior convictions, gained control of a hospital transport vehicle and eloped from the hospital less than 12 hours after admission. Hospital staff were returning the patient to the hospital from a supervised medical outing when staff left the vehicle keys in the ignition unattended with the patient in the vehicle. Staff exited the vehicle, and the patient, who was in STRs, accessed the keys and sped away at speeds of up to 100 mph. The patient, no longer in STRS, was found several days later in a muddy slough and was taken to a hospital for medical treatment. The hospital had not developed P&amp;Ps, nor trained staff, about actions staff should take to prevent this from occurring. Those conditions resulted in actual harm for Patient 11 and potential harm to other patients, hospital staff, and the public. Although the hospital had initiated an investigation in response to this event and had identified some practice gaps and initiated corrective actions, it had not completed its investigation, and had not implemented immediate corrective actions to mitigate the possibility of recurrence for other patients, hospital staff, and the public while the internal investigation was in process, and long-term corrective actions were determined, planned, and implemented. These findings were</p>	A 144			

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A 144	<p>Continued From page 12</p> <p>determined to represent an IJ situation. Refer to Tag A000 at the beginning of this SOD report for the details of the IJ identification, notification, removal plan approval, and verification of removal.</p> <p>Findings include:</p> <p>Following are findings related to the hospital's failure to prevent elopement of justice-involved patients during secure transport in hospital vehicles while under supervision of hospital staff:</p> <p>1. During interview with DQM, DSC, DS and other hospital staff on 09/12/2023 at 1445 and 09/12/2023 at 1605, the staff provided the following information regarding an incident involving Patient 11:</p> <ul style="list-style-type: none"> <li>* The patient was a "justice-involved" patient which meant they required "secure transport" with STRs for transport to other facilities for medical services.</li> <li>* On 08/30/2023, the patient was involved in a physical altercation with another patient and required emergency medical services for lip and hand injuries. A hospital security staff member and another hospital staff member transported the patient in a hospital "minivan" to Salem Hospital ED. Prior to departure, the security staff member applied STRs to the patient.</li> <li>* Later that same day the same two hospital staff members transported the patient back to the hospital in the same vehicle. Both hospital staff were seated in the front seats of the van, one in the driver's seat and one in the passenger's seat. There was a space between the two front seats. The patient was seated in a back seat behind the front passenger's seat.</li> <li>* Upon arrival to hospital sally port 9, the security</li> </ul>	A 144			



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A 144	<p>Continued From page 13</p> <p>staff member (the driver) got out of the vehicle and walked to the other side of the vehicle to help the patient get out. The patient, who was in STRs, unbuckled their seatbelt, slid between the two front seats into the driver's seat, and sped away. Both staff members were standing outside the vehicle when this occurred. The security staff member attempted to stop the patient by reaching inside the vehicle, and sustained an abrasion to their elbow.</p> <p>* Hospital staff called 9-1-1, reported the incident, and during law enforcement pursuit of the patient, the vehicle reached speeds of up to 100 mph.</p> <p>* The patient was found on 09/02/2023 in a slough in North Portland.</p> <p>* When the patient was found, they were no longer in STRs. The STRs were not found and staff did not know how the patient got out of them.</p> <p>* The patient was taken to LEMC, where they remained for four days, for medical care.</p> <p>* The transport vehicle was found but was not available for observation because it had been damaged during the incident and was no longer on hospital premises.</p> <p>2. An incident document regarding Patient 11 reflected that on 08/30/2023 at "approximately 1825 hours, I [Employee 8] was instructed to escort [Patient 11] from Lighthouse 2 [unit] to [Salem Hospital] ... I escorted the patient into ... Sally Port 9 and put [them] in 'chain restraints, legs and hands, and double locked them ... then I reported to Access Control that [patient], [Employee 11] and I were going to [Salem Hospital]. A 2015 white Dodge Caravan was parked at ... Sally Port 9. The van is fleet number 50 ... I opened the door and the patient sat on the middle passenger seat ... the patient buckled [themselves] up. I checked the seat belt, and it</p>	A 144			

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A 144	Continued From page 14 was tight ... When we arrived at [Salem Hospital], I parked the van ... The patient was checked in ... patient's upper [lip was] treated and stitched. [Patient] was never out of my sight nor [uncuffed]. Approximately 2230 hours ... Salem Hospital provided [Employee 11] with discharge paperwork and told us that we could leave ... I escorted the patient to the van and helped [them] sit on the seat. Then the [patient] buckled [themselves] up ... Prior to my arrival, I contacted the Access Control and advised them that I will be at Sally Port 9 in a few minutes. I also requested an additional security staff to escort the patient to the unit. Approximately 2250 hours we arrived at the Sally Port 9. There are three parking spots at the Sally Port 9 and two vans had been already parked there. I parked the van behind another two vans, perpendicular to Sally Port 9, approximately 30-35 feet away. Then I shut the headlights down and exited the van. I left the key in the ignition. I do not remember if the van was left running. I walked around the van and opened the door for the patient. The patient was sitting and still buckled up. [Employee 11] also exited the van, but the front passenger door was still wide open. I was leaning into the van, through the rear passenger door to unbuckle the patient from the van. As I was doing this, the patient suddenly unbuckled [themselves] and jumped into the driver seat. When I saw the patient in the driver seat, I attempted to jump into the front passenger seat to try to stop [them]. At the same time the patient put the van into gear and accelerated away ... When the patient drove away, I was hit by the vehicle and was thrown to the ground, slamming my left elbow into the pavement, and [scraping] a large amount of skin off ... The van sped up and quickly drove away ... I could hear the squeal of the van's tires ..."	A 144			

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A 144	Continued From page 15  3. The medical record for Patient 11 included the following information: * The patient was admitted with diagnoses that included bipolar disorder, personality disorder, and history of self-harm. * An RN note dated 08/30/2023 at 1436 reflected, "[Patient] ... with charges of attempted murder (Felony A), robbery, assault, weapon use, and weapon possession ..." * An MD note dated 08/30/2023 at 1802 reflected, " ... [Patient] had an altercation with one of [their] peers ... Patient got punched in the face and ended up getting injured lip and injury of left hand. We are sending patient to Salem ED for medical care for injuries ..." * An MD note dated 08/30/2023 at 1911 reflected the patient was admitted to "Oregon State Hospital for ... restoration of trial competency pursuant to Oregon Revised Statute (ORS) 161.370 ... in an order dated 8/22/23 signed by the Honorable Judge [name]. [Patient] was charged with eighteen offenses ... for events alleged to have occurred between 3/12/22 and 8/2/22 ... Suicide/Aggression assessment: Suicidal risk on admission considered moderate. [Patient] reports superficial self-harm with a piece of broken glass ... Also reports two suicide attempts, one by OD of prescription sleep medication, the other by strangulation ... Aggression risk on admission considered moderate. [Patient] is currently charged with a number of violent crimes including Attempted Murder and several counts of Domestic Violence." * The patient was transported to Salem Hospital for medical care on 08/30/2023 at approximately 1800. * An RN note dated 08/31/2023 at 0610 reflected,	A 144			

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A 144	<p>Continued From page 16</p> <p>"Approx 2240 [on 08/30/2023], notified by escort staff that patient had stolen state vehicle and left [the hospital] unauthorized ... patient had jumped into front seat of vehicle after driver had exited, [MHT] was able to exit car, patient then drove car away ... patient had made statements about 'running away' prior to unauthorized leave, along with several threats to assault a peer ..."</p> <p>* The patient was "discharged due to elopement on 08/30/2023."</p> <p>4. During tour of sally ports 8 and 9 with the DS and SMS on 09/12/2023 beginning at 1555, observations included:</p> <p>* A secure door led directly from inside sally Port 8 into an enclosed, secure vehicle drive-in garage that led to the outside of the building. A floor to ceiling garage door was observed between the drive-in garage and the outside of the building so that a vehicle could drive fully into the garage and have the doors closed and secured behind the vehicle. From outside, the drive-in garage door was accessed by badge entry.</p> <p>* In contrast to sally port 8, sally port 9 had a secure door that led directly to the outside of the building, and no drive-in garage.</p> <p>* Vehicle roundabout and parking spaces were observed outside sally port 9. Staff present during the tour stated the elopement incident involving Patient 11 occurred outside sally port 9 near the roundabout.</p> <p>* Observation of the inside of a Dodge Caravan parked outside sally port 9 revealed captain style driver and passenger seats in front with a space between the two seats. A standard key entry ignition was observed next to the steering wheel on the right side. Two captain style passenger seats were observed directly behind the front seats with a space between the two seats. One</p>	A 144			

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A 144	<p>Continued From page 17</p> <p>captain style seat was observed in the rear. Standard seatbelts were observed throughout the vehicle. No barrier or other device was observed separating the front seats from the other seats. No first aid kit was observed in the vehicle. Staff present during the tour stated the vehicle was similar to the vehicle used in the elopement incident involving Patient 11.</p> <p>*****</p> <p>Following are findings related to failure to develop and implement P&amp;Ps that ensured patient safety and safety of others during secure transport of justice-involved patients. Policies, procedures, and other information were unclear, inconsistent and fragmented. Examples include:</p> <p>5.a. During interview with the CFO/COO and DQM on 09/21/2023 at 1540, CFO/COO provided the following information regarding secure transport of justice-involved patients:</p> <ul style="list-style-type: none"> <li>* Prior to 2022 the hospital had a contract with "Marion County" law enforcement to carry out the hospital's secure transports of justice-involved patients. In 2022, "Marion County" informed the hospital they would no longer carry out those transports.</li> <li>* During the interview, a CMS waiver request document regarding OSH, dated 01/11/2023, was reviewed. It included that: <ul style="list-style-type: none"> <li>- The individual requesting the waiver was OSH's Superintendent.</li> <li>- "... OSH is responsible for providing a safe and secure environment for its patients and staff, and ensuring that it maintains supervision and control of those patients who are committed to its care by state courts and the Psychiatric Security Review Board (PSRB) ... In addition, when patients</li> </ul> </li> </ul>	A 144			

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A 144	<p>Continued From page 18</p> <p>require emergency services or other specialized medical care not available at OSH, the hospital has an obligation to transport patients to external medical providers in the community and to facilitate all necessary medical care ..."</p> <p>- "... OSH previously arranged for the local sheriff's office to provide secure transport to certain justice involved patients when they are transported to outside medical care. However, OSH's local sheriff's office notified the hospital in June of 2022 that, due to staff shortages, it would no longer be able to provide afterhours [sic] secure medical transports after August 12, 2022 and would stop all secure medical transports after September 11, 2022."</p> <p>* On 08/11/2022, the CMO put out a directive indicating that hospital security staff would be carrying out secure transports of justice-involved patients, including application of STRs.</p> <p>5.b. The CMO directive dated 08/11/2022 referred to in 5.a. was provided and reflected:</p> <p>* "This CMO Directive modifies OSH Policy 8.039, 'Secure Transport Restraints.' The intent is to clarify several frequently asked questions, given recent changes in availability of law enforcement personnel and lack of clarity regarding when Secure Transport Restraints (STRs) are not required. STRs are used only for off-grounds custody transportation reasons for patients committed under the following statutes:"</p> <p>- "Oregon Revised Statute (ORS) 161.370 (.370);"</p> <p>- "ORS 161.295 (Guilty Except for Insanity [GEI]), if the patient does not have off grounds privileges granted by Forensic Risk Review;"</p> <p>- "ORS 426.701/.702 (Extremely Dangerous Persons [EDP]), if the patient does not have off-grounds privileges granted by Forensic</p>	A 144			

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A 144	<p>Continued From page 19 Risk Review."</p> <p>* "STRs may be applied only by law enforcement personnel or, if law enforcement personnel are unavailable, by members of the Safety and Security Department trained on the proper use of STRs."</p> <p>* "At least two persons must accompany a patient requiring STRs for all off-grounds medical care ... When law enforcement personnel are available, at least one of these must be OSH staff ... When law enforcement personnel are unavailable, at least two OSH staff must accompany the patient, one of which must be a member of the Safety and Security Department trained on the proper use of STRs."</p> <p>* "Exceptions to the use of STRs ... STRs may not be used for patients under a civil commitment, Voluntary by Guardian/Health Care Representative status, or Voluntary status, under any circumstances ... STRs may not be used for pregnant patient believed to be in active labor ... STRs must be applied following delivery if otherwise required ... If it is medically contraindicated to place STRs on a patient ... the physician/nurse practitioner may recommend to law enforcement personnel or trained Safety and Security Department staff that STRs not be placed on one or more limbs ... Temporary removal of STRs for medical procedures, including imaging or phlebotomy, is permitted ...Removal of STRs during overnight sleep studies requires the approval of the Chief Medical Officer or designee ... This directive remains in effect until OSH Policy 8.039, 'Secure Transport Restraints,' is updated or the directive is otherwise rescinded."</p> <p>5.c. During an interview with DQM on 09/21/2023 at ~ 1550, the DQM stated the CMO directive</p>	A 144			

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A 144	<p>Continued From page 20 dated 08/11/2023 in 5.b. described "justice-involved patients" as, "patients committed under the following statutes: 'Oregon Revised Statute (ORS) 161.370 (.370) ... ORS 161.295 (Guilty Except for Insanity [GEI]) ... ORS 426.701/.702 (Extremely Dangerous Persons [EDP]) ..."</p> <p>5.d. During interview with DS and DQM on 09/14/2023 at 1555 they identified the following two hospital P&amp;Ps as those that addressed secure transport of justice-involved patients with STRs applied by hospital staff: * A P&amp;P titled "Transporting Patients," Protocol 6.005.2; and * A P&amp;P titled "Medical Transport of .370 patients and GEI without Privileges in STR's," Protocol 6.015.1.</p> <p>5.e. The P&amp;P titled "Transporting Patients," Protocol 6.005.2, dated effective 08/01/2016, included: * "It is the protocol of the Oregon State Hospital Security Department to provide for precautions necessary to guard against unauthorized leave as well as a system to ensure the wellbeing of patients, staff and the public while escorting patients ..." * "'Transporter' means the staff person designated to be in charge of the trip/transfer and security ... 'Trip' means the escorting of a patient from an Oregon State Hospital facility to a medical appointment, court appearance, discharge or other activity and returning the patient to the same Oregon State Hospital facility, or a transfer between OSH campuses or Federal, State, County facilities or other approved facility. This also includes on-campus trips." * "... Only law enforcement personnel are</p>	A 144			



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 144	<p>Continued From page 21</p> <p>authorized to transport patients that require the use of secure transport restraints ..."</p> <p>* "The escorted patient may be pat-searched prior to the trip or transfer and upon return to the location of origin ... These searches will usually be done by staff from the area the patient is assigned."</p> <p>* "Transporters will use approved DAS vehicles for transportation ... The patient must be seated in the rear seat, there are no exceptions. A seatbelt will be used at all times. Regardless of how many staff are going on the appointment the patient is never allowed to sit in the front seat."</p> <p>* "If the trip/transport will be in a vehicle with two transporters and one patient, if available, the rear doors will have the child safety locks engaged ... The transporters will inspect the transport vehicle for escape devices and contraband before and after the trip/transfer."</p> <p>* "Patients are required to use a seat belt when being transported. This will not be optional unless a medical condition prohibits the use of seatbelts. Seat belt locks may be used as needed for high profile or medically compromised patients to ensure the seat belt remains in place for the trip."</p> <p>* "The primary duty of the transporter is to prevent unauthorized leave and protect the patient and public from harm. Transport staff shall always ensure the patient is secured in the vehicle before any staff get in the vehicle."</p> <p>* "When patient misconduct occurs, the transporter will determine whether or not to discontinue the trip/transfer and return the patient. Transporters will inform unit staff and make a chart entry in the patient's medical record."</p> <p>The P&amp;P stated patients may be "pat-searched" prior to a trip. The P&amp;P was not clear under what circumstances a patient may or may not be</p>	A 144			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/07/2023  
FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>384008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/05/2023</b>
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A 144	<p>Continued From page 22</p> <p>"pat-searched."</p> <p>The P&amp;P stated transporters will use approved DAS vehicles for transportation. The P&amp;P did not specify which vehicles were "approved" for this purpose, nor how to identify them.</p> <p>The P&amp;P stated patients must be seated in the rear seat. Refer to findings 9.c through 16.d. below which reflect the hospital's failure to ensure staff were trained regarding patient seating arrangements and other activities regarding transport in hospital vehicles.</p> <p>The P&amp;P stated patients are required to use a seat belt when being transported. The P&amp;P did not stipulate who was required to ensure the patient's seatbelt was buckled.</p> <p>The P&amp;P stated seat belt locks may be used as needed for "high profile" or medically compromised patients. The P&amp;P was not clear how "high profile" patients were determined and which vehicles had seat belt lock capability.</p> <p>The P&amp;P stated rear doors will have the child safety locks engaged, if available. The P&amp;P did not include a door locking protocol when child safety locks were not available.</p> <p>The P&amp;P did not include consideration of vehicle window access with regard to patient safety during transport.</p> <p>The P&amp;P did not include which sally port should be used for departures and arrivals.</p> <p>The P&amp;P stated when patient misconduct occurs, the transporter will determine whether or not to discontinue the trip and return the patient. The P&amp;P did not describe "misconduct" nor how this should be managed during patient transport, including during transport to a medical facility for medical services.</p> <p>The P&amp;P did not address secure transport of justice-involved patients by hospital staff to other facilities, including clear and comprehensive</p>	A 144			

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A 144	Continued From page 23 steps to prevent elopement.  5.f. The P&P titled "Medical Transport of 370 Patients and GEI Without Privileges Patient in STR's by Marion County Sheriff," Protocol 6.015.1, dated effective 01/19/2017, included: * "Replaces all previously dated protocols related to this subject ... This applies to .370 patients and GEI patients without privileges going off-campus." * "... The Transport Unit will assign staff to pick up the patient from the PCU and escort the patient to the sally-port 8 holding area ... Upon arrival of the Marion County Sheriff's (MCS) deputies to sally-port 8, Transport Unit staff will transfer physical custody to the Marion County Sheriff's deputies to have STR's applied in the holding area ... The patient will then be escorted by Transport Unit staff and MCS deputy to the vehicle in sally-port 8 for departure ... One transport staff will accompany the MCS Deputy for the duration of the appointment. Under special circumstances a unit staff may also accompany the MCS Deputy and the transport staff on the appointment ... In the event that sally-port 8 is not available the unit staff will escort the patient to meet the MCS Deputy at sally-port 9 ... The patient may not be escorted through sally-port 9 if another patient is in the sally-port ... MCS will remove the STR's in the sally-port 8 holding area before the patient is escorted back to the unit ... This policy includes all GEI patients without privileges." The P&P was primarily related to steps and processes related to application of STRs and transport of justice-involved patients by MCS and did not provide steps and processes related to secure transport by hospital staff, including clear and comprehensive steps to prevent elopement.	A 144			

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A 144	Continued From page 24 5.g. The P&P titled "Secure Transport Restraints," Policy 8.039, dated 02/05/2017, included: * "Oregon State Hospital (OSH) will provide necessary care to each patient safely while complying with custody transportation requirements for each patient committed to OSH. Secure transport restraints (STRs) may only be used as described in this policy for custody transportation reasons ... During off-grounds transportation, STRs must be used on a patient committed under Oregon Revised Statute (ORS) 161.370 (.370) or under ORS 161.295 (Guilty Except for Insanity [GEI]) who does not have off-grounds privileges granted by the Forensic Risk Review Panel." * "STRs may not be used on a civilly committed or voluntarily admitted patient ..." * "STRs may only be used outside the secure perimeter. STRs may not be used within the secure perimeter ..." * "STRs may not be used in patient care areas for managing behavioral emergencies ..." * "STRs may only be applied or removed by law enforcement personnel. OSH HCP may not apply or remove STRs on a patient." * "The provisions of this policy apply for the duration of a patient's transportation and stay outside the secure perimeter." * "Unless indicated otherwise, this policy supersedes all other STR policies or procedures." The P&P stated OSH staff may not apply or remove STRs and was primarily related to application of STRs by law enforcement personnel. The P&P did not provide steps and processes related to the hospital's current practice of permitting application of STRs and secure transport to other facilities of justice-involved patients by hospital staff, including clear and comprehensive steps to	A 144			

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A 144	<p>Continued From page 25 prevent elopement.</p> <p>5.h. The CMO directive titled "Secure transport restraints for medical transport" and dated 01/09/2018 reflected that, "Using secure transport restraints (STRs) for Oregon State Hospital (OSH) patients during medical transport is regulated by OSH Policy and Procedure 8.039, 'Secure Transport Restraints'. This directive modifies OSH Policy and Procedure 8.039, 'Secure Transport Restraints,' and is effective immediately."</p> <p>* "When a physician or nurse practitioner determines that an urgent medical need requires patient transport to an outside acute-care facility and the patient ... lacks off-grounds privileges and is committed under Oregon Revised Statute (ORS) 161.295 (Guilty Except for Insanity [GEI]) or ORS 462.701 (Extremely Dangerous Persons), or is committed under ORS 161.370; and ... represents a significant risk of elopement or a significant safety risk to the general public, then Security Department staff may apply STRs on the patient if the Sheriff's Department is not immediately available to apply the STRs."</p> <p>* "This directive will remain in effect until OSH Policy and Procedure 8.039, 'Secure Transport Restraints,' is updated or the directive is otherwise rescinded."</p> <p>The CMO directive included no further information regarding secure transport or STRs, including but not limited to STR application/removal, STR keys management/control, patient monitoring and supervision, and staff training/competencies.</p> <p>5.i. The P&amp;P titled "On-grounds and Off-grounds Movement," Policy 6.006, dated 03/22/2021 reflected that, "All movement outside the secure</p>	A 144			

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A 144	Continued From page 26 perimeter, including on-grounds and off Grounds activities and discharges, requires a trip slip, with the exception of a situation involving an emergency medical condition ... All movement must comply with privileges or other requirements established by Risk Review ... 'Secure perimeter' means restricted high-security buildings, areas, and quads within the sallyport [sic] exits operated to manage movement of persons within the OSH campus ... 'Trip slip' refers to the form completed any time a patient leaves the secure perimeter ... A patient committed to OSH pursuant to Oregon Revised Statute (ORS) 161.370, ORS 161.365, or admitted under an inter-agency agreement may not go anywhere outside the secure perimeter unless the patient is attending a doctor ordered appointment or court-ordered hearing ... Before escorting a patient outside the secure perimeter, staff must complete the patient escort training on iLearn ... Staff must use a handheld radio or a state-issued cellphone [sic] when outside the secure perimeter ... Escorting staff are responsible to obtain and carry supplies necessary for the outing ... First aid kits are required on all off-grounds outings. They are located in every state vehicle ... Unless the Safety and Security Director approves an exception, patients must exit the secure perimeter at sallyports [sic] with Security checkpoints ..." The P&P stated that, before escorting a patient outside the secure perimeter, staff must complete a patient escort training in iLearn. The P&P did not describe content of "escort training," including frequency, whether demonstrated competencies were required, and whether training included transport of justice-involved patients and STRs applied by hospital staff. The P&P stated patients must exit the secure perimeter at sally ports with security checkpoints.	A 144			

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A 144	<p>Continued From page 27</p> <p>The P&amp;P did not state which sally ports had security checkpoints, nor whether all sally ports with security checkpoints were appropriate for departures and arrivals of justice-involved patients.</p> <p>5.j. Refer to finding 5.b. regarding CMO directive dated 08/11/2022. The directive stated STRs may be applied by hospital security staff trained on proper use of STRs and "at least two" persons must accompany a patient requiring STRs. The directive did not include any further information regarding staff training requirements, including content; frequency; whether demonstrated competencies were required; nor what "proper use" entailed, including monitoring and supervision during use. The directive did not describe circumstances when more than two persons must accompany a patient in STRs, nor how this was determined.</p> <p>5.k. During interview with MST, DS and other hospital staff on 09/14/2023 at 1300, the following information was provided related to secure transport of justice-involved patients:</p> <ul style="list-style-type: none"> <li>* Regarding number of staff required during transport, "no fewer than two staff to one patient" transport the patient and stay with the patient during the entire trip.</li> <li>* Regarding STRs, a hospital security staff member applies those prior to departure and they remain in place for the entire trip.</li> <li>* Regarding sally port for departure/arrival, Monday through Friday, sally port 9 should be used because sally port 8 is "busy." Sally port 8 is used "after hours."</li> <li>* Regarding getting in the transport vehicle, two staff remain outside the vehicle until the patient is in the vehicle and the patient's seatbelt is</li> </ul>	A 144			

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A 144	<p>Continued From page 28</p> <p>buckled.</p> <ul style="list-style-type: none"> <li>* Regarding seatbelts, "Most patients put their own seatbelt on. If they request assistance, we assist them."</li> <li>* Regarding seating arrangement in the vehicle, the patient sits on a bench seat in the very back so there is more distance between the patient and the staff in the front seats.</li> <li>* Regarding vehicle door locks, "when we check out the vehicle at the beginning of the day, we check to make sure the child locks are on."</li> <li>* Regarding monitoring/observing patient during transport, the passenger is "more vigilant" because the other person is driving. The driver uses a "pull down" mirror so they can also watch the patient.</li> <li>* Regarding vehicle key control/management, "we don't have a procedure or protocol for that." When not in the ignition, keys are "usually kept in the driver's pocket."</li> <li>* Regarding first aid or other medical supplies in the vehicle, "usually there isn't any."</li> </ul> <p>5.I. During interview on 09/21/2023 at 1305 with the TCST and other hospital staff, the TCST provided the following information regarding STRs applied by hospital staff:</p> <ul style="list-style-type: none"> <li>* STRs included metal handcuffs (locking), metal ankle cuffs (locking), a metal waist chain, and a padlock.</li> </ul> <p>The TCST provided a detailed description regarding application of STRs that included but was not limited to:</p> <ul style="list-style-type: none"> <li>* Patient communication and instructions.</li> <li>* Checking handcuff and ankle cuff locks and swivels function.</li> <li>* Checking pad lock function.</li> <li>* Patient and staff position during STRs application.</li> </ul>	A 144			



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A 144	<p>Continued From page 29</p> <ul style="list-style-type: none"> <li>* Order of STRs application.</li> <li>* Chain management and position.</li> <li>* Chain padlock application.</li> <li>* Handcuff reducers/adjusters.</li> <li>* Vinyl cuffs.</li> <li>* Gait safety after application of STRs.</li> </ul> <p>The TCST provided the following additional information:</p> <ul style="list-style-type: none"> <li>* Security staff are responsible for management of STRs.</li> <li>* Regarding STR keys, all "security and transport staff" are issued STR keys on hire. STR keys are comprised of a "universal" cuff key and a pad lock key. STR keys are kept on a "big, strong extender attached to [staff's] belt with a clip." The hospital has no process for tracking STR keys.</li> <li>* Regarding handcuff reducers, those are applied to the inner aspect of handcuffs "to make them smaller" for patient's with smaller wrists.</li> <li>* Regarding vinyl cuffs, those are applied to patients during MRIs or other medical procedures in which metal cuffs are contraindicated.</li> </ul> <p>5.m. During interview on 09/28/2023 at 1430 with SMS and other hospital staff present, the SMS provided the following information regarding justice-involved patients under supervision of hospital staff and transported by EMS to other facilities for medical services:</p> <ul style="list-style-type: none"> <li>* One hospital "security staff" member and one hospital "clinical staff" member goes in the ambulance with EMS personnel.</li> <li>* "Generally" the security staff rides in the back of the ambulance with the patient, and the clinical staff rides in the front (passenger seat) of the ambulance.</li> <li>* Upon arrival to the medical facility, a hospital security staff and a hospital clinical staff stay with the patient for the duration of the patient's</li> </ul>	A 144			

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A 144	<p>Continued From page 30</p> <p>medical facility encounter and return transport back to the hospital.</p> <p>* The SMS stated the hospital had no P&amp;Ps related to justice-involved patients under supervision of hospital staff and transported by EMS to other facilities for medical services. The SMS stated, "We're working on this."</p> <p>5.n. During interview with DQM and DSC on 09/21/2023 at 1120 and 09/21/2023 at 1415, the following information was provided:</p> <p>* The hospital had no P&amp;Ps regarding application of STRs by hospital staff.</p> <p>* Regarding STR keys, a "universal cuff key" was used for all handcuffs and ankle cuffs.</p> <p>* STR keys at OSH-Salem were issued to staff on a "bi-ring" where keys could be easily removed. However, at OSH-JC, STR keys were issued to staff on a welded key ring where they could not be removed. The staff acknowledged STR keys management processes were not consistent.</p> <p>*****</p> <p>Following are findings related to failure to develop and implement staff training that ensured patient safety and safety of others during secure transport of justice-involved patients:</p> <p>6. An OSHA document dated 09/11/2023 regarding the elopement incident involving Patient 11 included the following staff training information:</p> <p>* "OSH requires two trained OSH staff members to accompany a patient on a secure medical transport to a community provider and during the duration of the outside medical care ... Every secure medical transport must have at least one Transport Mental Health Aide (TMHA) or Mental</p>	A 144			

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A 144	<p>Continued From page 31</p> <p>Health Security Technician (MHST) from OSH's Security Department ... TMHAs are primarily responsible for patient transportation at the hospital ... MHSTs have general security obligations at the hospital but may provide patient transportation when needed ... Only trained security staff are permitted to use secure transport restraints on patients. When two security staff members are not available, a trained unit treatment staff member may serve as the second trained OSH staff member on a secure medical transport. The treatment staff member assists security personnel during the patient transport and provides mental health support to the patient ..."</p> <p>7. During interview with DQM and other hospital staff on 09/15/2023 at 1115, the following information was provided regarding staff training/education that addressed secure transport of justice-involved patients by hospital staff:</p> <ul style="list-style-type: none"> <li>* MHTs were required to complete "Patient Movement Outside the Secure Perimeter" training.</li> <li>* MHSTs had no formal training/education requirements regarding secure transport of justice-involved patients. "That's clearly a gap for us ... that has not been formalized."</li> <li>* TMHAs were required to complete "On the Job Training Transport" during orientation.</li> </ul> <p>8.a. A staff training/education slide presentation titled "Welcome to OSH 2023 Annual Education on: Patient Movement Outside the Secure Perimeter" was reviewed. This training was specific to steps and processes related to group outings and "re-entry" into the secure perimeter and did not address secure transport of</p>	A 144			

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A 144	<p>Continued From page 32</p> <p>justice-involved patients by hospital staff to other facilities, including clear and comprehensive steps to prevent elopement.</p> <p>8.b. An undated onboarding training document titled "Transport On the Job Training - 2 Week Orientation" was reviewed and reflected: * "When a new staff starts in Transport they receive a binder that includes:" This was followed by titles of 12 P&amp;Ps and protocols including but not limited to: - "Protocol 6.005.2 Transporting Patients" - "Protocol 6.009.0 Patient Escape Off-Campus Transport" - "Protocol 6.015.1 Medical Transport of .370 patients and GEI without Privileges in [STRs]" - "Policy 8.039 Secure Transport Restraints" * "Staff spend the first day reviewing these policies and protocols and then there is an acknowledgement form that they sign and date indicating that they have read and understand them ..." The P&amp;Ps in this onboarding training document did not provide clear and comprehensive steps and processes related to secure transport of justice-involved patients by hospital staff to other facilities, including steps to prevent elopement.</p> <p>*****</p> <p>9.a. A Trip Slip document related to a justice-involved patient, Patient 12, reflected the patient was transported to "Salem Hospital Imaging" in a hospital vehicle with Employees 1 and 3 on 04/21/2023. It included the following: * "Off Grounds" trip. * "Trip Departure Time: 14:15." * "Priv [sic] Level ... No Privileg [sic] [meaning patient required secure transport with STRs]."</p>	A 144			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>384008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/05/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>OREGON STATE HOSPITAL DISTINCT PART</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2600 CENTER STREET NE</b> <b>SALEM, OR 97301</b>		
(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	<p>Continued From page 33</p> <ul style="list-style-type: none"> <li>* "Staff Accompanying" followed by two staff names, Employees 1 and 3.</li> <li>* "Transportation: State Van/Car."</li> <li>* "Return Time: 14:15, which was unclear as it was the same time as the "Trip Departure Time: 14:15" above.</li> </ul> <p>There was no documentation that reflected whether "State Van/Car" was an "approved DAS vehicle. Refer to finding 5.e. that reflects, " Transporters will use approved DAS vehicles for transportation." Due to the lack of documentation, there was no assurance that an approved vehicle for purposes of secure transport was used. There was no documentation that reflected who applied STRs on the patient. Refer to finding 5.b. that reflects a staff member trained on "proper use of STRs" must accompany the patient. Due to the lack of documentation, there was no assurance that only trained staff accompanied the patient. There was no documentation that reflected which sally port was used for trip departure and arrival. Refer to finding 4 regarding security and design differences between sally 8 and 9. Due to the lack of documentation, there was no assurance an appropriate sally port was used for departure and arrival.</p> <p>9.b. During interview and review of Trip Slip documentation; and Employee 1 and Employee 3's education/training records with DQM and other hospital staff on 09/21/2023 beginning at 1620, hospital staff provided the following information:</p> <ul style="list-style-type: none"> <li>* On 04/21/2023, Employees 1 and 3 transported a justice-involved patient, Patient 12, to "Salem Hospital Imaging" for "pre-planned" medical services by secure transport with STRs.</li> <li>* Employee 1 was not authorized to apply STRs to patients.</li> </ul>	A 144			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>384008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/05/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>OREGON STATE HOSPITAL DISTINCT PART</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2600 CENTER STREET NE</b> <b>SALEM, OR 97301</b>		
(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	<p>Continued From page 34</p> <ul style="list-style-type: none"> <li>* The staff confirmed the lack of documentation on the Trip Slip.</li> <li>* The staff confirmed the lack of staff training/education in findings 9.c and 9.d. below.</li> </ul> <p>9.c. Regarding Employee 1, BHS2 with hire date 03/02/1998, training/education records failed to address secure transport of justice-involved patients by hospital staff to other facilities, including clear and comprehensive steps to prevent elopement. Examples included, there was no documentation of education/training related to who was responsible to visually monitor and supervise the patient during the trip, including during departure and arrival; maintaining control of transport vehicle keys and preventing patient access to keys; patient and staff seating position/arrangement in transport vehicles; management of vehicle door locks; management of patient behaviors, including potential escalation while transport vehicle is in motion; appropriate vehicle selection from available fleet, including make/model; and education/training/competencies related to STRs, including but not limited to application, removal, storage, keys management and control, and patient monitoring. Employee 1's training/education records reflected they had completed a training titled "Patient Movement Outside the Secure Perimeter" on 06/15/2022. However, refer to finding 8.a. which reflects this training did not address secure transport of justice-involved patients by hospital staff to other facilities, including clear and comprehensive steps to prevent elopement. Additionally, Employee 1's education/training records contained no documentation of education/training related to Patient's Rights.</p>	A 144			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>384008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/05/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>OREGON STATE HOSPITAL DISTINCT PART</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2600 CENTER STREET NE</b> <b>SALEM, OR 97301</b>		
(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 9.d. Regarding Employee 3, TMHA with hire date 07/24/2011, training/education records failed to address secure transport of justice-involved patients by hospital staff to other facilities, including clear and comprehensive steps to prevent elopement. Examples included, there was no documentation of education/training related to who was responsible to visually monitor and supervise the patient during the trip, including during departure and arrival; maintaining control of transport vehicle keys and preventing patient access to keys; patient and staff seating position/arrangement in transport vehicles; management of vehicle door locks; management of patient behaviors, including potential escalation while transport vehicle is in motion; appropriate vehicle selection from available fleet, including make/model; and education/training/competencies related to STRs, including but not limited to application, removal, storage, keys management and control, and patient monitoring. Employee 3's training/education records reflected they had completed a training titled "Patient Movement Outside the Secure Perimeter" on 06/23/2022. However, refer to finding 8.a. which reflects this training did not address secure transport of justice-involved patients by hospital staff to other facilities, including clear and comprehensive steps to prevent elopement. Additionally, Employee 3's education/training records contained no documentation of required education/training titled "On the Job Training Transport" and no documentation of education/training related to Patient's Rights.  *****  10.a. A Trip Slip document related to a	A 144			

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NAME OF PROVIDER OR SUPPLIER  <b>OREGON STATE HOSPITAL DISTINCT PART</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2600 CENTER STREET NE</b> <b>SALEM, OR 97301</b>		
(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	<p>Continued From page 36</p> <p>justice-involved patient, Patient 13, reflected the patient was transported to "Valley View Derm clinic" on 03/10/2023. It included the following:</p> <ul style="list-style-type: none"> <li>* "Off Grounds" trip.</li> <li>* "Trip Departure Time: 13:22."</li> <li>* "Priv [sic] Level ... No Privileg [sic]."</li> <li>* "Staff Accompanying" followed by one name, Employee 2.</li> <li>* "Transportation: State Van/Car."</li> <li>* "Return Time: 13:44" with no return date.</li> </ul> <p>The departure and return times were not clear as the return time was only 22 minutes after departure time.</p> <p>There was no documentation that reflected whether "State Van/Car" was an "approved DAS vehicle. Refer to finding 5.e. that reflects "Transporters will use approved DAS vehicles for transportation." Due to the lack of documentation, there was no assurance that an approved vehicle for purposes of secure transport was used. There was no documentation that reflected who applied STRs on the patient. Refer to finding 5.b. that reflects staff trained on "proper use of STRs" must accompany the patient. Due to the lack of documentation, there was no assurance that only trained staff accompanied the patient. There was no documentation that reflected which sally port was used for trip departure and arrival. Refer to finding 4 regarding security and design differences between sally 8 and 9. Due to the lack of documentation, there was no assurance an appropriate sally port was used for departure and arrival.</p> <p>10.b. Review of a "Transporters" schedule document dated 03/10/2023 reflected, "STR ... [Patient 13] - Valley View Dermatology" and "1300-1445" in columns next to Employee 2 and another employee. It was not clear who</p>	A 144			



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NAME OF PROVIDER OR SUPPLIER  <b>OREGON STATE HOSPITAL DISTINCT PART</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2600 CENTER STREET NE SALEM, OR 97301</b>		
(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	<p>Continued From page 37</p> <p>transported the patient, as the Trip Slip documentation listed the name of only Employee 2, while the transporter schedule suggested Employee 2 and another staff member transported the patient. The trip times between the Trip Slip and transporter schedule were inconsistent. Due to this inconsistent documentation, it was not clear how many and which hospital staff "accompanied" the patient during the trip.</p> <p>10.c. During interview and review of Trip Slip documentation and Employee 2's education/training records with DQM and other hospital staff on 09/21/2023 beginning at 1620, hospital staff provided the following information: * On 03/10/2023, Employee 2 and another staff transported a justice-involved patient, Patient 13, to "Valley View Derm clinic" for "pre-planned" medical services by secure transport with STRs. * The staff confirmed the documentation regarding transport staff was not clear. * The staff confirmed the lack of training/education in finding 10.d. below.</p> <p>10.d. Regarding Employee 2, TMHA with hire date 04/04/2011, similar to examples in findings 9.c. and 9.d., training/education records failed to address secure transport of justice-involved patients by hospital staff to other facilities, including clear and comprehensive steps to prevent elopement. Additionally, Employee 2's education/training records contained no documentation of required education/training titled "On the Job Training Transport" and no documentation of education/training related to Patient's Rights.</p> <p>*****</p>	A 144			

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NAME OF PROVIDER OR SUPPLIER  <b>OREGON STATE HOSPITAL DISTINCT PART</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2600 CENTER STREET NE</b> <b>SALEM, OR 97301</b>		
(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	<p>Continued From page 38</p> <p>11.a. A Trip Slip document related to a justice-involved patient, Patient 14, reflected the patient was transported to "Salem Health Imaging" in a hospital vehicle with Employees 3 and 6 on 08/11/2023. It included the following:                      * "Off Grounds" trip.                      * "Trip Departure Time: 14:54."                      * "Priv [sic] Level ... No Privileg [sic]."                      * "Staff Accompanying" followed by two staff names, Employees 3 and 6.                      * "Transportation: State Van/Car."                      * "Return Time: 16:23" with no return date.                      There was no documentation that reflected an "approved " vehicle was used for transport. There was no information on the Trip Slip that reflected who applied STRs on the patient. There was no information on the Trip Slip that reflected what sally port was used for departure and arrival.</p> <p>11.b. During interview and review of Trip Slip documentation and Employee 6's education/training records with DQM and other hospital staff on 09/21/2023 beginning at 1620, hospital staff confirmed the lack of training/education in finding 11.c. below.</p> <p>11.c. Regarding Employee 6, TMHA with hire date 10/27/2014, similar to examples in findings 9.c. and 9.d., training/education records failed to address secure transport of justice-involved patients by hospital staff to other facilities, including steps to prevent elopement. Additionally, Employee 6's education/training records contained no documentation of required education/training titled "On the Job Training Transport" and no documentation of education/training related to Patient's Rights.</p>	A 144			

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NAME OF PROVIDER OR SUPPLIER  <b>OREGON STATE HOSPITAL DISTINCT PART</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2600 CENTER STREET NE</b> <b>SALEM, OR 97301</b>		
(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  11.d. Refer to the finding 9.d. regarding lack of training/education documentation for Employee 3.  *****  12.a. A Trip Slip document related to a justice-involved patient, Patient 15, reflected the patient was transported to "[Salem Hospital] imaging" in a hospital vehicle with Employees 4 and 5 on 07/20/2023. It included the following: * "Off Grounds" trip. * "Trip Departure Time: 10:32." * "Priv [sic] Level ... No Privileg[sic]." * "Staff Accompanying" followed by two staff names, Employees 4 and 5. * "Transportation: State Van/Car." * "Return Time: 11:49" with no return date. There was no documentation that reflected an "approved" vehicle was used for transport. There was no information on the Trip Slip that reflected who applied STRs on the patient. There was no information on the Trip Slip that reflected what sally port was used for departure and arrival.  12.b. During interview and review of Trip Slip documentation and review of Employee 4 and 5's education/training records with DQM and other hospital staff on 09/21/2023 beginning at 1620, hospital staff provided the following information: * On 07/20/2023, Employees 4 and 5 transported a justice-involved patient, Patient 15 to Salem Hospital imaging department for "pre-planned" medical services by secure transport with STRs. * The staff confirmed the lack of training/education in findings 12.c. and 12.d. below.	A 144			

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NAME OF PROVIDER OR SUPPLIER  <b>OREGON STATE HOSPITAL DISTINCT PART</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2600 CENTER STREET NE</b> <b>SALEM, OR 97301</b>		
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A 144	<p>Continued From page 40</p> <p>12.c. Regarding Employee 4, TMHA with hire date 12/10/2012, similar to examples in findings 9.c. and 9.d., training/education records failed to address secure transport of justice-involved patients by hospital staff to other facilities, including steps to prevent elopement. * Employee 4's training/education records reflected they had completed a training titled "Patient Movement Outside the Secure Perimeter" on 06/16/2022. However, this training did not address secure transport of justice-involved patients by hospital staff to other facilities, including clear and comprehensive steps to prevent elopement. * Additionally, Employee 4's education/training records contained no documentation of required education/training titled "On the Job Training Transport" and no documentation of education/training related to Patient's Rights.</p> <p>12.d. Regarding Employee 5, MHST with hire date 06/09/2014, similar to examples in findings 9.c. and 9.d., training/education records failed to address secure transport of justice-involved patients by hospital staff to other facilities, including steps to prevent elopement. * Employee 5's training/education records reflected they had completed a training titled "Patient Movement Outside the Secure Perimeter" on 06/16/2022. However, this training did not address secure transport of justice-involved patients by hospital staff to other facilities, including clear and comprehensive steps to prevent elopement. * Additionally, Employee 5's education/training records contained no documentation of education/training related to Patient's Rights.</p> <p>*****</p>	A 144			

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NAME OF PROVIDER OR SUPPLIER  <b>OREGON STATE HOSPITAL DISTINCT PART</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2600 CENTER STREET NE SALEM, OR 97301</b>		
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A 144	<p>Continued From page 41</p> <p>13.a. A Trip Slip document related to a justice-involved patient, Patient 10, reflected the patient was transported to "Salem ER" on 08/11/2023. It included the following:</p> <ul style="list-style-type: none"> <li>* "Off Grounds" trip.</li> <li>* "Trip Departure Time: 16:40."</li> <li>* "Priv [sic] Level ... No Privileg [sic]."</li> <li>* "Staff Accompanying" followed by two staff names, Employee 7 and one other staff.</li> <li>* "Transportation: State Van/Car."</li> <li>* "Return Time: 1:04" with no return date.</li> </ul> <p>There was no documentation that reflected an "approved" vehicle was used for transport. There was no information on the Trip Slip that reflected who applied STRs on the patient. There was no information on the Trip Slip that reflected what sally port was used for departure and arrival.</p> <p>13.b. During interview and review of Trip Slip documentation and Employee 7's education/training records with DQM and other hospital staff on 09/21/2023 beginning at 1620, hospital staff provided the following information:</p> <ul style="list-style-type: none"> <li>* On 08/11/2023, Employee 7 and another staff transported a justice-involved patient, Patient 10, to "Salem ER" for "emergent" medical services by secure transport with STRs.</li> <li>* The staff confirmed the lack of training/education in finding 13.c. below.</li> </ul> <p>13.c. Regarding Employee 7, MHST with hire date 02/29/2016, similar to examples in findings 9.c. and 9.d., training/education records failed to address secure transport of justice-involved patients by hospital staff to other facilities that included clear and comprehensive steps to prevent elopement.</p>	A 144			

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A 144	<p>Continued From page 42</p> <ul style="list-style-type: none"> <li>* Employee 7's training/education records reflected they had completed a training titled "Patient Movement Outside the Secure Perimeter" on 06/23/2022. However, this training did not address secure transport of justice-involved patients by hospital staff to other facilities, including clear and comprehensive steps to prevent elopement.</li> <li>* Additionally, Employee 7's education/training records contained no documentation of required education/training titled "On the Job Training Transport" and no documentation of education/training related to Patient's Rights.</li> </ul> <p>*****</p> <p>14.a. A Trip Slip document related to Patient 11's elopement incident on 08/30/2023 was reviewed. The document reflected the patient was transported to Salem Hospital ED in a hospital vehicle on 08/30/2023 and included the following:</p> <ul style="list-style-type: none"> <li>* "Purpose: "Emergency Trip - laceration"</li> <li>* No documentation of trip departure time.</li> <li>* "Priv [sic] Level ... No Privile [sic]."</li> <li>* "Escorting Staff:" followed by a blank space.</li> <li>* "Trip Staff" followed by one staff name, Employee 8.</li> <li>* "Staff Contact on Trip:" followed by one staff name, Employee 8.</li> <li>* "Transportation: State Van/Car."</li> <li>* "Trip Comment:" followed by a blank space.</li> <li>* No documentation of trip return date or time.</li> </ul> <p>The Trip Slip reflected "Trip Staff" and "Staff Contact" as the name of one staff. According to the Trip Slip documentation, only one staff transported the patient. However, refer to finding 2 that reflects Employees 8 and 11 transported the patient.</p> <p>There was no documentation that reflected an</p>	A 144			

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A 144	<p>Continued From page 43</p> <p>"approved" vehicle was used for transport. There was no information on the Trip Slip that reflected who applied STRs on the patient. There was no information on the Trip Slip that reflected what sally port was used for departure and arrival.</p> <p>14.b. During interview and review of Trip Slip documentation and Employee 8 and 11's education/training records with DQM and other hospital staff on 09/20/2023 at 1540 and 09/21/2023 at 1620, hospital staff provided the following information:                      * Employee 8 was the driver in the transport vehicle during the elopement incident involving Patient 11 on 08/30/2023.                      * Employee 11 was the front seat passenger in the transport vehicle during the elopement incident involving Patient 11 on 08/30/2023.                      * The staff confirmed the lack of training/education in findings 14.c and 14.d. below.</p> <p>14.c. Regarding Employees 8, MHST with hire date 03/20/2017, similar to examples in findings 9.c. and 9.d., training/education records failed to address secure transport of justice-involved patients by hospital staff to other facilities, including clear and comprehensive steps to prevent elopement.                      * Employee 8's records reflected they had reviewed and read "Medical Transport," Protocol 3.006 on 08/11/2020. However, this protocol primarily addressed various commitment types and reception center processes, and did not address secure transport of justice-involved patients by hospital staff, including clear and comprehensive steps to prevent elopement.                      * Additionally, Employee 8's education/training</p>	A 144			

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A 144	Continued From page 44 records contained no documentation of education/training related to Patient's Rights.  14.d. During interview on 09/14/2023 at 2100, Employee 8 confirmed they were the vehicle driver in the elopement incident involving Patient 11 on 08/30/2023. Employee 8 provided the following additional information: * They confirmed the information in finding 2. * They did not normally work "in transportation" and the incident involving Patient 11 was the first time they had transported a patient in a hospital vehicle. * They applied STRs on the patient before departing to Salem Hospital ED, and STRs remained in place for the duration of the Salem Hospital ED encounter and return transport to the hospital. * At least two staff should accompany a patient during transport but "it was possible there should be more than two because the policy says at least two." * They were not sure where in the vehicle the patient should sit. Patient 11 sat in the "middle" row seat directly behind the front passenger seat. They assisted the patient with getting in and out of the vehicle. They would not be able to assist the patient with sitting in one of the rear row seats because "I would have to crawl on my hands and knees to reach the patient." * They stated they did not know if the vehicle doors were locked during transport of Patient 11, and they did not know if vehicle doors were supposed to be locked during transport of patients. * They did not know if any first aid supplies were in the vehicle. * They confirmed they had not been trained regarding what to do if a patient's behaviors	A 144			



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A 144	<p>Continued From page 45</p> <p>escalated during transport, including when a vehicle is in motion.</p> <p>* Sally port 2, 5, 8, or 9 could be used for patient departures/arrivals, "whichever is closest to the [patient's] unit."</p> <p>14.e. Regarding Employees 11, MHT with hire date 07/11/2022, similar to examples in findings 9.c. and 9.d., training/education records failed to address secure transport of justice-involved patients by hospital staff to other facilities, including clear and comprehensive steps to prevent elopement.</p> <p>* Employee 11's training/education records reflected they had completed "Patient Movement Outside the Secure Perimeter" training on 12/30/2022. However, this training did not address secure transport of justice-involved patients by hospital staff to other facilities, including clear and comprehensive steps to prevent elopement.</p> <p>14.f. During interview on 09/15/2023 at 0715, Employee 11 confirmed they were the vehicle passenger during the elopement incident involving Patient 11 on 08/30/2023. Employee 11 provided the following additional information:</p> <p>* The incident involving Patient 11 was the first time they had transported a patient in a hospital vehicle.</p> <p>* Employee 11 was asked if, prior to the incident involving Patient 11, the hospital had provided them training related to their responsibilities when transporting justice-involved patients in hospital vehicles. Employee 11 stated, "No. Not at all."</p> <p>*****</p> <p>15.a. A Trip Slip document related to a</p>	A 144			

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A 144	<p>Continued From page 46</p> <p>justice-involved patient, Patient 17, reflected the patient was transported to "Salem ER" on 07/24/2023. It included the following:</p> <ul style="list-style-type: none"> <li>* "Off Grounds" trip.</li> <li>* "Trip Departure Time: 16:49."</li> <li>* "Priv Level [sic]... No Privileg [sic]."</li> <li>* "Staff Accompanying" followed by two staff names, Employees 9 and 10.</li> <li>* "Transportation: State Van/Car."</li> <li>* "Return Time: 19:08" with no return date.</li> </ul> <p>There was no documentation that reflected an "approved" vehicle was used for transport. There was no information on the Trip Slip that reflected who applied STRs on the patient. There was no information on the Trip Slip that reflected what sally port was used for departure and arrival.</p> <p>15.b. During interview and review of Trip Slip documentation and Employee 9 and 10's education/training records with DQM and other hospital staff on 09/21/2023 beginning at 1620, hospital staff provided the following information:</p> <ul style="list-style-type: none"> <li>* On 07/24/2023, Employees 9 and 10 transported a justice-involved patient, Patient 17, to "Salem ER" for "emergent" medical services by secure transport with STRs.</li> <li>* Employee 9 was not authorized to apply STRs.</li> <li>* The staff confirmed the lack of training/education in finding 15.c. below.</li> </ul> <p>15.c. Regarding Employee 9, MH RN with hire date 04/06/2020, similar to examples in findings 9.c. and 9.d., training/education records failed to address secure transport of justice-involved patients by hospital staff to other facilities, including clear and comprehensive steps to prevent elopement.</p> <ul style="list-style-type: none"> <li>* Employee 9's training/education records</li> </ul>	A 144			

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A 144	<p>Continued From page 47</p> <p>reflected they had completed training titled "Patient Movement Outside the Secure Perimeter" on 06/20/2022. However, this training did not address secure transport of justice-involved patients by hospital staff to other facilities for outside medical care, including clear and comprehensive steps to prevent elopement.</p> <p>15.d. Refer to findings 16.c. and 16.d. below regarding Employee 10's lack of training/education.</p> <p>*****</p> <p>16.a. A Trip Slip document related to a justice-involved patient, Patient 16, reflected the patient was transported to Salem Hospital on 08/10/2023. It included the following:            * "Off Grounds" trip.            * "Trip Departure Time: 19:00."            * "Priv Level [sic] ... No Privileg [sic]."            * "Staff Accompanying" followed by one staff name, Employee 10.            * "Transportation: State Van/Car."            * "Return Time: 16:20" with no return date.            There was no documentation that reflected an "approved" vehicle was used for transport.            There was no information on the Trip Slip that reflected who applied STRs on the patient.            There was no information on the Trip Slip that reflected what sally port was used for departure and arrival.</p> <p>16.b. Review of a "Staff Hourly Assignment" document dated 08/10/2023 "Swing Shift" reflected "[Emergency] Room" from 1900 - 2200 with Patient 16's initials in a column next to the name of a staff member who was not Employee 10.</p>	A 144			

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A 144	<p>Continued From page 48</p> <p>The Trip Slip documentation reflected "Trip Staff" was Employee 10 and the "Staff Hourly Assignment" document suggested another staff member went on the trip. It was not clear which and how many hospital staff transported the patient.</p> <p>16.c. During interview and review of Trip Slip documentation with DQM and other hospital staff on 09/21/2023 beginning at 1620, hospital staff provided the following information: * On 08/10/2023, Employee 10 and another staff member transported a justice-involved patient, Patient 16, to Salem Hospital for "emergent" medical services by secure transport with STRs. * The staff confirmed the documentation regarding transport staff was not clear. * The staff confirmed Employee 10's lack of training/education in finding 16.d. below.</p> <p>16.d. Regarding Employee 10, MHST with hire date 06/06/2022, similar to examples in findings 9.c. and 9.d., training/education records failed to address secure transport of justice-involved patients by hospital staff to other facilities, including steps to prevent elopement. * Employee 10's training/education records reflected they had completed a training titled "Patient Movement Outside the Secure Perimeter." However, this training did not address secure transport of justice-involved patients by hospital staff to other facilities for outside medical care, including clear and comprehensive steps to prevent elopement.</p> <p>17.a. During interview with the DS and other hospital staff on 09/13/2023 at 1240, they stated STRs applied by hospital staff, including application, monitoring, and potential</p>	A 144			

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A 144	<p>Continued From page 49</p> <p>complications, would be documented as follows:</p> <ul style="list-style-type: none"> <li>* On "Trips Slips." However, refer to finding 17.b. that reflects, "trip slips were not required for emergent medical outings."</li> <li>* On incident reports for any "incidents" involving STRs.</li> <li>* There would be no documentation in medical records.</li> </ul> <p>Due to the lack of documentation, there was no assurance STRs applied by and under supervision of hospital staff, were appropriately and safely managed and monitored.</p> <p>17.b. In email from the DQM dated 09/19/2023 at 1010, they provided the following information regarding Trip Slip documentation and secure transport of justice-involved patients by hospital staff:</p> <ul style="list-style-type: none"> <li>* Regarding hospital staff responsible for monitoring patients for potential complications related to STRs, the email reflected, "This responsibility falls with the Security Department Staff assigned to the trip. These staff names are typically listed on the trip slips, although ... trip slips are not required for emergent trips."</li> <li>* Regarding hospital departure and arrival locations at the hospital, the email reflected, "This information is not captured in our current documentation system ... several sally ports have been used for pickup [sic] and return from secure trips."</li> <li>* Regarding vehicles used for pick-up and return to hospital, the email reflected, "This information is not captured in our current documentation system. For most secure medical transports [an] OSH Dodge minivan is used."</li> <li>* Regarding hospital locations where staff applied STRs, the email reflected, "This information is not captured in our current documentation system ...</li> </ul>	A 144			

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A 144	<p>Continued From page 50</p> <p>most typically STRs are applied within the secure perimeter, directly outside of the sally port being used to exit."</p> <p>* Regarding the date and time STRs were applied by staff, the email reflected, "We do not have this specific information."</p> <p>* Regarding identifying names and titles of who applied STRs, the email reflected, "This information is not captured in our current documentation system. In the case of pre-scheduled trips, one of the two staff listed on the trip slip (both are Security Department Staff) is the person to apply the STRs. For emergent trips, there are cases where STRs are applied by a member of Security who is not assigned to the trip, but who is helping to prepare the patient to quickly depart."</p> <p>*****</p> <p>Following are findings related to failure to prevent non-justice-involved patients who did not require transport with STRs, from having STRs applied by hospital staff and incurring injuries:</p> <p>18.a. Incident documentation regarding Patient 9 reflected that, on 08/14/2023 at 0730, "We got to [Patient 9's] room [at Salem Hospital] ... [they were] agitated and [upset] and confused. I noticed that [they were] in full STRs ... I thought [they] usually [go to their] appointments with no STRs. But maybe something changed? with [their] privileges ... [MST] checked [their] privilege level, and we [saw they] had 2:1 [for] outside medical ... When I got to Salem hospital the [Salem Hospital] RN ... and I made a plan on how we were going to approach on taking the [STRs] off ... [patient] was confused and agitated, [they were] laying up right about 45 degrees on the</p>	A 144			

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A 144	<p>Continued From page 51</p> <p>hospital bed, [they were] naked ... [They] had a urinal and [were] trying to pee which [they weren't] able to, [they] tried to throw the urinal at me ... After talking with [patient] and explaining [that] we were going to take the [STRs] off [they started] to calm down ... I started taking off the [lower STRs] on [patient's] legs, they were on too tight they left red marks on both legs. Then I took the upper [STRs] off, both the arm [cuffs] were on too tight, they also had red marks. I unlocked the pad lock on [their] side [Patient] couldn't sit up 90 degrees [due] to abdominal pain. So we slowly and gently took them off from one side to the other side, from what I was able to see there was a little redness but around [their] waist was loose." Incident review documentation reflected, "[Patient] was at Salem hospital for treatment. During this time it was noted that [they] had STRs applied when [they] had privileges 2:1 ... Misinformation was given. The [patient's] privilege level was not physically confirmed ... The transporting security staff ... was given the wrong information regarding [patient's] privileges ... this information came from Reception Center staff ... as well as [unit staff]. Both had stated that the patient did not have privileges and the need for [STRs]."</p> <p>18.b. Review of Trip Slip documentation related to Patient 9 reflected the patient was transported to Salem Hospital ED on 08/13/2023. It included the following: * "Off Grounds" trip. * "Trip Departure Time: 13:04." * "Priv [sic] Level ... No Privileg [sic]."</p> <p>18.c. An email received on 10/05/2023 at 0936 from hospital staff reflected that the patient was transported from the hospital to Salem Hospital</p>	A 144			

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A 144	<p>Continued From page 52</p> <p>on 08/13/2023 at 1304 and that two MHSTs "placed the restraints on the patient ... trip was taken by ambulance [EMS]. The [EMS] medics came to the unit/patient room. The STR's [sic] were placed on the patient in [patient's] room prior to the departure ..."</p> <p>18.d. The medical record for Patient 9 was reviewed and reflected the patient was admitted to the hospital on 06/10/2022 with diagnoses that included major neurocognitive disorder and bipolar disorder.</p> <p>* An RN note dated 07/29/2023 at 1807 reflected, "... [Patient] has 2:1 [privileges] for medical ..."</p> <p>* On 08/13/2023 the patient had "coffee ground emesis," had SaO2 of 89%, and was transported to Salem Hospital for medical treatment.</p> <p>* The patient returned to the hospital on 08/14/2023, experienced confusion, and was transported back to Salem Hospital later that same day.</p> <p>* The patient returned to the hospital on 08/17/2023 at 1440.</p> <p>* There was no documentation that the RN assessed the patient's legs, arms and waist "red marks" and "redness" upon the patient's return to the hospital, either on 08/14/2023, 08/17/2023 or thereafter. This was confirmed in an email received from hospital staff on 10/04/2023 at 1659.</p> <p>18.e. During interview and review of the medical record and incident documentation involving Patient 9 with DQM and other hospital staff on 09/22/2023 at 1030, the following information was provided:</p> <p>* On 08/13/2023, hospital security staff applied STRs on the patient and the patient was transported to Salem Hospital for treatment of</p>	A 144			



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A 144	<p>Continued From page 53</p> <p>coffee ground emesis.</p> <p>* The patient had "2:1 privileges" for medical outings, which meant two OSH staff should go with the patient during transport to and from Salem Hospital and stay with the patient for the duration of their Salem Hospital encounter. It also meant the patient was not a justice-involved patient and did not require STRs for transport.</p> <p>* After transport to Salem Hospital, it was discovered STRs should not have been applied to the patient. A hospital staff then went to Salem Hospital and removed the STRs. Upon removal, the STRs were noted to be "too tight" and had left "red marks" and "redness" on the patient's arms, legs and waist.</p> <p>* The patient was discharged from Salem Hospital and transported back to the hospital on 08/14/2023.</p> <p>* After return to the hospital, on 08/14/2023, the patient was noted to be confused and was transported back to Salem Hospital. The patient was discharged from Salem Hospital and transported back to the hospital on 08/17/2023.</p> <p>*****</p> <p>Following are findings related to failures to ensure STRs applied by hospital staff for secure transport of justice-involved patients were maintained in accordance with manufacturer's IFUs.</p> <p>19.a. During tour of sally ports 8 and 9 with the DS and SMS on 09/12/2023 beginning at 1555, observations included:</p> <p>* A locked, wall-mounted cabinet labeled "Transport/Security Use Only" inside the building near sally ports 8 and 9. The cabinet was opened and two sets of STRs were observed. Each set</p>	A 144			

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A 144	<p>Continued From page 54</p> <p>consisted of two metal handcuffs connected with a chain, two metal ankle cuffs connected with a metal chain, and a metal waist chain with an attached pad lock. A yellow highlighter and a small zip lock plastic baggie containing two black handcuff "helpers" was also observed in the cabinet. The outside of the plastic baggie had "Handcuff Helper" printed on it and manufacturer "Installation" instructions that read, "Open handcuff and place hook portion of Helper [at] hinge point. Push Helper onto handcuff locking arm and lock into place. Made in USA by Zak Tool www.zaktool.com."</p> <p>19.b. During a tour of sally ports 8 and 9 with the DQM, SMS and other hospital staff on 09/28/2023 beginning at 1250, observations included:</p> <p>* A wall mounted cabinet similar to the cabinet in finding 19.a. near the entry door to sally port 9. The cabinet was opened and labels were observed affixed to the inside of the cabinet that read, "Standard Belly Chains ... Standard Shackles 4 Sets ... Large Belly Chains 2 Sets ... Handcuff Reducers 4 Sets." STRs, a metal detector wand, a baggie with one set of handcuff reducers, and a beige-colored fabric drawstring bag were observed inside the cabinet. The fabric bag had approximately 20 round, rust-colored stains that looked like liquid had splattered or spilled on or inside the bag. During interview at the time of the observation, the SMS stated the fabric bag was used for "carrying STRs around discretely." Refer to the manufacturer IFUs in findings 19.e. that reflects, "... one or more of the following issues may mean the restraint will not function or perform properly ... Signs of rust ... Keep the ratchet and key hole free of dirt, lint or other foreign substances which may hinder</p>	A 144			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>384008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/05/2023</b>
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A 144	<p>Continued From page 55 proper functioning."</p> <p>19.c. During interview on 09/21/2023 at 1445 with DQM and DSC, they stated they did not think the hospital had any P&amp;Ps that addressed inventory and PM of STRs and those had not been done "since at least February [2023]."</p> <p>19.d. In an email received on 10/02/2023 at 1252, hospital staff confirmed there was no inventory of the hospital's STRs and no documentation of PM in accordance with manufacturer's IFUs. The email reflected, "... staff are in the process of conducting an [STR] inventory, and this is not completed ... We are not aware of the specific manufacturer of our [STRs], although some appear to be from a company called 'Peerless'. No paperwork exists that we are aware of related to instructions for use ... we do not have instructions about preventative or initial maintenance ... The OSH Security Department will need to determine the manufacturer of the STRs in use at OSH and then reach out to the one (or more) manufacturers to see if this information can be obtained ..."</p> <p>19.e. Manufacturer IFU manuals for "Peerless" STRs provided by hospital staff on 10/02/2023 at 1444, were reviewed and included: * A "Peerless Handcuff Company Chain Link Handcuff Instruction Manual," dated "2/2015," that contained the following detailed IFUs: - "Use of this equipment may be inherently dangerous ... Before using this equipment you must ... Read and understand all instructions for use ... Get specific training for use. Become acquainted with its capabilities and limitations ... Understand and accept the risks involved ... Failure to understand any of these warnings may</p>	A 144			

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A 144	Continued From page 56 result in injury to you and others." - "... WARNING, specific training in the activities defined in the field of application is essential before use. This product must only be used by competent and adequately trained individuals ... You should become acquainted with its capabilities and limitations ... If you are not able, or not in a position to assume this responsibility or to take this risk, do not use this equipment." - "Restraints should be inspected regularly. A periodic in-depth inspection should be conducted. The frequency of the inspection should be governed by the type and the intensity of use. To keep better track of equipment history it is preferable to assign a single restraint or multiple sets of restraints to a unique user." * "Visual Inspection ... Some problems can be detected by close visual inspection of the restraint. Finding one or more of the following issues may mean the restraint will not function or perform properly ... Single Strand is bent or not aligned properly ... Worn or damaged Single Strand teeth ... Double Strand are pinched closed or spread open ... Signs of rust at Single Strand rivet, Double Lock hole or in lock area ... Broken or missing lock parts ... Key Post Missing ... Foreign object seen in the Key Hole ... Swivel is bent ... Links between cuffs are bent or broken ..." - "Function Check of the Lock ... To test for possible ratcheting and lock related issues conduct the following steps ... 1. Check Single Strand Action ... 2. Check Double Lock at Large Range ... 3. Un-Double Lock the restraint. Re-check the Single Strand Action as above. 4. Check Double Lock at Mid Range ... 5. Un-Double Lock the restraint. Re-check the Single Strand Action as above. 6. Check Double Lock at Small Range ... 7. Repeat steps 1 thru 6 on other half of the restraint."	A 144			

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A 144	Continued From page 57 - "Standard Operating Procedures ... It is recommended that periodic checks be made of the subject's hands and wrists to avoid soft tissue or nerve damage ... A handcuffed subject should be considered a threat. The restrained subject should be kept under observation ... This device is not designed to be fully pick proof, shim proof or tamper resistant. It is recommended that periodic checks of the restraint be made to ensure it is secured as intended ... Store the handcuffs in the 'loaded' position by pushing the single strand through the ratchet until the last click (the tip of the single strand will extend above the double strand) ... Make sure the double lock is not engaged. Two keys are provided. Carry both keys at all times. One should be readily available for the removal of the handcuffs, the other concealed on your person for emergency use ... Whenever possible handcuff the subject with the hands behind the back. If the subject is injured or has a physical disability handcuffing behind the back may not be possible or should be avoided. After both wrists are secured, immediately double lock the handcuffs. This will prevent over tightening and make picking the locks more difficult. Properly adjusted, they should fit snugly and securely. Check that the skin is not pinched. Over tightening can cause soft tissue and/or nerve damage. Perform periodic checks to insure the individual's hands are in good condition and to deter any possible escape. Never handcuff a subject to yourself, to a fixed object, or to a vehicle. Removing handcuffs can present as many possible safety threats as applying them. It is important to follow a handcuff removal procedure ... Having other law enforcement personnel present is highly recommended." - "Care and Maintenance ... Use only approved	A 144			

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A 144	Continued From page 58 restraining procedures such as the guidelines in this manual. Frequent review and practice of proper procedures will increase your safety and efficiency. Approved procedures will also help to ensure your restraints continue to function properly ... avoid dropping onto or banging against hard surfaces ... If exposed to moisture dry thoroughly. Most importantly, dry the inside locking mechanisms. The cuffs can be dried in an oven at low temperature (below 300° Fahrenheit) or placed on a heater. Re-oil following the instructions ... When unlocking your restraint be careful not to over torque the key guide post. This will loosen the post causing it to fall out. Also, be careful not to over rotate the key causing the key flag to break off or become stuck in the locking mechanism. Use extra caution when using oversize keys. More information available at <a href="http://www.peerless.net">www.peerless.net</a> . - "Maintenance - Restraints should receive regular care and maintenance. Inspect them frequently. Keep the ratchet and key hole free of dirt, lint or other foreign substances which may hinder proper functioning. Routinely clean and lubricate using quality light weight oils. Apply liberally making sure the oil has worked into the locking mechanism, double lock hole and single strand pivot area. After lubricating remove all excess oil from handling surfaces so the restraints are not slippery. Black oxide finishes may require more frequent lubrication and may tend to rust if subjected to moisture and/or not kept properly oiled ... WARNING: Care should be taken when using cleaning solvents and lubricants on Peerless High Security restraints. See <a href="http://www.peerless.net">www.peerless.net</a> - FAQ question on care and maintenance of High Security restraints for more information." - The instruction manual also included detailed	A 144			

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A 144	<p>Continued From page 59</p> <p>instructions regarding: "General Information" "Standard Handcuff Procedures" "Unlocking Handcuffs" "Storage" "Repairs" "Modifications" "Product Obsolescence" "When to Retire Your Equipment"</p> <p>* A "Peerless Handcuff Company Leg Iron Instruction Manual," dated "2/2015," contained similarly detailed IFUs to those found in the instruction manual for handcuffs above.</p> <p>- "Use of this equipment may be inherently dangerous ... Before using this equipment you must ... Read and understand all instructions for use ... Get specific training for use ... Become acquainted with its capabilities and limitations ... Understand and accept the risks involved. Failure to understand any of these warnings may result in injury to you and others."</p> <p>- "... WARNING - specific training in the activities defined in the field of application is essential before use. This product must only be used by competent and adequately trained individuals ... You should become acquainted with its capabilities and limitations ... If you are not able, or not in a position to assume this responsibility or to take this risk, do not use this equipment."</p> <p>- "Inspection ... Restraints should be inspected regularly. A periodic in-depth inspection should be conducted. The frequency of the inspection should be governed by the type and the intensity of use. To keep better track of equipment history it is preferable to assign a single restraint or multiple sets of restraints to a unique user."</p> <p>- "Visual Inspection ... problems can be detected by close visual inspection ... one or more of the</p>	A 144			

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A 144	<p>Continued From page 60</p> <p>following issues may mean the restraint will not function or perform properly ... Single Strand is bent or not aligned properly ... Worn or damaged Single Strand teeth ... Double Strand are pinched closed or spread open ... Signs of rust at Single Strand rivet, Double Lock hole or in lock area ... Broken or missing lock parts ... Key Post Missing ... Foreign object seen in the Key Hole ... Swivel is bent ... Links between cuffs are bent or broken ..."</p> <p>- The instruction manual also included instructions regarding: "General Information" "Field of Application" "Leg Iron Nomenclature" "Function Check of the Lock" "Standard Operating Procedures" "Basic Application Procedures" "Instructions for Unlocking Leg Irons" "Storage" "Care and Maintenance" "Repairs" "Modifications" "Product Obsolescence" "When to Retire Your Equipment"</p> <p>19.f. In an email received on 10/24/2023 at 1545, hospital staff confirmed the hospital had no P&amp;Ps that addressed STR PM. The email reflected that, at the time of the elopement incident involving Patient 11, "OSH did not have written protocols pertaining to STR preventive maintenance."</p> <p>*****</p> <p>Following are findings related to the hospital's failure to ensure staff responses to patient incidents included timely, clear and complete investigations to identify causes and to plan and</p>	A 144			



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 144	Continued From page 61 implement corrective actions:  20. Refer to the findings cited at Tag A145 under CFR 482.13(c) - Standard: Freedom from Abuse. Those findings reflect that the hospital failed to ensure staff responses to patient incidents included timely, clear and complete investigations to identify causes and to plan and implement corrective actions to prevent recurrence for the affected patients and others. Incidents included but were not limited to failure to prevent patients from entering unauthorized areas unsupervised; failure to ensure staff closed and locked secure doors; failure to prevent staff from applying STRs to patients when not required; elopement attempts; exit seeking behaviors; and security measures during transports.	A 144			
A 145	<b>PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT</b> 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 interviews, review of medical record and incident documentation for 9 of 11 patients (Patients 1, 2, 3, 4, 5, 7, 8, 9 and 10), review of staff education/training records for 8 of 11 staff (Employees 1, 2, 3, 4, 5, 6, 7, and 8), review of P&Ps, and review of other documentation, it was determined that the hospital failed to fully implement P&Ps to ensure each patient's right to be free from all forms of abuse and neglect. Identification of, investigations of, and response to incidents that reflected potential neglect that resulted in actual and potential patient harm, were not clear, complete, and timely to ensure	A 145			

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A 145	<p>Continued From page 62 those incidents and events did not recur.</p> <p>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."</p> <p>Further, the CMS Interpretive Guidelines reflect those components necessary for effective abuse protection include, but are not limited to:</p> <ul style="list-style-type: none"> <li>o Prevent.</li> <li>o Identify. The hospital creates and maintains a proactive approach to identify events and occurrences that may constitute or contribute to abuse and neglect.</li> <li>o Investigate. The hospital ensures, in a timely and thorough manner, objective investigation of all allegations of abuse, neglect or mistreatment.</li> <li>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.</li> </ul> <p>Findings include:</p> <p>1.a. The P&amp;P titled, "Incident Reporting," dated 12/15/2022 reflected, "OSH staff must accurately report incidents in accordance with this policy. In response, OSH must conduct thorough</p>	A 145			

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A 145	<p>Continued From page 63</p> <p>investigations, prepare reports showing the tracking and trending of data, and implement and monitor corrective actions ..."</p> <p>1.b. The P&amp;P titled, "Patient Abuse or Mistreatment Allegation reflected, "... abuse or mistreatment conduct is prohibited at OSH and includes, but not limited to ... abandonment ... withdrawal or neglect of duties and obligations owed a patient by staff ... physical harm to a patient caused by other than accidental means, self defense, or that appears to be at variance with the explanation given of the injury by staff ... willful infliction of physical pain or injury ... neglect ... verbal abuse or mistreatment ... condoning abuse or mistreatment ... financial exploitation ... involuntary seclusion of a patient for the convenience of the staff or to discipline the patient ... wrongful use of a physical restraint upon a patient ... Abuse and mistreatment allegations will be investigated by the Office of Training, Investigations, and Safety (OTIS). All categories of prohibited conduct allegations will be examined as part of the OTIS investigation ... Staff must report patient allegations of abuse or mistreatment as delineated in this policy and other applicable regulations."</p> <p>1.c. The P&amp;P titled, "Transportation and Activity Supervision," dated 11/17/2022 reflected, "Transporting Staff ... Visually verify that all doors and gates are latched closed and locked after entering or exiting an area ... All staff are responsible to maintain situational awareness for closure of secure doors ..."</p> <p>1.d. The P&amp;P titled, "Enhanced Supervision," dated 11/09/2017 reflected, "OSH also strives to provide all necessary care to patients ... which</p>	A 145			

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A 145	<p>Continued From page 64</p> <p>may include assigning staff to monitor a patient's comfort and/or wellbeing, to prevent unintentional harm, and to prevent interference with medically necessary devices or procedures ... The psychiatrist or psychiatric mental health nurse practitioner (PMHNP), using clinical input from other members of the interdisciplinary treatment team (IDT), must determine the type and level of enhanced supervision necessary to safeguard patients and staff ..."</p> <p>2.a. Incident documentation for Patient 1 reflected that, on 03/12/2023 at 0940, the patient entered a dining hall unsupervised through "secure" doors that were supposed to be locked, and accessed coffee. Incident review documentation reflected that this type of incident was "Secure Door left Unlocked/Open" and contributing factors included "... the door between Bridges treatment mall and the lower treatment mall was left unlocked during the treatment hours." Interventions and actions included only "Staff education" and "Staff should check the doors to make sure locked as indicated ... Program Director to follow-up ... to make sure Tx Mall staff are reminded about ensuring doors are locked."</p> <p>There was no further documentation of an investigation, to include:</p> <ul style="list-style-type: none"> <li>* How long the door was unlocked.</li> <li>* How long the patient was unsupervised in the dining room.</li> <li>* Whether the coffee the patient accessed was hot.</li> <li>* Whether the patient was harmed as a result of the incident.</li> <li>* Evaluation against P&amp;Ps, including door closure/locking and patient monitoring/supervision P&amp;Ps as applicable, to</li> </ul>	A 145			

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A 145	<p>Continued From page 65</p> <p>determine whether they were followed. * Additionally, it was not clear when staff "training" and "reminders" had occurred or were planned, and how reoccurrence of similar incidents would be prevented for this patient and other patients in the meantime.</p> <p>3.a. Incident documentation for Patient 2 reflected that on, 03/17/2023 at 1731, "... while on grounds [patient] tried to leave Junction City Hospital Campus without authorization ... Two staff ... on the walk called Access Control to report that [they] had a runner on Dreas Way ... Upon arrival [patient] was walking heading towards Milliron Road when Security Personnel made first initial contact with [patient] ... At approximately 1740 Security and [patient] arrived back at the Hospital. At approximately 1750 [patient] was assisted [to] the van and secured to a back board and Stryker Stretcher ... then transported on the stretcher to the [unit] [to] seclusion room where [patient] was secured to a restraint bed and placed on locked seclusion at approximately [sic] 1805 ... [MHST] reported that [they were] hit in the face by [patient] ..." Incident review documentation reflected that this type of incident was an "Unauthorized Leave/Significant Attempt" and "Physical Aggression to Staff ..." Contributing factors reflected, "Confirmed reports by staff that witnessed or were involved in the incident and documented incident. Patient also confirmed [their] actions." There was no further documentation of an investigation.</p> <p>3.b. Review of the medical record for Patient 2 reflected that the "[Patient] was on an on grounds walk when [patient] took off running ... Security arrived and [patient] started to swing at them hitting one security staff several times until they</p>	A 145			

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NAME OF PROVIDER OR SUPPLIER  <b>OREGON STATE HOSPITAL DISTINCT PART</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2600 CENTER STREET NE</b> <b>SALEM, OR 97301</b>		
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A 145	<p>Continued From page 66</p> <p>were able to take [patient] down to the ground, they then got [patient] onto a stretcher, transported [them] back to the hospital ..."</p> <p>3.c. During interview and review of the incident documentation with the MIRS and other hospital staff on 09/20/2023 beginning at 1200, the MIRS confirmed that although the incident occurred 6 months ago on 03/17/2023, the investigation was "still ongoing" and there was no further documentation of an investigation.</p> <p>4.a. Incident documentation for Patient 3 reflected that on, 04/02/2023 at 1720, "[Patient 3] had walked out the main unit exit doors and was walking the area in front of the elevators ... Presumably [patient] followed a staff member off of the unit or managed to reach the door and push on it before it had closed after a staff member had entered or exited the unit. We did not see which staff member this may have been ..." Incident review documentation reflected that this type of incident was an "Unauthorized Leave/Significant Attempt" and contributing factors included "major neurocognitive disorder. [Patient] regularly exit-seeks ..." Interventions and actions included "Patient Education ... Staff Education ... [Patient] was asked not to push on exit doors. However, due to [their] poor memory it is unlikely [they] will remember ... Staff are taking annual training on making sure doors are closed before walking off ... unknown for sure which staff left the unit that [patient] followed out ..."</p> <p>4.b. Review of the medical record for Patient 3 reflected that on, 04/01/2023 at 1942, "Patient was exit seeking around med pass time, pushing on the exit doors two separate times." There was no RN or other documentation in the medical</p>	A 145			

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A 145	<p>Continued From page 67 record regarding the incident on 04/02/2023.</p> <p>There was no documentation of an investigation that included:</p> <ul style="list-style-type: none"> <li>* How long the patient was off the unit.</li> <li>* Whether staff who entered and exited the doors around the time of the incident were interviewed to determine how the incident occurred.</li> <li>* Whether the door was checked to ensure it was functioning properly.</li> <li>* Whether the patient was harmed as result of the incident.</li> <li>* Evaluation of door closure/locking and supervision/monitoring P&amp;Ps to determine whether they were followed.</li> <li>* Additionally, it was not clear when "annual training" was scheduled, nor how reoccurrence of similar incidents would be prevented for this patient and other patients in the meantime.</li> </ul> <p>4.c. During interview and review of incident and medical record documentation with DQM and other hospital staff on 09/25/2023 at 1330, the staff stated "It looks like [Patient 3] may have followed a staff member off the unit." The staff confirmed there was no RN or other documentation in the medical record about the incident.</p> <p>5.a. Incident documentation for Patient 4 reflected that "On 05/11/2023 at about 1630 I was sent to Salem Hospital to relieve a Oregon State Hospital Transport employee ... [patient] was discharged from Salem Hospital so I moved the patient to a waiting room by the Emergency Room ambulance [sic] bay entrance. Once in the waiting room the patient stood up and approached the entry of the waiting room ... I then got picked up from the hospital by Oregon State Hospital</p>	A 145			

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A 145	<p>Continued From page 68</p> <p>security ... Once we were back on Oregon State Hospital grounds I [recommended] that we go into sally port 8. But we ultimatley [sic] approached sally port 7 with the patient, when access control told us we could not enter through sally port 7 with a patient. When we turned around to walk to sally port 9 the patient turned and started running slowly due to [their] ankle restraints on. I redirected [patient] ... We then [entered] sally port 9, removed the restraints from the patient. I then escorted the patient back to [unit] ..." Incident review documentation reflected that this type of incident was "Other: Perceived Exit Seeking Behavior." The only follow up action was "Patient Education."</p> <p>There was no documentation of an investigation, to include:</p> <ul style="list-style-type: none"> <li>* Why staff approached sally port 7 after originally recommending sally port 8.</li> <li>* Why staff were told they could not enter sally port 7.</li> <li>* It was not clear which sally port(s) staff should have entered or were permitted to enter with this patient, nor why staff attempted to enter sally port 7 if it was not permitted.</li> <li>* Evaluation against transport departure/arrival P&amp;Ps to determine whether they were fully developed, implemented and followed during this incident.</li> <li>* The only follow up action was patient-specific and did not include an evaluation of possible staff actions or gaps in P&amp;Ps that may have contributed to the incident.</li> </ul> <p>Due to the lack of thorough investigation and follow-up actions, there was no assurance similar incidents would be prevented for this patient and other patients.</p>	A 145			



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A 145	<p>Continued From page 69</p> <p>6.a. Incident documentation for Patient 5 reflected that on, 05/12/2023 at 1030, "[Patient] was in line at treatment mall waiting for transport back to the unit. At 1145 [staff name] notice [sic] [patient] was no long [sic] in line and was not in the line of sight. [Staff name] went down the hall looking for [patient] ... [opened] the fitness room and [patient] was inside running on the treadmill ..." Incident review documentation reflected, "Patient was found in fitness room unsupervised ... door was left unlocked and patient has a history of checking for unlocked doors." Interventions and actions included "Patient Education ... Staff Education ... Discussed IR with mall manager ... and [they] will [follow up] with [their] staff ..."</p> <p>6.b. Review of the medical record for Patient 5 reflected:                      * On 05/12/2023 at 0726 "Staff providing ... three safety and five random checks, each hour ... Continue with Enhanced Supervision Close OBS ... RN will continue to monitor per TCP."                      * On 05/12/2023 at 1200 "During the end of group at 1045 ... [fitness room ] door did not latch all the way because of the air pressure ... the fitness room door [was] wide open with [patient] on the treadmill ... it looks like the door did not close all the way, so [patient] was able to open the door ..."                      * On 05/12/2023 at 1354 "[Patient] was at line to return to the unit from treatment mall in the 1000 hour. Moments later [patient] was not in line ... [Patient] was found in the fitness room unauthorized and unsupervised running on the treadmill."                      * On 05/12/2023 at 2017 "... OT note for 5/3/23: "Pt attempted to use the Tread mill. [Patient] was wearing [their] jacket and [their] pockets were over flowing with items such as magazines. [Patient] was not receptive to instructions on how</p>	A 145			

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A 145	<p>Continued From page 70</p> <p>to use the Treadmill. [Patient] was setting it too fast and then jumping off of it."</p> <p>There was no documentation of an investigation, to include:</p> <ul style="list-style-type: none"> <li>* Whether the patient's TCP of "Enhanced Supervision Close OBS" was followed.</li> <li>* Whether the patient was harmed as result of the incident, particularly with consideration of their recent unsafe behaviors when using the treadmill.</li> <li>* Evaluation against door closure/locking and patient supervision/monitoring P&amp;Ps in order to determine whether they were followed.</li> </ul> <p>Due to the lack of thorough investigation and follow-up actions, there was no assurance similar incidents would be prevented for this patient and other patients.</p> <p>7.a. Incident documentation for Patient 7 reflected that on, 06/27/2023 at 1130, the patient eloped off a unit after a psychologist believed the patient was a staff member. "Pt stated to the psychologist that [they were] a staff member, appeared dressed in normal clothing and was well spoken. After staff [let them] off the unit, [staff] realized [their] mistake and brought the pt back ..." Incident review documentation reflected that this type of incident was an "Unauthorized Leave/Significant Attempt" and contributing factors included "[Patient's] clothing appeared to be clean street clothing ... hygiene was good ... thought process was linear/goal oriented with a full affect (smiling) and great social skills. [Patient] was a new admit that unit psychologist had not met before. These factors contributed to the staff member believing that [patient] could be a staff ..." Interventions and actions included "[Patient] has had several incidents of exit seeking ... has required significant prompting ...</p>	A 145			

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A 145	<p>Continued From page 71 started emergency medications 6/30/2023 due to more exit seeking attempts ..."</p> <p>There was no documentation of an investigation, to include: * Evaluation of door closure, patient identification, or other P&amp;Ps, as applicable, to determine whether they were followed. * How long the patient was off the unit. In addition, follow-up actions were patient-specific and did not address potential staff actions. Due to the lack of thorough investigation and follow-up actions, there was no assurance similar incidents would be prevented for this patient and other patients.</p> <p>8.a. Incident documentation for Patient 8 reflected that on, 06/30/2023 at 1430, "... [Patient 8] was found alone in the laundry room ... Earlier today at 1100 a Work order was placed due to the door being found to not be closing securely." Incident review documentation reflected, "Type of Incident ... Unattended/Wandering patient ... Work order was placed due to the door being found to not be closing securely ... Patient Education Provided ... Incident Debrief ... Staff education provided and work order placed."</p> <p>8.b. Review of the medical record of Patient 8 reflected there was no RN documentation related to this incident. This was confirmed on 09/25/2023 at 1325 during an interview and review of incident and medical record documentation with DQM and other hospital staff.</p> <p>There was no documentation of an investigation, to include: * When staff last saw the patient. * How long the patient was unattended in the</p>	A 145			

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A 145	<p>Continued From page 72 laundry room. * Outcome of the "Incident debrief." * Whether the patient was harmed as result of the incident. * How long the door was not closing securely and whether the work order was carried out and the door repaired. * Evaluation of patient monitoring/observation P&amp;Ps to determine whether staff followed those. * Evaluation of door closure P&amp;Ps to determine whether staff followed those, and whether P&amp;Ps described actions that should be taken to prevent patient access through doors to restricted areas while waiting for door repairs. Due to the lack of thorough investigation and follow-up actions, there was no assurance similar incidents would be prevented for this patient and other patients.</p> <p>9.a. Incident documentation for Patient 9 reflected that on, 08/03/2023 at 0950, "[Patient] was walking out from the Personal Belonging's [sic] room ..." Incident review documentation reflected the type of incident was "Secure Door left Unlocked/Open ... Property door may not have latched properly or [patient] pushed it hard enough to release the magnetic latch ..." Interventions and actions reflected only "Door was secured following instance and checked for latch not securing. Medication changes ... lab levels monitored to make sure that [patient] is taking [their] medications and not diverting meds. [Patient] has agreed to 'work on my manners.'"</p> <p>There was no documentation of an investigation, to include: * The outcome of the door check "for latch not securing." * Evaluation of door closure/locking P&amp;Ps to</p>	A 145			

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A 145	<p>Continued From page 73</p> <p>determine whether staff followed those.</p> <p>* Follow up regarding whether the patient did or did not push the door "hard enough to release the magnetic latch" and, if so, what follow up actions were indicated.</p> <p>* How long the patient was in the Personal Belongings room.</p> <p>* Whether the patient was harmed as result of the incident.</p> <p>Due to the lack of thorough investigation and follow-up actions, there was no assurance similar incidents would be prevented for this patient and other patients.</p> <p>9.b. Review of the medical record of Patient 9 reflected:</p> <p>*An RN note dated 08/03/2023 at 1823 reflected "Pt continues to [be] very labile ... is very on edge ... Many near altercations ... PRN Quetiapine offered at 1033, but [they] refused ..." The record contained no RN documentation of the incident involving the patient in the Personal Belongings room, including no RN assessment of the patient's behaviors preceding the incident or assessment of the patient after the incident, including behaviors and assessment for injuries.</p> <p>9.c. During interview and review of incident and medical record documentation with DQM and other hospital staff on 09/25/2023 at 1410, the staff stated Patient 9 gained access to a "secure, locked" personal belongings room; and confirmed there was no nurse documentation in the medical record related to this incident, including an RN assessment of patient behaviors preceding and after the incident and potential injuries.</p> <p>10. Refer to the findings cited at Tag A144 regarding Patient 9. Those findings reflected the</p>	A 145			

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A 145	<p>Continued From page 74</p> <p>hospital's failure to prevent Patient 9, a non-justice-involved patients who did not require STRs during transport, from having STRs applied by hospital staff on or around 08/14/2023 and incurring injuries. Similarly, the hospital failed to conduct a thorough investigation and follow-up actions to ensure similar incidents would be prevented for this patient and other patients.</p> <p>11.a. Incident documentation for Patient 10 reflected that on, 08/28/2023, "... at approximately 1004 I responded to a code blue ... for a medical emergency ... At approximately 1018 the ambulance arrived and was brought to the unit ... we knew STRs would be needed ... The ambulance departed at approximately 1034 and [staff] called ... at 1120 to inform [that] the patient had not been placed in STR'S [sic] ..." Incident review documentation reflected "The contributing factors for STR's [sic] not being placed on pt ... are a diffusion of responsibility and faulty assumptions ... Reception Center ... reported that [they] did not hear MHST lead ... mention anything about STR's [sic] ... [staff] believed STR's [sic] had already been placed on [patient], they were not. [Staff] was already in the Ambulance. When [staff] entered the ambulance, [they] assumed STR's [sic] had been placed on pt ... which they were not." The only actions taken were "Incident Debrief" and "Staff Education." There was no documentation of an investigation, to include:</p> <ul style="list-style-type: none"> <li>* Evaluation of secure transport and STR P&amp;Ps to determine whether staff followed those and whether P&amp;Ps clearly described staff responsibilities when involved in secure transport activities.</li> <li>* How long the patient was without STRs, and whether the patient or others were harmed as</li> </ul>	A 145			

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A 145	Continued From page 75 result of the incident. * The content of the education, who was educated, or when the education was conducted. Due to the lack of thorough investigation and follow-up actions, there was no assurance similar incidents would be prevented for this patient and other patients.  11.b. Review of the medical record of Patient 10 reflected: * An RN note dated 08/28/2023 at 1510 reflected "... [patient] ... [non-responsive] - Code Blue called ... EMS arrived on unit ... pt sent to Salem Hospital ER via 911 at 1025. Unit staff went with pt."  11.c. During interview and review of incident and medical record documentation with DQM and other hospital staff on 09/22/2023 at 1155, the staff stated Patient 10 was a justice-involved patient with commitment type GEI, had active personality disorder and violence towards others, and required secure transport with STRs during transport to other facilities for medical services. The staff confirmed STRs should have been applied to the patient prior to transport but were not.  12. Refer to the findings cited at Tag A144. Those findings reflected that education/training records for Employees 1, 2, 3, 4, 5, 6, 7 and 8 lacked documentation of education/training related to Patient's Rights.	A 145			
A 164	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(2)  Restraint or seclusion may only be used when	A 164			

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A 164	<p>Continued From page 76</p> <p>less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.</p> <p>This STANDARD is not met as evidenced by: Based on documentation in 1 of 1 medical record reviewed for restraint and seclusion (Patient 8) and review of P&amp;Ps, it was determined the hospital failed to develop and implement P&amp;Ps that ensured restraint and seclusion interventions were only used when less restrictive interventions had been attempted, were clearly documented and determined ineffective to protect the patient or others from harm in accordance with hospital P&amp;Ps.</p> <p>Findings include:</p> <p>1. The P&amp;P titled, "Seclusion and Restraints" dated 12/21/2020 reflected: * "If staff are concerned a situation may approach imminent danger of harm, the physician, NP, or RN must assess the situation and guide the team in the safest, most appropriate, least restrictive intervention to mitigate the risk of physical harm. This may include calling a Code Green to assure that sufficient staff are present to safely respond, if physical intervention is necessary." * "Before using an intervention, staff must evaluate ... the degree of the patient's trauma history ... the potential for psychological harm to the patient ..." * "Patients in seclusion or restraint must be continuously monitored." * "A patient's environment while in seclusion or restraint must be made as comfortable as reasonably possible (e.g., elevating the patient's head, providing a blanket or pillow)." * "Immediately after application of seclusion or</p>	A 164			



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>OREGON STATE HOSPITAL DISTINCT PART</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2600 CENTER STREET NE</b> <b>SALEM, OR 97301</b>		
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A 164	Continued From page 77 mechanical restraint, the RN must document on the Emergency Seclusion and Restraint Entry Note and the Emergency Seclusion or Restraint Flowsheet. Each form must be completed, filed, and routed as directed on the form ... Initial documentation must include a description of the patient's behavior and interventions used, and other less-restrictive interventions considered or attempted ... Documentation about an event must be promptly completed and include ... the patient's response to the intervention ... assessments and care provided ... the rationale and plan for continuing the restrictive intervention, as applicable ... the plan to reduce the intervention; and ... when or how the patient meets release criteria to discontinue the intervention." * Attachment B, "Restrictive Intervention Tasks Timeline," reflected "Restart this process whenever move to a more restrictive intervention" and included the following RN tasks: "During situation ... Assess for imminent risk of serious harm ... Consider less restrictive interventions ... Temporarily authorize intervention, if needed ... Monitor situation." * "Debrief, Reports ... Staff who were involved in the event must promptly debrief each event and use the information to prevent or reduce the need for such measures in the future ... Staff must attempt to debrief with the patient throughout the restrictive event. The debrief and debrief attempts must be documented on the 'Emergency Seclusion or Restraint Review' form ... After each episode of seclusion or mechanical restraint, at least two IDT members must review and consider modifying the patient's TCP interventions within five working days of the event (excluding weekends and holidays) ... If no changes are made, the IDT must document the justification for	A 164			

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A 164	<p>Continued From page 78</p> <p>not modifying the TCP on the 'IDT Review of Seclusion or Restraint Event' section of the 'Emergency Seclusion or Restraint Review' form ..."</p> <p>2. The medical record of Patient 8 reflected the patient was manually restrained, then placed in seclusion and 4-point restraints for over an hour from 1600-1705, and then was kept in seclusion for an additional 2 hours from 1705 until 1905. Documentation failed to clearly describe that less restrictive alternatives or interventions had been attempted prior to restraint and seclusion implementation. Examples included: * An RN note dated 09/11/2023 reflected that "Around 1555 pt stripped naked and was sitting on the floor at the TV room. [Patient] was talking gibberish and was not responding to verbal prompts or redirection. Code green was called as pt was not willing to walk to seclusion room or dress up. Restraint episode ensued and patient was escorted to the seclusion room and the door was locked. When security was restraining [patient] to the bed, pt was heard stating 'that's tight' and then [they] immediately went back to talking gibberish. [Patient] immediately asked to use the bathroom and a bed pan was offered. Pt was downgraded to seclusion at 1705 and released from seclusion room at 1905 ..." The RN documentation reflected: - There was no RN assessment of the patient to determine why the patient was talking gibberish and not responding, including potential medication or other causes. - It was not clear what was meant by "pt [was] not willing to ... dress up," and there was no RN documentation that reflected staff attempted to assist the patient with dressing or considered other privacy interventions. It was not clear why</p>	A 164			

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A 164	<p>Continued From page 79</p> <p>the patient was not "escorted" to their room or other private area instead of being "escorted" to a seclusion room.</p> <ul style="list-style-type: none"> <li>- There was no RN documentation that reflected less restrictive interventions were attempted after the initial "restraint episode ensued" and before placing the patient in seclusion; or after the patient was placed in seclusion and before restraining the patient to the bed with 4-point restraints.</li> <li>- When security was restraining the patient to the bed, the patient stated "that's tight." There was no documentation that reflected the RN assessed the patient at the time the patient was restrained to ensure the restraints were appropriately applied.</li> <li>- The patient "immediately asked to use the bathroom and a bed pan was offered." There was no RN documentation that reflected whether the patient used the "offered" bedpan, including an RN assessment of the patient's elimination needs with respect to their behaviors and continuation of restraints and seclusion at that time. The patient was not "downgraded" to seclusion until over an hour later, at 1705.</li> <li>- There was no RN documentation that reflected staff considered the degree of the patient's trauma history and potential for psychological harm before initiating restraint and seclusion in accordance with hospital P&amp;Ps.</li> <li>- There was no RN documentation that reflected the patient's environment was made as comfortable as reasonably possible in accordance with hospital P&amp;Ps, including consideration of their privacy and dignity while naked in 4-point restraints in a seclusion room.</li> </ul> <p>* A "Seclusion/Restraint" order dated 09/11/2023 and signed by a NP at 1605 reflected "Manual</p>	A 164			

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A 164	<p>Continued From page 80</p> <p>Restraint," "Seclusion," and "Mechanical Restraint" were initiated on 09/11/2023 at 1600 and "Authorized for up to ... 4 hours." The "Indication" for these was "Patient removed all clothing and would not be redirected in the milieu." There was no documentation of less restrictive interventions attempted.</p> <p>* An RN "Emergency Seclusion or Restraint Entry Note" dated 09/11/2023 at 1600 reflected that the type of restraints used were "Seclusion" and "Restraint" and "Objective Description of Patient Behavior Leading to Emergency Event" was "pt disrobed in milieu, not following staff redirection." The "Less Restrictive Methods Offered/Utilized: (check all that apply)" was followed by seven intervention choices of which two were checked, "PRN medications offered" and "Disengage/Back off/Give space." The documentation reflected the patient's response to the alternatives tried and rationale for more restrictive interventions was "incoherent speech pattern." The document reflected the patient was "released" from restraint and seclusion on 09/11/2023 at 1905. The RN documentation did not clearly reflect alternatives or less restrictive interventions were attempted and determined ineffective. For example, there was no documentation that reflected:</p> <ul style="list-style-type: none"> <li>- Which PRN medications were offered, including names, dosages, routes, indications, and an assessment of why those were considered appropriate to address the patient's behaviors and how they might reduce the need for restraint and/or seclusion.</li> <li>- When PRN medications were offered, including whether those were offered before manual restraint, before seclusion, before 4-point restraints, or all of those times.</li> </ul>	A 164			

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A 164	<p>Continued From page 81</p> <p>- How long, when, and where staff "attempted disengaging, backing off, and giving space." For example, it was not clear if those were attempted before manual restraint, before seclusion, before 4-point restraints, or all of those times.</p> <p>In addition, the medical record lacked documentation that reflected the RN assessed the patient for imminent risk of serious harm and considered less restrictive interventions before more restrictive interventions were initiated, per hospital P&amp;Ps. For example, the documentation reflected:</p> <p>- " ... pt disrobed in milieu, not following staff redirection." However, there was no RN assessment of the patient's risk for imminent harm when the patient was removed from the milieu and placed in seclusion that described why the patient needed the addition of 4-point restraints while in seclusion, and there was no documentation of alternatives or less restrictive interventions attempted and determined ineffective, including patient response, before addition of 4-point restraints.</p> <p>In addition, the note included an "Initial RN Assessment" of which the following sections were not completed as required by hospital P&amp;P: BP, Pulse, RR, Capillary Refill, Skin integrity, "Difficulties with respirations or speaking?", "Obvious signs of circulatory compromise?", "Obvious signs of injury or skin integrity issues?", and "Obvious signs of physical distress?" A box after "BP" was checked for "Unable to obtain." However, there was no explanation why a BP was unable to be obtained.</p> <p>* A NP Face-to-Face "Seclusion/Restraint Note" dated 09/11/2023 at 1650 reflected:</p> <p>- "Time of Face-To-Face Assessment: 1605"</p> <p>- "Restrictive Intervention Used: Manual restraint,</p>	A 164			

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A 164	<p>Continued From page 82</p> <p>mechanical restraint, seclusion." - "[Patient] completely disrobed in the milieu and would not be redirected. Staff attempted to cover [patient] with a blanket but [patient] ripped it off. [Patient] would not return to [their] room or put [their] clothing back on." - "[Patient] has a history of frequent disrobing in the milieu, resulting in seclusion." - "Assessment/Plan: [Patient] laying on the bed in the seclusion room completely disrobed and in four-point restraints. Danger to [themselves] as [peers] may show predatory behavior. Patient historically has been completely taking off clothes in the milieu frequently, sometimes daily. 1. Seclusion for up to four hours or until can demonstrate and verbalize safety. 2. RN to assess hourly per OSH protocol. 3. PRN medications if needed." The "plan" was unclear and did not include individualized, patient-specific interventions. For example, the plan included no further information regarding "PRN medications" including medication name, dose, route, and indication.</p> <p>The documentation was not clear related to alternatives or less restrictive interventions attempted. For example, although the documentation reflected the patient "would not be redirected ... staff attempted to cover the patient with a blanket ... [patient] would not return to their room or put clothing back on," it was not clear when and where those occurred. For example, it was not clear if those were attempted before manual restraint, before seclusion, before 4-point restraints, or all of those times.</p> <p>* An RN "Emergency Seclusion or Restraint Flowsheet" dated 09/11/2023 reflected: - At "1615 ... Agitation Scale ... 2 [Frequent mood swings, restless, pacing, is able to respond to</p>	A 164			

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A 164	Continued From page 83 limit setting] ... Agression [sic] Code ... 2 [Verbal threats or threatening postures] ..." and "Comments ... thrashing [illegible entries]." It was not clear which of these applied. It was not clear how the patient could be "pacing" while in 4-point restraints and why restraints and seclusion were continued if the patient was "able to respond to limit setting." In addition, some of the documentation was illegible. - At "1630 ... Agitation Scale ... 2 [Frequent mood swings, restless, pacing, is able to respond to limit setting] ... Agression [sic] Code ... 2 [Verbal threats or threatening postures] ..." and "Comments ... thrashing around." - At "1645 ... Agitation Scale ... 2 [Frequent mood swings, restless, pacing, is able to respond to limit setting] ... Agression [sic] Code ... 2 [Verbal threats or threatening postures] ... Elimination" and "Comments ... [illegible entries] bed pan, gibberish." Some of the documentation was illegible and there was no further assessment of elimination needs and possible impact on the patient's behaviors, or potential for less restrictive interventions. - At "1700 ... Agitation Scale ... 2 [Frequent mood swings, restless, pacing, is able to respond to limit setting] ... Agression [sic] Code ... 1 [Unpredictable, tense, irritable] ..." and "Comments ... naked in restraints." Directly below these timed entries reflected: - Untimed entry "Mental Status (mood & affect, behavior, verbalization/thought content): Clothes provided, pt agreeing to downgrade from restraints to seclusion, pt completely nude, responding to internal stimuli." - Untimed entry "Physical health/comfort: No s/s of distress or discomfort." It was not clear how this was determined considering the patient was described as "thrashing" and "thrashing around"	A 164			

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A 164	<p>Continued From page 84 at 1615 and 1630 above.</p> <ul style="list-style-type: none"> <li>- Untimed entry "Imminent harm to self/others? Yes ... Rationale: Unpredictable." It was not clear how "unpredictable" was rationale for imminent harm to self/others.</li> <li>- Untimed entry "Ready for release? ... No... Rationale ... Plan to downgrade from 4 point restraints to seclusion ..."</li> <li>- Untimed entry "Release criteria reviewed with patient? Yes ... Response: [illegible entry] a lot better [illegible entry] doing it."</li> <li>- At "1715 ... out of restraints."</li> </ul> <p>There was no RN documentation that reflected staff made the patient's environment as comfortable as reasonably possible with consideration of their privacy and dignity while naked and in 4-point restraints on a bed in a seclusion room.</p> <p>* An "Emergency Seclusion or Restraint Review" document signed by an RN and dated 09/11/2023 at 1605 reflected:</p> <ul style="list-style-type: none"> <li>- "Start time: 1600 End time: 1905"</li> <li>- "Briefly describe the event: disrobed in milieu, refusing all staff redirection"</li> <li>- "Are there any pre-existing medical conditions/disabilities/limitations/trauma that were considered?" This was followed by unchecked "Yes" and "No" boxes. There was no documentation that reflected the RN or other staff considered the degree of the patient's trauma history before initiating restraint and seclusion in accordance with hospital P&amp;Ps.</li> <li>- The "Patient Debrief With Staff" section was not completed as follows: "What happened that led to this event?" This was followed by a blank space. "Which of your coping skills did you choose to use to gain self-control?" This was followed by a</li> </ul>	A 164			



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A 164	Continued From page 85 blank space. "What can you do to prevent this from happening again?" This was followed by a blank space. "How can staff support you to manage this type of situation in the future?" This was followed by a blank space. - "Please indicate your agreement or disagreement with the following statements ... While in Seclusion or restraint" followed by "My privacy needs were met," "My physical needs were met," "I felt safe," "Staff counseled me about the event," "I was told what I needed to do to be released from S or R," each followed by "Strongly Agree," "Agree," "Neutral," "Disagree," and "Strongly Disagree," of which none were marked. - "Review of family suggestions with the patient's consent." This was followed by a blank space. - "Date of IDT Review: 9/14/23 ... Patient Present ... No." - "Does the treatment care plan include supports and interventions that address patient behaviors that led to this event ... Yes." There was no information that reflected what those "supports and interventions" were and if they existed before or were added after the 09/11/2023 restraint and seclusion event. - "If necessary, what changes were made to the patient's treatment care plan? N/A." It was not clear whether the TCP was modified following the 09/11/2023 restraint and seclusion event, and, if not modified, what the justification was for not modifying it in accordance with hospital P&Ps.	A 164			
A 186	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(16)(iii)  [there must be documentation in the patient's medical record of]	A 186			

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A 186	Continued From page 86  Alternatives or other less restrictive interventions attempted (as applicable);  This STANDARD is not met as evidenced by: Based on documentation in 1 of 1 medical record reviewed for restraint and seclusion (Patient 8) and review of P&Ps, it was determined the hospital failed to develop and implement P&Ps that ensured alternatives or less restrictive interventions to restraint and seclusion were clearly documented and attempted in accordance with hospital P&Ps.  Findings include:  1. Refer to the findings cited at Tag A164 under CFR 482.13(e) - Standard: Restraint or Seclusion. Those findings reflect that the hospital failed to ensure restraint and seclusion interventions were only used when less restrictive interventions had been attempted and were clearly documented.	A 186			
A 196	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(f)(1)  Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion- (i) Before performing any of the actions specified in this paragraph; (ii) As part of orientation; and (iii) Subsequently on a periodic basis consistent with hospital policy.	A 196			

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A 196	<p>Continued From page 87</p> <p>This STANDARD is not met as evidenced by: Based on interview, review of staff training/education records for 11 of 11 hospital staff (Employees 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11), review of restraint/seclusion training/education materials, review of P&amp;Ps, and review of other documentation, it was determined the hospital failed to fully develop and implement restraint and seclusion and STRs P&amp;Ps in the following areas:</p> <ul style="list-style-type: none"> <li>* The hospital failed to fully develop P&amp;Ps that ensured restraint and seclusion training and competencies were required as part of orientation and, subsequent to orientation, on a periodic basis that was defined in hospital P&amp;Ps.</li> <li>* The hospital failed to fully develop and implement P&amp;Ps that ensured staff demonstrated competencies in implementation of patient seclusion, including but not limited to monitoring, assessment, and provision of care.</li> <li>* The hospital failed to develop and implement P&amp;Ps that ensured hospital staff were trained and had demonstrated competencies related to STRs, including but not limited to application; removal; storage; keys management and control; and patient safety, supervision and monitoring.</li> </ul> <p>Findings include:</p> <p>Following reflects the hospital's failure to fully develop P&amp;Ps that ensured restraint and seclusion training and competencies were required as part of orientation, and subsequent to orientation, on a periodic basis and was defined in hospital P&amp;Ps:</p> <p>1.a. The P&amp;P titled "Seclusion and Restraints," dated 12/21/2020 reflected: * Under Attachment E, "Training Requirements ...</p>	A 196			

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A 196	Continued From page 88 All staff with direct patient care responsibilities and any other staff involved in the use of seclusion or restraint must receive ongoing training and demonstrate competency and understanding of the following ... OSH philosophy, goals, and policies regarding the use of seclusion or restraint ... techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion, possible medical conditions, history of trauma, age or developmental variables, and cultural issues that may contribute to aggressive behaviors ... viewpoints of patients who have experienced seclusion ..." * "In addition ... Nursing Services staff must receive ongoing training and demonstrate competence in the following ... monitoring and taking appropriate action to protect the physical and psychological well-being of the patient who is restrained or secluded, including, but not limited to: respiratory and circulatory status, range of motion in the extremities, skin integrity, and vital signs ... checking for nutritional or hydration needs, and meeting those needs ... addressing hygiene and elimination needs ... recognizing readiness for discontinuing seclusion or restraint, including observing and reporting specific behavioral changes that indicate seclusion or restraint is no longer necessary, and how these relate to individual release criteria ... helping a patient meet behavior criteria for the discontinuation of seclusion or restraint ... recognizing when to contact the physician/NP or emergency medical services in order to evaluate or treat the patient's physical or mental status ..." Although the P&P indicated staff "must receive ongoing training and demonstrate competency," it did not require training and competencies as part	A 196			

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A 196	<p>Continued From page 89</p> <p>of orientation and did not define "ongoing" to ensure, subsequent to orientation, staff were trained on a clearly defined periodic basis or that training intervals included consideration of the hospital's patient population.</p> <p>1.b. An undated document provided in response to a request for a list of restraints approved for use by hospital staff reflected: * "Behavioral Restraints: Soft waist to wrist restraint Soft ankle restraints chest strap Net restraint (rarely used)" * "Secure Transport Restraints (STRs): We utilize a system that includes a waist chain (standard linked metal chain) attached to standard metal handcuffs. Additionally, as part of this system we utilize leg restraints which are a larger style 'handcuff' designed to fit around the ankles. The ankle cuffs are attached to the same smaller style linked chain."</p> <p>1.c. An undated document provided in response to a request for a list of staff permitted to apply restraints reflected: * "Behavioral Restraints: Mental health security technician Transporting mental health aide Security Operations Supervisor 2 Mental health therapy technician Registered nurse Licensed practical nurse Activity coordinators Staff support coaches Unit administrators PMHNP Psychiatric Mental Health Nurse Practitioner Psychiatrists ..."</p>	A 196			

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A 196	<p>Continued From page 90</p> <p>* "Secure Transport Restraints (STRs): Mental health security technician Transporting mental health aide Security Operations Supervisor 2"</p> <p>1.d. Regarding seclusion competencies specifically, an email from the DQM dated 10/03/2023 at 1505 reflected, "I don't believe our policies specifically state the frequency of seclusion competency ..."</p> <p>Following reflects the hospital's failure to develop and implement P&amp;Ps that ensured staff demonstrated competencies related to patient seclusion:</p> <p>4. The P&amp;P titled, "Training for Staff," dated 05/16/2023 reflected "Training provided by OSH must meet applicable state and federal regulations. When required by policy or regulations, staff must demonstrate competency before a training is considered complete ... Training directed by this policy must be documented ... The OSH Learning and Development Department must maintain records of all class lesson plans and attendance records used in training provided by OSH ..."</p> <p>5. New Employee Orientation restraint and seclusion training materials failed to include demonstrated competencies related to patient seclusion. Examples include:</p> <p>5.a. The undated NEO staff training PowerPoint titled, "Welcome To Safe Together Day 2: Intervention &amp; Safe Containment" provided to "medium and high patient contact staff" did not include evidence of demonstrated and documented competencies related to seclusion.</p>	A 196			

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A 196	<p>Continued From page 91</p> <p>The only reference to seclusion was Slide 10, where it reflected, "Seclusion &amp; Restraint Responsibilities ... Know Your Role."</p> <p>5.b. The undated "Safe Together Instructor Lesson Plan NEO Day 2: Intervention &amp; Safe Containment" provided to RN, LPN, MHT and MHST staff did not include evidence of demonstrated and documented staff competencies related to seclusion. The only references to seclusion in the lesson plan were:</p> <ul style="list-style-type: none"> <li>- "Wrist cuffs need to be tight; a nurse will check and assess the restraints before staff leave the seclusion room."</li> <li>- "Staff can demonstrate downgrading to seclusion ... (Group [Exercise] ... Backboard to Stryker to Bed) ... All staff stay in their roles while moving to the seclusion room ... Before leaving the seclusion room the nurse needs to check tightness of all restraints ..."</li> <li>- "Leaving the seclusion room ... (Group [Exercise] ... assessments and downgrading ... The RN will do a behavioral release assessment every hour from the start time of the event ... a patient comes out of seclusion when they are safe ... Removing restraints ... 5 staff minimum, arms on arms, legs on legs and a nurse (can be LPN if downgrading to seclusion) ..."</li> <li>- "If time allows, this is where we have the class put it all together by working through a scenario. Have a lead build a team and give them the information they need to make a plan. They will have an opportunity to de-escalate, and the patient instructor will dictate where the team ends up. The outcome could be a successful de-escalation or hands on, with seclusion or restraint depending on the scenario and the proper application of skills learned in the class."</li> </ul>	A 196			

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A 196	<p>Continued From page 92</p> <p>5.c. The undated NEO staff training PowerPoint titled, "Welcome To Safe Together For Nurses" provided for RN and LPN staff lacked evidence of demonstrated and documented competencies related to patient seclusion.</p> <p>6. Annual restraint and seclusion training materials failed to include evidence of demonstrated and documented competencies related to patient seclusion. Examples include:</p> <p>6.a. The undated staff training PowerPoint titled, "Welcome To Safe Together For Nurses" provided for RN and LPN staff annually lacked evidence of a process for demonstrated and documented competencies related to patient seclusion.</p> <p>6.b. A blank undated "Safe Together Competency Checklist Salem" provided by the DTS on 09/21/2022 was reviewed and included spaces for checking competencies for:</p> <ul style="list-style-type: none"> <li>* "Distance &amp; Deflection"</li> <li>* "Primary Hold"</li> <li>* "Escort"</li> <li>* "Moving to Floor"</li> <li>* "Arm Control"</li> <li>* "Leg Control"</li> <li>* "Head Control"</li> <li>* "Mechanical Restraints"</li> <li>* "Soft Shield"</li> </ul> <p>The competency checklist did not include patient seclusion.</p> <p>7.a. Regarding Employee 1, BHS2 with hire date 03/02/1998: Review of Employee 1's training/education records lacked documentation of demonstrated competencies related to patient seclusion.</p>	A 196			



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A 196	Continued From page 93 7.b. Regarding Employee 2, TMHA with hire date 04/04/2011: Review of Employee 2's training/education records lacked documentation of demonstrated competencies related to patient seclusion. 7.c. Regarding Employee 3, TMHA with hire date 07/24/2011: Review of Employee 3's training/education records lacked documentation of demonstrated competencies related to patient seclusion. 7.d. Regarding Employee 4, TMHA with hire date 12/10/2012: Review of Employee 4's training/education records lacked documentation of demonstrated competencies related to patient seclusion. 7.e. Regarding Employee 5, MHST with hire date 06/09/2014: Review of Employee 5's training/education records lacked documentation of demonstrated competencies related to patient seclusion. 7.f. Regarding Employee 6, TMHA with hire date 10/27/2014: Review of Employee 6's training/education records lacked documentation of demonstrated competencies related to patient seclusion. 7.g. Regarding Employee 7, MHST with hire date 02/29/2016: Review of Employee 7's training/education records lacked documentation of demonstrated competencies related to patient seclusion. 7.h. Regarding Employees 8, MHST with hire date 03/20/2017: Review of Employee 8's training/education records lacked documentation of demonstrated competencies related to patient seclusion. 7.i. Regarding Employee 9, MH RN with hire date 04/06/2020: Review of Employee 9's training/education records lacked documentation of demonstrated competencies related to patient	A 196			

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A 196	<p>Continued From page 94</p> <p>seclusion.</p> <p>7.j. Regarding Employee 10, MHST with hire date 06/06/2022: Review of Employee 10's training/education records lacked documentation of demonstrated competencies related to patient seclusion.</p> <p>7.k. Regarding Employees 11, MHT with hire date 07/11/2022: Review of Employee 11's training/education records lacked documentation of demonstrated competencies related to patient seclusion.</p> <p>7.l. During interview and review of staff education/training records with DQM and other hospital staff on 09/20/2023 at ~ 1540 and 09/21/2023 at ~ 1530, the following information was provided:</p> <ul style="list-style-type: none"> <li>* The staff confirmed Employees 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11 had participated or were permitted to participate in implementation of patient seclusion.</li> <li>* The staff confirmed the lack of staff seclusion competencies in findings 7.a. through 7.k.</li> </ul> <p>7.m. During interview on 09/21/2023 at ~ 1430, the DTS stated restraint and seclusion training were conducted during NEO and "yearly." However, the DTS stated seclusion competencies were not included in the hospital's restraint and seclusion training. The DTS confirmed there was no documentation of seclusion competencies for Employees 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11.</p> <p>7.n. Review of a document titled, "All OSH S&amp;R Events - HLOC" reflected there were 1071 patient "Seclusion" events for 03/01/2023 through 09/12/2023.</p>	A 196			

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A 196	Continued From page 95 Following reflects the hospital's failure to develop and implement P&Ps that ensured hospital staff were trained and had demonstrated competencies related to STRs:  8.a. Refer to the findings cited at Tag A144 under CFR 482.13(c) - Standard: Privacy and Safety. Those findings reflect the hospital failure to develop and implement P&Ps that ensured staff, including Employees 2, 3, 4, 5, 6, 7, 8 and 10 were trained and had demonstrated competencies related to STRs.  8.b. Review of a document titled "STR Trips [March] 2023-July 2023 Report out" was provided in response to a list of patients restrained using leg shackles, belly chain, handcuffs and/or other chain-type devices (STRs) applied by hospital staff and/or used while under supervision of hospital staff, including within the hospital and during outings and transport to other facilities/locations. The document included: * For March 2023, 124 trips involving ~ 78 patients. * For April 2023, 100 trips involving ~ 80 patients. * For May 2023, 125 trips involving ~ 82 patients. * For June 2023, 104 trips involving ~ 77 patients. * For July 2023, 80 trips involving ~ 58 patients.	A 196			
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	A 263			

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A 263	<p>Continued From page 96</p> <p>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.</p> <p>The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.</p> <p>This CONDITION is not met as evidenced by: Based on observation, interviews, review of medical record and incident documentation for 9 of 11 patients (Patients 1, 2, 3, 4, 5, 7, 8, 9 and 10), documentation in 1 of 1 medical record reviewed for restraint and seclusion (Patient 8), review of incident and medical record documentation for 3 of 3 patients reviewed for nursing services (Patients 3, 8, and 9), review of off grounds transport documentation for 9 of 9 patients (Patients 9, 10, 11, 12, 13, 14, 15, 16 and 17), review of staff education/training records for 11 of 11 staff (Employees 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11), review of staff education/training materials, review of manufacturer's instructions for STRs, review of hospital P&amp;Ps, 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 hospital patients.</p> <p>This Condition-level deficiency represents a limited capacity on the part of the hospital to provide safe and adequate care.</p> <p>Findings include:</p> <p>1. Refer to the findings cited at Tag A115 under</p>	A 263			

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A 263	Continued From page 97	A 263			
A 395	<p>CFR 482.13 - CoP: Patient's Rights.</p> <p>RN SUPERVISION OF NURSING CARE</p> <p>CFR(s): 482.23(b)(3)</p> <p>A registered nurse must supervise and evaluate the nursing care for each patient.</p> <p>This STANDARD is not met as evidenced by: Based on interviews, review of incident and medical record documentation for 3 of 3 patients reviewed for nursing services (Patients 3, 8, and 9), review of hospital P&amp;Ps, and review of other documentation, it was determined that the hospital failed to ensure the RN supervised and evaluated the nursing care of patients as follows: * Failure to ensure the RN supervised and prevented patients from accessing unauthorized areas unsupervised; and evaluated patient behaviors and potential injuries. * Failure to ensure the RN evaluated patient skin conditions following STRs applied by hospital staff that should not have been applied.</p> <p>Findings include:</p> <p>1. Refer to the findings cited at Tag A144 under CFR 482.13(c) - Standard: Privacy and Safety. Those findings reflect that the hospital failed to ensure the RN evaluated Patient 9's skin conditions after hospital staff applied STRs to the patient that should not have been applied.</p> <p>2. Refer to the findings cited at Tag A145 under CFR 482.12(c) - Standard: Privacy and Safety. Those findings reflect that the hospital failed to ensure the RN supervised and evaluated Patients 3, 8, and 9 including patient behaviors and potential injuries related to unauthorized access</p>	A 395			

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A 395	Continued From page 98 to secure areas.	A 395			
A 724	FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE CFR(s): 482.41(d)(2)  Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation, interviews, review of hospital P&Ps, review of manufacturer's instructions for STRs, and review of other documentation, it was determined that the hospital failed to ensure that STRs applied by hospital staff had been maintained to ensure safe working order in accordance with manufacturer's instructions.  Findings include:  1. Refer to the findings cited at Tag A144 under CFR 482.13(c) - Standard: Privacy and Safety. Those findings reflect the hospital's failure to ensure STRs applied by hospital staff were maintained to ensure safe working order in accordance with manufacturer's IFUs.	A 724			