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

January 21, 2026

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

Re: Medicare Provider Number 384008
Rescind Termination Action
Restore Deemed Status
OR00056397/OR00056508/OR00056560/OR00056645/OR00056689
OR00056691/OR00056693/OR00056695/OR00056696/OR00056700/
OR00056715

Dear Administrator:

On January 9, 2026, Healthcare Management Solutions, LLC (HMS), completed a revisit survey authorized by the Centers for Medicare & Medicaid Services (CMS). HMS determined that the hospital was in compliance with the Medicare Conditions of Participation (CoP).

Based on the revisit findings and recommendation, the Centers for Medicare and Medicaid Services (CMS) is rescinding the termination action. Effective the date of this letter, we are also removing your facility from the State Agency's survey jurisdiction and restoring your facility's deemed status, based on your continued accreditation by Joint Commission.

We have forwarded copies of this letter to the accrediting organization and the State Survey Agency.

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

Sincerely,

RAngeldones

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	384008	A. BUILDING _____ B. WING _____	R-C 01/09/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 000}	INITIAL COMMENTS A Psychiatric Hospital Complaint Revisit Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare and Medicaid Services. An unannounced on-site Psychiatric Hospital Complaint Revisit Survey (Event ID: TLWP14) conducted at the above-named Hospital from 01/06/26 to 01/07/26 resulted in a finding of substantial compliance respective to the applicable Condition of Participation (CoP) 42 CFR 482. The hospital is certified for 738 in-patient beds. The average daily census is 539.7.	{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.