PUBLIC HEALTH DIVISION, Center for Health Protection
Health Care Regulation and Quality Improvement Section
Health Facility Licensing and Certification Program
Kate Brown, Governor

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Nurse Staffing Report

Facility Name: Legacy Mount Hood Medical Center

Report Publication Date: December 9, 2021

Report Republication Date: November 21, 2022

DISCLAIMER: This report was provided to the hospital administrator and both co-chairs of the hospital-wide nurse staffing committee prior to publication.

The hospital submitted a Plan of Correction to address deficiencies cited in the report. The Plan of Correction has been approved by the Oregon Health Authority.

If you need this information in an alternate format,
please call our office at (971) 673-0540 or TTY 711.

Health Care Regulation and Quality Improvement
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December 9, 2021

Gretchen Nichols
Hospital Administrator
Legacy Mount Hood Medical Center
24800 SE Stark Street
Gresham, OR 97030

Tanya Shanks-Connors
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Legacy Mount Hood Medical Center
24800 SE Stark Street
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Patrick Blankenship
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24800 SE Stark Street
Gresham, OR 97030

Sara Hinkeldey
Nurse Staffing Committee Co-Chair
Legacy Mount Hood Medical Center
24800 SE Stark Street
Gresham, OR 97030

RE: Nurse Staffing Survey

Dear Ms. Nichols, Ms. Shanks-Connors, Mr. Blankenship and Ms. Hinkeldey:

On October 28, 2021 our office completed a nurse staffing survey at your facility. The survey revealed one or more violations of the Oregon Administrative Rules for Nurse Staffing Services.

Enclosed is the Report for that visit. You must complete the Plan of Correction and return it to our office within **thirty (30) business days** of your receipt of this letter. Please submit the Plan of Correction to mailbox.nursestaffing@state.or.us or submit it by regular mail to the address above. **The hospital administrator's signature and the date signed must be recorded on the Nurse Staffing Report Cover Sheet and submitted with the Plan of Correction.** Please keep a copy of the Plan of Correction for your files.

The Plan of Correction must include the following information for each deficiency cited:

1. A detailed description of how the hospital plans to correct the specific deficiency identified;
2. The procedure(s) for implementing the plan for the specific deficiency;
3. A timeline or date by which the hospital expects to implement the corrective actions;
4. The description of monitoring procedure(s) that the hospital will perform to prevent a recurrence of the specific deficiency identified; and
5. The title of the person who will be responsible for implementing the corrective actions described.

A Plan of Correction Guidance document is also enclosed for your convenience.

The hospital may indicate disagreement with the report in the Plan of Correction. Regardless of disagreement, the hospital must submit a plan to correct the deficiency as identified in the report. As noted in Oregon Administrative Rule 333-501-0025(2), the OHA does not treat the signed Plan of Correction as an admission of the violations alleged in the report.

To set up a conference call to discuss any questions or concerns regarding the report or the Plan of Corrections, please contact our office at mailbox.nursestaffing@state.or.us.

Sincerely,

Nurse Staffing Survey Team
Oregon Health Authority
Public Health Division
Health Care Regulation and Quality Improvement

Enclosures: Nurse Staffing Report Cover Letter
Nurse Staffing Report
Plan of Correction Guidance

If you need this material in an alternate format, please call (971)673-0540 or TTY 711

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E 000 Initial Comments

This report reflects the findings of a full nurse staffing survey that was initiated on 10/18/2021 and concluded on 10/28/2021.

The hospital was evaluated for compliance with the Oregon Administrative Rules for hospital Nursing Services Staffing set forth in OAR Chapter 333, Division 510. The deficiencies identified during the survey follow in this report.

Each deficiency ("tag") listed in the report includes rule text, the deficient practice statement and survey findings. The tag begins with the Oregon Administrative Rule text and includes the statutory authority for the rule. The deficient practice statement always begins with the statement "This Rule is not met as evidenced by" and explains how the hospital failed to meet the rule requirements. The findings begin with the statement "Findings Include:" and provide specific examples of the deficiency based on surveyor observations, interviews and record reviews.

For each tag cited in the Nurse Staffing Report, the hospital must write a detailed description of how the hospital plans to correct the deficiency identified in the deficient practice statement. The facility must address the deficiency at a hospital-wide level and not only for the units or specialties with findings listed in the report. When the facility addresses the deficiency in its Plan of Correction, it must also address:

1. Corrective Action: A detailed description of how the hospital plans to correct the specific deficiency identified.
2. Implementation: The procedure(s) for implementing the plan for the specific deficiency.
3. Implementation Date: A timeline or date by which the hospital expects to implement the corrective actions. By statute, the hospital must implement its Plan of Correction no later than 45 business days after OHA approves the facility's Plan of Correction.
4. Monitoring: The description of monitoring procedure(s) that the hospital will perform to prevent recurrence of the specific deficiency identified. The hospital must monitor at least quarterly to ensure compliance.
5. Responsible Party: The title of the person who will be responsible for implementing the corrective action described. The hospital should only list one or two individuals as the responsible party. The listed responsible party is responsible for ensuring implementation of the corrective actions listed in the Plan of Correction and is permitted to delegate some of this work.

The hospital may involve the nurse staffing committee to assist in finding and implementing solutions to the deficiencies. It is ultimately the responsibility of the hospital to ensure that the Plan of Correction is written, implemented, and that the hospital returns to compliance. Plans of Correction can be submitted as a Word document, Excel spreadsheet, Adobe PDF or other format as desired by the hospital.

OHA hosts conference calls with hospitals to discuss areas of concern regarding the report or formulating a Plan of Correction. Conference calls should include those who will draft the Plan of Correction; Staffing Committee Co-Chairs and the CNO may also benefit from participating. To request a conference call, email mailbox.nursestaffing@state.or.us.

The following abbreviations, acronyms and definitions may be used:
ADT - Admissions, discharges and transfers
ANM - Assistant nurse manager
CNA - Certified nursing assistant
CY - Calendar year
DC - Direct care
DKA - Diabetic ketoacidosis
DPCS - Director of Patient Care Services
Endo - Endoscopy Unit
FBC - Family Birth Center
GNO - General Nursing Orientation
HNSP - Hospital nurse staffing plan
ICU - Intensive Care Unit
IV - Intravascular or intravenous
LH - Legacy Health
LMHMC - Legacy Mount Hood Medical Center
LPN - Licensed practical nurse
MS - Medical Specialties Unit
NEO - New Employee Orientation
NM - Nurse manager
NSC - Nurse staffing committee
NSM - Nursing staff member
NSP - Nurse staffing plan
OAR - Oregon Administrative Rule
OHA - Oregon Health Authority
Pt - Patient
RN - Registered nurse

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SAT - Spontaneous awakening trial
SSOU - Surgical Specialties Outpatient Unit
SSU - Short Stay Unit
VP CNO - Vice President Chief Nursing Officer

E 604 Nurse Staffing Documentation

(3) A hospital shall keep and maintain all records necessary to demonstrate compliance with ORS 441.152 to 441.177. These records shall:
(a) Be maintained for no fewer than three years;
(b) Be promptly provided to the Authority upon request; and
(c) Include, at minimum:
(A) The staffing plan;
(B) The hospital nurse staffing committee charter;
(C) Staffing committee meeting minutes;
(D) Documentation showing how all members of the staffing committee were selected;
(E) All complaints filed with the staffing committee;
(F) Personnel files for all nursing staff positions that include, at minimum, job descriptions, required licensure and specialized qualifications and competencies required for the individual's assigned nurse specialty or unit;
(G) Documentation showing work schedules for nursing staff in each hospital nurse specialty or unit;
(H) Documentation showing actual hours worked by all nursing staff;
(I) Documentation showing all work schedule variances that resulted in the use of replacement nursing staff;
(J) Documentation showing how many on-call hours, if any, required nursing staff to be on the hospital premises;
(K) Documentation showing how many required meeting, education and training hours, if any, were required of nursing staff;
(L) The hospital's mandatory overtime policy and procedure;
(M) Documentation showing how many, if any, overtime hours were worked by nursing staff;
(N) Documentation of all waiver requests, if any, submitted to the Authority;
(O) Documentation showing how many, if any, additional hours were worked due to emergency circumstances and the nature of those circumstances;
(P) The list of on-call nursing staff used to obtain replacement nursing staff;
(Q) Documentation showing how and when the hospital updates its list of on-call staff used to obtain replacement nursing staff and how the hospital determines eligibility to remain on the list;
(R) Documentation showing the hospital's procedures for obtaining replacement nursing staff, including efforts made to obtain replacement staff;
(S) Documentation showing the hospital's actual efforts to seek replacement staff when needed;
(T) Documentation showing each actual instance in which the hospital implemented the policy described in OAR 333-510-0110(2)(g) to initiate limitations on admission or diversion of patients to another hospital; and
(U) All staffing committee reports filed with the hospital administration following a review of the staffing plan.
Stat. Auth.: ORS 413.042, 441.155, 441.169, 441.173 & 441.185
Stats. Implemented: ORS 441.155, 441.169, 441.173 & 441.185

(OAR 333-510-0045(3))

This Rule is not met as evidenced by:

Based on interview and review of HNSP Unit Questionnaires, unit NSPs and documentation of 4 of 9 NSM personnel records (NSMs 1, 3, 4 and 20) for 2 of 4 units (MS and ICU), it was determined that the hospital failed to maintain documentation showing the specialized qualifications and competencies for NSMs as required by subsection (c)(F).

Findings include:

1. This citation reflects repeated noncompliance with the requirement under OAR 333-510-0045(3).
OHA previously cited the hospital for noncompliance with this rule in the nurse staffing survey initiated on 05/22/2017. The previous citation reflected the hospital failed to maintain documentation showing how all members of the NSC were selected, and the specialized qualifications and competencies for NSMs in ICU, FBC, SSOU and Endo units.

2. Review of MS HNSP Unit Questionnaire, completed and signed by MS DC RN Unit Representative and MS NM on 10/18/2021, reflected that RNs were required to complete "GNO & NEO" upon hire.

3. Review of "LMHMC RN STAFF NURSE" position description, dated "January 2021", reflected RNs "[demonstrate] accountability for completion of required education and competencies" and "competencies will be identified and assessed by the manager according to required time frames."

4. Review of "Unit/Program Professional Development Plan ... Unit: Med-Spec - RN Professional Development Plan for CY 2021 (January

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2021 - December 2021)" reflected that MS RNs were required to complete NEO and GNO training.

5. Review of personnel records for MS RN NSM 20, hired 12/28/2020, lacked documentation showing validation and completion of all required competencies, including:
* "Surgical/Procedural: Performs nursing assessment appropriate for patients undergoing a procedure"
* "Emergent, Critical Conditions or Events: Demonstrates the ability to plan and perform care including age appropriate interventions. Demonstrates skill with set-up, maintenance and/or troubleshooting of ..."
* "Medication Administration"

6. During interview with DPCS, MS ANM and MS NM on 10/20/2021 beginning at 1255, they confirmed Findings 2 - 5 and confirmed that MS RN NSM 20 had not completed the competency checklist as of 10/19/2021. They stated that the usual orientation period for MS RNs is six weeks.

7. Revisit Survey: Review of ICU HNSP Unit Questionnaire, completed and signed by ICU DC RN Unit Representative and ICU NM on 10/19/2021, included ICU "Unit/Program Professional Development Plan" as an attachment to the questionnaire. It reflected that newly hired ICU RNs were to complete the "Critical Care Competency Checklist" by "end of orientation."

8. Revisit Survey: Review of ICU NSP, approved 02/22/2021, reflected the following under the section "Specialized Staff Qualifications and Competencies": "On hire: RNs complete the specialty critical care competency validation tool."

9. Revisit Survey: During interview with VP CNO, DPCS, and NSC NM Co-Chair on 10/19/2021 beginning at 1430, they confirmed Findings 7 and 8 and stated that the competency checklist was an electronic form found in "E+", the hospital's electronic learning system.

10. Revisit Survey: During interview with VP CNO, DPCS and NSC NM Co-Chair on 10/19/2021 beginning at 1610, they stated that the hospital's disaster plan had been implemented and was in effect on the following dates:
* Period #1 - 07/20/2020 through 01/18/2021
* Period #2 - 02/12/2021 through 02/15/2021
* Period #3 - 08/18/2021 through the date of this NSS.
During interview, they stated that events like the COVID-19 pandemic caused the disaster plan implementation periods impacted completion of orientation and training, as well as documentation of training and orientation requirements.

11. Revisit Survey: Review of personnel records for ICU RN NSM 1, hired 01/11/2021, lacked documentation of all required qualifications, competencies and trainings. For example:
* An "Historical Clocking Detail Report" reflected ICU RN NSM 1's first date of orientation was 01/11/2021 and last date of orientation was 03/20/2021.
* An electronically generated "LH.CORE Critical Care Competency Checklist" for ICU RN NSM 1 reflected that for 42 of 49 competencies, he/she had been determined to be competent and that evaluations were completed by "Verbal Test" on 10/14/2021, which was nine months after he/she had started on ICU and approximately seven months after he/she had completed his/her orientation and was working independently. Those competencies included, for example: "Standards of Performance"; "Respiratory System: Demonstrates the ability to plan and perform care ... Demonstrates skill with set-up, maintenance, and troubleshooting"; "Cardiovascular System: Performs set up and maintenance of hemodynamic monitoring equipment, as well as medications"; "Emergent, Critical Conditions or Events: Performs nursing assessment appropriate for patients during emergent, critical conditions or events"; "End of Life: Demonstrates the ability to plan and perform and evaluate compassionate care interventions for the patient and family at end of life"; and "Harm Prevention Care Bundles: Demonstrates the ability to assess, plan, perform, and evaluate harm prevention interventions."
* For the remaining nine competencies, the checklist reflected competency evaluation process had "Not Started" as of this NSS. There were no competency methods, outcomes or completion dates documented. Those competencies included, for example: "Equipment"; "Monitoring During Procedure"; "IV Sedation Medications: Versed"; and "IV Sedation Medications: Fentanyl".

12. Revisit Survey: Review of personnel records for ICU RN NSM 3, hired 12/28/2020, lacked documentation of all required qualifications, competencies and trainings. An electronically generated "LH.CORE Critical Care Competency Checklist" for ICU RN NSM 3 reflected that for 34 of 42 competencies, he/she had been determined to be competent and competency evaluations had been completed on 04/13/2021. For the remaining eight competencies, ICU RN NSM 3 had been determined to be competency and the competency evaluations had been completed and competency evaluations had been completed by "Verbal Test" on 10/14/2021, six months after his/her orientation. Those competencies included, for example:
* "Genitourinary System: Demonstrates the ability to plan and perform care ... Demonstrates skill with set-up, maintenance and/or troubleshooting";
* "Pain/Comfort: Performs nursing assessment appropriate for patients with alteration in comfort";
* "Surgical/Procedural: Demonstrates the ability to prepare the room with proper safety equipment and assist the patient for the following procedures";
* "Emergent, Critical Conditions or Events: Demonstrates the ability to plan and perform ... Demonstrates skill with set-up, maintenance and/or troubleshooting";
* "Medication Administration"; and
* "Intravascular Therapy: Demonstrates ability to initiate and manage a patient with IV therapy and applies interventions to prevent infections or other complications".

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13. Revisit Survey: Review of personnel records for ICU RN NSM 4, hired 08/10/2020, lacked documentation of all required qualifications, competencies and trainings. For example:
* An "Historical Clocking Detail Report" reflected ICU RN NSM 4's first date of orientation was 08/10/2020 and last date of orientation was 09/24/2020.
* An electronically generated "LH.CORE Critical Care Competency" for ICU RN NSM 4 reflected that for 42 of 42 competencies the competency evaluation process was "Not Started" as of the date of this survey. There were no competency methods, outcomes or completion dates documented during the orientation period that ended approximately 13 months prior to this survey.

14. Revisit Survey: During interview with VP CNO, DPCS and NSC NM Co-Chair on 10/19/2021 beginning at 1430, they confirmed Findings 11 -13. Additionally, they stated that ICU RN NSM 1 had been working independently since April 2021 and ICU RN NSM 4 had been working independently since his/her orientation period ended in September 2020. They confirmed that ICU RN NSM 4's orientation checklist had been due by 11/09/2020.

15. Revisit Survey: In response to the findings related to lack of competency documentation, a summary document signed by ICU NM was provided and reflected that ICU RN NSM 1 "was on orientation for 3 months in January 11, 2021 - March 14, 2021. During this time, [he/she] was paired with an experienced preceptor and was observed and coached to ensure [he/she] was a competent ICU RN. During this orientation period ... there were 3 meetings ... and based on preceptor feedback [ICU RN NSM 1] was found competent to care for our ICU patients. The pandemic made it challenging to get required documentation for orientation completed. Due to this lack of documentation, further assessment was completed by clinical practice support and a unit charge RN to ensure the staff member was safe to care for critical care patients." The following documents were attached to the summary:
* A "Meeting note summary with [ICU RN NSM 1]" with a meeting date of 07/14/2021 at 1600-1700 completed by a Nurse Education and Practice Specialist. The summary reflected that three patient cases had been reviewed with ICU RN NSM 1 and he/she had been determined to be "competent in [his/her] understanding of DKA, treatment, and monitoring of patients with DKA ... sepsis and septic shock, as well as the treatment, and care of a patient with septic shock ... and care of SAT/SBT in the mechanically ventilated patient." This summary document does not reflect a competency evaluation equivalent to "LH.CORE Critical Care Competency Checklist" completed on 10/14/2021.
* A summary "Preceptor Evaluation for [ICU RN NSM 1] Sept 1 - October 8th" signed by an ICU CN reflected the following: "After evaluating [ICU RN NSM 1]'s work performance on the unit between the weeks of September 1st, 2021 and October 8th, 2021, I have determined [ICU RN NSM 1] to be fully competent in [his/her] role as a critical care nurse working in our ICU." This summary document does not reflect a competency evaluation equivalent to "LH.CORE Critical Care Competency Checklist" completed on 10/14/2021.

16. Revisit Survey: ICU RN NSM 1 was hired 01/11/2021, near the end of Disaster Plan Period #1, referenced in Finding 10. There were approximately six to seven months since ICU RN NSM 1's hire, during which the hospital's disaster plan was not in effect and during which the required documentation for orientation in the form of "LH.CORE Critical Care Competency Checklist" could have been completed as required by ICU NSP and ICU Professional Development Plan.

17. Revisit Survey: In response to the findings related to lack of competency documentation, a summary document signed by ICU NM was provided and reflected ICU RN NSM 4 "was on orientation from August 10, [2020] - September 20, [2020]. During this time, [he/she] was paired with an experienced preceptor and was observed and coached to ensure [he/she] was a competent ICU RN. During this orientation period ... There were 2 meetings ... Based on preceptor feedback, [his/her] past work history, and [ICU RN NSM 4's] ability to articulate standard care, treatment and anticipate outcomes based on interventions, [he/she] was found competent to care for ICU patients. Due to the pandemic expected documentation of orientation was not completed by the preceptors, but competence determined during the preceptor/orientation meetings, have been proven by evidence in [his/her] daily care."

18. Revisit Survey: ICU RN NSM 4 was hired 08/10/2020 and his/her orientation period ended on 09/24/2020 during the Disaster Plan Period #1 referenced in Finding 10. There were approximately six to seven months since ICU RN NSM 4's hire during which the hospital's disaster plan was not in effect and during which the required documentation for orientation in the form of "LH.CORE Critical Care Competency Checklist" could have been completed as required by ICU NSP and ICU Professional Development Plan.

19. Revisit Survey: ICU RN NSM 3 was hired 12/28/2020, near the end of Disaster Plan Period #1, referenced in Finding 10. There were approximately four months since ICU RN NSM 3's orientation competencies had been documented on 04/13/2021, during which the hospital's disaster plan was not in effect and during which the required documentation for orientation in the form of "LH.CORE Critical Care Competency Checklist" could have been completed as required by ICU NSP and ICU Professional Development Plan.

E 628 NSP Requirement

(1) Each hospital shall implement a written hospital-wide staffing plan for nursing services that is developed and approved by the hospital nurse staffing committee established in accordance with ORS 441.154 and OAR chapter 333 division 510 rules.
Stat. Auth.: ORS 413.042 & 441.155
Stats. Implemented: ORS 441.155

(OAR 333-510-0110(1))

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This Rule is not met as evidenced by:

Based on interview and review of HNSP Unit Questionnaires and unit NSPs for 4 of 4 units (MS, SSU, ICU and FBC), it was determined that the hospital failed to implement a hospital-wide NSP developed and approved by the NSC in accordance with these rules:
* NSPs were not fully developed or complete.

Findings include:

1. This citation reflects repeated noncompliance with the requirement under OAR 333-510-0110(1).
OHA previously cited the hospital for noncompliance with this rule in the nurse staffing survey initiated on 05/22/2017. The previous citation reflected noncompliance in ICU, FBC, SSOU and Endo units.

2. Refer to NSP findings that reflects the NSPs the units were working under were not complete or clear.
* For Tag E632, refer to findings for MS, SSU, ICU and FBC.
* For Tag E646, refer to findings for MS, SSU, ICU and FBC.

E 632 NSP: ADT

(2) The staffing plan:
(b) Must be based on a measurement of hospital unit activity that quantifies the rate of admissions, discharges and transfers for each hospital unit and the time required for a direct care registered nurse belonging to a hospital unit to complete admissions, discharges and transfers for that hospital unit;
Stat. Auth.: ORS 413.042 & 441.155
Stats. Implemented: ORS 441.155

(OAR 333-510-0110(2)(b))

This Rule is not met as evidenced by:

Based on interview and review of HNSP Unit Questionnaires and unit NSPs for 4 of 4 units (MS, SSU, ICU and FBC), it was determined the hospital failed to implement a hospital-wide NSP that was developed based on measures of unit activity that quantified the rate of admissions, discharges and transfers for each unit and the time required for a direct care RN to complete those tasks.

Findings include:

1. This citation reflects repeated noncompliance with the requirements under OAR 333-510-0110(2)(b).
OHA previously cited the hospital for noncompliance with this rule in the nurse staffing survey initiated on 05/22/2017. The previous citation reflected noncompliance in FBC, SSOU, and Endo units.

2. Review of MS HNSP Unit Questionnaire, completed and signed by MS DC Unit Representative and MS NM on 10/18/2021, reflected that the response to the question "the Nurse Staffing Plan quantifies time for direct care nurses to complete admissions, discharges and transfers for the unit" was "No."

3. Review of MS NSP, approved by NSC on 04/26/2021, reflected it did not include required ADT information. MS NSP included data related to the numbers of ADT but did not reflect data related to the amount of time it takes MS NSMs to complete those ADT tasks as required by OAR 333-510-0110(2)(b).

4. Review of SSU HNSP Unit Questionnaire, completed and signed by SSU DC Unit Representative and SSU NM on 10/18/2021, reflected that the response to the question "the Nurse Staffing Plan quantifies time for direct care nurses to complete admissions, discharges and transfers for the unit" was "No."

5. Review of SSU NSP, approved by NSC on 04/26/2021, reflected it did not include required ADT information. SSU NSP included data related to the numbers of ADT but did not reflect data related to the amount of time it takes SSU NSMs to complete those ADT tasks as required by OAR 333-510-0110(2)(b).

6. During interview with VP CNO, DPCS and NSC NM Co-Chair on 10/19/2021 beginning at 1550, they confirmed Findings 2 - 5. They stated that data related to the amount of time it takes for NSMs to complete ADT tasks had not been gathered for MS or FBC.

7. Revisit Survey: Review of ICU HNSP Unit Questionnaire, completed and signed by ICU DC Unit Representative and ICU NM on 10/19/2021, reflected that the response to the question "the Nurse Staffing Plan quantifies time for direct care nurses to complete admissions, discharges and transfers for the unit" was "No."

8. Revisit Survey: Review of ICU NSP, approved by NSC on 02/22/2021, reflected it did not include required ADT information. ICU NSP included data related to the numbers of ADT but did not reflect data related to the amount of time it takes ICU NSMs to complete those ADT

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tasks as required by OAR 333-510-0110(2)(b).

10. Revisit Survey: Review of FBC HNSP Unit Questionnaire, completed and signed by FBC DC Unit Representative and FBC NM on 10/19/2021, reflected that the response to the question "the Nurse Staffing Plan quantifies time for direct care nurses to complete admissions, discharges and transfers for the unit" was "No."

11. Revisit Survey: Review of FBC NSP, approved by NSC on 02/24/2021, reflected it did not include required ADT information. FBC NSP included data related to the numbers of ADT but did not reflect data related to the amount of time it takes FBC NSMs to complete those ADT tasks as required by OAR 333-510-0110(2)(b).

12. During interview with VP CNO, DPCS and NSC NM Co-Chair on 10/19/2021 beginning at 1550, they confirmed Findings 7 - 11. They stated that data related to the amount of time it takes for NSMs to complete ADT tasks had not been gathered for ICU or FBC.

E 646 NSP: Tasks Unrelated to Providing Direct Care

(2) The staffing plan:
(h) Must consider tasks not related to providing direct care, including meal breaks and rest breaks;
Stat. Auth.: ORS 413.042 & 441.155
Stats. Implemented: ORS 441.155

(OAR 333-510-0110(2)(h))

This Rule is not met as evidenced by:

Based on interview, review of HNSP Unit Questionnaires, Meal and Rest Break tools and unit NSPs for 4 of 4 units (MS, SSU, ICU and FBC), it was determined the hospital failed to implement a hospital-wide NSP that was developed to consider for each unit meal breaks, rest breaks and other tasks not related to direct patient care and ensured NSMs received breaks required and maintained the staffing ratio required in the NSP during these tasks.

Findings include:

1. This citation reflects repeated noncompliance with the requirement under OAR 333-510-0110(2)(h).
OHA previously cited the hospital for noncompliance with this rule in the nurse staffing survey initiated on 05/22/2017. The previous citation reflected noncompliance in ICU, FBC and SSOU.

2. Review of MS Meal and Rest Break Practice tool, completed and signed by MS DC Unit Representative and MS NM on 10/19/2021, reflected MS did not "document when nursing staff members take rest breaks" and did not "document when nursing staff members miss rest breaks."

3. During interview with a MS DC RN on 10/18/2021 at the time of unit onsite tour, he/she confirmed that there was no process to document whether MS NSMs took meal breaks, there was no process for documenting whether MS NSMs took rest breaks and that the unit used the "buddy system" to cover one another during breaks. This was not consistent with MS NSP and did not clearly reflect how meal and rest breaks were covered and did not ensure minimum numbers of staff during meal and rest breaks.

4. Review of SSU Meal and Rest Break Practice tool, completed and signed by SSU DC Unit Representative and SSU NM on 10/18/2021, reflected SSU NSP did not "describe rest break practices on the unit."

5. Review of SSU NSP, approved by NSC on 04/26/2021, reflected the following related to provision of meal and rest breaks for SSU: "Unit Target ... The number of nurses for which lunch coverage is required is always considered ... Breaks and Lunch considerations: The hours of care required to provide lunches and breaks is considered when patient assignments are made by the charge nurse the day prior. The charge nurse and other qualified nurses within the department may be used to provide lunch coverage for short stay staff as needed." SSU NSP was unclear related to how meal and rest breaks were covered and did not ensure minimum numbers of staff during meal and rest breaks.

6. Revisit Survey: Review of ICU Meal and Rest Break Practice tool, completed by ICU DC Unit Representative and ICU NM on 10/19/2021, reflected ICU did not "document when nursing staff members take rest breaks" and did not "document when nursing staff members miss rest breaks."

7. Revisit Survey: During interview with an ICU DC RN on 10/18/2021 at the time of onsite unit tour, he/she stated ICU NSP included provisions to ensure that all NSMs received breaks and that minimum numbers were met. He/she stated that there was documentation to reflect whether ICU NSMs took meal breaks but that ICU did not document whether ICU NSMs took rest breaks.

8. Revisit Survey: Review of FBC Meal and Rest Break Practice tool, completed and signed by FBC DC Unit Representative and FBC NM on 10/19/2021, reflected that FBC NSP did not "describe rest break practices on the unit."

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NAME OF PROVIDER OR SUPPLIER, STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED
14-1337	LEGACY MOUNT HOOD MEDICAL CENTER 24800 SE STARK STREET GRESHAM, OR 97030	10/28/2021

E 646 Continued From page 6

9. Revisit Survey: Review of FBC NSP, approved by NSC on 02/24/2021, reflected the following related to provision of meal and rest breaks for FBC: "Unit Target ... The target staffing ratio is not designed to reflect the minimum staffing required ... Break and Lunch considerations: The hours of care required to provide lunches and breaks are considered at the time when staffing levels are determined. The presence of a charge nurse and other direct care staff within the department is also a consideration as these staff members are qualified to provide lunch coverage. The CN assures appropriate staff/pt ratio during meal breaks according to the staffing plan ratios as described..." FBC NSP was unclear related to how meal and rest breaks were covered and
did not ensure minimum numbers of staff during meal and rest breaks.

10. In NSM interviews completed between 10/11/2021 and 10/25/2021, 80 of 109 respondents indicated that the unit is short staffed when a NSM is on a meal or rest break, that the unit uses a buddy system to cover for NSMs on meal or rest breaks, or they do not know whether the unit has the required staffing when NSMs are on meal or rest breaks.

11. In NSM interviews completed between 10/11/2021 and 10/25/2021, 44 of 109 respondents indicated that in the past year they experienced one or more shifts in which they missed meal and/or rest breaks because there was not sufficient staff to cover that time.

Health Care Regulation and Quality Improvement
800 NE Oregon Street, Suite 465
Portland, Oregon 97232
971-673-0540
971-673-0556 (Fax)

November 18, 2022

Bahaa Wanly
Hospital Administrator
Legacy Mount Hood Medical Center
24800 SE Stark Street
Gresham, OR 97030

Tanya Shanks-Connors
Chief Nursing Officer
Legacy Mount Hood Medical Center
24800 SE Stark Street
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Patrick Blankenship
Hospital Nurse Staffing Committee Co-Chair
Legacy Mount Hood Medical Center
24800 SE Stark Street
Gresham, OR 97030

Sara Hinkeldey
Hospital Nurse Staffing Committee Co-Chair
Legacy Mount Hood Medical Center
24800 SE Stark Street
Gresham, OR 97030

RE: POC Determination Letter for Nursing Staffing Survey – POC Sufficient

Dear Mr. Wanly, Ms. Shanks-Connors, Mr. Blankenship, and Ms. Hinkeldey:

This letter provides notification that your Plan of Correction (POC), in response to deficiencies cited during the nurse staffing survey completed on October 28, 2021 has been received, reviewed, and accepted by the Public Health Division, Oregon Health Authority, Health Care Regulation and Quality Improvement.

In accordance with the requirements of Oregon Administrative Rule 333-501-0035(7), the hospital must implement the corrections within 45 business days after receiving the Oregon Health Authority's determination that the POC is sufficient. Surveyors will conduct a revisit to verify that the POC has been implemented within 60 business days.

Thank you for your attention to this matter. If you have any questions, please contact our office at mailbox.nursestaffing@odhsoha.oregon.gov.

Sincerely,

Nurse Staffing Survey Team
Oregon Health Authority
Public Health Division
Health Care Regulation and Quality Improvement

If you need this information in an alternate format, please call our office at (971) 673-0540 or TTY 711.

PUBLIC HEALTH DIVISION, Center for Health Protection
Health Care Regulation and Quality Improvement Section
Health Facility Licensing and Certification Program
Kate Brown, Governor

Oregon Health Authority

Survey & Certification Unit
800 NE Oregon Street, Suite 465
Portland, OR 97232
Voice: (971) 673-0540
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TTY: 711
http://www.healthoregon.org/nursestaffing
mailbox.nursestaffing@state.or.us

Nurse Staffing Survey and Revisit Survey
Legacy Mount Hood Medical Center
October 28, 2021

On October 28, 2021, our office completed a:

- ☒ Nurse staffing survey
- ☐ Nurse staffing revisit for
  - ☒ The 2017 nurse staffing survey
  - ☐ The [Year] nurse staffing complaint investigation
- ☐ Nurse staffing complaint investigation

at your facility. The survey revealed one or more violations of the Oregon Administrative Rules for Nurse Staffing Services.

The following report describes any deficiencies noted during the survey, with each deficiency ("tag") including rule text, the deficient practice statement and survey findings. It is the responsibility of the hospital to ensure to write a Plan of Correction addressing each tag cited in this report, that the Plan of Correction is written, and that the hospital returns to compliance.

The hospital administrator's signature and the date must be recorded in the space provided below.

The hospital may indicate disagreement with the report in the Plan of Correction. Regardless of disagreement, the hospital must submit a plan to correct the deficiency as identified in this report. As noted in Oregon Administrative Rule 333-501-0025(2), the OHA does not treat the signed Plan of Correction as an admission of the violations alleged in the report.

Gretchen Nichols
Name of Hospital Administrator (Printed)

12.22.21
Date

Gretchen Nichols
Name of Hospital Administrator (Signed)

Nurse Staffing Survey Legacy Mount Hood Medical Center
Plan of Correction
October 7, 2022

E 604: Nurse Staffing Documentation

(3) A hospital shall keep and maintain all records necessary to demonstrate compliance with ORS 441.152 to 441.177. The records shall: (c) Include, at minimum: (F) Personnel files for all nursing staff positions that include, at minimum, job descriptions, required licensure and specialized qualifications and competencies required for the individual's assigned nurse specialty or unit.

Implementation plan: Unit leaders will review all direct care staff members professional development files (competency files) within 45 days of approval of plan of correction. Unit leaders will assess files for job descriptions, required licensure, specialized qualifications, and competencies. Any deficiencies in professional development files will be corrected to ensure that all job descriptions, required licensure and specialized qualifications are current, and any missing competencies will be verified with direct observation or verbal review

Implementation date: No more than 45 business days from OHA approval.

Monitoring: Audits will occur quarterly to ensure 100% compliance. Audits will be performed by the specialty unit leader and direct care staff member of the hospital nurse staffing committee. If deficiencies in documentation are found in any nurse or CHT's professional development file during the quarterly audits, the deficiencies will be corrected to ensure that all job descriptions, required licensure and specialized qualifications are current, and any missing competencies will be verified with direct observation or verbal review.

Responsible Party: CNO

E 628: Each hospital shall implement a written hospital-wide staffing plan for nursing services that is developed and approved by the hospital nurse staffing committee
Implementation plan: Nurse staffing plans will be updated and approved to include all necessary required elements as prescribed by SB 469 When approving the staffing plans the MHMC HNSC will use the template based on the OHA Nurse Staffing Sample Survey Toolkit's HNSC "Written Staffing Plan Review" (NSSampleSurveyToolKit.pdf (oregon.gov), pg. 49) to ensure that all necessary elements are present within each specialty unit's staffing plan.

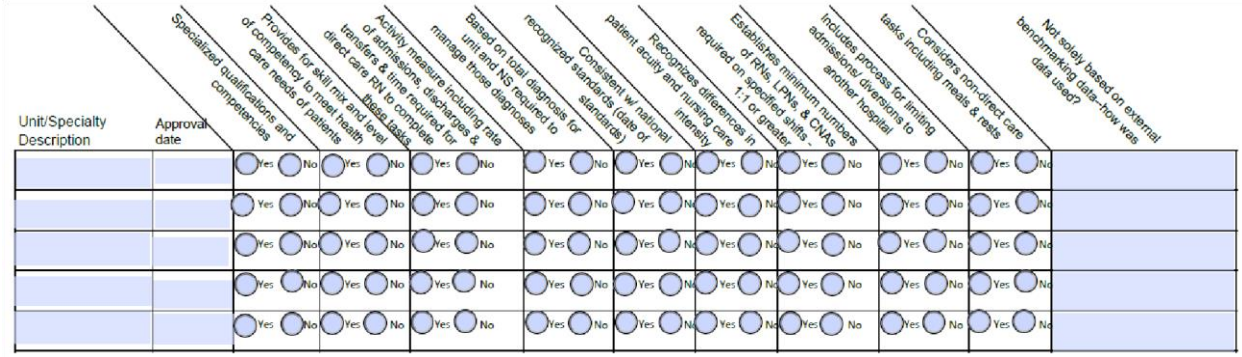

Figure 1: Example of Written Staffing Plan Review

Implementation date: No more than 45 business days from OHA approval.

Monitoring: All staffing plans will be reviewed quarterly by the HNSC Co-Chairs utilizing the "Written Staffing Plan Review" document to ensure that all necessary elements are present within each department staffing plan. Instances of noncompliance will be reviewed with the department leadership by the HNSC co-chairs and the NSP will be amended and resubmitted for approval at the next scheduled HNSC. Monitoring will continue until 100% compliance has been achieved for three consecutive quarters.
Responsible party: Hospital Nurse Staffing Committee Co-Chairs

E 632: NSP: ADT

(2) the staffing plan (b) Must be based on a measurement of hospital unit activity that quantifies the rate of admissions, discharges and transfers for each hospital unit and the time required for a direct care registered nurse belonging to a hospital unit to complete admissions, discharges, and transfers for that hospital unit.
Stat. Auth: ORS 413.042 & 441.155
Stats. Implemented: ORS 441.155

Implementation plan: All hospital nurse staffing plans will be updated and approved to include the amount of time it takes for admissions, discharges, and transfers (ADT).

Implementation date: No more than 45 business days from OHA approval.

Monitoring: When evaluating and approving NSP's each plan will be evaluated to ensure that it includes quantified time needed to complete admissions, discharges, and transfers. The quantified time will be documented on the Legacy Mount Hood Annual Staffing Plan Review document, and approval of plans will be documented in meeting minutes. Unit leaders and direct care staff members will review their plans quarterly to determine if quantified time for ADT is accurate. If quantified time is no longer accurate, unit leader and direct care staff member will update their unit staffing plan and present their staffing plan at the next Hospital Nurse Staffing Committee Meeting for review and approval.

Responsible Party: Hospital Nurse Staffing Committee Co-Chairs

E 646: Nurse Staffing Plan: Tasks not related to providing direct care.

(2) The staffing plan (h) Must consider tasks not related to providing direct care, including meal and rest breaks.
Stat. Auth: ORS 413.042 & 441.155
Stats. Implemented: ORS 441.155

Implementation plan: Staffing plans did not include processes to cover tasks not related to direct patient care. All hospital nurse staffing plans will be updated to include staffing processes to cover tasks not related to direct care. Processes will ensure that minimum staffing is met and will include unit specific coverage for meal and rest breaks. At the time of the OHA audit, LMHMC did not track

rest breaks on all units, so there was not documentation to support that all RN's and CHT's received their breaks. The Legacy Health Time and Attendance clocking system was updated to include attestation of rest breaks. When approving and updating staffing plans annually, the percentage of shifts where staff members missed lunch or rest breaks will be documented on the Legacy Mount Hood Annual Staffing Plan Review document with the goal of 95% compliance. This data will be utilized to determine if staffing plans are effective.

Implementation date: No more than 45 business days from OHA approval.

Monitoring: Unit leaders will review the percentage of missed rest breaks for nurses and CHT' quarterly. If >5% of required rest and meal breaks are missed on a specialty unit (goal is to ensure 95% compliance), individual staffing plan will be revised to ensure that all nurses and CHT's receive their rest and meal breaks and that minimum staffing is maintained. The revised plans will be presented at the next Hospital Nurse Staffing Committee Meeting for review and approval.

Responsible party: CNO