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

Survey & Certification Unit
800 NE Oregon Street, Suite 465 Portland,
OR 97232
Voice: (971) 673-0540
Fax: (971) 673-0556
TTY: 711
http://www.healthoregon.org/nursestaffing
mailbox.nursestaffing@odhsoha.oregon.gov

Nurse Staffing Report

Facility Name: St Charles Medical Center Bend

Report Publication Date: June 21, 2022

Report Republication Date: August 3, 2022

Report Final Publication Date: December 12, 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
800 NE Oregon Street, Suite 465
Portland, Oregon 97232
971-673-0540
971-673-0556 (Fax)

July 28, 2022

David Golda
Hospital Administrator
St Charles Bend
2500 NE Neff Road
Bend, OR 97701

Debbie Robinson
Chief Nursing Officer
St Charles Bend
2500 NE Neff Road
Bend, OR 97701

Joel Hernandez
Nurse Staffing Committee Co-Chair
St Charles Bend
2500 NE Neff Road
Bend, OR 97701

Daniel Davis
Nurse Staffing Committee Co-Chair
St Charles Bend
2500 NE Neff Road
Bend, OR 97701

RE: **AMENDED** Nurse Staffing Survey

Dear Mr. Golda, Ms. Robinson, Mr. Hernandez and Mr. Davis:

On April 29, 2022 our office completed a nurse staffing survey and complaint investigation at your facility. The survey revealed one or more violations of the Oregon Administrative Rules for Nurse Staffing Services.

The amendment to the report is described under Tag 000 and begins with the following notation: *

Enclosed is the **Amended** 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 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 Sheet
Nurse Staffing Report
Plan of Correction Guidance Document

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

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NAME OF PROVIDER OR SUPPLIER, STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED
14-1457	ST. CHARLES BEND CAMPUS 2500 NE NEFF ROAD BEND, OR 97701	04/29/2022

E 000 Initial Comments

*** This Statement of Deficiencies was revised to correct an error in Tag E628 on 07/26/2022. Finding 1 of Tag E628 referenced findings under Tag E640; however, Tag E640 was not cited in this report. The reference to Tag E640 has been removed.

This report reflects the findings of a full nurse staffing survey that was initiated on 04/19/2022 and concluded on 04/29/2022.

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.

The survey also included an unannounced, onsite nurse staffing complaint investigation of complaint #OR30088. Some allegations contained in the complaint were found to be substantiated.

The survey also included a revisit survey of the full nurse staffing survey and complaint investigation of #OR12598 that was initiated on 06/19/2017 and concluded on 07/06/2017. It also included a revisit survey of the complaint investigation of #OR22791 that was initiated on 04/08/2021 and concluded on 04/09/2021. The deficiencies identified during the revisit are incorporated into this report.

Each deficiency ("tag") listed in the report includes rule text, the deficient practice statement and survey findings. The tag begins with the statement "This Rule is not met as evidenced by" and explains how the hospital practices 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 practices 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 status the hospital must implement its Plan of Correction no later than 45 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 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:

ADC - Average daily census
AHA - American Heart Association
AMSN - Academy of Medical-Surgical Nurses
AMN - Assistant nurse manager
BHU - Sageview Behavioral Health Unit
BLS - Basic life support
BMAT - Banner Mobility Assessment Tool
CBL - Computer-based learning
CNA - Certified nursing assistant
CNO - Chief nursing officer
CPPD - Clinical Practice and Professional Development Department
DC - Direct care
DWC - Director of Women and Children
ED - Emergency Department
Ed. - Edition
EDD - Emergency Department Director
EPIC - An electronic health record system

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NAME OF PROVIDER OR SUPPLIER, STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED
14-1457	ST. CHARLES BEND CAMPUS 2500 NE NEFF ROAD BEND, OR 97701	04/29/2022

E 000 Continued From page 1

FBC - Family Birthing Center
FDP - Facility disaster plan
FTE - Full time equivalent
HNSC - Hospital nurse staffing committee
HNSP - Hospital nurse staffing plan
HS - Hour of sleep
ICU - Intensive Care Unit
LPN - Licensed practical nurse
MDU/PCU - Medical Diagnostics Unit/Procedural Care Unit
Med/Surg - Medical/Surgical
MEWS - Modified Early Warning System
NDNQI - National Database of Nursing Quality Indicators
NICU - Neonatal Intensive Care Unit
NIH - National Institutes of Health
NIHSS - National Institutes of Health Stroke Scale
NM - Nurse manager
NSC - Nurse staffing committee
NSM - Nursing staff member
NSP - Nurse staffing plan
OAR - Oregon Administrative Rule
OHA - Oregon Health Authority
Ortho/Neuro- Orthopedics/Neurology Unit
OSBN - Oregon State Board of Nursing
PACU - Post-anesthesia Care Unit
PALS - Pediatric advanced life support
PCU - Progressive Care Unit
Peds - Pediatric unit
PES - Psychiatric Emergency Services
Rehab- Rehabilitation Services
RN - Registered nurse
RQI - Resuscitation Quality Improvement
SCHS - St. Charles Health System
SSU - Surgical Specialties Unit
TNCC - Trauma nursing care course
TNHPPD - Total nursing hours per patient day

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;

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NAME OF PROVIDER OR SUPPLIER, STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED
14-1457	ST. CHARLES BEND CAMPUS 2500 NE NEFF ROAD BEND, OR 97701	04/29/2022

E 604 Continued From page 2

(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 and unit NSPs for 3 of 5 units (Ortho/Neuro, SSU and ED) and documentation of 5 of 14 NSM personnel records (NSMs 1, 2, 5, 6 and 17), it was determined 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 and complaint investigation initiated on 06/19/2017. The previous citation reflected noncompliance in ED, BHU, MDU/PCU, ICU and SSU units.

2. Review of undated document titled "Nurse Staffing Plan Requirement Ortho Neuro," reflected the following qualification and training requirements for Ortho RNs: "Ketamine infusions ... Annual RN skills day ... Annual RN computer based learning modules ... BLS quarterly (RQI), and NIH Stroke education every 2 years ... Behavioral Management Training within 90 days of hire and annually."

3. Review of Annual skills day document, titled "RN Skills 2021," reflected the following 10 competency trainings were included:
* "Demonstrate correct application of wrist restraints"
* "Identify four steps prior to safe patient handling"
* "Describe delegation and new CNA scope of practice"
* "Describe glucose monitoring, timing of administration of insulin, HS snacks"
* "Describe Foley Insertion, Care, Maintenance"
* "Wrench in early sepsis warning or MEWS, List warning signs of Sepsis"
* "List steps in Central Line dressing change"
* "Describe BMAT levels"
* "Identify stages and care for pressure ulcer prevention"
* "Assess upper and lower extremities circulation and neurological post-surgery, describe compartment syndrome"

4. During interview with Ortho/Neuro NM on 04/20/2022 at the time of Ortho/Neuro personnel record review, he/she stated that Ortho/Neuro NSM 17 missed the 2021 Annual RN skills day referenced in Finding 2, so he/she completed "make up" modules later.

5. Review of personnel records for Ortho/Neuro RN NSM 17, hired on 01/09/2017, lacked documentation of all required qualifications, competencies and trainings. For example:
* There was no documentation provided that he/she completed the Annual RN skills day in 2021.
* Review of CBL "make up modules" completed in 2021 reflected no documentation of the following competencies that were required in "RN Skills 2021": "Describe delegation and new CNA scope of practice"; "Describe glucose monitoring, timing of administration of insulin, HS snacks"; "Wrench in early sepsis warning or MEWS, List warning signs of Sepsis"; "Describe BMAT levels"; and "Identify stages and care for pressure ulcer prevention."

6. Revisit Survey: Review of SSU HNSP Unit Questionnaire, completed and signed by SSU DC Unit Representative and SSU NM on 04/19/2022, reflected the following qualifications, competencies and trainings were required for SSU NSMs:
* A 1-page document titled "Current New Hire eLearnings Position: CNA 2 (92)," which contained a list of 39 online modules;
* A 1-page document titled "Annual eLearnings 2021 Position: CNA 2 (92)," which contained a list of 36 online modules;
* A 1-page document titled "Current Traveler New Hire eLearnings Position: CNA Traveler," which contained a list of 26 online modules;
* A 1-page document titled "Current New Hire eLearnings Position: RN - Surgical Specialties (941)," which contained a list of 40 online modules;
* A 1-page document titled "Annual eLearnings 2021 Position: RN - Surgical Specialties (941)," which contained a list of 38 online modules; and
* A 1-page document titled "Current Traveler New Hire eLearnings Position: RN Traveler," which contained a list of 28 online modules.

7. Revisit Survey: Review of SSU NSP, approved by NSC on 06/02/2021, reflected the following for required staff competencies: "Initial hire competencies, BLS, RN Annual Skills Day (including bariatric training), ketamine and lidocaine low dose infusion training for RN, AVADE within 60 days of hire and annually." SSU NSP did not list CNA requirements.

8. Revisit Survey: Review of position description titled "RN - Acute Care - System," dated 04/19/2022, reflected the following qualifications were required for SSU RNs:
* "Current Oregon RN License"

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NAME OF PROVIDER OR SUPPLIER, STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED
14-1457	ST. CHARLES BEND CAMPUS 2500 NE NEFF ROAD BEND, OR 97701	04/29/2022

E 604 Continued From page 3

* "AHA Basic Life Support for Healthcare Provider certification:

9. Revisit Survey: Review of position description titled "CNA 1," dated 04/19/2022, reflected the following qualifications were required for SSU CNAs:
* "Certified Nursing Assistant - Level 1 with the Oregon State Board of Nursing"
* "AHA Basic Life Support for Healthcare Provider certification"

10. Revisit Survey: Review of a 57-page booklet titled, "Covid-19 Response Acute Care Services Orientation Handbook RN Traveler Orientation Checklists," dated 02/25/2022, reflected a 1-page checklist titled "Acute Care Traveler Onboarding Check List" that included 33 skills.

11. Revisit Survey: Review of policy titled "Orientation of New Caregivers," dated 08/19/2021, reflected the following related to qualifications, competencies and trainings:
* "The purpose of this document is to ensure all new caregivers receive required orientation to St. Charles Health System (SCHS)."
* There are three tiers of orientation: ... General Orientation ... Clinical Orientation ... Department Orientation ..."
* "Instructions ... All General Orientation requirements must be completed prior to attending Clinical Orientation or Departmental Orientation."
* "... Department Orientation ... Department Orientation is ... tailored to the new caregiver's job description ... A standard department version of the caregiver's orientation checklist will be kept in the department ..."
*... System Competencies ... Initial basic competencies are validated in Clinical Orientation, followed by validation of individualized competency expectations at the department level during department orientation ... competency is assessed, validated, and documented using position descriptions, skills checklists, competency packets, and by direct observation by validators ... folders are kept by the caregiver's direct supervisor ... they must be complete, and meet the requirements of SCHS, State and Federal regulatory and governing bodies."
* "Definitions ... Caregiver - SCHS Employee ... General Orientation is a comprehensive orientation for all SCHS caregivers (full-time, part-time, providers, relief and temporary) who are slated for three months or total."

12. Revisit Survey: Review of personnel records for SSU CNA NSM 1, hired on 01/19/2022, lacked documentation of all required qualifications, competencies and trainings. For example:
* His/her personnel records lacked documentation that the 9 of 39 online modules were completed for the required "Current New Hire eLearnings Position: CNA 2 (92)," including: "CNA Incentive Spirometer," "CNA Tasks Associated with Oxygen," "CNA Tasks Associated with Skin Care," "Condition Help," "Lymphedema," "Population-Specific Care," "Preventing Central-Line - Associated Bloodstream Infections," "Preventing Surgical Site Infections," and "Radiation Safety."
* A second transcript of eLearning modules, titled "Transfer from CNA Trainee (sic) to CNA 1 - [NSM 1's name]," included a handwritten note at the top of the page which reflected, "Required." This list contained 19 modules, 7 of which did not have documentation of completion, including: "Universal Protocol," "Population-Specific Care," "Preventing Central-Line - Associated Bloodstream Infections," "Preventing Surgical Site Infections," "Condition Help," "Radiation Safety" and "Lymphedema."

13. Revisit Survey: Review of personnel records for SSU RN NSM 2, hired on 11/29/2021, lacked documentation of all required qualifications, competencies and trainings. During review, two additional checklists which were not described in SSU NSP were provided and described as required competencies:
* A 7-page document titled "Core RN Unit Orientation," completed on 12/29/2021, reflected: "Please complete all sections before employee independently provides care or service and no later than the first 30 days of employment." Four items were not completed, including: "Oxygen Shut off."
* A 10-page document titled "Acute Care Core RN Unit Orientation," completed by Validator on 12/29/2021 and signed by SSU RN NSM 2 on 01/23/2022, lacked method of validation for multiple skills. It was also not clear how SSU RN NSM 2 completed a "3 and 6 month check in" on 12/29/2021, which was 1 month after his/her initial start date.

14. Revisit Survey: Review of personnel records for SSU traveler RN NSM 5, hired on 01/17/2022, lacked documentation of all required qualifications, competencies, and trainings. He/she had required licenses and certificates, but lacked documentation of all other required qualifications, competencies and trainings for SSU RNs.

15. Revisit Survey: During interview with SSU NM, SSU ANM and Prineville CNO on 04/20/2022 beginning at 1223, they confirmed Findings 6 - 14.
* As it related to SSU RN NSM 1, SSU NM stated "[He/she] is missing a few" and that the required initial competencies were required to be completed within "90 days." He/she further confirmed that SSU RN NSM 1's initial competencies were due 04/19/2022. He/she later stated that the competencies were actually due 04/22/2022, however, 04/19/2022 was 90 days after SSU RN NSM 1's initial start date of 01/19/2022.
* As it related to SSU traveler RN NSM 5, they stated: "CPPD does the orientation for travelers. They are onboarded rapidly." They stated the hospital was "unable to locate the caregiver's sign-off." Prineville CNO stated he/she "reached out to CPPD and [they] did not have documentation of unit onboarding training" for SSU traveler RN NSM 5.
* When asked about traveler competencies, they stated that traveler competencies "should be in FDP NSP." They also confirmed that the "Current Traveler New Hire eLearnings Position: RN Traveler" and the "Covid-19 Response Acute Care Services Orientation Handbook RN Traveler Orientation Checklists" were not in SSU NSP; that the differences in qualifications, competencies and trainings for traveler RNs had not been approved by the NSC; and that "unit Core competencies are not required of travelers."

16. Revisit Survey: Review of ED HNSP Unit Questionnaire, completed and signed by ED DC Unit Representative and ED NM on

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NAME OF PROVIDER OR SUPPLIER, STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED
14-1457	ST. CHARLES BEND CAMPUS 2500 NE NEFF ROAD BEND, OR 97701	04/29/2022

E 604 Continued From page 4

04/19/2022, reflected the following qualifications, competencies and trainings were required for ED NSMs:
* A 2-page document titled "Required New Hire Education October 2021 Position: ED RN (875)," which contained a list of 76 online modules.
* A 1-page document titled "Annual eLearnings 2021 Position: ED RN (875)," which contained a list of 40 online modules.
* A 1-page document titled "Current Traveler New Hire eLearnings Position: RN Traveler," which contained a list of 28 online modules.
* A position description titled "RN - Emergency Department," dated 04/19/2022, which included "Current Oregon RN License," "AHA Basic Life Support for Healthcare Provider certification," "AHA ACLS," "AHA PALS," and "TNCC & Code Grey training required within 6 months."
* A policy titled "Orientation of New Caregivers," dated 08/19/2021.

17. Revisit Survey: Review of ED NSP, approved by NSC on 11/01/2021, reflected the following qualifications, competencies, and trainings were required for ED RNs: "RN: ACLS, PALS, TNCC, BLS, Code Gray, OSBN license, Annual CBL's (sic), NIHHS."

18. Revisit Survey: Refer to Finding 11, which reflects the orientation and skill validation required by the "Orientation of New Caregivers" policy, dated 08/19/2021.

19. Revisit Survey: Review of personnel records for ED traveler RN NSM 6, hired on 12/06/2021, did not clearly reflect documentation of all required qualifications, competencies and trainings for ED RNs. For example:
* A 5-page document titled "Nurse Traveler Orientation Emergency Department," updated 08/27/2021, included 29 skills and reflected: "By signing this document, I attest to completing all the required validation methods as listed above in addition to review of SCHS policies and practical application of information located in the clinical orientation resource book pertinent to my caregiver role. This competence assessment will be provided by me, to my manager after completion of all competencies, to be stored in my competency tracking file." Twenty-seven of the 29 skills were dated 04/20/2022, the second day of this nurse staffing survey. Two skills did not have a signature or a date: "Restraints" and "Traveler RN to Read and Review: Standards of Care ... Emergency Department Triage ... Emergency Department Standing Orders ... High Alert (High Risk) Medications ..." ED traveler RN NSM 6's name was printed on the last page of the checklist and his/her signature was blank with a handwritten note: "Training done virtually, will obtain signature next shift" followed by ED ANM initials and date of 04/20/2022.
* A 1-page document titled "Self-Assessment Action Plan" dated 04/20/2022, reflected an expected due date of 04/21/2022 for the skills on the document and "Caregiver to not perform independently until completed, must have on-unit resource for skills."
* An 8-page document titled "Emergency Department Skills Checklist," completed and signed by ED traveler RN NSM 6 on 11/02/2021, included a list of 284 skills. It reflected ED traveler RN NSM 6 was to "mark your level of experience" with the skills. He/she marked 124 skills as "1 - No Experience" or "2 - Minimal Experience," including the following skills under the "Provision of Care" section: "Abdominal Aortic Aneurysm ... Cardiac Arrest ... Cardiac tamponade ... Central line insertion ... Hemopneumothorax ... Laryngospasm ... Abdominal trauma ... Esophageal bleed ... Closed head injury ... Encephalitis ... Externalized VP shunts ... Seizures ... Pelvic sheeting/pelvic binder ... Bites ... burns ... Major trauma ... Anaphylactic shock ... Neurogenic shock ... Tuberculosis ... Varicella ... Pertussis ... Meningitis ... Recognition of suspected child abuse/neglect ... Reporting of suspected child abuse/neglect." He/she also marked "1 - No Experience" or "2 - Minimal Experience" for the following skills under "ED Pharmacology" section: "Amiodarone ... Atropine ... Vitamin K ... Charcoal ... Digoxin ... Dilantin ... Dobutamine ... Dopamine ... Epinephrine ... Ipecac ... Nitroglycerine ... Succinylcholine ..."
* There was no other documentation provided to reflect ED traveler RN NSM 6 met the required qualifications, competencies and trainings for ED RNs, including the required checklist "Required New Hire Education October 2021 Position: ED RN (875)," which contained a list of 76 online modules as described in Finding 16.

20. Revisit Survey: During interview with ED NM, ED ANM and EDD on 04/21/2022 beginning at 0940, they confirmed Findings 16 - 19. ED ANM stated he/she "could not find the original paperwork from orientation" for ED traveler RN NSM 6, which was required per SCHS policy "Orientation of New Caregivers" and which stated "... A standard department version of the caregiver's orientation checklist will be kept in the department." They confirmed that ED ANM completed the orientation checklist again with ED traveler RN NSM 6 on 04/20/2022, the second day of the NSS. They also confirmed that the "Current Traveler New Hire eLearnings Position: RN Traveler" and the "Nurse Traveler Orientation Emergency Department" competencies were not included in ED NSP and that the traveler orientation checklists filled out for ED traveler RN NSM 6 had not been approved by the NSC.

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))

This Rule is not met as evidenced by:

Based on interview and review of HNSP Unit Questionnaires and unit NSPs for 4 of 5 units (Peds, SSU, ICU and ED), it was determined 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.

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NAME OF PROVIDER OR SUPPLIER, STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED
14-1457	ST. CHARLES BEND CAMPUS 2500 NE NEFF ROAD BEND, OR 97701	04/29/2022

E 628 Continued From page 5

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 and complaint investigation initiated on 06/19/2017. The previous citation reflected noncompliance in BHU, MDU/PCU, ICU, ED and SSU units.

2. Refer to NSP findings that reflects the NSPs the units were working under were not complete or clear.
* For Tag E630 refer to findings for SSU and ED.
* For Tag E632 refer to findings for ICU.
* For Tag E636 refer to findings for Peds and SSU.
* For Tag E638 refer to findings for ED.
* For Tag E646 refer to findings for SSU and ED.

E 630 NSP: Qualifications and Competencies

(2) The staffing plan:
(a) Must be based on the specialized qualifications and competencies of the nursing staff and provide for the skill mix and level of competency necessary to ensure that the hospital is staffed to meet the health care needs of patients;
Stat. Auth.: ORS 413.042 & 441.155
Stats. Implemented: ORS 441.155

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

This Rule is not met as evidenced by:

Based on interview and review of HNSP Unit Questionnaires and unit NSPs for 2 of 5 units (SSU and ED), it was determined the hospital failed to implement a hospital-wide NSP that was developed based on the qualifications and competencies needed by nursing staff for each unit, and that provided for the skill mix and level of competency needed to ensure that patients' needs were met.

Findings include:

1. This citation reflects repeated noncompliance with the requirement under OAR 333-510-0110(2)(a).
OHA previously cited the hospital for noncompliance with this rule in the nurse staffing survey and complaint investigation initiated on 06/19/2017. The previous citation reflected noncompliance in BHU, MDU/PCU, ICU, ED and SSU units.

2. Revisit Survey: Review of SSU HNSP Unit Questionnaire, completed and signed by SSU DC Unit Representative and SSU NM on 04/19/2022, reflected the following qualifications, competencies, and trainings were required for SSU NSMs:
* A 1-page document titled "Current New Hire eLearnings Position: CNA 2 (92)," which contained a list of 39 online modules;
* A 1-page document titled "Annual eLearnings 2021 Position: CNA 2 (92)," which contained a list of 36 online modules;
* A 1-page document titled "Current Traveler New Hire eLearnings Position: CNA Traveler," which contained a list of 26 online modules;
* A 1-page document titled "Current New Hire eLearnings Position: RN - Surgical Specialties (941)," which contained a list of 40 online modules;
* A 1-page document titled "Annual eLearnings 2021 Position: RN - Surgical Specialties (941)," which contained a list of 38 online modules; and
* A 1-page document titled "Current Traveler New Hire eLearnings Position: RN Traveler," which contained a list of 28 online modules.

3. Revisit Survey: Review of SSU NSP, approved by NSC on 06/02/2021, did not clearly reflect the qualifications, competencies and trainings required for SSU NSMs. For example, it did not include the following qualifications, competencies, and trainings which were required:
* "Orientation of New Caregivers" policy, dated 08/19/2021
* A 1-page document titled "Current New Hire eLearnings Position: CNA 2 (92)," which contained a list of 39 online modules;
* A 1-page document titled "Annual eLearnings 2021 Position: CNA 2 (92)," which contained a list of 36 online modules;
* A 1-page document titled "Current Traveler New Hire eLearnings Position: CNA Traveler," which contained a list of 26 online modules;
* A 1-page document titled "Current New Hire eLearnings Position: RN - Surgical Specialties (941)," which contained a list of 40 online modules;
* A 1-page document titled "Annual eLearnings 2021 Position: RN - Surgical Specialties (941)," which contained a list of 38 online modules; and
* A 1-page document titled "Current Traveler New Hire eLearnings Position: RN Traveler," which contained a list of 28 online modules.

Additionally, SSU NSP did not include provisions to allow SSU traveler RNs to have different qualifications, competencies and trainings than non-contracted SSU RNs.

3. Revisit Survey: During interview with SSU NM, SSU ANM, and Prineville CNO on 04/20/2022 beginning at 1223, they confirmed that the additional required checklists were not included in SSU NSP. They also confirmed that the "Current Traveler New Hire eLearnings Position:

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NAME OF PROVIDER OR SUPPLIER, STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED
14-1457	ST. CHARLES BEND CAMPUS 2500 NE NEFF ROAD BEND, OR 97701	04/29/2022

E 630 Continued From page 6

RN Traveler" and the "Covid-19 Response Acute Care Services Orientation Handbook RN Traveler Orientation Checklists" were not included in SSU NSP and that the differences in qualifications, competencies and trainings for SSU traveler RNs had not been approved by the NSC.

4. Revisit Survey: Review of ED HNSP Unit Questionnaire, completed and signed by ED DC Unit Representative and ED NM on 04/19/2022, reflected the following qualifications, competencies, and trainings were required for ED NSMs:
* A 2-page document titled "Required New Hire Education October 2021 Position: ED RN (875)," which contained a list of 76 online modules.
* A 1-page document titled "Annual eLearnings 2021 Position: ED RN (875)," which contained a list of 40 online modules.
* A 1-page document titled "Current Traveler New Hire eLearnings Position: RN Traveler," which contained a list of 28 online modules.
* A position description titled "RN - Emergency Department," dated 04/19/2022, which included "Current Oregon RN License," "AHA Basic Life Support for Healthcare Provider certification," "AHA ACLS," "AHA PALS," and "TNCC & Code Grey training required within 6 months."
* A policy titled "Orientation of New Caregivers," dated 08/19/2021.

5. Revisit Survey: Review of ED NSP, approved by NSC on 11/01/2021, did not clearly reflect the qualifications, competencies, and trainings required for ED NSMs. For example, it did not include the following qualifications, trainings, and competencies that were required for ED NSMs:
* The policy titled "Orientation of New Caregivers," dated 08/19/2021.
* A 2-page document titled "Required New Hire Education October 2021 Position: ED RN (875)," which contained a list of 76 online modules.
* A 1-page document titled "Annual eLearnings 2021 Position: ED RN (875)," which contained a list of 40 online modules.
* A 1-page document titled "Current Traveler New Hire eLearnings Position: RN Traveler," which contained a list of 28 online modules.

Additionally, ED NSP did not include provisions to allow ED traveler RNs to have different qualifications, competencies and trainings than non-contracted ED RNs.

6. Revisit Survey: During interview with ED NM, ED ANM and EDD on 04/21/2022 beginning at 0940, they confirmed that the "Current Traveler New Hire eLearnings Position: RN Traveler" and the "Nurse Traveler Orientation Emergency Department" competencies were not included in ED NSP and the different qualifications, competencies, and trainings for ED traveler RNs had not been approved by the NSC.

7. In NSM interviews completed between 04/12/2022 and 04/26/2022, 33 of 252 respondents indicated that in the past year they have been scheduled to work with patients for whom they do not have current competencies.

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 1 of 5 units (ICU), 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 DC RN to complete those tasks.

Findings include:

1. This citation reflects repeated noncompliance with the requirement under OAR 333-510-0110(2)(b).
OHA previously cited the hospital for noncompliance with this rule in the nurse staffing survey and complaint investigation completed on 06/19/2017. The previous citation reflected noncompliance in MDU/PCU and ED units.

2. Review of ICU HNSP Unit Questionnaire, completed and signed by ICU DC Unit Representative and ICU NM on 04/19/2022, reflected that the time for DC RNs to complete admissions, discharges and transfers for ICU was not quantified in ICU NSP as required. In the questionnaire, the documented responses from ICU DC Unit Representative and ICU NM, regarding this requirement, were "No."

3. Review of ICU NSP, approved by NSC on 02/05/2020, reflected that the rate of admissions was insufficient; rates of discharges and transfers were not quantified; and that the time for an ICU DC RN to complete admissions, discharges and transfers was not quantified. For example, the "Admissions" section of ICU NSP reflected: "Emergency Department ... 35% ... OR PACU ... 25% ... Transfer within Facility ... 20% ... Direct Admit ... 20%." This rate did not include a timeframe, numbers of patients, nor applicable shifts. Additionally, the section titled "Admissions, Discharges and Transfers (ADT) (333-510-0110)" in ICU NSP was left blank.

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NAME OF PROVIDER OR SUPPLIER, STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED
14-1457	ST. CHARLES BEND CAMPUS 2500 NE NEFF ROAD BEND, OR 97701	04/29/2022

E 632 Continued From page 7

3. During interview with ICU NM on 04/20/2022 at the time of ICU NSP review, he/she confirmed Findings 1 and 2.

E 636 NSP: Nationally Recognized Evidence-Based Std

(2) The staffing plan:
(d) Must be consistent with nationally recognized evidence-based standards and guidelines established by professional nursing specialty organizations such as, but not limited to: The American Association of Critical Care Nurses, American Operating Room Nurses (AORN), or American Society of Peri-Anesthesia Nurses (ASPAN);
Stat. Auth.: ORS 413.042 & 441.155
Stats. Implemented: ORS 441.155

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

This Rule is not met as evidenced by:

Based on interview and review of HNSP Unit Questionnaires and unit NSPs for 2 of 5 units (Peds and SSU), it was determined the hospital failed to implement a hospital-wide NSP that was developed to reflect for each unit consistency with current, nationally-recognized standards and guideline established by professional nursing specialty organizations.

Findings include:

1. This citation reflects repeated noncompliance with the requirement under OAR 333-510-0110(2)(d).
OHA previously cited the hospital for noncompliance with this requirement in the nurse staffing survey and complaint investigation initiated on 06/19/2017. The previous citation reflected noncompliance in BHU, MDU/PCU, ICU and SSU units.

2. Review of Peds HNSP Unit Questionnaire, completed and signed by Peds DC Unit Representative and Peds NM on 04/19/2022, reflected that evidence-based standards and guidelines established by professional nursing organizations were not used in the development of Peds NSP. In the questionnaire, the documented response was "No" and "reached out to pediatric units on the West Coast including magnet organizations."

3. Review of Peds NSP, approved by NSC on 10/06/2020, reflected that evidence-based standards and guidelines established by professional organizations were not used. The section titled "Nationally recognized standards (333-510-0110)" in Peds NSP was left blank.

4. During interview with Peds ANM and DWC at the time of Peds NSP review, they confirmed Findings 2 and 3. They stated that the prior Peds NM had done a literature search in December 2021 and was unable to find any national guidelines for pediatric units.

5. Revisit Survey: Review of SSU HNSP Unit Questionnaire, completed and signed by SSU DC Unit Representative and SSU NM on 04/19/2022, reflected that evidence-based standards and guidelines established by professional nursing organizations were not used in the development of SSU NSP. In the questionnaire, the documented response was "no recognized standards identified for Med/Surg nursing."

6. Revisit Survey: Review of SSU NSP, approved by NSC on 05/02/2021, reflected that evidence-based standards and guidelines established by professional nursing organizations were not used. In the section titled "Nationally Recognized Evidence Based on Standards of Practice" in SSU NSP, it stated "none identified for Med/Surg nursing."

7. Revisit Survey: During interview with SSU NM, SSU ANM, and Prineville CNO on 04/20/2022 beginning at 1415, they confirmed Findings 5 and 6. They stated that there were "no recognized standards for Med/Surg nursing to use as resources for standards of care."
During the interview, SSU NM stated that other resources were used to develop SSU NSP, including:
* American Nurses Association (2021). Nursing: Scope and Standards of Practice (4th Ed.)
* American Medical-Surgical Nurses (2016). Cure (sic) Curriculum for Medical-Surgical Nursing (5th Ed.), Pitman, NJ, AMSN
* OSBN (2021). Scope of Practice OSBN: Board of Nursing Chapter 851, Division 45. Retrieved February 23, 2021.

However, SSU NSP did not clearly reference these other resources used to develop SSU NSP.

E 638 NSP: Patient Acuity & Nursing Care Intensity

(2) The staffing plan:
(e) Must recognize differences in patient acuity and nursing care intensity;
Stat. Auth.: ORS 413.042 & 441.155
Stats. Implemented: ORS 441.155

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

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NAME OF PROVIDER OR SUPPLIER, STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED
14-1457	ST. CHARLES BEND CAMPUS 2500 NE NEFF ROAD BEND, OR 97701	04/29/2022

E 638 Continued From page 8

This Rule is not met as evidenced by:

Based on interview and review of HNSP Unit Questionnaires and unit NSPs for 1 of 5 units (ED), it was determined the hospital failed to implement a hospital-wide NSP that was developed to recognize for each unit differences in patient acuity and nursing care intensity.

Findings include:

1. This citation reflects repeated noncompliance with the requirement under OAR 333-510-0110(2)(e).
OHA previously cited the hospital for noncompliance with this rule in the nurse staffing survey and complaint investigation initiated on 06/19/2017. The previous citation reflected the hospital was noncompliant in BHU, MDU/PCU, ICU, ED and SSU units.

2. Revisit Survey: Review of ED HNSP Unit Questionnaire, completed and signed by ED DC Unit Representative and ED NM on 04/19/2022, reflected ED NSP lacked a clear method, system or criteria for objectively determining acuity and nursing care intensity for individual patients. It reflected that "Its (sic) the charge nurse and primary RN who work together to determine [patient acuity and nursing care intensity]. Reducing or increasing assignment or providing additional resources as needed to support patient care. There are multiple tools in EPIC that give (sic) charge nurse visuals of pt acuity/intensity. Tools cant (sic) tell the entire story of a rapidly decompensating or critical patient. Nurse & charge nurse must communicate needs and status of assignment." Additionally, it reflect, "The charge nurse, any nurse and leadership are all part of the discussion, we have resources (sic) nurse(s) and a surge plan."

3. Revisit Survey: During onsite unit interview with ED DC RN on 04/19/2022 beginning at 1225, he/she stated that acuity and intensity were determined by using "ESI triage to assign acuity. Intensity is also [measured] but the RN ratio is 3:1 and [RNs] can sometimes carry a 4th patient in the hall." He/she also added that acuity and intensity were determined "... by the Charge Nurse, who keeps a pulse on the RN workload. [Acuity and intensity] is really measured by the Charge Nurse." When asked if this process was reflected in ED NSP, he/she responded, "I'm not seeing that on here" and "that's what I have experienced."

4. Revisit Survey: Review of ED NSP, approved by NSC on 11/01/2021, reflected it lacked a clear method, system or criteria for objectively determining acuity and nursing care intensity for individual patients. In ED NSP, the section titled "Minimum Staffing and Acuity Modifications" reflected, "Due to varying affects (sic) COVID has had on our ADC we are not adjusting FTE's related to current ADC ... Recognition of acuity and intensity (333-510-0110): See Surge plan..." However, Surge plan was not attached to ED NSP approved by NSC. Therefore, ED NSP did not clearly describe the method, system or criteria for objectively determining acuity and nursing care intensity for individual patients. Additionally, the processes referenced in Findings 2 and 3 were not clearly reflected in ED NSP.

5. Revisit Survey: During interview with ED NM, ED ANM and EDD on 04/20/2022 beginning at 1200, they confirmed Findings 2 - 4 and agreed that the process for determining individual acuity and intensity and that the Charge Nurse decision-making process was not clearly defined in ED NSP. ED NM stated that there "were multiple factors in EPIC" that the Charge Nurse utilizes to assist in determining acuity and intensity, such as "number of patients, orders, tasks, track boards, overdue tasks ..." and that "The Charge Nurse looks at all inputs and reviews with the RNs" and then uses available support, such as "Pod Leads" and "Resource Nurses" to assist ED RNs with assignments. However, it was not clear how this decision-making allowed for objectively determining individual patient acuity and nursing care intensity.

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 review of Meal and Rest Break Practice tool and unit NSPs for 2 of 5 units (SSU and ED), 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 that NSMs received breaks as required. The NSP did not provide for additional NSMs to maintain the staffing number required in the NSP during these tasks, creating the possibility that the units did not meet the minimum staffing required for the duration of tasks not related to direct patient care.

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 and complaint investigation completed on 06/19/2017. The previous citation reflected noncompliance in BHU, MDU/PCU, SSU, ED and ICU units.
* OHA previously cited the hospital for noncompliance with this rule in the nurse staffing complaint investigation completed on 04/08/2021. The previous citation reflected noncompliance in MSVS unit.

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NAME OF PROVIDER OR SUPPLIER, STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED
14-1457	ST. CHARLES BEND CAMPUS 2500 NE NEFF ROAD BEND, OR 97701	04/29/2022

E 646 Continued From page 9

2. Complaint #OR30088: Review of SSU Meal and Rest Break Practice tool, completed and signed by SSU DC Unit Representative and SSU NM on 04/19/2022, reflected that SSU drops below the minimum number of NSMs specified in SSU NSP during meal breaks.

3. Complaint #OR30088: Review of SSU NSP, approved by NSC on 06/02/2021, reflected the following related to meal and rest break practices on SSU:
* "... Lunch RN will be provided ... If Lunch RN is not available, the rest and meal break support steps ... will be utilized"
* "Staff will be assigned times for all rest and meal breaks"
*" ... In the event a Staff RN is unable to take a rest or meal break ... the following steps will be taken to support rest and meal breaks ... The Lunch RN and Staff RN will reschedule the assigned ... time ... The Charge RN will cover the Staff RN ... The Staff will request ... another Staff RN who can safely cover the assignment in accordance with the unit based staffing plan"
* " ... If the above options are not viable, the Staff RN will acknowledge the missed rest or meal break through the timeclock attestation ... CNAs ... or RNs working in the place of CNAs ... will coordinate with assigned RNs on rest and break times ... Assigned RNs will assume duties ... Pass phone to CNA remaining on floor ... RN will call backup CNA for urgent needs during rest/meal periods ... CN will assist in covering meals and lunch breaks as needed ..."

It was not clear how this process ensured that SSU NSMs received all meal and rest breaks as required and that SSU did not drop below the minimum numbers of SSU NSMs during meal and rest breaks.

4. Complaint #OR30088: Review of untitled staffing matrix attached to SSU NSP reflected the number of SSU NSMs required on SSU for different shifts and patient censuses. Neither the staffing matrix nor the NSP clearly reflected how minimum numbers were maintained during meal and rest break coverage when the unit was at low census. For example:
* The staffing matrix reflected that when there were 1 - 4 patients on SSU for "Day Shift", the minimum number of NSMs would be 1 "Charge RN," 1 "Staff RN" and 0 "Lunch RN."
* The staffing matrix reflected that when there were 5 patients on SSU for "Eve Shift", the minimum number of NSMs would be "1 Charge RN", 1 "Staff RN", and 0 "Lunch RN."

SSU NSP did not ensure SSU would maintain minimum numbers of NSMs during meal and rest breaks.

5. In NSM interviews completed between 04/12/2022 and 04/26/2022, 125 of 252 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.

6. In NSM interviews completed between 04/12/2022 and 04/26/2022, 150 of 252 respondents indicated that in the past year they experienced one or more shifts in which they missed a meal and/or rest break because there was not sufficient staff to cover that time.

E 652 NSP Annual Review

(1) The staffing committee shall:
(a) Review the staffing plan at least once per year; and
(b) At any other time specified by either co-chair of the staffing committee.
Statutory/Other Authority: ORS 413.042 & 441.156
Statutes/Other Implemented: ORS 441.156

(OAR 333-510-0115(1)(a)(b))

This Rule is not met as evidenced by:

Based on interview and review of HNSP Unit Questionnaires, unit NSPs, and HNSC Co-Chair Pre-Interview Questionnaire, it was determined the hospital failed to review the staffing plan in accordance with these rules:
* The NSP was not reviewed at least once per year.

Findings include:

1. Review of HNSC Co-Chair Pre-Interview Questionnaire, completed and signed by NSC DC Co-Chair and NSC NM Co-Chair on 04/14/2022, reflected the response to the question "... the nurse staffing committee reviewed all unit nurse staffing plans at least once in the past 12 months" was left blank. An explanation was provided in the questionnaire that reflected: "Pandemic Response slowed this work. Committee has schedule to review all units by year end (2022)."

2. During interview with NSC NM Co-Chair on 04/19/2022 beginning at 1500, he/she confirmed that the NSC had not conducted annual NSP reviews for several units. He/she later provided a list of units with NSPs that had not been reviewed in the past 12 months. These units included:
* ICU, last reviewed by NSC "02/20"
* PCU, last reviewed by NSC "02/20"
* PES, last reviewed by NSC "03/20"
* Pre-Surgery, last reviewed by NSC "09/20"

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NAME OF PROVIDER OR SUPPLIER, STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED
14-1457	ST. CHARLES BEND CAMPUS 2500 NE NEFF ROAD BEND, OR 97701	04/29/2022

E 652 Continued From page 10

* Cath Lab, last reviewed by NSC "11/20"
* Dialysis, last reviewed by NSC "09/20"
* MDU, last reviewed by NSC "12/20"
* NICU, last reviewed by NSC "10/20"
* FBC, last reviewed by NSC "10/20"
* Rehab, last reviewed by NSC "12/20"
* Wound Ostomy, last reviewed by NSC "10/20"
* Cancer Services, last reviewed by NSC "12/20"

3. Review of Peds HNSP Unit Questionnaire, completed and signed by Peds DC Unit Representative and Peds ANM on 04/19/2022, reflected the NSC last completed its annual review of Peds NSP on 10/07/2020.

4. Review of Peds NSP reflected it was last approved on 10/07/2020.

5. During interview with Peds ANM and DWC on 04/20/2022 at the time of review of Peds NSP annual review, they confirmed Peds NSP was last reviewed by NSC on 10/07/2020.

6. Review of ICU HNSP Unit Questionnaire, completed and signed by ICU DC Unit Representative and ICU NM on 04/19/2022, reflected the NSC last completed its annual review of ICU NSP "2/2020."

7. Review of ICU NSP reflected it was last approved on 02/05/2020.

8. During interview with ICU NM on 04/20/2022 at the time of review of ICU NSP annual review, he/she confirmed ICU NSP was last reviewed by NSC on 02/05/2020.

E 654 NSP Annual Review Factors

(2) In reviewing the staffing plan, the staffing committee shall consider:
(a) Patient outcomes;
(b) Complaints regarding staffing, including complaints about a delay in direct care nursing or an absence of direct care nursing;
(c) The number of hours of nursing care provided through a hospital unit compared with the number of patients served by the hospital unit during a 24-hour period;
(d) The aggregate hours of mandatory overtime worked by nursing staff;
(e) The aggregate hours of voluntary overtime worked by nursing staff;
(f) The percentage of shifts for each hospital unit for which staffing differed from what is required by the staffing plan;
(g) Any other matter determined by the committee to be necessary to ensure that the hospital is staffed to meet the health care needs of patients; and
(h) Any report filed by a nursing staff member stating the nursing staff member's belief that the hospital unit engaged in a pattern of requiring direct care nursing staff to work overtime for nonemergency care.
Stat. Auth.: ORS 413.042 & 441.156
Stats. Implemented: ORS 441.156

(OAR 333-510-0115(2))

This Rule is not met as evidenced by:

Based on interview and review of HNSP Unit Questionnaires, unit NSPs and HNSC Co-Chair Pre-Interview Questionnaire, it was determined that the hospital failed to ensure the NSC reviewed the NSPs by considering all of the factors specified in the rules.

Findings include:

1. Refer to Tag E652 which reflects that the NSP for the following units had not been reviewed by the NSC within the past 12 months:
* ICU, last reviewed by NSC "02/20"
* PCU, last reviewed by NSC "02/20"
* PES, last reviewed by NSC "03/20"
* Pre-Surgery, last reviewed by NSC "09/20"
* Cath Lab, last reviewed by NSC "11/20"
* Dialysis, last reviewed by NSC "09/20"
* MDU, last reviewed by NSC "12/20"
* NICU, last reviewed by NSC "10/20"
* FBC, last reviewed by NSC "10/20"
* Rehab, last reviewed by NSC "12/20"
* Wound Ostomy, last reviewed by NSC "10/20"
* Cancer Services, last reviewed by NSC "12/20"

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NAME OF PROVIDER OR SUPPLIER, STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED
14-1457	ST. CHARLES BEND CAMPUS 2500 NE NEFF ROAD BEND, OR 97701	04/29/2022

E 654 Continued From page 11

2. Review of ED HNSP Unit Questionnaire, completed and signed by ED DC Unit Representative and ED NM on 04/19/2022, reflected that ED failed to provide the following data to the NSC for ED NSP's annual review: Percentage of shifts for which staffing differed from the NSP.

3. During interview with ED NM, ED ANM and EDD on 04/20/2022 beginning at 1215, they confirmed Finding 2.

E 656 NSP Annual Report

(3) Following its review of the staffing plan, the staffing committee shall issue a written report to the hospital that indicates whether the staffing plan ensures that the hospital is adequately staffed and meets the health care needs of patients. If the report indicates that it does not, the staffing committee shall modify the staffing plan as necessary to accomplish this goal.
Stat. Auth.: ORS 413.042 & 441.156
Stats. Implemented: ORS 441.156

(OAR 333-510-0115(3))

This Rule is not met as evidenced by:

Based on interview and review of HNSP Unit Questionnaires, unit NSPs and HNSC Co-Chair Pre-Interview Questionnaire, it was determined the hospital failed to issue a report to indicate whether the staffing plan ensures adequate staffing to meet the health care needs of patients.

Findings include:

1. Refer to Tag E652, which reflects that the NSP for the following units were not reviewed by the NSC within the past 12 months. There was no document provided that reflected a written report issued to the hospital indicating whether the staffing plans for the following units ensure that the hospital is adequately staffed to meet the health care needs of patients.
* ICU, last reviewed by NSC "02/20"
* PCU, last reviewed by NSC "02/20"
* PES, last reviewed by NSC "03/20"
* Pre-Surgery, last reviewed by NSC "09/20"
* Cath Lab, last reviewed by NSC "11/20"
* Dialysis, last reviewed by NSC "09/20"
* MDU, last reviewed by NSC "12/20"
* NICU, last reviewed by NSC "10/20"
* FBC, last reviewed by NSC "10/20"
* Rehab, last reviewed by NSC "12/20"
* Wound Ostomy, last reviewed by NSC "10/20"
* Cancer Services, last reviewed by NSC "12/20"

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
Fax: (971) 673-0556
TTY: 711
http://www.healthoregon.org/nursestaffing
mailbox.nursestaffing@state.or.us

Nurse Staffing Survey and Revisit Survey
St Charles Medical Center Bend
April 29, 2022

On April 29, 2022, our office completed a:

- ☒ Nurse staffing survey
- ☒ Nurse staffing revisit for
  - ☒ The 2017 nurse staffing survey
  - ☒ The 2017 and 2021 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.

David Golda
Name of Hospital Administrator (Printed)

8-10-2022
Date

Name of Hospital Administrator (Signed)

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

December 6, 2022

David Golda
Hospital Administrator
St. Charles Bend Campus
2500 NE Neff Road
Bend, OR 97701

Meredith Gould
Chief Nursing Officer
St. Charles Bend Campus
2500 NE Neff Road
Bend, OR 97701

Joel Hernandez
Hospital Nurse Staffing Committee Co-Chair
St. Charles Bend Campus
2500 NE Neff Road
Bend, OR 97701

Daniel Davis
Hospital Nurse Staffing Committee Co-Chair
St. Charles Bend Campus
2500 NE Neff Road
Bend, OR 97701

RE: POC Determination Letter for Nursing Staffing Survey and Complaint Investigation OR30088 – POC Sufficient

Dear Mr. Golda, Ms. Gould, Mr. Hernandez, and Mr. Davis:

This letter provides notification that your Plan of Correction (POC), in response to deficiencies cited during the nurse staffing survey and complaint investigation completed on April 29, 2022 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) and Oregon Administrative Rule 333-501-0040(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.

St. Charles HEALTH SYSTEM

Campus: Bend Hospital	Accreditation body: Oregon Health Authority

Standard/EP/COPS:

E 604 OAR 333-510-0045(3) 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

Subject: Nurse Staffing Documentation
Title: E 604

Date survey completed: 4/29/2022 Official letter received: 6/17/2022	**RFI Plan of Correction due:** Response due to OHA: 08/15/2022 (extension)

Process owner and title (person in charge of the plan of action and bringing RFI into compliance):

Daniel Davis, RN, Co-Chair Bend Staffing Committee

Ultimately responsible and title (process owner supervisor, responsible for RFI compliance and ongoing compliance):

Debbie Robinson, RN, CNO, St. Charles Bend Campus

Official Findings:

(OAR 333-510-0045(3))
This Rule is not met as evidenced by:
Based on interview and review of HNSP Unit Questionnaires and unit NSPs for 3 of 5 units (Ortho/Neuro, SSU and ED) and documentation
of 5 of 14 NSM personnel records (NSMs 1, 2, 5, 6 and 17), it was determined 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 and complaint investigation initiated on
06/19/2017. The previous citation reflected noncompliance in ED, BHU, MDU/PCU, ICU and SSU units.
2. Review of undated document titled "Nurse Staffing Plan Requirement Ortho Neuro," reflected the following qualification and training
requirements for Ortho RNs: "Ketamine infusions ... Annual RN skills day ... Annual RN computer based learning modules ... BLS quarterly
(RQI), and NIH Stroke education every 2 years ... Behavioral Management Training within 90 days of hire and annually."

3. Review of Annual skills day document, titled "RN Skills 2021," reflected the following 10 competency trainings were included:
* "Demonstrate correct application of wrist restraints"
* "Identify four steps prior to safe patient handling"
* "Describe delegation and new CNA scope of practice"
* "Describe glucose monitoring, timing of administration of insulin, HS snacks"
* "Describe Foley Insertion, Care, Maintenance"
* "Wrench in early sepsis warning or MEWS, List warning signs of Sepsis"
* "List steps in Central Line dressing change"
* "Describe BMAT levels"
* "Identify stages and care for pressure ulcer prevention"
* "Assess upper and lower extremities circulation and neurological post-surgery, describe compartment syndrome"
4. During interview with Ortho/Neuro NM on 04/20/2022 at the time of Ortho/Neuro personnel record review, he/she stated that
Ortho/Neuro NSM 17 missed the 2021 Annual RN skills day referenced in Finding 2, so he/she completed "make up" modules later.
5. Review of personnel records for Ortho/Neuro RN NSM 17, hired on 01/09/2017, lacked documentation of all required qualifications,
competencies and trainings. For example:
* There was no documentation provided that he/she completed the Annual RN skills day in 2021.
* Review of CBL "make up modules" completed in 2021 reflected no documentation of the following competencies that were required in
"RN Skills 2021": "Describe delegation and new CNA scope of practice"; "Describe glucose monitoring, timing of administration of insulin,
HS snacks"; "Wrench in early sepsis warning or MEWS, List warning signs of Sepsis"; "Describe BMAT levels"; and "Identify stages and
care for pressure ulcer prevention."
6. Revisit Survey: Review of SSU HNSP Unit Questionnaire, completed and signed by SSU DC Unit Representative and SSU NM on
04/19/2022, reflected the following qualifications, competencies and trainings were required for SSU NSMs:
* A 1-page document titled "Current New Hire eLearnings Position: CNA 2 (92)," which contained a list of 39 online modules;
* A 1-page document titled "Annual eLearnings 2021 Position: CNA 2 (92)," which contained a list of 36 online modules;
* A 1-page document titled "Current Traveler New Hire eLearnings Position: CNA Traveler," which contained a list of 26 online modules;
* A 1-page document titled "Current New Hire eLearnings Position: RN - Surgical Specialties (941)," which contained a list of 40 online
modules;

* A 1-page document titled "Annual eLearnings 2021 Position: RN - Surgical Specialties (941)," which contained a list of 38 online
modules; and
* A 1-page document titled "Current Traveler New Hire eLearnings Position: RN Traveler," which contained a list of 28 online modules.
7. Revisit Survey: Review of SSU NSP, approved by NSC on 06/02/2021, reflected the following for required staff competencies: "Initial
hire competencies, BLS, RN Annual Skills Day (including bariatric training), ketamine and lidocaine low dose infusion training for RN,
AVADE within 60 days of hire and annually." SSU NSP did not list CNA requirements.
8. Revisit Survey: Review of position description titled "RN - Acute Care - System," dated 04/19/2022, reflected the following qualifications
were required for SSU RNs:
* "Current Oregon RN License"
* "AHA Basic Life Support for Healthcare Provider certification:
9. Revisit Survey: Review of position description titled "CNA 1," dated 04/19/2022, reflected the following qualifications were required for
SSU CNAs:
* "Certified Nursing Assistant - Level 1 with the Oregon State Board of Nursing"
* "AHA Basic Life Support for Healthcare Provider certification"
10. Revisit Survey: Review of a 57-page booklet titled, "Covid-19 Response Acute Care Services Orientation Handbook RN Traveler
Orientation Checklists," dated 02/25/2022, reflected a 1-page checklist titled "Acute Care Traveler Onboarding Check List" that included 33
skills.
11. Revisit Survey: Review of policy titled "Orientation of New Caregivers," dated 08/19/2021, reflected the following related to
qualifications, competencies and trainings:
* "The purpose of this document is to ensure all new caregivers receive required orientation to St. Charles Health System (SCHS)."
* There are three tiers of orientation: ... General Orientation ... Clinical Orientation ... Department Orientation ..."
* "Instructions ... All General Orientation requirements must be completed prior to attending Clinical Orientation or Departmental
Orientation."
* "... Department Orientation ... Department Orientation is ... tailored to the new caregiver's job description ... A standard department version
of the caregiver's orientation checklist will be kept in the department ..."
*... System Competencies ... Initial basic competencies are validated in Clinical Orientation, followed by validation of individualized
competency expectations at the department level during department orientation ... competency is assessed, validated, and documented using
position descriptions, skills checklists, competency packets, and by direct observation by validators ... folders are kept by the caregiver's
direct supervisor ... they must be complete, and meet the requirements of SCHS, State and Federal regulatory and governing bodies."
* "Definitions ... Caregiver - SCHS Employee ... General Orientation is a comprehensive orientation for all SCHS caregivers (full-time,
part-time, providers, relief and temporary) who are slated for three months or total."

12. Revisit Survey: Review of personnel records for SSU CNA NSM 1, hired on 01/19/2022, lacked documentation of all required
qualifications, competencies and trainings. For example:
* His/her personnel records lacked documentation that the 9 of 39 online modules were completed for the required "Current New Hire
eLearnings Position: CNA 2 (92)," including: "CNA Incentive Spirometer," "CNA Tasks Associated with Oxygen," "CNA Tasks Associated
with Skin Care," "Condition Help," "Lymphedema," "Population-Specific Care," "Preventing Central-Line - Associated Bloodstream
Infections," "Preventing Surgical Site Infections," and "Radiation Safety."
* A second transcript of eLearning modules, titled "Transfer from CNA Trainee (sic) to CNA 1 - [NSM 1's name]," included a handwritten
note at the top of the page which reflected, "Required." This list contained 19 modules, 7 of which did not have documentation of
completion, including: "Universal Protocol," "Population-Specific Care," "Preventing Central-Line - Associated Bloodstream Infections,"
"Preventing Surgical Site Infections," "Condition Help," "Radiation Safety" and "Lymphedema."
13. Revisit Survey: Review of personnel records for SSU RN NSM 2, hired on 11/29/2021, lacked documentation of all required
qualifications, competencies and trainings. During review, two additional checklists which were not described in SSU

NSP were provided
and described as required competencies:
* A 7-page document titled "Core RN Unit Orientation," completed on 12/29/2021, reflected: "Please complete all sections before employee
independently provides care or service and no later than the first 30 days of employment." Four items were not completed, including:
"Oxygen Shut off."
* A 10-page document titled "Acute Care Core RN Unit Orientation," completed by Validator on 12/29/2021 and signed by SSU RN NSM 2
on 01/23/2022, lacked method of validation for multiple skills. It was also not clear how SSU RN NSM 2 completed a "3 and 6 month check
in" on 12/29/2021, which was 1 month after his/her initial start date.
14. Revisit Survey: Review of personnel records for SSU traveler RN NSM 5, hired on 01/17/2022, lacked documentation of all required
qualifications, competencies, and trainings. He/she had required licenses and certificates, but lacked documentation of all other required
qualifications, competencies and trainings for SSU RNs.
15. Revisit Survey: During interview with SSU NM, SSU ANM and Prineville CNO on 04/20/2022 beginning at 1223, they confirmed
Findings 6 - 14.
* As it related to SSU RN NSM 1, SSU NM stated "[He/she] is missing a few" and that the required initial competencies were required to be
completed within "90 days." He/she further confirmed that SSU RN NSM 1's initial competencies were due 04/19/2022. He/she later stated
that the competencies were actually due 04/22/2022, however, 04/19/2022 was 90 days after SSU RN NSM 1's initial start date of
01/19/2022.
* As it related to SSU traveler RN NSM 5, they stated: "CPPD does the orientation for travelers. They are onboarded rapidly." They stated
the hospital was "unable to locate the caregiver's sign-off." Prineville CNO stated he/she "reached out to CPPD and [they] did not have
documentation of unit onboarding training" for SSU traveler RN NSM 5.
* When asked about traveler competencies, they stated that traveler competencies "should be in FDP NSP." They also confirmed that the
"Current Traveler New Hire eLearnings Position: RN Traveler" and the "Covid-19 Response Acute Care Services Orientation Handbook RN
Traveler Orientation Checklists" were not in SSU NSP; that the differences in qualifications, competencies and trainings for traveler RNs
had not been approved by the NSC; and that "unit Core competencies are not required of travelers."

16. Revisit Survey: Review of ED HNSP Unit Questionnaire, completed and signed by ED DC Unit Representative and ED NM on
04/19/2022, reflected the following qualifications, competencies and trainings were required for ED NSMs:
* A 2-page document titled "Required New Hire Education October 2021 Position: ED RN (875)," which contained a list of 76 online
modules.
* A 1-page document titled "Annual eLearnings 2021 Position: ED RN (875)," which contained a list of 40 online modules.
* A 1-page document titled "Current Traveler New Hire eLearnings Position: RN Traveler," which contained a list of 28 online modules.
* A position description titled "RN - Emergency Department," dated 04/19/2022, which included "Current Oregon RN License," "AHA
Basic Life Support for Healthcare Provider certification," "AHA ACLS," "AHA PALS," and "TNCC & Code Grey training required within 6
months."
* A policy titled "Orientation of New Caregivers," dated 08/19/2021.
17. Revisit Survey: Review of ED NSP, approved by NSC on 11/01/2021, reflected the following qualifications, competencies, and trainings
were required for ED RNs: "RN: ACLS, PALS, TNCC, BLS, Code Gray, OSBN license, Annual CBL's (sic), NIHHS."
18. Revisit Survey: Refer to Finding 11, which reflects the orientation and skill validation required by the "Orientation of New Caregivers"
policy, dated 08/19/2021.
19. Revisit Survey: Review of personnel records for ED traveler RN NSM 6, hired on 12/06/2021, did not clearly reflect documentation of
all required qualifications, competencies and trainings for ED RNs. For example:
* A 5-page document titled "Nurse Traveler Orientation Emergency Department," updated 08/27/2021, included 29 skills and reflected: "By
signing this document, I attest to completing all the required validation methods as listed above in addition to review of SCHS policies and

practical application of information located in the clinical orientation resource book pertinent to my caregiver role. This competence
assessment will be provided by me, to my manager after completion of all competencies, to be stored in my competency tracking file."
Twenty-seven of the 29 skills were dated 04/20/2022, the second day of this nurse staffing survey. Two skills did not have a signature or a
date: "Restraints" and "Traveler RN to Read and Review: Standards of Care ... Emergency Department Triage ... Emergency Department
Standing Orders ... High Alert (High Risk) Medications ..." ED traveler RN NSM 6's name was printed on the last page of the checklist and
his/her signature was blank with a handwritten note: "Training done virtually, will obtain signature next shift" followed by ED ANM initials
and date of 04/20/2022.
* A 1-page document titled "Self-Assessment Action Plan" dated 04/20/2022, reflected an expected due date of 04/21/2022 for the skills on
the document and "Caregiver to not perform independently until completed, must have on-unit resource for skills."
* An 8-page document titled "Emergency Department Skills Checklist," completed and signed by ED traveler RN NSM 6 on 11/02/2021,
included a list of 284 skills. It reflected ED traveler RN NSM 6 was to "mark your level of experience" with the skills. He/she marked 124
skills as "1 - No Experience" or "2 - Minimal Experience," including the following skills under the "Provision of Care" section: "Abdominal
Aortic Aneurysm ... Cardiac Arrest ... Cardiac tamponade ... Central line insertion ... Hemopneumothorax ... Laryngospasm ... Abdominal
trauma ... Esophageal bleed ... Closed head injury ... Encephalitis ... Externalized VP shunts ... Seizures ... Pelvic sheeting/pelvic binder ...
Bites ... burns ... Major trauma ... Anaphylactic shock ... Neurogenic shock ... Tuberculosis ... Varicella ... Pertussis ... Meningitis ...
Recognition of suspected child abuse/neglect ... Reporting of suspected child abuse/neglect." He/she also marked "1 - No Experience" or "2 -
Minimal Experience" for the following skills under "ED Pharmacology" section: "Amiodarone ... Atropine ... Vitamin K ... Charcoal ...
Digoxin ... Dilantin ... Dobutamine ... Dopamine ... Epinephrine ... Ipecac ... Nitroglycerine ... Succinylcholine ..."
* There was no other documentation provided to reflect ED traveler RN NSM 6 met the required qualifications, competencies and trainings
for ED RNs, including the required checklist "Required New Hire Education October 2021 Position: ED RN (875)," which contained a list
of 76 online modules as described in Finding 16.
20. Revisit Survey: During interview with ED NM, ED ANM and EDD on 04/21/2022 beginning at 0940, they confirmed Findings 16 - 19.
ED ANM stated he/she "could not find the original paperwork from orientation" for ED traveler RN NSM 6, which was required per SCHS
policy "Orientation of New Caregivers" and which stated "... A standard department version of the caregiver's orientation checklist will be
kept in the department." They confirmed that ED ANM completed the orientation checklist again with ED traveler RN NSM 6 on
04/20/2022, the second day of the NSS. They also confirmed that the "Current Traveler New Hire eLearnings Position: RN Traveler" and the
"Nurse Traveler Orientation Emergency Department" competencies were not included in ED NSP and that the traveler orientation checklists
filled out for ED traveler RN NSM 6 had not been approved by the NSC.

Plan of Action:

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 action. By statute, the hospital must implement its Plan of Correction no later than 45 days after OHA approves the facility's Plan of Correction.

Requirement For Improvement (RFI)

4. Monitoring: The description of the monitoring procedure(s) that the hospital will perform to prevent a 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.

What	Who	When	Status
Ortho/Neuro, Surgical, and Emergency Room departments will have all documents required to demonstrate defined department specialized qualifications and competencies present and available	Ortho/Neuro Manager, Lisa Firkus, RN Surgical Manager, Wendy Wait, RN ED Manager, Michelle Robinson, RN	No later than 45 business days after OHA approves facility plan of correction (estimated 11/30/22).	In progress
All units with a NSP will have all documents required to demonstrate defined departments specialized qualifications and competencies present and available.	Daniel Davis, RN, Co-Chair Bend Staffing Committee	No later than 45 business days after OHA approves facility plan of correction (estimated 11/30/22).	In progress

How: Ortho/Neuro, Surgical, and Emergency departments will confirm that each NSM has all required documents, as outlined in the department's approved NSP, to demonstrate compliance with department's specialized qualifications and competencies.

How: All departments with a NSP will confirm that each NSM has all required documents, as outlined in the department's approved NSP, to demonstrate compliance with department's specialized qualifications and competencies.

Monitoring: Quarterly audits will be performed selecting 10 caregiver records per department to assess if all required documents demonstrate compliance with defined department specialized qualifications and competencies.

RFI closed	Who: Name/title	Date

St. Charles HEALTH SYSTEM

Campus: Bend Hospital	Accreditation body: Oregon Health Authority
Standard/EP/COPS: E 628 NSP Requirement 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	
Subject: Nurse Staffing Documentation Title: E 628	
Date survey completed: 4/29/2022 Official letter received: 6/17/2022	**RFI Plan of Correction due:** Response due to OHA: 08/15/2022 (extension)

Process owner and title (person in charge of the plan of action and bringing RFI into compliance):
Daniel Davis, RN, Co-Chair Bend Staffing Committee
Ultimately responsible and title (process owner supervisor, responsible for RFI compliance and ongoing compliance):
Debbie Robinson, RN, CNO, St. Charles Bend Campus

Official Findings:

(OAR 333-510-0110(1)) This Rule is not met as evidenced by:

This Rule is not met as evidenced by: Based on interview and review of HNSP Unit Questionnaires and unit NSPs for 4 of 5 units (Peds, SSU, ICU and ED), it was determined 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 and complaint investigation initiated on 06/19/2017. The previous citation reflected noncompliance in BHU, MDU/PCU, ICU, ED and SSU units.

Requirement For Improvement (RFI)

2. Refer to NSP findings that reflects the NSPs the units were working under were not complete or clear.

* For Tag E630 refer to findings for SSU and ED.
* For Tag E632 refer to findings for ICU.
* For Tag E636 refer to findings for Peds and SSU.
* For Tag E638 refer to findings for ED.
* For Tag E646 refer to findings for SSU and ED.

Plan of Action:

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 action. By statute, the hospital must implement its Plan of Correction no later than 45 days after OHA approves the facility's Plan of Correction.
4. Monitoring: The description of the monitoring procedure(s) that the hospital will perform to prevent a 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.

What	Who	When	Status
Refer to POC response for Tag E630, E632, E636, E638, and E646	Daniel Davis, RN, Co-Chair Bend Staffing Committee	No later than 45 business days after OHA approves facility plan of correction (estimated 11/30/22)	In progress

How: Refer to POC response for Tag E630, E632, E636, E638, and E646

RFI closed	Who: Name/title	Date

Campus: Bend Hospital	Accreditation body: Oregon Health Authority
Standard/EP/COPS: E 630 NSP: Qualifications and Competencies (2) The staffing plan: (a) Must be based on the specialized qualifications and competencies of the nursing staff and provide for the skill mix and level of competency necessary to ensure that the hospital is staffed to meet the health care needs of patients; Stat. Auth.: ORS 413.042 & 441.155 Stats. Implemented: ORS 441.155	
Subject: Nurse Staffing Documentation Title: E 630	
Date survey completed: 4/29/2022 Official letter received: 6/17/2022	**RFI Plan of Correction due:** Response due to OHA: 08/15/2022 (extension)

Process owner and title (person in charge of the plan of action and bringing RFI into compliance): Daniel Davis, RN, Co-Chair Bend Staffing Committee
Ultimately responsible and title (process owner supervisor, responsible for RFI compliance and ongoing compliance): Debbie Robinson, RN, CNO, St. Charles Bend Campus

Official Findings:

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

This Rule is not met as evidenced by:

Based on interview and review of HNSP Unit Questionnaires and unit NSPs for 2 of 5 units (SSU and ED), it was determined the hospital failed to implement a hospital-wide NSP that was developed based on the qualifications and competencies needed by nursing staff for each unit, and that provided for the skill mix and level of competency needed to ensure that patients' needs were met.

Findings include:

1. This citation reflects repeated noncompliance with the requirement under OAR 333-510-0110(2)(a).

Requirement For Improvement (RFI)

OHA previously cited the hospital for noncompliance with this rule in the nurse staffing survey and complaint investigation initiated on

06/19/2017. The previous citation reflected noncompliance in BHU, MDU/PCU, ICU, ED and SSU units.

2. Revisit Survey: Review of SSU HNSP Unit Questionnaire, completed and signed by SSU DC Unit Representative and SSU NM on

04/19/2022, reflected the following qualifications, competencies, and trainings were required for SSU NSMs:

* A 1-page document titled "Current New Hire eLearnings Position: CNA 2 (92)," which contained a list of 39 online modules;

* A 1-page document titled "Annual eLearnings 2021 Position: CNA 2 (92)," which contained a list of 36 online modules;

* A 1-page document titled "Current Traveler New Hire eLearnings Position: CNA Traveler," which contained a list of 26 online modules;

* A 1-page document titled "Current New Hire eLearnings Position: RN - Surgical Specialties (941)," which contained a list of 40 online

modules;

* A 1-page document titled "Annual eLearnings 2021 Position: RN - Surgical Specialties (941)," which contained a list of 38 online

modules; and

* A 1-page document titled "Current Traveler New Hire eLearnings Position: RN Traveler," which contained a list of 28 online modules.

3. Revisit Survey: Review of SSU NSP, approved by NSC on 06/02/2021, did not clearly reflect the qualifications, competencies and

trainings required for SSU NSMs. For example, it did not include the following qualifications, competencies, and trainings which were

required:

* "Orientation of New Caregivers" policy, dated 08/19/2021

* A 1-page document titled "Current New Hire eLearnings Position: CNA 2 (92)," which contained a list of 39 online modules;

* A 1-page document titled "Annual eLearnings 2021 Position: CNA 2 (92)," which contained a list of 36 online modules;

* A 1-page document titled "Current Traveler New Hire eLearnings Position: CNA Traveler," which contained a list of 26 online modules;

* A 1-page document titled "Current New Hire eLearnings Position: RN - Surgical Specialties (941)," which contained a list of 40 online

modules;

* A 1-page document titled "Annual eLearnings 2021 Position: RN - Surgical Specialties (941)," which contained a list of 38 online

modules; and

* A 1-page document titled "Current Traveler New Hire eLearnings Position: RN Traveler," which contained a list of 28 online modules.

Additionally, SSU NSP did not include provisions to allow SSU traveler RNs to have different qualifications, competencies and trainings than non-contracted SSU RNs.

3. Revisit Survey: During interview with SSU NM, SSU ANM, and Prineville CNO on 04/20/2022 beginning at 1223, they confirmed that

the additional required checklists were not included in SSU NSP. They also confirmed that the "Current Traveler New Hire eLearnings

Position: RN Traveler" and the "Covid-19 Response Acute Care Services Orientation Handbook RN Traveler Orientation Checklists" were

not included in SSU NSP and that the differences in qualifications, competencies and trainings for SSU traveler RNs had not been approved

by the NSC.

4. Revisit Survey: Review of ED HNSP Unit Questionnaire, completed and signed by ED DC Unit Representative and ED NM on

04/19/2022, reflected the following qualifications, competencies, and trainings were required for ED NSMs:

* A 2-page document titled "Required New Hire Education October 2021 Position: ED RN (875)," which contained a list of 76 online

modules.

* A 1-page document titled "Annual eLearnings 2021 Position: ED RN (875)," which contained a list of 40 online modules.

* A 1-page document titled "Current Traveler New Hire eLearnings Position: RN Traveler," which contained a list of 28 online modules.

* A position description titled "RN - Emergency Department," dated 04/19/2022, which included "Current Oregon RN License," "AHA

Basic Life Support for Healthcare Provider certification," "AHA ACLS," "AHA PALS," and "TNCC & Code Grey training required within 6

months."

* A policy titled "Orientation of New Caregivers," dated 08/19/2021.

5. Revisit Survey: Review of ED NSP, approved by NSC on 11/01/2021, did not clearly reflect the qualifications, competencies, and

trainings required for ED NSMs. For example, it did not include the following qualifications, trainings, and competencies that were required

for ED NSMs:

* The policy titled "Orientation of New Caregivers," dated 08/19/2021.

* A 2-page document titled "Required New Hire Education October 2021 Position: ED RN (875)," which contained a list of 76 online

modules.

* A 1-page document titled "Annual eLearnings 2021 Position: ED RN (875)," which contained a list of 40 online modules.

* A 1-page document titled "Current Traveler New Hire eLearnings Position: RN Traveler," which contained a list of 28 online modules.

Additionally, ED NSP did not include provisions to allow ED traveler RNs to have different qualifications, competencies and trainings than

non-contracted ED RNs.

6. Revisit Survey: During interview with ED NM, ED ANM and EDD on 04/21/2022 beginning at 0940, they confirmed that the "Current

Traveler New Hire eLearnings Position: RN Traveler" and the "Nurse Traveler Orientation Emergency Department" competencies were not

included in ED NSP and the different qualifications, competencies, and trainings for ED traveler RNs had not been approved by the NSC.

7. In NSM interviews completed between 04/12/2022 and 04/26/2022, 33 of 252 respondents indicated that in the past year they have been

scheduled to work with patients for whom they do not have current competencies.

Plan of Action:

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 action. By statute, the hospital must implement its Plan of Correction no later than 45 days after OHA approves the facility's Plan of Correction.
4. Monitoring: The description of the monitoring procedure(s) that the hospital will perform to prevent a 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.

What	Who	When	Status
The approved Emergency Department and Surgical NSP will include the qualifications and competencies needed by nursing staff members, that provides for the skill mix and level of competency needed to assure patient care needs are met. This will include any variations, i.e.: traveler requirements.	ED Manager, Michelle Robinson, RN Surgical Manager, Wendy Wait, RN	No later than 45 business days after OHA approved the facility plan of correction (estimated 11/30/22).	In progress
All units' NSO will include the qualifications and competencies needed by nursing staff members that provides for the skill mix and level of competency needed to	Daniel Davis, RN, Co-Chair Bend Staffing Committee	No later than 45 business days after OHA approved the facility plan of correction	In progress

Requirement For Improvement (RFI)

assure patient care needs are met. This will include any variations, i.e.: traveler requirements.		(estimated 11/30/22).	

How: The Emergency Department and Surgical floor will present and have approved by the BSC their NSP. The plans will include qualifications and competencies needed by nursing staff for each of these units, assuring that it provides for the skill mix and level of competency needed to meet patient care needs.

How: All NSPs will be reviewed to determine if they include the qualifications and competencies needed by nursing staff for each of the specific departments, assuring that they provide for the skill mix and level of competency needed to meet that department's patient care needs.

Monitoring: NSP revisions will remain as a standing agenda item at the BSC until the work to update all plans is completed. Direct observation during BSC meetings to assure qualifications and competencies are addressed in each department plan. Quarterly reviews will be conducted to assure all plans are current to meet the skill mix and level of competency for the department's patient care needs.

RFI closed	Who: Name/title	Date

St. Charles HEALTH SYSTEM

Campus: Bend Hospital	Accreditation body: Oregon Health Authority
Standard/EP/COPS: 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	
Subject: Nurse Staffing Documentation Title: E 632	
Date survey completed: 4/29/2022 Official letter received: 6/17/2022	**RFI Plan of Correction due:** Response due to OHA: 08/15/2022 (extension)

Process owner and title (person in charge of the plan of action and bringing RFI into compliance): Daniel Davis, RN, Co-Chair Bend Staffing Committee
Ultimately responsible and title (process owner supervisor, responsible for RFI compliance and ongoing compliance): Debbie Robinson, RN, CNO, St. Charles Bend Campus

Official Findings:

(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 1 of 5 units (ICU), 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 DC RN to complete those tasks.

Requirement For Improvement (RFI)

Findings include:

1. This citation reflects repeated noncompliance with the requirement under OAR 333-510-0110(2)(b).

OHA previously cited the hospital for noncompliance with this rule in the nurse staffing survey and complaint investigation completed on

06/19/2017. The previous citation reflected noncompliance in MDU/PCU and ED units.

2. Review of ICU HNSP Unit Questionnaire, completed and signed by ICU DC Unit Representative and ICU NM on 04/19/2022, reflected

that the time for DC RNs to complete admissions, discharges and transfers for ICU was not quantified in ICU NSP as required. In the

questionnaire, the documented responses from ICU DC Unit Representative and ICU NM, regarding this requirement, were "No."

3. Review of ICU NSP, approved by NSC on 02/05/2020, reflected that the rate of admissions was insufficient; rates of discharges and

transfers were not quantified; and that the time for an ICU DC RN to complete admissions, discharges and transfers was not quantified. For

example, the "Admissions" section of ICU NSP reflected: "Emergency Department ... 35% ... OR PACU ... 25% ... Transfer within Facility ...

20% ... Direct Admit ... 20%." This rate did not include a timeframe, numbers of patients, nor applicable shifts. Additionally, the section

titled "Admissions, Discharges and Transfers (ADT) (333-510-0110)" in ICU NSP was left blank.

3. During interview with ICU NM on 04/20/2022 at the time of ICU NSP review, he/she confirmed Findings 1 and 2.

Plan of Action:

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 action. By statute, the hospital must implement its Plan of Correction no later than 45 days after OHA approves the facility's Plan of Correction.
4. Monitoring: The description of the monitoring procedure(s) that the hospital will perform to prevent a recurrence of the specific deficiency identified. The hospital must monitor at least quarterly to ensure compliance.

Requirement For Improvement (RFI)

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.

What	Who	When	Status
The ICU NSP will be adjusted to include ADT and the time required to complete admission, discharges, and transfers, and will be approved by BSC.	ICU Manager, Monica Shultz, RN	No later than 45 business days after OHA approves the facility plan of correction (estimated 11/30/22)	In progress
All units' NSP will have ADT addressed in approved staffing plan. This will include the time required to complete admissions, discharges, and transfers.	Daniel Davis, RN, Co-Chair Bend Staffing Committee	No later than 45 business days after OHA approves the facility plan of correction (estimated 11/30/22)	In progress

How: The ICU will present and have approved by the BSC their NSP. This will include a measurement that quantifies the rate of admissions, discharges, and transfers and the time required for a direct care registered nurse to complete admissions, discharges, and transfers in the ICU.

How: All NSPs will be reviewed to determine if they include measurement that quantifies the rate of admissions, discharges, and transfers and the time required for a direct care registered nurse to complete admissions, discharges, and transfers. Any NSPs not reflecting this information will be revised and be brought back for BSC review and approval.

Monitoring: NSP revisions will remain as a standing agenda item at the BSC until the work to update all plans are completed. Direct observation during BSC meeting to assure all plans reference admissions, discharges, and transfers and the time to complete. Quarterly reviews will be conducted to assure all plans are referencing ADT.

RFI closed	Who: Name/title	Date

Campus: Bend Hospital	Accreditation body: Oregon Health Authority
Standard/EP/COPS: E 636 NSP: Nationally Recognized Evidence-Based Std (2) The staffing plan: (d) Must be consistent with nationally recognized evidence-based standards and guidelines established by professional nursing specialty organizations such as, but not limited to: The American Association of Critical Care Nurses, American Operating Room Nurses (AORN), or American Society of Peri-Anesthesia Nurses (ASPAN); Stat. Auth.: ORS 413.042 & 441.155 Stats. Implemented: ORS 441.155	
Subject: Nurse Staffing Documentation Title: E 636	
Date survey completed: 4/29/2022 Official letter received: 6/17/2022	**RFI Plan of Correction due:** Response due to OHA: 08/15/2022 (extension)

Process owner and title (person in charge of the plan of action and bringing RFI into compliance):
Daniel Davis, RN, Co-Chair Bend Staffing Committee
Ultimately responsible and title (process owner supervisor, responsible for RFI compliance and ongoing compliance):
Debbie Robinson, RN, CNO, St. Charles Bend Campus

Official Findings:

(OAR 333-510-0110(2)(d))
This Rule is not met as evidenced by:

Based on interview and review of HNSP Unit Questionnaires and unit NSPs for 2 of 5 units (Peds and SSU), it was determined the hospital
failed to implement a hospital-wide NSP that was developed to reflect for each unit consistency with current, nationally-recognized standards
and guideline established by professional nursing specialty organizations.

Findings include:

1. This citation reflects repeated noncompliance with the requirement under OAR 333-510-0110(2)(d).

OHA previously cited the hospital for noncompliance with this requirement in the nurse staffing survey and complaint investigation initiated
on 06/19/2017. The previous citation reflected noncompliance in BHU, MDU/PCU, ICU and SSU units.

2. Review of Peds HNSP Unit Questionnaire, completed and signed by Peds DC Unit Representative and Peds NM on 04/19/2022, reflected
that evidence-based standards and guidelines established by professional nursing organizations were not used in the development of Peds
NSP. In the questionnaire, the documented response was "No" and "reached out to pediatric units on the West Coast including magnet
organizations."

3. Review of Peds NSP, approved by NSC on 10/06/2020, reflected that evidence-based standards and guidelines established by professional
organizations were not used. The section titled "Nationally recognized standards (333-510-0110)" in Peds NSP was left blank.

4. During interview with Peds ANM and DWC at the time of Peds NSP review, they confirmed Findings 2 and 3. They stated that the prior
Peds NM had done a literature search in December 2021 and was unable to find any national guidelines for pediatric units.

5. Revisit Survey: Review of SSU HNSP Unit Questionnaire, completed and signed by SSU DC Unit Representative and SSU NM on
04/19/2022, reflected that evidence-based standards and guidelines established by professional nursing organizations were not used in the
development of SSU NSP. In the questionnaire, the documented response was "no recognized standards identified for Med/Surg nursing."

6. Revisit Survey: Review of SSU NSP, approved by NSC on 05/02/2021, reflected that evidence-based standards and guidelines established
by professional nursing organizations were not used. In the section titled "Nationally Recognized Evidence Based on Standards of Practice"
in SSU NSP, it stated "none identified for Med/Surg nursing."

7. Revisit Survey: During interview with SSU NM, SSU ANM, and Prineville CNO on 04/20/2022 beginning at 1415, they confirmed
Findings 5 and 6. They stated that there were "no recognized standards for Med/Surg nursing to use as resources for standards of care."
During the interview, SSU NM stated that other resources were used to develop SSU NSP, including:
* American Nurses Association (2021). Nursing: Scope and Standards of Practice (4th Ed.)
* American Medical-Surgical Nurses (2016). Cure (sic) Curriculum for Medical-Surgical Nursing (5th Ed.), Pitman, NJ, AMSN
* OSBN (2021). Scope of Practice OSBN: Board of Nursing Chapter 851, Division 45. Retrieved February 23, 2021.

However, SSU NSP did not clearly reference these other resources used to develop SSU NSP.

Requirement For Improvement (RFI)

Plan of Action:

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 action. By statute, the hospital must implement its Plan of Correction no later than 45 days after OHA approves the facility's Plan of Correction.
4. Monitoring: The description of the monitoring procedure(s) that the hospital will perform to prevent a 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.

What	Who	When	Status
The approved Surgical and Pediatrics NSP will include reference to nationally recognized staffing standards. In the absence of a nationally recognized standard, the NSP will include other standards or reference materials used to develop unit based NSP.	Pediatrics Manager, Emma Vlossak, RN Surgical Manager, Wendy Wait, RN	No later than 45 business days after OHA approved the facility plan of correction (estimated 11/30/22).	In progress
All units NSP will include reference to national recognized staffing standards in the absence of nationally recognized standards the approved NSP will include other standards or reference materials used to develop unit based NSP.	Daniel Davis, RN, Co-Chair Bend Staffing Committee	No later than 45 business days after OHA approved the facility plan of correction (estimated 11/30/22).	In progress

How: The Surgical and Pediatric units will present and have approved by the BSC their NSP. These plans will include reference to nationally recognized staffing standards. In the absence of a nationally recognized standard, the NSP will include other standards or reference materials used to develop unit based NSP.

Requirement For Improvement (RFI)

How: All NSPs will be reviewed to determine if they include reference to nationally recognized staffing standards. In the absence of nationally recognized staffing standards, they will include other standards or reference materials used to develop their unit-based plans. Monitoring: NSP revisions will remain as a standing agenda item at the BSC until the work to update all plans is completed. Direct observation during BSC meetings to assure they include reference to nationally recognized staffing standards. Quarterly reviews will be conducted to assure all plans are referencing current nationally recognized staffing standards.

RFI closed	Who: Name/title	Date

Campus: Bend Hospital	Accreditation body: Oregon Health Authority
Standard/EP/COPS: E 638 NSP: Patient Acuity & Nursing Care Intensity (2) The staffing plan: (e) Must recognize differences in patient acuity and nursing care intensity; Stat. Auth.: ORS 413.042 & 441.155 Stats. Implemented: ORS 441.155	
Subject: Nurse Staffing Documentation Title: E 638	
Date survey completed: 4/29/2022 Official letter received: 6/17/2022	**RFI Plan of Correction due:** Response due to OHA: 08/15/2022 (extension)

Process owner and title (person in charge of the plan of action and bringing RFI into compliance):
Daniel Davis, RN, Co-Chair Bend Staffing Committee
Ultimately responsible and title (process owner supervisor, responsible for RFI compliance and ongoing compliance):
Debbie Robinson, RN, CNO, St. Charles Bend Campus

Official Findings:

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

This Rule is not met as evidenced by:
Based on interview and review of HNSP Unit Questionnaires and unit NSPs for 1 of 5 units (ED), it was determined the hospital failed to implement a hospital-wide NSP that was developed to recognize for each unit differences in patient acuity and nursing care intensity.

Findings include:

1. This citation reflects repeated noncompliance with the requirement under OAR 333-510-0110(2)(e). OHA previously cited the hospital for noncompliance with this rule in the nurse staffing survey and complaint investigation initiated on 06/19/2017. The previous citation reflected the hospital was noncompliant in BHU, MDU/PCU, ICU, ED and SSU units.

Requirement For Improvement (RFI)

2. Revisit Survey: Review of ED HNSP Unit Questionnaire, completed and signed by ED DC Unit Representative and ED NM on 04/19/2022, reflected ED NSP lacked a clear method, system or criteria for objectively determining acuity and nursing care intensity for individual patients. It reflected that "Its (sic) the charge nurse and primary RN who work together to determine [patient acuity and nursing care intensity]. Reducing or increasing assignment or providing additional resources as needed to support patient care. There are multiple tools in EPIC that give (sic) charge nurse visuals of pt acuity/intensity. Tools cant (sic) tell the entire story of a rapidly decompensating or critical patient. Nurse & charge nurse must communicate needs and status of assignment." Additionally, it reflect, "The charge nurse, any nurse and leadership are all part of the discussion, we have resources (sic) nurse(s) and a surge plan."

3. Revisit Survey: During onsite unit interview with ED DC RN on 04/19/2022 beginning at 1225, he/she stated that acuity and intensity were determined by using "ESI triage to assign acuity. Intensity is also [measured] but the RN ratio is 3:1 and [RNs] can sometimes carry a 4th patient in the hall." He/she also added that acuity and intensity were determined "... by the Charge Nurse, who keeps a pulse on the RN workload. [Acuity and intensity] is really measured by the Charge Nurse." When asked if this process was reflected in ED NSP, he/she responded, "I'm not seeing that on here" and "that's what I have experienced."

4. Revisit Survey: Review of ED NSP, approved by NSC on 11/01/2021, reflected it lacked a clear method, system or criteria for objectively determining acuity and nursing care intensity for individual patients. In ED NSP, the section titled "Minimum Staffing and Acuity Modifications" reflected, "Due to varying affects (sic) COVID has had on our ADC we are not adjusting FTE's related to current ADC ... Recognition of acuity and intensity (333-510-0110): See Surge plan..." However, Surge plan was not attached to ED NSP approved by NSC. Therefore, ED NSP did not clearly describe the method, system or criteria for objectively determining acuity and nursing care intensity for individual patients. Additionally, the processes referenced in Findings 2 and 3 were not clearly reflected in ED NSP.

5. Revisit Survey: During interview with ED NM, ED ANM and EDD on 04/20/2022 beginning at 1200, they confirmed Findings 2 - 4 and agreed that the process for determining individual acuity and intensity and that the Charge Nurse decision-making process was not clearly defined in ED NSP. ED NM stated that there "were multiple factors in EPIC" that the Charge Nurse utilizes to assist in determining acuity and intensity, such as "number of patients, orders, tasks, track boards, overdue tasks ..." and that "The Charge Nurse looks at all inputs and reviews with the RNs" and then uses available support, such as "Pod Leads" and "Resource Nurses" to assist ED RNs with assignments. However, it was not clear how this decision-making allowed for objectively determining individual patient acuity and nursing care intensity.

Plan of Action:

Requirement For Improvement (RFI)

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 action. By statute, the hospital must implement its Plan of Correction no later than 45 days after OHA approves the facility's Plan of Correction.
4. Monitoring: The description of the monitoring procedure(s) that the hospital will perform to prevent a 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.

What	Who	When	Status
The approved ED NSP will include the differences in patient acuity and nursing care intensity	ED Manager, Michelle Robinson, RN	No later than 45 business days after OHA approved the facility plan of correction (estimated 11/30/22).	In progress
All units' NSPs will have patient acuity and nursing care intensity addressed in approved staffing plan	Daniel Davis, RN, Co-Chair Bend Staffing Committee	No later than 45 business days after OHA approved the facility plan of correction (estimated 11/30/22).	In progress

How: The ED will present and have approved by the BSC to include approach to measuring patient acuity and intensity.

How: All NSPs will be reviewed to determine if they include process for measuring patient acuity and intensity. Any NSPs not reflecting this information will be revised and be brought back to BSC for review and approval.

Monitoring: NSP revisions will remain as a standing agenda item at the BSC until the work to update all plans are completed. Direct observation during BSC meetings to assure all plans include documentation of the process to recognize the differences in acuity and intensity. Quarterly reviews will be conducted to assure all plans include process to recognize differences in patient acuity and intensity.

Requirement For Improvement (RFI)

RFI closed	Who: Name/title	Date

Campus: Bend Hospital	Accreditation body: Oregon Health Authority
Standard/EP/COPS: 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	
Subject: Nurse Staffing Documentation Title: E 646	
Date survey completed: 4/29/2022 Official letter received: 6/17/2022	**RFI Plan of Correction due:** Response due to OHA: 08/15/2022 (extension)

Process owner and title (person in charge of the plan of action and bringing RFI into compliance): Daniel Davis, RN, Co-Chair Bend Staffing Committee
Ultimately responsible and title (process owner supervisor, responsible for RFI compliance and ongoing compliance): Debbie Robinson, RN, CNO, St. Charles Bend Campus

Official Findings:

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

This Rule is not met as evidenced by:

Based on review of Meal and Rest Break Practice tool and unit NSPs for 2 of 5 units (SSU and ED), 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 that NSMs received breaks as required. The NSP did not provide for additional NSMs to maintain the staffing number required in the NSP during these tasks, creating the possibility that the units did not meet the minimum staffing required for the duration of tasks not related to direct patient care.

Findings include:

Requirement For Improvement (RFI)

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 and complaint investigation completed on 06/19/2017. The previous citation reflected noncompliance in BHU, MDU/PCU, SSU, ED and ICU units.
* OHA previously cited the hospital for noncompliance with this rule in the nurse staffing complaint investigation completed on 04/08/2021. The previous citation reflected noncompliance in MSVS unit.

2. Complaint #OR30088: Review of SSU Meal and Rest Break Practice tool, completed and signed by SSU DC Unit Representative and SSU NM on 04/19/2022, reflected that SSU drops below the minimum number of NSMs specified in SSU NSP during meal breaks.

3. Complaint #OR30088: Review of SSU NSP, approved by NSC on 06/02/2021, reflected the following related to meal and rest break practices on SSU:
* "... Lunch RN will be provided ... If Lunch RN is not available, the rest and meal break support steps ... will be utilized"
* "Staff will be assigned times for all rest and meal breaks"
*" ... In the event a Staff RN is unable to take a rest or meal break ... the following steps will be taken to support rest and meal breaks ... The Lunch RN and Staff RN will reschedule the assigned ... time ... The Charge RN will cover the Staff RN ... The Staff will request ... another Staff RN who can safely cover the assignment in accordance with the unit based staffing plan"
* " ... If the above options are not viable, the Staff RN will acknowledge the missed rest or meal break through the timeclock attestation ... CNAs ... or RNs working in the place of CNAs ... will coordinate with assigned RNs on rest and break times ... Assigned RNs will assume duties ... Pass phone to CNA remaining on floor ... RN will call backup CNA for urgent needs during rest/meal periods ... CN will assist in covering meals and lunch breaks as needed ..." It was not clear how this process ensured that SSU NSMs received all meal and rest breaks as required and that SSU did not drop below the minimum numbers of SSU NSMs during meal and rest breaks.

4. Complaint #OR30088: Review of untitled staffing matrix attached to SSU NSP reflected the number of SSU NSMs required on SSU for different shifts and patient censuses. Neither the staffing matrix nor the NSP clearly reflected how minimum numbers were maintained during meal and rest break coverage when the unit was at low census. For example:
* The staffing matrix reflected that when there were 1 - 4 patients on SSU for "Day Shift", the minimum number of NSMs would be 1 "Charge RN," 1 "Staff RN" and 0 "Lunch RN."
* The staffing matrix reflected that when there were 5 patients on SSU for "Eve Shift", the minimum number of NSMs would be "1 Charge RN", 1 "Staff RN", and 0 "Lunch RN." SSU NSP did not ensure SSU would maintain minimum numbers of NSMs during meal and rest breaks.

5. In NSM interviews completed between 04/12/2022 and 04/26/2022, 125 of 252 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.

6. In NSM interviews completed between 04/12/2022 and 04/26/2022, 150 of 252 respondents indicated that in the past year they experienced one or more shifts in which they missed a meal and/or rest break because there was not sufficient staff to cover that time

Plan of Action:

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 action. By statute, the hospital must implement its Plan of Correction no later than 45 days after OHA approves the facility's Plan of Correction.
4. Monitoring: The description of the monitoring procedure(s) that the hospital will perform to prevent a 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.

What	Who	When	Status
Surgical floor and Emergency department will revise NSPs to address tasks not related to providing direct patient care, including meal breaks & rest breaks, assuring the required staffing numbers are maintained during these tasks.	Surgical Manager, Wendy Wait, RN ED Manager, Michelle Robinson, RN	No later than 45 business days after OHA approves facility plan of correction (estimated 11/30/22).	In progress
All units' NSP will address task not related to providing direct patient care including meal breaks & rest breaks, assuring the required staffing numbers are maintained during these tasks.	Daniel Davis, RN, Co-Chair Bend Staffing Committee	No later than 45 business days after OHA approves facility plan of correction (estimated 11/30/22).	In progress

Requirement For Improvement (RFI)

How: Surgical floor and Emergency Department will review their meal & rest break plan to assure required minimum staffing numbers are maintained during these activities. Revisions will be approved by Bend Staffing Committee. How: All units will review their meal & rest break plan to assure required minimum staffing numbers are maintained during these activities. Revisions will be approved by Bend Staffing Committee. Monitoring: Missed rest and meal break data will be shared with departments during their daily huddles and monthly with the Bend Staffing Committee to evaluate effectiveness of department level staffing plans and assure they are adhered to during meal and rest break periods. Departments with missed meal and rest breaks will be asked to evaluate plan and return to staffing committee for needed plan revisions.

RFI closed	Who: Name/title	Date

St. Charles HEALTH SYSTEM

Campus: Bend Hospital	Accreditation body: Oregon Health Authority
Standard/EP/COPS: E 652 NSP Annual Review (1) The staffing committee shall: (a) Review the staffing plan at least once per year; and (b) At any other time specified by either co-chair of the staffing committee. Statutory/Other Authority: ORS 413.042 & 441.156 Statutes/Other Implemented: ORS 441.156	
Subject: Nurse Staffing Documentation Title: E 652	
Date survey completed: 4/29/2022 Official letter received: 6/17/2022	**RFI Plan of Correction due:** Response due to OHA: 08/15/2022 (extension)

Process owner and title (person in charge of the plan of action and bringing RFI into compliance): Daniel Davis, RN, Co-Chair Bend Staffing Committee
Ultimately responsible and title (process owner supervisor, responsible for RFI compliance and ongoing compliance): Debbie Robinson, RN, CNO, St. Charles Bend Campus

Official Findings:

(OAR 333-510-0115(1)(a)(b))

This Rule is not met as evidenced by:

1. Based on interview and review of HNSP Unit Questionnaires, unit NSPs, and HNSC Co-Chair Pre-Interview Questionnaire, it was determined the hospital failed to review the staffing plan in accordance with these rules: * The NSP was not reviewed at least once per year.

Findings include:

Review of HNSC Co-Chair Pre-Interview Questionnaire, completed and signed by NSC DC Co-Chair and NSC NM Co-Chair on 04/14/2022, reflected the response to the question "... the nurse staffing committee reviewed all unit nurse staffing plans at least once in the past 12 months" was left blank. An explanation was provided in the

questionnaire that reflected: "Pandemic Response slowed this work. Committee has schedule to review all units by year end (2022)."

2. During interview with NSC NM Co-Chair on 04/19/2022 beginning at 1500, he/she confirmed that the NSC had not conducted annual NSP reviews for several units. He/she later provided a list of units with NSPs that had not been reviewed in the past 12 months. These units included:
* ICU, last reviewed by NSC "02/20"
* PCU, last reviewed by NSC "02/20"
* PES, last reviewed by NSC "03/20"
* Pre-Surgery, last reviewed by NSC "09/20"
* Cath Lab, last reviewed by NSC "11/20"
* Dialysis, last reviewed by NSC "09/20"
* MDU, last reviewed by NSC "12/20"
* NICU, last reviewed by NSC "10/20"
* FBC, last reviewed by NSC "10/20"
* Rehab, last reviewed by NSC "12/20"
* Wound Ostomy, last reviewed by NSC "10/20"
* Cancer Services, last reviewed by NSC "12/20"

3. Review of Peds HNSP Unit Questionnaire, completed and signed by Peds DC Unit Representative and Peds ANM on 04/19/2022, reflected the NSC last completed its annual review of Peds NSP on 10/07/2020.

4. Review of Peds NSP reflected it was last approved on 10/07/2020.

5. During interview with Peds ANM and DWC on 04/20/2022 at the time of review of Peds NSP annual review, they confirmed Peds NSP was last reviewed by NSC on 10/07/2020.

6. Review of ICU HNSP Unit Questionnaire, completed and signed by ICU DC Unit Representative and ICU NM on 04/19/2022, reflected the NSC last completed its annual review of ICU NSP "2/2020."

7. Review of ICU NSP reflected it was last approved on 02/05/2020.

8. During interview with ICU NM on 04/20/2022 at the time of review of ICU NSP annual review, he/she confirmed ICU NSP was last reviewed by NSC on 02/05/2020.

Plan of Action:

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 action. By statute, the hospital must implement its Plan of Correction no later than 45 days after OHA approves the facility's Plan of Correction.

4. Monitoring: The description of the monitoring procedure(s) that the hospital will perform to prevent a 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.

What	Who	When	Status
All NSP, will be renewed at least annually by Bend Staffing Committee	• Pediatrics Manager, Emma Vlossak, RN • ICU Manager, Monica Shultz, RN • PCU Manager, Don Jacobs, RN • PES ANM, Taylor Jones, RN • Pre-Surgery Manager, Ammon Charles, RN • Cath Lab Manager, Krista Gardinier, RN • Dialysis Manager, Monica Shultz, RN • MDU Manager, Megan Chaffin, RN • NICU Manager, Emma Vlossak, RN • FBC Manager, Brooke Jensen, RN • Rehab Manager, Deb Gardner, RN • Wound Ostomy Manager, Bethany Klier, RN • Cancer Services Manager, Lori Tritto, RN In addition to: • Radiology Manager, Chris Hauth, RN	No later than 45 business days after OHA approves the facility plan of correction (estimated 11/30/22)	In progress

Requirement For Improvement (RFI)

	• Surgical Manager, Wendy Wait, RN • Ortho/Neuro Manager, Lisa Firkus, RN • Medical Manager, Shalis Stinson, RN • IMCU Manager, Kelly Plunkett, RN		

How: Develop BSC presentation schedule to accommodate all department nurse staffing plans to be presented and approved by committee. Monitoring: Monitor process monthly and adjust staffing committee report out schedule to meet targets. Report out at BSC during monthly meetings any plans not in compliance and those plans expiring in the next three months.

RFI closed	Who: Name/title	Date

Campus: Bend Hospital	Accreditation body: Oregon Health Authority
Standard/EP/COPS: E 654 NSP Annual Review Factors (2) In reviewing the staffing plan, the staffing committee shall consider: (a) Patient outcomes; (b) Complaints regarding staffing, including complaints about a delay in direct care nursing or an absence of direct care nursing; (c) The number of hours of nursing care provided through a hospital unit compared with the number of patients served by the hospital unit during a 24-hour period; (d) The aggregate hours of mandatory overtime worked by nursing staff; (e) The aggregate hours of voluntary overtime worked by nursing staff; (f) The percentage of shifts for each hospital unit for which staffing differed from what is required by the staffing plan; (g) Any other matter determined by the committee to be necessary to ensure that the hospital is staffed to meet the health care needs of patients; and (h) Any report filed by a nursing staff member stating the nursing staff member's belief that the hospital unit engaged in a pattern of requiring direct care nursing staff to work overtime for nonemergency care. Stat. Auth.: ORS 413.042 & 441.156 Stats. Implemented: ORS 441.156	
Subject: Nurse Staffing Documentation Title: E 654	
Date survey completed: 4/29/2022 Official letter received: 6/17/2022	**RFI Plan of Correction due:** Response due to OHA: 08/15/2022 (extension)

Process owner and title (person in charge of the plan of action and bringing RFI into compliance): Daniel Davis, RN, Co-Chair Bend Staffing Committee
Ultimately responsible and title (process owner supervisor, responsible for RFI compliance and ongoing compliance): Debbie Robinson, RN, CNO, St. Charles Bend Campus

Official Findings: (OAR 333-510-0115(2))

Requirement For Improvement (RFI)

This Rule is not met as evidenced by:

Based on interview and review of HNSP Unit Questionnaires, unit NSPs and HNSC Co-Chair Pre-Interview Questionnaire, it was determined that the hospital failed to ensure the NSC reviewed the NSPs by considering all of the factors specified in the rules.

Findings include:

1. Refer to Tag E652 which reflects that the NSP for the following units had not been reviewed by the NSC within the past 12 months:
* ICU, last reviewed by NSC "02/20"
* PCU, last reviewed by NSC "02/20"
* PES, last reviewed by NSC "03/20"
* Pre-Surgery, last reviewed by NSC "09/20"
* Cath Lab, last reviewed by NSC "11/20"
* Dialysis, last reviewed by NSC "09/20"
* MDU, last reviewed by NSC "12/20"
* NICU, last reviewed by NSC "10/20"
* FBC, last reviewed by NSC "10/20"
* Rehab, last reviewed by NSC "12/20"
* Wound Ostomy, last reviewed by NSC "10/20"
* Cancer Services, last reviewed by NSC "12/20"

2. Review of ED HNSP Unit Questionnaire, completed and signed by ED DC Unit Representative and ED NM on 04/19/2022, reflected that ED failed to provide the following data to the NSC for ED NSP's annual review: Percentage of shifts for which staffing differed from the NSP.

3. During interview with ED NM, ED ANM and EDD on 04/20/2022 beginning at 1215, they confirmed Finding 2

Plan of Action:

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 action. By statute, the hospital must implement its Plan of Correction no later than 45 days after OHA approves the facility's Plan of Correction.
4. Monitoring: The description of the monitoring procedure(s) that the hospital will perform to prevent a 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.

Requirement For Improvement (RFI)

What	Who	When	Status
All NSPs will contain a review of all required elements within the last 12 months.	• Pediatrics Manager, Emma Vlossak, RN • ICU Manager, Monica Shultz, RN • PCU Manager, Don Jacobs, RN • PES ANM, Taylor Jones, RN • Pre-Surgery Manager, Ammon Charles, RN • Cath Lab Manager, Krista Gardinier, RN • Dialysis Manager, Monica Shultz, RN • MDU Manager, Megan Chaffin, RN • NICU Manager, Emma Vlossak, RN • FBC Manager, Brooke Jensen, RN • Rehab Manager, Deb Gardner, RN • Wound Ostomy Manager,	No later than 45 business days after OHA approves the facility plan of correction (estimated 11/30/22)	In progress

	Bethany Klier, RN • Cancer Services Manager, Lori Tritto, RN In addition to: • Radiology Manager, Chris Hauth, RN • Surgical Manager, Wendy Wait, RN • Ortho/Neuro Manager, Lisa Firkus, RN • Medical Manager, Shalis Stinson, RN • IMCU Manager, Kelly Plunkett, RN		

How: Develop BSC presentation schedule to accommodate all department nurse staffing plans to be presented and approved by committee.

Monitoring: Monitor process monthly and adjust presentation schedule to meet targets. Report out at BSC during monthly meetings any plans not in compliance and those plans expiring in the next three months.

At each meeting, for every department staffing plan brought forward to BSC to review and approve, the members will determine if all required elements are present in the plan before the entire plan goes forward for vote. Incomplete plans may be discussed but will not be finalized. A template of all required elements will be present for reference when plans are being reviewed by committee members.

RFI closed	Who: Name/title	Date

St. Charles HEALTH SYSTEM

Campus: Bend Hospital	Accreditation body: Oregon Health Authority
Standard/EP/COPS: E 656 NSP Annual Report (3) Following its review of the staffing plan, the staffing committee shall issue a written report to the hospital that indicates whether the staffing plan ensures that the hospital is adequately staffed and meets the health care needs of patients. If the report indicates that it does not, the staffing committee shall modify the staffing plan as necessary to accomplish this goal. Stat. Auth.: ORS 413.042 & 441.156 Stats. Implemented: ORS 441.156	
Subject: Nurse Staffing Documentation Title: E 656	
Date survey completed: 4/29/2022 Official letter received: 6/17/2022	**RFI Plan of Correction due:** Response due to OHA: 08/15/2022 (extension)

Process owner and title (person in charge of the plan of action and bringing RFI into compliance): Daniel Davis, RN, Co-Chair Bend Staffing Committee
Ultimately responsible and title (process owner supervisor, responsible for RFI compliance and ongoing compliance): Debbie Robinson, RN, CNO, St. Charles Bend Campus

Official Findings:

(OAR 333-510-0115(3))

This Rule is not met as evidenced by:

Based on interview and review of HNSP Unit Questionnaires, unit NSPs and HNSC Co-Chair Pre-Interview Questionnaire, it was determined the hospital failed to issue a report to indicate whether the staffing plan ensures adequate staffing to meet the health care needs of patients.

Findings include:

1. Refer to Tag E652, which reflects that the NSP for the following units were not reviewed by the NSC within the past 12 months. There was no document provided that reflected a written report issued to the hospital indicating whether the staffing

plans for the following units ensure that the hospital is adequately staffed to meet the health care needs of patients.
* ICU, last reviewed by NSC "02/20"
* PCU, last reviewed by NSC "02/20"
* PES, last reviewed by NSC "03/20"
* Pre-Surgery, last reviewed by NSC "09/20"
* Cath Lab, last reviewed by NSC "11/20"
* Dialysis, last reviewed by NSC "09/20"
* MDU, last reviewed by NSC "12/20"
* NICU, last reviewed by NSC "10/20"
* FBC, last reviewed by NSC "10/20"
* Rehab, last reviewed by NSC "12/20"
* Wound Ostomy, last reviewed by NSC "10/20"
* Cancer Services, last reviewed by NSC "12/20"

Plan of Action:

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 action. By statute, the hospital must implement its Plan of Correction no later than 45 days after OHA approves the facility's Plan of Correction.
4. Monitoring: The description of the monitoring procedure(s) that the hospital will perform to prevent a 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.

What	Who	When	Status
The staffing committee will issue a written report to the hospital that indicates whether the NSP ensures the hospital is adequately staffed and meets the health care needs of the patients, once all staffing plans have been reviewed by BSC within the last 12 months.	Daniel Davis, RN, Co-Chair Bend Staffing Committee	No later than 45 business days after OHA approved the facility plan of correction (estimated 11/30/22).	In progress

How: Once all department nurse staffing plans have been reviewed and approved by BSC, within the last 12 months, a review will be conducted and an annual report developed to indicate whether the staffing plans ensure adequate staffing,

Requirement For Improvement (RFI)

to meet the healthcare needs of our patients. This report will be shared with hospital administration. Monitoring: See tag E652 NSP Annual Review. The BSC will monitor departments not reviewed in the last 12 months and those expiring in the next 3 months to plan presentations to come into compliance. Once in compliance staffing committee will complete a review and develop an annual report to administration. This is scheduled to occur in December 2022. If not completed in December, it will remain on each meeting agenda until complete.

RFI closed	Who: Name/title	Date