Nurse Staffing Report

Facility Name: St Charles Bend Campus
Report Publication Date: March 14, 2025

DISCLAIMER: This report was provided to the hospital administrator, chief nursing officer, and both co-chairs of the nurse staffing committee prior to publication. It has also been provided to the union(s) representing the complainant(s), if applicable.

For each violation cited in the report, OHA shall:

- Issue a warning for the first violation in a four-year period
- Impose a civil penalty of $1,750 for the second violation of the same provision in a four-year period
- Impose a civil penalty of $2,500 for the third violation of the same provision in a four-year period
- Impose of a civil penalty of $5,000 for the fourth and subsequent violations of the same provision in a four-year period

The enforcement notice issued to the hospital is included at the end of this report.

NOTE: Any violations listed in ORS 441.792 found before June 1, 2025, will not be relied upon for determining the applicable sanction on or after June 1, 2025, the date OHA can begin issuing civil penalties. 2023 Oregon Laws, Chapter 507, Section 29(4). The sanction for a violation of the same provision after June 1, 2025 will be a warning letter.

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

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Hospital: St. Charles Health System, Inc. **DBA St. Charles Bend Campus**

Case No. SCBC 2024-07

Complaint #s: OR49180, OR49896, OR51130, OR51241, OR51380, and OR51449

HOSPITAL STAFFING COMPLAINT INVESTIGATION REPORT

The Oregon Health Authority, Health Care Regulation and Quality Improvement Program (OHA) is responsible for processing complaints concerning compliance with certain hospital staffing laws. ORS 441.791. OHA can only investigate valid complaints filed within 60 days from the date of the violation alleged in the complaint. ORS 441.791(1), (6). A valid complaint means a complaint containing an allegation that if assumed to be true is a violation listed in ORS 441.792.

Summary of Report Findings: Based on its investigation and the findings of fact set out below, OHA finds:

- Three violations of ORS 441.792(2)(d) as alleged in complaint #s OR49896, OR51130, and OR51449.
- No violations of ORS 441.792(2)(d) as alleged in complaint #s OR49180, OR51241, and OR51380.

I. Summary of Complaints

In March 2024, OHA received one complaint which alleged that St. Charles Health System, Inc. DBA St. Charles Bend Campus ("St. Charles Bend") failed to comply with registered nurse (RN) and certified nursing assistant (CNA) staffing levels in the Intensive Care Unit (ICU) Nurse Staffing Plan (NSP) on one shift in March 2024.

In April 2024, OHA received one complaint which alleged that St. Charles Bend failed to comply with RN staffing levels in the Neonatal Intensive Care Unit (NICU) NSP on one shift in April 2024.

In June 2024, OHA received four complaints for shifts in June 2024 which alleged that St. Charles Bend:

- Failed to comply with RN staffing levels in the Progressive Care Unit (PCU) NSP on one shift.
- Failed to comply with CNA staffing levels in the PCU NSP on one shift.
- Failed to comply with RN staffing levels in the NICU NSP on two shifts.

A. Complaint #OR49180

On March 18, 2024, OHA received complaint #OR49180 which alleged that St. Charles Bend failed to comply with the RN and CNA staffing levels in the ICU NSP during the day shift starting on March 17, 2024, a violation of ORS 441.792(2)(d). OHA determined the complaint was valid for investigation on June 4, 2024, and opened its investigation on July 3, 2024.

B. Complaint #OR49896

On April 13, 2024, OHA received complaint #OR49896 which alleged that St. Charles Bend failed to comply with the RN staffing levels in the NICU NSP between 1900 – 0730 on April 13, 2024, a violation of ORS 441.792(2)(d). OHA determined the complaint was valid for investigation on June 4, 2024, and opened its investigation on July 3, 2024.

C. Complaint #OR51130

On June 1, 2024, OHA received complaint #OR51130 which alleged that St. Charles Bend failed to comply with the RN staffing levels in the PCU NSP during the 12-hour day shift on June 1, 2024, a violation of ORS 441.792(2)(d). OHA determined the complaint was valid for investigation on June 11, 2024, and opened its investigation on July 3, 2024.

D. Complaint #OR51241

On June 2, 2024, OHA received complaint #OR51241 which alleged that St. Charles Bend failed to comply with the RN staffing levels in the NICU NSP during the 12-hour night shift starting on June 2, 2024, a violation of ORS 441.792(2)(d). OHA determined the complaint was valid for investigation on June 20, 2024, and opened its investigation on July 3, 2024.

E. Complaint #OR51380
On June 4, 2024, OHA received complaint #OR51380 which alleged that St. Charles Bend failed to comply with the RN staffing levels in the NICU NSP during the 12-hour day shift on June 4, 2024, a violation of ORS 441.792(2)(d). OHA determined the complaint was valid for investigation on June 25, 2024, and opened its investigation on July 3, 2024.

F. Complaint #OR51449
On June 5, 2024, OHA received complaint #OR51449 which alleged that St. Charles Bend failed to comply with the CNA staffing levels in the PCU NSP during the 12-hour day shift on June 5, 2024, a violation of ORS 441.792(2)(d). OHA determined the complaint was valid for investigation on June 25, 2024, and opened its investigation on July 3, 2024.

II. Findings and Facts

A. ICU NSP
The NSP applicable to complaint #OR49180 was titled "Unit Staffing Plan & Scope of Service … ICU 2023" and is referred to as the "ICU NSP" in this report. The ICU NSP established a minimum number of RNs.

The ICU NSP stated that "Our minimum number of staff required for 1 patient is 2 RN and 1 charge nurse to ensure lunch covergae [sic]."

Although the ICU NSP included tables titled "Staffing Guide 2023", the ICU NSP did not incorporate or otherwise reference the guide as minimum or required staffing levels. Therefore, OHA has no basis to conclude that the ICU NSP required the shift to be staffed according to those tables.

Based on the language in the ICU NSP, the NSP set a minimum standard that the shift be staffed with two RNs.

As it relates to CNA staffing levels, the ICU NSP did not establish a required staffing level for CNAs. OHA has no basis to enforce compliance with a staffing level where the NSP did not establish a staffing level.

B. NICU NSP
The NSP applicable to complaint #s OR49896, OR51241, and OR51380 was titled "Unit Staffing Plan & Scope of Service … Area: NICU" and is referred to as the "NICU NSP" in this report.

The NICU NSP was approved by the St. Charles Bend Nurse Staffing Committee (NSC) on January 17, 2024. NSC meeting minutes, dated January 17, 2024, reflected the NSC was comprised of 18 members and that a quorum of members was present, with 16 members and two alternates in attendance. Six direct care staff members and six nurse manager members participated in the vote. The minutes reflected that the NICU NSP was

presented, a motion was made to approve the plan, that the “Motion approved by 6 nursing staff and 6 nursing leadership at 8:19am with no members objecting or abstaining”, and “NICU staffing plan approved as presented”.

The NICU NSP established minimum numbers of RNs and maximum RN-to-patient ratios.

The NICU NSP included excerpts from House Bill 2697, reflecting “… (b) In an intensive care unit, a direct care registered nurse is assigned to no more than two patients … (i) In an intermediate care unit, a direct care registered nurse is assigned to no more than three patients …”

During an interview conducted with the St. Charles Bend Nurse Staffing Committee (NSC) Co-Chairs via email on June 14, 2024, in response to the question, “As it relates to the NICU NSP, when is a 1:2 maximum RN-to-patient ratio followed in the NICU, and when is a 1:3 ratio followed?”, the NSC Direct Care Co-Chair and NSC Nurse Manager Co-Chair stated, “Average acuity patients follow a 1:3 ratio, High acuity patients follow a 1:2 ratio and Extreme acuity patients follow a 1:1 ratio.”

Even though the NSC Direct Care Co-Chair and NSC Nurse Manager Co-Chair stated that RNs were to be assigned to no more than one patient if their assigned patient was of “[e]xtreme acuity”, this staffing level was not reflected as a required staffing level in the NSP approved by the NSC and therefore is unenforceable.

The NSP also included a table titled “Ratio-Based (Patient Classification) Method”, which reflected nurse-to-patient ratios factors and were described as “Standards for professional nurse staffing for perinatal units (AWHONN, 2022)”, “Guidelines for Perinatal Care (AAP & ACOG, 2017)”, and “Recommendations”. Because these staffing levels were referenced as “Guidelines” and “Recommendations”, OHA has no basis to enforce these additional factors as required staffing levels.

As it related to minimum numbers of RNs, the NICU reflected that “minimum staffing when one patient is present is 4 RN’s [sic]. 2 RN’s [sic] to remain in the unit at all times; 2 available to respond to emergencies (charge and transport RN).”

Additionally, the NICU NSP included staffing requirements for a delivery support team provided by the unit: “NICU will provide a delivery support team (R-team) … This team includes at minimum two qualified staff members to manage the baby (R-nurse & RT), an experienced staff member to document in real time any resuscitative intervertions [sic] and who is able to support team leader in decision making (Charge Nurse or NICU R-team trained RN).”

Based on the language in the NICU NSP, the NSP set standards that the shift be staffed with at least the minimum number of RNs based on patient census and that RNs be assigned no more than two patients if any assigned patient was “High” acuity and no more than three patients if assigned patients were “Average” acuity.

C. IMCU/PCU NSP

The NSP applicable to complaint #s OR51130 and OR51449 was titled “Unit Staffing Plan & Scope of Service … Area: Stepdown Units (IMCU [Intermediate Care Unit] & PCU)” and is referred to as the “IMCU/PCU NSP” in this report.

The IMCU/PCU NSP was approved by the St. Charles Bend NSC on January 17, 2024. The St. Charles Bend NSC meeting minutes, dated January 17, 2024, reflected the NSC was comprised of 18 members and that a quorum of members was present, with 16 members and two alternates in attendance. Six direct care staff members and six nurse manager members participated in the vote. The minutes reflected that the IMCU/PCU NSP was presented, a motion was made to approve the plan, “Motion approved by 6 nursing staff and 6 nursing leadership at 10:13am with no members objecting or abstaining”, and “IMCU / PCU Staffing Plan approved as presented”.

The IMCU/PCU NSP established maximum RN-to-patient ratios and maximum numbers of patients that CNAs could be assigned at a time.

The IMCU/PCU NSP contained the following ratios and maximum assignments:

Nurse to Patient Ratio	Day shift : 1:3 Night shift : 1:3
CNA Assignments	Day shift : Not to exceed 7 patients at a time Night shift: Not to exceed 11 patients at a time

In addition, the IMCU/PCU NSP stated “When any patient is present in the department there is a minimum staffing of two licensed staff members present on the unit.” It was not clear whether “licensed staff members” referred specifically to nursing staff members or if it included non-nursing licensed staff, so OHA has no authority to enforce this as a required nurse staffing level.

Based on the language in the IMCU/PCU NSP, the NSP set standards that RNs be assigned no more than three patients, that CNAs be assigned tasks for no more than seven patients at a time on a day shift, and that CNAs be assigned tasks for no more than 11 patients at a time on night shift.

D. Staffing during the shift

1. Complaint #OR49180:

Review of staffing documentation for the ICU day shift on March 17, 2024, reflected:

- At least one patient was present on the unit.
- At least eight RNs worked from approximately 0700 to 1930.
- No fewer than six RNs were on the unit during meal breaks.

Because the ICU NSP did not establish a required staffing level for CNAs, CNA staffing levels for ICU during the day shift on March 17, 2024,were immaterial and not included in this report.

2. Complaint #OR49896:

Review of staffing documentation for the NICU night shift starting on April 13, 2024, reflected:

- At least one patient was present on the unit.
- At least seven RNs worked from approximately 1900 to 0730.
- Patient assignments for RNs with only “Average” acuity patients did not exceed a 1:3 RN-to-patient ratio during the shift.
- The patient assignment for the one RN with a “High” acuity patient exceeded a 1:2 RN-to-patient ratio during the shift.

3. Complaint #OR51130:

Review of staffing documentation for the PCU 12-hour day shift on June 1, 2024, reflected:

- One RN was assigned four patients from approximately 0700 to 1500.

4. Complaint #OR51241:

Review of staffing documentation for the NICU 12-hour night shift starting on June 2, 2024, reflected:

- At least one patient was present on the unit.
- At least four RNs worked from approximately 1900 to 0730.
- Patient assignments for RNs with only “Average” acuity patients did not exceed a 1:3 RN-to-patient ratio during the shift.
- Patient assignments for RNs with any “High” acuity patients did not exceed a 1:2 RN-to-patient ratio during the shift.

5. Complaint #OR51380:

Review of staffing documentation for the NICU 12-hour day shift on June 4, 2024,reflected:

- At least one patient was present on the unit.
- At least four RNs worked from approximately 0700 to 1930.
- No fewer than four RNs were on the unit during meal breaks.

- Patient assignments for RNs with only “Average” acuity patients did not exceed a 1:3 RN-to-patient ratio during the shift, including during meal breaks.
- Patient assignments for RNs with any “High” acuity patients did not exceed a 1:2 RN-to-patient ratio during the shift, including during meal breaks.

6. Complaint #OR51449:
Review of staffing documentation for the PCU 12-hour day shift on June 5, 2024, reflected:
- One CNA was assigned tasks for ten patients at the same time.
- One CNA was assigned tasks for nine patients at the same time.
- One CNA was assigned tasks for eight patients at the same time.
- One CNA was assigned tasks for seven patients.

III. Analysis of Alleged Violations

A. Complaint #OR49180

RN Staffing Levels

During the ICU day shift on March 17, 2024, at least one patient was present on the unit, and the ICU NSP therefore required two RNs. ICU was staffed with at least six RNs, including during meal breaks. RN Staffing on March 17, 2024, for the ICU day shift therefore did not fail to comply with the ICU NSP.

CNA Staffing Levels

The ICU NSP did not establish a required staffing level for CNAs. Because there was no staffing level to violate, CNA staffing could not violate the ICU NSP.

Summary of Allegations

There is no violation of ORS 441.792(2)(d) under the facts presented by Complaint #OR49180.

B. Complaint #OR49896
During the NICU night shift starting on April 13, 2024, at least one patient was present on the unit, and the NICU NSP therefore required four RNs. The NICU NSP also required that the maximum number of patients assigned to an RN not exceed three if assigned patients were “Average” acuity and not exceed two if any assigned patient was “High” acuity. NICU was staffed with at least seven RNs from approximately 1900 to 0730. The patient assignment exceeded 1:2 for one RN with a “High” acuity patient. Staffing on April 13, 2024, for the NICU night shift therefore failed to comply with the NICU NSP.

The hospital failed to follow the RN staffing requirement set forth in the NSP during the night shift starting on April 13, 2024. The failure to comply was not an allowed deviation under ORS 441.765(6) because the unit manager did not notify the hospital NSC within 10 days of any deviations on the April 13, 2024 night shift.

There is one violation of ORS 441.792(2)(d) under the facts presented by Complaint #OR49896.

C. Complaint #OR51130

During the PCU 12-hour day shift starting on June 1, 2024, the IMCU/PCU NSP required that the maximum number of patients assigned to an RN not exceed three. One RN was assigned four patients during the shift. Staffing on June 1, 2024 for the PCU day shift therefore failed to comply with the IMCU/PCU NSP.

The hospital failed to follow the RN staffing requirement set forth in the NSP during the 12-hour day shift on June 1, 2024. The failure to comply was not an allowed deviation under ORS 441.765(6) because the unit manager did not notify the hospital NSC within 10 days of any deviations on the June 1, 2024 day shift.

There is one violation of ORS 441.792(2)(d) under the facts presented by Complaint #OR51130.

D. Complaint #OR51241

During the NICU 12-hour night shift starting on June 2, 2024, at least one patient was present on the unit, and the NICU NSP therefore required four RNs. The NICU NSP also required that the maximum number of patients assigned to an RN not exceed three if assigned patients were “Average” acuity and not exceed two if any assigned patient was “High” acuity. NICU was staffed with at least four RNs from approximately 1900 to 0730. Patient assignments did not exceed 1:3 for RNs with “Average” acuity patients and did not exceed 1:2 for RNs with any “High” acuity patients. Staffing on June 2, 2024 for the NICU night shift therefore did not fail to comply with the NICU NSP.

There is no violation of ORS 441.792(2)(d) under the facts presented by Complaint #OR51241.

E. Complaint #OR51380

During the NICU 12-hour day shift on June 4, 2024, at least one patient was present on the unit, and the NICU NSP therefore required four RNs. NICU was staffed with at least four RNs from approximately 1900 to 0730, including during meal breaks.

The NICU NSP also required that the maximum number of patients assigned to an RN not exceed three if assigned patients were “Average” acuity and not exceed two if any assigned patient was “High” acuity. Patient assignments did not exceed 1:3 for RNs with

“Average” acuity patients and did not exceed 1:2 for RNs with any “High” acuity patients, including during meal breaks.

Staffing on June 4, 2024 for the NICU day shift therefore did not fail to comply with the NICU NSP.

There is no violation of ORS 441.792(2)(d) under the facts presented by Complaint #OR51380.

F. Complaint #OR51449

During the PCU 12-hour day shift on June 5, 2024, the IMCU/PCU NSP required a maximum task assignment of seven patients for a CNA. Three CNAs working this shift each had a maximum task assignment greater than seven. Staffing on June 5, 2024 for the PCU day shift therefore failed to comply with the IMCU/PCU NSP.

The hospital failed to follow the CNA staffing requirement set forth in the NSP on the June 5, 2024 12-hour day shift. The failure to comply was not an allowed deviation under ORS 441.765(6) because the unit manager did not notify the hospital NSC within 10 days of any deviations on the June 5, 2024 day shift.

There is one violation of ORS 441.792(2)(d) under the facts presented by Complaint #OR51449.

IV. Conclusion

Prior to June 1, 2025, OHA may only issue a letter of warning for the first violation of a provision of ORS 441.792.

Based on its investigation, OHA concludes there were no violations of ORS 441.792(2)(d) as alleged in complaint #s OR49180, OR51241, and OR51380. OHA will not take any enforcement action based on the complaints listed above.

Based on its investigation, OHA concludes there were three violations of ORS 441.792(2)(d) as alleged in complaint #s OR49896, OR51130, and OR51449. A warning was previously issued to St. Charles Bend for a violation of ORS 441.792(2)(d) relating to complaint #OR49941. OHA will not take any other action regarding the violations of ORS 441.792(2)(d) found in complaint #s OR49896, OR51130, and OR51449. ORS 441.792(1).

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on March 13, 2025, I directed to be served the **HOSPITAL STAFFING COMPLAINT INVESTIGATION REPORT** upon the individuals or entities and by the method indicated below:

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