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	384008	A. BUILDING _____ B. WING _____	C 05/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS	A 000		

This report reflects the findings of an unannounced, onsite Federal complaint investigation survey at the OSH-Salem main campus for complaints OR49910 and OR49922. The survey was initiated on 04/24/2024 and concluded with an exit conference on 05/06/2024.

The survey also included virtual observations, as described in this report, of OSH's off-campus, Medicare certified satellite located in Junction City, Oregon. The OSH-Junction City campus is approximately 65 miles, and one hour and 15 minutes drive time, from the OSH-Salem main campus.

The hospital was evaluated for compliance with the applicable requirements of the following hospital Conditions of Participation (CoPs):
* CFR 482.12 - CoP: Governing Body
* CFR 482.13 - CoP: Patient's Rights
* CFR 482.23 - CoP: Nursing Services
* CFR 482.60 - CoP: Special Provisions for Psychiatric Hospitals

On 04/19/2024 the hospital self-reported to CMS and OHA an incident that occurred on 04/18/2024 that involved Patient 1. The hospital reported that upon entry to the hospital's AD, Patient 1's condition was not assessed, including vital signs. After transport by w/c through the hospital to the inpatient unit Patient 1 had been assigned to they were found to be without a pulse. Resuscitation efforts, initiated by hospital staff and continued by EMS staff who were called to the hospital, were not successful and the patient was pronounced dead on the inpatient unit ~ 69 minutes after arrival to the hospital. Prior to the start of this SA

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investigation, the hospital had initiated an internal investigation and taken action to ensure that all patients would have a brief assessment and vital signs by an AD RN upon arrival to mitigate the possibility that a similar event could recur while its internal investigation continued and further corrective actions were planned. However, during the survey the SA survey team found that those actions alone were not sufficient to prevent potential serious adverse outcomes to other patients. The medical emergency supplies and equipment in the AD were disorganized, including that they were scattered in at least four different locations, some in other departments and inpatient units. The failure to properly manage those supplies and equipment did not ensure a timely and efficient medical emergency response should patients who arrive to the AD be identified to have a medical emergency. The following survey actions were taken as result of the SA survey team findings:

* On Friday, 04/26/2024 beginning at ~ 1130, the SA survey team met with the SA Survey Manager to review survey findings for potential IJ. Review of video-recordings, interviews, and record review to that point in the survey reflected gaps in processes and staff responses to patient emergencies that created opportunity for a similar incident to recur and are described more fully under Tag A-144 of this report at Findings 18 through 21.c. A draft IJ template for Tag A-144 was initiated.
* On 04/26/2024 at beginning at ~ 1530 the survey team and Survey Manager reviewed and finalized the draft IJ template for Tag A-144.
* On 04/26/2024 at ~ 1615 the survey team and Survey Manager presented the completed IJ template to the Interim DS, CNO, DOQ, and DSC

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and gave instructions regarding removal of the IJ.
* On 04/30/2024 at ~ 1040 the hospital submitted its IJ Removal Plan.
* On 04/30/2024 at ~ 1115 the survey team reviewed the IJ Removal Plan and determined it could not be approved as written.
* On 04/30/2024 at ~ 1515 the survey team provided the hospital feedback regarding the IJ Removal Plan.
* On 05/01/2024 at ~ 0910 the hospital submitted a revised IJ Removal Plan which outlined actions that included, but was not limited to:
* On the OSH-Salem campus, the hospital consolidated the locations of the emergency supplies and equipment, including code blue emergency equipment bag, AED, suction machine, Narcan, and O2 tank onto an Admissions Emergency Cart. The cart will be kept in one room in the AD. The hospital updated the sign on the outside of the door to the room to alert staff about the location of the Admissions Emergency Cart.
* On the OSH-JC campus, the hospital consolidated the locations of the emergency supplies and equipment, including AED, suction machine, Narcan, and O2 tank onto an Admissions Emergency Cart. The cart will be located in a room in the Admissions area. The hospital will place a sign outside the door to the room to alert staff to the location of the cart.
* The hospital created an inventory list of the medical supplies and equipment at each campus that will be kept on the Admissions Emergency Carts.
* All AD nurses on the OSH-Salem campus were notified in writing of the updated location and inventory of the Admission Emergency Cart and confirmed in writing that they received and understood this information via attestation.

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* All unit nurses who admit new patients on the OSH-JC campus will be notified in writing of updated location and inventory of the Admissions Emergency Cart. No nurse will be able to admit new patients until they have completed an attestation.
* Admissions Emergency Cart Inventory Lists will be reviewed at both campuses to ensure all required medical equipment are on the carts, all supplies are in good working order and within their expiration date, and that the signs indicating the location of emergency equipment are intact and accurate.
* The IJ removal plan with a full implementation date/time of 05/02/2024 at 1200 was determined to be acceptable by the survey team and Survey Manager.
* On 05/01/2024 at ~ 1000 the revised IJ Removal Plan with an implementation date/time of 05/02/2024 at 12:00 noon was reviewed and approved by the survey team and Survey Manager.
* On 05/01/2024 at ~ 1035 the hospital was informed that the IJ Removal Plan was approved.
* On 05/02/2024 at ~ 1230 the survey team initiated an unannounced, onsite IJ removal verification visit and verified that the actions contained in the approved IJ Removal Plan had been implemented. The survey team conferred with the Survey Manager regarding the verification visit findings.
* On 05/02/2024 at ~ 1640 the survey team informed the hospital that the IJ was removed.
* On 05/02/2024 at ~ 1650 the Survey Manager notified CMS of the findings of the IJ removal verification visit.

The findings from the survey that follow in this report reflected that the allegations in the two

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complaints were substantiated and Condition-Level deficiencies under the following CoPs were identified:
* CFR 482.12 - CoP: Governing Body
* CFR 482.13 - CoP: Patient's Rights
* CFR 482.23 - CoP: Nursing Services
* CFR 482.60 - CoP: Special Provisions for Psychiatric Hospitals

This report was revised on 05/28/2024 per CMS request. Revised text is in bold font.
****

* Hospital departments & hospital level-of-care units referenced throughout this report may include:
AD - Admissions Department
AN1, AN2, AN3 - Anchors 1, 2, 3 units @ OSH-Salem
FW1, FW3 - Flowers 1, 3 units @ OSH-Salem
LH1, LH2, LH3 - Lighthouse 1, 2, 3 units @ OSH-Salem
MN1, MN2, MN3 - Mountain 1, 2, 3 units @ OSH-JC

* Hospital staff referenced throughout this report may include:
AAG - OSH's DOJ Assistant Attorney General
ADM - Admissions Department Manager
BOM - Business Operations Manager
BOM1 - Business Operations Manager 1
CDC - Code Blue Coordinator
CFO/COO - Chief of Operations
COM - Chief of Medicine
COP - Chief of Psychiatry
CMO - Chief Medical Officer
CNO - Chief Nursing Officer
DLD - Director of Learning and Development
DNS - Director of Nursing Services

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DOS - Director of Security
DS - Deputy Superintendent
DSC - Director of Standards and Compliance
DQM - Director of Quality Management
IRSI - Incident Response Systems Investigator
JCA - OSH Junction City Campus Administrator
LPN - Licensed Practical Nurse
MD - medical doctor, physician
MHST - Mental Health Security Technician
MHT - Mental Health Therapist
MHT2 - Mental Health Therapist 2
MHTT - Mental Health Therapy Technician
NM - Nurse Manager
NP - Nurse Practitioner
OBC - Onboarding Coordinator
OS2 - Office Specialist 2
OSHS - OSH Superintendent, Administrator OSH
PD - Program Director
PMHNP - Psychiatric Mental Health Nurse Practitioner
PNM - Program Nurse Manager
POD - Psychiatrist On Duty
RN - Registered Nurse
SOS - Security Operations Supervisor
SS - Security Staff
TMHA - Transporting Mental Health Aid
****

* Abbreviations and acronyms used throughout this report may include:
& - and
~ - approximately
@ - at
= - greater than or equal to
- number
+ - plus
x - times
x1 - one time
ADC - Automated Dispensing Cabinet

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AED - Automated External Defibrillator
approx - approximately
AR - Admitting Room
CEO - Chief Executive Officer
CFR - Code of Federal Regulations
CIR - Critical Incident Review
CMS - Federal Centers for Medicare and Medicaid Services
comm - communication(s)
CoP - Condition of Participation
CPR - Cardiopulmonary Resuscitation
DC - Douglas County
DHS- Oregon Department of Human Services
DOJ - Oregon Department of Justice
e.g. - for example
ED - Emergency Department
E-Kit - Emergency Kit, a secure, portable container that stores specific medications that are used to treat patients in emergency situations.
EMT, emt - Emergency Medical Technician
EOC - Environment of Care
Epi - Epinephrine
Eval - Evaluation
ExLg - Extra Large
H&P - History and Physical
HCP - Health Care Personnel
HCRQI - Health Care Regulation and Quality Improvement
HFA - Hydrofluoroalkane
HR - Human Resources
IDT - Interdisciplinary Team
IJ - Immediate Jeopardy
IP - in-patient
JC - Junction City
Lf. - Left
Lg - Large
LIP - Licensed Independent Practitioner
M-F - Monday through Friday
mcg - microgram

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mg - milligrams
MH - Mental health
mL - milliliter
N - No
N/A - not applicable
NS - Nurses Station
O2 - Oxygen
OAR - Oregon Administrative Rule
OHA - Oregon Health Authority
OQM - OSH Office of Quality Management
OSH - Oregon State Hospital
OSH-JC - Oregon State Hospital satellite campus in Junction City, Oregon
OSH-Salem - Oregon State Hospital main campus in Salem, Oregon
OSP - Oregon State Police
OTIS - DHS/OHA Office of Training, Investigation and Safety
P&P, PP - policy(ies) and procedure(s)
PET - Program Executive Team
PHD - OHA Public Health Division
PRN - as needed
p.s.i. - pounds per square inch
Pt, pt - patient
r/t - related to
RCA - Root Cause Analysis
RCM - Rounds, Census, Milieu
rm - room
Rt - Right
S&C - Standards and Compliance
SA - The CMS designated State Agency responsible for enforcement of the Federal hospital regulations. In Oregon that is the Public Health Division office of Health Care Regulation and Quality Improvement within the Oregon Health Authority.
Sally Port - Secure controlled building entry
(sic) - In a quote reflects the language, spelling or punctuation is recorded as in the original

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A 000	Continued From page 8 document. SOM - CMS State Operations Manual SSM - w/c - wheelchair Y - Yes **********	A 000		
A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: ********** Based on observations, review of video recordings, interviews, review of incident and medical record documentation for 1 of 1 patient (Patient 1), review of 4 of 4 AD staff training records (RNs 1, 2, 3, and 4), review of OSH internal investigation documentation, review of medical emergency supplies and equipment documentation, review of medical emergency response documentation, review of training documentation, and review of P&Ps and procedural manuals, it was determined that the governing body failed to ensure the provision of safe and appropriate care to patients in the hospital in a manner that complied with all Conditions of Participation. The cumulative effect of these systemic failures resulted in this Condition-level deficiency that	A 043		

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represents a limited capacity on the part of the hospital to provide safe and adequate care.

Findings include:

1. Refer to the findings cited under this Condition at Tag A-093, CFR 482.12(f)(2) - Standard: Emergency Services. This Standard applies to hospitals that do not have a dedicated, organized emergency services department and therefore must develop and maintain written P&Ps for evaluation of emergencies, initial treatment, and referral when appropriate. The findings cited reflect that the hospital failed to fully develop and implement P&Ps and systems to ensure timely and appropriate assessment and response to individuals anywhere on campus who exhibited signs of a potential medical emergency (Tag A-093.)

2. Refer to the findings cited at Tag A-115, CFR 482.13 - CoP: Patient's Rights, that reflects the hospital failed to fully develop and implement P&Ps that ensured each patient's right to receive care in a safe setting. The hospital's failures to ensure appropriate patient assessment and provisions for response to medical emergencies created an unsafe EOC that likely contributed to harm and death of one patient and created the likelihood of harm to other patients (Tag A-144).

3. Refer to the findings cited at Tag A-385, CFR 482.23 - CoP: Nursing Services, that reflects the hospital failed to fully develop and implement P&Ps that ensured that patient needs were met by ongoing RN assessment and response to the nursing and emergency care needs of the patient population of each department (Tag A-392).

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A 043	Continued From page 10 4. Refer to the findings cited at Tag A-1600, CFR 482.60 - CoP: Special Provisions for Psychiatric Hospitals, that reflects the hospital failed to comply with all CoPs specified in CFRs 482.1 through 482.23 and CFRs 482.25 through 482.57 as the following CoPs were determined to be out of compliance (Tag A-1605): * CFR 482.12 - CoP: Governing Body * CFR 482.13 - CoP: Patient's Rights * CFR 482.23 - CoP: Nursing Services **********	A 043		
A 093	EMERGENCY SERVICES CFR(s): 482.12(f)(2) If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate. This STANDARD is not met as evidenced by: ********** Based on observations, review of video recordings, interviews, review of incident and medical record documentation for 1 of 1 patient (Patient 1), review of 4 of 4 AD staff training records (RNs 1, 2, 3, and 4), review of OSH internal investigation documentation, review of medical emergency supplies and equipment documentation, review of medical emergency response documentation, review of training documentation, and review of P&Ps, it was determined that the hospital's failures to fully develop and implement P&Ps that ensured appropriate and timely provisions for response to medical emergencies anywhere on campus, at this hospital that did not have a dedicated	A 093		

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A 093	Continued From page 11	A 093		

Emergency Department, included:
* Failure to ensure AD and inpatient RN staff were determined to be qualified to conduct appropriate and timely assessment of patient condition and identification of the need for medical emergency response.
* Failure to ensure RN staff requested the immediate presence of a physician when the patient's unresponsive physical condition was believed to be behavioral versus medical.
* Failure to provide safe and adequate initial treatment of a person who experienced a medical emergency in an organized and coordinated manner.
* Failure to ensure that medical emergency supplies and equipment were organized and managed to ensure availability of necessary items during a medical emergency response.

Findings include:

1. The findings that follow reflect that the hospital failed to ensure that RN staff promptly assessed Patient 1's condition and initiated medical emergency response based on the patient's unresponsive condition that was immediately evident upon arrival to the hospital. When AD RN first observed the patient in the law enforcement transport vehicle they stated they saw the patient's eyes open briefly. That was the only detectable movement the patient made between the time they were transferred from the back of the transport vehicle until another RN who had accompanied the patient for transport from the AD to the inpatient unit checked for a pulse after the transport and entry into the patient's assigned inpatient room. RNs and other hospital staff failed to respond timely to the patient's unresponsive and motionless condition in the manner in which

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a reasonable or prudent layperson, or a person with BLS CPR training, would do should an individual who exhibited the same signs and condition be observed elsewhere in the hospital or in the community. The RNs responsible for the patient in the AD and en route to the inpatient unit failed to request the presence of a physician to determine whether the patient's unresponsive condition was behavioral, as law enforcement transporters claimed, versus medical. Once the medical emergency response had been initiated in the inpatient unit, the response was not conducted in an organized and coordinated manner. Further, survey findings revealed that medical emergency supplies in the AD where Patient 1 was initially observed were not organized or managed to ensure timely response. Refer to Tag A-144 for additional information regarding Patient 1's encounter, and the findings that resulted in identification of an IJ situation.

2.a. A document titled "OSH Office of Quality Management" was reviewed. It included the following information:
* "Incident Nature: Sentinel Event - Unexpected Patient Death"
* "Date/Time of Incident: 04/18/2024 1115hrs"
* "At approx. 1047 hrs. access control informed admissions Douglas County jail transport were waiting with [Patient 1] for admission to OSH. Staff arrived and the country [sic] transport vehicle entered a Sally Port, at approximately 1054 hrs. Deputies told [RN 4] [that Patient 1] would need a wheelchair because [they were] 'catatonic' and at times 'flops around like a fish'. This was reported to have been described to nursing staff as normal behavior by [Patient 1]. As [Patient 1] was transferred from the transport van to the wheelchair, at approximately 1101 hrs, the

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admission [RN 4] reported [they] observed [Patient 1's] eyes open and close, possibly in response to light hitting [Patient 1's] eyes. [Patient 1] was wheeled into OSH admissions at approximately 1102 hrs. Additional staff were called to the admissions area and assisted in photographing [Patient 1] for identification. Douglas County transport restraints were removed from [Patient 1] and [they were] taken, via wheelchair, to Lighthouse 1 by OSH Staff. During this process [Patient 1] was noted as not moving on [their] own accord and staff held the patients [sic] legs up with a blanket so [their] feet would not drag on the floor. Staff and the patient arrived on the unit at approx. 1107hrs. where the patient was taken directly to a patient room. As [Patient 1] was being transferred to the bed an RN decided to check the patient for a pulse and found none. Sternal rubs were done with no response and additional checks found no pulse. A Code Blue was initiated and additional staff arrived and life saving procedures were performed including the use of CPR and an AED. Narcan and epinephrine were administered and were ineffective. Paramedics arrived at approx. 1121hrs and took over life saving efforts. [Patient 1] was pronounced dead at 1156 hrs."

2.b. In regard to Narcan and epinephrine administration, Patient 1's medical record included a Psychiatry General Note written by psychiatrist MD 30 and dated and timed 04/18/2024 at 1451. It reflected that the Narcan was administered by OSH staff, and in regard to epinephrine administration the note reflected that "EMS arrived at approximately 1125-1126 and took over the management of the code. They continued CPR for approximately 30 more minutes and per their report, gave 5 rounds of

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epinephrine. Patient did not achieve return of spontaneous circulation at any point following the start of the code, and patient was eventually pronounced dead by EMS at 1156 on 4/18/24."

3.a. During interview on 04/24/2024 at 1105 with RN 4, they stated they had worked in AD since August 2023. RN 4 provided the following information regarding Patient 1:
* A "Douglas County" transport van pulled into Sally Port 8 drive-in garage. The deputies said the patient would need a wheelchair because they had not been able to get into the van themselves and had been "flopping around like a fish." The deputies stated that was the patient's baseline.
* RN 4 stated they got a wheelchair for the patient and went to the back of the van with a security staff. The patient, who was in the back of the van, "opened their eyes and moved a little". RN 4 introduced themselves to the patient. The deputies told the patient, "We'll get you out [of the van]" and the patient closed their eyes. RN 4 stated "I thought [the patient was] not being cooperative" and asked for more security staff. RN 4 stated 5-6 security staff came. The deputies gave the patient a few minutes to get out of the van and when they did not, the deputies lifted the patient to the wheelchair. RN 4 stated the deputies held the patient's legs up while they wheeled the patient backwards from the van into the AR.
* RN 4 stated in the AR "we got a photo of the patient for [their] ID" and the deputies said it would be OK to remove the patient's cuffs because they had never been aggressive. The deputies removed the cuffs. The patient was not able to hold their head up and "kept [their] eyes closed." RN 4 stated the patient was slouched

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with their head to one side, and "not holding it up like a normal person holds their head."
* RN 4 stated "typically we take a temperature and ask about a cough" in the AR. RN 4 stated they did not check the patient's temperature or any other vital signs and did not ask the patient if they had a cough. When RN 4 was asked if the patient was breathing, they stated, "I didn't observe any chest rise and fall." In response to the surveyor's follow-up question in regard to indications of oxygenation such as the patient's skin color and appearance, RN 4 additionally stated that the patient "was African American, had dry skin, and I didn't notice anything abnormal."
* RN 4, a unit nurse, and security staff pushed the patient in the wheelchair from the AR to LH1. One of the security staff lifted the patient's legs with a blanket so their legs wouldn't drag. When they got to the patient's room on the unit, the unit RN and 2 security staff laid the patient supine on the bed. RN 4 stated, "At that point, I knew something was off because there was no response from the patient, so I checked for a pulse. Nothing. I checked a sternal rub and nothing." The patient had no pulse and was not breathing, and they called a code blue.

3.b. Incident documentation recorded by AD RN 4, dated 04/18/2024 and untimed, reflected that "Access control called the main admissions office phone at around 10:47 to report that Douglas County was waiting to get into Sally Port 8 for an admission. Douglas County was scheduled to drop off two admits to OSH today on 4/18. [Patient 26] who was scheduled to admit to FW1, and [Patient 1] was scheduled to admit to LH1. The Douglas county transport van was waiting in the circle outside of OSH for roughly 5-10 minutes, due to there being a secure transport

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van in Sally Port 8. [RN 3] admissions RN, went outside Sally Port 9 to talk to the Douglas county officers to find out how the pts were doing. When [RN 3] came back through Sally Port 9, [they] reported to me ([RN 4] Admissions RN) that the officers said [Patient 1] will need a 'wheelchair' because [the patient] 'flops around like a fish' and is 'catatonic'. After secure transport left Sally Port 8. Douglas county pulled into Sally Port 8. FW3 unit staff showed up first, and [RN 3] who was assigned to admit [Patient 26] brought in [Patient 26] and introduced them to the FW3 staff and that pt was taken to FW3. [Patient 1's] unit staff from LH1 ([RN 13] along with unit MHT) showed up next. I was assigned to admit [Patient 1] as I had done [their] pre-admit note in avatar as well as a nurse to nurse with the jail RN. The deputy standing in the admissions area adjacent to Sally Port 8 then reported to me, '[Patient 1] won't stand up, [they're] catatonic. [They'll] need a wheelchair'. RN asked the deputy '[They] won't stand at all?', and deputy responded 'No'. Wheelchair and a blanket was obtained by this RN. [MHST 18] was the security assigned to help with admissions for 4/18. As Sally Port 8 doors were opened by access control, [MHST 18] held open the doors while this RN followed deputies to the back of the van with the wheelchair. The deputies opened up both doors to the back of the van. [Patient 1] was seen sitting in a slumped position with [their] back against van partition. As soon as the van doors opened, there was sunlight that came streaming into the back of the van, and this RN could see [Patient 1's] eye open and close. Deputies said to [Patient 1] that they needed [them] to get into the wheelchair and gave [the patient] a few seconds but pt did not make any movements or indication that [they were] going to get up. Deputies then assisted pt

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on either side and lifted the pt into the wheelchair. RN introduced [themselves] to [Patient 1] and explained [they were] at the hospital but pt did not respond. RN asked for pt to lift [their] legs, so [they] could be wheeled, but [Patient 1] did not lift [their] legs. Both deputies each lifted one of the pt's legs by the pant leg so [the patient's] heels would not be dragging, and this RN wheeled [Patient 1] backwards into the adjacent admitting room connected to Sally Port 8. [MHST 18] had called for additional security at the request of this RN, who were also present in the admitting area. A photo was obtained of [the patient] for [their] ID badge for security, but [they] did not open [their] eyes. This RN was assessing whether or not the cuffs should be removed in the admitting area, or on the unit for safety, when officers reported that they did not see [the patient] as a threat, and [they] had 'never been physically violent'. This RN gave the directive for officers to remove the cuffs as pt was not exhibiting any signs of aggressive behaviors. Cuffs were removed by officers. Pt was wheeled by security to LH1, with one security wrapping a blanket underneath pt's legs and lifting them up so they did not drag on the floor. Admissions RN and unit staff followed as well. Pt was taken onto LH1 unit, and down one of the first hallways on the right hand side as you enter the unit, where the pt's assigned bedroom was. Pt was wheeled into [their] room, and staff informed [the patient] that it was [their] bedroom and [they] could get up. One staff member said '[Patient] won't get up, [they're] catatonic'. Security and unit RN and another staff lifted the pt onto the bed. Pt was now in a supine position on the bed. Unit RN, [RN 13], then began doing [their] assessment. [RN 13] tried verbal stimuli, yelling pt's name, checking radial and pedal pulse, checked for breathing. This RN checked for radial pulse on

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the right side, and there was no pulse felt. This RN confirmed with [RN 13] there was no pulse. Compressions were started, and a code blue was called on the radio by security. Crash cart was obtained with AED. Pt was moved to the floor in supine position for compressions and ambu bag was used for breath. 911 was called. Two OSH medical doctors arrived. AED advised no shock. EMS arrived and took over care."

4. Incident documentation recorded by LH1 RN 13, dated 04/18/2024 and untimed, reflected that "I was the RN assigned to [Patient 1's] admission along with [MHT2 8]. We were called to the admission Sally Port around 1100 and waited in line as the county had two patients and the first was going to a different unit. [MHT2 8] and I remained outside the Sally Port per protocol, waiting for report from the [AD RN 4]. It was reported that the pt was not cooperating, would not walk, and [AD RN 4] retrieved a wheelchair. Security arrived at the Sally Port, evidently having been paged by admissions. The pt was retrieved from the transport vehicle utilizing the wheelchair and brought into the Sally Port; I was not able to observe the pt from my vantage point outside the Sally Port. It was reported to us that the pt was continuing to be uncooperative and not responding. Two security staff wheeled the pt out of the Sally Port, one pushing [TMHA 19], the other holding the pt's legs up with a blanket draped under [the patient's] ankles ([MHST 20], switched with [MHST 17] at some point). We quickly made our way to LH1; I walked alongside the wheelchair, attempting to engage the pt, explain the plan. We passed the bubble on LH1 at 1111. We had decided to take [Patient 1] directly to [their] room and transfer [them] to [their] bed. On arrival to [patient's] room, security

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[TMHA 19] and I immediately lifted the pt out of the wheelchair and onto the bed. During that transfer, I noted the pt was more limp than would have been expected from a simply unresponsive pt. I immediately began checking for a pulse on [their] R wrist and began calling [their] name loudly. I performed sternal rubs when I could not elicit a response verbally. When there continued to be no response I requested staff call a code blue (code was called @ 1114). I then attempted to find a pulse under [the patient's] upper arm, carotid, pedal while continuing to attempt to rouse [them] verbally and with sternal rubs and watch for chest rise (this was difficult to assess as [the patient] was in loose fitting jail clothing). I pulled open [the patient's] eye lid and noted a dilated pupil; I used my flashlight to test reactivity and no reactivity was seen. Staff arrived quickly and we began chest compressions (@ 1115). Staff arrived with the AED and crash cart. After applying the AED pads, we transferred the pt to the floor to have a more firm surface and continued compressions alternating with AMBU bag respirations following CPR protocol. Narcan was requested and administered by [PMHNP 23]. Various staff and medical personnel rotated through administering compressions and AMBU respirations. CPR was continued per protocol, following prompts from AED (no shock ever advised) until paramedics arrived and took over the situation."

5. On 04/24/2024 beginning at 1155, survey team review of multiple camera views of video-recordings, without audio capability, revealed the following timeline of events that occurred on 04/18/2024 when the vehicle Patient 1 was transported in from Douglas County Jail arrived to the OSH Sally Port 8. Regarding the

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video review there was no camera view provided in Sally Port 8 that showed directly into the back of the transport van used to transport Patient 1 so that the entirety of the inside of the van could be visualized. The camera that showed the view at the back of the van was mounted off to the side of the Sally Port so that a side view of the right rear of the van could be visualized. With both rear van doors opened only a small portion of the inside of the back compartment could be seen. In addition, the quality and clarity of some of the video footage was poor and details of some images were not clear. Further, there were occasions during video review where video skipped several seconds when there was activity occurring. Commonly video may skip seconds or minutes when there is no activity occurring.

* Between ~ 1054:52 and 1056:23 two camera views inside Sally Port 8 showed: A DC Jail transport van drove into Sally Port 8 with two DC deputies seated in the front seats. The garage door closed after the van had fully entered the Sally Port. A DC deputy walked to the back of the van, opened one of the back doors, removed two bundles of items, and walked away towards the door to the admitting room. At ~ 1056:07 Patient 26 exited the van through the passenger right side doors and walked in front of the second DC deputy towards the door to the admitting room.

* Between ~ 1058:18 and 1100:20 one camera view inside Sally Port 8 showed: A DC deputy walked back to the back of the van, opened one of the back doors and looked inside momentarily, then started to close the door, then reopened it and looked inside and left it open. They stood at the back of the van and periodically looked inside through the open door.

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* Between ~ 1100:21 and 1102:20 two camera views inside Sally Port 8 showed: The second DC deputy approached the back of the van and joined the first deputy, immediately followed by RN 4 who pushed a w/c towards the back of the van. The deputies opened the other door so that both back van doors were open. At ~ 1100:28 only a portion of Patient 1's lower body was visualized up against the rear left side of the van. They were positioned on the floor so that their body was facing the interior of the left rear corner side panel of the van, their left buttocks could be seen on the van floor, the left side of their body was at the very end of the floor where the door closure was, their left leg was observed to be bent at the knee and had partially fallen outside of the van. The two deputies picked Patient 1 up off the van floor and in awkward and uncoordinated movements took the patient out of the van and rotated them to place them in the w/c. There was no indication that Patient 1 was assisting or resisting. The parts of their body that could be visualized were limp. Patient 1, who was Black, was positioned in the w/c with their shoulders at the level of the top of the w/c seat back, their head slumped fully forward towards their chest, and their eyes closed. RN 4 folded a blue blanket and place it around Patient 1's chest and shoulders and wrapped the ends around the w/c handles. At 1101:38 as the RN began to pull the w/c backward towards the admitting room Patient 1's upper body was observed to be positioned lower in the w/c and slumped toward the left. As their head was slumped forward, the lower part of their face, including mouth and nose, was covered by the blue blanket. At ~ 1102:01 as RN 4 pulled the w/c backwards along the side of the van towards the admitting room door, both

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deputies bent over the patient and made movements consistent with each having picked up one of the patient's pants legs to lift the patient's feet off the ground.

* At ~ 1102:24 one camera view inside the admitting room attached to Sally Port 8 showed: RN 4 pulled the w/c with Patient 1 backward into the admitting room. One deputy had hold of the patient's right pant leg near the hem with their right hand. The other deputy had hold of the patient's left pant leg near the middle of the pant leg with their left hand. Both of the patient's bare feet were dangling slightly above the floor. The patient's hands were cuffed in their lap. Their head was slumped forward, their eyes were closed, and their face was covered by the blue blanket that was held in place by RN 4 around their chest and shoulders and the w/c handles.

* Between ~ 1102:30 and 1105:50 one camera view inside the admitting room showed: RN 4 parked Patient 1 in the w/c near the middle of the room. The deputies' positions around the patient's body periodically block the camera view. At this time four other staff (not including RN 4 and the two deputies) arrived into the room. The RN can be seen to lean over towards the patient on the left side of the w/c and arms are extended toward the patient although the patient cannot be seen behind one of the deputies. At ~ 1103:02 the deputies stepped away and the patient was observed to be slumped further down in the w/c, however, the patient's face was no longer covered by the blue blanket that remained around their chest and shoulders. It looked as though RN 4 had their right hand on or near the blanket below the patient's face as if they moved the blanket to uncover the patient's face. The patient

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was motionless and their eyes were closed. At that time there were at least six other staff in the room. RN 4 stepped away and back from the w/c and was observed to address the deputies and staff that had gathered in the room who all stood and faced the patient within a few feet of the patient. Two of those staff stepped towards and leaned towards the patient and took photographs of the patient with cell phones. Then there were eight other staff in the room. The 11 people in the room (excluding the patient) were observed to talk amongst themselves and to the group while Patient 1 remained motionless in the w/c with their wrists in law enforcement transport restraints, their chin laid on their chest, and their eyes closed. Patient 1 showed no signs of movement. At ~ 1104:18 RN 4 slightly leaned toward the patient, extended their arm, and may have touched the blue blanket, the patient's clothing near their shoulder, or the w/c. It was not clear. At ~ 1104:24 one of the staff persons approached the patient, leaned toward them, and extended their arm towards the patient. There was no visible response or movement from Patient 1. At ~ 1104:29 a DC deputy removed the law enforcement transport restraints from the patient's wrists. At ~ 1105:08 when their right hand was free from those restraints their right forearm, wrist, and hand slid down and across their right thigh. At that time the patient was observed to have slid further down in the w/c, the blue blanket was removed, their head remained slumped fully forward with their chin on their chest, their eyes were closed, and their legs were extended straight in front of them with their bare feet on the ground. At ~ 1105:27 a staff person took the blue blanket and with assistance from another staff person positioned it under and around both the patient's legs at the knees and

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formed a handle of sorts to lift the patient's legs up off the ground. At that time the patient's buttocks were near to sliding off of the w/c and their arms had fallen off their thighs onto the w/c seat on either side of their body. At ~ 1105:44 one staff person pushed the w/c forward and another staff person held the blanket that was around the patient's legs to keep them off the ground and the group moved towards the door out of the admitting room into a hallway towards the inpatient unit. At no time while in the admitting room did the patient assist or resist, nor did they open their eyes or demonstrate any observable movement. At no time was there any meaningful touch or other activity by any staff that could be construed as a patient assessment component.

* Between ~ 1105:50 and 1108:30 four camera views showed: The two staff who pushed the w/c and held the patient's legs up were joined by RN 13 and six other staff as they transported Patient 1 through hospital hallways to the inpatient unit. Patient 1 remained motionless with their eyes closed and slumped to the left with their arms laid limply on the w/c seat on either side of their body and their chin laid on their chest. Overhead camera views during the transport showed that the blanket around the patient's knees used to hold the patient's legs up during transport had been tied and knotted or twisted. At ~ 1108:30 staff pushed the patient in the w/c into the assigned patient room on the inpatient unit and that was last video observation of Patient 1.

* Video recording beginning at 1108:30 captured staff activities in the hallway outside the room after Patient 1 entered the room, and after the Code Blue response had been initiated. Those video observations are described below under

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6. The findings that follow reflect the hospital's failure to ensure an organized and coordinated medical emergency response.

7. Incident documentation recorded by LH1 NM, dated 04/18/2024 and untimed, reflected that "Staff came to my office inside the nurses station to advise me that a code blue (medical emergency) was needed for this patient as the code blue was being called over the radio. I responded, running down the south hall to the patient's room at 1115 as the code blue was being called via overhead page. When I entered the patient bedroom the patient was non-responsive, eyes closed, without respirations, without pulse (as assessed by another RN present). I advised that staff begin chest compressions and then I ran to obtain the crash cart/code blue cart. When I returned to the patient bedroom I opened the code cart, gave the code blue sheet and clipboard to unit [OS2 24] and assigned [them] to the recorder role. I then entered the patient bedroom and advised that staff move the patient from the patient bed onto the floor after the current set of chest compressions were complete. Staff used the patient's blanket to lower this patient from [their] bed onto the floor and resumed chest compressions. More staff entered the scene and the automatic external defibrillator was brought to the scene. A nurse took a position at the patient's head and administered 2 rescue breaths using the ambu-bag between each set of 30 compressions. I took the role of code lead and asked staff to switch out with the person administering chest compressions to prevent

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physical exhaustion while counting chest compressions out loud. Staff continued to administer chest compressions and rescue breaths and the AED was attached to the patient. The AED analyzed and advised no shock, chest compressions and rescue breaths continued. Medical doctors and other staff continued to arrive and rescue attempts continued. This patient was pronounced deceased by our physicians at 1156 and at that time EMTs were present. It was later reported to me that the unit nurse assigned to the admission called for the code blue as this patient was being moved from the wheelchair to the patient bed by security and admissions office staff. Per staff report, the patient was slumped down in the wheelchair unable to maintain an upright posture while [they were] being transported to the unit."

8. Video recordings of the Code Blue medical emergency response for Patient 1 on 04/18/2024 revealed a disorganized and uncoordinated response as follows:

~ 1108:29 - Patient 1 was transported into the inpatient room in a w/c. RN 13 and other staff entered the room. Multiple staff entered and exited the room and others milled around outside the room with no demonstration of urgency. Another patient exited the patient room across the hall from Patient 1's room.
~ 1110:34 - MHST 14 walked at a leisurely pace and without urgency down the hall from the NS toward the patient room, pushed a mobile vital signs machine on wheels, and entered the patient room ~ 14 seconds later at ~ 1110:48.
~ 1111:56 - LH1 NM and Agency LPN 21 walked down the hallway from the NS towards the patient room at a quicker pace than previous staff,

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however, with minimal urgency. (The video observation is contrary to the incident documentation under Finding 7 above that described the response of LH1 NM as "I responded, running down the south hall to the patient's room ...")
~ 1112:14 - LH1 NM ran down the hall away from the patient room toward the NS. More staff, some at a quicker pace, began to arrive and gather in the hallway outside of the patient room while some entered the room.
~ 1112:33 - Staff were observed to push a Red Emergency Cart down the hall from the NS toward the patient room. It arrived at the patient room at 1112:45 and was positioned outside the doorway of that room where it remained until it was pushed further down the hall away from the room after EMS arrived.

~ 1112:45 until the arrival of EMS at ~ 1124:01 video recording showed: More staff arrived and continued to enter the patient's room and gather in the hall. The number of staff gathered in the hallway between the patient's room and the NS, particularly in the vicinity of the patient's room, created increased congestion that presented an obstacle for navigation through the hall, including for other patients whose rooms were between Patient 1's room and the NS. At times there were 20 or more staff, and may have included patients, in the space outside the room and there was no way to determine how many were in the room as staff continued to enter and exit. The crowd that had gathered did not leave a clear pathway for EMS who arrived at ~ 1124:01 with ~ eight EMT and Fire responders, a gurney, and EMS equipment.

Additionally, during the scene described above,

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multiple staff in the hallway were observed to do nothing, staff lined up against the hallway walls, some staff stood on their tiptoes or crowded the doorway of the room to try to see in the room, others engaged in various discussions and activities. Agency RN 26 and Agency LPN 25 were observed to open and look in, or retrieve items from drawers on the Red Emergency Cart, and then they would leave the drawers partially open. (There was no incident or medical record documentation by either Agency RN 26 or Agency LPN 25 regarding their activities and tasks during the Code Blue.)

~ 1112:46 - OS2 24 was observed to stand immediately next to the Red Emergency Cart at the patient room doorway with a clipboard to which a form was attached, looked at their left wrist, and recorded something on the form. During the video the form was discerned to be the Code Blue Flow Sheet. During the duration of this code activity captured on the video recordings until ~ 1125:17 OS2 24 never entered Patient 1's room, and they were not positioned during much of that time to be able to observe the code activities that were being carried out in the room. For example: They were observed to wander in the hallway outside the room, they stood to the left of the doorway without a view into the room, they stood in the hallway approaching the opposite wall, they sometimes leaned forward to look into the room and sometimes that was through a number of other staff that crowded the doorway, they crouched down on their knees in the hallway to the left of the door, they sat down on the floor on their knees and lower legs in the hallway, they talked with other staff. Up until ~ 1124:39 OS2 24 had the clipboard in their possession. The video skipped ~ 10 seconds at

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that time. The next time recorded was ~ 1124:51 and OS2 24 was observed to walk down the hall away from the patient's room and further from the NS without the clipboard in their possession. (On 05/09/2024 at ~ 1500 staff that included the DNS, LH1 NM, CBC, PD, DQM, and DSC confirmed that the form OS2 24 could be seen writing on in the video was a Code Blue Flow Sheet, and that it was the same Code Blue Flow Sheet provided during the survey for Patient 1.)

~ 1124:33 - Staff present demonstrated a lack of situational awareness in relation to the placement of the Red Emergency Cart. When staff began to exit the scene and hallway a staff person pushed the Red Emergency Cart further away from the patient's room, further down the hallway from where staff were gathered, and further away from the NS. At ~ 1124:57 the only staff near the cart walked away from it and no staff looked in the cart's direction until 1125:16. The Red Emergency Cart had a suction machine placed on the top and at least two of the cart doors were partially open. The video recording provided ended at 1125:17.

9.a. While there were medical record entries by various staff about the Code Blue response, the Code Blue Flow Sheet for the 04/18/2024 response for Patient 1 was not complete. There were only three entries made on the form in the multitude of required boxes and spaces. Those were the Date, Time, Time of Code Blue, and a checkmark on the "Yes" box for AED utilization. Otherwise, there were several short unclear entries, some with associated times, written in the margins of the form. For example, "11:26 EMS" and "gray sweatshirt" and "8th." Nor was the form authenticated by whoever made the entries, including in the required space for "Recorder".

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9.b. Incident documentation recorded by LH1 NM, dated 04/18/2024 and untimed, reflected they " ... gave the code blue sheet and clipboard to unit [OS2 24] and assigned [them] to the recorder role ... I took the role of code lead ... " However, review of the Code Blue Flow Sheet reflected the following spaces on the form were blank:
*"Team Captain:" and Team Captain "Title:"
*"Recorder printed name:" and "Signature:" and "Date:" and "Time:"

9.c. The "Medications administered" table on the "Code Blue Flow Sheet" had columns for "Time," "Medication," "Dose," "Route," and "Effect." Those spaces were completely blank. There was no documentation on the flow sheet related to the administration of the Narcan that was identified as given in incident and medical record documentation. Nor was the dose given found in any of that documentation. Further, the incident and medical record documentation related to the Narcan order and administration was unclear and inconsistent as follows:
* A Nursing Progress Note written by LH1 RN 13 and dated and timed 04/18/2024 at 1304 reflected in regard to Narcan administration that "Narcan was requested and administered by [PMHNP 23]."
* A Psychiatry General Note written by psychiatrist MD 30 and dated and timed 04/18/2024 at 1451 reflected in regard to Narcan administration that they "gave telephone order to [Agency LPN 21] RN [sic] for Narcan to be administered to the patient. [PMHNP 23] administered the intranasal Narcan prior to EMS arrival (at approx. 1125-1126). Intranasal Narcan was the only formulation we had on hand on the unit at this time, per staff report."

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A 093	Continued From page 31 * A Psychiatry General Note written by psychiatrist MD 27 and dated and timed 04/18/2024 at 1838 reflected in regard to Narcan administration that "When I was informed that [Patient 1] had not received Narcan yet, I ordered the Narcan be given, presuming that both it would be safe in the absence of potential intoxication/overdose and also that it would be potentially extremely beneficial if [the patient] were intoxicated/obtunded from opioids. Nursing staff went to obtain this and it was given via intranasal route several minutes later." * Incident documentation by Agency LPN 21, dated 04/18/2024 and untimed, reflected that "[MD 30] and [PMHNP 22] gave TO for narcan, I ran to grab the narcan and handed it to nurse that was by patient side." * Incident documentation by Agency RN 12, dated 04/18/2024 and untimed, reflected that "Nasal Narcan administered as ordered without effectiveness result." * An "Oregon State Hospital Non-Medication Telephone Orders" form that contained a medication order dated 04/18/2023 at 1120. The order was written as "Give Narcan 4 mg intranasal x1 now for unresponsiveness." The handwritten entry in the "Nurse Printed Name" was barely legible [Agency LPN 21]. The handwritten entry on the "Nurse Signature" space was illegible and was followed by what may have been written as "LPN" although it was difficult to discern. The "Date" and "Time" of the nurse signature was 04/18/2024 at 1130 and there was an initial in the "Nurse 'Readback' Initials" space. The print and signature name of an [PMHNP 22] followed the nurse's information and was dated and timed 04/24/2024 at 1102, six days after the event. There were no other LIP orders in the medical record.	A 093		

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* There were no medical record or incident notes related to Patient 1 by PMHNP 22 who was identified in documentation as having ordered Narcan and who signed the Telephone Order for it.
* There were no medical record or incident notes related to Patient 1 by PMHNP 23 who was identified in documentation as having ordered Narcan and as having administered it. .
* Each of the medical record and incident notes written by the two MDs, an RN, and an LPN reflected that Narcan was ordered by different LIPs.
* In the incident documentation by Agency LPN 21 they wrote they "grabbed" the Narcan and then handed it to another "nurse." There was no documentation by Agency LPN 21 or the other "nurse" to reflect who that "nurse" was and what that "nurse" did with the medication.
* In the incident documentation by Agency RN 12 their note was written consistent with the way a nurse who administered the medication would document and as if RN 12 had administered the Narcan.
* There was no documentation of Narcan administration by the person that administered the medication in the medical record or on the Code Blue Flow Sheet.

9.d. Incident documentation recorded by [TM 34], dated 04/18/2024 and untimed, reflected that "As compressions continued, I was tasked with gathering staff's names that were involved or present for the medical emergency ... I provided the list of staff members involved to LH1 Unit Administrator [UA 35]." It was unclear whether the names and roles of all staff who presented and gathered as observed in the video recording had

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been identified. There was no documentation included on or with the Code Blue Flow Sheet that identified all staff who presented or participated.

9.e. Further, the following spaces on the Code Blue Flow Sheet were blank:
* "Time of onset:"
* "Location:"
* "Chief Complaint:"
* A table with seven columns for "[time, blood pressure, pulse, respirations, temperature, pulse oximetry on room air or supplemental O2, blood glucose]"
* "Pertinent physical findings:"
* "Defibrillation: __No __Yes" and "How many times:" and "Successful: __No __Yes"
* "EMS called at:" and "EMS arrived at:"
*"Physician/nurse practitioner called hospital at:"
*"Patient transported by: __N/A __OSH transport __EMS Time:"
*"Disposition of patient:"
*"Emergency contact called: __No __Yes Name: Relationship: Phone number:"
*"Provide copies of the following to the EMS Team: __ Medication administration record __Vital signs flow sheet __ Laboratory data __Emergency medical transfer report __ Diagnostic (e.g., EKG) __ Medical H&P"

10.a. The P&P titled "Code Blue Medical Emergency" dated 01/21/2020 was reviewed. It stated that "[OSH] will provide immediate response to any medical emergency that presents anywhere on campus and requires a coordinated team effort ..."

The P&P attachment, "Procedures A," consisted of a table with two columns for "Responsible

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Person/Group" and "Procedures." Those persons were listed as:
- "First responder"
- "Second responder"
- "Security"
- "Team Captain"
- "Physician/NP/RN"
- "Equipment Monitor"
- "Airway Rescuer"
- "Recorder"
- "Communicator"
- "Crowd Control Monitor"
- "Photocopy"

10.b. Duties delineated for each role/title were vague and unclear. For example:
* The "Team Captain" duties included: "Assign roles and responsibilities ... Assist with completing the Code Blue Flowsheet ..."
* The "Equipment Monitor" duties included: "Verify all of the emergency equipment arrives to the scene ... Prepare and hand out equipment as needed or directed by the Team Captain ... Monitor emergency equipment throughout the incident."
* The "Recorder" duties included: "Complete the Code Blue Flowsheet."
* The "Crowd Control Monitor" duties included: "Maintain safety of the scene and milieu as necessary ... Verify essential personnel have access to the scene, person, and emergency equipment ... Request the Communicator cancel responders when sufficient responders have arrived at the scene ..."

10.c.The procedures were not clearly written to ensure staff were trained and knowledgeable to be able to competently carry out the required duties/tasks in an organized and coordinated

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manner. For example:
* It was not clear how roles were to be assigned and how and where those were to be recorded.
* It was not clear what "assist with" completing the Flowsheet meant.
* It was not clear what "emergency equipment" was to arrive to the scene and what was meant by "monitor emergency equipment ..." The equipment was not specified, nor was there reference to other applicable P&Ps.
* There was no direction r/t where the Recorder needed to locate themselves, and otherwise obtain the necessary information, to ensure they could clearly and completely "Complete the Code Blue Flowsheet."
* It was not clear how the "safety of the scene and milieu" was determined, who "essential personnel" were, or who and how many persons were considered "sufficient responders."
* It was not clear who was responsible to monitor and manage the presence of other patients at or near the scene to ensure safety of those patients and others.
* There were no mentions of emergency medications or reference to other applicable P&Ps. It was not clear which role was to obtain and prepare Code Blue medications, from where those were to be obtained, and who was to administer them.

11. The review of the Code Blue video recording and the Code Blue documentation for Patient 1 failed to demonstrate that roles and responsibilities for all Code Blue positions had been assigned and that duties/tasks had been carried out. Further, the Code Blue Flowsheet used during Patient 1's Code Blue did not align with the procedure requirements in Procedures A.

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12.a. During interview with staff that included the DSC, DLD, and OBC on 05/06/2024 beginning at 1235 they confirmed the Code Blue training dates for the AD RNs 1 through 4 and stated there were no drills or hands-on practice, return demonstrations, or competency evaluations associated with those trainings, including during annual "refreshers." They further stated that hospital-wide Code Blue drills had not been conducted since the Covid-19 pandemic. They stated those were recently resumed on 04/23/2024 and that on that date on the OSH-Salem campus 54 staff participated in Code Blue drills, and on 04/26/2024 on the OSH-JC campus 13 staff participated in Code Blue drills. They further confirmed that none of the four AD RNs had been present or participated in the Code Blue drills conducted on 04/23/2024 and 04/26/2024.

12.b. Review of AD RN Code Blue training records reflected the following:
* For RN 1 the documentation showed that since 2020 they had a 20-minute online Code Blue training on 03/26/2020, an online Code Blue training on 04/24/2021, and a 30-minute Code Blue "refresher" on 02/27/2023 during 2023 Annual Training.
* For RN 2 the documentation showed that since 2020 they had a 30 minute Code Blue "refresher" on 04/02/2024 during 2024 Annual Training.
* For RN 3 the documentation showed that since 2020 they had a 20-minute online Code Blue training on 05/07/2020, an online Code Blue training on 03/12/2021, and none since.
* For RN 4 the documentation showed that since 2020 they had a 20-minute online Code Blue training on 04/18/2020, an online Code Blue training on 05/08/2021, and none since.

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13. The findings that follow reflect the hospital's failure to ensure that medical emergency supplies and equipment were organized and managed to ensure availability of necessary items during a medical emergency response.

14. During tour of AD with DSC, PD and ADM on 04/24/2024 at 1020, observations included:
* Upon entering AD hall, a secure door at the end of the hall led into the AR. From inside the AR, a secure door led into the Forensics Evaluation area. Another secure door from the AR led directly into Sally Port 8's vehicle drive-in garage. A floor to ceiling garage door was observed between the drive-in garage and the outside of the building so that a vehicle could drive fully into the garage and have the doors closed and secured behind the vehicle.
* From the AD hall, to the right of the AR entry door, a secure door lead into the AD office. A sliding window was observed between the AD office and drive-in garage so that AD staff could open the window and communicate with individuals in the garage.
* From the AD hall, to the left of the entry AR door and across the hall from the AD office, a secure door led into room G04-117A.
* A secure door leading to Sally Port 9 was observed near the Admissions office. Sally Port 9 had a secure door that led directly to the outside of the building and no drive-in garage.

15.a. During a second tour of AD on 04/24/2024 at 1610 with Interim DS, DSC, and RN 3, observations included:
* In AD office, a portable oxygen tank and a blue duffle type Code Blue Bag. The bag had multiple

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zippered top and side pockets with red breakaway locks. The bag was opened and contained an Ambu bag, dressings, pulse oximeter, oxygen tubing, pen lights, and other emergency supplies. There was no inventory list observed that identified the contents of the Code Blue Bag. A clipboard with multiple copies of partially completed "Emergency Equipment Checklist" Attachment A was observed near the Code Blue Bag.
* In Room G04-117A, a tackle box style Emergency Kit was observed with a green breakaway lock. The lid read "Emergency Box" in red professional type print.
* An AED was observed mounted on the wall in the Forensics Evaluation area down a hall and around a corner from the AR.
* Observation of the path from AR to outside AN1 nurse station involved leaving AD and going through 3 secure doors.

15.b. "Emergency Equipment Checklist" Attachment A observed in Admitting office near the Code Blue Bag was reviewed. There was no date that reflected when it had been created or revised. The top portion of the checklist had spaces for recording month and year and stated "Consult with Nursing Supervisor if any equipment problems. Every section must be completed." The checklist had a "Date" column with rows numbered 1-31 for checking the following items each day in a month:
- "Y N" for "AED Present"
- "Y N" for "Code Blue Bag or Red Cart Lock Intact."
- "Y N" for "Emergency Med Box Lock Intact"
- "Y N" for "Oxygen Tank = 1000 p.s.i."
- "Y N" for "Suction Machine Charged, Clean & Operational"

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The checklist also had spaces for recording time, comments, and signature each day.

15.c. The "Emergency Equipment Checklist, Attachment A for January 2024 dated "Month/Year: 1/2024" was reviewed and was incomplete and did not provide assurance emergency supplies and equipment were checked and available when needed. Examples included:
- The spaces for documenting the time was blank every day of the month.
- For 01/01/2024, 01/15/2024, 01/16/2024, 01/17/2024, 01/19/2024 and 01/31/2024, "Y" and "N" were not circled or otherwise marked for "Code Blue Bag or Red Cart Lock Intact" and "Oxygen Tank = 1000 p.s.i." checks. In addition, spaces for documenting signature were blank for those dates.
- The columns for documenting "AED Present", "Emergency Med Box Lock Intact", and "Suction Machine Charged, Clean & Operational" had a squiggly line drawn through each and there was no documentation that reflected those had been checked.
- The spaces for documenting comments were blank every day of the month.

15.d. The "Emergency Equipment Checklist, Attachment A for February 2024 dated "Month/Year: Feb 2024" was reviewed and was incomplete. Examples included:
- The spaces for documenting the time was blank every day of the month.
- For dates 02/02/2024, 02/09/2024, 02/16/2024, and 02/19/2024, "Y" and "N" were not circled or otherwise marked for "Code Blue Bag or Red Cart Lock Intact" and "Oxygen Tank = 1000 p.s.i." checks. Spaces for documenting signature were

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blank for those dates.
- The columns for documenting "AED Present", "Emergency Med Box Lock Intact", and "Suction Machine Charged, Clean & Operational" had a squiggly line drawn through each.
- The spaces for documenting comments were all blank.

15.e. The "Emergency Equipment Checklist, Attachment A for March 2024 dated "Month/Year: March 2024" was reviewed:
- The spaces for documenting "Time" was blank every day of the month.
- For 03/01/2024, "Y" and "N" were not circled or otherwise marked for "Code Blue Bag or Red Cart Lock Intact" check and the signature space was blank.
- For 03/01/2024, 03/18/2024, 03/19/2024, 03/20/2024, 03/21/2024 and 03/22/2024, "Y" and "N" were not circled or otherwise marked for "Oxygen Tank = 1000 p.s.i." checks.
- The columns for documenting "AED Present", "Emergency Med Box Lock Intact", and "Suction Machine Charged, Clean & Operational" had a squiggly line drawn through each and there was no documentation that reflected those had been checked.
- The spaces for documenting comments were blank every day of the month.

15.f. The "Emergency Equipment Checklist, Attachment A for April 2024 dated "Month/Year: April" was reviewed:
- The spaces for documenting the time was blank every day through the date of this survey.
- For 04/10/2024, 04/11/2024, 04/12/2024, 04/15/2024, 04/16/2024, 04/22/2024, 04/23/2024 and 04/24/2024, "Y" and "N" were not circled or otherwise marked for "Code Blue Bag or Red

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Cart Lock Intact" and "Oxygen Tank = 1000 p.s.i." checks. Spaces for documenting signature were blank for those dates.
- The columns for documenting "AED Present", "Emergency Med Box Lock Intact", and "Suction Machine Charged, Clean & Operational" had a squiggly line drawn through each and there was no documentation that reflected those had been checked.
- The spaces for documenting comments were blank every day of the month.

15.g. The checklist being used in OSH-Salem AD was not the same version as the "Emergency/Medical Equipment Checklist" Attachment A with revision date "10/2023" in the P&P titled "Emergency and Multi-Patient-Use Medical Equipment" in Finding 18.c. below. For example, the checklist being used in AD reflected "AED Present". The checklist in the P&P reflected "AED shows green check". The checklist being used in AD included "Code Blue Bag" and "Emergency Med Box Lock Intact." The checklist in the P&P did not include those. The checklist in the P&P included "Medical Equipment Disinfected" and the checklist being used in AD did not include a medical equipment disinfection. In addition, observations of the Code Blue Bag in Findings 15.a. and 16.a. reflected it had multiple zippered pockets with breakaway locks. However, the checklist did not provide instructions or a system for tracking each of those to ensure the bag had not been opened and emergency supplies removed without staff awareness.

15.h. During interview on 04/24/2024 at 1620, RN 3 stated:
* If a patient was unresponsive in AD they would call a code blue and use the emergency supplies

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and medication observed in Finding 15.a. above or a "code cart might be brought from an inpatient unit."
* The Emergency Kit in Room G04-117A contained Narcan.
* There was no suction equipment in AD and if a patient needed suction "a code cart would be brought from [AN1]." The closest code cart was inside the nurse's station in AN1.
* The Code Blue Bag with emergency supplies observed in Finding 15.a. should have a supplies list attached to the bag that identified the emergency supplies inside the bag. RN 3 looked for the supplies list and could not find it.
* The "Emergency Equipment Checklist" observed near the Code Blue Bag should be completed "Monday through Friday".

16.a. During tour of AD with DSC and PD on 04/25/2024 at 1230, observations included:
* The door leading into AD office had an ~ 8.5 x 11 size, professional type sign on the door that read "Code Blue ... Emergency Equipment." Handwritten entries added to the sign included "Blue bag + O2 are here AED by rm G04-121 (Forensic Eval [illegible marks] East Security hall)".
* Observation with RN 1 of a Code Blue Bag in the AD office revealed it was the same style observed during AD tour on 04/24/2024 at 1610. Four red breakaway locks were observed on the zippered top and side pockets. No inventory list was observed with the bag. The bag was opened with RN 1 and contents were observed and compared with an inventory list that had been received for the Code Blue Bag from hospital leadership earlier the same day. The inventory list was untitled, undated and had sections for "Center", "Rt. Side" and "Lf. Side" pockets.

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A 093	Continued From page 43 Review of the inventory list and observation of the items in the Code Blue Bag reflected they were inconsistent and unclear. Examples included: - The inventory list reflected "Center [pocket] ... Pen Light (on lid with pens) & Steno Note Pad ... [quantity] ... 2 [and] 1" with a diagonal line crossed through "2 [and] 1". Pen lights and steno note pad were observed in the bag. However, it was not clear how many or whether they should be in the bag as the quantities on the inventory sheet were lined out. -The inventory list reflected the "Rt. Side [pocket] ... Blood Pressure cuffs Lg/ExLg ... [quantity] ... 1 [and] 1" with a diagonal line crossed though "1 [and] 1". Blood pressure cuffs were observed in the bag. Similarly, it was not clear whether they should be in the bag as the quantities on the inventory sheet were lined out. "Rt. Side [pocket]" also included "Stethoscope/oximeter ... [quantity] ... 1 [and] 1" with a diagonal line crossed through "1 [and] 1". Similarly, those items were observed in the bag. - The inventory list reflected "Lf. Side [pocket] ... 3 [inch] roll gauze & 4 [inch] Coban ... [quantity] 2 and 1" with a diagonal line crossed through "2 and 1". Similarly, those items were observed in the bag. - No protective eyewear was on the inventory list. Protective eyewear was observed in the bag. - The list included 3 oxygen tubing nasal cannulas. Two oxygen tubing nasal cannulas were observed in the bag. - The list included 2 oxygen non-rebreather face masks. One oxygen non-rebreather face mask was observed in the bag. A Yankauer Suction tip with tubing was observed in the bag. No suction machine or other suction items or equipment were observed in the bag. No Narcan or other medications were observed in	A 093		

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the bag.
These findings were confirmed with RN 1 at the time of the observation.

16.b. During interview on 04/25/2024 at 1230, RN 1 stated:
* They started working in the AD about 6 months ago and AD was where they normally worked.
* Most new admit patients and patients returning from medical appointments enter the hospital through Sally Port 8. Patients arriving in vehicles too large to enter Sally Port 8 and patients without behavior problems sometimes enter through Sally Port 9.
* There is frequently a line of transport vehicles waiting to bring patients in through Sally Ports 8 and 9. The vehicles wait in parking spaces outside Sally Ports 8 and 9 "or wherever they can find a spot."
* Sometimes deputies call ahead and let AD staff know if a patient is "coming in hot", meaning the patent was having behavioral issues. RN 1 stated while transport vehicles are waiting to bring patients into the hospital, they usually try to "touch bases" with the deputies by going outside and talking to the deputies about how the patients are doing. They do not start evaluating patients until patients are getting out of the vehicle. If a patient had a medical problem while waiting in a transport vehicle, they would do a "formal assessment" of the patient and if the patient had a "serious issue" they would call a code blue.
* If they needed Narcan for a patient, they would get it from the Code Blue Bag or from an Omnicell in AN1. "We don't have an Omnicell [in AD]."
* If they needed suction equipment for a patient, that would be in the Code Blue Bag in AD.
* Regarding the red breakaway locks observed

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on the Code Blue Bag, RN 1 stated that after the Code Blue Bag was opened, the Code Blue Team was notified. The Code Blue Team checked the Code Blue Bag inventory, restocked the bag, and replaced the breakaway locks on the bag.
* They confirmed there was no supplies inventory sheet with the Code Blue Bag.
* They were not sure who checked the AED in Forensics Evaluation area to ensure it would be present and functioning if needed.

17. A second interview was conducted with RN 1 on 04/25/2024 at 1255 after they confirmed the Code Blue Bag in Finding 16.a. did not have all equipment necessary for patient suctioning, nor Narcan. Regarding obtaining suction equipment during a patient emergency, RN 1 stated "I'd have to go to [an inpatient] unit to get it or a code team person would get it." Regarding obtaining Narcan during a patient emergency, RN 1 stated "I'd go to the Omnicell at [AN1] or ask a deputy. If it was my patient, I'd stay with the patient and have another nurse go get it."

18.a. During interview on 04/25/2024 at 1200, DSC stated the P&P titled "Emergency and Multi-Patient-Use Medical Equipment" in Finding 18.b. was applicable hospital-wide including in AD.

18.b. The P&P titled "Emergency and Multi-Patient-Use Medical Equipment," dated approved 03/01/2024 included:
* "The purpose of this protocol is to describe the expectations and procedures for controlling, monitoring, and disinfecting emergency and multi-patient-use medical equipment available on patient living units at Oregon State Hospital (OSH) ..."

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A 093	Continued From page 46 * "All Oregon State Hospital living units must have a red emergency cart that is secured with a break-away lock, a suction machine, an automated external defibrillator (AED), and a portable oxygen tank, all of which are consistently controlled, secured, monitored, and ready to use ... Daily checks of the above items are performed by a nurse and are documented on the Emergency/Medical Checklist (Attachment A) ... The Lead Nurse is responsible for ensuring that the actions described in this protocol are performed ... The actions described in this protocol are generally performed on the Night Shift, although individual units may designate another shift for this purpose ..." * "The presence of the AED, and the green check is showing, must be verified each day ... The OSH Medical Equipment Coordinator must be immediately notified of defective equipment and related issues." * "Red emergency carts must be stocked and locked at all times when not in use ... If the lock is found to be broken or missing, the contents must be checked against the Inventory Sheet ... The Inventory Sheet is taped to the top of the cart and also to the clipboard in the top drawer of the cart ... The Code Blue Team must be notified of the need for replacement items and a new break-away lock ... Contact information for the Code Blue Team is available ... on the Inventory Sheet, available in the red emergency cart ... and ... on a sticker on the top of the red emergency cart." * "The status of the portable oxygen tank must be verified each day ... The oxygen tank must be replaced if the amount of oxygen is less than 1000 pounds per square inch (psi)." * "The availability of the suction machine machine, and related supplies, must be verified	A 093		

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each day ... The suction machine must be ready for use with a package of suction tubing and a package containing oral suctioning want secured in the wide black plastic band on the front of the machine ..."
* "Emergency medical equipment located in areas other than patient living units and treatment malls is maintained by the Code Blue Team."

18.c. Attachment A, titled "Emergency/Medical Equipment Checklist" dated revised "10/2023" was reviewed. The top portion of the checklist had spaces for recording unit, month and year and stated "Every section MUST be completed. Notify unit nursing management (or designee) of equipment problems." The checklist had a "Date" column with rows numbered 1-31 for checking the following items each day of the month:
* "Y/N" for "AED shows green check"
* "Y/N" for "Red Emergency Cart Lock Present"
* "Y/N" for "Oxygen Tank = 1000 p.s.i."
* "Y/N" for "Suction Machine Plugged In, Tubing/Wand Present"
* "Y/N" for "Medical Equipment Disinfected Complete WEEKLY"
The checklist also had spaces for recording comments and RN/LPN signature each day.
The P&P was not clear regarding how breakaway locks were tracked to ensure security, integrity and availability of emergency supplies and equipment. For example, it was not clear if those were to be numbered, unnumbered or a specific color considering numbered, unnumbered and different colored locks were observed on emergency carts and kits during the survey. The P&P did not include further process for management of emergency supplies and equipments in areas other than living units, such as AD, including a system for tracking breakaway

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locks.

19.a. The P&P titled "Override Process for Medications in Emergency Situations" dated 05/05/2023 reflected:
* "Purpose and Applicability ... To ensure medications are always readily and safely available for use at Oregon State Hospital (OSH), this policy ... This policy applies to all staff who order, dispense, or administer medications."
* "Staff must follow Procedures A to retrieve emergency medications from ADCs and from E-Kits when authorized in emergency situations ... Emergency medications are as listed in Attachment A and Attachment B."

19.b. Procedures A included:
* "Nurse ... Assess the patient ... Upon receipt of a verbal order from the practitioner to administer emergency medication ... Retrieve the medication(s) from the Automated Dispensing Cabinet (ADC) .... or from the Emergency Kit (E-Kit) ... Administer to the patient ... If medication from an E-Kit was used, complete the E-Lot requisition form attached to each kit and scan it to the pharmacy."
* "Pharmacy ... Upon receipt of an E-Kit requisition, deliver a replacement E-Kit and retrieve the opened E-Kit ... Prepare the opened E-Kit for redeployment ... Reconcile and replenish standard contents of E-Kits ... Review and record the expiration of all drug contents, and Stage the newly replenished E-Kit for deployment."

19.c. Attachment A reflected "Emergency Medications Stocked in Automated Dispensing Cabinets (ADC)" and included:
* "Stocked in all unit, treatment mall, and Medical Clinic ADCs on both campuses with the noted

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minimum quantities" followed by a list of medications:
"Aspirin (Uncoated) 325 mg - 2 tablets ..."
"Charcoal, Activated Suspension (Acti-Dose) 50 grams - 1 tube/bottle ..."
"Dextrose/Glucose ... 40% (15 grams) - 2 tubes ..."
"Diphenhydramine (Benadryl) a. 50 mg/mL - 2 vials b. 25 mg - 10 capsules c. 50 mg - 10 capsules ..."
"Epinephrine (Epi-Pen) 0.3 mg/0.3 mL - 1 auto-injector syringe ..."
"Glucagon 1 mg - 2 kits ..."
"Haloperidol (Haldol) a. 5 mg/mL - 2 vials b. 5 mg - 10 tablets c. 10 mg - 10 tablets ..."
"Lorazepam (Ativan) ... a. 2 mg/mL - 2 vials b. 1 mg - 10 tablets c. 2 mg - 10 tablets ..."
"Naloxone (Narcan) 4 mg/spray - 2 devices ..."
"Nitroglycerin (Nitrostat) 0.4 mg - 1 bottle ..."
"Olanzapine (Zyprexa) a. 10 mg/2 mL - 2 vials ... b. 5 mg - 10 tablets c. 10 mg - 10 tablets."
* "Additionally stocked in all treatment mall and Medical Clinic ADCs on both campuses with the noted minimum quantities ... Albuterol (Proair/Proventil) a. 90 mcg (HFA) - 1 inhaler b. 3 mL nebulizer solution - 5 vials."

19.d. Attachment B reflected "Emergency Medications Stocked in Emergency Kits (E-Kits) ... Admissions Emergency Kit ... Naloxone (Narcan) 4 mg/spray - 2 devices". Attachment B did not include Epi Pen in Admissions Emergency Kit. Refer to Findings 20.a. and 21.a. that reflected Epi Pen was observed in Emergency Kits in OSH-Salem AD and OSH-JC Admissions area. The P&P did not include further information about how breakaway locks on E-Kits were managed and tracked. The P&P reflected additional emergency medications were stocked

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and available in inpatient units and other areas that were not available in Salem campus AD and JC admissions areas. P&Ps were not clear how staff in Salem campus AD and JC admissions area were to obtain those additional emergency medications should they be needed for a patient emergency.

20.a. The OSH-Salem AD was toured during the IJ verification visit with Interim DS, DSC, and ADM on 05/02/2024 at 1300. Observations inside room G04-117A with ADM included:
* A 6 drawer Red Emergency Cart with one blue breakaway lock on the outside. The lock had no number or other information for tracking to ensure cart security. This created the possibility that contents could be tampered, removed and lock replaced without staff being alerted. The outside of Drawers 1, 2, 3, 4 and 6 were labeled with the contents of the drawers. Drawer 5 was not labeled and no items were observed inside the drawer.
* An "Admissions Code Blue Equipment Check Sheet" inventory list dated "Updated 4/30/2024" was observed. The inventory list was separated into 6 sections for Drawers 1 through 6, with supplies/equipment in each drawer.
Observation and of cart labels, cart contents, and the inventory list revealed inconsistencies between those. For example:
- Sterile tongue depressors, roll gauze and Coban were observed inside Drawer 3 and were on the check sheet for Drawer 3, but were not observed on any of the drawer labels.
- A label on Drawer 3 reflected "EMT scissors" and EMT type scissors were observed in Drawer 3. The check list reflected only "scissors" which could be confused with regular office type scissors.

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* A tackle box style Emergency Kit with breakaway lock was observed in Drawer 6. The top of the kit had a white label that read "Earliest Expiration 2/25" with a signature and a title. It was not clear whether the expiration date was intended to be February 25 or February 2025. A 2-page, front/back document titled "Admissions Emergency Kit" was observed in a plastic sleeve with the kit.

Page 1 was a list that reflected two medications were in the kit, Narcan and Epi Pen. It included:

- Naloxone (Narcan) 2 mg/mL syringe, quantity "2" with the following unclear expiration dates "4/24" with 3 lines marked through and no indication regarding when or why it was marked through, and below that "2/25". The "Dosage & Administration" reflected "Adult 1 mg/1mL in each nostril" and "Indications" reflected "Suspected opiate overdose."
- "Epi pen", quantity "1" with unclear expiration date "3/25" and no dosage, administration or indication information.

The top of page 2 reflected it was a "Record of Inspection for Intact Seal and Expiration Date (Required Monthly)." The document had multiple spaces for recording signature, title, date and lock #. Review of the document reflected it was unclear and lacked evidence of seal and expiration inspections that were "required monthly".

- The first entry dated 11/10/2022 included signature, title and lock # 10572981.
- The next entry dated 03/16/ 2023 included a signature, title and lock # 10572989. There was no documentation that reflected the lock (seal) and expiration date had been checked between 11/10/2022 and 03/16/2023. It was additionally not clear why the lock # had changed.
- The next entry dated 04/11/2023 included a

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signature, title, "(inspection)" handwritten and no lock #. It was not clear what had been "inspected."
- The next entry dated 05/10/2023 included a signature, no title and lock # 10572996. It was not clear why the lock # had changed.
- The next entry dated 09/12/2023 included a signature, title, and the word "date" followed by a check mark, and no lock #. It was not clear what "date" had been checked.
- The next entry dated 09/15/2023 included a signature, no title and lock # 10285209. The documentation lacked evidence that reflected the lock and expiration date had been checked between 05/10/2023 and 09/15/2023. It was not clear why the lock # had changed.
- The next entry dated 03/05/2024 included a signature, title and lock # 10285209. The documentation lacked evidence that reflected the lock and expiration had been checked between 09/15/2023 and 03/05/2024.
* The "Emergency/Medical Equipment Checklist" dated revised "10/2023" in Finding 18.c. was observed with the cart.

20.b. During interview on 05/02/2024 at the time of the OSH-Salem IJ verification visit, ADM confirmed there was no number on the blue breakaway lock on the Red Emergency Cart. ADM stated that if the blue breakaway lock was broken, the Code Blue Team had replacement blue breakaway locks and would restock the cart and replace the lock.

21.a. During the OSH-JC IJ verification visit on 05/02/2024 beginning at 1410, the area "where admits come in" was observed by virtual remote monitoring with Interim DS, JCA, JC nursing staff and other hospital leadership. Observations

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included:
* A 6 drawer Red Emergency Cart. The outside of Drawers 1, 2, 3, 4 and 6 were labeled indicating the contents of the drawers. Drawer 5 was not labeled and no items were observed inside the drawer. The cart had red breakaway lock # 3842072 on the outside. This was inconsistent with observations of the AD Red Emergency Cart in Finding 20.a. above which had an unnumbered blue breakaway lock.
* The same "Admissions Code Blue Equipment Check Sheet" inventory list used for the AD Red Emergency Cart in Finding 20.a. above was observed.
Observation of cart labels, cart contents, and inventory list revealed inconsistencies between those. For example:
- A package of stethoscope ear pieces and diaphragms were observed in Drawer 2 and were not on the checklist or any of the drawer labels.
- Sterile tongue depressors, roll gauze and Coban were observed in Drawer 3 and were on the check sheet for Drawer 3, but were not observed on any of the drawer labels.
- A label on Drawer 3 reflected "Trauma sheers". Similar to AD, the check list reflected only "scissors" which could be confused with regular office type scissors.
- A pulse oximeter inside Drawer 3 was labeled "Tx Mall 3" which could create confusion as to where that piece of equipment should be kept.
* An Emergency Medication Kit with breakaway lock # 3842071 was observed in Drawer 6. A document titled "JC Admissions Emergency Kit" was observed in a plastic sleeve with the kit and indicated Narcan and Epi pen were inside the kit. The document was similar to the document titled "Admissions Emergency Kit" observed with the Emergency Medication Kit during tour of AD

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A 093	Continued From page 54 during the IJ verification visit on 05/02/2024. However, there was no "Record of Inspection for Intact Seal and Expiration Date". The document included no evidence the Emergency Kit breakaway lock # was checked to ensure the lock had not been removed, contents tampered with, and medications readily available when needed. * An "Emergency/Medical Equipment Checklist" for May 2024 dated revised "07/2021" was observed with the Red Emergency Cart. This was not the same version observed during tour of AD during the IJ verification visit on 05/02/2024 in Finding 20.a. above, nor the version in the P&P titled "Emergency and Multi-Patient-Use Medical Equipment" in Findings 18.b. and 18.c. 21.b. During interview on 05/02/2024 with OSH-JC nursing staff and other hospital staff at the time of the remote OSH-JC IJ verification visit, the following information was provided: * The hospital had a designated Code Blue Team that consisted of 2 staff. The same 2 staff covered JC and Salem campuses. * The Code Blue Team had replacement breakaway locks for the Red Emergency Carts. * The Code Blue Team tracked breakaway lock #s on Red Emergency Carts "whenever we call them". * They confirmed "Emergency/Medical Equipment Checklist" dated "07/2021" was observed with the Red Emergency Cart. **********	A 093		
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights.	A 115		

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A 115	Continued From page 55 This CONDITION is not met as evidenced by: **********	A 115		

Based on observations, review of video recordings, interviews, review of incident and medical record documentation for 1 of 1 patient (Patient 1), review of 4 of 4 AD staff training records (RNs 1, 2, 3, and 4), review of OSH internal investigation documentation, review of medical emergency supplies and equipment documentation, review of medical emergency response documentation, review of training documentation, and review of P&Ps and procedural manuals, it was determined that the hospital failed to fully develop and implement P&Ps that ensured each patient's right to receive care in a safe setting. The hospital's failures to ensure appropriate patient assessment and organized response to medical emergencies created an unsafe EOC that likely contributed to harm and death of one patient and created the likelihood of harm to other patients.

As stated in Tag A-0000 of this report, based on findings that medical emergency supplies and equipment were not organized to ensure timely and efficient medical emergency response as described under Tag A-144 of this report at Findings 18 through 21.c., on 04/26/2024 the hospital was notified that an IJ situation had been determined to exist. An IJ Removal Plan was approved on 05/01/2024 and the IJ was subsequently removed on 05/02/2024 after onsite verification that the IJ Removal Plan had been implemented.

The cumulative effect of these systemic failures resulted in this Condition-level deficiency that represents a limited capacity on the part of the

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hospital to provide safe and adequate care.

Findings include:

1. Refer to the findings cited under this Condition at Tag A-144, CFR 482.13(c)(2) - Standard: Privacy and Safety, that reflects that P&Ps and systems for the provision of safe care were not fully developed or implemented and failures included (Tag A-144):
* Failure to ensure AD and inpatient RN staff carried out assigned duties to provide appropriate and timely assessment of patient condition and identification of the need for medical emergency response.
* Failure to ensure RN staff requested the immediate presence of a physician when the patient's unresponsive physical condition was believed to be behavioral versus medical.
* Failure to ensure other staff demonstrated appropriate response to a patient whose condition indicated the need for medical emergency response.
* Failure to ensure that medical emergency supplies and equipment were organized and managed to ensure availability of necessary items during a medical emergency response.
* Failure to ensure an organized and coordinated medical emergency response during which:
- The roles of staff who responded were not clear and demonstrated;
- The tasks performed were not clearly identified and thoroughly documented, including orders for and administration of emergency medication;
- Situational awareness was not maintained.
* Failure to ensure AD staff practices for patient care were in accordance with, and supported by, written and approved P&Ps.
* Failure to ensure AD staff completed organized

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A 115	Continued From page 57 and documented AD orientation and onboarding that ensured clinical and procedural competency for patient care operations in that department. **********	A 115		
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: ********** Based on observations, review of video recordings, interviews, review of incident and medical record documentation for 1 of 1 patient (Patient 1), review of 4 of 4 AD staff training records (RNs 1, 2, 3, and 4), review of OSH internal investigation documentation, review of medical emergency supplies and equipment documentation, review of medical emergency response documentation, review of training documentation, and review of P&Ps and procedural manuals, it was determined that the hospital failed to fully develop and implement P&Ps that ensured each patient's right to receive care in a safe setting. The hospital's failures to ensure appropriate patient assessment and organized response to medical emergencies created an unsafe EOC that likely contibuted to harm and death of one patient and created the likelihood of harm to other patients and included: * Failure to ensure AD and inpatient RN staff carried out assigned duties to provide appropriate and timely assessment of patient condition and identification of the need for medical emergency response. * Failure to ensure RN staff requested the immediate presence of a physician when the	A 144		

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patient's unresponsive physical condition was believed to be behavioral versus medical.
* Failure to ensure other staff demonstrated appropriate response to a patient whose condition indicated the need for medical emergency response.
* Failure to ensure that medical emergency supplies and equipment were organized and managed to ensure availability of necessary items during a medical emergency response.
* Failure to ensure an organized and coordinated medical emergency response during which:
- The roles of staff who responded were not clear and demonstrated;
- The tasks performed were not clearly identified and thoroughly documented, including orders for and administration of emergency medication;
- Situational awareness was not maintained.
* Failure to ensure AD staff practices for patient care were in accordance with, and supported by, written and approved P&Ps.
* Failure to ensure AD staff completed organized and documented AD orientation and onboarding that ensured clinical and procedural competency for patient care operations in that department.

As stated in Tag A-0000 of this report, based on findings that medical emergency supplies and equipment were not organized to ensure timely and efficient medical emergency response as described below in this Tag at Findings 18 through 21.c., on 04/26/2024 the hospital was notified that an IJ situation had been determined to exist. An IJ Removal Plan was approved on 05/01/2024 and the IJ was subsequently removed on 05/02/2024 after onsite verification that the IJ Removal Plan had been implemented.

Findings include:

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1. The findings that follow for Patient 1 reflect the hospital's failure to ensure the provision of care and services in a safe and appropriate manner. For example:
* RN staff failed to conduct appropriate and timely assessment and vital signs for Patient 1 who arrived at the hospital from jail. When AD RN first observed the patient in the transport vehicle they stated they saw the patient's eyes open briefly. That was the only detectable movement the patient made between the time they were transferred from the back of the transport vehicle until another RN who had accompanied the patient for transport from the AD to the inpatient unit checked for a pulse after the transport and entry into the patient's assigned inpatient room ~ eight minutes later.
* AD and inpatient RN staff failed to make independent decisions using their own nursing judgement that would call for an immediate assessment and emergency response to an unresponsive and motionless person.
* Other hospital staff failed to respond to the patient's unresponsive and motionless condition in the manner in which a reasonable or prudent layperson, or a person with BLS CPR training, would do should an individual who exhibited the same signs and condition be observed elsewhere in the hospital or in the community.
* RN and other staff inappropriately deferred to, believed without reasoning or questioning, and acted upon DC deputies' characterizations of the patient's unresponsive condition as being purposeful as in "choosing not to walk," "won't stand up," and "refusal to respond," "normal" and "usual," and "catatonic."
* RN staff who were responsible for the patient in the AD and en route to the inpatient unit failed to

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requested the immediate presence of a physician when the patient's unresponsive physical condition was believed to be behavioral versus medical.

2.a. During the entrance conference on 04/24/2024 beginning at 1035, hospital staff that included the Interim OSHS/CMO, Interim DS, COP, COM, CNO, DQM, and AAG confirmed the hospital's 04/19/2024 self-report of an incident that occurred on 04/18/2024 that involved Patient 1.

2.b. During review of incident documentation and hospital response with staff that included the Interim DS, DQM, DSC, COP, COM, DOS, PD, BOM1, and AAG on 04/24/2024 beginning at 1440 staff described the hospital's investigation and actions taken to date. A document titled "Investigative Memo," dated 04/24/2024 provided a summary of the information given by staff during the incident and response review on 04/24/2024 and included the following:
* "Date of incident: 4/18/2024"
* "Incident Nature: Unexpected patient death"
* "The purpose of this memo is to document the investigative process and immediate actions associated with the unexpected patient death on 4/18/2024, [Patient 1]."
* "The following is a timeline of events, and all times are approximate:
- Patient arrival, 1047 hrs.
- Patient entry into sallyport in County Transport Vehicle, 1057 hrs.
- Patient wheeled into Admissions area in wheelchair, 1102 hrs.
- Patient on unit (1107 hrs.) and was taken to [their] room (off camera location) where [they were] transferred to [a] bed and staff took vitals.

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Staff called a code blue at 1114 hrs. due to no pulse found.
- EMS arrived at OSH at 1118 hrs.
- EMS arrived on the Unit at 1123 hrs.
- Time of death called at 1156 hrs.
- EMS Departed OSH at 1200 hrs.
- Oregon State Police (OSP Case number: SP24-121397) was notified (1123 hrs.) and arrives at 1222 hrs.
- Security and OSH Incident Report and Systems Investigation (IRSI) staff reviewed video independent of each other.
- County Medical Examiner arrived 1246 hrs. (departed at 1536 hrs.)
- OSH Director of Quality Management ... consulted with OSH Interim Superintendent ... and was directed to initiate Joint Commission Reporting of a Sentinel Event.
- [DQM] sent email notification of the Sentinel event to OSH Legal Representation, Department of Justice - Oregon (DOJ) on 4/18/24.
- IRSI Review of video and screening document was sent to DOJ and Standards and Compliance for Joint Commission Reporting."
* "Actions in response to preliminary investigative findings: Video review and policy evaluation identified no policy requirement for vitals check on new admissions. On 4/19/2024 OSH Interim Superintendent [and CMO] memorialized 'CMO Directive - Admission vitals 4-19-24' based on initial investigative findings that vitals were not taken of the patient upon admission."
* "At the time of this memo this event is still under investigation by Oregon State Police and is scheduled for a Root Cause Analysis by OSH Standards and Compliance."

2.c. Review of the document on OSH letterhead, signed by the CMO/Interim OSHS and dated

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04/19/2024, reflected the following:
"To all OSH staff, This CMO Directive modifies and adds to OSH policy 6.058, 'Admissions.' To ensure that patients who may be medically unstable on arrival are promptly assessed and receive necessary medical care as soon as possible, it is my directive, effective April 19, 2024, that:
* An Admissions RN must perform a brief assessment for every patient admitted to OSH, including - at minimum - vital signs and visual observation to identify any medical needs requiring immediate attention, before the patient leaves the Admissions area. This assessment must be documented in the patient's medical record.
* If a patient is not responsive to staff in the Admissions area, the possibility of a medical emergency must be immediately assessed.
* If a patient is too combative to safely obtain vital signs, this must be communicated to the unit RN and documented in the medical record, along with the nature of the patient's behavior.
This directive will remain in effect until policy 6.058 is updated."

2.d. A document titled "OSH Office of Quality Management" was reviewed. It included the following information:
* "Incident Nature: Sentinel Event - Unexpected Patient Death"
* "Date/Time of Incident: 04/18/2024 1115hrs"
* "At approx. 1047 hrs. access control informed admissions Douglas County jail transport were waiting with [Patient 1] for admission to OSH. Staff arrived and the country [sic] transport vehicle entered a Sally Port, at approximately 1054 hrs. Deputies told [RN 4] [that Patient 1] would need a wheelchair because [they were]

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'catatonic' and at times 'flops around like a fish'. This was reported to have been described to nursing staff as normal behavior by [Patient 1]. As [Patient 1] was transferred from the transport van to the wheelchair, at approximately 1101 hrs, the admission [RN 4] reported [they] observed [Patient 1's] eyes open and close, possibly in response to light hitting [Patient 1's] eyes. [Patient 1] was wheeled into OSH admissions at approximately 1102 hrs. Additional staff were called to the admissions area and assisted in photographing [Patient 1] for identification. Douglas County transport restraints were removed from [Patient 1] and [they were] taken, via wheelchair, to Lighthouse 1 by OSH Staff. During this process [Patient 1] was noted as not moving on [their] own accord and staff held the patients [sic] legs up with a blanket so [their] feet would not drag on the floor. Staff and the patient arrived on the unit at approx. 1107hrs. where the patient was taken directly to a patient room. As [Patient 1] was being transferred to the bed an RN decided to check the patient for a pulse and found none. Sternal rubs were done with no response and additional checks found no pulse. A Code Blue was initiated and additional staff arrived and life saving procedures were performed including the use of CPR and an AED. Narcan and epinephrine were administered and were ineffective. Paramedics arrived at approx. 1121hrs and took over life saving efforts. [Patient 1] was pronounced dead at 1156 hrs."

2.e. In regard to Narcan and epinephrine administration, Patient 1's medical record included a Psychiatry General Note written by psychiatrist MD 30 and dated and timed 04/18/2024 at 1451. It reflected that the Narcan was administered by OSH staff, and in regard to

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epinephrine administration the note reflected that "EMS arrived at approximately 1125-1126 and took over the management of the code. They continued CPR for approximately 30 more minutes and per their report, gave 5 rounds of epinephrine. Patient did not achieve return of spontaneous circulation at any point following the start of the code, and patient was eventually pronounced dead by EMS at 1156 on 4/18/24."

3. During interview on 04/24/2024 at 1030 with ADM the following information was provided:
* AD normally has 4 AD RNs at all times.
* Most admissions come in through Sally Ports 8 and 9.
* When a transport vehicle arrives in Sally Port 8 drive-in garage, the deputy from the vehicle will check in with an AD nurse at the window between the garage and AD office. The AD nurse will talk to the deputy to find out "how the transport was" and any issues they need to know. The AD nurse tells the deputy to leave the patient in the vehicle and an AD nurse and a security staff will meet the patient at the vehicle before they get out. The AD nurse starts their assessment before the patient gets out of the vehicle by checking their behavior "to make sure they will be safe" and if needed, get a wheelchair for the patient.
* After the patient is brought inside the AR, restraints are removed and and AD nurse will ask the patient if they have a cough or any illnesses, and take their temperature. ADM stated a full set of vital signs were sometimes taken in AR "[depending on] how cooperative the patient is."
* When done in AR, a minimum of an AD nurse, unit nurse, and a MHT escort the patient to the unit the patient is being admitted to. The AD nurse gives report to the unit staff as they are "walking through the hall to the unit." When they

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get to the unit, staff "do vitals, weight, admissions process and shower."
* Regarding Patient 1, ADM stated 2 patients were in the transport vehicle upon arrival, Patient 1 and another patient. The deputies said Patient 1 was not being compliant so they brought the other patient in first and went through the process of checking them in before bringing Patient 1 in. After that, an AD nurse and security staff went out to the vehicle and met Patient 1 who was inside the vehicle. ADM asked the surveyor if they wanted to talk to RN 4, the AD nurse who went out to the vehicle.

4. During interview on 04/24/2024 at ~ 1205 regarding Patient 1, DQM stated the DC deputies had stopped at another location before arriving at Sally Port 8. When they arrived there were two patients in their transport vehicle, Patient 1 and another patient.

5.a. During interview on 04/24/2024 at 1105 with RN 4, they stated they had worked in AD since August 2023. RN 4 provided the following information regarding Patient 1:
* A "Douglas County" transport van pulled into Sally Port 8 drive-in garage. The deputies said the patient would need a wheelchair because they had not been able to get into the van themselves and had been "flopping around like a fish." The deputies stated that was the patient's baseline.
* RN 4 stated they got a wheelchair for the patient and went to the back of the van with a security staff. The patient, who was in the back of the van, "opened their eyes and moved a little". RN 4 introduced themselves to the patient. The deputies told the patient, "We'll get you out [of the van]" and the patient closed their eyes. RN 4

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stated "I thought [the patient was] not being cooperative" and asked for more security staff. RN 4 stated 5-6 security staff came. The deputies gave the patient a few minutes to get out of the van and when they did not, the deputies lifted the patient to the wheelchair. RN 4 stated the deputies held the patient's legs up while they wheeled the patient backwards from the van into the AR.

* RN 4 stated in the AR "we got a photo of the patient for [their] ID" and the deputies said it would be OK to remove the patient's cuffs because they had never been aggressive. The deputies removed the cuffs. The patient was not able to hold their head up and "kept [their] eyes closed." RN 4 stated the patient was slouched with their head to one side, and "not holding it up like a normal person holds their head."

* RN 4 stated "typically we take a temperature and ask about a cough" in the AR. RN 4 stated they did not check the patient's temperature or any other vital signs and did not ask the patient if they had a cough. When RN 4 was asked if the patient was breathing, they stated, "I didn't observe any chest rise and fall." In response to the surveyor's follow-up question in regard to indications of oxygenation such as the patient's skin color and appearance, RN 4 additionally stated that the patient "was African American, had dry skin, and I didn't notice anything abnormal."

* RN 4, a unit nurse, and security staff pushed the patient in the wheelchair from the AR to LH1. One of the security staff lifted the patient's legs with a blanket so their legs wouldn't drag. When they got to the patient's room on the unit, the unit RN and two security staff laid the patient supine on the bed because the patient would not get on the bed themselves. RN 4 stated, "At that point, I knew something was off because there was no

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response from the patient, so I checked for a pulse. Nothing. I checked a sternal rub and nothing." The patient had no pulse and was not breathing, and they called a code blue.

5.b. Incident documentation recorded by AD RN 4, dated 04/18/2024 and untimed, reflected that "Access control called the main admissions office phone at around 10:47 to report that Douglas County was waiting to get into Sally Port 8 for an admission. Douglas County was scheduled to drop off two admits to OSH today on 4/18. [Patient 26] who was scheduled to admit to FW1, and [Patient 1] was scheduled to admit to LH1. The Douglas county transport van was waiting in the circle outside of OSH for roughly 5-10 minutes, due to there being a secure transport van in Sally Port 8. [RN 3] admissions RN, went outside Sally Port 9 to talk to the Douglas county officers to find out how the pts were doing. When [RN 3] came back through Sally Port 9, [they] reported to me ([RN 4] Admissions RN) that the officers said [Patient 1] will need a 'wheelchair' because [the patient] 'flops around like a fish' and is 'catatonic'. After secure transport left Sally Port 8. Douglas county pulled into Sally Port 8. FW3 unit staff showed up first, and [RN 3] who was assigned to admit [Patient 26] brought in [Patient 26] and introduced them to the FW3 staff and that pt was taken to FW3. [Patient 1's] unit staff from LH1 ([RN 13] along with unit MHT) showed up next. I was assigned to admit [Patient 1] as I had done [their] pre-admit note in avatar as well as a nurse to nurse with the jail RN. The deputy standing in the admissions area adjacent to Sally Port 8 then reported to me, '[Patient 1] won't stand up, [they're] catatonic. [They'll] need a wheelchair'. RN asked the deputy '[They] won't stand at all?', and deputy responded 'No'.

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Wheelchair and a blanket was obtained by this RN. [MHST 18] was the security assigned to help with admissions for 4/18. As Sally Port 8 doors were opened by access control, [MHST 18] held open the doors while this RN followed deputies to the back of the van with the wheelchair. The deputies opened up both doors to the back of the van. [Patient 1] was seen sitting in a slumped position with [their] back against van partition. As soon as the van doors opened, there was sunlight that came streaming into the back of the van, and this RN could see [Patient 1's] eye open and close. Deputies said to [Patient 1] that they needed [them] to get into the wheelchair and gave [the patient] a few seconds but pt did not make any movements or indication that [they were] going to get up. Deputies then assisted pt on either side and lifted the pt into the wheelchair. RN introduced [themselves] to [Patient 1] and explained [they were] at the hospital but pt did not respond. RN asked for pt to lift [their] legs, so [they] could be wheeled, but [Patient 1] did not lift [their] legs. Both deputies each lifted one of the pt's legs by the pant leg so [the patient's] heels would not be dragging, and this RN wheeled [Patient 1] backwards into the adjacent admitting room connected to Sally Port 8. [MHST 18] had called for additional security at the request of this RN, who were also present in the admitting area. A photo was obtained of [the patient] for [their] ID badge for security, but [they] did not open [their] eyes. This RN was assessing whether or not the cuffs should be removed in the admitting area, or on the unit for safety, when officers reported that they did not see [the patient] as a threat, and [they] had 'never been physically violent'. This RN gave the directive for officers to remove the cuffs as pt was not exhibiting any signs of aggressive behaviors. Cuffs were removed by officers. Pt

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was wheeled by security to LH1, with one security wrapping a blanket underneath pt's legs and lifting them up so they did not drag on the floor. Admissions RN and unit staff followed as well. Pt was taken onto LH1 unit, and down one of the first hallways on the right hand side as you enter the unit, where the pt's assigned bedroom was. Pt was wheeled into [their] room, and staff informed [the patient] that it was [their] bedroom and [they] could get up. One staff member said '[Patient] won't get up, [they're] catatonic'. Security and unit RN and another staff lifted the pt onto the bed. Pt was now in a supine position on the bed. Unit RN, [RN 13], then began doing [their] assessment. [RN 13] tried verbal stimuli, yelling pt's name, checking radial and pedal pulse, checked for breathing. This RN checked for radial pulse on the right side, and there was no pulse felt. This RN confirmed with [RN 13] there was no pulse. Compressions were started, and a code blue was called on the radio by security. Crash cart was obtained with AED. Pt was moved to the floor in supine position for compressions and ambu bag was used for breath. 911 was called. Two OSH medical doctors arrived. AED advised no shock. EMS arrived and took over care."

6. Incident documentation recorded by MHST 18, dated 04/18/2024 and untimed, reflected that "I, [MHST 18], was the admissions security staff to assist during the admit with the new patient [Patient 1]. There were two patients from Douglas County admitting today and [Patient 1] was the second one to come in at approximately 1105. When the Deputies arrived, they had let us know that this patient was not talking or moving but that this was usual for [them]. They recommended that we bring a wheelchair due to [the patient] choosing not to walk but that it was "[their]

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normal" per the deputy. They mentioned that they had to help place [Patient 1] into the vehicle to bring [them] here to OSH. [AD RN 4] took a wheelchair to the van where the patient was sitting. The officers asked the patient to exit the vehicle a couple times to which the patient did not move. I am unsure as to who helped the patient exit the vehicle and place [them] into the wheelchair. I stood holding the door at sallyport 8 open and called for additional security. Additional security responded. [AD RN 4] introduced [themselves] when [they] entered the building, then I introduced myself and let [the patient] know I would be taking [their] photo for [their] OSH ID badge. I took [the patient's] photo. [AD RN 4] asked [the patient] to contract for safety and there was no response. The deputies assured us that the patient would be safe and that this is just how [they were]. So [AD RN 4] gave them the go ahead to remove the cuffs. Another security staff asked, "is [the patient] catatonic?" and the deputies responded saying "pretty much."

7. Incident documentation recorded by MHST 16, dated 04/18/2024 and untimed, reflected that "... a call came over the radio for additional security assistance at Sallyport 8 with a new admit at 11:03. As I got closer to Sallyport 8 I could see security staff and two sheriff deputies standing in a semicircle around [Patient 1], who was still out of view to me in the admissions room attached to sallyport 8. There were two unit staff, [RN 13] and [MHT2 8], standing outside the room waiting for the admit per protocol, as I tried to quietly enter the room to not disrupt anything. I could see the admissions [RN 4], standing next to [Patient 1] attempting to get [them] to respond and open [their] eyes, but [they] just sat slumped in the wheelchair, in full cuffs, and unresponsive.

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Someone leaned over to me to let me know that this was a behavior, and I took that to mean that this situation was going to be unpredictable due to this being a new admission with no prior hospitalization. It is protocol to hear the patient agree to safety before we can release [them] from [their] cuffs. The deputies mentioned that [the patient] hadn't been violent, that all their assistance was because [they were] 'catatonic' and refused to respond. I saw that the unit staff had propped open the door to listen, so I stepped out to fill them in on what the deputies had said. When I came back into the room, they started to remove the cuffs, so I left the room again to open doors ahead of them to ease the transportation process. [TMHA 19] was pushing the wheelchair while [MHST 20] was holding [the patient's] legs up with a blanket, so [their] feet didn't drag on the ground. Halfway there, [MHST 17] swapped out with [MHST 20] and carried the patient's legs in a blanket. Once we got to the patient's new unit, LH1, [RN 13] wanted to assess the patient in [their] room (Room# G02-143) so [RN 13] and security staff lifted the patient from the chair to the bed. [RN 13] sent someone to grab the vitals machine while [they] continued to rub on the patient's chest, tap [their] shoulders, and shout [their] name. I stood out in the hallway due to patients walking by the room, redirecting them as they came near."

8. Incident documentation recorded by MHST 17, dated 04/18/2024 and untimed, reflected that "When I arrived at Sally Port 8, I saw the admission, [Patient 1] slouched down in a wheelchair unresponsive with closed eyes. Admission [RN 4] asked the two deputies from Douglas County how [Patient 1] has [sic] been on the way over from Douglas County? One of the

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deputies stated, 'This is how [the patient] always, [sic] is unresponsive and is catatonic.' [RN 4] was attempting to get a response from [the patient]. One of the deputies stated, '[the patient] is not violent we just needed to get [them] out of the truck by force because [they were] not cooperating with us.' [RN 4] stated [they] did not want to transport [Patient 1] in the wheelchair with [their] feet being dragged. [TMHA 19] stated we can use a blanket to hold [the patient's] feet up and have someone hold the blanket while escorting the patient. [MHST 20] began to assist with holding the blanket while [TMHA 19] was pushing the wheelchair to Lighthouse 1. I relived [sic] [MHST 20] due to [them] needing a break. Once we arrived on Lighthouse 1 in the main entry hall, [the patient] continued to slide down in the wheelchair I asked security to assist me in helping move up [Patient 1] in the wheelchair. Staff then entered the south hall and went into room G02-143. [RN 13] and [TMHA 19] and I assisted [the patient] to [their] bed. [RN 13] began to do an assessment on [the patient] and began to check [their] pulse on [their] right wrist, [RN 13] stated [they were] not feeling any pulse."

9. Incident documentation recorded by SOS 31, dated 04/18/2024 and untimed, reflected they were "Sending this incident report on the behalf of [MHST 14]. sometime early this morning before 11 o'clock security was called over the radio to assist with an admission at Sallyport 8. Myself and [MHST 32] responded. We walked into the foyer area. To the left of me, I saw [Patient 1] sitting in a wheelchair, patient was slightly slumped or slouched in the wheelchair. Eyes closed with a blanket placed around the cuff [sic] area/torso. Patient had jail clothes on with no shoes or socks. Patient had belly chain and wrist

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restraints, but no ankle restraints from what I saw. The deputies from Douglas County jail stated that the patient was unresponsive. I heard someone unknown to me reference the unresponsiveness to being catatonic, at which the deputies responded yes but that is normal for [the patient]. They proceeded to state that the patient is not assaultive hasn't been since being there in the jail but that [they] just [don't] respond. The admission nurse [RN 4] requested the deputies remove the cuffs. The cuffs were removed. [MHST 20] put a blanket underneath the patients legs, lifting them in the air to not drag on the ground. [TMHA 19] pushing the wheelchair. We got Halfway to the bubble, we stopped so that [MHST 20] could be swapped out for somebody else and repositioned the patient's body on wheelchair. [TMHA 19] and I then lifted the patient bringing [them] back fully on the chair and proceeded to the patients [sic] room. Unit nurse [RN 13], [TMHA 19] and I lifted the patient out of the wheelchair assisting [them] to the bed. [RN 13] began checking for responsiveness. [RN 13] then requested for the vital machine and code blue to be called. Throughout the remainder of the code blue, I assisted in updating Access Control and Dispatch for on [sic] information from Salem Police and Fire Emts. Patients time of death was 1156."

10. Incident documentation recorded by MHST 20, dated 04/18/2024 and untimed, reflected that "I responded to a call for security assistance at Sally Port 8. When I arrived, I saw Douglas County Deputies and OSH staff were standing around a patient, later identified as [Patient 1], that was in a wheelchair. The Deputies described [the patient] as being catatonic. I asked the Deputies if [the patient] had been responsive at

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all during the trip, they said that [the patient] was moving up and down in the back of the van. I then turned towards [the patient] and addressed [them] loudly and there was no response. I observed that there was abnormally thick but clear saliva around [their] mouth, I addressed [the patient] again and there was no response. [MHST 18], who was assigned new admissions processing then took a picture of [Patient 1], as part of the admissions process. It was then decided that since [the patient] appeared not to be cooperative with us that we would use a blanket to lift [their] legs so that we could easily transport [them] to Lighthouse 1 via the use of a wheelchair."

11. Incident documentation recorded by TMHA 19, dated 04/18/2024 and untimed, reflected that "The admissions [RN 4] made the decision to have the deputies remove the restraints before we moved the patient to Lighthouse 1, after the restraints where removed I grabbed the wheelchair handles while [MHST 20] held up the patients' legs with the assistance of a blanket while we moved the patient to Lighthouse 1. On arrival to the unit, we moved [the patient] into [their] assigned room (unknown number), the unit nurse who accompanied us from admission to the unit [RN 13] asked that we move [the patient] on the bed. [MHST 14] grabbed the patients left shoulder while I grabbed the right shoulder and [RN 13] grabbed [the patient's] legs and we move [sic] the patient from the wheelchair on to the bed. The patient was still [sic] appeared to be in [sic] catatonic at that time. After assisting with the movement, I left as I was already late for my assigned lunch period."

12. Incident documentation recorded by LH1 NM, dated 04/18/2024 and untimed, reflected that

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"[LH1 NM] is writing this incident report on behalf of [MHT 33]: I was doing the RCM/SSM checks - I saw [Patient 1] being taken to [their] room via wheelchair and [they] looked lifeless - security pushing [them] in a wheelchair - [the patient's] hands were hanging out to the sides and staff were holding [their] legs to keep [them] in the wheelchair."

13. Incident documentation recorded by LH1 RN 13, dated 04/18/2024 and untimed, reflected that "I was the RN assigned to [Patient 1's] admission along with [MHT2 8]. We were called to the admission Sally Port around 1100 and waited in line as the county had two patients and the first was going to a different unit. [MHT2 8] and I remained outside the Sally Port per protocol, waiting for report from the [AD RN 4]. It was reported that the pt was not cooperating, would not walk, and [AD RN 4] retrieved a wheelchair. Security arrived at the Sally Port, evidently having been paged by admissions. The pt was retrieved from the transport vehicle utilizing the wheelchair and brought into the Sally Port; I was not able to observe the pt from my vantage point outside the Sally Port. It was reported to us that the pt was continuing to be uncooperative and not responding. Two security staff wheeled the pt out of the Sally Port, one pushing [TMHA 19], the other holding the pt's legs up with a blanket draped under [the patient's] ankles ([MHST 20], switched with [MHST 17] at some point). We quickly made our way to LH1; I walked alongside the wheelchair, attempting to engage the pt, explain the plan. We passed the bubble on LH1 at 1111. We had decided to take [Patient 1] directly to [their] room and transfer [them] to [their] bed. On arrival to [patient's] room, security [TMHA 19] and I immediately lifted the pt out of

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the wheelchair and onto the bed. During that transfer, I noted the pt was more limp than would have been expected from a simply unresponsive pt. I immediately began checking for a pulse on [their] R wrist and began calling [their] name loudly. I performed sternal rubs when I could not elicit a response verbally. When there continued to be no response I requested staff call a code blue (code was called @ 1114). I then attempted to find a pulse under [the patient's] upper arm, carotid, pedal while continuing to attempt to rouse [them] verbally and with sternal rubs and watch for chest rise (this was difficult to assess as [the patient] was in loose fitting jail clothing). I pulled open [the patient's] eye lid and noted a dilated pupil; I used my flashlight to test reactivity and no reactivity was seen. Staff arrived quickly and we began chest compressions (@ 1115). Staff arrived with the AED and crash cart. After applying the AED pads, we transferred the pt to the floor to have a more firm surface and continued compressions alternating with AMBU bag respirations following CPR protocol. Narcan was requested and administered by [PMHNP 23]. Various staff and medical personnel rotated through administering compressions and AMBU respirations. CPR was continued per protocol, following prompts from AED (no shock ever advised) until paramedics arrived and took over the situation."

14. On 04/24/2024 beginning at 1155, survey team review of multiple camera views of video-recordings, without audio capability, revealed the following timeline of events that occurred on 04/18/2024 when the vehicle Patient 1 was transported in from Douglas County Jail arrived to the OSH Sally Port 8. Regarding the video review there was no camera view provided

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in Sally Port 8 that showed directly into the back of the transport van used to transport Patient 1 so that the entirety of the inside of the van could be visualized. The camera that showed the view at the back of the van was mounted off to the side of the Sally Port so that a side view of the right rear of the van could be visualized. With both rear van doors opened only a small portion of the inside of the back compartment could be seen. In addition, the quality and clarity of some of the video footage was poor and details of some images were not clear. Further, there were occasions during video review where video skipped several seconds when there was activity occurring. Commonly video may skip seconds or minutes when there is no activity occurring.

* Between ~ 1054:52 and 1056:23 two camera views inside Sally Port 8 showed: A DC Jail transport van drove into Sally Port 8 with two DC deputies seated in the front seats. The garage door closed after the van had fully entered the Sally Port. A DC deputy walked to the back of the van, opened one of the back doors, removed two bundles of items, and walked away towards the door to the admitting room. At ~ 1056:07 Patient 26 exited the van through the passenger right side doors and walked in front of the second DC deputy towards the door to the admitting room.

* Between ~ 1058:18 and 1100:20 one camera view inside Sally Port 8 showed: A DC deputy walked back to the back of the van, opened one of the back doors and looked inside momentarily, then started to close the door, then reopened it and looked inside and left it open. They stood at the back of the van and periodically looked inside through the open door.

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* Between ~ 1100:21 and 1102:20 two camera views inside Sally Port 8 showed: The second DC deputy approached the back of the van and joined the first deputy, immediately followed by RN 4 who pushed a w/c towards the back of the van. The deputies opened the other door so that both back van doors were open. At ~ 1100:28 only a portion of Patient 1's lower body was visualized up against the rear left side of the van. They were positioned on the floor so that their body was facing the interior of the left rear corner side panel of the van, their left buttocks could be seen on the van floor, the left side of their body was at the very end of the floor where the door closure was, their left leg was observed to be bent at the knee and had partially fallen outside of the van. The two deputies picked Patient 1 up off the van floor and in awkward and uncoordinated movements took the patient out of the van and rotated them to place them in the w/c. There was no indication that Patient 1 was assisting or resisting. The parts of their body that could be visualized were limp. Patient 1, who was Black, was positioned in the w/c with their shoulders at the level of the top of the w/c seat back, their head slumped fully forward towards their chest, and their eyes closed. RN 4 folded a blue blanket and place it around Patient 1's chest and shoulders and wrapped the ends around the w/c handles. At 1101:38 as the RN began to pull the w/c backward towards the admitting room Patient 1's upper body was observed to be positioned lower in the w/c and slumped toward the left. As their head was slumped forward, the lower part of their face, including mouth and nose, was covered by the blue blanket. At ~ 1102:01 as RN 4 pulled the w/c backwards along the side of the van towards the admitting room door, both deputies bent over the patient and made

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movements consistent with each having picked up one of the patient's pants legs to lift the patient's feet off the ground.

* At ~ 1102:24 one camera view inside the admitting room attached to Sally Port 8 showed: RN 4 pulled the w/c with Patient 1 backward into the admitting room. One deputy had hold of the patient's right pant leg near the hem with their right hand. The other deputy had hold of the patient's left pant leg near the middle of the pant leg with their left hand. Both of the patient's bare feet were dangling slightly above the floor. The patient's hands were cuffed in their lap. Their head was slumped forward, their eyes were closed, and their face was covered by the blue blanket that was held in place by RN 4 around their chest and shoulders and the w/c handles.

* Between ~ 1102:30 and 1105:50 one camera view inside the admitting room showed: RN 4 parked Patient 1 in the w/c near the middle of the room. The deputies' positions around the patient's body periodically block the camera view. At this time four other staff (not including RN 4 and the two deputies) arrived into the room. The RN can be seen to lean over towards the patient on the left side of the w/c and arms are extended toward the patient although the patient cannot be seen behind one of the deputies. At ~ 1103:02 the deputies stepped away and the patient was observed to be slumped further down in the w/c, however, the patient's face was no longer covered by the blue blanket that remained around their chest and shoulders. It looked as though RN 4 had their right hand on or near the blanket below the patient's face as if they moved the blanket to uncover the patient's face. The patient was motionless and their eyes were closed. At

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that time there were at least six other staff in the room. RN 4 stepped away and back from the w/c and was observed to address the deputies and staff that had gathered in the room who all stood and faced the patient within a few feet of the patient. Two of those staff stepped towards and leaned towards the patient and took photographs of the patient with cell phones. Then there were eight other staff in the room. The 11 people in the room (excluding the patient) were observed to talk amongst themselves and to the group while Patient 1 remained motionless in the w/c with their wrists in law enforcement transport restraints, their chin laid on their chest, and their eyes closed. Patient 1 showed no signs of movement. At ~ 1104:18 RN 4 slightly leaned toward the patient, extended their arm, and may have touched the blue blanket, the patient's clothing near their shoulder, or the w/c. It was not clear. At ~ 1104:24 one of the staff persons approached the patient, leaned toward them, and extended their arm towards the patient. There was no visible response or movement from Patient 1. At ~ 1104:29 a DC deputy removed the law enforcement transport restraints from the patient's wrists. At ~ 1105:08 when their right hand was free from those restraints their right forearm, wrist, and hand slid down and across their right thigh. At that time the patient was observed to have slid further down in the w/c, the blue blanket was removed, their head remained slumped fully forward with their chin on their chest, their eyes were closed, and their legs were extended straight in front of them with their bare feet on the ground. At ~ 1105:27 a staff person took the blue blanket and with assistance from another staff person positioned it under and around both the patient's legs at the knees and formed a handle of sorts to lift the patient's legs

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up off the ground. At that time the patient's buttocks were near to sliding off of the w/c and their arms had fallen off their thighs onto the w/c seat on either side of their body. At ~ 1105:44 one staff person pushed the w/c forward and another staff person held the blanket that was around the patient's legs to keep them off the ground and the group moved towards the door out of the admitting room into a hallway towards the inpatient unit. At no time while in the admitting room did the patient assist or resist, nor did they open their eyes or demonstrate any observable movement. At no time was there any meaningful touch or other activity by any staff that could be construed as a patient assessment component.

* Between ~ 1105:50 and 1108:30 four camera views showed: The two staff who pushed the w/c and held the patient's legs up were joined by RN 13 and six other staff as they transported Patient 1 through hospital hallways to the inpatient unit. Patient 1 remained motionless with their eyes closed and slumped to the left with their arms laid limply on the w/c seat on either side of their body and their chin laid on their chest. Overhead camera views during the transport showed that the blanket around the patient's knees used to hold the patient's legs up during transport had been tied and knotted or twisted. At ~ 1108:30 staff pushed the patient in the w/c into the assigned patient room on the inpatient unit and that was last video observation of Patient 1.

* Video recording beginning at 1108:30 captured staff activities in the hallway outside the room after Patient 1 entered the room, and after the Code Blue response had been initiated. Those video observations are described below under Finding 28 of this Tag.

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A 144	Continued From page 82 15.a. On 05/02/2024 at ~ 1320 while in the AD the survey team observed that a Douglas County Jail transport van was parked in Sally Port 8. DC deputies agreed to show the survey team and hospital staff present the inside of the back of the van. A rear compartment that was fully separated from the rest of the van was observed. It was the entire width of the van and ~ 3 feet deep. It was divided into two unequal sections with a rigid divider from floor to ceiling comprised of metal on the bottom portion and metal screen on the top portion. The larger section comprised ~ two thirds of the width of the van. Each section contained a built-in black metal box that was covered with a silver metal top. Near the top and center of each black box there was a handle that protruded outward under which a padlock was dangling. The boxes were the entire width of each section and were ~ 2 feet high off the floor. The floor space that remained in each section between the box and the interior end of the van where the back doors closed was ~ one foot. 15.b. During the observation the DC deputies indicated that individuals in custody who had behavior problems were sometimes transported in that rear compartment and could sit on either side of the divider in the back of the van. 15.c. In an email received on 05/06/2024 at 1101 the DSC provided a photo from the security video of the 05/02/2024 observation. The photo showed the license plate number of the back of the van observed on 05/02/2024 was the same license plate number as the van observed in the video recordings of the 04/18/2024 Patient 1 transport. 16. Documentation in Patient 1's medical record	A 144		

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consisted of the following documents:
* An "Oregon State Hospital Non-Medication Telephone Orders" form that contained a medication order for Narcan dated 04/18/2023 at 1120.
* A Douglas County Circuit Court "Order of Commitment to Oregon State Hospital."
* A Pre Admit Note written by AD RN 4 and dated and timed 04/18/2024 at 1338 that reflected the RN's encounter with Patient 1 that is also described under Finding 5.b. above in this Tag.
* A Nursing Progress Note written by LH1 RN 13 and dated and timed 04/18/2024 at 1304 that reflected the RN's encounter with Patient 1 that is also described under Finding 13 above in this Tag.
* A Nursing Progress Note written by the LH1 NM and dated and timed 04/18/2024 at 1636 that reflected the NM's encounter with Patient 1 from the time they were notified that a Code Blue was needed for Patient 1 who had arrived on LH1 and is also described under Finding 27 below in this Tag.
* A Psychiatry General Note that was written by a psychiatrist, MD 30, and dated and timed 04/18/2024 at 1451. It reflected the MD's encounter with Patient 1 from the time they responded to the Code Blue called on LH1.
* A Psychiatry General Note that was written by a psychiatrist, MD 27, and dated and timed 04/18/2024 at 1838. It reflected the MD's encounter with Patient 1 from the time they responded to the Code Blue called on LH1.
There was no other documentation in the medical record.

17.a. As described under Finding 2.c. above in this Tag, the Interim OSHS, who was the CMO, issued a "CMO Directive" dated 04/19/2024 that

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contained three parts: 1. AD RNs would perform and document a brief assessment that included vital signs upon patient entry to AD and prior to transport to the inpatient unit. 2. If a patient was not responsive in AD the possibility of a medical emergency must be immediately assessed. 3. If a patient was combative to have vital signs taken while in the AD, that was to be communicated to the unit RN and documented.

17.b. Regarding the 1st and 3rd items on the CMO Directive, the medical records of all patients admitted to the hospital beginning the day of the CMO Directive, 04/19/2024, through 04/25/2024 were reviewed. The review reflected that 22 of those 24 patients had the brief assessment and vital signs required by the CMO Directive documented in their medical records.

17.c. In one record where a brief assessment and vital signs were not documented in the AD, Patient 2 on 04/19/2024, the inpatient note on that date reflected the patient arrived on the inpatient unit at 0945 and was ambulatory with crutches and communicative with staff. The CMO Directive was issued by email to AD staff on 04/19/2024 at 1007, after the two morning admissions on 04/19/2024. In the second record where vital signs were not taken in the AD, Patient 24 on 04/25/2024, the patient's behavior was too combative and in accordance with the 3rd CMO Directive item the medical record contained the required AD RN note, and additionally an incident report had been filed by the AD RN.

17.d.. The 2nd item on the CMO Directive required that if a patient was not responsive in AD, the possibility of a medical emergency must

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A 144	Continued From page 85 be immediately assessed. Survey findings revealed that if a patient was observed or assessed to require a medical emergency response in the AD the disorganized and fragmented state of the medical emergency supplies and equipment in that area was such that a response would not likely be timely or efficient. The detailed findings are described under Findings 18 through 21.c. below and were the basis for identification of the IJ situation referred to under the Deficient Practice Statement above for this Tag, and under Tag A-0000. ********** 18. The findings that follow reflect the hospital's failure to ensure medical emergency supplies and equipment were organized and managed to ensure availability of necessary items during a medical emergency response. 19. During tour of AD with DSC, PD and ADM on 04/24/2024 at 1020, observations included: * Upon entering AD hall, a secure door at the end of the hall led into the AR. From inside the AR, a secure door led into the Forensics Evaluation area. Another secure door from the AR led directly into Sally Port 8's vehicle drive-in garage. A floor to ceiling garage door was observed between the drive-in garage and the outside of the building so that a vehicle could drive fully into the garage and have the doors closed and secured behind the vehicle. * From the AD hall, to the right of the AR entry door, a secure door lead into the AD office. A sliding window was observed between the AD office and drive-in garage so that AD staff could open the window and communicate with individuals in the garage. * From the AD hall, to the left of the entry AR door	A 144		

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and across the hall from the AD office, a secure door led into room G04-117A.
* A secure door leading to Sally Port 9 was observed near the Admissions office. Sally Port 9 had a secure door that led directly to the outside of the building and no drive-in garage.

20.a. During a second tour of AD on 04/24/2024 at 1610 with Interim DS, DSC, and RN 3, observations included:
* In AD office, a portable oxygen tank and a blue duffle type Code Blue Bag. The bag had multiple zippered top and side pockets with red breakaway locks. The bag was opened and contained an Ambu bag, dressings, pulse oximeter, oxygen tubing, pen lights, and other emergency supplies. There was no inventory list observed that identified the contents of the Code Blue Bag. A clipboard with multiple copies of partially completed "Emergency Equipment Checklist" Attachment A was observed near the Code Blue Bag.
* In Room G04-117A, a tackle box style Emergency Kit was observed with a green breakaway lock. The lid read "Emergency Box" in red professional type print.
* An AED was observed mounted on the wall in the Forensics Evaluation area down a hall and around a corner from the AR.
* Observation of the path from AR to outside AN1 nurse station involved leaving AD and going through 3 secure doors.

20.b. "Emergency Equipment Checklist" Attachment A observed in Admitting office near the Code Blue Bag was reviewed. There was no date that reflected when it had been created or revised. The top portion of the checklist had spaces for recording month and year and stated

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"Consult with Nursing Supervisor if any equipment problems. Every section must be completed." The checklist had a "Date" column with rows numbered 1-31 for checking the following items each day in a month:
- "Y N" for "AED Present"
- "Y N" for "Code Blue Bag or Red Cart Lock Intact."
- "Y N" for "Emergency Med Box Lock Intact"
- "Y N" for "Oxygen Tank = 1000 p.s.i."F- "Y N" for "Suction Machine Charged, Clean & Operational"

The checklist also had spaces for recording time, comments, and signature each day.

20.c. The "Emergency Equipment Checklist, Attachment A for January 2024 dated "Month/Year: 1/2024" was reviewed and was incomplete and did not provide assurance emergency supplies and equipment were checked and available when needed. Examples included:
- The spaces for documenting the time was blank every day of the month.
- For 01/01/2024, 01/15/2024, 01/16/2024, 01/17/2024, 01/19/2024 and 01/31/2024, "Y" and "N" were not circled or otherwise marked for "Code Blue Bag or Red Cart Lock Intact" and "Oxygen Tank = 1000 p.s.i." checks. In addition, spaces for documenting signature were blank for those dates.
- The columns for documenting "AED Present", "Emergency Med Box Lock Intact", and "Suction Machine Charged, Clean & Operational" had a squiggly line drawn through each and there was no documentation that reflected those had been checked.
- The spaces for documenting comments were blank every day of the month.

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A 144	Continued From page 88 20.d. The "Emergency Equipment Checklist, Attachment A for February 2024 dated "Month/Year: Feb 2024" was reviewed and was incomplete. Examples included: - The spaces for documenting the time was blank every day of the month. - For dates 02/02/2024, 02/09/2024, 02/16/2024, and 02/19/2024, "Y" and "N" were not circled or otherwise marked for "Code Blue Bag or Red Cart Lock Intact" and "Oxygen Tank = 1000 p.s.i." checks. Spaces for documenting signature were blank for those dates. - The columns for documenting "AED Present", "Emergency Med Box Lock Intact", and "Suction Machine Charged, Clean & Operational" had a squiggly line drawn through each. - The spaces for documenting comments were all blank. 20.e. The "Emergency Equipment Checklist, Attachment A for March 2024 dated "Month/Year: March 2024" was reviewed: - The spaces for documenting "Time" was blank every day of the month. - For 03/01/2024, "Y" and "N" were not circled or otherwise marked for "Code Blue Bag or Red Cart Lock Intact" check and the signature space was blank. - For 03/01/2024, 03/18/2024, 03/19/2024, 03/20/2024, 03/21/2024 and 03/22/2024, "Y" and "N" were not circled or otherwise marked for "Oxygen Tank = 1000 p.s.i." checks. - The columns for documenting "AED Present", "Emergency Med Box Lock Intact", and "Suction Machine Charged, Clean & Operational" had a squiggly line drawn through each and there was no documentation that reflected those had been checked.	A 144		

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- The spaces for documenting comments were blank every day of the month.

20.f. The "Emergency Equipment Checklist, Attachment A for April 2024 dated "Month/Year: April" was reviewed:
- The spaces for documenting the time was blank every day through the date of this survey.
- For 04/10/2024, 04/11/2024, 04/12/2024, 04/15/2024, 04/16/2024, 04/22/2024, 04/23/2024 and 04/24/2024, "Y" and "N" were not circled or otherwise marked for "Code Blue Bag or Red Cart Lock Intact" and "Oxygen Tank = 1000 p.s.i." checks. Spaces for documenting signature were blank for those dates.
- The columns for documenting "AED Present", "Emergency Med Box Lock Intact", and "Suction Machine Charged, Clean & Operational" had a squiggly line drawn through each and there was no documentation that reflected those had been checked.
- The spaces for documenting comments were blank every day of the month.

20.g. The checklist being used in OSH-Salem AD was not the same version as the "Emergency/Medical Equipment Checklist" Attachment A with revision date "10/2023" in the P&P titled "Emergency and Multi-Patient-Use Medical Equipment" in Findings 22.b. and 22.c. below. For example, the checklist being used in AD reflected "AED Present". The checklist in the P&P reflected "AED shows green check". The checklist being used in AD included "Code Blue Bag" and "Emergency Med Box Lock Intact." The checklist in the P&P did not include those. The checklist in the P&P included "Medical Equipment Disinfected" and the checklist being used in AD did not include a medical equipment disinfection.

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In addition, observations of the Code Blue Bag in Findings 20.a. and 21.a. reflected it had multiple zippered pockets with breakaway locks. However, the checklist did not provide instructions or a system for tracking each of those to ensure the bag had not been opened and emergency supplies removed without staff awareness

20.h. During interview on 04/24/2024 at 1620, RN 3 stated:
* If a patient was unresponsive in AD they would call a code blue and use the emergency supplies and medication observed in Finding 20.a. above or a "code cart might be brought from an inpatient unit."
* The Emergency Kit in Room G04-117A contained Narcan.
* There was no suction equipment in AD and if a patient needed suction "a code cart would be brought from [AN1]." The closest code cart was inside the nurse's station in AN1.
* The Code Blue Bag with emergency supplies observed in Finding 20.a. should have a supplies list attached to the bag that identified the emergency supplies inside the bag. RN 3 looked for the supplies list and could not find it.
* The "Emergency Equipment Checklist" observed near the Code Blue Bag should be completed "Monday through Friday".

21.a. During tour of AD with DSC and PD on 04/25/2024 at 1230, observations included:
* The door leading into AD office had an ~ 8.5 x 11 size, professional type sign on the door that read "Code Blue ... Emergency Equipment." Handwritten entries added to the sign included "Blue bag + O2 are here AED by rm G04-121 (Forensic Eval [illegible marks] East Security hall)".

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A 144	Continued From page 91 * Observation with RN 1 of a Code Blue Bag in the AD office revealed it was the same style observed during AD tour on 04/24/2024 at 1610. Four red breakaway locks were observed on the zippered top and side pockets. No inventory list was observed with the bag. The bag was opened with RN 1 and contents were observed and compared with an inventory list that had been received for the Code Blue Bag from hospital leadership earlier the same day. The inventory list was untitled, undated and had sections for "Center", "Rt. Side" and "Lf. Side" pockets. Review of the inventory list and observation of the items in the Code Blue Bag reflected they were inconsistent and unclear. Examples included: - The inventory list reflected "Center [pocket] ... Pen Light (on lid with pens) & Steno Note Pad ... [quantity] ... 2 [and] 1" with a diagonal line crossed through "2 [and] 1". Pen lights and steno note pad were observed in the bag. However, it was not clear how many or whether they should be in the bag as the quantities on the inventory sheet were lined out. -The inventory list reflected the "Rt. Side [pocket] ... Blood Pressure cuffs Lg/ExLg ... [quantity] ... 1 [and] 1" with a diagonal line crossed though "1 [and] 1". Blood pressure cuffs were observed in the bag. Similarly, it was not clear whether they should be in the bag as the quantities on the inventory sheet were lined out. "Rt. Side [pocket]" also included "Stethoscope/oximeter ... [quantity] ... 1 [and] 1" with a diagonal line crossed through "1 [and] 1". Similarly, those items were observed in the bag. - The inventory list reflected "Lf. Side [pocket] ... 3 [inch] roll gauze & 4 [inch] Coban ... [quantity] 2 and 1" with a diagonal line crossed through "2 and 1". Similarly, those items were observed in the bag.	A 144		

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- No protective eyewear was on the inventory list. Protective eyewear was observed in the bag.
- The list included 3 oxygen tubing nasal cannulas. Two oxygen tubing nasal cannulas were observed in the bag.
- The list included 2 oxygen non-rebreather face masks. One oxygen non-rebreather face mask was observed in the bag.
* A Yankauer Suction tip with tubing was observed in the bag. No other suction items or equipment were observed in the bag.
* No Narcan or other medications were observed in the bag.
These findings were confirmed with RN 1 at the time of the observation.

21.b. During interview on 04/25/2024 at 1230, RN 1 provided the following information:
* They started working in the AD about 6 months ago and AD was where they normally worked.
* Most new admit patients and patients returning from medical appointments enter the hospital through Sally Port 8. Patients arriving in vehicles too large to enter Sally Port 8 and patients without behavior problems sometimes enter through Sally Port 9.
* There is frequently a line of transport vehicles waiting to bring patients in through Sally Ports 8 and 9. The vehicles wait in parking spaces outside Sally Ports 8 and 9 "or wherever they can find a spot."
* Sometimes deputies call ahead and let AD staff know if a patient is "coming in hot", meaning the patent was having behavioral issues. RN 1 stated while transport vehicles are waiting to bring patients into the hospital, they usually try to "touch bases" with the deputies by going outside and talking to them about how the patients are doing. They do not start evaluating patients until patients

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are getting out of the vehicle. If a patient had a medical problem while waiting in a transport vehicle, they would do a "formal assessment" of the patient and if the patient had a "serious issue" they would call a code blue.
* If they needed Narcan for a patient, they would get it from the Code Blue Bag or from an Omnicell in AN1. RN 1 stated "We don't have an Omnicell [in AD]."
* If they needed suction equipment for a patient it would be in the Code Blue Bag in AD.
* Regarding the red breakaway locks observed on the Code Blue Bag, RN 1 stated that after the Code Blue Bag was opened, the Code Blue Team was notified. The Code Blue Team checked the Code Blue Bag inventory, restocked the bag, and replaced the breakaway locks on the bag.
* They confirmed there was no supplies inventory sheet with the Code Blue Bag.
* They were not sure who checked the AED in Forensics Evaluation area to ensure it would be present and functioning if needed.

21.c. A second interview was conducted with RN 1 on 04/25/2024 at 1255 after they confirmed the Code Blue Bag in Finding 21.a. did not have all equipment necessary for patient suction, nor Narcan. Regarding obtaining suction equipment during a patient emergency, RN 1 stated "I'd have to go to [an inpatient] unit to get it or a code team person would get it." Regarding obtaining Narcan during a patient emergency, RN 1 stated "I'd go to the Omnicell at [AN1] or ask a deputy. If it was my patient, I'd stay with the patient and have another nurse go get it."

22.a. During interview on 04/25/2024 at 1200, DSC stated the P&P titled "Emergency and Multi-Patient-Use Medical Equipment" in Finding

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A 144	Continued From page 94 22.b. was applicable hospital-wide including in AD. 22.b. The P&P titled "Emergency and Multi-Patient-Use Medical Equipment," dated approved 03/01/2024 included: * "The purpose of this protocol is to describe the expectations and procedures for controlling, monitoring, and disinfecting emergency and multi-patient-use medical equipment available on patient living units at Oregon State Hospital (OSH) ..." * "All Oregon State Hospital living units must have a red emergency cart that is secured with a break-away lock, a suction machine, an automated external defibrillator (AED), and a portable oxygen tank, all of which are consistently controlled, secured, monitored, and ready to use ... Daily checks of the above items are performed by a nurse and are documented on the Emergency/Medical Checklist (Attachment A) ... The Lead Nurse is responsible for ensuring that the actions described in this protocol are performed ... The actions described in this protocol are generally performed on the Night Shift, although individual units may designate another shift for this purpose ..." * "The presence of the AED, and the green check is showing, must be verified each day ... The OSH Medical Equipment Coordinator must be immediately notified of defective equipment and related issues." * "Red emergency carts must be stocked and locked at all times when not in use ... If the lock is found to be broken or missing, the contents must be checked against the Inventory Sheet ... The Inventory Sheet is taped to the top of the cart and also to the clipboard in the top drawer of the cart ... The Code Blue Team must be notified of the	A 144		

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need for replacement items and a new break-away lock ... Contact information for the Code Blue Team is available ... on the Inventory Sheet, available in the red emergency cart ... and ... on a sticker on the top of the red emergency cart."
* "The status of the portable oxygen tank must be verified each day ... The oxygen tank must be replaced if the amount of oxygen is less than 1000 pounds per square inch (psi)."
* "The availability of the suction machine machine, and related supplies, must be verified each day ... The suction machine must be ready for use with a package of suction tubing and a package containing oral suctioning want secured in the wide black plastic band on the front of the machine ..."
* "Emergency medical equipment located in areas other than patient living units and treatment malls is maintained by the Code Blue Team."

22.c. Attachment A, titled "Emergency/Medical Equipment Checklist" dated revised "10/2023" was reviewed. The top portion of the checklist had spaces for recording unit, month and year and stated "Every section MUST be completed. Notify unit nursing management (or designee) of equipment problems." The checklist had a "Date" column with rows numbered 1-31 for checking the following items each day of the month:
* "Y/N" for "AED shows green check"
* "Y/N" for "Red Emergency Cart Lock Present"
* "Y/N" for "Oxygen Tank = 1000 p.s.i."
* "Y/N" for "Suction Machine Plugged In, Tubing/Wand Present"
* "Y/N" for "Medical Equipment Disinfected Complete WEEKLY"
The checklist also had spaces for recording comments and RN/LPN signature each day.

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It was not clear how breakaway locks were tracked to ensure security and availability of emergency supplies and equipment. For example, it was not clear if those were to be numbered, unnumbered or a specific color considering numbered, unnumbered and different colored locks were observed on emergency carts and kits during the survey. The P&P did not include further process for management of emergency supplies and equipments in areas other than living units such as AD, including a system for tracking breakaway locks.

23.a. The P&P titled "Override Process for Medications in Emergency Situations" dated 05/05/2023 reflected:
* "Purpose and Applicability ... To ensure medications are always readily and safely available for use at Oregon State Hospital (OSH), this policy ... This policy applies to all staff who order, dispense, or administer medications."
* "Staff must follow Procedures A to retrieve emergency medications from ADCs and from E-Kits when authorized in emergency situations ... Emergency medications are as listed in Attachment A and Attachment B."

23.b. Procedures A included:
* "Nurse ... Assess the patient ... Upon receipt of a verbal order from the practitioner to administer emergency medication ... Retrieve the medication(s) from the Automated Dispensing Cabinet (ADC) .... or from the Emergency Kit (E-Kit) ... Administer to the patient ... If medication from an E-Kit was used, complete the E-Lot requisition form attached to each kit and scan it to the pharmacy."
* "Pharmacy ... Upon receipt of an E-Kit requisition, deliver a replacement E-Kit and

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retrieve the opened E-Kit ... Prepare the opened E-Kit for redeployment ... Reconcile and replenish standard contents of E-Kits ... Review and record the expiration of all drug contents, and Stage the newly replenished E-Kit for deployment."

23.c. Attachment A reflected "Emergency Medications Stocked in Automated Dispensing Cabinets (ADC)" and included:
* "Stocked in all unit, treatment mall, and Medical Clinic ADCs on both campuses with the noted minimum quantities" followed by a list of medications:
"Aspirin (Uncoated) 325 mg - 2 tablets ..."
"Charcoal, Activated Suspension (Acti-Dose) 50 grams - 1 tube/bottle ..."
"Dextrose/Glucose ... 40% (15 grams) - 2 tubes ..."
"Diphenhydramine (Benadryl) a. 50 mg/mL - 2 vials b. 25 mg - 10 capsules c. 50 mg - 10 capsules ..."
"Epinephrine (Epi-Pen) 0.3 mg/0.3 mL - 1 auto-injector syringe ..."
"Glucagon 1 mg - 2 kits ..."
"Haloperidol (Haldol) a. 5 mg/mL - 2 vials b. 5 mg - 10 tablets c. 10 mg - 10 tablets ..."
"Lorazepam (Ativan) ... a. 2 mg/mL - 2 vials b. 1 mg - 10 tablets c. 2 mg - 10 tablets ..."
"Naloxone (Narcan) 4 mg/spray - 2 devices ..."
"Nitroglycerin (Nitrostat) 0.4 mg - 1 bottle ..."
"Olanzapine (Zyprexa) a. 10 mg/2 mL - 2 vials ... b. 5 mg - 10 tablets c. 10 mg - 10 tablets."
* "Additionally stocked in all treatment mall and Medical Clinic ADCs on both campuses with the noted minimum quantities ... Albuterol (Proair/Proventil) a. 90 mcg (HFA) - 1 inhaler b. 3 mL nebulizer solution - 5 vials."

23.d. Attachment B reflected "Emergency

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Medications Stocked in Emergency Kits (E-Kits) ... Admissions Emergency Kit ... Naloxone (Narcan) 4 mg/spray - 2 devices". Attachment B did not include Epi Pen in Admissions Emergency Kits. Refer to Findings 24.a. and 25.a. that reflected Epi Pen was in Emergency Kits in OSH-Salem AD and OSH-JC Admissions area. The P&P did not include further information about how breakaway locks on E-Kits were managed and tracked. The P&P reflected additional emergency medications were stocked and available in inpatient units and other areas that were not available in Salem campus AD and JC admissions areas. P&Ps were not clear how staff in Salem campus AD and JC admissions area were to obtain those additional emergency medications should they be needed for a patient emergency.

24.a. The OSH-Salem AD was toured during the IJ verification visit with Interim DS, DSC, and ADM on 05/02/2024 at 1300. Observations inside room G04-117A with ADM included:
* A 6 drawer Red Emergency Cart with one blue breakaway lock on the outside. The lock had no number or other information for tracking to ensure cart security. This created the possibility that contents could be tampered, removed and lock replaced without staff being alerted. The outside of Drawers 1, 2, 3, 4 and 6 were labeled with the contents of the drawers. Drawer 5 was not labeled and no items were observed inside the drawer.
* An "Admissions Code Blue Equipment Check Sheet" inventory list dated "Updated 4/30/2024" was observed. The inventory list was separated into 6 sections for Drawers 1 through 6, with supplies/equipment in each drawer.
Observation and of cart labels, cart contents, and

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the inventory list revealed inconsistencies between those. For example:
- Sterile tongue depressors, roll gauze and Coban were observed inside Drawer 3 and were on the check sheet for Drawer 3, but were not observed on any of the drawer labels.
- A label on Drawer 3 reflected "EMT scissors" and EMT type scissors were observed in Drawer 3. The check list reflected only "scissors" which could be confused with regular office type scissors.
* A tackle box style Emergency Kit with breakaway lock was observed in Drawer 6. The top of the kit had a white label that read "Earliest Expiration 2/25" with a signature and a title. It was not clear whether the expiration date was intended to be February 25 or February 2025. A 2-page, front/back document titled "Admissions Emergency Kit" was observed in a plastic sleeve with the kit.
Page 1 was a list that reflected two medications were in the kit, Narcan and Epi Pen. It included:
- Naloxone (Narcan) 2 mg/mL syringe, quantity "2" with the following unclear expiration dates "4/24" with 3 lines marked through and no indication regarding when or why it was marked through, and below that "2/25". The "Dosage & Administration" reflected "Adult 1 mg/1mL in each nostril" and "Indications" reflected "Suspected opiate overdose."
- "Epi pen", quantity "1" with unclear expiration date "3/25" and no dosage, administration or indication information.
The top of page 2 reflected it was a "Record of Inspection for Intact Seal and Expiration Date (Required Monthly)." The document had multiple spaces for recording signature, title, date and lock #. Review of the document reflected it was unclear and lacked evidence of seal and

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expiration inspections that were "required monthly".
- The first entry dated 11/10/2022 included signature, title and lock # 10572981.
- The next entry dated 03/16/ 2023 included a signature, title and lock # 10572989. There was no documentation that reflected the lock (seal) and expiration date had been checked between 11/10/2022 and 03/16/2023. It was additionally not clear why the lock # had changed.
- The next entry dated 04/11/2023 included a signature, title, "(inspection)" handwritten and no lock #. It was not clear what had been "inspected."
- The next entry dated 05/10/2023 included a signature, no title and lock # 10572996. It was not clear why the lock # had changed.
- The next entry dated 09/12/2023 included a signature, title, and the word "date" followed by a check mark, and no lock #. It was not clear what "date" had been checked.
- The next entry dated 09/15/2023 included a signature, no title and lock # 10285209. The documentation lacked evidence that reflected the lock and expiration date had been checked between 05/10/2023 and 09/15/2023. It was not clear why the lock # had changed.
- The next entry dated 03/05/2024 included a signature, title and lock # 10285209. The documentation lacked evidence that reflected the lock and expiration had been checked between 09/15/2023 and 03/05/2024.
* The "Emergency/Medical Equipment Checklist" dated revised "10/2023" in Finding 22.c. was observed with the cart.

24.b. During interview on 05/02/2024 at the time of the OSH-Salem IJ verification visit, ADM confirmed there was no number on the blue

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breakaway lock on the Red Emergency Cart. ADM stated that if the blue breakaway lock was broken, the Code Blue Team had replacement blue breakaway locks and would restock the cart and replace the lock.

25.a. During the OSH-JC IJ verification visit on 05/02/2024 beginning at 1410, the area "where admits come in" was observed by virtual remote monitoring with Interim DS, JCA, JC nursing staff and other hospital leadership. Observations included:
* A 6 drawer Red Emergency Cart. The outside of Drawers 1, 2, 3, 4 and 6 were labeled indicating the contents of the drawers. Drawer 5 was not labeled and no items were observed inside the drawer. The cart had red breakaway lock # 3842072 on the outside. This was inconsistent with observations of the AD Red Emergency Cart in Finding 24.a. above which had an unnumbered blue breakaway lock.
* The same "Admissions Code Blue Equipment Check Sheet" inventory list used for the AD Red Emergency Cart in Finding 24.a. above was observed.
Observation of cart labels, cart contents, and inventory list revealed inconsistencies between those. For example:
- A package of stethoscope ear pieces and diaphragms were observed in Drawer 2 and were not on the checklist or any of the drawer labels.
- Sterile tongue depressors, roll gauze and Coban were observed in Drawer 3 and were on the check sheet for Drawer 3, but were not observed on any of the drawer labels.
- A label on Drawer 3 reflected "Trauma sheers". Similar to AD, the check list reflected only "scissors" which could be confused with regular office type scissors.

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- A pulse oximeter inside Drawer 3 was labeled "Tx Mall 3" which could create confusion as to where that piece of equipment should be kept.
* An Emergency Medication Kit with breakaway lock # 3842071 was observed in Drawer 6. A document titled "JC Admissions Emergency Kit" was observed in a plastic sleeve with the kit and indicated Narcan and Epi pen were inside the kit. The document was similar to the document titled "Admissions Emergency Kit" observed with the Emergency Medication Kit during tour of AD during the IJ verification visit on 05/02/2024. However, there was no "Record of Inspection for Intact Seal and Expiration Date". The document included no evidence the Emergency Kit breakaway lock # was checked to ensure the lock had not been removed, contents tampered with, and medications readily available when needed.
* An "Emergency/Medical Equipment Checklist" for May 2024 dated revised "07/2021" was observed with the Red Emergency Cart. This was not the same version observed during tour of AD during the IJ verification visit on 05/02/2024 in Finding 24.a. above, nor the version in the P&P titled "Emergency and Multi-Patient-Use Medical Equipment" in Findings 22.b and 22.c. above.

25.b. During interview on 05/02/2024 with OSH-JC nursing staff and other hospital staff at the time of the remote OSH-JC IJ verification visit, the following information was provided:
* The hospital had a designated Code Blue Team that consisted of 2 staff. The same 2 staff covered JC and Salem campuses.
* The Code Blue Team had replacement breakaway locks for the Red Emergency Carts.
* The Code Blue Team tracked breakaway lock #s on Red Emergency Carts "whenever we call them".

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A 144	Continued From page 103 * They confirmed "Emergency/Medical Equipment Checklist" dated "07/2021" was observed with the Red Emergency Cart. ********** 26. The findings that follow reflect the hospital's failure to ensure an organized and coordinated medical emergency response: 27. Incident documentation recorded by LH1 NM, dated 04/18/2024 and untimed, reflected that "Staff came to my office inside the nurses station to advise me that a code blue (medical emergency) was needed for this patient as the code blue was being called over the radio. I responded, running down the south hall to the patient's room at 1115 as the code blue was being called via overhead page. When I entered the patient bedroom the patient was non-responsive, eyes closed, without respirations, without pulse (as assessed by another RN present). I advised that staff begin chest compressions and then I ran to obtain the crash cart/code blue cart. When I returned to the patient bedroom I opened the code cart, gave the code blue sheet and clipboard to unit [OS2 24] and assigned [them] to the recorder role. I then entered the patient bedroom and advised that staff move the patient from the patient bed onto the floor after the current set of chest compressions were complete. Staff used the patient's blanket to lower this patient from [their] bed onto the floor and resumed chest compressions. More staff entered the scene and the automatic external defibrillator was brought to the scene. A nurse took a position at the patient's head and administered 2 rescue breaths using the ambu-bag between each set of 30 compressions. I took the role of code lead and	A 144		

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asked staff to switch out with the person administering chest compressions to prevent physical exhaustion while counting chest compressions out loud. Staff continued to administer chest compressions and rescue breaths and the AED was attached to the patient. The AED analyzed and advised no shock, chest compressions and rescue breaths continued. Medical doctors and other staff continued to arrive and rescue attempts continued. This patient was pronounced deceased by our physicians at 1156 and at that time EMTs were present. It was later reported to me that the unit nurse assigned to the admission called for the code blue as this patient was being moved from the wheelchair to the patient bed by security and admissions office staff. Per staff report, the patient was slumped down in the wheelchair unable to maintain an upright posture while [they were] being transported to the unit."

28. Video recordings of the Code Blue medical emergency response for Patient 1 on 04/18/2024 revealed a disorganized and uncoordinated response as follows:

~ 1108:29 - Patient 1 was transported into the inpatient room in a w/c. RN 13 and other staff entered the room. Multiple staff entered and exited the room and others milled around outside the room with no demonstration of urgency. Another patient exited the patient room across the hall from Patient 1's room.
~ 1110:34 - MHST 14 walked at a leisurely pace and without urgency down the hall from the NS toward the patient room, pushed a mobile vital signs machine on wheels, and entered the patient room ~ 14 seconds later at ~ 1110:48.
~ 1111:56 - LH1 NM and Agency LPN 21 walked

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down the hallway from the NS towards the patient room at a quicker pace than previous staff, however, with minimal urgency. (The video observation is contrary to medical record documentation referenced under Finding 16 above, and incident documentation under Finding 27 above, that described the response of LH1 NM as "I responded, running down the south hall to the patient's room ...")
~ 1112:14 - LH1 NM ran down the hall away from the patient room toward the NS. More staff, some at a quicker pace, began to arrive and gather in the hallway outside of the patient room while some entered the room.
~ 1112:33 - Staff were observed to push a Red Emergency Cart down the hall from the NS toward the patient room. It arrived at the patient room at 1112:45 and was positioned outside the doorway of that room where it remained until it was pushed further down the hall away from the room after EMS arrived.

~ 1112:45 until the arrival of EMS at ~ 1124:01 video recording showed: More staff arrived and continued to enter the patient's room and gather in the hall. The number of staff gathered in the hallway between the patient's room and the NS, particularly in the vicinity of the patient's room, created increased congestion that presented an obstacle for navigation through the hall, including for other patients whose rooms were between Patient 1's room and the NS. At times there were 20 or more staff, and may have included patients, in the space outside the room and there was no way to determine how many were in the room as staff continued to enter and exit. The crowd that had gathered did not leave a clear pathway for EMS who arrived at ~ 1124:01 with ~ eight EMT and Fire responders, a gurney, and EMS

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equipment.

Additionally, during the scene described above, multiple staff in the hallway were observed to do nothing, staff lined up against the hallway walls, some staff stood on their tiptoes or crowded the doorway of the room to try to see in the room, others engaged in various discussions and activities. Agency RN 26 and Agency LPN 25 were observed to open and look in, or retrieve items from drawers on the Red Emergency Cart, and then they would leave the drawers partially open. (There was no incident or medical record documentation by either Agency RN 26 or Agency LPN 25 regarding their activities and tasks during the Code Blue.)

~ 1112:46 - OS2 24 was observed to stand immediately next to the Red Emergency Cart at the patient room doorway with a clipboard to which a form was attached, looked at their left wrist, and recorded something on the form. During the video the form was discerned to be the Code Blue Flow Sheet. During the duration of this code activity captured on the video recordings until ~ 1125:17 OS2 24 never entered Patient 1's room, and they were not positioned during much of that time to be able to observe the code activities that were being carried out in the room. For example: They were observed to wander in the hallway outside the room, they stood to the left of the doorway without a view into the room, they stood in the hallway approaching the opposite wall, they sometimes leaned forward to look into the room and sometimes that was through a number of other staff that crowded the doorway, they crouched down on their knees in the hallway to the left of the door, they sat down on the floor on their knees and lower legs in the

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hallway, they talked with other staff. Up until ~ 1124:39 OS2 24 had the clipboard in their possession. The video skipped ~ 10 seconds at that time. The next time recorded was ~ 1124:51 and OS2 24 was observed to walk down the hall away from the patient's room and further from the NS without the clipboard in their possession. (On 05/09/2024 at ~ 1500 staff that included the DNS, LH1 NM, CBC, PD, DQM, and DSC confirmed that the form OS2 24 could be seen writing on in the video was a Code Blue Flow Sheet, and that it was the same Code Blue Flow Sheet provided during the survey for Patient 1.)

~ 1124:33 - Staff present demonstrated a lack of situational awareness in relation to the placement of the Red Emergency Cart. When staff began to exit the scene and hallway a staff person pushed the Red Emergency Cart further away from the patient's room, further down the hallway from where staff were gathered, and further away from the NS. At ~ 1124:57 the only staff near the cart walked away from it and no staff looked in the cart's direction until 1125:16. The Red Emergency Cart had a suction machine placed on the top and at least two of the cart doors were partially open. The video recording provided ended at 1125:17.

29.a. While there were medical record entries by various staff about the Code Blue response, the Code Blue Flow Sheet for the 04/18/2024 response for Patient 1 was not complete. There were only three entries made on the form in the multitude of required boxes and spaces. Those were the Date, Time, Time of Code Blue, and a checkmark on the "Yes" box for AED utilization. Otherwise, there were several short unclear entries, some with associated times, written in the margins of the form. For example, "11:26 EMS"

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and "gray sweatshirt" and "8th." Nor was the form authenticated by whoever made the entries, including in the required space for "Recorder".

29.b. Incident documentation recorded by LH1 NM, dated 04/18/2024 and untimed, reflected they " ... gave the code blue sheet and clipboard to unit [OS2 24] and assigned [them] to the recorder role ... I took the role of code lead ... " However, review of the Code Blue Flow Sheet reflected the following spaces on the form were blank:
*"Team Captain:" and Team Captain "Title:"
*"Recorder printed name:" and "Signature:" and "Date:" and "Time:"

29.c. The "Medications administered" table on the "Code Blue Flow Sheet" had columns for "Time," "Medication," "Dose," "Route," and "Effect." Those spaces were completely blank. There was no documentation on the flow sheet related to the administration of the Narcan that was identified as given in incident and medical record documentation. Nor was the dose given found in any of that documentation. Further, the incident and medical record documentation related to the Narcan order and administration was unclear and inconsistent as follows:
* A Nursing Progress Note written by LH1 RN 13 and dated and timed 04/18/2024 at 1304 reflected in regard to Narcan administration that "Narcan was requested and administered by [PMHNP 23]."
* A Psychiatry General Note written by psychiatrist MD 30 and dated and timed 04/18/2024 at 1451 reflected in regard to Narcan administration that they "gave telephone order to [Agency LPN 21] RN [sic] for Narcan to be administered to the patient. [PMHNP 23]

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administered the intranasal Narcan prior to EMS arrival (at approx. 1125-1126). Intranasal Narcan was the only formulation we had on hand on the unit at this time, per staff report."
* A Psychiatry General Note written by psychiatrist MD 27 and dated and timed 04/18/2024 at 1838 reflected in regard to Narcan administration that "When I was informed that [Patient 1] had not received Narcan yet, I ordered the Narcan be given, presuming that both it would be safe in the absence of potential intoxication/overdose and also that it would be potentially extremely beneficial if [the patient] were intoxicated/obtunded from opioids. Nursing staff went to obtain this and it was given via intranasal route several minutes later."
* Incident documentation by Agency LPN 21, dated 04/18/2024 and untimed, reflected that "[MD 30] and [PMHNP 22] gave TO for narcan, I ran to grab the narcan and handed it to nurse that was by patient side."
* Incident documentation by Agency RN 12, dated 04/18/2024 and untimed, reflected that "Nasal Narcan administered as ordered without effectiveness result."
* An "Oregon State Hospital Non-Medication Telephone Orders" form that contained a medication order dated 04/18/2023 at 1120. The order was written as "Give Narcan 4 mg intranasal x1 now for unresponsiveness." The handwritten entry in the "Nurse Printed Name" was barely legible [Agency LPN 21]. The handwritten entry on the "Nurse Signature" space was illegible and was followed by what may have been written as "LPN" although it was difficult to discern. The "Date" and "Time" of the nurse signature was 04/18/2024 at 1130 and there was an initial in the "Nurse 'Readback' Initials" space. The print and signature name of an [PMHNP 22]

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followed the nurse's information and was dated and timed 04/24/2024 at 1102, six days after the event. There were no other LIP orders in the medical record.

* There were no medical record or incident notes related to Patient 1 by PMHNP 22 who was identified in documentation as having ordered Narcan and who signed the Telephone Order for it.
* There were no medical record or incident notes related to Patient 1 by PMHNP 23 who was identified in documentation as having ordered Narcan and as having administered it. .
* Each of the medical record and incident notes written by the two MDs, an RN, and an LPN reflected that Narcan was ordered by different LIPs.
* In the incident documentation by Agency LPN 21 they wrote they "grabbed" the Narcan and then handed it to another "nurse." There was no documentation by Agency LPN 21 or the other "nurse" to reflect who that "nurse" was and what that "nurse" did with the medication.
* In the incident documentation by Agency RN 12 their note was written consistent with the way a nurse who administered the medication would document and as if RN 12 had administered the Narcan.
* There was no documentation of Narcan administration by the person that administered the medication in the medical record or on the Code Blue Flow Sheet.

29.d. Incident documentation recorded by [TM 34], dated 04/18/2024 and untimed, reflected that "As compressions continued, I was tasked with gathering staff's names that were involved or present for the medical emergency ... I provided

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the list of staff members involved to LH1 Unit Administrator [UA 35]." It was unclear whether the names and roles of all staff who presented and gathered as observed in the video recording had been identified. There was no documentation included on or with the Code Blue Flow Sheet that identified all staff who presented or participated.

29.e. Further, the following spaces on the Code Blue Flow Sheet were blank:
* "Time of onset:"
* "Location:"
* "Chief Complaint:"
* A table with seven columns for "[time, blood pressure, pulse, respirations, temperature, pulse oximetry on room air or supplemental O2, blood glucose]"
* "Pertinent physical findings:"
* "Defibrillation: __No __Yes" and "How many times:" and "Successful: __No __Yes"
* "EMS called at:" and "EMS arrived at:"
*"Physician/nurse practitioner called hospital at:"
*"Patient transported by: __N/A __OSH transport __EMS Time:"
*"Disposition of patient:"
*"Emergency contact called: __No __Yes Name: Relationship: Phone number:"
*"Provide copies of the following to the EMS Team: __ Medication administration record __Vital signs flow sheet __ Laboratory data __Emergency medical transfer report __ Diagnostic (e.g., EKG) __ Medical H&P"

30.a. The P&P titled "Code Blue Medical Emergency" dated 01/21/2020 was reviewed. It stated that "[OSH] will provide immediate response to any medical emergency that presents anywhere on campus and requires a

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A 144	Continued From page 112 coordinated team effort ..." The P&P attachment, "Procedures A," consisted of a table with two columns for "Responsible Person/Group" and "Procedures." Those persons were listed as: - "First responder" - "Second responder" - "Security" - "Team Captain" - "Physician/NP/RN" - "Equipment Monitor" - "Airway Rescuer" - "Recorder" - "Communicator" - "Crowd Control Monitor" - "Photocopy" 30.b. Duties delineated for each role/title were vague and unclear. For example: * The "Team Captain" duties included: "Assign roles and responsibilities ... Assist with completing the Code Blue Flowsheet ..." * The "Equipment Monitor" duties included: "Verify all of the emergency equipment arrives to the scene ... Prepare and hand out equipment as needed or directed by the Team Captain ... Monitor emergency equipment throughout the incident." * The "Recorder" duties included: "Complete the Code Blue Flowsheet." * The "Crowd Control Monitor" duties included: "Maintain safety of the scene and milieu as necessary ... Verify essential personnel have access to the scene, person, and emergency equipment ... Request the Communicator cancel responders when sufficient responders have arrived at the scene ..."	A 144		

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A 144	Continued From page 113 30.c. The procedures were not clearly written to ensure staff were trained and knowledgeable to be able to competently carry out the required duties/tasks in an organized and coordinated manner. For example: * It was not clear how roles were to be assigned and how and where those were to be recorded. * It was not clear what "assist with" completing the Flowsheet meant. * It was not clear what "emergency equipment" was to arrive to the scene and what was meant by "monitor emergency equipment ..." The equipment was not specified, nor was there reference to other applicable P&Ps. * There was no direction r/t where the Recorder needed to locate themselves, and otherwise obtain the necessary information, to ensure they could clearly and completely "Complete the Code Blue Flowsheet." * It was not clear how the "safety of the scene and milieu" was determined, who "essential personnel" were, or who and how many persons were considered "sufficient responders." * It was not clear who was responsible to monitor and manage the presence of other patients at or near the scene to ensure safety of those patients and others. * There were no mentions of emergency medications or reference to other applicable P&Ps. It was not clear which role was to obtain and prepare Code Blue medications, from where those were to be obtained, and who was to administer them. 30.d. The review of the Code Blue video recording and the Code Blue documentation for Patient 1 failed to demonstrate that roles and responsibilities for all Code Blue positions had been assigned and that duties/tasks had been	A 144		

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carried out. Further, the Code Blue Flowsheet used during Patient 1's Code Blue did not align with the procedure requirements in Procedures A.

31.a. During interview with staff that included the DSC, DLD, and OBC on 05/06/2024 beginning at 1235 they confirmed the Code Blue training dates for the AD RNs 1 through 4 and stated there were no drills or hands-on practice, return demonstrations, or competency evaluations associated with those trainings, including during annual "refreshers." They further stated that hospital-wide Code Blue drills had not been conducted since the Covid-19 pandemic. They stated those were recently resumed on 04/23/2024 and that on that date on the OSH-Salem campus 54 staff participated in Code Blue drills, and on 04/26/2024 on the OSH-JC campus 13 staff participated in Code Blue drills. They further confirmed that none of the four AD RNs had been present or participated in the Code Blue drills conducted on 04/23/2024 and 04/26/2024.

31.b. Review of AD RN Code Blue training records reflected the following:
* For RN 1 the documentation showed that since 2020 they had a 20-minute online Code Blue training on 03/26/2020, an online Code Blue training on 04/24/2021, and a 30-minute Code Blue "refresher" on 02/27/2023 during 2023 Annual Training.
* For RN 2 the documentation showed that since 2020 they had a 30 minute Code Blue "refresher" on 04/02/2024 during 2024 Annual Training.
* For RN 3 the documentation showed that since 2020 they had a 20-minute online Code Blue training on 05/07/2020, an online Code Blue training on 03/12/2021, and none since.

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A 144	Continued From page 115 * For RN 4 the documentation showed that since 2020 they had a 20-minute online Code Blue training on 04/18/2020, an online Code Blue training on 05/08/2021, and none since. ********** 32.a. The findings that follow reflect the hospital's failure to ensure there were formal, written, and approved P&Ps and other resources for AD patient care operations, and that AD staff were knowledgeable and competent to perform their duties. 32.b. Review of the "Oregon State Hospital - Salem Organizational Structure" chart that was "Last Updated 4/1/24" showed that the AD, the ADM, and the RNs who worked in the AD, reported to the OSH Deputy Superintendent in hospital administration and were not part of the Nursing Department. 32.c. Review of the AD Staff List provided reflected that the ADM's title was "Business Operations Manager." There was no indication in information gathered during the survey that the ADM who was assigned oversight and responsibility for the AD RNs and the nursing and patient care services provided in the AD was an RN themselves. Further confirmation was provided by the DSC in an email on 05/16/2024 at 1503 that the ADM was not an RN. 32.d. During interviews on 04/24/2024 beginning at 1030, on 04/25/2024 at 1230, on 04/25/2024 beginning at 1340, and on 05/02/2024 beginning at ~ 1300 the following information was provided or confirmed. Staff that were included in one or more of those sessions included the ADM, AD RN 1, DSC, DQM, Interim DS, DLD, OBC, and	A 144		

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other nursing, education and S&C staff:
* The hours of operation of the AD were Monday through Friday business hours. There were four AD RNs who worked eight-hour shifts with slightly staggered start times.
* The AD RNs were not part of the Nursing Department and did not fall under the direction of the CNO. Rather, the oversight of the AD operations was the responsibility of hospital administration.
* Nursing Department P&Ps did not apply to the AD RNs.
* There were no formalized, written, and approved P&Ps for AD patient care operations and procedures.
* There were no provisions for direct observation of patients at the time the transport van entered the Sally Port, nor direct observation of patients who waited in transport vehicles upon their arrival to the hospital's premises prior to the transport van entry into the Sally Port.
* Systems and processes for Nursing Department staff orientation, onboarding, and annual training did not apply to the AD RNs.
* There was no formal and organized AD orientation and onboarding program, and that there was no documentation of AD orientation and onboarding for the two most recent AD RNs who started in 08/2023, and no documentation of competency evaluations.
* The onboarding process for AD RNs was described as "shadowing" one of the other two AD RNs on "how to get people into the door with the deputies" for "usually about two weeks before they're turned loose." There were no
* Two manuals were presented as the only written resource documents for AD patient care operations and procedures. They were not current or approved, and contained unclear and

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inconsistent information related to patient care operations.

32.e. A manual titled "Admissions Department" had the date 04/05/2024 at the bottom of each page. It contained unclear information and was incomplete. For example:
* It contained sections and paragraphs that had language written in red ink and some written in purple ink. It was unclear what those denoted. During interviews referenced above the ADM stated that the purple was the "nursing" section, and the red was language that needed to be updated.
* On Page 5 of the manual it described that AD personnel included four MH Triage RNs. It further stated that "Each position with the [AD] plays a pivotal role ... Each staff in these positions have a duty to perform their positions ... in accordance to [sic] all policies and procedures set by OSH and the Admissions Director for all department functions." However, during interviews referenced above there were no AD P&Ps.
* A yellow highlighted excerpt on Page 20 of the manual was written was "The [MH] Triage RN will document in a closing note, at minimum, how the patient presented upon arrival ... check vitals (O2), Temp, and BP, when possible ..." The date on the bottom of that page was 04/05/2024, prior to the 04/18/2024 admission of Patient 1. However, during interviews referenced above the ADM stated that that although the manual reflected last revisions were made on 04/05/2024, the excerpt had been added to the manual after the Patient 1's 04/18/2024 admission and after the 04/19/2024 CMO Directive. In a written response from the ADM received on 05/02/2024 they wrote in regard to confirmation of the date and time that the edit had been "This is not

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possible."
* In addition, the added excerpt was unclear about the extent of vitals to be taken as it said to check vitals, but specified only Temp, and BP, when possible.
* The Admissions Department manual contained no reference to medical emergency response, or maintenance of emergency supplies or equipment in the AD.

32.f. A manual titled "Mental Health Admissions Triage Nurse" contained unclear information and was incomplete. For example:
* Written at the bottom of various pages of the manual were dates of 06/13/2021, 06/25/2021 and 07/13/2022. It was unclear what date the manual was last determined to be current.
* In the manual on a page titled "Day of Admission" with the date 06/13/2021 at the bottom of the page there were three paragraphs. One included direction for the MH Triage RN to obtain a temperature on patients upon arrival. That was not done for Patient 1 on 04/18/2024 and staff confirmed during the interviews referenced above that there was no written AD P&P for that practice.
* Although the AD operated M-F day shift hours and was only staffed with AD RNs at those times, the manual reflected that "Evening, Nights, and Weekends Admissions" could occur. It was unclear how those would be managed, including whether patients would be assessed and vitals taken. During the interviews referenced above the ADM indicated there were no P&Ps for that at this time and that they needed to develop a process to include PNMs for after hours admissions.
* The manual contained a copy of a seven-page "Sentinel Event Alert" published by The Joint Commission dated 09/12/2017. It was unclear

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A 144	Continued From page 119 what it's purpose was as there was no explanation for that elsewhere in the manual. * The manual included a P&P for restraints with a date of 12/21/2020. It was confirmed that was not the current version of that P&P. * The manual contained a copy of the P&P for "Admission of Patients with Medical Problems" dated 10/03/2018 that directed that "If a newly admitted patient experiences an emergency medical condition. OSH will provide emergency care as indicated in OSH Policy 8.002 ..." However, there was no other information in the manual for medical emergency response in the AD, including for maintenance of emergency supplies or equipment. **********	A 144		
A 385	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: ********** Based on observations, review of video recordings, interviews, review of incident and medical record documentation for 1 of 1 patient (Patient 1), review of 4 of 4 AD staff training records (RNs 1, 2, 3, and 4), review of OSH internal investigation documentation, review of medical emergency supplies and equipment documentation, review of medical emergency response documentation, review of training documentation, and review of P&Ps and procedural manuals, it was determined that the	A 385		

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hospital failed to fully develop and implement P&Ps that ensured that the nursing services provided were under the supervision of an RN, that patient needs were met by ongoing nursing assessment, and that nursing personnel responded to the nursing and emergency care needs of the patient population of each department.

The cumulative effect of these systemic failures resulted in this Condition-level deficiency that represents a limited capacity on the part of the hospital to provide safe and adequate care.

Findings include:

1. Refer to the findings cited under this Condition at Tag A-392, CFR 482.23(b) - Standard: Staffing and Delivery of Care, that reflects the hospital failed to ensure that the nursing services provided were under the supervision of an RN, and that nursing personnel were knowledgeable regarding patient assessment to ensure appropriate and timely response to the nursing and emergency care needs of the patient population of each department (A392).

2. Refer to the findings cited at Tag A-115, CFR 482.13 - CoP: Patient's Rights, that reflects the hospital failed to fully develop and implement P&Ps that ensured each patient's right to receive care in a safe setting. The hospital's failures to ensure appropriate patient assessment and provisions for response to medical emergencies created an unsafe EOC that likely contributed to harm and death of one patient and created the likelihood of harm to other patients (Tag A-144).
****

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A 392	STAFFING AND DELIVERY OF CARE CFR(s): 482.23(b) The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for care of any patient. This STANDARD is not met as evidenced by: ********** Based on observations, review of video recordings, interviews, review of incident and medical record documentation for 1 of 1 patient (Patient 1), review of 4 of 4 AD staff training records (RNs 1, 2, 3, and 4), review of OSH internal investigation documentation, review of medical emergency supplies and equipment documentation, review of medical emergency response documentation, review of training documentation, and review of P&Ps and procedural manuals, it was determined that the hospital's failures to fully develop and implement P&Ps that ensured nursing services were under the supervision of an RN, and that nursing personnel were knowledgeable and competent to provide appropriate and timely patient assessment and response to the nursing and emergency care needs of the patient population of each department included: * Failure to ensure AD RN and inpatient RN staff relied upon independent nursing judgement to provide appropriate and timely assessment of patient condition and identification of the need for medical emergency response. * Failure to ensure RN staff requested the	A 392		

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immediate presence of a physician when the patient's unresponsive physical condition was believed to be behavioral versus medical.
* Failure to ensure that an RN supervised the nursing services in the AD and that AD RN practices for patient care were in accordance with, and supported by, written and approved P&Ps, and that they completed organized and documented AD orientation and onboarding that ensured clinical and procedural competency for patient care operations in that department.

Findings include:

1. The findings that follow reflect that RN staff failed to conduct appropriate and timely assessment and vital signs for Patient 1 who arrived at the hospital from jail. When AD RN first observed the patient in the transport vehicle they stated they saw the patient's eyes open briefly. That was the only detectable movement the patient made between the time they were transferred from the back of the transport vehicle until another RN who had accompanied the patient for transport from the AD through the hospital to the inpatient unit checked for a pulse after the transport and entry into the patient's assigned inpatient room. Neither of those RNs made independent decisions using their own nursing judgement that would call for an immediate assessment and emergency response to an unresponsive and motionless person. Instead those RNs inappropriately deferred to, believed without reasoning or questioning, and acted upon DC deputies' characterizations of the patient's unresponsive condition as being purposeful as in "choosing not to walk," "won't stand up," and "refusal to respond," "normal" and "usual," and "catatonic." Those RNs failed to

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request the immediate presence of a physician to evaluate whether the patient's unresponsive physical condition was behavioral versus medical. Refer to Tag A-144 for additional information regarding Patient 1's encounter.

2. A document titled "OSH Office of Quality Management" was reviewed. It included the following information:
* "Incident Nature: Sentinel Event - Unexpected Patient Death"
* "Date/Time of Incident: 04/18/2024 1115hrs"
* "At approx. 1047 hrs. access control informed admissions Douglas County jail transport were waiting with [Patient 1] for admission to OSH. Staff arrived and the country [sic] transport vehicle entered a Sally Port, at approximately 1054 hrs. Deputies told [RN 4] [that Patient 1] would need a wheelchair because [they were] 'catatonic' and at times 'flops around like a fish'. This was reported to have been described to nursing staff as normal behavior by [Patient 1]. As [Patient 1] was transferred from the transport van to the wheelchair, at approximately 1101 hrs, the admission [RN 4] reported [they] observed [Patient 1's] eyes open and close, possibly in response to light hitting [Patient 1's] eyes. [Patient 1] was wheeled into OSH admissions at approximately 1102 hrs. Additional staff were called to the admissions area and assisted in photographing [Patient 1] for identification. Douglas County transport restraints were removed from [Patient 1] and [they were] taken, via wheelchair, to Lighthouse 1 by OSH Staff. During this process [Patient 1] was noted as not moving on [their] own accord and staff held the patients [sic] legs up with a blanket so [their] feet would not drag on the floor. Staff and the patient arrived on the unit at approx. 1107hrs. where the

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patient was taken directly to a patient room. As [Patient 1] was being transferred to the bed an RN decided to check the patient for a pulse and found none. Sternal rubs were done with no response and additional checks found no pulse. A Code Blue was initiated and additional staff arrived and life saving procedures were performed including the use of CPR and an AED. Narcan and epinephrine were administered and were ineffective. Paramedics arrived at approx. 1121hrs and took over life saving efforts. [Patient 1] was pronounced dead at 1156 hrs."

3.a. During review of incident documentation and hospital response with staff that included the Interim DS, DQM, DSC, COP, COM, DOS, PD, BOM1, and AAG on 04/24/2024 beginning at 1440 staff described the hospital's investigation and actions taken to date. A document titled "Investigative Memo," dated 04/24/2024 provided a summary of the information given by staff during the incident and response review on 04/24/2024 and included the following:
* "Date of incident: 4/18/2024"
* "Incident Nature: Unexpected patient death"
* "The purpose of this memo is to document the investigative process and immediate actions associated with the unexpected patient death on 4/18/2024, [Patient 1]."
* "Actions in response to preliminary investigative findings: Video review and policy evaluation identified no policy requirement for vitals check on new admissions. On 4/19/2024 OSH Interim Superintendent [and CMO] memorialized 'CMO Directive - Admission vitals 4-19-24' based on initial investigative findings that vitals were not taken of the patient upon admission."

3.b. Review of the document on OSH letterhead,

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signed by the CMO/Interim OSHS and dated 04/19/2024, reflected the following:
"To all OSH staff, This CMO Directive modifies and adds to OSH policy 6.058, 'Admissions.' To ensure that patients who may be medically unstable on arrival are promptly assessed and receive necessary medical care as soon as possible, it is my directive, effective April 19, 2024, that:
* An Admissions RN must perform a brief assessment for every patient admitted to OSH, including - at minimum - vital signs and visual observation to identify any medical needs requiring immediate attention, before the patient leaves the Admissions area. This assessment must be documented in the patient's medical record.
* If a patient is not responsive to staff in the Admissions area, the possibility of a medical emergency must be immediately assessed.
* If a patient is too combative to safely obtain vital signs, this must be communicated to the unit RN and documented in the medical record, along with the nature of the patient's behavior.
This directive will remain in effect until policy 6.058 is updated."

4.a. During interview on 04/24/2024 at 1105 with RN 4, they stated they had worked in AD since August 2023. RN 4 provided the following information regarding Patient 1:
* A "Douglas County" transport van pulled into Sally Port 8 drive-in garage. The deputies said the patient would need a wheelchair because they had not been able to get into the van themselves and had been "flopping around like a fish." The deputies stated that was the patient's baseline.
* RN 4 stated they got a wheelchair for the patient

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and went to the back of the van with a security staff. The patient, who was in the back of the van, "opened their eyes and moved a little". RN 4 introduced themselves to the patient. The deputies told the patient, "We'll get you out [of the van]" and the patient closed their eyes. RN 4 stated "I thought [the patient was] not being cooperative" and asked for more security staff. RN 4 stated 5-6 security staff came. The deputies gave the patient a few minutes to get out of the van and when they did not, the deputies lifted the patient to the wheelchair. RN 4 stated the deputies held the patient's legs up while they wheeled the patient backwards from the van into the AR.

* RN 4 stated in the AR "we got a photo of the patient for [their] ID" and the deputies said it would be OK to remove the patient's cuffs because they had never been aggressive. The deputies removed the cuffs. The patient was not able to hold their head up and "kept [their] eyes closed." RN 4 stated the patient was slouched with their head to one side, and "not holding it up like a normal person holds their head."
* RN 4 stated "typically we take a temperature and ask about a cough" in the AR. RN 4 stated they did not check the patient's temperature or any other vital signs and did not ask the patient if they had a cough. When RN 4 was asked if the patient was breathing, they stated, "I didn't observe any chest rise and fall." In response to the surveyor's follow-up question in regard to indications of oxygenation such as the patient's skin color and appearance, RN 4 additionally stated that the patient "was African American, had dry skin, and I didn't notice anything abnormal."
* RN 4, a unit nurse, and security staff pushed the patient in the wheelchair from the AR to LH1. One of the security staff lifted the patient's legs with a

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blanket so their legs wouldn't drag. When they got to the patient's room on the unit, the unit RN and 2 security staff laid the patient supine on the bed. RN 4 stated, "At that point, I knew something was off because there was no response from the patient, so I checked for a pulse. Nothing. I checked a sternal rub and nothing." The patient had no pulse and was not breathing, and they called a code blue.

4.b. Incident documentation recorded by AD RN 4, dated 04/18/2024 and untimed, reflected that "Access control called the main admissions office phone at around 10:47 to report that Douglas County was waiting to get into Sally port 8 for an admission. Douglas County was scheduled to drop off two admits to OSH today on 4/18. [Patient 26] who was scheduled to admit to FW1, and [Patient 1] was scheduled to admit to LH1. The Douglas county transport van was waiting in the circle outside of OSH for roughly 5-10 minutes, due to there being a secure transport van in Sally Port 8. [RN 3] admissions RN, went outside Sally port 9 to talk to the Douglas county officers to find out how the pts were doing. When [RN 3] came back through Sally port 9, [they] reported to me ([RN 4] Admissions RN) that the officers said [Patient 1] will need a 'wheelchair' because [the patient] 'flops around like a fish' and is 'catatonic'. After secure transport left Sally port 8. Douglas county pulled into Sally port 8. FW3 unit staff showed up first, and [RN 3] who was assigned to admit [Patient 26] brought in [Patient 26] and introduced them to the FW3 staff and that pt was taken to FW3. [Patient 1's] unit staff from LH1 ([RN 13] along with unit MHT) showed up next. I was assigned to admit [Patient 1] as I had done [their] pre-admit note in avatar as well as a nurse to nurse with the jail RN. The deputy

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standing in the admissions area adjacent to Sally port 8 then reported to me, '[Patient 1] won't stand up, [they're] catatonic. [They'll] need a wheelchair'. RN asked the deputy '[They] won't stand at all?', and deputy responded 'No'. Wheelchair and a blanket was obtained by this RN. [MHST 18] was the security assigned to help with admissions for 4/18. As Sally port 8 doors were opened by access control, [MHST 18] held open the doors while this RN followed deputies to the back of the van with the wheelchair. The deputies opened up both doors to the back of the van. [Patient 1] was seen sitting in a slumped position with [their] back against van partition. As soon as the van doors opened, there was sunlight that came streaming into the back of the van, and this RN could see [Patient 1's] eye open and close. Deputies said to [Patient 1] that they needed [them] to get into the wheelchair and gave [the patient] a few seconds but pt did not make any movements or indication that [they were] going to get up. Deputies then assisted pt on either side and lifted the pt into the wheelchair. RN introduced [themselves] to [Patient 1] and explained [they were] at the hospital but pt did not respond. RN asked for pt to lift [their] legs, so [they] could be wheeled, but [Patient 1] did not lift [their] legs. Both deputies each lifted one of the pt's legs by the pant leg so [the patient's] heels would not be dragging, and this RN wheeled [Patient 1] backwards into the adjacent admitting room connected to Sally port 8. [MHST 18] had called for additional security at the request of this RN, who were also present in the admitting area. A photo was obtained of [the patient] for [their] ID badge for security, but [they] did not open [their] eyes. This RN was assessing whether or not the cuffs should be removed in the admitting area, or on the unit for safety, when officers reported that

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they did not see [the patient] as a threat, and [they] had 'never been physically violent'. This RN gave the directive for officers to remove the cuffs as pt was not exhibiting any signs of aggressive behaviors. Cuffs were removed by officers. Pt was wheeled by security to LH1, with one security wrapping a blanket underneath pt's legs and lifting them up so they did not drag on the floor. Admissions RN and unit staff followed as well. Pt was taken onto LH1 unit, and down one of the first hallways on the right hand side as you enter the unit, where the pt's assigned bedroom was. Pt was wheeled into [their] room, and staff informed [the patient] that it was [their] bedroom and [they] could get up. One staff member said '[Patient] won't get up, [they're] catatonic'. Security and unit RN and another staff lifted the pt onto the bed. Pt was now in a supine position on the bed. Unit RN, [RN 13], then began doing [their] assessment. [RN 13] tried verbal stimuli, yelling pt's name, checking radial and pedal pulse, checked for breathing. This RN checked for radial pulse on the right side, and there was no pulse felt. This RN confirmed with [RN 13] there was no pulse. Compressions were started, and a code blue was called on the radio by security. Crash cart was obtained with AED. Pt was moved to the floor in supine position for compressions and ambu bag was used for breath. 911 was called. Two OSH medical doctors arrived. AED advised no shock. EMS arrived and took over care."

5. Incident documentation recorded by LH1 RN 13, dated 04/18/2024 and untimed, reflected that "I was the RN assigned to [Patient 1's] admission along with [MHT2 8]. We were called to the admission Sally Port around 1100 and waited in line as the county had two patients and the first was going to a different unit. [MHT2 8] and I

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remained outside the Sally Port per protocol, waiting for report from [AD RN 4]. It was reported that the pt was not cooperating, would not walk, and [AD RN 4] retrieved a wheelchair. Security arrived at the Sally Port, evidently having been paged by admissions. The pt was retrieved from the transport vehicle utilizing the wheelchair and brought into the Sally Port; I was not able to observe the pt from my vantage point outside the Sally Port. It was reported to us that the pt was continuing to be uncooperative and not responding. Two security staff wheeled the pt out of the Sally Port, one pushing [TMHA 19], the other holding the pt's legs up with a blanket draped under [the patient's] ankles ([MHST 20], switched with [MHST 17] at some point). We quickly made our way to LH1; I walked alongside the wheelchair, attempting to engage the pt, explain the plan. We passed the bubble on LH1 at 1111. We had decided to take [Patient 1] directly to [their] room and transfer [them] to [their] bed. On arrival to [patient's] room, security [TMHA 19] and I immediately lifted the pt out of the wheelchair and onto the bed. During that transfer, I noted the pt was more limp than would have been expected from a simply unresponsive pt. I immediately began checking for a pulse on [their] R wrist and began calling [their] name loudly. I performed sternal rubs when I could not elicit a response verbally. When there continued to be no response I requested staff call a code blue (code was called @ 1114). I then attempted to find a pulse under [the patient's] upper arm, carotid, pedal while continuing to attempt to rouse [them] verbally and with sternal rubs and watch for chest rise (this was difficult to assess as [the patient] was in loose fitting jail clothing). I pulled open [the patient's] eye lid and noted a dilated pupil; I used my flashlight to test reactivity and no

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reactivity was seen. Staff arrived quickly and we began chest compressions (@ 1115). Staff arrived with the AED and crash cart. After applying the AED pads, we transferred the pt to the floor to have a more firm surface and continued compressions alternating with AMBU bag respirations following CPR protocol. Narcan was requested and administered by [PMHNP 23]. Various staff and medical personnel rotated through administering compressions and AMBU respirations. CPR was continued per protocol, following prompts from AED (no shock ever advised) until paramedics arrived and took over the situation."

6.a. The incident documentation described under Findings 6.b. through 6.g. below include further indications that Patient 1's unresponsive and concerning condition was evident yet RN 4 failed to assess and respond and allowed staff to remove the patient's motionless body from the AD and transport them throughout the hospital, and RN 13 failed to assess and respond at the time they assumed care of the patient outside of the AD.

6.b. Incident documentation recorded by MHST 18, dated 04/18/2024 and untimed, reflected that "I, [MHST 18], was the admissions security staff to assist during the admit with the new patient [Patient 1]. There were two patients from Douglas County admitting today and [Patient 1] was the second one to come in at approximately 1105. When the Deputies arrived, they had let us know that this patient was not talking or moving but that this was usual for [them]. They recommended that we bring a wheelchair due to [the patient] choosing not to walk but that it was "[their] normal" per the deputy. They mentioned that they

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had to help place [Patient 1] into the vehicle to bring [them] here to OSH. [AD RN 4] took a wheelchair to the van where the patient was sitting. The officers asked the patient to exit the vehicle a couple times to which the patient did not move. I am unsure as to who helped the patient exit the vehicle and place [them] into the wheelchair. I stood holding the door at sallyport 8 open and called for additional security. Additional security responded. [AD RN 4] introduced [themself] when [they] entered the building, then I introduced myself and let [the patient] know I would be taking [their] photo for [their] OSH ID badge. I took [the patient's] photo. [AD RN 4] asked [the patient] to contract for safety and there was no response. The deputies assured us that the patient would be safe and that this is just how [they were]. So [AD RN 4] gave them the go ahead to remove the cuffs. Another security staff asked, "is [the patient] catatonic?" and the deputies responded saying "pretty much."

6.c. Incident documentation recorded by TMHA 19, dated 04/18/2024 and untimed, reflected that "The admissions [RN 4] made the decision to have the deputies remove the restraints before we moved the patient to Lighthouse 1, after the restraints where removed I grabbed the wheelchair handles while [MHST 20] held up the patients' legs with the assistance of a blanket while we moved the patient to Lighthouse 1. On arrival to the unit, we moved [the patient] into [their] assigned room (unknown number), the unit nurse who accompanied us from admission to the unit [RN 13] asked that we move [the patient] on the bed. [MHST 14] grabbed the patients left shoulder while I grabbed the right shoulder and [RN 13] grabbed [the patient's] legs and we move [sic] the patient from the wheelchair on to the

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bed. The patient was still [sic] appeared to be in [sic] catatonic at that time. After assisting with the movement, I left as I was already late for my assigned lunch period."

6.d. Incident documentation recorded by MHST 16, dated 04/18/2024 and untimed, reflected that "... a call came over the radio for additional security assistance at Sallyport 8 with a new admit at 11:03. As I got closer to Sallyport 8 I could see security staff and two sheriff deputies standing in a semicircle around [Patient 1], who was still out of view to me in the admissions room attached to sallyport 8. There were two unit staff, [RN 13] and [MHT2 8], standing outside the room waiting for the admit per protocol, as I tried to quietly enter the room to not disrupt anything. I could see the admissions [RN 4], standing next to [Patient 1] attempting to get [them] to respond and open [their] eyes, but [they] just sat slumped in the wheelchair, in full cuffs, and unresponsive. Someone leaned over to me to let me know that this was a behavior, and I took that to mean that this situation was going to be unpredictable due to this being a new admission with no prior hospitalization. It is protocol to hear the patient agree to safety before we can release [them] from [their] cuffs. The deputies mentioned that [the patient] hadn't been violent, that all their assistance was because [they were] 'catatonic' and refused to respond. I saw that the unit staff had propped open the door to listen, so I stepped out to fill them in on what the deputies had said. When I came back into the room, they started to remove the cuffs, so I left the room again to open doors ahead of them to ease the transportation process. [TMHA 19] was pushing the wheelchair while [MHST 20] was holding [the patient's] legs up with a blanket, so [their] feet didn't drag on the

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ground. Halfway there, [MHST 17] swapped out with [MHST 20] and carried the patient's legs in a blanket. Once we got to the patient's new unit, LH1, [RN 13] wanted to assess the patient in [their] room (Room# G02-143) so [RN 13] and security staff lifted the patient from the chair to the bed. [RN 13] sent someone to grab the vitals machine while [they] continued to rub on the patient's chest, tap [their] shoulders, and shout [their] name. I stood out in the hallway due to patients walking by the room, redirecting them as they came near."

6.e. Incident documentation recorded by MHST 17, dated 04/18/2024 and untimed, reflected that "When I arrived at Sally Port 8, I saw the admission, [Patient 1] slouched down in a wheelchair unresponsive with closed eyes. Admission [RN 4] asked the two deputies from Douglas County how [Patient 1] has [sic] been on the way over from Douglas County? One of the deputies stated, 'This is how [the patient] always, [sic] is unresponsive and is catatonic.' [RN 4] was attempting to get a response from [the patient]. One of the deputies stated, '[the patient] is not violent we just needed to get [them] out of the truck by force because [they were] not cooperating with us.' [RN 4] stated [they] did not want to transport [Patient 1] in the wheelchair with [their] feet being dragged. [TMHA 19] stated we can use a blanket to hold [the patient's] feet up and have someone hold the blanket while escorting the patient. [MHST 20] began to assist with holding the blanket while [TMHA 19] was pushing the wheelchair to Lighthouse 1. I relived [sic] [MHST 20] due to [them] needing a break. Once we arrived on Lighthouse 1 in the main entry hall, [the patient] continued to slide down in the wheelchair I asked security to assist me in

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helping move up [Patient 1] in the wheelchair. Staff then entered the south hall and went into room G02-143. [RN 13] and [TMHA 19] and I assisted [the patient] to [their] bed. [RN 13] began to do an assessment on [the patient] and began to check [their] pulse on [their] right wrist, [RN 13] stated [they were] not feeling any pulse."

6.f. Incident documentation recorded by MHST 20, dated 04/18/2024 and untimed, reflected that "I responded to a call for security assistance at Sally Port 8. When I arrived, I saw Douglas County Deputies and OSH staff were standing around a patient, later identified as [Patient 1], that was in a wheelchair. The Deputies described [the patient] as being catatonic. I asked the Deputies if [the patient] had been responsive at all during the trip, they said that [the patient] was moving up and down in the back of the van. I then turned towards [the patient] and addressed [them] loudly and there was no response. I observed that there was abnormally thick but clear saliva around [their] mouth, I addressed [the patient] again and there was no response. [MHST 18], who was assigned new admissions processing then took a picture of [Patient 1], as part of the admissions process. It was then decided that since [the patient] appeared not to be cooperative with us that we would use a blanket to lift [their] legs so that we could easily transport [them] to Lighthouse 1 via the use of a wheelchair."

6.g. Incident documentation recorded by LH1 NM, dated 04/18/2024 and untimed, reflected that "[LH1 NM] is writing this incident report on behalf of [MHT 33]: I was doing the RCM/SSM checks - I saw [Patient 1] being taken to [their] room via wheelchair and [they] looked lifeless - security pushing [them] in a wheelchair - [the patient's]

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hands were hanging out to the sides and staff were holding [their] legs to keep [them] in the wheelchair."

7. On 04/24/2024 beginning at 1155, survey team review of multiple camera views of video-recordings, without audio capability, revealed the following timeline of events that occurred on 04/18/2024 when the vehicle Patient 1 was transported in from Douglas County Jail arrived to the OSH Sally Port 8. Regarding the video review there was no camera view provided in Sally Port 8 that showed directly into the back of the transport van used to transport Patient 1 so that the entirety of the inside of the van could be visualized. The camera that showed the view at the back of the van was mounted off to the side of the Sally Port so that a side view of the right rear of the van could be visualized. With both rear van doors opened only a small portion of the inside of the back compartment could be seen. In addition, the quality and clarity of some of the video footage was poor and details of some images were not clear. Further, there were occasions during video review where video skipped several seconds when there was activity occurring. Commonly video may skip seconds or minutes when there is no activity occurring.

* Between ~ 1054:52 and 1056:23 two camera views inside Sally Port 8 showed: A DC Jail transport van drove into Sally Port 8 with two DC deputies seated in the front seats. The garage door closed after the van had fully entered the Sally Port. A DC deputy walked to the back of the van, opened one of the back doors, removed two bundles of items, and walked away towards the door to the admitting room. At ~ 1056:07 Patient 26 exited the van through the passenger right

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side doors and walked in front of the second DC deputy towards the door to the admitting room.

* Between ~ 1058:18 and 1100:20 one camera view inside Sally Port 8 showed: A DC deputy walked back to the back of the van, opened one of the back doors and looked inside momentarily, then started to close the door, then reopened it and looked inside and left it open. They stood at the back of the van and periodically looked inside through the open door.

* Between ~ 1100:21 and 1102:20 two camera views inside Sally Port 8 showed: The second DC deputy approached the back of the van and joined the first deputy, immediately followed by RN 4 who pushed a w/c towards the back of the van. The deputies opened the other door so that both back van doors were open. At ~ 1100:28 only a portion of Patient 1's lower body was visualized up against the rear left side of the van. They were positioned on the floor so that their body was facing the interior of the left rear corner side panel of the van, their left buttocks could be seen on the van floor, the left side of their body was at the very end of the floor where the door closure was, their left leg was observed to be bent at the knee and had partially fallen outside of the van. The two deputies picked Patient 1 up off the van floor and in awkward and uncoordinated movements took the patient out of the van and rotated them to place them in the w/c. There was no indication that Patient 1 was assisting or resisting. The parts of their body that could be visualized were limp. Patient 1, who was Black, was positioned in the w/c with their shoulders at the level of the top of the w/c seat back, their head slumped fully forward towards their chest, and their eyes closed. RN 4 folded a blue blanket

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and place it around Patient 1's chest and shoulders and wrapped the ends around the w/c handles. At 1101:38 as the RN began to pull the w/c backward towards the admitting room Patient 1's upper body was observed to be positioned lower in the w/c and slumped toward the left. As their head was slumped forward, the lower part of their face, including mouth and nose, was covered by the blue blanket. At ~ 1102:01 as RN 4 pulled the w/c backwards along the side of the van towards the admitting room door, both deputies bent over the patient and made movements consistent with each having picked up one of the patient's pants legs to lift the patient's feet off the ground.

* At ~ 1102:24 one camera view inside the admitting room attached to Sally Port 8 showed: RN 4 pulled the w/c with Patient 1 backward into the admitting room. One deputy had hold of the patient's right pant leg near the hem with their right hand. The other deputy had hold of the patient's left pant leg near the middle of the pant leg with their left hand. Both of the patient's bare feet were dangling slightly above the floor. The patient's hands were cuffed in their lap. Their head was slumped forward, their eyes were closed, and their face was covered by the blue blanket that was held in place by RN 4 around their chest and shoulders and the w/c handles.

* Between ~ 1102:30 and 1105:50 one camera view inside the admitting room showed: RN 4 parked Patient 1 in the w/c near the middle of the room. The deputies' positions around the patient's body periodically block the camera view. At this time four other staff (not including RN 4 and the two deputies) arrived into the room. The RN can be seen to lean over towards the patient on the

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left side of the w/c and arms are extended toward the patient although the patient cannot be seen behind one of the deputies. At ~ 1103:02 the deputies stepped away and the patient was observed to be slumped further down in the w/c, however, the patient's face was no longer covered by the blue blanket that remained around their chest and shoulders. It looked as though RN 4 had their right hand on or near the blanket below the patient's face as if they moved the blanket to uncover the patient's face. The patient was motionless and their eyes were closed. At that time there were at least six other staff in the room. RN 4 stepped away and back from the w/c and was observed to address the deputies and staff that had gathered in the room who all stood and faced the patient within a few feet of the patient. Two of those staff stepped towards and leaned towards the patient and took photographs of the patient with cell phones. Then there were eight other staff in the room. The 11 people in the room (excluding the patient) were observed to talk amongst themselves and to the group while Patient 1 remained motionless in the w/c with their wrists in law enforcement transport restraints, their chin laid on their chest, and their eyes closed. Patient 1 showed no signs of movement. At ~ 1104:18 RN 4 slightly leaned toward the patient, extended their arm, and may have touched the blue blanket, the patient's clothing near their shoulder, or the w/c. It was not clear. At ~ 1104:24 one of the staff persons approached the patient, leaned toward them, and extended their arm towards the patient. There was no visible response or movement from Patient 1. At ~ 1104:29 a DC deputy removed the law enforcement transport restraints from the patient's wrists. At ~ 1105:08 when their right hand was free from those restraints their right

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forearm, wrist, and hand slid down and across their right thigh. At that time the patient was observed to have slid further down in the w/c, the blue blanket was removed, their head remained slumped fully forward with their chin on their chest, their eyes were closed, and their legs were extended straight in front of them with their bare feet on the ground. At ~ 1105:27 a staff person took the blue blanket and with assistance from another staff person positioned it under and around both the patient's legs at the knees and formed a handle of sorts to lift the patient's legs up off the ground. At that time the patient's buttocks were near to sliding off of the w/c and their arms had fallen off their thighs onto the w/c seat on either side of their body. At ~ 1105:44 one staff person pushed the w/c forward and another staff person held the blanket that was around the patient's legs to keep them off the ground and they moved towards the door out of the admitting room into a hallway towards the inpatient unit. At no time while in the admitting room did the patient assist or resist, nor did they open their eyes or demonstrate any observable movement. At no time was there any meaningful touch or other activity by any staff that could be construed as a patient assessment component.

* Between ~ 1105:50 and 1108:30 four camera views showed: The two staff who pushed the w/c and held the patient's legs up were joined by RN 13 and six other staff as they transported Patient 1 through hospital hallways to the inpatient unit. Patient 1 remained motionless with their eyes closed and slumped to the left with their arms laid limply on the w/c seat on either side of their body and their chin laid on their chest. Overhead camera views during the transport showed that the blanket around the patient's knees used to

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hold the patient's legs up during transport had been tied and knotted or twisted. At ~ 1108:30 staff pushed the patient in the w/c into the assigned patient room on the inpatient unit and that was last video observation of Patient 1.

8.a. During interview with staff that included the DSC, DLD, and OBC on 05/06/2024 beginning at 1235 they confirmed the Code Blue training dates for the AD RNs 1 through 4 and stated there were no drills or hands-on practice, return demonstrations, or competency evaluations associated with those trainings, including during annual "refreshers." They further stated that hospital-wide Code Blue drills had not been conducted since the Covid-19 pandemic. They stated those were recently resumed on 04/23/2024 and that on that date on the OSH-Salem campus 54 staff participated in Code Blue drills, and on 04/26/2024 on the OSH-JC campus 13 staff participated in Code Blue drills. They further confirmed that none of the four AD RNs had been present or participated in the Code Blue drills conducted on 04/23/2024 and 04/26/2024.

8.b. Review of AD RN Code Blue training records reflected the following:
* For RN 1 the documentation showed that since 2020 they had a 20-minute online Code Blue training on 03/26/2020, an online Code Blue training on 04/24/2021, and a 30-minute Code Blue "refresher" on 02/27/2023 during 2023 Annual Training.
* For RN 2 the documentation showed that since 2020 they had a 30 minute Code Blue "refresher" on 04/02/2024 during 2024 Annual Training.
* For RN 3 the documentation showed that since 2020 they had a 20-minute online Code Blue

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training on 05/07/2020, an online Code Blue training on 03/12/2021, and none since.
* For RN 4 the documentation showed that since 2020 they had a 20-minute online Code Blue training on 04/18/2020, an online Code Blue training on 05/08/2021, and none since.

9.a. Review of the "Oregon State Hospital - Salem Organizational Structure" chart that was "Last Updated 4/1/24" showed that the AD, the ADM, and the RNs who worked in the AD, reported to the OSH Deputy Superintendent in hospital administration and were not part of the Nursing Department.

9.b. Review of the AD Staff List provided reflected that the ADM's title was "Business Operations Manager." There was no indication in information gathered during the survey that the ADM who was assigned oversight and responsiblity for the AD RNs and the nursing and patient care services provided in the AD was an RN themself. Further confirmation was provided by the DSC in an email on 05/16/2024 at 1503 that the ADM was not an RN.

9.c. During interviews on 04/24/2024 beginning at 1030, on 04/25/2024 at 1230, on 04/25/2024 beginning at 1340, and on 05/02/2024 beginning at ~ 1300 the following information was provided or confirmed. Staff that were included in one or more of those sessions included the ADM, AD RN 1, DSC, DQM, Interim DS, DLD, OBC, and other nursing, education and S&C staff:
* The hours of operation of the AD were Monday through Friday business hours. There were four AD RNs who worked eight-hour shifts with slightly staggered start times.
* The AD RNs were not part of the Nursing

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Department and did not fall under the direction of the CNO. Rather, the oversight of the AD operations was the responsibility of hospital administration.
* Nursing Department P&Ps did not apply to the AD RNs.
* There were no formalized, written, and approved P&Ps for AD patient care operations and procedures.
* There were no provisions for direct observation of patients at the time the transport van entered the Sally port, nor direct observation of patients who waited in transport vehicles upon their arrival to the hospital's premises prior to the transport van entry into the Sally port.
* Systems and processes for Nursing Department staff orientation, onboarding, and annual training did not apply to the AD RNs.
* There was no formal and organized AD orientation and onboarding program, and that there was no documentation of AD orientation and onboarding for the two most recent AD RNs who started in 08/2023, and no documentation of competency evaluations.
* The onboarding process for AD RNs was described as "shadowing" one of the other two AD RNs on "how to get people into the door with the deputies" for "usually about two weeks before they're turned loose." There were no
* Two manuals were presented as the only written resource documents for AD patient care operations and procedures. They were not current or approved, and contained unclear and inconsistent information related to patient care operations.

9.d. A manual titled "Admissions Department" had the date 04/05/2024 at the bottom of each page. It contained unclear information and was

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incomplete. For example:
* It contained sections and paragraphs that had language written in red ink and some written in purple ink. It was unclear what those denoted. During interviews referenced above the ADM stated that the purple was the "nursing" section, and the red was language that needed to be updated.
* On Page 5 of the manual it described that AD personnel included four MH Triage RNs. It further stated that "Each position with the [AD] plays a pivotal role ... Each staff in these positions have a duty to perform their positions ... in accordance to [sic] all policies and procedures set by OSH and the Admissions Director for all department functions." However, during interviews referenced above there were no AD P&Ps.
* A yellow highlighted excerpt on Page 20 of the manual was written was "The [MH] Triage RN will document in a closing note, at minimum, how the patient presented upon arrival ... check vitals (O2), Temp, and BP, when possible ..." The date on the bottom of that page was 04/05/2024, prior to the 04/18/2024 admission of Patient 1. However, during interviews referenced above the ADM stated that that although the manual reflected last revisions were made on 04/05/2024, the excerpt had been added to the manual after the Patient 1's 04/18/2024 admission and after the 04/19/2024 CMO Directive. In a written response from the ADM received on 05/02/2024 they wrote in regard to confirmation of the date and time that the edit had been "This is not possible."
* In addition, the added excerpt was unclear about the extent of vitals to be taken as it said to check vitals, but specified only Temp, and BP, when possible.
* The Admissions Department manual contained

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no reference to medical emergency response, or maintenance of emergency supplies or equipment in the AD.

9.e. A manual titled "Mental Health Admissions Triage Nurse" contained unclear information and was incomplete. For example:
* Written at the bottom of various pages of the manual were dates of 06/13/2021, 06/25/2021 and 07/13/2022. It was unclear what date the manual was last determined to be current.
* In the manual on a page titled "Day of Admission" with the date 06/13/2021 at the bottom of the page there were three paragraphs. One included direction for the MH Triage RN to obtain a temperature on patients upon arrival. That was not done for Patient 1 on 04/18/2024 and staff confirmed during the interviews referenced above that there was no written AD P&P for that practice.
* Although the AD operated M-F day shift hours and was only staffed with AD RNs at those times, the manual reflected that "Evening, Nights, and Weekends Admissions" could occur. It was unclear how those would be managed, including whether patients would be assessed and vitals taken. During the interviews referenced above the ADM indicated there were no P&Ps for that at this time and that they needed to develop a process to include PNMs for after hours admissions.
* The manual contained a copy of a seven-page "Sentinel Event Alert" published by The Joint Commission dated 09/12/2017. It was unclear what it's purpose was as there was no explanation for that elsewhere in the manual.
* The manual included a P&P for restraints with a date of 12/21/2020. It was confirmed that was not the current version of that P&P.
* The manual contained a copy of the P&P for

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A 392	Continued From page 146 "Admission of Patients with Medical Problems" dated 10/03/2018 that directed that "If a newly admitted patient experiences an emergency medical condition. OSH will provide emergency care as indicated in OSH Policy 8.002 ..." However, there was no other information in the manual for medical emergency response in the AD, including for maintenance of emergency supplies or equipment. **********	A 392		
A1600	Special Provisions for Psychiatric Hospitals CFR(s): 482.60 Special Provisions Applying to Psychiatric Hospitals - Psychiatric hospitals must... This CONDITION is not met as evidenced by: ********** Based on observations, review of video recordings, interviews, review of incident and medical record documentation for 1 of 1 patient (Patient 1), review of 4 of 4 AD staff training records (RNs 1, 2, 3, and 4), review of OSH internal investigation documentation, review of medical emergency supplies and equipment documentation, review of medical emergency response documentation, review of training documentation, and review of P&Ps and procedural manuals it was determined that the hospital failed to comply with the CFR 482.60(b), Meet Hospital CoPs, under the "Special Provisions Applying to Psychiatric Hospitals," that required the hospital meet all CoPs specified in CFRs 482.1 through 482.23 and CFRs 482.25 through 482.57 The cumulative effect of these systemic failures resulted in this Condition-level deficiency that	A1600		

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represents a limited capacity on the part of the hospital to provide safe and adequate care.

Findings include:

1. Refer the findings cited under this Condition at Tag A-1605, CFR 482.60(b) - Standard: Meet Hospital CoPs, that reflects the hospital failed to comply with the following CoPs (Tag A-1605):
* CFR 482.12 - CoP: Governing Body
* CFR 482.13 - CoP: Patient's Rights
* CFR 482.23 - CoP: Nursing Services

2. Refer to the findings cited at Tag A-043, CFR 482.12 - CoP: Governing Body, that reflects the governing body failed to ensure the provision of safe and appropriate care to patients in the hospital in a manner that complied with all CoPs. Those findings included for this hospital that did not have a dedicated Emergency Department, failure to ensure appropriate assessment and initial treatment of individuals anywhere on the hospital's campus who exhibited a need for a medical emergency response (Tag A-093).

3. Refer to the findings cited at Tag A-115, CFR 482.13 - CoP: Patient's Rights, that reflects the hospital failed to fully develop and implement P&Ps that ensured each patient's right to receive care in a safe setting. The hospital's failures to ensure appropriate patient assessment and provisions for response to medical emergencies created an unsafe EOC that likely contributed to harm and death of one patient and created the likelihood of harm to other patients (Tag A-144).

4. Refer to the findings cited at Tag A-385, CFR 482.23 - CoP: Nursing Services, that reflects the hospital failed to fully develop and implement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	384008	A. BUILDING _____ B. WING _____	C 05/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A1600	Continued From page 148 P&Ps that ensured that the nursing services were under the supervision of an RN, that patient needs were met by ongoing nursing assessment, and that nursing personnel responded to the nursing and emergency care needs of the patient population of each department (Tag A-392). **********	A1600		
A1605	Meet Hospital CoPs CFR(s): 482.60(b) [Psychiatric hospitals must] Meet the Conditions of Participation specified in§§482.1 through 482.23 and §§482.25 through 482.57; This STANDARD is not met as evidenced by: ********** Based on observations, review of video recordings, interviews, review of incident and medical record documentation for 1 of 1 patient (Patient 1), review of 4 of 4 AD staff training records (RNs 1, 2, 3, and 4), review of OSH internal investigation documentation, review of medical emergency supplies and equipment documentation, review of medical emergency response documentation, review of training documentation, and review of P&Ps and procedural manuals it was determined that the hospital failed to comply with all CoPs specified in CFRs 482.1 through 482.23 and CFRs 482.25 through 482.57 as the following CoPs were determined to be out of compliance: * CFR 482.12 - CoP: Governing Body * CFR 482.13 - CoP: Patient's Rights * CFR 482.23 - CoP: Nursing Services The cumulative effect of these systemic failures resulted in this Condition-level deficiency that represents a limited capacity on the part of the	A1605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1605	Continued From page 149 hospital to provide safe and adequate care. Findings include: 1. Refer to the findings cited at Tag A-043, CFR 482.12 - CoP: Governing Body, that reflects the governing body failed to ensure the provision of safe and appropriate care to patients in the hospital in a manner that complied with all CoPs. Those findings included for this hospital that did not have a dedicated Emergency Department, failure to ensure appropriate assessment and initial treatment of individuals anywhere on the hospital's campus who exhibited a need for a medical emergency response (Tag A-093). 2. Refer to the findings cited at Tag A-115, CFR 482.13 - CoP: Patient's Rights, that reflects the hospital failed to fully develop and implement P&Ps that ensured each patient's right to receive care in a safe setting. The hospital's failures to ensure appropriate patient assessment and provisions for response to medical emergencies created an unsafe EOC that likely contributed to harm and death of one patient and created the likelihood of harm to other patients (Tag A-144). 3. Refer to the findings cited at Tag A-385, CFR 482.23 - CoP: Nursing Services, that reflects the hospital failed to fully develop and implement P&Ps that ensured that the nursing services were under the supervision of an RN, that patient needs were met by ongoing nursing assessment, and that nursing personnel responded to the nursing and emergency care needs of the patient population of each department (Tag A-392). **********	A1605		