Oregon State Hospital CMS Findings Response

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 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon State Hospital Distinct Part	**2600 Center Street NE Salem, OR 97301**

To: State Licensing Agency, mailbox.hclc@dhsoha.state.or.us
Rosanna Angeldones
Karyn Thrapp
Wendy Edwards

CC: Sejal Hathi, Kris Kautz, Sara Walker, Karen Jamieson, Nicole Mobley, Tom Anhalt, Jason Stringer, Aisha Krebs, Amber Shoebridge, Jim Aguilar, Ryan Bell

Re: Opportunity to Correct

Please find enclosed our completed Plan of Correction along with the signed first page of Form CMS-2567 (02-99).

The completed plan outlines corrective actions Oregon State Hospital has identified through clinical, operational, and administrative review. Corrections address deficiencies through process improvement, process creation, policy revision, and outcome measures at the local and leadership level. This plan will ensure services are meeting quality standards for review by the governing body as will be documented in our QAPI plan.

Dr. Sara Walker, OSH Interim-Superintendent, is responsible for implementing the entirety of this plan.

We look forward to meeting the Conditions of Participation and resuming deemed status.

Sincerely,

Sara C. Walker, MD (she/her)
Chief Medical Officer & Interim Superintendent
Oregon State Hospital
Desk: 503-945-8962
Mobile: 541-680-4732
sara.walker@oha.oregon.gov

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 07/03/2024

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 This report reflects the findings of an unannounced, onsite Federal complaint investigation survey at the OSH-Salem main campus for complaints OR50743, OR50765 and OR51018. The survey was initiated on 05/29/2024 and an exit conference was conducted on 07/03/2024. Because of additional information received from the hospital after the exit conference, the survey was concluded on 07/12/2024. The survey also included record review, as described in this report, from 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 contained within the following hospital Conditions of Participation (CoPs): * CFR 482.12 - CoP: Governing Body * CFR 482.13 - CoP: Patient's Rights * CFR 482.21 - CoP: Quality Assessment and Performance Improvement Program * CFR 482.23 - CoP: Nursing Services * CFR 482.25 - CoP Pharmaceutical Services * CFR 482.41 - CoP: Physical Environment * CFR 482.60 - CoP: Special Provisions for Psychiatric Hospitals During the survey it was determined that an IJ situation existed. Refer to Standard-level Tag A-144 under the Patient's Rights CoP for the details of the IJ and it's removal on 07/24/2024,	A 000	Attached Plan of Correction for: • Fed - A- 0043 - 482.12 - Governing Body • Fed - A - 0115 - 482.13 - Patient Rights • Fed - A - 0144 - 482.13(c)(2) - Patient Rights: Care In Safe Setting • Fed - A - 0145 - 482.13(c)(3) - Patient Rights: Free From Abuse/Harassment • Fed - A - 0263 - 482.21 - QAPI • Fed - A - 0286 - 4821.21(a),(c)(2),(e)(3) - Patient Safety • Fed - A - 0385 - 482.23 - Nursing Services • Fed - A - 0395 - 482.23(b)(3) - RN Supervision of Nursing Care • Fed - A - 0700 - 482.41 - Physical Environment • Fed - A - 0701 - 482.41(a) - Maintenance of Physical Plant • Fed - A - 0724 - 482.41(d)(2) - Facilities, Supplies, Equipment Maintenance • Fed - A - 1600 - 482.60 - Special Provisions for Psychiatric Hospitals • Fed - A - 1605 - 482.60(b) - Meet Hospital CoPs	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Oregon State Hospital CMS Findings Response

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 7/3/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon State Hospital Distinct Part	**2600 Center Street NE Salem, OR 97301**

Glossary of Terms

Administrative Directive

"Administrative Directive" is a document authorized and issued by the Superintendent or designee to establish, supplement, augment, and/or clarify operating policies, procedures, and/or protocols. Administrative directives supersede policy and are effective until the affected referenced document is updated or until otherwise rescinded.

Clinical/Administrative Debrief Meeting (CADM)

"Clinical/Administrative Debrief Meeting (CADM)" Is an OSH internal process that is directed by the Superintendent and occurs directly after the report of an adverse patient event has been triaged by IRSI. A CADM team conducts staff interviews and documentation review to identify initial actions that may be taken quickly to mitigate the risk of a similar event occurring again.

Code Blue

"Code Blue" means bringing together a group of staff to respond to an immediate medical emergency.

Code Blue Drills

"Code Blue Drills" are opportunities for OSH staff to practice their medical emergency response skills.

Code Blue Team

"Code Blue Team" refers to the RN's who are responsible for training medical emergency response, reviewing code blue events, and are tasked with overseeing the emergency medical equipment.

Code Green

"Code Green" means bringing together a group of staff to respond to an immediate behavioral emergency.

Code Green Drills

"Code Green Drills" are opportunities for OSH staff to practice their behavioral emergency

response skills including some de-escalation skills and hands on techniques.

Continuous Rounds, Census, and Milieu Management (RCM)

"Continuous Rounds, Census, and Milieu Management (RCM)" means the assignment of dedicated direct care Nursing or Treatment Services staff to continuously move through and monitor all patient care areas of a unit or treatment mall for the dual purposes of verifying patients' status and whereabouts and ensuring a safe and therapeutic physical environment (ex: ensuring doors are secured and no potential ligatures are present in the environment). This is documented on a standardized form generated from the electronic health record to be specific to the patient unit or treatment area.

Corrective Action Review Body (CARB)

"Corrective Action Review Body (CARB)" is a new OSH group developed as part of this Plan of Correction. The purpose of this body is to oversee and maintain accountability for implementation and monitoring of corrective actions generated as a result of internal critical incident investigations.

Critical Incident

"Critical incident" is an event that poses a serious threat to patient safety and requires a thorough review to ensure system failures are being identified and addressed."

Direct Care Staff

"Direct Care Staff" refers to staff whose primary job function is to work directly with patients. This includes staff from Nursing, Treatment Services, Psychiatry, Psychology, Social Work, Treatment Care Plan Specialists and Peer Recovery Specialists.

Electronic Health Record (EHR)

The Electronic Health Record (EHR) is an electronic version of a patient's medical history, that is maintained by the provider over time and may include all of the key administrative clinical data relevant to that person's care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports.

Enhances Supervision (ES)

"Enhances Supervision (ES)" is careful monitoring and/or intervention by which staff supervise a patient.

Hospital Level of Care (HLOC)

"Hospital Level of Care (HLOC)" for Oregon State Hospital purposes, an inpatient psychiatric setting which provides medical, behavioral, and nursing services not available in residential

or other outpatient settings. At Oregon State Hospital, HLOC units are:

- Junction City Campus: Mountain 1, Mountain 2, and Mountain 3
- Salem Campus: Anchor 1, Anchor 2, Anchor 3, Bird 1, Bird 2, Bird 3, Butterfly 1, Butterfly 2, Butterfly 3, Flower 1, Flower 2, Flower 3, Leaf 1, Leaf 2, Leaf 3, Lighthouse 1, Lighthouse 2, Lighthouse 3, Tree 1, Tree 2, and Tree 3

Incident Response and System Investigation (IRSI) Department

"Incident Response and System Investigation (IRSI) Department" is a department within Quality Assurance. IRSI Department reviews and investigates incidents that occur at OSH.

Incident Reporting

"Incident Reporting" is a process by which OSH must conduct thorough investigations, prepare reports showing the tracking and trending of data, and implement and monitor corrective or preventative actions. Every staff member who witnesses a reportable incident as defined in policy must promptly report the incident in the OSH incident reporting systems when possible.

Incident Review Form (IRF)

"Incident Review Form (IRF)"is the form completed to record a written response to an Incident Report. This form is submitted to the Program Executive Team or Department Manager for further review.

Interdisciplinary Team (IDT)

"Interdisciplinary Team (IDT)" is group that includes the patient, their guardian or representative and other persons important to the patient if applicable, treatment care plan specialist (TCPS), and other clinicians responsible for specialized active treatment, as appropriate. The IDT is responsible to coordinate planning and oversight of a patient's care and treatment.

Leadership Governance Team

OSH Leadership Governance Team is a team developed to oversee, manage, and coordinate cross functional processes, projects, and initiatives for OSH. This will be accomplished by oversite of committees, system investigations and root cause analysis reviews, and regulatory readiness reviews.

Level of Care (LOC)

"Level of Care (LOC)" is the range of available services provided from the most integrated setting to the most restrictive and most intensive in an inpatient setting.

OSH CMS Compliance Team

Glossary of Terms

"OSH CMS Compliance Team" is a team developed to ensure the Plan of Correction developed in response to the CMS survey is effective and sustaining on both campuses. This will be accomplished by reviewing audit compliance & assigning follow up actions (as needed).

OSH Performance System

"OSH Performance System" is the mechanism by which OSH meets the requirements of its Quality Assurance Performance Improvement (QAPI) plan. The Performance System focuses on the organization's fundamental work processes and desired outcomes, while driving structure around measurement and metrics. The Performance System helps the hospital generate targeted Initiatives and the use of problem-solving techniques to address areas where performance is poor.

Oregon State Hospital (OSH)

"Oregon State Hospital (OSH)" is a forensic psychiatric treatment facility for adults from throughout Oregon who need hospital-level of care. There are two campuses, one in Salem and one in Junction City.

OSP

"OSP" refers to Oregon State Police.

Performance System Steering Committee (PSSC)

"Performance system Steering Committee (PSSC)" is a sub-committee of the OSH Executive Team. The PSSC is responsible for managing the ongoing implementation and maintenance of the OSH Performance System.

Program Director

"Program Director" is an individual with appropriate professional qualifications and experience who is designated to manage the operation of a program.

Program Executive Team (PET)

"Program Executive Team (PET)" refers to a program team who are responsible for ensuring the effective and efficient functioning of the clinical processes within the program.

Protective Mail

"Protective Mail" is classified as legal, official and journalist mail.

Restrictive Events

"Restrictive Events" are an event that uses seclusion or another type of restraint.

Glossary of Terms

Restraint

"Restraint" is defined by Centers for Medicare and Medicaid (CMS) in 42 CFR § 482.13(e) as any manual method (including a physical escort), physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

Safe Together Training

"Safe Together Training" is OSH's training for response to behavioral crisis. Includes relationship-building, verbal de-escalation, assault prevention, and procedures for manual and mechanical restraint to minimize injury.

Sample Size

The actual number of events that will be sampled are calculated each month by a Data Analyst based on number of incidents occurring, specifically for each audit plan. If the number of events is 50 or less, the total being audited will be 100%. If the number of events is more than 50, the number of events needed to be audited in each random sample will be calculated based on the statistical standard of a 95% confidence interval with a +/- 5% margin of error.

Secure Residential Treatment Facility (SRTF)

"Secure Residential Treatment facility (SRTF)" is defined as a program licensed by OHA to provide services on a 24-hour basis for six to sixteen individuals with mental, emotional or behavior disturbances or alcohol or drug dependence. An SRTF is approved by OHA to restrict an individual's exit from the setting through the use of approved locking devices on individual exit doors, gates or other closures.

Seclusion

"Seclusion" is defined by CMS in 42 CFR § 482.13(e) as the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior in a behavioral emergency.

SEED

"Staff Education, Engagement and Development (SEED)" is OSH's department that includes Learning and Development (Education and Development Department and Nursing Education and Training), Code Blue nurses Training and Support Department (Safe Together, CPS, and Staff Support and Engagement teams-which includes HEART.

Standard Work

"Standard Work" is a performance improvement tool used to provide detailed representation and documentation of the most efficient process as it is known today. It breaks down current state work into the elements and characteristics needed to understand and perform a process repeatedly.

Staff

"Staff" includes employees, volunteers, trainees, interns, contractors, vendors, and other state employees assigned to work at OSH.

Transfer Tracker

"Transfer Tracker" is a tool which notes important clinical and risk information as it applies to patient placement.

Treatment Care Plan (TCP)

"Treatment Care Plan (TCP)" is an individualized treatment plan of care for patients.

Unit Safety and Security Management (SSM)

"Unit Safety and Security Management (SSM)" means the assignment of dedicated care Nursing staff to continuously move through and monitor all patient care areas of a unit for the purpose of continuous rounds focused on unit safety and security management (SSM) on each unit when patients are present. Items of focus include ligatures, sharps, contraband, prohibited items, property and/or excessive items that are modified or stored in undesignated areas. This is documented on a standardized flowsheet to be specific to the patient unit.

Glossary of Terms

Oregon State Hospital CMS Findings Response

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 07/03/2024
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
Oregon State Hospital Distinct Part		**2600 Center Street NE Salem, OR 97301**	
Fed – A – 043 – 482.12 – Governing Body			

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference: A-115, A-263, A-385, A-700, A-1600

Fed – A – 0043 – 482.12 – Governing Body A-0043

Oregon State Hospital CMS Findings Response

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 07/03/2024
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
Oregon State Hospital Distinct Part		**2600 Center Street NE Salem, OR 97301**	
Fed – A – 0115 – 482.13 – Patient Rights			

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference: A-144, A-145

Oregon State Hospital CMS Findings Response

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

CORRECTING THE DEFICIENCY

I. Failure to ensure situational awareness and diligent observation and monitoring of patient condition and status, including whether patients were alive and breathing.

II. Failure to ensure situational awareness and diligent observation and monitoring of patient location to ensure patients were not in unauthorized areas.

1) List the Plan of Correction for specific deficiency cited:

- Chief Nursing Officer (CNO) issued an RCM Administrative Directive for Lead RN.
- Updated Nursing Protocol 2.020 Continuous Rounds, Census, and Milieu (RCM) Management.
- RNs will complete the 4-hour training, Admissions, RCM, Medical Emergency RN Class.
- Updated Nurse Onboarding to include Admissions, RCM, Medical Emergency RN Class.
- Updated Nursing Staff Onboarding to include training for RCM process.
  - New employees complete in-person training that is tracked in Workday.
- Updated Patient Unit Census and Status Flowsheet form.
- Created and deployed 24/7 video monitoring team to evaluate staff presence in the milieu who are responsible for monitoring of blind spots, enhanced supervision orders are followed, and no personal electronic devices are present.
  - Created standardized work and communication surrounding video monitoring processes.

2) List procedures/process for implementing the acceptable Plan of Correction for each deficiency cited:

- CNO issued an RCM Administrative Directive for Lead RN to provide additional oversight, quality assurance and on-site training.
  - The lead RN must accompany the two staff assigned to the RCM viability checks at the top of the hour, at least three times per shift.
    - The lead RN must confirm respirations with the assigned staff, the accuracy of additional observations, and adequate adherence to 2.020 RCM Management.
    - The lead RN must document on the RCM flowsheet when they conduct each of the three viability checks during their shift.
- OSH updated 2.020 RCM Management.
  - Update protocol to match requirements noted in Administrative Directive above.
  - Nursing staff required to attest they read, understand, will follow the protocol, and seek guidance from manager, if necessary.
  - The attestation will be reflected in Workday.
- RNs will complete the 4-hour training, Admissions, RCM, Medical Emergency RN Class, to improve, among other things, the observation and monitoring of patients.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

- Course objectives include:
  - RNs will understand the new RCM expectations for ensuring patient viability; RNs will be oriented to the Admission Intake Assessment; RNs will be able to report the assessments they would do to manage patient, staff, and milieu concerns for each covered scenario/body system; RNs will understand that they are focused on gathering assessment information and deciding next steps for a medical emergency, including but not limited to calling a code blue, calling a psychiatric practitioner, calling a code green, providing an intervention for/to a patient; RNs will understand the requirement to use Situation, Behavior, Assessment, Recommendation (SBAR) when discussing a patient's condition with another psychiatric/medical provider; RNs will understand that they may not diagnose a patient's condition, but must recognize the signs of possible medical or psychiatric emergency and respond accordingly.
- Upon completion of the instructional portion of the class, a competency quiz will be given.
- 100-80%: the RN is deemed competent.
- 79-61%: the RN must retake the competency portion of each subject (same day).
- 60% or below: the RN must retake the entire class within 2 weeks. Until the RN demonstrates competency, they will be reassigned outside of patient care.
  - The competency will be reflected in Workday.

- Updated Nurse Onboarding training
  - Curriculum was updated to include the 4-hour Admissions, RCM, Medical Emergency RN Class.
- Updated Nursing Staff Onboarding training for RCM process
  - Curriculum was updated to include training on RCM process related to ensuring patient viability per Nursing protocol 2.020.
- Patient Unit Census and Status Flowsheet form has been updated to have a space for lead RN to initial confirming they ensured viability three times a shift.
  - This Unit Census and Status Flowsheet tracks patient location and viability every hour.
- Video monitoring:
  - Video monitoring team operates 24 hours per day to observe staff and patient activity in unit milieu, to ensure staff maintain situational awareness and diligent observation and monitoring of patient condition, location, and status.
  - The video monitoring team will immediately report policy and protocol violations as follows:
    - If the Unit Nurse Managers or Unit Administrators are on duty, they will be contacted via telephone to take corrective action.
    - If the Unit Nurse Managers or Unit Administrators are not on duty, the Program Nurse Managers will be contacted via telephone to take corrective action.
    - Reported incidents and action taken will be recorded on a video monitoring log.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

- Created standard work to define duties for Nurse Manager and Unit Administrator to conduct audits of recorded video as compared to video monitoring log and unit functional assignments, to ensure staff compliance with expectations regarding milieu presence, viability checks, and patient location monitoring.

3) What monitoring and tracking procedures will be used to ensure the plan of correction is effective?

- Standards and Compliance will audit the RCM form to verify Lead RN has completed three viability observations during their shift.
  - Audit findings will be reported to the OSH CMS Compliance Team.
    - Level One
      - Audit on a monthly basis.
      - Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in Sample Size in the glossary.
      - Compliance Target 90%.
      - This level of auditing will continue until the compliance reaches 90% for four consecutive months, at which point the auditing intensity can move to Level Two.
    - Level Two
      - Audit on a quarterly basis.
      - Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in Sample Size in the glossary.
      - Compliance Target 90%.
      - This level of auditing will continue until the compliance reaches 90% for four consecutive quarters, at which point the auditing intensity can move to Level Three.
      - If, during Level Two auditing, compliance drops below 90%, audit intensity will revert to Level One.
    - Level Three
      - Audit on an annual basis.
      - Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in Sample Size in the glossary.
      - Compliance Target 90%.
      - This level of auditing will continue until the Leadership Governance Team determines that auditing is no longer required.
      - If, during Level Three auditing, compliance drops below 90%, audit intensity will revert to Level Two.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

- Video Monitoring Team Lead Worker will review 10% of RCM forms audited by Standards & Compliance against video to verify that viability checks are completed as documented, and that patient location (per video) is consistent with location as documented on RCM form.
  - Audit findings will be reported to the OSH CMS Compliance Team.
    - Level One
      - Audit on a monthly basis.
      - Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in Sample Size in the glossary.
      - Compliance Target 90%.
      - This level of auditing will continue until the compliance reaches 90% for four consecutive months, at which point the auditing intensity can move to Level Two.
    - Level Two
      - Audit on a quarterly basis.
      - Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in Sample Size in the glossary.
      - Compliance Target 90%.
      - This level of auditing will continue until the compliance reaches 90% for four consecutive quarters, at which point the auditing intensity can move to Level Three.
      - If, during Level Two auditing, compliance drops below 90%, audit intensity will revert to Level One.
    - Level Three
      - Audit on an annual basis.
      - Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in Sample Size in the glossary.
      - Compliance Target 90%.
      - This level of auditing will continue until the Leadership Governance Team determines that auditing is no longer required.
      - If, during Level Three auditing, compliance drops below 90%, audit intensity will revert to Level Two.

4) Date of completion for correction deficiency cited: October 4, 2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

III. Failure to ensure diligent and consistent registration/check-in of visitors prior to in-person patient visitation sessions.

1) List the Plan of Correction for specific deficiency cited:

- Security developed and implemented an electronic calendar-based patient visitor scheduling, check-in/out program. This program tracks visitor times, dates, and monitors the visitor check-in/check-out process.
- Develop Security Protocol to describe training and standard work for the electronic calendar-based patient visitor scheduling program.

2) List procedures/process for implementing the acceptable plan of correction for each deficiency cited:

- Completed development of the electronic calendar-based visitor scheduling program.
- Developed training to Reception staff on the new electronic calendar-based patient visitor scheduling program.
- The new Security electronic calendar-based patient visitor scheduling program tracks the following information:
  - Initials of the Reception staff member scheduling the visit
  - Patient name
  - Notes of potential concerns for visit (contraband risk, acuity risk, past visitor behavioral issues)
  - Patient ID#
  - Patient Unit
  - Scheduled visit time
  - Adult visitor name(s)
  - Relationship to patient
  - Visitor phone #
  - Visitor possessions
  - Number of minor visitors (if applicable)
  - Minors' relation to patient (if applicable)
  - Visitor Badge #
  - Arrival time of visitor
  - Departure time of visitor
  - Initials of the Reception staff who checks the visitor in
  - Initials of the Reception staff who checks the visitor out
- The process that occurs before visitation:
  - Visitors submit an online application and agree to have a background check completed.
  - Visitor application and background check results via LEDS (Law Enforcement Data Systems) are sent to Security Managers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

  - Security Managers review visitor application and background check results and provide their recommendation to the IDT Team.
  - Security staff will verify name on photo ID against electronic system at the time of visit.
- Scheduling Visitation
  - No walk-in visitation
  - Reception staff must ensure patient is approved for visitation in Avatar
  - Reception staff must schedule appointment in the electronic Patient Visitor system
- In order to have a visitation, visitors must have the proper approvals and be found in the electronic Patient Visitor system.
- Develop Security Protocol 3.008 Patient Visitor Processing to provide standard work for the processing of visitors as outlined above.
- Review Security Protocol 3.008 Patient Visitor Processing with all current and future Reception staff. Reception staff are required to attest they read, understand, will follow the protocol, and seek guidance from manager, if necessary.
  - Security Protocol 3.008 will be part of onboarding for Reception staff. Onboarded Reception staff will attest they have read, understand, will follow the protocol, and seek guidance from manager, if necessary.

3) What monitoring and tracking procedures will be used to ensure the plan of correction is effective?

- Security Department will perform a one-time audit to verify Reception staff attestation of protocol 3.008 is 90% or above.
- Security Managers will monitor in person the patient visitation process at least two times a week to verify the policy and protocols are being followed. Real-time coaching will be provided by managers to Security staff if necessary. Written documentation of the monitoring will be submitted to the OSH CMS Compliance Team.
  - Audit findings will be reported to the OSH CMS Compliance Team.
    - Level One
      - Audit on a monthly basis.
      - Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in “Sample Size” in the glossary.
      - Compliance Target 90%.
      - This level of auditing will continue until the compliance reaches 90% for four consecutive months, at which point the auditing intensity can move to Level Two.
    - Level Two
      - Audit on a quarterly basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

- Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in "Sample Size" in the glossary.
- Compliance Target 90%.
- This level of auditing will continue until the compliance reaches 90% for four consecutive quarters, at which point the auditing intensity can move to Level Three.
- If, during Level Two auditing, compliance drops below 90%, audit intensity will revert to Level One.

▪ Level Three

- Audit on an annual basis.
- Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in "Sample Size" in the glossary.
- Compliance Target 90%.
- This level of auditing will continue until the Leadership Governance Team determines that auditing is no longer required.
- If, during Level Three auditing, compliance drops below 90%, audit intensity will revert to Level Two.

4) Date of completion for correction deficiency cited: October 4, 2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

IV. Failure to ensure diligent and consistent screening of visitors prior to in-person patient visitation sessions to prevent the entry of drugs and other contraband into the hospital, and to prevent the passing those from visitor to patient.

V. Failure to ensure situational awareness and diligent observation of patient and visitor behaviors and interactions during in-person visitation sessions to prevent the passing of drugs and other contraband from visitor to patient.

1) List the Plan of Correction for specific deficiency cited:

- Issue an Administrative Directive associated to Policy 8.026, Visitors to Patients, with new requirement that in-person visitation for all patients on Hospital Level of Care units must be non-contact only.
- Develop and implement Security Protocol 5.019, and Nursing Protocol 2.260 to standardize non-contact visitation with patients.
- Added a non-contact visitation space on the Junction City campus.
- Develop and implement Security Protocol 5.015 Pat Downs and Security Protocol 5.016 Metal Detection Screening to standardize the processes for the use of a metal detection wand and physical pat downs of patients and visitors.
- Security Protocol 5.019 Visitation sets forth clear guidelines for visitor processing. These visitor processing steps are critical steps in the mitigation of contraband being introduced to OSH.

2) List procedures/process for implementing the acceptable plan of correction for each deficiency cited:

- Will implement non-contact visitation for all Hospital Level of Care patients on both the Salem and Junction City campus. There will be no in-person visitation that allows for physical contact between the visitor and the patient for Hospital Level of Care patients on either campus.
  - Non-Contact visitation is visitation where the patient and visitor are separated by a physical barrier and are in two separate rooms. The patient is seated on one side of a clear plexiglass partition and the visitor is seated on the other side. The patient and visitor communicate through a phone.
  - The visits are one (1) patient to one (1) visitor with a total of five (5) visitors/patient spaces on the Salem campus and a total of four (4) visitor spaces on the Junction City Campus.
  - Patients and visitors do not come into physical contact with each other at any point in the non-contact visitation process. Although, there is no physical contact between visitors and patients, visitors are subjected to the normal visitor screening processes for contraband before they enter the secure perimeter.
  - Video Monitoring Team will be conducting video surveillance of non-contact visitation for both Salem and Junction City.
    - **Protocol 5.019 Visitation, Section C: Security's Roles During Non-Contact Visitation**
      A. Processing for Non-Contact Visitation
      - Security staff will process and search visitors for non-contact visitation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

- Security staff will escort visitors for non-contact visitation from the Lobby to the non-contact visitation area.
- Security staff will collaborate with the Nursing staff, who are staffing non-contact visitation, to ensure that they contact Security staff to escort the visitors out of the secure perimeter at the end of the visit.
- At the end of the non-contact visitation Security staff will escort the visitors out of Sally Port One.
- Security staff, including Reception staff, required to attest they read, understand, will follow the protocol 5.019, and seek guidance from manager, if necessary.
  - Security Protocol 5.019 will be part of onboarding for Security staff. Onboarded Security staff will attest they have read, understand, will follow the protocol, and seek guidance from manager, if necessary.

- **Roles during Non-Contact Visitation**

Reception Role:

- Notify the unit Lead Registered Nurse (RN) or Unit Administrator by a call or email when a non-contact visit is scheduled.
- On the day of the scheduled visitation verify the visitor's visitation status in the electronic health record (EHR), as applicable.

Security Role:

- Work with Nursing staff who are staffing the non-contact visitation to coordinate visitor transport from the lobby to the non-contact visitation area.
- Notify Nursing staff when visitors are in the non-contact visitation room.
- Escort the visitor from the non-contact visitation area to the lobby at the conclusion of visitation and after the patient has been transported back to their unit.

Nursing Role:

- When Security staff have confirmed the visitors are in the non-contact visitation area, staff must escort the patient to the non-contact visitation area following all applicable transportation ratios per Policy 6.024 Transportation and Supervision Ratios.
- Transport staff may return to their unit after the patient has been handed off to staff working non-contact visitation.
- Staff working non-contact visitation must follow established Nursing Protocol 2.260 Non-contact Visitation regarding the supervision of non-contact visitation.
  - Nursing staff will complete an online training in Workday to communicate and establish the expectations of Nursing protocol 2.260.
- The patient is transported back to their unit prior to the departure of the visitor. Staff working non-contact visitation contacts the unit staff to escort the patient back to the unit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

        - Contact security to escort the visitors back to the lobby.
- Develop and implement Security Protocol 5.015 Pat Downs and Security Protocol 5.016 Metal Detection Screening. These protocols were designed to standardize the work and expectations for those who conduct pat downs and metal detection.
    - Train Security staff on protocols 5.015 and 5.016. Training includes physical competencies led by Security manager.
        - Security staff are required to attest they read, understand, will follow protocol 5.015 and 5.016, and seek guidance from manager, if necessary.
- Security Protocol 5.019 Visitation will set forth clear guidelines for visitor processing.
    - Security Protocol 5.019 Visitation, B: Processing Visitors into the Secure Perimeter.
        - Visitors must present valid identification and check in at the Reception Center before being allowed inside the Lobby.
        - Visitation will be terminated for visitors who do not follow the guidelines laid out in these protocols which include, but may not be limited to:
            - Declining to be searched by either a metal detector or a pat down (if one has been deemed necessary).
            - Engages in conflict with security staff, patients, or other visitors.
            - Attempts to conceal any item on their person that has not been pre-approved by this protocol.
            - If the patient requests that the visit end.
            - Dress Code Violations.
            - If the visitor brings medication, medical devices, or animals with them that have not been pre-approved.
            - Intoxication.
        - Visitors must undergo a search with the Metal Detection Screening device per Security Protocol 5.016 to enter the secure perimeter.
            - Security staff from are responsible for processing visitors.
        - Security staff must screen visitors for visitation in the lobby, ensure non-approved items are stored in a locker, and transport the visitors into the secure perimeter via Sally Port One.
            - Visitors must enter and exit through Sally Port One; no other Sally Ports are authorized for processing or transportation.
        - Security staff have the authority to refuse entry to any visitor who does not agree to a metal detection search following the guidelines from Security Protocol 5.016.
            - If a visitor refuses a metal detection search, Security staff shall terminate the visit, document the event in the Security Communication Log, and submit an Incident Report.
            - If a visitor refuses to follow the guidelines from Protocol 5.016 the Shift Supervisor or Lead staff must be immediately notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

  - If a visitor arrives in an outfit that violates the Dress Code, they will be allowed to reschedule their visit for the same day, if there are open visiting spots. Reception staff will not overbook visitation due to dress code violations.
    - Visitors may bring these items into visitation:
      - Their locker keys.
      - Their visitor badge.
      - Pre-disclosed and approved prescribed medication.
      - Pre-approved medical equipment.
      - Some additional items may be approved for children's visits.
    - If a visitor insists on bringing additional items into visitation, Security staff are allowed to terminate the visit immediately.
- Develop and implement Security Protocol 5.015 Pat Downs to standardize patient pat downs for visitation.
  - Security Protocol 5.015 Pat Downs addresses specific standard work as it relates to the process of completing a personal search of a patient and pat downs of visitors. Conducting patient pat downs is a critical step in the process of mitigating the introduction of contraband into the hospital or onto the patient units following outings.
    - A pat down is permitted when there are security and safety concerns. Patient pat downs are also conducted in the following instances:
      - Before and after a patient leaves the secure perimeter.
      - Before a unit search or a patient's room search.
      - In cases of suspected security and safety issues, staff must obtain approval from the Security shift supervisor or Program Nurse Manager before conducting a pat down and adhere to the guidelines outlined in Policy 8.041 Patient Personal Searches.
      - A search using a metal detection device is required before a pat down is performed following the guidelines laid out in Protocol 5.016.
      - A personal search should not take place in the milieu or the presence of peers if another option is available. The patient may be relocated to a safe and neutral location to maintain their dignity during the pat down process.
      - Security staff should conduct the pat-down in a location within the view of the camera surveillance system. This guideline should be followed unless a search is warranted outside of the secure perimeter.
      - If a pat-down is warranted during an off-unit activity, the patient may not resume the activity or return to their unit until the search has been completed.
      - Relocating a patient to a neutral location, or under the surveillance of a camera may not always be feasible due to safety or security concerns and does not apply to patients entering or exiting the secure perimeter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

- Visitor pat downs will be conducted in the following instance:
  - After the determination by Security staff has been made that a metal detection search is not sufficient to detect suspected contraband, Security staff will ask the visitor for consent to perform a pat down. If visitor does not consent, visitation will be cancelled.
- If a patient is noncooperative with a pat down and is engaging in behaviors that result in a safety or security concern, Security staff are to collaborate with a nurse and refer to Policy 6.003 Seclusion and Restraints and Policy 8.033 Workplace Violence Prevention for guidance.
  - If a patient is noncooperative with a personal search or pat down Security staff must document the incident in the Incident Reporting System Program and the Security Department's Communication Log.
- Conducting the Pat Down
  - Pat downs must be conducted by a minimum of two staff members.
    - One staff member will be responsible for the pat down while the second will be responsible for searching the property or extra clothing items.
    - If there is a risk of patient aggression it is recommended to position two staff members behind the patient being searched at each shoulder while a third staff member performs the search.
    - In the case that only one Security staff is available for the pat down they may get assistance from the escorting HCP per Policy 8.041 Personal Searches.
  - Pat downs must be conducted by a staff member of the same sex or same gender identity as the patient per policy 6.061 Patient Transfer.
    - In an emergent situation a Security staff, physician or registered nurse may conduct a pat down that is not the same sex or same gender identity as the patient.
    - All staff members must wear gloves throughout the search process.
    - Patients being searched are required to wear a base layer of clothing. All additional items such as hats, gloves, coats, multiple layers of shirts, extra socks, and shoes must be removed. Additionally, the patient must turn out their pockets.
      - These items shall be given to the second staff member for them to search.
      - Security staff may search these by hand in addition to using the handheld metal detection wand or the X-Ray Machine.
  - Staff members must verbalize their actions before executing them for transparency with the patient being searched. The staff will ensure that the patient is aware of why the search is being conducted and what will occur before the process begins.
    - The Security staff conducting the screening must approach the patient in a courteous and respectful manner.
    - Security staff must provide a clear explanation of the pat down process to the individual. This may include details such as what items the staff are looking for, what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

items are not permitted, or where and when the Security staff will place their hands on the patient.
    - Security staff may offer the patient the chance to ask questions or address any concerns they may have about the pat down process.
- The person being searched will stand with legs approximately shoulder width apart and their arms outstretched.
- Staff must begin at the collar area of the shirt by ensuring that collars are lifted and checked.
- During the search, staff will pat, sweep, and thoroughly check the individual's clothing.
- Staff will then ensure that the waist band and pockets are thoroughly checked.
- Staff will then search the legs while avoiding the groin area. The staff will pay special attention to the cuff of the pant leg, ensuring that they are unrolled.
- If the patient being searched is wearing a bra, staff members must use the back of their hands to check the bra strap. Security staff will use the back of their hand to pat and sweep the back of the bra strap. Security staff will position themselves behind the patient and reach around them, staff will then use the back of their hand to check the front of the bra strap in a sweeping motion.
- If the patient is not wearing a bra, they will pull their shirt away from their body and shake the shirt out.
    - Security staff must maintain the utmost respect and sensitivity to the possible trauma that a patient may have experienced throughout this process.
- When searching the legs of an individual wearing a dress, staff members must ensure that clothing material always remains between their hands and the individual's legs.

- Security protocol 5.016 Metal Detection Screening addresses specific standard work as it relates to the process of using a metal detection wand of a patient or visitor. Metal detection screening is a critical process step in contraband mitigation efforts for both patients and visitors.
    - Security Protocol 5.016 Metal Detection Screening
        - It is recommended that two staff members perform Metal Detection Screenings: one to operate the metal detector wand and another to inspect items such as coats, hats, and gloves. Inspection methods of these extra items may include a physical search or screening through an x-ray machine.
        - Security staff must ensure that the metal detection wand is in proper working condition. Follow Procedures A for Wand Maintenance.
        - Security staff must verify that the individual being screened is prepared and has been notified of the process.
            - The Security staff conducting the screening will approach the individual in a courteous and respectful manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

- Security staff will provide a clear explanation of the screening process to the individual. This may include details such as what items the staff are looking for, what items are not permitted, or where to stand and of the audible alerts that the metal detector wand will make.
- Security staff may offer the individual the chance to ask questions or address any concerns the individual may have about the screening process. This will ensure that the person is prepared and aware of what to expect during the screening procedure.

- For an exemption to the metal detection screening the individual being screened must provide OSH approved documentation of a medical condition or device.
- About the Device
  - The wand detects all types of conductive metals, including ferrous, nonferrous, and stainless steel.
  - Conductive metals are metals with the ability to hold an electric current.
  - Ferrous metals are metals where the primary element is iron.
  - Nonferrous metals are metals where iron is not the primary element.
    - Examples include, but are not limited to, aluminum, copper, and titanium.
- Operating Instructions
  - The wand is activated by switching on the Power Switch by moving it either forward or backward. The Green Alert Light will turn on and then the Red Alert Light turn on. The Red Alert Light will be accompanied by an audible alert.
  - Prior to use, staff must ensure that the wand is fully charged and operational. If there is not an audible alert, this means that the wand has not powered on and staff should take this wand out of circulation, document the equipment failure in the Incident Reporting System and submit a Work Order to Facilities.
  - An Amber Light Alert indicates a low battery. Security staff must not use a low battery detector and must instead install new batteries or locate a charged wand.
  - After turning the wand on there are two ways it can be used: vibration mode and audible mode. Staff can choose either option while considering the specifics of each search.
  - Security staff must ensure that the wands are detecting metal by running the wand over a metal object to guarantee that the Red Alert Light turns on and it is accompanied by either an audible alert or a vibrating alert.
    - Security staff may run the wand over their security keys, as these keys must always be on their person.
  - If the wand does not make audible alert or vibrate after being run over metal, Security staff must take the wand to be stored in the security office and find a working replacement to conduct the search.
    - After prioritizing the search Security staff must document the equipment failure in the Incident Reporting System and submit a Work Order to Facilities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

        - After use, the wand must be turned off, ensuring that the Green Alert Light has been turned off, and stored in the proper location detailed in Attachment A of this protocol.
    - Conducting a Metal-Detection Screening
        - Throughout the process, maintain clear communication with the individual being screened, providing instructions and reassurance as needed to ensure cooperation and comfort.
        - Before beginning the screening process, Security staff should ensure that sleeves and cuffs are unrolled, and pockets have been turned out. The person being screened must wear a base layer of clothing. Extra layers including hats, gloves, coats, extra socks, and shoes should be removed and searched separately.
        - Staff will instruct the individual to stand with their arms outstretched and their legs shoulder-width apart.
        - Starting at the person's head, run the wand close to the body (approximately two inches) without making physical contact. Scan the neck area, shoulder blades, and then move down each arm from shoulder to fingertips.
        - Continue scanning down the individual's back, focusing on the waistline and moving down the back of the legs and between the legs, while not contacting the groin area.
        - Security staff will instruct the individual to raise each foot, one at a time, to allow for scanning. Staff will allow individuals to use a wall to balance themselves if necessary.
        - Security staff will scan the front of the person from their chest to their fingertips and the front of their legs, maintaining a two-inch proximity to the person's body and without making physical contact.
        - If the wand alerts to the presence of metal, staff must investigate further through manual inspection or additional screening methods as necessary. If any items of concern are identified during the screening process staff must follow established protocols for confiscation of prohibited items and contraband.
            - If there are any items found during the screening process, staff will document the event in the Security Department's Communication Logs, and Incident Reporting System Program.
            - After completion of the screening process, ensure the proper storage of the metal detection wand.

3) What monitoring and tracking procedures will be used to ensure the plan of correction is effective?

- Security Managers will review video of visitation on random dates and times to ensure Security staff assigned to oversee visitation are performing their duties according to OSH Policy & Protocols. All video periods reviewed will be recorded on a video monitoring log.
    - Audit findings will be reported to the OSH CMS Compliance Team.
        - Level One
            - Audit on a monthly basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

- Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in "Sample Size" in the glossary.
- Compliance Target 90%.
- This level of auditing will continue until the compliance reaches 90% for four consecutive months, at which point the auditing intensity can move to Level Two.

▪ Level Two
- Audit on a quarterly basis.
- Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in "Sample Size" in the glossary.
- Compliance Target 90%.
- This level of auditing will continue until the compliance reaches 90% for four consecutive quarters, at which point the auditing intensity can move to Level Three.
- If, during Level Two auditing, compliance drops below 90%, audit intensity will revert to Level One.

▪ Level Three
- Audit on an annual basis.
- Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in "Sample Size" in the glossary.
- Compliance Target 90%.
- This level of auditing will continue until the Leadership Governance Team determines that auditing is no longer required.
- If, during Level Three auditing, compliance drops below 90%, audit intensity will revert to Level Two.

- Security managers will monitor the entire visitation process based on randomized dates. Security managers will be in person for visitor check-in, the pat down and metal detection process in the lobby. Managers will provide in the moment coaching to staff as needed. Managers will have a standard form to track errors they have observe and immediate actions taken.
- Security Department will perform a one-time audit to verify Security staff, including Reception staff, attestation of protocol 5.019 is 90% or above.
- Security Department will perform a one-time audit to verify Security staff, including Reception staff, attestation of protocol 5.015 and 5.016 is 90% or above.
- Nursing Department will perform a one-time audit to verify Nursing staff have completed the online training of protocol 2.260 is 90% or above.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

4) Date of completion for correction deficiency cited: October 4, 2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

VI. Failure to investigate causes of the recurring presence and patient possession of drugs and other contraband that resulted in an unsafe EOC in the hospital.

1) List the Plan of Correction for specific deficiency cited:

- Reference: A-145

- OSH has clear procedures/systems for investigation of incidents and adverse events that constitute potential abuse or neglect as defined by CMS. Details of this process can be found in the attached process map and are supported by existing OSH policies, procedures and standard work.
  - See attachment A: Incident Investigation Pathways map
  - See attachment B: Policy 1.003 Attachment B-Critical Incident Grid
- OSH will develop tools to collect and analyze investigative findings from the Incident Review Forms completed after reportable incidents.
- The investigative findings trend data will be integrated into the existing OSH Performance System and evaluated based on the Quality Assurance Performance Improvement (QAPI) plan.
  - Corrective action will be developed to prevent recurrence as necessitated by evaluation of investigatory findings and incident event data per QAPI plan requirements.
  - Data analysis of the investigative findings trend data, and any Performance Improvement initiatives associated with the analysis, are reported to Executive Team quarterly per QAPI plan requirements.

2) List procedures/process for implementing the acceptable plan of correction for each deficiency cited:

CMS indicated OSH had not conducted investigations for the incident reports related to contraband or prohibited items to prevent the recurrence of contraband or prohibited items in the following cases:

23 instances "Contraband/prohibited items"
Eight instanced of "Medication diversion" or "Medication found"
Seven instances of "Tools/sharps missing/unattended"

OSH reviewed these instances and found that it had completed investigations in 35 of the 38 identified incidents, with the remaining 3 still pending. OSH also reviewed trend data that indicates that contraband found has dropped since patient 5's death by nearly 40% between May 2024 and September 2024. For preventative actions generated by these (and other) investigations, please see Plan of Correction for Tag 145 III.

OSH recognizes that prior investigations did not prevent these instances of contraband and prohibited items, and that additional actions are required to identify and implement corrective actions to prevent the recurrence of contraband and prohibited items coming into patient possession. Thus, OSH is taking the actions identified in section one:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

The Quality Management Department will analyze options for selection, tracking, and monitoring of investigative findings, and implement these new collection tools, leveraging existing data analysis systems to incorporate investigative findings data.

The Quality Management Department will identify the group responsible for inputting the investigatory findings data into an identified system and will identify the process for how the data will be analyzed in the current QAPI plan.

The PSSC will identify and will be responsible for implementing corrective action(s) to prevent recurrence as based on evaluation of investigatory findings and incident event data per QAPI plan requirements.

Corrective Actions will be monitored for success with the PSSC reporting to the Exec Team quarterly regarding investigatory findings data and trends, and any Performance Improvement Initiatives.

The Executive Team will remove barriers for improvements as requested by PSSC in quarterly reports. PSSC will monitor trend data to evaluate if Performance Improvement Initiatives are sufficient, per PSSC standard processes. Per QAPI requirements, all high-risk data trends and subsequent Performance Improvement initiatives are reported quarterly to the OSH Governing Body for input on direction and resource allocation.

3) What monitoring and tracking procedures will be used to ensure the plan of correction is effective?

- Standards and Compliance will audit PSSC meeting minutes to ensure the hospital continues to analyze and compare internal data over time to identify levels of performance, patterns, trends, and variations, and corrective actions are sustained through the QAPI structure.
  - Audit findings will be reported to the OSH CMS Compliance Team.
    - Level One
      - Audit on a monthly basis.
      - Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in “Sample Size” in the glossary.
      - Compliance Target 90%.
      - This level of auditing will continue until the compliance reaches 90% for four consecutive months, at which point the auditing intensity can move to Level Two.
    - Level Two
      - Audit on a quarterly basis.
      - Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in “Sample Size” in the glossary.
      - Compliance Target 90%.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A - 144 – 482.13(c)(2) Patient Rights: Care In Safe Setting			

- This level of auditing will continue until the compliance reaches 90% for four consecutive quarters, at which point the auditing intensity can move to Level Three.
- If, during Level Two auditing, compliance drops below 90%, audit intensity will revert to Level One.

▪ Level Three
- Audit on an annual basis.
- Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in “Sample Size” in the glossary.
- Compliance Target 90%.
- This level of auditing will continue until the Leadership Governance Team determines that auditing is no longer required.
- If, during Level Three auditing, compliance drops below 90%, audit intensity will revert to Level Two.

4) Date of completion for correction deficiency cited: October 4, 2024

Oregon State Hospital CMS Findings Response

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 7/03/2024
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
Oregon State Hospital Distinct Part		2600 Center Street NE Salem, OR 97301	
Fed - A – 145-482.13(c)(3)- Patient Rights: Free from Abuse/Harassment			

CORRECTING THE DEFICIENCY

I. Failure to conduct and provide clear and complete investigation to identify and address all evident gaps and findings, and to document the analysis of those gaps and findings to reflect whether all potential concerns were sustained or not.

1) List the Plan of Correction for specific deficiency cited:

- Review current investigation process (detailed in Policies 1.003 Incident Reporting and 2.012 Sentinel Event) for critical incident investigations to identify any potential gaps.
- Review current documentation process for critical incident investigations to identify opportunities for improvement.
- Develop and implement CADM Final Findings/Action To-Date report template. To be completed after CADM process, reflecting initial contributory findings, and immediate actions taken related to those findings to date.
- Develop and implement a Final Findings Report template to be completed after all critical incident investigations with systemic contributory findings.
- Develop an Administrative Directive associated with policy 1.003, Incident Reporting, providing guidance to all staff on immediate responses to reportable incidents.
- Update the Incident Report entry form and the Incident Review Form to capture immediate response actions taken by OSH staff after a reportable incident.

2) List procedures/process for implementing the acceptable plan of correction for each deficiency cited:

- Review current investigation process (detailed in 1.003 Incident Reporting and 2.012 Sentinel Event) for critical incident investigations to identify any potential gaps.
  - Policies directing the critical incident investigation process exist and reflect expected current practice. Procedure documents will be updated to reflect the changes listed below related to reports generated after investigations of critical incidents.
  - IRSI Department, Program Directors, Executive Team and Patient Safety Compliance Analysts are required to attest they have read, understood, and will follow the procedures, and seek guidance if necessary.
- Review current documentation process for critical incident investigations to identify opportunities for improvement. Two procedural updates are needed to standardize investigatory reports.
  - Develop/implement CADM - Findings/Action To-Date report template and standard work.
    - Procedural details:
      - Report to be completed after CADM process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 384008	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 7/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A – 145-482.13(c)(3)- Patient Rights: Free from Abuse/Harassment			

        - Report will reflect initial contributory findings and immediate actions taken related to those findings to date.
    - Develop/implement Critical Incident Final Report template and standard work to be completed after all critical incident investigations with systemic contributory findings.
        - Procedural details:
            - Final report to be completed after leadership review.
            - Report will reflect contributory findings, pertinent negatives, and actions taken.
- Develop an Administrative Directive (AD) associated with policy 1.003, Incident Reporting.
    - AD will provide guidance and expectations to all staff regarding:
        - Immediate response to reportable incidents, focused on ensuring patient and staff safety.
        - Immediate response to reportable incidents, focused on understanding the cause of event and taking immediate action to prevent recurrence, to the extent possible prior to a more formalized investigation (as described in existing OSH processes. See Attachment A : Incident Investigation Pathways map)
            - *Note: OSH has established expectations for immediate response for numerous reportable incidents which are described in policy/protocols. These include; contraband, sexual contact, falls, found medication, and wandering patient. These existing processes will be supported by the AD.*
    - All OSH staff are required to attest they read, understand, will follow the protocol, and seek guidance from manager, if necessary.
    - The attestation will be reflected in Workday.
    - New Employee Orientation and Onboarding staff must complete these training during orientation and onboarding. Annual Incident Reporting training will be completed by all OSH staff as part of annual requirements.
- Update the Incident Report entry form to require documentation of immediate actions taken per AD expectations. This will be a mandatory field in the IR entry form and staff will not be able to submit the form if this section is not completed.
    - All staff will be trained via Workday.
- OSH will update the Incident Review Form (IRF) to include a section requiring the description of immediate actions taken in response to reportable incidents (as directed by the AD described above).

3) What monitoring and tracking procedures will be used to ensure the plan of correction is effective?

- Standards and Compliance will perform a one-time audit to verify IRSI Department, Program Directors, Executive Team and Patient Safety Compliance Analysts have attested to procedure changes to Policy 1.003 and 2.012 is 90% or above.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 384008	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 7/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A – 145-482.13(c)(3)- Patient Rights: Free from Abuse/Harassment			

- Standards and Compliance will audit the "CADM Final Findings/Action To-Date Report" to confirm it reflects initial contributory findings and immediate actions taken related to those findings to date.
  - Audit findings will be reported to the OSH CMS Compliance Team.
    - Level One:
      - Audit on a monthly basis.
      - Sample Size: 100%.
      - Compliance Target: 90%.
      - This level of auditing will continue until the compliance reaches 90% for four consecutive months, at which point the auditing intensity can move to Level Two.
    - Level Two:
      - Audit on a quarterly basis.
      - Sample Size: 100%.
      - Compliance Target: 90%.
      - This level of auditing will continue until the compliance reaches 90% for four consecutive quarters, at which point the auditing intensity can move to Level Three.
      - If during Level Two auditing, compliance drops below 90%, audit intensity will revert to Level One.
    - Level Three:
      - Audit on an annual basis.
      - Sample Size: 100%.
      - Compliance Target: 90%.
      - This level of auditing will continue until the Leadership Governance Team determines that auditing is no longer required.
      - If during Level Three auditing, compliance drops below 90%, audit intensity will revert to Level Two.
- Standards and Compliance will audit the "Critical Incident Final Report" to confirm it reflects non-contributory findings, pertinent negatives, and actions taken to date.
  - Audit findings will be reported to the OSH CMS Compliance Team.
    - Level One:
      - Audit on a monthly basis.
      - Sample Size: 100%.
      - Compliance Target: 90%.
      - This level of auditing will continue until the compliance reaches 90% for four consecutive months, at which point the auditing intensity can move to Level Two.
    - Level Two:
      - Audit on a quarterly basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 384008	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 7/03/2024
NAME OF PROVIDER OR SUPPLIER Oregon State Hospital Distinct Part		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 Center Street NE Salem, OR 97301	
Fed - A – 145-482.13(c)(3)- Patient Rights: Free from Abuse/Harassment			

    - Sample Size: 100%.
    - Compliance Target: 90%.
    - This level of auditing will continue until the compliance reaches 90% for four consecutive quarters, at which point the auditing intensity can move to Level Three.
    - If during Level Two auditing, compliance drops below 90%, audit intensity will revert to Level One.
  - Level Three:
    - Audit on an annual basis.
    - Sample Size: 100%.
    - Compliance Target: 90%.
    - This level of auditing will continue until the Leadership Governance Team determines that auditing is no longer required.
    - If during Level Three auditing, compliance drops below 90%, audit intensity will revert to Level Two.
- Standards and Compliance will perform a one-time audit to verify all staff have attested to AD to Policy 1.003 is 90% or above.
- Standards and Compliance will perform a one-time audit to verify all staff have completed Workday training on Incident Report entry form requiring documentation of immediate actions taken is 90% or above.
- PETs and Department Directors will audit the IRF forms for completion of the section describing the effective and meaningful immediate action taken to ensure patient and staff safety.
  - Audit findings will be reported to the OSH CMS Compliance Team.
    - Level One
      - Audit on a monthly basis.
      - Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in Sample Size in the glossary.
      - Compliance Target 90%.
      - This level of auditing will continue until the compliance reaches 90% for four consecutive months, at which point the auditing intensity can move to Level Two.
    - Level Two
      - Audit on a quarterly basis.
      - Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in Sample Size in the glossary.
      - Compliance Target 90%.
      - This level of auditing will continue until the compliance reaches 90% for four consecutive quarters, at which point the auditing intensity can move to Level Three.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 384008	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 7/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A – 145-482.13(c)(3)- Patient Rights: Free from Abuse/Harassment			

- If, during Level Two auditing, compliance drops below 90%, audit intensity will revert to Level One.

- Level Three
  - Audit on an annual basis.
  - Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in Sample Size in the glossary.
  - Compliance Target 90%.
  - This level of auditing will continue until the Leadership Governance Team determines that auditing is no longer required.
  - If, during Level Three auditing, compliance drops below 90%, audit intensity will revert to Level Two.

4) Date of completion for correction deficiency cited: October 4, 2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 384008	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 7/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A – 145-482.13(c)(3)- Patient Rights: Free from Abuse/Harassment			

II. Failure to implement the corrective action planned as a result of internal investigation findings.

1) List the Plan of Correction for specific deficiency cited:

- Develop and implement standard work for implementation of action items developed as a result of internal investigation of critical incidents.
- Develop and initiate a Corrective Action Review Body to oversee and to maintain accountability for implementation and monitoring of corrective actions generated as a result of internal critical incident investigations.
- Ongoing monitoring of effectiveness of standard work and Corrective Action Review Body oversight resulting in implementation of corrective actions planned as a result of internal investigation findings.

2) List procedures/process for implementing the acceptable plan of correction for each deficiency cited:

- Create Standard work required for implementation of action items planned as a result of internal investigation findings for critical incidents. The standard work requires the following:
  - OSH will appoint an accountable person and responsible Executive Team member for each approved action item based on internal investigation findings.
    - Accountable person will work with an assigned Performance Improvement Analyst to develop a written work plan for implementation of the action item.
      - A written work plan will be required for all action items planned as a result of internal investigation findings and will include deliverables, timelines, and owners.
  - Accountable person will deliver a written monthly status report to Quality Management. Report will include updates to deliverables (as detailed in the written work plan), timelines, and any barriers.
  - Quality Management will provide a dashboard of action items status to leadership; to be received and reviewed at the monthly accountability meeting of the Corrective Action Review Body.
- Create the Corrective Action Review Body's charter to include regular monitoring of completion of all corrective actions generated as a result of internal investigations for critical incidents.
  - Conduct meetings according to Charter.

3) What monitoring and tracking procedures will be used to ensure the plan of correction is effective?

- Standards and Compliance will audit the Corrective Action Review Body's monthly report to the Executive Team to monitor progress, completion, and implementation of corrective actions generated as a result of internal investigations for critical incidents.
  - Audit findings will be reported to the OSH CMS Compliance Team.
    - Level One:
      - Audit on a monthly basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 384008	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 7/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A – 145-482.13(c)(3)- Patient Rights: Free from Abuse/Harassment			

- Sample Size: 100%.
- Compliance Target: 90%.
- This level of auditing will continue until the compliance reaches 90% for four consecutive months, at which point the auditing intensity can move to Level Two.

▪ Level Two:
- Audit on a quarterly basis.
- Sample Size: 100%.
- Compliance Target: 90%.
- This level of auditing will continue until the compliance reaches 90% for four consecutive quarters, at which point the auditing intensity can move to Level Three.
- If during Level Two auditing, compliance drops below 90%, audit intensity will revert to Level One.

▪ Level Three:
- Audit on an annual basis.
- Sample Size: 100%.
- Compliance Target: 90%.
- This level of auditing will continue until the Leadership Governance Team determines that auditing is no longer required.
- If during Level Three auditing, compliance drops below 90%, audit intensity will revert to Level Two.

4) Date of completion for correction deficiency cited: October 4,2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 384008	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 7/03/2024
NAME OF PROVIDER OR SUPPLIER Oregon State Hospital Distinct Part		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 Center Street NE Salem, OR 97301	
Fed - A – 145-482.13(c)(3)- Patient Rights: Free from Abuse/Harassment			

III. Failure to prevent patient harm and potential harm as a result of failures to provide care and services necessary to prevent the presence of contraband and prohibited items, and to assess, observe, and monitor patient condition and location.

1) List the Plan of Correction for specific deficiency cited:

- Reference: A-144 II, A-144 III, A-144 IV, A-144 V, A-144 VI

- Patient mail screening, prevention of medication diversion and patient Urine Drug Screening (UDS) are all part of OSH's contraband mitigation efforts to ensure a safe and therapeutic environment for patients, which also directly impact staff safety.
- Revise patient mail delivery process to introduce screening and verification that contraband is not present or, if present, does not reach the patient.
  - Issued an administrative directive to update Policy 7.001 Mail and Packages for Patients
  - Review/update mail screening process
  - Develop and implement standard work as a result of updated mail screening procedures
- According to accepted standards of medication management practices, OSH requires crushing of medications that have moderate to high risk for abuse in order to minimize the potential for diversion.
  - Review/update Policy 10.003 Medication Crush
  - Create patient information tool to advise patients and staff of changes
- Review/update Nursing Services Department Standard Work Process for Urine Drug Screen Collection with Direct Observation
  - Develop and implement updated UDS procedures, including testing a sample size of patients monthly
  - Develop and implement standard work as a result of updated screening procedures
- Issue Administrative Directive updating Policy 1.003 Incident Reporting to clarify reporting requirements based on urine drug screen results.

2) List procedures/process for implementing the acceptable plan of correction for each deficiency cited:

- Patient Mail:
  - To prevent transmission of contraband in mail, issued an administrative directive for Policy 7.001 Mail and Packages for Patients to describe updated security precautions as detailed in OAR 309-102 and as described below.
    - Security staff are required to attest they read, understand, will follow the administrative directive, and seek guidance from manager, if necessary.
    - Onboarded Security staff will attest they have read, understand, will follow the protocol, and seek guidance from manager, if necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 384008	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 7/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A – 145-482.13(c)(3)- Patient Rights: Free from Abuse/Harassment			

  - Update and implement mail screening process, including:
    - Patients no longer receive the original physical copy of standard mail; photocopies are provided instead, with the exception of "protected mail"
    - Protected mail is opened by Security staff in front of patient to search for contraband prior to providing it to the patient
  - Staff required to complete updated training 2024 Annual Education: Updated Patient Mail and Packages at Oregon State Hospital
- Medication Crush:
  - To reduce opportunities for medication diversion, update Policy 10.003 Medication Crush to remove the ability for prescribers to override the crush policy for a specific medication unless they have obtained written CMO approval.
    - Prescribing practitioners required to attest they have read, understood, and will follow the policy, and seek guidance if necessary.
- Urine Drug Screening (UDS) of Patients**:**
  - Develop and implement updated UDS procedures, including testing a random sample of patients (10 per business day on Salem campus, 3 per business day on Junction City campus).
  - Update and implement Nursing Services Department Standard Work Process for Random Urine Drug Screen Collection with Direct Observation
    - Nursing staff required to attest they have read, understood, and will follow the updated standard work process, and seek guidance if necessary.
  - Issue Administrative Directive updating Policy 1.003 Incident Reporting to require that confirmed presence of a substance not prescribed to the patient in a UDS, or absence of an expected substance that is prescribed to the patient, must be reported by Psychiatry staff and investigated. Reporting is the responsibility of Psychiatry staff because, as the attending practitioners, they are responsible for knowing all prescribed medications and laboratory results of their assigned patients.
    - Psychiatry staff are required to attest they have read, understood, and will follow the directive, and seek guidance if necessary.
    - Onboarded Psychiatry staff will attest they have read, understand, will follow the protocol, and seek guidance from manager, if necessary.

3) What monitoring and tracking procedures will be used to ensure the plan of correction is effective?

- Patient Mail:
  - Operations Security Supervisor will report weekly to Standards and Compliance on any mail that was delivered to a patient that was not photocopied according to Policy 7.001 to Standards and Compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 384008	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 7/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A – 145-482.13(c)(3)- Patient Rights: Free from Abuse/Harassment			

        - Standards and Compliance will report to the OSH CMS Compliance Team on a monthly basis for a period of 6 months with the target of zero instances of mail being delivered to a patient outside of policy requirements of 7.001. This level of monitoring will continue until the Leadership Governance Team determines that monitoring is no longer required.
    - Standards and Compliance will perform a one-time audit to verify Security staff attestation of Administrative Directive to Policy 7.001 is 90% or above.
- Medication Crush:
    - Pharmacy will perform a one-time audit to ensure current “Do Not Crush” orders are discontinued, unless there’s CMO authorization to write a “Do Not Crush” order, based on the Policy 10.003 Medication Crush.
        - Audit findings will be reported to the OSH CMS Compliance Team.
        - Standards and Compliance will monitor all “Do Not Crush” medication orders monthly to identify if any are written outside the requirements outlined in Policy 10.003 Medication Crush.
    - Audit findings will be reported to the OSH CMS Compliance Team.
        - Level One:
            - Audit on a monthly basis.
            - Sample Size: 100%.
            - Compliance Target: 90%.
            - This level of auditing will continue until the compliance reaches 90% for four consecutive months, at which point the auditing intensity can move to Level Two.
        - Level Two:
            - Audit on a quarterly basis.
            - Sample Size: 100%.
            - Compliance Target: 90%.
            - This level of auditing will continue until the compliance reaches 90% for four consecutive quarters, at which point the auditing intensity can move to Level Three.
            - If during Level Two auditing, compliance drops below 90%, audit intensity will revert to Level One.
        - Level Three:
            - Audit on an annual basis.
            - Sample Size: 100%.
            - Compliance Target: 90%.
            - This level of auditing will continue until the Leadership Governance Team determines that auditing is no longer required.
            - If during Level Three auditing, compliance drops below 90%, audit intensity will revert to Level Two.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 384008	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 7/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A – 145-482.13(c)(3)- Patient Rights: Free from Abuse/Harassment			

- Urine Drug Screening (UDS) process:
  - Standards and Compliance will monitor the number of UDS completed each month against the number expected.
    - Findings will be reported to the OSH CMS Compliance Team monthly for a period of 6 months or until the Leadership Governance Team determines that monitoring is no longer required.
  - PSSC will review and monitor the Incident Report data related to UDS results and respond according to QAPI requirements.

4) Date of completion for correction deficiency cited: October 4, 2024

Oregon State Hospital CMS Findings Response

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 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon State Hospital Distinct Part	**2600 Center Street NE Salem, OR 97301**

Fed – A – 0263 – 482.21 – QAPI

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference: A-115, A-286, A-385, A-700, A-1600

Oregon State Hospital CMS Findings Response

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 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon State Hospital Distinct Part	**2600 Center Street NE Salem, OR 97301**

Fed – A – 0286 – 482.21(a),(c)(2),(e)(3) – Patient Safety

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference: A-145

Fed – A – 0286 – 482.21(a),(c)(2),(e)(3) – Patient Safety

Oregon State Hospital CMS Findings Response

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 07/03/2024
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
Oregon State Hospital Distinct Part		**2600 Center Street NE Salem, OR 97301**	
Fed – A – 0385 – 482.23 – Nursing Services			

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference: A-395

Oregon State Hospital CMS Findings Response

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A – 395 – 482.23(b)(3) – RN Supervision of Nursing Care			

CORRECTING THE DEFICIENCY

RNs assigned to the provision and supervision of patient care failed to ensure that each patient's nursing and safety needs were met by ongoing assessment, observation, and monitoring, including in response to patient change of condition; and that all other nursing personnel provided care and services in a manner that ensured the ongoing health and safety of the hospital's vulnerable psychiatric population.

1) List the Plan of Correction for specific deficiency cited:

- Create Nursing Medical Emergency Response Guide that directs RN response to all medical emergencies based on scoring results
- RNs will complete a 4-hour training, Admissions, RCM, Medical Emergency RN Class
  - Upon completion of the instructional portion of the class, a competency quiz will be given.
- Update Nurse Onboarding to include Admissions, RCM, Medical Emergency RN Class
- Issued an administrative directive, effective July 8th, requiring direct observation by a Registered Nurse acting as lead to observe no less than three viability checks of all patients per shift. The RN will confirm respirations with the person assigned to RCM and validate accuracy of observations. The RN will document on the RCM flowsheet each time they observe viability checks.
- Update Patient Unit Census and Status Flowsheet forms.

2) List procedures/process for implementing the acceptable Plan of Correction for each deficiency cited:

- Create Nursing Medical Emergency Response Guide to be completed by the assigned RN.
  - Section 1 of the assessment concerns Emergency Signs – If any of the conditions outlined there (which include a non-responsive patient with abnormal vital signs) are present, the assigned RN must call a Code Blue immediately.
  - Section 2 of the assessment is Triage Early Warning Signs Score (which screens for bleeding, vital signs abnormality, mental status abnormality, etc.)
    - If score is 1-2 the assigned RN must call a second RN for validation;
    - If score is 3-5 the assigned RN must call Reception (in Salem) or Access Control (in JC) to call the Psychiatrist on Duty;
    - If score is 6 or above the assigned RN must call a Code Blue.
- Administrative Directive has been issued requiring all RNs to use the Nursing Medical Emergency Response Guide for any medical response. If medical response results in a Code Blue, the RN must document results using the system template in the EHR.
  - All Nursing staff must read and attest to this directive
- Created system template in EHR for documenting the RN's assessment and intervention of medical concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A – 395 – 482.23(b)(3) – RN Supervision of Nursing Care			

  - Nursing Medical Response System Template: This document requires the RN to document their assessment findings using the Nursing Medical Emergency Response Guide for each system assessment, including:
    - Respiratory:
    - Cardiac/Circulatory:
    - Neurological:
    - Pain:
    - Fracture/Threatened Limb:
    - Intervention:
    - RN or MD notified, if applicable (include name, date, and time of notification):
    - Code Blue Called: Yes or No
    - Patient transferred to outside facility: Yes or No
    - Patient Emergency Contact notified, if applicable (include name, date, and time of notification)
- All RNs have completed a 4-hour training, Admissions, RCM, Medical Emergency RN Class, which focuses on the admission process (receiving and assessing a patient, developing initial nursing plan of care), the correct completion of RCM and viability checks, and a refresher on completing RN assessment using review of patient body systems (symptoms and signs).
  - Course objectives include:
    RNs will understand the new RCM expectations for ensuring patient viability; RNs will be oriented to the Admission Intake Assessment; RNs will be able to report the assessments to manage patient, staff, and milieu concerns for each covered scenario/body system; RNs will understand they are focused on gathering assessment information and deciding next steps for a medical emergency, including but not limited to calling a Code Blue, calling a psychiatric practitioner, calling a Code Green, providing an intervention for/to a patient; RNs will understand the requirement to use Situation, Behavior, Assessment, Recommendation (SBAR) when discussing a patient's condition with another psychiatric/medical provider; RNs will understand that they may not diagnose a patient's condition but must recognize the signs of possible medical or psychiatric emergency and respond accordingly.
  - Upon completion of the instructional portion of the class, a competency quiz will be given. Scores are attributed as follows:
    - 100-80%: the RN is deemed competent.
    - 79-61%: the RN must retake the competency portion of each subject (same day).
    - 60% or below: the RN must retake the entire class within 2 weeks. Until the RN demonstrates competency, they will be reassigned outside of patient care.
      - The competency will be reflected in Workday.
- Updated Nurse Onboarding training
  - Curriculum has been updated to include the 4-hour Admissions, RCM, Medical Emergency RN Class.

Oregon State Hospital CMS Findings Response

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A – 395 – 482.23(b)(3) – RN Supervision of Nursing Care			

- Administrative Directive requiring direct observation of viability checks: RN is to observe the accuracy of the viability check by ensuring the staff member does the following:
  - At the top of the hour, two staff must complete the Patient Unit Census and Status Flowsheet to verify the location and status of each patient. While doing so, if they observe a patient who is non-verbal or who is not up and moving about, both staff must verify two respirations. This will be done by observing the patient for no less than 10 seconds, watching for respirations (as evidenced by chest rise and fall) for a minimum of 2 respirations.
  - If the patient is in a room with a large window (e.g., television room, activity room), and the patient's positioning allows for it, staff may observe for respirations through the window. If the patient cannot be clearly observed through the window, staff must move to a location which allows the patient's respirations to be visually or audibly confirmed, which could be in the open doorway or somewhere inside the room.
  - If the patient is their bedroom and the door is closed, staff must look through the window to observe if the patient is awake, up/moving, or communicating with staff or peers. If the patient is laying down and they are not spontaneously verbal, staff must observe the patient for 10 seconds and visualize 2 respirations. If 2 respirations cannot be confirmed by both staff, staff must quietly open the door.
  - If the patient is in Seclusion or Restraint, staff may perform the 10 second observation of the patient, and confirm at least 2 respirations, from the anteroom.
  - In the above situations, if respirations cannot be confirmed by both staff from the open doorway, or from where they are observing the patient, staff must enter the room and move close enough to the patient for both staff to observe 2 respirations. If staff are still unable to confirm respirations, they must physically place their hand on the patient and attempt to rouse the patient. If unable to rouse the patient, staff must immediately call the unit RN into the room for further assessment.
  - If additional light is needed to clearly observe the patient, staff must use a red-filtered flashlight to illuminate the patient. If a brighter light is needed at any time, a white light flashlight is available in the nurse's station. Care must be taken to avoid flashing the light in the patient's face and instead staff should focus the light on the patient's torso.
  - The status of each patient must be documented on the Patient Census and Status Flowsheet, using the codes available on the flowsheet as soon as each patient check is completed. At the end of the round, after all patients have been checked, both staff must attest, via initials and signature on the Patient Census and Status Flowsheet, that they observed that each patient is breathing.
- Updated Patient Unit Census and Status Flowsheet forms to include:
  - Modification to allow for a second staff person initial to confirm viability.
  - Modification to allow for Lead RN to initial to confirm viability as well as validate accuracy of observations.

Oregon State Hospital CMS Findings Response

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed - A – 395 – 482.23(b)(3) – RN Supervision of Nursing Care			

3) What monitoring and tracking procedures will be used to ensure the Plan of Correction is effective?

- Nursing Department performed one-time audit to verify all RNs not on extended leave attended 4-hour Admission, RCM, Medical Emergency RN Class.
- Standard and Compliance began auditing July 8, 2024, after every Code Blue event that occurred, that there is documentation of assessment in Avatar using the Nursing Medical Emergency Response Guide.
    - Audit findings will be reported to the OSH CMS Compliance Team.
        - Level One
            - Audit on a monthly basis.
            - Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in "Sample Size" in the glossary.
            - Compliance Target 90%.
            - This level of auditing will continue until the compliance reaches 90% for four consecutive months, at which point the auditing intensity can move to Level Two.
        - Level Two
            - Audit on a quarterly basis.
            - Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in "Sample Size" in the glossary.
            - Compliance Target 90%.
            - This level of auditing will continue until the compliance reaches 90% for four consecutive quarters, at which point the auditing intensity can move to Level Three.
            - If, during Level Two auditing, compliance drops below 90%, audit intensity will revert to Level One.
        - Level Three
            - Audit on an annual basis.
            - Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in "Sample Size" in the glossary.
            - Compliance Target 90%.
            - This level of auditing will continue until the Leadership Governance Team determines that auditing is no longer required.
            - If, during Level Three auditing, compliance drops below 90%, audit intensity will revert to Level Two.

4) Date of completion for correction deficiency cited: October 4, 2024

Oregon State Hospital CMS Findings Response

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 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon State Hospital Distinct Part	**2600 Center Street NE Salem, OR 97301**

Fed – A – 0700 – 482.41 – Physical Environment

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference: A-701, A-724

Oregon State Hospital CMS Findings Response

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 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon State Hospital Distinct Part	**2600 Center Street NE Salem, OR 97301**

Fed – A – 0701 – 482.41(a) – Maintenance of Physical Plant

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference: A-144 III, A-144 IV, A-144 V

Oregon State Hospital CMS Findings Response

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed – A – 0724 – 482.41(d)(2) – Facilities, Supplies, Equipment Maintenance			

CORRECTING THE DEFICIENCY

The hospital failed to ensure patient safety equipment/devices used for screening individuals, including visitors, for drugs and other contraband were maintained in accordance with manufacturer's recommendations, to ensure they operated and functioned as designed and intended, and were efficient and accurate.

1) List the Plan of Correction for specific deficiency cited:

- OSH Security will develop and implement Security Protocol 5.016 Metal Detection Screening, Attachment A, Metal Detector Wand Inventory and Maintenance.
- OSH Security will develop and implement a "Wand Live Inventory and Maintenance Log" to track monthly audit data.

2) List procedures/process for implementing the acceptable plan of correction for each deficiency cited:

- Develop Security Protocol 5.016 Metal Detection Screening. As part of this protocol development, create Metal Detector Wand Inventory and Maintenance Audit Form to ensure metal detection wand inventory and maintenance is consistently performed and documented.
  - Train Security staff on the protocol, including physical competencies. This training will be led by either a Security manager, or the Security Training Development Specialist.
  - Security staff required to attest they read, understand, will follow the protocol 5.016, and seek guidance from manager, if necessary.
  - Training and protocol review will be part of onboard new staff in the Security Department.
  - All staff and future staff will attest that they have read, understand, and will follow the directions of protocol 5.016, and seek manager guidance if needed.
  - 5.016 Metal Detection Screening's Metal Detector Wand Inventory and Maintenance Audit Form will address specific standard work as it relates to the monthly metal detection wand audits and individual unit maintenance.
    - Wand Maintenance
      - Maintenance of the GARETT SuperScanner Metal Detection Wand is to be a functional audit performed monthly. The functionality test must include the following:
        - Confirm the attachment of the safety sling.
        - Confirm the device is turning off and on.
          - The device is on when the light turns red and then green. The green light is accompanied by an audible alert.
        - Confirm the device is detecting metal.
          - Determined by running the object over a metal object and there being a red-light alert and an audible alert or the vibrating alert.
        - Confirm no part of the device is damaged or missing.

Oregon State Hospital CMS Findings Response

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed – A – 0724 – 482.41(d)(2) – Facilities, Supplies, Equipment Maintenance			

        - Confirm new batteries are placed in the device if needed.
            - When the battery is at 10% power an amber light will alert, indicating the need of a power change.
            - When the amber light is present there is only an hour of power left in the device.
        - Confirm the battery cover is secure.
    - Factory Service
        - If the device does not pass the monthly maintenance test, the wand must be pulled out of circulation and sent in for factory service.
        - The wand must be packed carefully into a box and include a detailed written summary of the issues, as well as a return address and contact information.
        - The wand is to be shipped to:
            - Garrett Metal Detectors – Service Department 1881 W. State St. Garland, TX 75042.
    - Documentation
        - If any device is taken out of circulation it must be documented by updating the Wand Live Inventory and Maintenance File.
        - The removal of the device from circulation must be communicated to the Security Team by submitting an Incident Report in the Incident Reporting System.
    - Wand Inventory
        - Refer to the document Wand Live Inventory and Maintenance File. This document will be accessible in the Security Teams Channel->Metal Detection and X-Ray Program.
        - The document will be audited monthly by the Learning and Development Specialist 2 and Standards & Compliance.
    - The Wand Live Inventory and Maintenance audit form will capture the following data:
        - Wand Location Detail and assigned asset number
        - Live inventory matches what is currently in the storage location? (Y/N)
        - Maintenance Completed? (Y/N)
        - Battery Replaced? (Y/N)
        - Employee Name Performing Maintenance
        - Date/Time Maintenance Completed
        - Any additional notes
            - The Wand Live Inventory and Maintenance data will be saved to the Security Teams channel>OSH Security Metal Detection and X-Ray Program.
- The Wand Inventory and Maintenance will be completed once a month by Security staff.

3) What monitoring and tracking procedures will be used to ensure the plan of correction is effective?

- Standards and Compliance will audit the Wand Live Inventory and Maintenance Log monthly to verify that all required data for the inspection is included in the documentation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. Building _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER **Oregon State Hospital Distinct Part**		STREET ADDRESS, CITY, STATE, ZIP CODE **2600 Center Street NE Salem, OR 97301**	
Fed – A – 0724 – 482.41(d)(2) – Facilities, Supplies, Equipment Maintenance			

- Audit findings will be reported to the OSH CMS Compliance Team.
  - Level One
    - Audit on a monthly basis.
    - Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in "Sample Size" in the glossary.
    - Compliance Target 90%.
    - This level of auditing will continue until the compliance reaches 90% for four consecutive months, at which point the auditing intensity can move to Level Two.
  - Level Two
    - Audit on a quarterly basis.
    - Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in "Sample Size" in the glossary.
    - Compliance Target 90%.
    - This level of auditing will continue until the compliance reaches 90% for four consecutive quarters, at which point the auditing intensity can move to Level Three.
    - If, during Level Two auditing, compliance drops below 90%, audit intensity will revert to Level One.
  - Level Three
    - Audit on an annual basis.
    - Sample Size: The number of events needed to be audited in each random sample will be calculated monthly using the statistical formula as defined in "Sample Size" in the glossary.
    - Compliance Target 90%.
    - This level of auditing will continue until the Leadership Governance Team determines that auditing is no longer required.
    - If, during Level Three auditing, compliance drops below 90%, audit intensity will revert to Level Two.
- Security managers will monitor the entire visitation process based on randomized dates. Security managers will be in person for visitor check-in, the pat down and metal detection process in the lobby. Managers will provide in the moment coaching to staff as needed. Managers will have a standard form to track errors they have observe and immediate actions taken.

4) **Date of completion for correction deficiency cited:** October 4, 2024

Oregon State Hospital CMS Findings Response

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 07/03/2024
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
Oregon State Hospital Distinct Part		**2600 Center Street NE Salem, OR 97301**	
Fed – A – 01600 – 482.60 – Special Provisions for Psychiatric Hospitals			

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference: A-043, A-115, A-263, A-385, A-700

Oregon State Hospital CMS Findings Response

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 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon State Hospital Distinct Part	**2600 Center Street NE Salem, OR 97301**

Fed – A – 01605 – 482.60(b) – Meet Hospital CoPs

CORRECTING THE DEFICIENCY

1: List the Plan of Correction for specific deficiency cited:

- Reference: A-043, A-115, A-263, A-385, A-700

Fed – A – 01605 – 482.60(b) – Meet Hospital CoPs

Attachment A: Incident Investigation Pathways map

Incident Investigation & Corrective Action Pathway

All Incidents at OSH receive the following review process (Level 0/1)

Local Manager conducts investigation and institutes corrective / preventative action

Work is documented on the Incident Review Form

Department Leadership Reviews

Does investigation and actions taken meet quality standards?

NO

YES

IRF Data sent to the Performance System

Incident Happens and Incident Report is Filed

Risk Analysis is Performed by IRSI and Level System is Applied

Which OSH Body Investigates in detail?

Level 1a

Safety Department

Work Place Violence Prevention SC

End Process

Level 2

IRSI

Just Systems Related?

NO

YES

Just Performance Related?

NO

YES

Combination of HR and Systems issues found

HR

End Process

IRSI Completes final Report

All Level 3 Incidents receive a CADM at the discretion of the Superintendent

All Level 3 incidents receive either an IRSI invetigation, or an RCA as determined during the triage process.

Level 3

Critical Incident Final Report

IRSI

CADM

RCA

LGT

CAT

Executive Team

Corrective Action Review Board

Yellow Boxes Responsible for Corrective Action Implementation

OREGON STATE HOSPITAL

POLICY ATTACHMENT

ATTACHMENT B:	Critical Incident Grid	**POLICY:**	1.003
POINT PERSON:	Incident Reporting Systems Investigation		
APPROVED:	Director of Quality Management	**DATE:**	**May 23, 2024**

SELECT ONE:

- ○ New policy attachment
- ◉ Minor/technical revision of existing policy attachment
- ○ Reaffirmation of existing policy attachment
- ○ Major revision of existing policy attachment

OSH Investigators screen all sexual contact and inappropriate touching incident for critical incident review.

Levels	Incident Type	Level of Review	Turnaround	Responsible Party for Incident Review Activities
1	Missed RCM or enhanced supervision checks, prohibited item possession, missed sharps counts and non-significant unauthorized leave/other	Track and Trend	IDT/local manager- 5 Business days PET/ Dept Chief- 5 Business Days *	Critical Incident Review
1A	Patient to staff assault other than Levels 2 or 3	Safety Assault Investigation	30 Calendar Days **	Safety
2 Serious/Critical	Abuse of illegal substance Atypical seclusion or restraint event Choking with Medical Intervention Illegal item possession Patient-patient assault or patient-staff assault with serious injury Serious crime Serious patient injury Serious self-harm Serious suicide attempt Serious system failure Significant Unauthorized leave	IRSI Investigation	20 business days***	Incident Report Systems Investigations (IRSI)
3	Permanent harm Severe harm Unexpected patient death Staff death while working	Superintendent (or Designee) and DOJ initiate interdisciplinary review.	As Directed	Standards and Compliance

All reportable incidents require an IRF. See IRSI Protocol 4.1 for additional information relating to Level 0 incidents. The above assignments are in addition to the IRF process. For a full list of Sentinel Incident Types, please see policy 2.012, 'Sentinel Events'.* From date of incident report distribution, **From date of assignment by IRSI, *** From assignment by Critical Incident Review (CIR)