DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Clinical Standards and Quality
Survey & Operations Group
San Francisco and Seattle Survey & Enforcement Division

August 23, 2024

Administrator
Oregon State Hospital Distinct Part
2600 Center Street Ne
Salem, OR 97301-2682

Re: Medicare Provider Number 384008
Intakes OR00050743/OR00050765/OR00051018

Dear Administrator:

Previously in a letter dated July 18, 2024, CMS issued a 23-Day Termination based on the findings of a complaint survey conducted on July 3, 2024. An Immediate Jeopardy (IJ) situation was found on June 6, 2024. The IJ situation was not abated by the exit of the survey. The CMS 23-Day Termination informed that the hospital's Medicare provider agreement could be terminated by August 10, 2024 if the IJ situation was not removed. On July 23, 2024, the IJ situation was removed. With this notice, CMS is extending the hospital's termination date. The additional intakes OR00031593, OR00037585, OR00044708, OR00045197, OR00048336, OR00049910, OR00049922 are being included in this extension.

A survey conducted by the Oregon Health Authority at Oregon State Hospital Distinct Part on July 3, 2024 found that the facility was not in substantial compliance with the following Conditions of Participation (CoPs) for hospitals.

42 C.F.R. § 482.12 Governing Body
42 C.F.R. § 482.13 Patient Rights
42 C.F.R. § 482.21 QAPI
42 C.F.R. § 482.23 Nursing Services
42 C.F.R. § 482.41 Physical Environment
42 C.F.R. § 482.60 Special Provisions for Psychiatric Hospitals

A listing of all deficiencies found is enclosed (Form CMS-2567, Statement of Deficiencies and Plan of Correction.).

When a hospital is found to be out of compliance with the CoPss, a determination must be made that the facility no longer meets the requirements for participation as a provider or supplier of services in the Medicare program. Such a determination has been made in the case of Oregon State Hospital Distinct Part and accordingly, the Medicare agreement between Oregon State Hospital Distinct Part and CMS is being terminated.

The date on which the Medicare agreement terminates is October 24, 2024.

The Medicare program will not make payment for services furnished to patients who are admitted on or after October 24, 2024. For inpatients admitted prior to October 24, 2024, payment may continue to be made for a maximum of 30 days of inpatient services furnished on or after October 24, 2024.

Termination can only be averted by correction of the deficiencies, through submission of an acceptable plan of correction (PoC) and subsequent verification of compliance by the state agency. The Form CMS 2567 with your POC, dated and signed by your facility's authorized representative must be submitted to the state agency no later than September 2, 2024. Please indicate your corrective actions on the right side of the Form CMS-2567 in the column labeled "Provider Plan of Correction", and list the corresponding deficiency number in the column to its left, labeled "ID Prefix Tag". Additionally, indicate your anticipated completion dates in the column labeled "Completion Date".

An acceptable PoC must contain the following elements:

1. The plan for correcting each specific deficiency cited;

2. The plan for improving the processes that led to the deficiency cited, including how the hospital is addressing improvements in its systems in order to prevent the likelihood of recurrence of the deficient practice;

3. The procedure for implementing the PoC, if found acceptable, for each deficiency cited;

4. A completion date for correction of each deficiency cited;

5. The monitoring and tracking procedures that will be implemented to ensure that the PoC is effective and that the specific deficiency(ies) cited remain corrected and in compliance with the regulatory requirements; and

6. The title of the person(s) responsible for implementing the acceptable PoC.

Copies of the Form CMS-2567, including copies containing the facility's PoC, are releasable to the public in accordance with the provisions of Section 1864(a) of the Act and 42 CFR 401.133(a). As such, the PoC should not contain personal identifiers, such as patient names, and you may wish to avoid the use of staff names. It must, however, be specific as to what corrective action the hospital will take to achieve compliance, as indicated above.

Your facility will be revisited to verify necessary corrections. If CMS determines that the reasons for termination remain, you will be so informed in writing, including the effective date of termination. If corrections have been made and your facility is in substantial compliance, the termination procedures will be halted, and you will be notified in writing.

If your Medicare agreement is terminated and you wish to be readmitted to the program, you must demonstrate to the state agency and CMS that you are able to maintain compliance. Readmission to the program will not be approved until CMS is reasonably assured that you are able to sustain compliance.

If you have any questions regarding this matter, please contact the Seattle Location at CMS_RO10_CEB@cms.hhs.gov to the ATTN: Rosanna Angeldones.

Sincerely,

RAngeldones

Rosanna Angeldones
Health Insurance Specialist
Acute & Continuing Care Branch
Centers for Medicare & Medicaid Services

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

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OREGON STATE HOSPITAL DISTINCT PART	2600 CENTER STREET NE SALEM, OR 97301

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A 000	INITIAL COMMENTS	A 000		

This report reflects the findings of an unannounced, onsite Federal complaint investigation survey at the OSH-Salem main campus for complaints 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,

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

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A 000	Continued From page 1 after the survey exit date. The findings from the survey that follow in this report reflected that the allegations in the three complaints were substantiated and Condition-level deficiencies under the following CoPs were identified: * CFR 482.12 - CoP: Governing Body * CFR 482.13 - CoP: Patient's Rights * CFR 482.21 - CoP: Quality Assessment and Performance Improvement Program * CFR 482.23 - CoP: Nursing Services * CFR 482.41 - CoP: Physical Environment * CFR 482.60 - CoP: Special Provisions for Psychiatric Hospitals The cumulative effect of the systemic failures that resulted in those Condition-level deficiencies represents a limited capacity on the part of the hospital to provide safe and adequate care. **********	A 000		
A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: ********** It was determined that the governing body failed to ensure the provision of safe and appropriate care to the hospital's vulnerable psychiatric population in a manner that complied with all	A 043		

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A 043	Continued From page 2 Conditions of Participation. The cumulative effect of these systemic failures resulted in this Condition-level deficiency that represents a limited capacity on the part of the hospital to provide safe and adequate care. This CoP refers to the following CoPs which are out of compliance. * Tag A-115, CFR 482.13 - CoP: Patient's Rights * Tag A-263, CFR 482.21 - CoP: QAPI * Tag A-385, CFR 482.23 - CoP: Nursing Services * Tag A-700, CFR 482.41 - CoP: Physical Environment * Tag A-1600, CFR 482.60 - CoP: Special Provisions for Psychiatric Hospitals **********	A 043		
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: ********** It was determined that the governing body failed to ensure each patient's rights were protected and promoted, including the right to receive care in a safe setting. Those failures created an unsafe Environment of Care ("EOC") that likely contributed to patient harm and death and created the likelihood of harm to other patients. The hospital failed to screen visitors; monitor in-person visits between patients and visitors; prevent contraband; observe and monitor patient condition, status, and location to ensure patients were safe and alive (Tag A-144). It further failed to conduct clear and complete investigations of adverse events that addressed all potential gaps and deficient practices; and failed to implement	A 115		

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A 115	Continued From page 3 and monitor corrective actions to prevent recurrence for other patients (Tag A-145). **********	A 115		
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: ********** Based on observations, review of video recordings, interviews, review of incident and patient care documentation for 19 of 23 patients (Patients 1, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, and 23), review of P&Ps, review of hospital directives, review of equipment inventory lists and manufacturer's instructions, and review of OSH internal investigation and corrective action plan documentation, it was determined that the hospital failed to fully develop and implement P&Ps that ensured each patient's right to receive care in a safe setting. The hospital's failures to monitor and observe patients' condition and location, to screen and monitor in-person visitation between patients and visitors, to prevent drugs and other contraband, to thoroughly investigate adverse events and to implement corrective actions, likely contributed to patient harm and death and created the likelihood of harm to other vulnerable psychiatric patients. Those failures included: * For Patient 5 and other patients, failure to ensure situational awareness and diligent observation and monitoring of patient condition and status, including whether patients were alive and breathing. * For Patient 22, failure to ensure situational awareness and diligent observation and	A 144		

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monitoring of patient location to ensure patients were not in unauthorized areas.
* Failure to ensure diligent and consistent registration/check-in of visitors prior to in-person patient visitation sessions.
* 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 of those from visitor to patient.
* 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.
* Failure to investigate causes of the recurring presence of, and patient possession of, drugs and other contraband that created an unsafe EOC in the hospital.

Findings 1.a. through 1.j. of this Tag reflect it was determined that a possible IJ situation existed based on findings that staff failed to conduct continuous rounds as required to ensure that patients were alive and breathing on the shift prior to Patient 5's death and on subsequent shifts after Patient 5's death, and that staff failed to ensure during continuous rounds that patients did not enter unauthorized areas and allowed Patient 22 to enter an unauthorized room. On 06/05/2024 the SA survey team and manager met to review possible IJ. On 06/06/2024, hospital leadership staff were presented with the IJ template. IJ Removal Plans submitted on 06/13/2024 and 06/24/2024 were not acceptable and were not approved. The third IJ Removal Plan submitted on 07/03/2024 was determined to be minimally acceptable after clarifications were provided at

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the request of the SA and was approved. The details of the IJ Removal Plan with a plan implementation date of 07/12/2024 at 2359 are described further in Finding 1.j. of this Tag. An onsite IJ Removal Verification Visit was conducted on 07/23/2024 and 07/24/2024 and the SA determined that IJ Removal Plan had been implemented.

Tag A-144 is a repeat deficiency previously cited on complaint and revisit surveys completed on 01/17/2022, 08/01/2022, 11/17/2022, 10/05/2023, 03/14/2024, and 05/06/2024.

Findings include:

1.a. During interview on 05/29/2024 beginning at 1115, hospital staff that included the Chief Medical Officer/Interim Oregon State Hospital Superintendent/Administrator ("CMO/Interim OSHS"), Interim Director of Security ("DS"), Chief Nursing Officer ("CNO"), Chief of Psychiatry ("COP"), Director of Quality Management ("DQM"), Director of Standards and Compliance ("DSC"), Program Director ("PD"), Director of Security ("DOS"), and OSH's DOJ Assistant Attorney General ("AAG") confirmed that on 05/24/2024 Patient 5 died unexpectedly on the Flowers 2 unit @ OSH-Salem ("FW2"). They provided the following information:
* Patient 5 had an in-person visitation with their parent during the evening on 05/23/2024.
* The next morning on 05/24/2024 at ~ 0815 Patient 5 was found unresponsive in their bed.
* A code blue [response to a medical emergency] was initiated by hospital staff, and Emergency Medical Services ("EMS") was called and responded. Resuscitation efforts were not successful and EMS pronounced Patient 5

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deceased.
* During the resuscitation efforts, another patient on the FW2 Unit reported to staff that the night before on 05/23/2024 Patient 5 had told them they had received something from their parent during visitation that might be drugs.
* Powder residue was found at Patient 5's bedside and was seized by Oregon State Police ("OSP").
* The hospital suspended in-person patient visitation until further notice on 05/24/2024 during their internal investigation into whether drugs were passed during visitation.
* Several staff who worked on the FW2 Unit the night shift after the patient visitation had been "duty-stationed" as there were questions about whether staff were performing rounds and checking patients during the night as required.

1.b. An untitled summary of actions taken dated and timed as 05/29/2024 at 1244 was provided as result of the interview conducted at 1115 above and reflected:
"* Suspended all on-site visits on both campuses before scheduled visitation was due to start on 5/24/2024.
* Notified patients * Notified all people scheduled to visit * Notified staff * Notified press * Posted notification on OSH social media page * Posted notification on OSH Internet page
* Security department searched Flower 2 for contraband on Friday, 5/24/2024, and on Saturday, 5/25/2024.
* Confirmed the patient did not interact with patients on other units following the visit on 5/23/2024. Between the visit, and the time patient returned to the unit, and the time of the medical emergency the patient did not have opportunities to receive or pass substances to other patients on

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other units. Because of this, no search of other units was done.
* Draft of a directive to staff is underway to enter patients' rooms if the patient is asleep to verify viability if it cannot be determined from the door.
* Communication to patients regarding change to viability checks is underway.
* Security staff who were involved have been removed from patient contact. This was the screener and security staff supporting visitation. Occurred 5/29/24 in the AM after a discussion with [Human Resources ("HR")]. Not in response to [Centers for Medicare & Medicaid Services ("CMS")] arrival, just a coincidence. One staff works swing shift and will be notified at 1400 on 5/29/24.
* Nursing staff who were involved have been duty stationed (on the unit, after the visitation, working during the night/day crossover on 5/24, prior to the medical emergency). Notice was given to staff at night on 5/24 - some staff work night shift.
* Clinical Administrative Debrief Meeting (CADM) was initiated on 5/28/2024."

During the interview on 05/29/2024 at 1115 the CMO/Interim OSHS confirmed that no other actions had been taken up to that time.

1.c. The 18-page "Protocol" titled "2.020 Continuous Rounds, Census, and Milieu (RCM) Management.pdf" dated as revised on 02/27/2024, included detailed direction for staff in relation to continuous rounds, including, but not limited to:

* "The purpose of this protocol is to establish performance expectations for nursing staff at Oregon State Hospital (OSH) related to conducting continuous rounds for the purpose of

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monitoring and verifying patients' status and whereabouts."

* Definitions included:
" 'Continuous' means on-going at all times."
" 'Viability' means the quality of being alive and breathing adequately to sustain life."

* "A. Nursing staff must perform continuous rounds focused on census and milieu management (RCM) at all times on each unit when patients are present."

* "C. ... No matter how scheduled, RCM assignments must cover all times during a shift and the following activities must be completed and documented on the RCM Flowsheet. i. Hourly Patient Census and Viability Checks, within 10 minutes of the top of every hour. ii. Hand-off report, at each change in RCM staff assignment, as described in this protocol."

* "D. Between swing and night shifts, and between night and day shifts, an off-going RN (or Lead LPN) and an on-coming RN (or Lead LPN) must conduct a collaborative patient viability round. (This round is not required to be completed between day and swing shifts.) 1. The off-going nurse and the on-coming nurse must together visualize each patient to verify both identity and viability. This verification may require pulling back the covers on a patient whose head is covered by bed linens or removing articles of clothing that may obstruct proper identification. a. The off-going nurse and the on-coming nurse must document the successful completion of these rounds by signing on the indicated signature lines at the top of the on-coming nurse's RCM Flowsheet."

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A 144	Continued From page 9 * "E. The RN (or Lead LPN) must verify that RCM duties are being continuously and accurately performed and documented by observing the RCM's actions and reviewing the RCM Flowsheet at least twice per shift. This verification does not require documentation." * "J. RCM staff must maintain awareness of the location and status of all patients assigned to the unit, including knowing if and when individual patients are off unit. This information must be accurately reflected on the RCM Flowsheet." * "K. RCM staff must verify that patients are remaining in authorized areas of the unit and must intervene if patients enter, or attempt to enter, unauthorized areas." * "L. RCM staff must verify that patients are not engaging in unsafe or unlawful behavior and must intervene if such behavior is noted. This includes but is not limited to: ... monitoring for potential sexual contact between patients and intervening ..." * "M. RCM staff must verify the presence and viability of each patient on the unit at least once per hour, at random intervals (within 10 minutes before or after the top of each hour). These checks must be documented on the RCM Flowsheet. 1. Verbal contact is not required during these checks, as long as visual verification of the patient's status is made. 2. To determine viability when a patient has their eyes closed or is non-verbal, staff must unobtrusively stand by to either visually or audibly confirm patient respirations. 3. When a patient is using a bathroom or shower, verbal confirmation of	A 144		

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presence and status is sufficient to verify viability ... For staff and patient safety, when entering patient bedrooms to perform patient checks, it may be preferable to utilize two staff, one stationed at the door and the other entering the room ... 6. RCM staff must document census and viability rounds on the RCM Flowsheet as follows ..."

* "P. The primary responsibility of RCM staff is the thorough completion of the RCM duties described previously."

1.d. Video observations of nursing staff continuous and hourly rounds and milieu presence protocols to ensure patients were alive and breathing were not followed during the night shift on 05/24/2024 prior to discovery of Patient 5 who was found unresponsive, cold to the touch, and not breathing in their room ~ four and ½ hours after they had last been observed alive.

* As described under Finding 1.c. above in this Tag, the hospital protocol for "Continuous Rounds, Census, and Milieu (RCM) Management" required staff to conduct "continuous rounds" for the purpose of monitoring and verifying the "status and location" of every patient and that "Hourly Patient Census and Viability Checks, within 10 minutes of the top of every hour" were to be conducted. "Viability" was defined as "the quality of being alive and breathing adequately to sustain life" and "To determine viability when a patient has their eyes closed or is non-verbal, staff must unobtrusively stand by to either visually or audibly confirm patient respirations."

* The 05/24/2024 patient census report for the

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FW2 South Hall reflected that four of the South Hall rooms had one patient each, and the other four of those rooms had two patients each, for a total of 12 patients on that hall. Video review of four hourly rounds of those eight patient rooms during the night shift on 05/24/2024 between the hours of 0415 and 0830 showed staff who conducted those rounds to stand in the hallway outside closed patient room doors, look momentarily through door windows into darkened rooms, and then move to the next rooms. As an example: On 05/24/2024 the rounds that began at 0457:51 at the first room were concluded when the staff person walked away from the last room and the 12th patient at 0458:28, for a total of 37 seconds. Those 37 seconds also included the time required to navigate from room to room down one side of the hall and back on the other side of the hall. Although a reasonable person could conclude that staff could not have both navigated the hallway and confirmed patient respirations visually or audibly for 12 patients during a 37 second period of time, the staff recorded on the RCM flowsheets that each of the 12 patients had "Eyes closed, [Respirations] Confirmed."

* The hospital protocol also stipulated that at shift change between evening shift and night shift, and between night shift and day shift, "the off-going nurse and the on-coming nurse must together visualize each patient to verify both identity and viability. This verification may require pulling back the covers on a patient whose head is covered by bed linens or removing articles of clothing that may obstruct proper identification."

* The video for 05/24/2024 South Hall shift change showed for rounds conducted by RN 2

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and RN 7 at ~ 0700 only one RN looked through door windows or briefly opened some patient room doors while the other RN stood in the hallway and held a clipboard. In addition, although RN 2 and RN 7 recorded that at 0700 eight of the 12 patients had "Eyes closed, [Respirations] Confirmed" at that time, documentation on the back of the report reflected that at 0700, seven of those eight patients departed for an "Off-Unit," "2nd floor Leisure" activity.

1.e. Video observations of Patient 5 and their room, Room 225, for 05/24/2024 night shift showed the following:

* ~ 0421 Patient 5 was observed to walk back into their room, Room 225, after they had spent time outside of their room walking around the unit. They were not seen to exit their room after that until they were moved from the room into the hallway after 0900 by EMS during unsuccessful resuscitation attempts.

* ~ 0457:51 video showed continuous rounds began. Mental Health Therapy Technician ("MHTT") 9 approached the door windows of patient Rooms 222 and 224 for 2/10th of a second then turned toward Room 225 on the opposite side of hallway took three steps toward Patient 5's Room 225 to within ~ 2 feet of the door, glanced toward the door window for 1/10th of a second then proceeded down the hall. MHTT 9 recorded on the RCM flowsheet that Patient 5 was in their room and had "Eyes closed, [Respirations] Confirmed" at that time.

* ~ 0556 video showed continuous rounds began. Those were conducted similarly to the 0457 rounds and MHTT 8 similarly recorded that

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Patient 5 was in their room and had "Eyes closed, [Respirations] Confirmed" at that time.

* ~ 0700 video showed continuous rounds began. Those were conducted by RN 2 and RN 7 as described above in Finding 1.d. and the RNs recorded that Patient 5 was in their room and had "Eyes closed, [Respirations] Confirmed" at that time.

* During interview on 05/30/2024 at 1520 with day shift RN 2 the following information was provided regarding Patient 5:
- RN 2 stated at "probably" 0655 or 0700 they did shift change viability rounds with night shift RN 7, who was an agency nurse. During the rounds, RN 7 visualized the patients and they, RN 2, did the writing on the RCM continuous rounds report. RN 2 told RN 7 "I'll do the writing and you do the visualization."
- RN 2 stated they "obviously" had no interactions with the patient.
- RN 2 stated RN 7 opened the door and "I believe" used a flashlight and said the patient was sleeping "so I wrote down [they were] sleeping and carried on." RN 2 stated "I visualized [the patient] and could see [they were] laying there." RN 2 stated the patient "looked like [they] always [do], curled up in bed with blankets." RN 2 stated they did not go into the patient's room to see if they were breathing.
- RN 2 stated later in the shift they went out to cue patients who still needed their medications ("meds") and they went to the patient's room, opened the door and said "It's Friday ... time for meds ... biscuits and gravy for breakfast." They stated the patient did not respond and that was typical for the patient. They stated the patient "plays possum" and usually gets up on their own.

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RN 2 stated the patient did not respond, they did not see the patient move, and they did not go into the room.

Refer also to RN 2's incident documentation under Finding 1.f. below.

* ~ 0800 video showed that no rounds were conducted. However, MHTT 1 recorded that at 0800 Patient 5, and six other patients on that hall, were in their rooms and had "Eyes closed, [Respirations] Confirmed" at that time.

* ~ 0806 video showed that MHTT 3 approached Patient 5's door, knocked on the door, opened the door, closed the door, then without urgency walked to check another patient ("pt") room then walked back down the hall to the Nurses Station ("NS").

* During an interview with MHTT 3 on 5/31/2024 beginning at 1300, the following information was provided regarding Patient 5:
- MHTT 3 stated they remembered the incident involving the patient. They normally worked day shift on FW2 and they came into FW2 at 0715 on the day the patient "passed away".
- MHTT 3 stated that they normally conducted rounds, called "visual rounds" every hour and those were documented on RCM forms. Their responsibilities during rounds were "Just to see if the patient is OK and what they are doing and check for breathing and stuff like that." The MHTT stated that during rounds they walk by each patient room and "only open the door if I can't see them moving from the [door] window." If they saw a patient moving from the window, they would document a "C" on the RCM which meant "active." If they did not see the patient moving,

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they would open the door, say the patient's name "to get their attention" and if the patient did not respond, they would get a second staff person to go check the patient with them. After getting a second staff person, they would both go in the room and tap the patient to check for breathing. The MHTT stated they were not allowed to go in patient rooms by themselves.
- MHTT 3 stated that "around 8:00ish the LPN told me a few patients had not gotten their meds so I went to Patient 5's room and I opened the door." The MHTT stated that the light was not on in the room. MHTT 3 stated, "I said Patient 5's name three times." The patient had headphones on so they didn't think the patient could hear them call their name. The MHTT stated the patient "looked totally normal." The patient was in bed "kind of sitting up, lying down but with [their] head up on the pillow, on [their] back." MHTT 3 did not think they could see the patient's eyes because "It was pretty dark in the room."
- The MHTT stated the patient had clothes on and they were "pretty sure" they had a blanket over them. The MHTT stated they did not go inside the patient's room at any time.
- The MHTT was asked by the surveyor if they could tell if the patient was breathing and they stated, "No, I didn't look for that." The MHTT stated that when the patient didn't answer, they let the License Practical Nurse ("LPN") know that they would have to take the patient's meds to them. The MHTT stated they did not say anything else to the LPN about the patient. The MHTT was asked by the surveyor if they saw anything suspicious in the room such as contraband and they stated, "No, I didn't look around."

Refer also to MHTT 3's incident documentation under Finding 1.f. below.

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* ~ 0825 video showed continuous rounds began. Those rounds by MHTT 1 who documented they conducted rounds at 0800. During those rounds the MHTT 1 did not look into or open the door to Patient 5's room.

* ~ 0834 video showed that the day shift RN 2 approached Patient 5's door, looked in the window, opened the door and looked in, closed the door, then without urgency walked away from the room and back down the hall.

* ~ 0847 video showed that LPN 5 approached Patient 5's door, opened the door, entered the room, and left the room with urgency after which staff began to urgently respond to Patient 5's room.

* On 05/30/2024 beginning at ~1320, during video review of the 05/24/2024 incident involving Patient 5, interviews with hospital staff present that included the CMO/Interim OSHS, the DS, CNO, Chief of Operations ("CFO/COO"), DQM, DSC, Incident Reporting System Incident Director "IRSID", DNS and others confirmed the following:
- Regarding checking for respirations if patient appeared asleep, staff stated "Protocol could include pulling down the blanket. They have to see the chest rise and fall."
- Regarding RCM rounds that began at ~ 0401 the video showed that the Mental Health Therapist ("MHT") walked up and down the South Hall and barely glanced in rooms, in some cases for less than one second, as they walked by. The DNS stated, "I don't think that is sufficient. We're in agreement."
- Regarding viability rounds at the beginning of each shift, staff stated that two RNs were

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required to conduct those rounds and "Both nurses should assess viability." However, regarding the RN viability rounds observed on video that began at ~ 0653 the DNS and DQM stated that viability checks by the two RNs was not happening and confirmed that the video showed that only one of the two RNs was looking into patient rooms to evaluate viability.
- Staff confirmed the video showed that no RCM rounds were conducted at 0800. RCMs did not happen until 0825 and the staff that conducted those rounds did not open Patient 5's door.

1.f. Incident documentation related to Patient 5 was reviewed and included the following:

* An incident report with incident date and time 05/24/2024 at 0900 was written by MHTT 1 and reflected the following: They were "tasked with RCM imedietly [sic] after at 0800 and was starting viabilitly [sic] with the RCM which included 3 close observations. I had started to do my check at 0800 ... I had walked down into the south hallway where one of my close observations was, looked into their room and they were awake so I went directly across the hall to look into the room which was Patient 5's room. When I looked into [their door window] the light was off and [they were] sitting upright as [they do] typically everyday at different points through the day. I have observed [them] previously in this position and it appeared to be [their] most preferred sleeping position. [Patient 5's] eyes were closed and [their] room darkened but not dark enough to not be able to see. As I was looking into [their] room one of my close observations from the room behind me came out of [their] room and said to me 'goodmorning' [sic] so I turned to [them] and replied 'good morning, it's good to see you.' At

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that point I was turned from [Patient 5's] bedroom window and I continued on checking the next room. I had finished viability and continued to do my close observation checks throughout the hour."

* An incident report with incident date and time 05/24/2024 at 0830 was written by RN 2 and reflected the following: "At about 0830 I spoke with LPN who was passing meds, and got a list of what patients who still needed their medications. I proceeded to [Patient 5's] room, and opened the door. The room was dark, and I said 'hey [Patient 5], it's time to get up for medication'. 'It is buscuit [sic] and gravy day for breakfast'. There was no response, which is typical of [them], who doesn't respond at times. When I returned to the nurses station I informed the LPN we should just delivery [sic] [their] meds to [their] room. Shortly later, about 0840ish, staff yelled 'We need a nurse to [Patient 5's] room right now'. Myself and [another staff] ran to [Patient 5's] room, and found [Patient 5] unresponsive. [Cardiopulmonary resuscitation ("CPR")] was immediately started ..."

* An incident report with incident date and time 05/24/2024 at 0840 was written by MHTT 3 and reflected the following: "Around 8am the LPN had asked me to get certain patients up to take their meds. [Patient 5] was one of those patients, I then went to knock on [their] door and said [their] name three times, I saw that [they had their] headphones in and assumed that's why [they] could not hear me. We are not allowed to go into patient bedrooms alone, so I told the LPN [Patient 5] was not getting out of bed. So [the LPN] could bring [them their] meds."

* An incident report with incident date and time

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A 144	Continued From page 19 05/24/2024 at 0847 was written by MHTT 4 and reflected the following: At 0847 "The [LPN 5] and I ... knocked on [Patient 5's] door so the Nurse can give [them their] medications. We opened the door and called out [Patient 5's] name but no response. [They were] laying in bed in a upright postion [sic] with headphones in [their] ears. So we turned on [the room] light and knocked on [the] wall to try and wake [them] up and still no response. I noticed then that [Patient 5] looked pale and stated to the nurse, '[Patient 5] looks pale.' I then went into [their] room and shook [their] shoulder and called [their] name once more but no response. At that time [Patient 5's] left arm went limp and fell to [their] side. I then felt [their] hand and [Patient 5] was really cold. I continued to check [their] pulse and notice that [they were] not breathing. I told the nurse [Patient 5] was not breathing and called a code blue and looked out the door and told the RN to come. RN rushed to the room and and [sic] stated, 'Call a code blue.' CPR was started right away at 0848 AM By [sic] LPN on the bed where [the patient] was lying ..." * An incident report with incident date and time 05/24/2024 at 0845 was written by LPN 5 and reflected the following: "During AM medication pass, writer noticed [Patient 5] did not come to med window and nursing staff requested floor staff to prompt patient. After noticing that patient did not come, writer decided to bring [the patient's] AM medication to [them]. Writer requested assistance from floor staff due to writer not being familiar with unit or patient. Writer and [MHTT 4] approached patient's room and knocked on the door. Writer called out to patient that its time for [their] medications and can [they] please sit up. Patient did not respond after multiple attempts from both writer and [MHTT 4].	A 144		

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Writer turned on the light and [MHTT 4] approached the patient to try to get [them] to wake up. [MHTT 4] turned to writer, said [Patient 5's] cold and tried to shake [the patient] awake. Writer closed the door to the patient room, cleared the hallway, called down to the hub to call the charge nurse and initiated CPR while patient was on the bed. [MHTT 4] called the code blue over the walkie."

* An incident report with incident date and time 05/24/2024 at 0847 was written by Nurse Manager ("NM") 6 and reflected the following: "Arrived in response to CODE BLUE. Found in room between two patient beds with staff performing CPR. Multiple doctors, nurses, and floor staff in room and immediate area to assist with emergency. Staff were actively moving other patients off unit. EMS notified and on the way. Arrived around 0900. CPR continued in room until EMS arrived. EMS staff on site, took over scene a little after 0900. [Emergency Medical Technicians ("EMTs")] noted rigor mortis had set in pt's jaw causing what looked like difficulty intubating pt. CPR continued until patient [death] called by EMTs @ 09:09:40. While in the nurses station, I overheard staff saying this patient had a visit last evening and there was a discussion about the possibility family passed the patient something, potentially contraband. While walking out of room after code over, EMT noted rolled up currency and what appeared to be a small amount of white powder noted. Room secured by [Security Manager] and [another] security staff. This information passed along to [Security Manager]."

1.g. Attempts to resuscitate Patient 5 by hospital staff and EMS who responded to the patient unit were not successful and Patient 5 was

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pronounced dead at 0909. Had continuous rounding been conducted as required by hospital protocol during the hours after Patient 5 re-entered their room at 0421, Patient 5 may have been identified to be in distress, struggling to breath, or unresponsive earlier and may have survived. However, Patient 5 was not "visualized" per the protocol during continuous rounds. Further, when Patient 5 was "visualized" at 0806, 0825, and 0834 and was unresponsive to staffs' verbal communications and had closed eyes, staff did not approach the patient's bedside to determine whether the patient was alive and breathing, rather they walked away with no sense of urgency to conduct other business. Only at 0847 when staff finally approached the patient's bedside and determined that they were "cold" and "not breathing" did staff respond.

1.h. On 05/29/2024, five days after Patient 5's death, and after the State Agency ("SA") investigation had been initiated, an email from the CNO was dated and timed as sent on 05/29/2024 at 1354. The "Subject" was "Nursing RCM Reminder" and an "Attachment" was identified as "2.020 Continuous Rounds, Census, and Milieu (RCM) Management.pdf" The email reflected: "This email is intended for all OSH Nursing staff. Good afternoon OSH Nursing, Last week we experienced the loss of a patient. This has been incredibly hard and traumatizing to people across the hospital. Please reach out to your manager if you need support. We have on-site and virtual support options. This event is under investigation, so details cannot be shared yet. What we want to highlight for now, is the importance of viability checks while doing RCM rounds. It is particularly tough when the patient is in bed. Being able to confirm respiration by watching for the rise and

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fall of the chest from the doorway is difficult at best. As a reminder, anyone assigned to RCM rounds must enter the patient's room to assure viability if that cannot be obtained from the doorway. Please use a second staff to enter when needed. We know this will likely result in sleep disruption for the patients as we begin to enter the room more frequently. We hope this will be a short-term directive as we are looking for a technology solution. Thank you, [CNO]"

There was no other evidence provided that other actions had been taken after the patient's death to monitor and observe staff practice to ensure staff were conducting RCM continuous rounds as required to determine "viability" or that patients were alive and breathing.

1.i.i. Video recordings and documentation of incidents that occurred after Patient 5's 05/24/2024 death and after the 05/29/2024 email referenced under Finding 1.h. above in this Tag had been sent to staff were reviewed. Those reflected that nursing staff hourly rounding and milieu presence processes to monitor and confirm patient condition and status showed minimal improvement. The rounding processes which were also required to monitor and confirm patient location were additionally not effective as a patient was allowed to enter and remain in the room of two opposite gender patients during the middle of the night.

1.i.ii. Video review of 17 RCM continuous rounds on the night shifts of 06/01/2024 and 06/02/2024 on the FW2 South Hall showed minimal to no change in the way staff conducted the continuous rounds and assessed "viability" or whether the patients were alive and breathing, in comparison

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with how those were conducted on 05/24/2024. The time taken and the proximity of RCM staff in relation to the patients, from the hallway looking through windows of closed doors into darkened patient rooms, were not sufficient to assess whether patients were alive and breathing.

* During review of the FW2 06/01/2024 and 06/02/2024 videos on 06/05/2024 beginning at 1105, with staff present that included the DSC, CNO, DNS, and CMO/Interim OSHS, the following information was provided:
- It was expected that during RCM rounds staff should "see" each patient's chest rise and fall or "hear" respirations.
- At the closed patient room door in the hallway staff were to look to see if each patient's eyes were closed. If so, staff were to look through the door window for the chest rise and fall. If staff can't see patient respirations they are to approach the patient to listen for respirations and pull covers back if needed.
- If staff can't confirm "viability" they are to go into the patient's room.
- In regard to the video review that showed minimal change to staff RCM practices from the 05/24/2024 video described in the Findings 1.d. and 1.e. above, the DNS stated, "I agree that the two nurses are not doing viability rounds" as required and that "only one RN was checking for viability."
- The DNS stated that the RCM video review showed observations for patient viability at patient room doors were "very brief" and "there are opportunities ... this is for benefit of patient safety."
- At ~ 1250 the DNS stated that we didn't need to look at more video and "we understand what you're showing us."

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A 144	Continued From page 24 1.i.iii. Review of the hospital's incident log or "tracker" included an incident that occurred on 06/02/2024 for Patient 22 identified with "Incident Type" of "Sexual Contact." * Incident documentation reflected that on 06/02/2024 on Flowers 1 unit @ OSH-Salem ("FW1") at "0350-0355. While doing RCM/[Safety and Security Management ("SSM")] rounding Nurse noticed [Patient 22] coming out of [the room of two opposite gender patients] on the South Hall. Nurse asked [Patient 22] what are you doing coming out of their room? [Patient 22] stated 'I was asking them to fix my [portable music ("MP3")] Player'. Writer informed [Patient 22 that they were] not allowed to enter other patients [sic] room. [Patient 22] stated '[They were] fine, and nothing happen [sic].' I spoke with [the two opposite gender patients] and asked them what happen [sic]; and why was [Patient 22] in there.? [sic] They stated '[Patient 22] came in and they asked [Patient 22] to leave, and [Patient 22] was there for 10 [minutes ("mins")]' ". * Review of the RCM "Unit Patient Census and Status Flowsheet" dated 06/02/2024 for night shift showed that Patient 22 was observed at 0301 in their "Bedroom - Eyes closed, [Respirations] Confirmed" and at 0400 Patient 22 was observed in their "Bedroom - Eyes closed, [Respirations] Confirmed." * During interviews at the time of incident and video reviews that occurred on 06/04/2024 beginning at 1105 and on 06/05/2024 beginning at 1105, with staff that included the DSC, CNO, DNS, and CMO/Interim OSHS, they confirmed that patients were not allowed to be in other	A 144		

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patients' rooms.

* Review of the FW1 floorplan and patient room assignments showed that Patient 22's room was near the middle of the East Hall, Room 138. The room of the two opposite gender patients was the room furthest from the NS at the end of the South Hall, Room 131. In order for Patient 22 to get to the other Room 138 they would have to walk down the East Hall past two other patient rooms, a laundry room, a kitchenette, and a large patient activity/common area to the front of the NS. From the front of the NS the patient would have to walk down the South Hall past a second large patient activity/common area, a kitchenette, a laundry room, and three patient rooms before arrival at the fourth patient room, Room 138, at the far end of the South Hall.

* According to RCM Protocol instructions delineated at Finding 1.c. above in this Tag, staff who conducted the RCM activities should have maintained a continuous presence in the milieu to be able to observe Patient 22's movements between unit hallways during the middle of the night to prevent Patient 22 from entering Room 31 in order to protect Patient 22 from potential sexual contact and other risks.

1.j. Although the email referenced under Finding 1.h. above in this Tag was sent to staff to remind them to follow RCM processes on 05/29/2024, that action had not been sufficient to ensure staff were confirming patient condition/status and location as required by the RCM protocol and the email. In response to the continuous rounds process findings identified under Finding 1.i. above the hospital was notified on 06/06/2024 that an IJ situation existed. Additional immediate

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action was determined to be required to ensure that the condition/status and locations of patients were monitored and confirmed, and that observations of patients who had their eyes closed were sufficient to confirm that those patients were alive. The IJ Removal Plan submitted on 07/03/2024 had an implementation date of 07/12/2024 at 2359 and was approved. It included the following actions:
* "OSH will issue an administrative directive, effective July 8th, requiring direct observation by a Registered Nurse acting as lead to observe no less than three viability checks 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."
* "The 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 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 (as evidenced by chest rise and fall) for a minimum of 2 respirations ... If the patient is in a room with a large window ... 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 ... If the patient is [sic] 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

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patient for 10 seconds and visualize 2 respirations. If 2 respirations cannot be confirmed by both staff, staff must quietly open the door ... 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."
* "OSH Staff who perform RCM rounds or supervise staff involved in RCM rounds have been notified and trained to the updated processes ... All Nursing staff will be instructed both verbally and in writing about the updated Continuous Rounds, Census, and Milieu (RCM) Management protocol, which include the observation requirements stated above. Staff will confirm in writing that they received, understood, and will follow the updated protocol, and that they will seek guidance and clarification from a supervisor for any questions, via attestation ... RNs acting in the lead capacity on each shift have received additional in-person training, including competency verification, regarding viability checks and the Continuous Rounds, Census, and Milieu Management protocol."
* The "three viability checks per shift" will be three "full RCM [rounds] of 'viability checks' of all patients on the unit."

2.a. After the code response for Patient 5 an incident report with incident date and time 05/24/2024 at 0900 was written by a Treatment Mall ("TXM") Activities Coordinator and reflected that they were "approached by flowers 2 client,

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[Patient 24]. [They] stated to me .. '[Staff name], my friend [Patient 5], I think is going to die. I'm not a Nark. I should have said something last night. [They] offered me drugs & told me [they] got them at [their] visitation last night. I think it was [their parent] & It looked like Fentanyl. I told [Patient 5] no way.' This writer told [Patient 24], 'to not worry, It is not your fault and you did the right thing telling me.' This writer immediately took [Patient 24] back to TXM and then went on to flowers 2 unit & reported to Manager ... [Manager] & I shared the conversation in the nurses station with [Security Manager] of what was exchanged with [Patient 24] and myself. I at that time went and got [Patient 24] and took [them] to [Security Manager] so they could speak, and after their conversation ended, I returned patient to TXM."

2.b. An email from the CMO/Interim OSHS was dated and timed as sent on 05/24/2024 at 1506. The "Subject" was "READ NOW: Urgent visitation pause" and an "Attachment" was identified as "Patient update- visitation 5-24-24.pdf" That email reflected: "This email is intended for all OSH employees. Dear OSH Team, Because of a significant incident related to passing of contraband from a visitor to a patient, we are pausing in-person visitation effective immediately, beginning with the 2 p.m. visits scheduled today, Friday, May 24. This was a decision the Executive Team did not make lightly. We know how important inperson visits are to patients and those who love them, and we know we are making the decision on a Friday before a holiday weekend. We will keep this pause as short as we can while we review our visitation policies and procedures and make improvements to ensure in-person visits are safe for patients, families and staff. Reception Center staff will contact visitors to

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let them know about this change. Unit managers will also ensure patients receive this information, beginning with patients who had visits scheduled this weekend. Below you will find a script to use when sharing this information with patients. Attached is a handout you can give to patients explaining the pause. Video visits remain available. Please continue to use our standard procedures for scheduling and facilitating video visits. We apologize again for the inconvenience to patients and their loved ones, and we will update you when we have information about how we plan to resume in-person visitation. Sincerely, [CMO/Interim OSHS]."

The email continued with "Script for discussing in-person visitation pause with patients: We are very sorry to share some difficult news. Because the hospital had a significant incident where a visitor passed contraband to a patient, we are pausing all in-person visitation effective immediately, beginning with visits at 2 p.m., Friday, May 24. We know this is disappointing and frustrating. We know you were looking forward to a visit, and we know your visitors were looking forward to seeing you. Our Reception Center team is contacting your visitors and letting them know a video visit is an option. We are going to review our visitation policies and procedures and make adjustments so we can return to safe in-person visits as soon as we can. We will let you and your visitors know when we are ready to resume in-person visits, including any new requirements."

2.c. During interview on 05/29/2024 at 1130 with DQM, DOS, PD, and other hospital staff present the following information was provided:
* The DOS stated an incident involving Patient 5

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occurred on 05/23/2024 in the evening.
* DQM stated that the investigation was still in process.
* The PD stated Patient 5's room was in FW2 Unit. The patient had a visit with a family member on 05/23/2024. The morning after the visit at about 0815 or 0830, the patient was found unresponsive in their room. A Code Blue was called, staff responded, and CPR was started. EMS arrived and the patient was pronounced dead.
* DOS stated after the code, Patient 24 wanted to talk to a security staff. Patient 24 told the staff that Patient 5 had told them that they received "drugs or something to that effect" from the family member who had visited the patient.
* PD stated, "a powder residue" in tin foil was found on the floor at Patient 5's bedside and "state police took it."
* DOS stated visitors make appointments for their visits, so the hospital knows ahead of time who is coming. Patient 5's visitor had an appointment at 1800 but they did not arrive "to get screened" until 1855. Patient 5's visitor went through the visitor screening process.
* DOS stated that the hospital has a visitation log of approved visitors who come into the hospital.
* DQM stated that all visitation occurs in Kirkbride Café. Nursing staff and security staff provide "eyes on" during patient visits.

During interview on 05/29/2024 at 1205, DQM stated they did not know what the powdery substance was that was found in Patient 5's room.

3.a. Processes and documentation for registration and check-in of visitors who arrived for in-person visitation sessions with Patient 5

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and other patients on 05/23/2024 were found to be inconsistent, unclear, and incomplete.

3.b. During interview on 05/29/2024 beginning at ~ 1315, with staff that included the DQM, DSC, IRSID, the CMO/Interim OSHS, CNO, and Risk Manager ("RM"), the following information was provided:
* Security staff run background checks of individuals who request patient visitation as part of an "approval" process to be able to participate in in-person visitation. Upon approval those names are added to the patient's medical record as an approved visitor.
* Approved visitors are scheduled for visitation on specific dates and times and must check in at the hospital's main reception desk to register and sign-in.
* There are two reception windows where all visitors must register, be signed-in on the visitor log for the window they presented to, and receive a visitor badge that must be worn during the duration of their visit.
* From reception, visitors move to the secure main lobby to be screened for contraband and prohibited items before being escorted to the designated visitation area in the Kirkbride Café where up to 11 patients at a time may have visitation sessions.

3.c. Review of the two "Visitor Sign-In" logs for 05/23/2024 revealed the following:

* The "Visitation" schedule for the "Kirkbride Café" 05/23/2024 showed that 19 individuals were scheduled for visitation sessions beginning at 1600.

However, the two "Visitor Sign-In" logs dated

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05/23/2024 showed that 17 individuals arrived at the hospital for visitation sessions. However, the names of visitors scheduled did not align with the names of those who arrived.
- For a "Time In" entry at 1600 the name of a visitor identified on the "Visitor Sign-In" log did not match any names identified on the "Visitation" schedule.
- The "Time In" entry for 1914 reflected the first names only for two persons. Those names were not found on the "Visitation" schedule.

* "Time-In" entries on the logs were not in chronological time order. The log for "Window # 1" showed that visitors presented in the following order on that day: 1100, 1020, 1543, 1544, 1547, 1555, 1600, 1604, 1616, 1706, 1100, 1846, 1855, 1914, 0815, 1150.

* Multiple entries contained more than one name of a visiting person entered on one line of the log. "Time In" entries recorded at 1543, 1555, 1846, 1914 each contained the names of two persons entered on one line. The "Badge ID #" space for those four entries showed two badge #s, however, it was not clear which of the two persons was assigned which badge #.

* The two "Visitor Sign-in" logs reflected that on 05/23/2024 36 individuals registered and checked-in for a variety of reasons, including for patient visitation sessions. However, 29 of those 36 entries lacked the visitors "Time Out" of the hospital and evidence they had returned the visitor badge.

3.d. During interview at the time of the visitor log review on 05/29/2024 beginning at 1315, staff confirmed the visitor logs contained unclear and

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missing information, including that each visitor was supposed to be documented on a separate line.

3.e. The findings regarding visitor check-in processes were consistent with surveyors' varied experiences during visitor check-in on the mornings of 05/29/2024 and 05/30/2024. Those included that the check-in process was concluded after the name of a surveyor, and presumably the time of entry and badge #, were written on a piece of torn scratch paper versus the "Visitor Sign-In" log.

4.a. Observations of the visitor check-in and screening areas with DSC and other hospital staff on 05/29/2024 at ~ 1020 when the survey team arrived at the hospital revealed:
* Observation of the main hospital entry included two visitor check-in windows and a secure door leading to the visitor screening area.
* The visitor screening area was located in the hospital's main lobby.
* Inside the visitor screening area, an X-ray scanner unit with a pass-through section used for screening items was observed.
* A thin black mat with two solid yellow foot shapes that indicated foot location and stance was observed on the floor in front of the X-ray unit.
* Stackable box style metal lockers with locks were observed near the X-ray unit.
* Seating for multiple individuals was observed across the room from the X-ray unit.
* A Security Staff ("SS") member had a handheld metal detector wand.

4.b. During interview on 05/29/2024 at ~ 1035 with a SS member at the visitor screening station,

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the following information was provided:
* Before visitors come to the hospital, they are told what needs to happen with their belongings upon their arrival.
* When they arrive, "we tell them to please lock up their belongings in a locker."
* Visitors are only allowed to bring a credit/debit card or cash inside so they can purchase food in the hospital café.
* If there is "something on a person" the metal detector wand will make a beeping noise.
* If the battery in the wand is low, the wand "doesn't work right" and "doesn't pick up anything."
* The SS member stated that "visitors go through with stuff in their pockets all the time."

4.c. During interview on 05/29/2024 at ~ 1120 the DOS stated that all visitors must go through the visitor screening area in the hospital's main lobby.

4.d. Video review of the screening of visitors in the hospital's main lobby on 05/23/2024, the date of Patient 5's visitation with their parent, showed that visitor wanding and screening measures were insufficient and inadequate for the purpose of drug and contraband detection. For example:

* Video beginning at 1559:14 showed a SS member completed the security screening and wanding process for nine visitors in a moving line at 1559:52. During those 38 seconds, the wanding time for some of the visitors was ~ 2 - 3 seconds. The screenings consisted of a cursory pass of the wand near the front and back of the persons' torso only, the back pass for some was conducted as the visitors walked away. There was no indication of any verbal communication between security and each visitor. None of the

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visitors were prompted to stand on the black mat.

* Video of a visitor screening showed that the SS member passed the wand briefly over the person beginning at 1850:43 and ending at 1850:47. The visitor was not standing on the black mat.

* Video of another visitor screening showed that the SS member passed the wand briefly over the person beginning at 1850:52 and ending at 1850:58. The visitor was not standing on the black mat.

* Video showed that Patient 5's parent arrived at the hospital, at 1851:20 approached the first check-in window at the reception desk, at 1852:00 entered the main lobby through the secure doors, and then entered a restroom in the main lobby. After they exited the restroom at ~ 1853:10 Patient 5's parent was observed to place a phone and other items removed from their pockets into one of the lockers. At 1853:49 a SS member began to run the wand briefly over the parent while the parent was still walking forward. The SS member moved the wand from the left shoulder to right shoulder, to mid right forearm, then one wave down the torso to the left knee area. The SS member walked around to the person's backside and moved the wand from left shoulder down to the left calf. That concluded the screening and both walked away from each other. The wand was not passed over all body areas, including the feet, the parent did not stand on the mat, and the wand was noted to be inches away from the areas that the wand was passed over. At 1854:20 the parent entered sally port with SS member to proceed to the visitation area.

* Video showed that two adult visitors entered the

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main lobby and approached the lockers at 1904:32. No one else was observed in the main lobby at that time. They milled around near the lockers and at 1904:53 the first visitor was observed to approach the second visitor closely and began touching the second visitor underneath the second visitor's long, untucked baseball type shirt near where the beltline or top of the pants would be. The visitor continued to actively touch and handle that area underneath the shirt while the second visitor looked around the room. This went on for ~ 23 seconds, when at 1905:16 the first visitor removed their hands from the second visitor's body and stepped away. Both visitors then sat in chairs.

The video showed that the SS member conducted a cursory wand screening for the first visitor that began at 1906:19 and ended at 1906:25. The wand screening for the second visitor began at 1906:25, consisted of a cursory 3-second pass across the visitor's stretched-out arms, erratic wand movements several inches away from the front of the visitor's body, and ended at 1906:32 after the back of the visitor's arms and legs were wanded. It was not evident that the visitor's torso or beltline area was wanded during the screening. Neither visitor was prompted to stand on the black mat.

Those two visitors were most closely aligned to the two visitors who were signed in on the "Visitor Sign-In" log with first names only and who were not on the "Visitation" scheduled as identified in Finding 3.c. above.

* Video observations showed that screening wands were passed at distance of greater than one inch away from the person being screened,

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contrary to directions in the Manufacturer's User Manual described under Findings 4.f. below, and raised questions about whether drugs and other contraband could be detected with the brief and cursory screenings observed. In the case of the visitors who presented to the lobby at 1904 their behaviors raised further questions about whether drugs or contraband were potentially being arranged or adjusted at the second visitor's beltline to avoid or prevent detection. In addition, it was unclear what purpose the black mat observed next to the screening station served as it was not observed being used during the video observations.

4.e. During interview on 06/03/2024 beginning at 1700 during the review of visitor screening video with staff that included the IRSID, the DQM, and DSC, staff agreed that the behaviors of the two visitors who arrived in the lobby at 1904 were "weird" and concerning.

4.f. The Manufacturer's "User Manual" for the Garrett "Super Scanner V" screening wand included the following information related to use and maintenance:
*There were three methods of "Alerts" for metal detection that were lights, an audible sound, and vibration.

* "When the Super Scanner V is operating, it will detect metal only while it is in motion. Move the instrument within approximately one inch from the person (object) being inspected. A sound will be heard or vibration felt and the Red Alert Light will illuminate whenever metal is detected. Operation is completely automatic. No 'retuning' is ever necessary. All conductive metals will be detected including ferrous, non-ferrous and stainless

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steel."

* "DETECTION PRINCIPLES AND CAPABILITIES - The Super Scanner V is an active hand-held metal detector with very high sensitivity to all metals including ferrous, non-ferrous and stainless steel. Detection and alarming takes place when the instrument is passed in close proximity to metal objects. Detection range is dependent upon the size and conductivity of the metal object. The larger the object, the greater the detection distance. The Super Scanner V is factory preset to nominal sensitivity with no operator adjustments required. This ensures that the detector will be used at the proper operating level established for the particular security need. Should nearby, stationary metal objects (floor rebar, metal walls or cell bars) cause interference to the scanning process, an Interference Elimination Button is available to momentarily reduce sensitivity so as to ignore the interfering nearby metal and permit precise scanning of the individual or object being scanned. When metal objects are encountered, the red [Light-Emitting Diode ("LED")] is activated along with an audible alarm or the vibration alarm (depending upon user setting). An optional earphone may be used by the operator. Further convenient LEDs include green for 'Power ON' status and amber for 'Low Battery" indication.'"

* "Maintenance - Periodic maintenance should include a daily check for battery condition, verification that the Super Scanner V detects metal and there are no loose or missing parts. A daily test standard can be established by using the [Flat Test Piece ("FTP")] or [Operational Test Piece ("OTP")] test piece available from Garrett, or simply by selecting an object the size of a large

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coin and noting the expected detection distance. A formal test program may be establish[ed] using the Test Kit [Hand Held Metal Detector ("HHMD")] [part number ("p/n")] 1626100 available from Garrett."

* "CAUTION: Always verify that the Super Scanner V is set to the desired sensitivity level by testing with appropriate targets anytime the sensitivity adjustment is changed. Do not affix metallic labels (or any material that might cause the detector to alarm) to the detection area of the Super Scanner V. Doing so might cause an imbalance within the detection field and thereby reduce scanning effectiveness. If the equipment is used in a manner not specified by the manufacturer, the protection provided by the equipment may be impaired. Use carbon, alkaline, or [Nickel-Metal Hybride ("NiMH")] batteries only. Operate within the specified temperature ranges of the battery."

* A "Recommended Body Scanning Procedure" diagram showed the manufacturer's instructions for the body position of a person being scanned, the position of the wand and the route of scanning front and back of persons, and the position of the wand and method for scanning feet.

4.g. Video observations described above were not in conformance with the diagram elements. For example: Observations showed that many visitors were only scanned front and back of torso areas and arms or feet were not scanned; The diagram showed the position of the arms to be at a person's side, slightly extended from the body, while the video observations showed visitors' arms raised to shoulder level and stretched

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straight out; The diagram showed the position of the wand over the visitor's body was always horizontal to the floor and the position of the wand over the feet to be vertical to the floor, while the video observations showed no consistent wand position used.

4.h. Refer to Finding 6 below that reflected the hospital had no written P&Ps or protocols for use and maintenance of those sensitive and important screening devices. A "Master Inventory" list of wands and locations reflected the hospital had 11 of the screening wands in operation.

5.a. During interview on 05/29/2024 beginning at 1115 with staff that included the CMO/Interim OSHS, the CNO, CFO/COO, DQM, DSC, AAG, PD, and DOS, the DOS stated that the Security Department "owns the visitation process" and indicated that nursing "also has their eyes on it."

During interview with DQM on 05/29/2024 at ~ 1515 they stated there were supposed to be two SS members and two nurses present during patient visitation sessions in Kirkbride Café. However, the DQM stated the second SS member "showed up later" after Patient 5's visit had started.

5.b. The "Patient Log for Visitation Date:" 05/23/2024 reflected the Patient 5 arrived in the visitation area at 1900 and was picked up for escort back to their unit at 2000. In addition the log showed that three other patients had visitation sessions at the same time and all four of the patients were picked up for return to their units at 2000.

5.c. Video review of the in-person visitation

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between Patient 5 and their parent on 05/23/2024 that began at ~ 1900 and ended between ~ 1950 and 2000 showed the following:

* Initially there was one SS member seated at a table at one end of the café, and two nursing staff members seated at a table at the other end of the café. In between those staff were several round, square, and smaller rectangular tables with chairs grouped closely together for the patients and their visitors. Later during the visitation, a second SS member joined the one seated at the one table, and a third nursing staff member joined the two seated nursing staff members at the other table. The second SS member, the third nursing staff member, and one of the two other nursing staff members were not present in the visitation room at all times during the visitation as they periodically came and went, and the third nursing staff member did not return. There were multiple times when only one SS member and one nursing staff member were present in the visitation room. Periodically throughout the visitation the SS members were observed to direct their attention away from the visitation, face each other, and engage in conversation. Similarly, that was observed between the nursing staff members. At times, both the SS members and the nursing staff members' attention was observed to be directed away from the visitation at the same time. One of the SS members was observed to talk on a cell phone during the visitation.

* It was not clear how staff members were able to visualize and observe the behaviors and actions of all the patients and visitors in the room from their seated positions. For example: One patient, seated at a small rectangular table, whose back

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was to the nursing staff members, sat directly across from one of their visitors. That visitor's back was to the SS members seated on the other side of the room. The front of the patient and visitor, their arms when they were on the table, and the table space in between the two of them could not be visualized as those were blocked from staff views by their bodies.

* Patient 5 and their parent sat at a round table in the café that had seating capacity for four. During the visitation the two of them were observed to focus attention on their feet under the table, shuffled and fidgeted their feet, looked downward toward the floor and feet, fidgeted with their pants. The SS members and nursing staff members failed to intervene or approach Patient 5 and their parent when they demonstrated those behaviors. Twice during the visitation both Patient 5 and their parent walked together out of the visitation space and down to the end of the corridor to the vending machines. On one of those occasions, the second SS member followed the pair. On the other occasion, it was not possible to observe their behaviors and interactions because of the inadequate camera view described further below.

* A second patient who had two visitors sat at another round table that had seating capacity for four.

* Although there were three other round tables and a square table each with seating capacity for four, a third patient who also had two visitors sat at a small rectangular table with seating capacity for two, significantly smaller than the round and square tables. One visitor sat directly across the table from the patient while the second visitor sat

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on a couch that was positioned up against the wall adjacent to the table. Those visitors were the two observed in the main lobby video described under Finding 4.d. above. Eventually during the visitation the second SS member got up from their seat, approached the second visitor, pulled up a chair from the round table next to the rectangular table, and prompted the visitor to sit in that chair at the narrow, shorter edge of the table that was not designed to accommodate a chair. Later during the visitation, the second SS member got up from their chair and walked partway along the perimeter of the room near the center of where the visitation tables were grouped. The SS member looked in the direction of the patient with two visitors that sat at the rectangular table, then turned and walked back away to their seat. In response to that, the second visitor immediately pushed their chair back away from the rectangular table on which they had had their arms positioned.

*Neither the first SS member or any of the three nursing staff members approached patients or visitors during the visitation.

*Camera views in the visitation café did not capture all parts of patient, visitor, and staff bodies and behaviors. For example: In one camera view only the upper half of Patient 5 and their parent's body and the lower half of three seated nursing staff members at the other end of the room could be visualized. In the other camera view only the back upper half of two of the nursing staff members bodies were visualized. In both views a patient and a visitor sat directly across from each other while each of their backs directly faced one of the camera views. The front of both of those persons, their arms, and the

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space in between the two of them could not be visualized. Two other camera views captured the corridor between the café entrance door and the main café area where the visitation occurred. Vending machines were located at the beginning of the corridor just inside the café entrance door. Although patients and visitors were observed to make trips to the vending machine during visitation the camera views provided only partial, barely visible views of the machines and individuals who stood in front of them

5.d. An incident report with incident date and time 05/23/2024 at 1900 was written by a SS member on 05/24/2024 and reflected the following: "On 05-23-2024, around 1900 while assigned to visitation in Kirkbride Cafe with [Mental Health Security Technician ("MHST")] when [Patient 5] was visiting [their parent] At the beginning of the visit, when [their parent] asked [the patient] how [they were] doing, [they told their parent they were] doing good, that [they] had a lot of money and could go buy $10.00 worth of food a week from the market right there. [Patient 5] further stated that [they] could have $50.00 a week that [they] could draw $30.00 on Tuesday and Thursday and was paid on Wednesday's [sic]. This was a very odd comment that I have never head in visiting and so I started to watch them more closely. [Patient 5] then glanced at me and asked [their parent] about [their] green shoes, with the short socks. Saying [the patient] really like them and asking where [the parent] got them. They both leaned over and looked at the shoes which [the parent] pointed out things about and them [sic] after a short time they sat up and went and got a pop from the vending machine. There was no other odd behaver [sic] during the visit."

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There was no indication that the SS member who wrote this incident report after the patient's death the following day had intervened at the time of the suspect behaviors, or at that time reported those to a manager or other leader on duty in the hospital who could come to the visitation area to evaluate and intervene as necessary.

5.e. During interview on 05/29/2024 beginning at 1115 and again on 06/05/2024 beginning at 0905 staff confirmed that the hospital had no special required qualifications or training requirements for SS members or nursing staff members who were assigned to monitor the in-person visitation sessions.

6. Review of a document titled "CMS Survey OR50743 Documentation Not Provided" dated as "Last updated 6/13/24" reflected the following in response to surveyors' requests for the hospital's written P&Ps and protocols related to visitor screening and patient visitation and revealed a lack of written P&Ps for screening activities and tasks:

* In regard to "Security- role/responsibility tied to visitations/is it listed in PD's or protocol," the "Reason Not Provided" was "We don't have any protocols specific to visitation. New wanding/pat down protocols almost ready to deploy alongside skill-based training. New protocols will be launched in the coming week."

* In regard to "Nursing Protocols on screening or visitation," the "Reason Not Provided" was "We do not have them."

* In regard to surveyor request for "... [Visitor to Patients] policy (8.026) and attachment

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[Procedures C] references to 'Screen the visitor and visitor belongings for contraband according to Security Department protocols.' Please provide those [Security Department] protocols that were in place on and prior to 05/23/2024 ... we've asked for this before and were told there were none ... want to further confirm." The "Reason Not Provided" was "We are working on a protocol now; currently have 3.007 which does not go into detail as to what that searching process is, only that it will happen ..."

* In regard to "[Visitors to Patients] Policy 8.026, Procedure C Attachment, references that staff are to 'Make a reasonable effort to staff the visit in accordance with Nursing and Security Guidelines.' Please provide the 'Nursing and Security Guidelines' that were in place on and prior to 05/23/2024 ... we've asked for this before and were told there were none ... want to further confirm." The "Reason Not Provided" was "... Nursing follows [Policy 6.024 Transportation and Supervision Ratios]. Nursing has no other protocols/guidelines regarding this. Also, Security does not have a current visitation protocol that covers things like staffing and expectations for standard work. We currently have one under construction ..."

* In regard to "Security wand maintenance records," the "Reason Not Provided" was "We do not have them."

7.a. Review of other incident reports for incidents/events that occurred after Patient 5's death on 05/24/2024 reflected that contraband and prohibited items were allowed to be in patients' possession, and demonstrated that investigations of prior contraband related

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occurrences had not been effective to prevent patients from accessing those.

7.b. Review of the incident log for the period of 05/29/2024 to 06/03/2024 revealed for that five-day period incident reports included the following:
* 23 instances "Contraband/prohibited items"
* Eight instanced of "Medication diversion" or "Medication found"
* Seven instances of "Sexual contact"
* Seven instances of "Tools/sharps missing/unattended"
* Four instances of "Unattended/Wandering Patient"

7.c. Incident report documentation reflected the following examples:

* On 05/24/2024 at 1330 on FW2 a second staff person wrote "Code Orange, Possible Fentanyl spill in [Patient 6's] clothing ... white powder was found: 1) On the Patients clothes that were in a laundry basket; 2) At the bottom of the laundry basket; 3) On the corner near the laundry basket. Coffee creamer and Splenda packets (Contraband in patients room) was found in the shoes of [Patient 6] that was being stored in the closet."

* In addition for Patient 6, on 05/24/2024 at 1330 on FW2 staff wrote "Patient Possession Prohibited Item ... When searching [Patient 6's] desk area I found white substance in a laundry basket and on [the patient's] desk. The substance appeared to be posibly [sic] creamer or splenda ... We finished searching locked the door and notified security."

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* On 05/24/2024 at 1300 on FW2 in Patient 7's room staff found "Patient Possession Prohibited Item ... a suspicious white powder 'spilled' on the side table by the bed ... decision made to lock and seal the room and ask for [OSP] to respond to investigate ... [OSP Officer] seized the powder from the table and released the room back to security."

* On 05/24/2024 at 1200 staff wrote "Contraband, Patient Possession Prohibited Item" and during a search in Patient 8's room "... due to the volume of items the patient has in [their] room ... 3 plastic bookmarks were moved to [the patient's] long-term storage, and 10 condoms were thrown away."

* On 05/26/2024 at 0949 on FW2 "... a ligature item was found in [Patient 9's room] ... The item appeared to be 2 white stretchable bands tied onto a pair of patient pants to make the pants tighter."

* On 05/29/2024 at 0800 on Anchors 2 unit @ OSH-Salem ("AN2") a MHT "... found [a] pill in [Patient 11's] ... bed ... pharmacist ... informed me that the pill is Depakote ... The Pill is being processed as evidence at this time."

* On 05/29/2024 at 1455 on Mountain 3 unit @ OSH-Junction City ("MN3") in Patient 12's room "... on the top shelf hidden behind books, I found a water bottle containing a liquid and fruit. Based on it's appearance, I believed it to be pruno." Pruno is also known "prison-wine," it is a dangerous alcoholic beverage home-made from a variety of ingredients including fruits, hard candy and other ingredients.

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* On 05/30/2024 at 0930 on FW1 staff wrote "... a strange object was noted on the desk of [Patient 13]. Upon inspection it was observed to be 2 pen casings (outer shells) taped together to make a straw, laying next to what appeared to be a trace amount of coffee creamer."

* On 05/30/2024 at 1755 on Flowers 3 unit @ OSH-Salem ("FW3") Patient 14 "... was in possession of a rectangular shaped take out plastic dish [they] said [they] picked out a [sic] trash bin when [they were] out in the yard today."

* On 05/30/2024 at 0830 on AN2 in Patient 15's room staff found "... a clear ziplock baggie sitting on [the patient's] shelf next to [their] desk."

* On 05/31/2024 at 0830 on AN2 staff wrote "I discovered a latex glove in [Patient 16's] sink. It appeared to be tied in a knot at the end and had liquid inside it."

* On 05/31/2024 at 0910 on Lighthouse 2 unit at OSH-Salem ("LH2") staff in Patient 17's room "... found three white pills on the floor. Nursing identified the pills as depakote [Extended Release]."

* On 05/31/2024 at 0930 on Mountain 2 unit @ OSH-Junction City ("MN2") in Patient 18's room staff wrote they "found the following contraband:
- wire wrapped in paper in an 'L' shape bent in the middle; the paper portion appeared to form an inch long handle of sorts leaving about 1 1/4 inch of open wire. Ink residue was visible on the wire portion. It appears that the wire had come from a medical mask.
- torn blue fabric hospital blanket and parts of the blanket. A hemmed portion of the blanket had

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been removed and had been seperated [sic] into two lengths of fabric that were about 12-14 inches in length.
- strandard [sic] office pen, not a 'flexy' style pen but a hard plastic pen.
- 'voodoo' style doll made from thread that appears to match the blue color of the torn blanket."

* On 06/01/2024 at 1030 on FW3 an RN wrote that an MHT had seen "... a regular pen (not a patient pen) 6-7 inches long ... fall out of [Patient 19's] pants pockets from a pair of pants while doing laundry in the laundry room." The MHT reported that when they told the patient "... that patients are not allowed to have non-pt. pens, that [Patient 19] seemed to be trying to quickly rip off some scotch tape that was on the pen wrapped around a receipt-looking paper that has information on it before handing the pen over to [the MHT]."

* On 06/01/2024 at 1800 on Tree 3 unit @ OSH-Salem ("TR3") "... staff identified contraband tied in a loop, measuring in length of about 20inches [sic], a rope like artifact, ripped from an article of clothing ... Both [Patient 20 and Patient 21] were observed using it as a head band on the crown of their head."

* On 06/02/2024 at 1120 on TR3 staff "... discovered a torn portion of a bra in the possession of [Patient 20]."

* On 06/02/2024 at 1155 on FW1 staff wrote that "at approx. 1055 during rounds [Patient 23] was observed standing in the bathroom in [their] room leaned over the window sill with white powder visible on the window sill and a splenda packet

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standing upright against the window, [their] head was leaned over the window sill with something in [their] hand touching [their] face with it. The staff that witnessed it addressed [Patient 23] and confiscated the splenda packet, when [the patient] brought the packet to the staff it was noted that what was in [their] hand was a rolled up ten dollar bill rolled which looked like a straw."

7.d. Review of the hospital's P&Ps regarding contraband and prohibited items included the following:

* The P&P titled "Contraband and Prohibited Items" dated 12/18/2017 reflected that "[OSH] will provide a safe treatment environment where items considered to be prohibited are restricted, and items considered to be contraband are not allowed on OSH property unless exempted in this policy ... Contraband is forbidden at all times on OSH property, including in patient-care areas ... Prohibited items are not allowed in patient possession in areas specified on the 'Prohibited Items' lists ... [Staff] may not provide prohibited items to a patient outside the provisions of this policy."

* The "Attachment A - OSH Patient Property-Item Access List" dated 07/06/2022 reflected the following items were included on the lengthy list titled "Contraband" or "Prohibited Items: No Access Allowed":
- "Drugs"
- "Foil, tin and aluminum"
- "Items that are manipulated or altered into something other than original, intended use"
- "Non-issued pens/pencils/markers (must be 'mini' length)"
- "Non-issued tape"

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- "Plastic bags or plastic wrap"
- "Prescription or over-the-counter drugs ..."
- "Tattooing ... devices"
- "Wire, cables, cords, or rope longer than 9 inches"

* The "Superintendent Directive" dated 06/15/2022 reflected it was issued to convey the OSHS's "directive that, effective July 6, 2022: ... Food may not be stored in patient rooms or in the Patient Property room."

7.e. Findings for Patients 6, 7, 13, and 23 above in this tag revealed the discovery in patient rooms of white powder substances, and Splenda and dry coffee creamer packets. The documentation was unclear whether the "packets" found were open or closed, and reflected in some cases that white powder substances were speculated to be sweetener or dry coffee creamer.

7.f. During interview at the time of the incident review on 06/04/2024 beginning at 1105 hospital staff present indicated that some patients were known to replicate behaviors of drug "snorting" by using other powder substances as a substitute for the drugs. Staff present were initially not sure whether sweetener and coffee creamer packets were allowed in patient rooms. As the discussion progressed, the DQM and IRSID confirmed that patients could have those in their possession to use during "coffee time" in the milieu, but that no, those condiments were "not allowed in patient rooms."

8. Refer to the findings for Patient 1 cited at Tag A-145, CFR 482.13(c)(3), Standard: Freedom from Abuse. Those findings reflected that the hospital failed to conduct a clear and complete

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A 144	Continued From page 53 investigation of the unexpected death of Patient 1 that identified and addressed all potential gaps, and further failed to implement corrective actions it had planned to address gaps it did identify. The failure to conduct complete investigations or implement corrective actions contributed to an unsafe environment and created risk of potential harm for other patients. **********	A 144		
A 145	PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT CFR(s): 482.13(c)(3) The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: ********** Based on observations, review of video recordings, interviews, review of incident and patient care documentation for 19 of 23 patients (Patients 1, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, and 23), review of P&Ps, review of hospital directives, review of equipment inventory lists and manufacturer's instructions, and review of OSH internal investigation and corrective action plan documentation, it was determined that the hospital failed to ensure each patient's right to be free from all forms of abuse and neglect. Prevention of, identification of, investigations of, and response to, incidents that reflected potential neglect that resulted in actual and potential patient harm, were not clear, complete, and accurate to ensure those incidents and events did not recur for the hospital's vulnerable psychiatric patients. Failures included: * For Patient 1, failure to conduct and provide clear and complete investigation to identify and	A 145		

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address all evident gaps and findings, and to document the analysis of those gaps and findings to reflect whether all potential concerns were substantiated or not.
* For Patient 1, failure to implement the corrective actions planned as result of internal investigation findings.
* Failure to prevent patient harm and potential harm as 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.

The CMS Interpretive Guidelines for this requirement at CFR 482.13(c)(3) reflects "Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish. This includes staff neglect or indifference to infliction of injury or intimidation of one patient by another. Neglect, for the purpose of this requirement, is considered a form of abuse and is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."

Further, the CMS Interpretive Guidelines reflect those components necessary for effective abuse protection include, but are not limited to:
o Prevent.
o Identify. The hospital creates and maintains a proactive approach to identify events and occurrences that may constitute or contribute to abuse and neglect.
o Investigate. The hospital ensures, in a timely and thorough manner, objective investigation of all allegations of abuse, neglect or mistreatment.
o Report/Respond. The hospital must assure that

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any incidents of abuse, neglect or harassment are reported and analyzed, and the appropriate corrective, remedial or disciplinary action occurs, in accordance with applicable local, State, or Federal law.

Tag A-145 is a repeat deficiency previously cited on complaint surveys completed on 01/17/2022, 08/01/2022, 11/17/2022, 10/05/2023, and 03/14/2024.

Findings include:

1.a. Interview with staff that included the CMO/Interim OSHS, the DQM, DSC, and IRSID on 05/30/2024 at ~ 1635 during review of patient deaths that had occurred at the hospital in 2023 and 2024 revealed that:
* Patient 1 unexpectedly died on the FW2 Unit on 11/02/2023.
* The patient was in a closed seclusion room at the time of their death.
* During a "medical situation" the patient started having psychotic symptoms and requested to go into seclusion.
* The hospital had reported the death to CMS by means of the electronic submission required for deaths associated with restraint or seclusion.

1.b. On 05/30/2024 surveyors requested incident and investigation documentation related to Patient 1's 11/02/2023 unexpected death. The following documents were provided:
* One incident report #66633 written by an RN on 11/02/2023
* Copy of an electronic form titled "CMS Report of a Hospital Death Associated With The Use of Restraint Or Seclusion" dated as submitted to CMS on 11/03/2023 at 1426.

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* Form CMS-10455 titled "Report of a Hospital Death Associated With Restraint Or Seclusion"

2. On 06/11/2024 at 1613 surveyors sent OSH an email with a request for the incident, internal investigation, and follow-up documentation. The email specified:
* "Regarding 11/02/2023 [Patient 1's] death:
- All incident investigation and corrective actions taken
- All restraint and seclusion documentation
- All medical record documentation for October and November 2023
- Patient's Treatment Plan in place for October and November 2023
- Code documentation
- More will be requested as needed."

3. On 06/13/2024 beginning at ~ 1220 with staff that included the CMO/Interim OSHS, Interim DS, DQM, DSC, COM ("Chief of Medicine"), Medical Clinic Manager ("MCM"), and AAG the following information was provided:
* The DQM stated the hospital did a CADM investigation and an Root Cause Analysis ("RCA") investigation for Patient 1's 11/02/2023 unexpected death.
* Investigation "action items" were submitted to the hospital's Accreditation Organization ("AO"), the Joint Commission, on 01/10/2024 and "approved" on 02/20/2024. Staff stated that the Joint Commission "sets the schedule for RCA events and follow-up."
* The patient's symptoms were "distressing" and included auditory hallucinations that were difficult to manage. The patient took medications that caused weight gain. The patient had sleep apnea and other diagnoses.
* On 10/13/2023 the patient was seen in the

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hospital's medical clinic for complaints of shortness of breath. Cholesterol medications were started, and a cardiac referral was made.
* There were no medical clinic progress notes written for the visit at that time.
* Diagnoses related to the patient's medical conditions were not updated in their medical record.
* Regarding the incident on the morning of 11/02/2023, staff provided a high-level summary of the events surrounding the patient's death that included: the patient walked up to the NS and reported they had difficulty breathing, they fell on the floor, and bumped their head. Nursing staff members responded, took vital signs, and got a chair for the patient. The patient had a history of "somatic symptoms." The patient got up and made threatening statements and requested seclusion. Staff helped the patient walk to seclusion and the patient fell onto their knees at the threshold of the seclusion door. The patient laid in a prone position on the floor. Staff moved the patient so the door would shut. The patient requested the seclusion room door be locked. The patient was rocking their head and rolling on the floor. The patient rolled onto their side, then stopped moving. Staff tried to wake the patient, the patient did not respond, a code was called and staff began resuscitation efforts, EMS responded, resuscitation efforts were not successful and Patient 1 died.
* Gaps identified and corrective actions planned in conjunction with the Joint Commission as result of the hospital's investigation were related to medical clinic integration with care plans, communications between the medical clinic and inpatient unit, and standardization of medical guidelines for patients with metabolic syndrome. Those corrective actions plans were to be

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implemented by March 2024.
* The DQM stated there were no findings or corrective action related to nursing. Nursing response to the patient's medical concerns in light of the patient's psychiatric symptoms was considered and discussed with nursing leadership but was not a causal finding.

4. On 06/13/2024 the following documents related to Patient 1's death were provided to the surveyors. Those did not include all of the documents requested on the 06/11/2024 email to the hospital specified under Finding 2 above:
* A "CADM Questionnaire Report_Redacted final," nine-page document titled "Clinical Administrative Debrief Meeting Process Questionnaire & Executive Report," that had a last date of 11/09/2023.
* A "ReportandActionItem_Submission_FINAL," 38-page document titled "ALT-0 Summary Report for Sentinel Event Number 445710" that had a footer date of 01/10/2024 at the bottom of each page. There were no other dates that reflected completion of the document.
* "[Attorney Client Privilege] Work Product Inc#445710 ... unexpected death" that was an email dated 03/19/2024 at 1720 from hospital staff to the hospital's AO, the Joint Commission, regarding a 02/20/2024 conference call discussion related to Patient 1's death incident corrective actions.
* Three "Clinic Protocols":
- "Metabolic Syndrome Practitioner Care" dated as "New" on 02/20/2024.
- "Medical Clinic Provider Documentation Standards" dated as "New" on 03/14/2024.
- "Clinical Practice Guideline for Metabolic Syndrome" that was not dated.
* "Rolling Monthly Averages, Note Submissions,"

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undated, one-page audit results document titled "% of Medical [Primary Care Provider ("PCP")] OnTime Note submission."
* Seven documents related to Code Blue training and staff attendance.

5. The CADM with a final date of 11/09/2023 was reviewed. It reflected the following:
* The following sections of the report were fully redacted:
- "What potential immediate actions, if any, should be considered to reduce the risk of recurrence?"
- "What communication and/or training needs are recommended?"
- "[Clinical Advisory Team ("CAT")] CADM Report Review Summary"
* "Information sources included ... chart notes, and 19 incident reports."
* Other referenced documentation that was not provided included the "seclusion entry note" and the on-call physician's documentation and note.
* In the CADM section for "Did this event identify potential gaps in care/treatment?" the only response was "Medical clinician documentation: there was inadequate documentation of treatment and diagnosis following an appointment for complaints of chest pain on October 13. Diagnosis of hyperlipidemia was not updated in the chart and there was no treatment note. Patient did receive appropriate care and follow up and was placed on medications. Related to this, the [Treatment Care Plan ("TCP")] was not updated to reflect new medical problem."

6.a. The RCA or "Report for Sentinel Event Number 445710" that was dated 01/10/2024 was reviewed. It reflected "Patient is a [age] African American [gender] admitted to [OSH] on

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A 145	Continued From page 60 12/22/2016 ... This was the patient's fourth admission ... due to [the patient's] ongoing severe psychiatric symptoms which consisted of auditory hallucinations (often of [one of their family members], which could be command in nature to harm [themselves] or others), paranoid delusions, intermittent agitation and physical aggression. [Patient 1] had undergone numerous medication trials to target [their] psychiatric symptoms. [Their] symptoms had improved over time but had continued to be quite prominent and highly distressing to the patient. Providing medications to treat [their] psychiatric symptoms was quite challenging due to [their] reluctance to agree to changes in [their] regimens as well as the patient experiencing significant side effects from the medications. Side effects included marked weight gain, prediabetes/insulin resistance, deconditioning, sleep apnea, and hyperlipidemia. When experiencing auditory hallucinations of [their family member], [they] often would take on the persona of [their family member] and at times could be highly assaultive resulting in serious staff injury. As a result, one element of [the patient's] treatment care planning was that if the patient asked to be placed in locked seclusion, [they were] allowed to do this as it was a way [they] would keep [their self] and others safe." 6.b. The RCA reflected "analysis" of the following four of 24 "items" : * "Question: 14. To what degree was all the necessary information available when needed? Accurate? Complete? Unambiguous? Organization Response: No process for Medical Clinic integration into treatment care planning." * "Question: 15. To what degree is communication among participants adequate for this situation? Organization Response: No	A 145		

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process developed for communication between unit and Medical Clinic."
* "Question: 20. What are the barriers to communication of potential risk factors? Organization Response: refer to Question #15."
* "Question: 21 . How is the prevention of adverse outcomes communicated as a high priority? Organization Response: No standardized medical guidelines for the care of patients with metabolic syndrome."
* The RCA included three "Root Cause Details ... Plan of Action ... [Measures of Success ("MOS")]" for three "items" identified in Questions 14, 15, 20, and 21. Refer to Findings 19.a. through 19.e. below that reflect those action plans had not been implemented as of the date of this survey.
* There was no analysis or organization response to the other 20 items.

7. The email dated 03/19/2024 at 1720 from hospital staff to the hospital's AO, the Joint Commission, regarding a 02/20/2024 conference call discussion related to Patient 1's death incident corrective actions was reviewed. The email reflected the hospital's three actions plans identified in the RCA had been re-stated (Refer to Findings 19.b. through 19.d. below) and a fourth action plan had been added. The fourth action plan was that the hospital would "offer at least 8 Code Blue drills throughout the year to the nursing staff during the regularly scheduled Code Green [response to a behavioral emergency] Drills, focusing on providing necessary medical care to aggressive or potentially aggressive patients. The first combined drill (Code Blue + Code Green) will be completed by 04/15/2024. MOS is implementation of this item to our calendar of drills. Frequency will be once a quarter on each of two campuses. Responsible

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A 145	Continued From page 62 Organization Leader is CNO." 8.a. On 07/03/2024 at 1405 the survey exit conference was conducted. Staff present included the CMO/Interim OSHS, the Interim DS, the DQM, DSC, CNO, AAG, DOS, IRSID, and others. During the exit conference preliminary findings for the survey, including related to Patient 1's death based on the information provided by the hospital to that point, were shared with the hospital staff. Those preliminary findings included potential gaps evident during surveyors' review of the internal investigation documentation provided by the hospital, that was also found to lack references to those potential gaps. 8.b. Hospital investigation event timelines showed that on the morning of 11/02/2023 while the pt stood at the medication window their legs buckled and they subsequently fell to the floor and complained of trouble breathing and chest pain. Staff responded to the patient and ~ 15 minutes later they were walked into the seclusion room. Upon entry to the seclusion room the description of the pt's condition at that time included that their "skin normal but clammy; difficulties with respirations/speaking; Obvious signs of physical distress: Reports [they] can't breathe, had chest pain, kept repeating 'I feel like I'm going to die.'" ~ six minutes later staff entered the room and then left. ~ eight minutes later the patient stopped moving. ~ two minutes later staff responded and did sternal rub with no response. At 0754 Code Blue was initiated and CPR started at 0755. Resuscitation efforts continued, but EMS was not called for ~ seven minutes after the code was called, at 0801. EMS arrived and the pt was pronounced dead at 0845.	A 145		

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A 145	Continued From page 63 8.c. There was no documentation in the investigation documents provided to reflect that nursing staff member practices and management of the patient's change of condition had been evaluated by the hospital to determine whether response to and assessment of the patient's change of condition was timely and appropriate. That includes a gap of several minutes between the time of observation of the patient in seclusion with obvious physical distress and the time they stopped moving, and a gap of several minutes from the time a code was called to the time EMS was called. The only gaps identified by the hospital's investigation were related to medical staff visits and documentation practices 8.d. On 07/03/2025 at the end of the exit conference, in response to the hospital's assertion that some of the preliminary findings related to the hospital's investigation of Patient 1's death were unfounded, the hospital was provided an opportunity to submit additional information it believed was pertinent to the incident. They were reminded that the surveyors had made prior requests for all incident, investigation, follow-up, and corrective action documentation related to Patient 1's unexpected death, including that all investigation documentation referenced in the CADM had also not been provided such as "... chart notes, and 19 incident reports." 9. On 07/05/2024 the following documents related to Patient 1's death and the hospital's investigation, previously requested by surveyors, were provided: * 18 incident reports related to events and circumstances around Patient 1's death on 11/02/2023, including the one solely provided to surveyors on 05/30/2024.	A 145		

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* Nine pages of "Progress Notes 11-2-2023" written about Patient 5's death by five nursing staff members.
* "[Psychiatric Security Review Board ("PSRB")] Hearing Notes" titled "Psychiatry PSRB Update Note dated 02/07/2023
* "Risk Review-Forensic" dated 08/24/2023
* "Forensic Risk Review" dated 08/25/2023
* "Treatment Care Plan" dated with "Plan Date" of 10/17/2023.
* Fourteen pages of 11 "Patient Progress Notes" written by RN and medical staff members from 06/30/2022 through 11/01/2023
* 29 incident reports for 21 incidents that occurred between 07/17/2022 and 11/01/2023.

10. Review of Patient 1's 10/17/2023 "Treatment Care Plan" revealed the following:
* "Psychiatric - [Patient 1] has a psychiatric diagnosis of Schizoaffective disorder, bipolar type, and [they attribute] these voices with an inability to control [their] violent impulsive behaviors. Historically, [the patient] states that [they continue] to hear voices even after multiple medication trials. [The patient] has expressed a desire to maintain safety and move forward in their treatment with a short-term goal of moving to a lower acuity program of care and earning privileges after meeting with the PSRB."
* Patient 1 "attended [their] 30 day treatment team meeting. [They] shared [they were] doing 'good.' 'My left leg hurts.' 'I'm kind of getting use [sic]to it.' (Medications for cholesterol) Regarding interactions with peers, 'I'm just minding my own business.' Family visits are 'good.' [They] questioned 'Are we still taking me down from that Zoloft?' [They are] open to submitting an application for patient paid employment. [Their] personal goals include obtaining a degree in

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'psychology.' [They have] 'no' thoughts to harm [themselves] nor others. Regarding symptoms, 'First thing in the morning I hear the voices.'"
* Patient 1 "is doing well. [They are] medication adherent. [They] partially [attend] social dining and will get a clamshell if [they choose] to eat on the unit. [They enjoy] engaging in valued therapeutic treatment activities such as music therapy, watching movies on [their] tablet, supported education, emotional wellness and fitness. [They engage] in 1: 1 assessments with clinical staff when requested."
* "Moderate risk of violence - Progressing - [Patient 1] has a history of physical assaults to staff and peers. [They state] that voices and command hallucinations create an inability to control impulses to physically assault others. [The patient] has been able to remain violence free for a satisfactory a [sic] period of time such that [their] need to have enhanced precautions has been discontinued and [they have] expressed a desire to remain safe and has a goal of moving forward to a lower acuity program of care and working with the PSRB to gain privileges which are currently on and off ground privileges with staff supervision."
* "RN and unit nursing staff will allow and encourage the use of the [seclusion] room for [Patient 1], as needed for reducing the risk of aggression and to allow [them] to feel safe when [they are] having trouble with urges to be physically aggressive to others ... After 9 p.m., if [they are] having significant overt symptoms causing milieu disruption staff will ask [them] to use the [seclusion] room. 1. If [Patient 1] requests to use unlock [sic] seclusion, nursing staff will let [them] in without asking questions. 2. If [Patient 1] requests to be locked in seclusion, nursing staff will lock [them] in without questions and tell RN.

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RN will follow seclusion and restraint procedures."
* Patient 1 "made homicidal threats 10/11/23 and requested to go to seclusion."
* "PSRB - Privileges - Risk Review approved the privileges of 2: 1 on-grounds and 2: 1 off-grounds for medical; all of these privileges must be supervised by at least one familiar staff. This approval was based on [Patient 1's] notable improvements over the past months, including medication adherence, actively coping with known triggers, proactively requesting the [seclusion] room for safety, engaging in individual treatment, and [their] [Interdisciplinary Team's ("IDT's")] familiarity with [the patient's] risks and mitigation."
* "Other things that are important to my health (items stable with treatment) - [Patient 1] has multiple medical concerns including chronic pain, asthma, and metabolic syndrome, which are all being managed with routine care and tracked by medical clinic."

During the 10/17/2023 treatment plan session the patient complained that their "left leg hurts." That was three days after the 10/13/2023 medical clinic appointment for which no progress notes were written. There was no indication in the treatment plan documentation that the patient's left leg pain had been assessed or evaluated on 10/17/2023 or thereafter.

11. Review of the 29 incident reports for 21 incidents/events between 07/17/2022 and 11/01/2023 revealed the following that supported the behavioral evaluation in the Treatment Care Plan dated 10/17/2023:
* Patient 1 had not assaulted other patients or staff since 02/03/2023.

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* On four occasions between 12/19/2022 and 02/03/2023 Patient 1 assaulted staff persons.
* On seven occasions between 07/24/2022 and 01/08/2023 Patient 1 assaulted or was involved in physical altercations with other patients.
* On three occasions between 10/28/2022 and 11/01/2023 Patient 1 hit themselves or banged their head against a wall.
* On seven occasions between 07/17/2022 and 12/09/2022 Patient 1 requested to go to the seclusion room for reasons the patient stated that included "before [they hurt] anyone" and "voices are telling [the patient] to attack someone and that's the only way to prevent it."
* The 10/11/2023 seclusion event referenced in the TCP under Finding 10 above was not included in the incident reports provided dated from 07/17/2022 through 11/01/2023.

12.a. On 07/12/2024 at 1305 surveyors met with hospital staff that included the CMO/Interim OSHS, the Interim DS, the DQM, DSC, CNO, AAG, and others to review the preliminary findings related to the review of the investigation documentation provided through 07/05/2024. Again, those findings included potential gaps evident during surveyors' review of the internal investigation documentation provided by the hospital, that was also found to lack references to those potential gaps. For example:

12.b. An RN Progress Note written by [RN 13] on 11/02/2023 reflected that "At 0730 [Patient 1] came to medication window for [their] morning medications. At the window [they] stated 'I can't breathe. I feel like I can't breathe.' Patient then slumped onto the ground. This RN ran around the window to talk to patient. Patient was awake and alert per [their] norm, but lying on the ground on

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A 145	Continued From page 68 [their] back. [They] stated, 'I just feel like I can't breathe' ... [Another RN] called the [On-Call Doctor ("OD")] and requested they come to the unit to assess the patient due to complaints of chest pain and shortness of breath" ... [Patient 1's] vitals were [Blood Pressure ("BP")] 120/78, 02 was 90%, pulse 97. While obtaining vitals, 02 went up to 98% "... Assisted patient to lie on the ground. After a few moments, patient sat up and stated that [they] wanted to go the [seclusion] room and then started talking as if [they were their family member]. As [their family member they] said 'you go to the [seclusion] room or punch everyone' ... At one point the [Unit Administrator] walked onto the unit and patient stated 'you've hit old [people] before. Hit that old [person].' [Unit Administrator] walked away from patient and patient voiced that [they] wanted to walk into the [seclusion] room." The note continued, reflected patient was assisted to the seclusion room and at ~ 0742 an RN "called OD again requesting that they come to see patient, again reporting that patient was complaining of shortness of breath and chest pain. A few moments later the staff in the [seclusion room] anteroom requested RN to come assess. 0753 This RN walked into the [seclusion] room and patient was lying on the ground on [their] side. [Patient 1] was not responding to voice. This RN pushed patient over onto [their] back and performed sternal rub while directing staff to grab a crash cart. A code blue was called at 0754. Staff started to respond. Patient opened [their] eyes and was breathing but lips were pale. There was a pulse initially but patient's eyes rolled back into [their] head while waiting for the crash cart. Another RN entered the room and compressions were started at 0755 ...	A 145		

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Three rounds of epi 0.3 [milligrams ("mg")] were given [Intramuscular ("IM")] left thigh per [DO 11], [Epinephrine ("Epi")] given 0802, 0805, 0808 per instructions over the course of the code without effect. EMS called at 0801."

12.c. Another RN's Progress Note written on 11/02/2023 reflected that that the RN was connected with a physician on the phone and that they reported to the physician the patient had fallen and the vital signs taken. Another RN "called on call doctor again and requested that they come see patient, again reporting that patient was complaining of shortness of breath and chest pain." Another physician was also notified by the RN of the event and per that physician the RN was directed to "call on call provider and have them see pt; on call provider notified of this request to see pt." The note reflected that "pt stated to [themselves] 'You're going to die in here'".

12.d. An MHT Progress Note written on 11/02/2023 reflected that when [Patient 1] complained of "difficulties breathing" at the NS window, the "[RN 13] grabbed the vital machine and started taking vitals. [The RN] had to do manual Blood Pressure Check ..." Further, the note reflected that the RN was "reassuring" the patient that "the On Call doctor was being notified."

12.e. An "Emergency Seclusion Or Restraint Entry Note" was reviewed. The only staff name/signature was [RN 13] who wrote the progress note above. It was dated as signed by [RN 13] on 11/02/2023 at "0745." The note reflected the following:
- Differences in ink color and differences in

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handwriting reflected at least two staff's entries on the form, and possibly three. Not all of those different entries had been signed and dated and timed.
- The date and time the patient was placed in seclusion was not documented.
- It was not clear if the vital signs on the form were the ones taken at the NS after the patient's fall, or had been taken and reassessed during the time the patient was in seclusion.
- Patient assessment information on the form reflected:
"BP 120/78 ... Pulse 97 ... [Respiratory Rate Unable to obtain]"
"Skin integrity: [Normal] ... Clammy"
"Difficulties with respirations or speaking? [Yes]"
"Obvious signs of circulatory compromise? [No]"
"Obvious signs of injury or skin integrity issues? [No]"
"Obvious signs of physical distress? [Yes]"
"Reports [they] can't breathe, has chest pain, kept repeating 'I feel like I'm going to die'"
"Patient's mood, affect, mental status, response to emergency measures, and any significant findings from physical assessment: Patient talking as though [they were their family member] saying [they] couldn't breathe, 'I feel like I'm going to die' and then alternating with 'Go to the [seclusion] room or punch everyone,' and made threats against [Unit Administrator] saying 'you know I've made you hurt old [people] before. Hit that old [person].'"
"Criteria for Release: ... Unable to discuss Patient in seclusion per request while awaiting OD to come assess further Code blue intiated [sic] at 0754 - See notes Seclusion ended at 0754."
"RN Exit Note After Release of Patient ... Seclusion ended at 0754 due to code blue. Pt expired 0845 per EMS"

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12.f. The notes referenced under Findings 12.b., 12.c., 12.d., and 12.e. above raised questions about the following:
* Timeliness of the on-call physician's response to nursing staff members requests for the physician to come to the unit to see the patient.
* There was no documentation of a second set of vital signs after the ones taken at the NS shortly after "0730" before the patient went into seclusion. The vital signs recorded on the Seclusion Entry Note are duplicative of those recorded in the progress notes taken at the NS. There is no evidence that vitals were taken while the patient was in seclusion and experienced further change of condition. Further the description of the patient's threats against the Unit Administrator had occurred outside of the seclusion room.
* Timeliness of the EMS call ~ seven minutes after hospital staff found the patient unresponsive and initiated CPR.
* Why the RN "had to do" a manual BP check even though they had "grabbed the vital machine." Was the vital machine not working, or broken?

There was no documentation in the investigation information provided to reflect that those potential gaps had been evaluated and analyzed to determine whether there were opportunities for improvement and if corrective actions were indicated to prevent recurrence.

12.g. During the review on 07/12/2024, hospital staff confirmed that all of the potential gaps discussed during the review, including those identified above, had either not been investigated or that analysis of the potential gap had not been

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documented. During that review hospital staff disclosed that there was other investigation documentation of Patient 1's death that had still not been provided, for example: Staff interview notes. This in spite of previous surveyor verbal and written requests for all of the incident and investigation documentation. The hospital was given yet another opportunity to submit that documentation by the end of day on 07/12/2024.

13. On 07/12/2024 at 1644 the DQM sent an email that stated: "OSH is in the process of providing the following documents, which will be uploaded to the shared drive by Monday morning ...
- Interview notes from the RCA.
- Provider notes associated with the event.
- Incident reports associated with the event and pertaining to typical patient behavior that influenced staff response during this event.
- Documents associated with the investigation, with the exception of those protected under Attorney Client Privilege.
- Written description of this RCA process."

This email further reflected that all investigation documentation was not provided and the hospital had determined to make its own "exception" to the SA's request.

14. On 07/12/2024 at 1710 the DSC sent an email that stated the investigation documents had been submitted and consisted of the following incident and investigation documentation related to Patient 1's death incident. Those documents included significant previously requested documentation that had not been provided such as all investigation documentation, including the seclusion note requested on 06/11/2024 as

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described under Finding 2 above:
* "[Seclusion-Restraint ("S-R")] Entry," one-page document titled "Emergency Seclusion or Restraint Entry Note" dated 11/02/2023.
* Four pages of "Provider Progress Notes - 11.02.23" written by Medical Doctor ("MD") 10, DO 11, and MD 12.
* "Written description of RCA Process," three-page undated document titled "RCA."
* Fourteen untitled "Investigation Notes" 1 through 14.
* Six untitled "Documents associated with the investigation" were provided, however, it was unclear what the relevance of many of the documents was to the hospital's internal investigation and the SA's request:
- An untitled 50-page document provided included an 11/02/2023 video timeline, Patient 1's death certification, and chart progress notes not in chronological order from 2016, 2017, 2018, 2019, 2020, 2021, and 2022. The relevance, for example, of chart notes back as far as 2016 was unclear.
- An untitled 100-page document provided also included an 11/02/2023 video timeline, Patient 1's death certification, and chart progress notes not in chronological order from 2016, 2017, 2018, 2019, 2020, 2021, and 2022.
- An untitled 102-page document provided included chart progress notes for Patient 1 not in chronological order from 2019, 2021, 2022 and 2023. Those included a "Medical Doctor/[Nurse Practitioner ("NP")]" progress note written on 11/07/2023, five days after Patient 1's death, for "Date of Service: 10/13/2023," the date of the medical clinic visit for which a note had previously not been written.
- An untitled 128-page document provided included chart progress notes for Patient 1 from

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2018, 2019, 2020, 2021, 2022, and 2023.
- An untitled 126-page document provided included assessments, and 51-pages of "Lab Results" for Patient 1 from 2017, 2018, 2019, 2020, 2021, 2022, and 2023. The relevance, for example, of lab results back as far back as 2017 was unclear.
- An untitled 164-page document provided included "Unit Nursing Shift to Shift Report" forms, chart notes, Treatment Care Plans, incident reports (most of which were duplicative), historical enhanced supervision orders from 2022 and 2023, 29 pages of "Diagnosis" lists from 2022 and 2023, History & Physical ("H&P") documentation from 2021. The document also contained seclusion/restraint event documentation for at least nine other patients. The relevance, for example, of "Diagnosis" lists back to 2022 and of seclusion/restraint documentation for other patients was unclear.
* "Code Blue Medical Emergency" P&P dated 01/21/2020 was provided.

15. The "Medical Doctor/NP" progress note written on 11/07/2023, five days after Patient 1's death, for "Date of Service: 10/13/2023" reflected "Subjective: Complaint of chest tightness, shortness of breath, some chest pain. Uses inhaler on unit. Symptoms are sporadic. Not necessarily associated with increased activity. The chest tightness/pain is new. Has not had at rest. The discomfort is fleeting. Chest discomfort does not radiate. No nausea associated with the chest discomfort. Denies palpitations, cough or [Dyspnea on Exertion ("DOE")] ...
Assessment/Plan: 1. Chest pain/[Shortness of Breath ("SOB")] symptoms worrisome in a patient who is morbidly obese and has metabolic syndrome, hyperlipidemia and is not taking a

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statin. Discussed this with patient. Discussed diet. Patient consented to start taking statin. Discussed potential side effect of muscle pain and to let me know if that happens. Will plan on check fasting lipids and hepatic panel in six months. Agreed to Cardiology referral." The note was signed and dated by an NP on 11/07/2023 at 1433.

16. Review of Patient 1's "State of Oregon ... Certificate of Death" that was "issued" on 11/13/2023 reflected "Cause of Death" was "Bilateral Pulmonary Thromboemboli ... due to ... Venous Thromboembolism."

17. Further, the investigation documentation provided multiple different timelines for the same events referenced by the hospital. Event timelines the CADM, the RCA, progress notes and Seclusion Entry note did not align. Although the hospital acknowledged those discrepant timelines, they failed to clearly rectify/clarify those as part of its investigation which further contributed to the unclear and disorganized internal investigation documentation that was provided by the hospital in parts on multiple dates, and included hundreds of pages of notes dating back to 2016 for which the relevancy was unclear.

18. During the 06/13/2024 review beginning at ~ 1220 with staff that included the CMO/Interim OSHS, Interim DS, DQM, DSC, COM, MCM, and AAG the following information was provided:
* Gaps identified and corrective actions planned in conjunction with the Joint Commission as result of the hospital's investigation of Patient 1's death were related to medical clinic integration with care plans, communications between the

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medical clinic and inpatient unit, and standardization of medical guidelines for patients with metabolic syndrome. Those corrective actions plans were to be implemented by March 2024.

19.a. Review of the corrective action plans that were developed revealed a lack of documentation to reflect that all of those plans had been implemented. During interview at the time of the review on 06/13/2024, none of the hospital, physician, or quality leadership staff present were aware of, had been tracking, or could confirm whether all of the audits planned to be started in March 2024 had been conducted. There was speculation that an absent physician had related documentation but would not return to the hospital until the following week of 06/17/2024. As of 07/12/2024, the final date provided for the hospital to submit additional information, no additional information related to implementation of the action plans had been provided. For example:

19.b. Corrective action plan one was that the "Medical Clinic Nurse Case Managers will screen all current OSH patients to identify any who are diagnosed with 3 or more conditions meeting the criteria for metabolic syndrome who do not currently carry that diagnosis. This will be a 100% patient audit, so MOS is that the audit is complete. Target date for completion is March 30, 2024. Responsible Organization Leader is CMO."

There was no documentation or evidence that those audits had been conducted and the action plan implemented.

19.c. Corrective action plan two was to "Develop

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and implement standard work for provision of PCP services, including requirements for timing and frequency of on-unit and in-clinic patient visits, communication with unit nursing staff and IDT, and collaboration with clinic staff and covering practitioners. MOS is weekly audit of 50% of PCP notes expected based on records of patients seen, looking for identification of who the PCP spoke to about the assessment and plan. Target: 90% of notes have documentation of who PCP spoke to as required. Responsible Organization Leader is CMO."

Correction action documentation revealed that a new protocol for "Medical Clinic Provider Documentation Standards" was dated as approved on 03/14/2024 and included timelines for notes submission, and other content requirements.

Review of the "% of Medical PCP OnTime Note submission" audit summary only reflected final % of compliance information for timely submission of medical staff notes. There was no audit information for any of the other aspects of corrective action plan two.

The audit summary form additionally contained a "Note" that reflected "It was unclear if the patients scheduled were seen and not documented, if the patient refused, or if the patient was seen and not documented on." During the 06/13/2024 review medical staff present stated that there was no expectation that medical or nursing staff document when patients refuse medical visits. In that case it was unclear how the hospital would audit whether the frequency of on-unit and in-clinic visits for patients met the standards. Further, documentation of patient response to all

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care and services, including their refusal of care and services, is required.

19.d. Corrective action plan three was to "Develop and implement clinical practice guideline for management of patients with metabolic syndrome diagnosis. Target: 90% of patients diagnosed with metabolic syndrome received care per guideline. MOS is completion of clinical guideline. Responsible Organization Leader is CMO."

Although the documentation reflected that the hospital had developed the clinical practice guidelines, there was no documentation or evidence that the audits to determine whether patients diagnosed with metabolic syndrome had received care per the guideline.

19.e. During interview at the time of the review on 06/13/2024 staff, including the DQM, confirmed the lack of evidence of corrective action plan implementation.

20. Refer to Findings 1.a. through 6 cited at Tag A-144 under CFR 482.13(c)(2), Standard: Privacy and Safety. Those findings reflect that the unexpected death of Patient 5 on 05/24/2024 was likely related to drug contraband provided during a patient visitation session and that staff failed to observe and monitor the patient's condition to ensure they were alive and breathing. Findings 7 under that Tag further reflected contraband and prohibited items were found in patients' possession for 16 other patients (Patients 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, and 23) after 05/24/2024 and that placed those patients at risk for harm. In addition, Findings 1.i.iii. under that Tag reflected that Patient 22 was

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A 145	Continued From page 79 not observed and monitored and was found in an unauthorized room with opposite gender patients after 05/24/2024 and was also placed at risk for harm. Those findings reflect that the hospital failed to prevent such occurrences as part of its abuse protection of patients. **********	A 145		
A 263	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: ********** It was determined that the governing body failed to ensure, through the QAPI program, the prevention and reduction of adverse events analyzing findings, and implementing actions to prevent recurrence of those (Tag A-286). Refer to the findings cited under this Condition at Tag A-286 under CFR 482.21(a), (c)(2), (e)(3) -	A 263		

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A 263	Continued From page 80 Standard: Patient Safety, that reflects the QAPI program failed to ensure that incidents and adverse patient events were clearly investigated and analyzed, and that corrective actions were planned and implemented to prevent recurrence of those, to promote learning throughout the hospital, and to establish clear expectations for patient safety. Those failures reflect the investigation of the unexpected death of Patient 1 was unclear and incomplete. All potential gaps or concerns evident in documentation related to Patient 1's death had not been analyzed to determine whether corrective actions were indicated, and corrective actions planned to address gaps that had been identified had not been implemented. Refer to the findings cited at Tag A-115, CFR 482.13 - CoP: Patient's Rights, that reflects the QAPI program failed to ensure each patient's rights were protected and promoted, including the right to receive care in a safe setting. Those failures created an unsafe EOC that likely contributed to patient harm and death for Patient 5 and created the likelihood of harm to other patients. The hospital failed to screen visitors; monitor in-person visits between patients and visitors; prevent contraband; observe and monitor patient condition, status, and location to ensure patients were safe and alive (Tag A-144). It further failed to conduct clear and complete investigations of adverse events that addressed all potential gaps and deficient practices; and failed to implement and monitor corrective actions to prevent recurrence for other patients (Tag A-145). Refer to the findings cited at Tag A-385, CFR 482.23 - CoP: Nursing Services, that reflects the	A 263		

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A 263	Continued From page 81 QAPI program failed to ensure patient nursing and safety needs were met by nursing personnel, under the supervision of the RN. The RN responsible for the care of each patient failed to ensure ongoing assessment, observation, monitoring, and provision of care and services. Those failures occurred during in-person visitation sessions between patients and visitors, and on the inpatient units. (Tag A-395). Refer to the findings cited at Tag A-700, CFR 482.41 - CoP: Physical Environment, that reflects the QAPI program failed to ensure the physical environment was maintained and arranged to provide a safe EOC. The hospital failed to ensure safety and security measures were sufficient to prevent the presence of drugs and other unsafe contraband in the EOC. Those measures were not fully developed, security personnel were not trained, and the failures occurred during visitor check-in, screening, and during in-person visitation sessions between patients and visitors (Tag A-701). In addition, screening equipment or devices had not been subject to preventive maintenance to ensure those operated as intended (Tag A-724). Refer to the findings cited at Tag A-1600, CFR 482.60 - CoP: Special Provisions for Psychiatric Hospitals, that reflects the QAPI program failed to ensure the hospital complied with all CoPs specified in CFRs 482.1 through 482.23 and CFRs 482.25 through 482.57 as the following CoPs were determined to be out of compliance. (Tag A-1605). **********	A 263		
A 286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3)	A 286		

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A 286	Continued From page 82 (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: ********** Based on interviews, review of incident and patient care documentation for 1 of 1 patient (Patient 1), review of P&Ps, and review of OSH internal investigation and corrective action plan documentation it was determined that the hospital failed to ensure that incidents and adverse patient events were clearly investigated and analyzed, and that corrective action plans it developed were implemented, to prevent recurrence of such events, to promote learning throughout the hospital, and to establish clear expectations for the safety of the hospital's vulnerable psychiatric	A 286		

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A 286	Continued From page 83 population. Tag A-286 is a repeat deficiency previously cited on complaint and revisit surveys completed on 01/17/2022, 08/01/2022, and 03/14/2024. Findings include: 1. Refer to the findings for Patient 1 cited at Tag A-145, CFR 482.13(c)(3) - Standard: Freedom from Abuse, that reflects the investigation of the unexpected death of Patient 1 was unclear and incomplete. All potential gaps or concerns evident in documentation related to Patient 1's death had not been analyzed to determine whether corrective actions were indicated, and corrective actions planned to address gaps that had been identified had not been implemented. **********	A 286		
A 385	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: ********** It was determined the governing body failed to ensure patient nursing and safety needs were met by nursing personnel, under the supervision of the RN. The RN responsible for the care of each patient failed to ensure ongoing assessment, observation, monitoring, and provision of care and services. Those failures occurred during in-person visitation sessions between patients and visitors, and on the	A 385		

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A 385	Continued From page 84 inpatient units. (Tag A-395). It was determined that the RN responsible for the hospital's nursing services failed to ensure that the nursing and safety needs of the hospital's vulnerable psychiatric patients were met and those failures likely contributed to patient harm and death and created the likelihood of harm to other vulnerable psychiatric patients. **********	A 385		
A 395	RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: ********** Based on observations, review of video recordings, interviews, review of incident and patient care documentation for 18 of 23 patients (Patients 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, and 23), review of P&Ps, review of hospital directives, and review of OSH internal investigation documentation, it was determined that the 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. Tag A-395 is a repeat deficiency previously cited on complaint and revisit surveys completed on	A 395		

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A 395	Continued From page 85 01/17/2022, 08/01/2022, 11/17/2022, 10/05/2023, and 03/14/2024. Findings include: 1. Refer to the findings cited at Tag A-144 under CFR 482.13(c)(2) - Standard: Privacy and Safety. Those findings reflect the failures of the nursing department and personnel to ensure: * Situational awareness and diligent assessment, observation, and monitoring of patient condition and status, including whether patients were alive and breathing for Patient 5 as described in Findings 1.a. through 1.j. * Situational awareness and diligent observation and monitoring 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 for Patient 5 as described in Findings 2.a. through 2.c., and 5.a. through 6. * Situational awareness and diligent observation and monitoring of patient location to ensure patients were not in unauthorized areas for Patient 22 as described in Finding 1.i.iii. * Failure to prevent the recurring presence of, and patient possession of, drugs and other contraband for Patients 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, and 23 as described in Findings 7.a. through 7.f. **********	A 395		
A 700	PHYSICAL ENVIRONMENT CFR(s): 482.41 The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services	A 700		

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A 700	Continued From page 86 appropriate to the needs of the community. This CONDITION is not met as evidenced by: ********** It was determined the governing body failed to ensure the physical environment was maintained and arranged to provide a safe EOC. The hospital failed to ensure safety and security measures were sufficient to prevent the presence of drugs and other unsafe contraband in the EOC. Those measures were not fully developed, security personnel were not trained, and the failures occurred during visitor check-in, screening, and during in-person visitation sessions between patients and visitors (Tag A-701). In addition, screening equipment or devices had not been subject to preventive maintenance to ensure those operated as intended (Tag A-724). Review of hospital directives, review of equipment inventory lists and manufacturer's instructions, and review of OSH internal investigation documentation, it was determined that the hospital failed to maintain an EOC free of hazards and risks to ensure the safety and well-being of the hospital's vulnerable psychiatric population and those failures likely contributed to patient harm and death and created the likelihood of harm to other vulnerable psychiatric patients. **********	A 700		
A 701	MAINTENANCE OF PHYSICAL PLANT CFR(s): 482.41(a) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: **********	A 701		

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Based on observations, review of video recordings, interviews, review of incident and patient care documentation for 17 of 23 patients (Patients 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, and 23), review of P&Ps, review of hospital directives, review of equipment inventory lists and manufacturer's instructions, and review of OSH internal investigation documentation, it was determined that the hospital failed to ensure the provision of a safe EOC that was maintained to minimize security and safety risks for the hospital's vulnerable psychiatric population.

Tag A-701 is a repeat deficiency previously cited on complaint and revisit surveys completed on 01/17/2022, 08/01/2022 and 11/17/2022.

Findings include:

1. Refer to the findings cited at Tag A-144 under CFR 482.13(c)(2) - Standard: Privacy and Safety. Those findings reflect the failures of the security department and personnel to ensure:
* Diligent and consistent registration/check-in of visitors prior to in-person patient visitation sessions as described in Findings 3.a. through 3.e.
* 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 of those from visitor to patient for Patient 5 and others as described in Findings 2.a. through 2.c., 4.a. through 4.h., and 6.
* Situational awareness and diligent observation and monitoring 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 for Patient

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(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 701	Continued From page 88 5 as described in Findings 2.a. through 2.c., and 5.a. through 6. * Safety and security measures were not sufficient to prevent the presence of, and patient possession of, drugs and other unsafe contraband in the EOC for Patients 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, and 23 as described in Findings 7.a. through 7.f. **********	A 701		
A 724	FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE CFR(s): 482.41(d)(2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: ********** Based on observations, review of video recordings, interviews, review of equipment inventory lists and manufacturer's instructions, and review of P&Ps it was determined 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. Tag A-724 is a repeat deficiency previously cited on the complaint survey completed on 10/05/2023. Findings include: 1. Refer to the findings cited at Tag A-144 under CFR 482.13(c) - Standard: Privacy and Safety.	A 724		

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

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A 724	Continued From page 89 Those findings reflect the failures of the security department and personnel to ensure that screening equipment/devices were subject to preventive maintenance as described in Findings 4.f., 4.h., and 6. **********	A 724		
A1600	Special Provisions for Psychiatric Hospitals CFR(s): 482.60 Special Provisions Applying to Psychiatric Hospitals - Psychiatric hospitals must... This CONDITION is not met as evidenced by: ********** It was determined that the governing body failed to ensure the hospital complied with all CoPs specified in CFRs 482.1 through 482.23 and CFRs 482.25 through 482.57 as the following CoPs were determined to be out of compliance (Tag A-1605): * CFR 482.12 - CoP: Governing Body * CFR 482.13 - CoP: Patient's Rights * CFR 482.21 - CoP: QAPI * CFR 482.23 - CoP: Nursing Services * CFR 482.41 - CoP: Physical Environment Refer to each CoP cited in this 2567 for the failures included in A1600. **********	A1600		
A1605	Meet Hospital CoPs CFR(s): 482.60(b) [Psychiatric hospitals must] Meet the Conditions of Participation specified in§§482.1 through 482.23 and §§482.25 through 482.57; This STANDARD is not met as evidenced by: ********** Based on observations, review of video recordings, interviews, review of incident and	A1605		

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A1605	Continued From page 90	A1605		

patient care documentation for 19 of 23 patients (Patients 1, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, and 23), review of P&Ps, review of hospital directives, review of equipment inventory lists and manufacturer's instructions, and review of OSH internal investigation and corrective action plan documentation, it was determined that the hospital failed to ensure it complied with all CoPs specified in CFR 482.1 through CFR 482.23 and CFR 482.25 through CFR 482.57 as the following CoPs were determined to be out of compliance:
* CFR 482.12 - CoP: Governing Body
* CFR 482.13 - CoP: Patient's Rights
* CFR 482.21 - CoP: QAPI
* CFR 482.23 - CoP: Nursing Services
* CFR 482.41 - CoP: Physical Environment

Tag A-1605 is a repeat deficiency previously cited on the complaint survey completed on 05/06/2024.

Findings include:

1. Refer to the findings cited at Tag A-043, CFR 482.12 - CoP: Governing Body, that reflects the governing body failed to ensure the provision of safe and appropriate care to patients in the hospital in a manner that complied with all CoPs.

2. Refer to the findings cited at Tag A-115, CFR 482.13 - CoP: Patient's Rights, that reflects the hospital failed to ensure each patient's rights were protected and promoted, including the right to receive care in a safe setting. Those failures created an unsafe EOC that likely contributed to patient harm and death and created the likelihood of harm to other patients. The hospital failed to screen visitors; monitor in-person visits between

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A1605	Continued From page 91	A1605		

patients and visitors; prevent contraband; observe and monitor patient condition, status, and location to ensure patients were safe and alive (Tag A-144). It further failed to conduct clear and complete investigations of adverse events that addressed all potential gaps and deficient practices; and failed to implement and monitor corrective actions to prevent recurrence for other patients (Tag A-145).

3. Refer to the findings cited at Tag A-263, CFR 482.21 - CoP: QAPI, that reflects the hospital failed to ensure, through the QAPI program, the prevention and reduction of adverse events including by conducting clear and thorough investigations of adverse events, analyzing findings, and implementing actions to prevent recurrence of those (Tag A-286).

4. Refer to the findings cited at Tag A-385, CFR 482.23 - CoP: Nursing Services, that reflects the hospital failed to ensure patient safety and nursing needs were met by nursing personnel, under the supervision of the RN. The RN responsible for the care of each patient failed to ensure ongoing assessment, observation, monitoring, and provision of care and services. Those failures occurred during in-person visitation sessions between patients and visitors, and on the inpatient units. (Tag A-395).

5. Refer to the findings cited at Tag A-700, CFR 482.41 - CoP: Physical Environment, that reflects the hospital failed to ensure the physical environment was maintained and arranged to provide a safe EOC. The hospital failed to ensure safety and security measures were sufficient to prevent the presence of drugs and other unsafe contraband in the EOC. Those measures were

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A1605	Continued From page 92 not fully developed, security personnel were not trained, and the failures occurred during visitor check-in, screening, and during in-person visitation sessions between patients and visitors (Tag A-701). In addition, screening equipment or devices had not been subject to preventive maintenance to ensure those operated as intended (Tag A-724). **********	A1605		