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

October 24, 2024

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

Re: Notice of Enforcement Action
Rescind Termination Action
Restore Deemed Status
OR00031593/OR00037585/OR00044708/OR45197/
OR00048336/OR00049910/OR00049922/
OR00050743/OR00050765/OR00051018

Dear Administrator:

A revisit survey conducted by the Oregon Health Authority at Oregon State Hospital Distinct Part on October 11, 2024 has found that Oregon State Hospital Distinct Part is now in substantial compliance with Federal requirements for participating in the Medicare and Medicaid programs.

Based on the State survey agency's revisit findings and recommendation, the Centers for Medicare and Medicaid Services (CMS) is rescinding the termination action and removing your facility from the State survey agency's jurisdiction.

Since Oregon State Hospital Distinct Part has been determined to be in compliance with the CoPs, you do not have to submit a plan of correction for any of the standard level survey deficiencies cited. However, under Federal disclosure rules a copy of the findings of this Medicare survey must be publicly disclosed within 90 days of the completion. You may therefore wish to submit for public disclosure, your comments on the survey findings, and any plans you may have for correcting the cited deficiencies.

Should you choose to submit a plan for correction, the evidence of correction is to be entered on the right side of Form CMS-2567, opposite the deficiency, and must be signed and dated by the an authorized official. Please submit your evidence of correction to the Oregon Health Authority by close of business, within ten (10) days of receipt of this letter.

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 this letter are being provided to the State survey agency and to the accrediting organization.

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 _____	R-C 10/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 000}	INITIAL COMMENTS This report reflects the findings of the unannounced, onsite Federal Medicare certification revisit survey completed on 10/11/2024. The revisit survey was result of complaint investigation surveys for complaints OR49910 and OR49922 that had concluded on 05/06/2024. During the revisit survey the hospital was evaluated for implementation of its Plan of Correction for the 05/06/2024 survey and for return to compliance with the Conditions of Participation (CoP). The hospital demonstrated it had implemented processes and systems to the extent that deficiencies at the Condition-level were determined to be corrected and it was back in substantial compliance with the following CoPs: * CFR 482.12 - CoP: Governing Body * CFR 482.13 - CoP: Patient's Rights * CFR 482.23 - CoP: Nursing Services * CFR 482.60 - CoP: Special Provisions for Psychiatric Hospitals Standard-level deficiencies follow in this report.	{A 000}		
{A 093}	EMERGENCY SERVICES CFR(s): 482.12(f)(2) If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate. This STANDARD is not met as evidenced by: Based on observations, interview, review of medical emergency supplies and equipment	{A 093}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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documentation, and review of the hospital's Plan of Correction (POC), it was determined that the hospital failed to ensure that medical emergency supplies and equipment processes were managed and documented consistently to ensure availability of necessary items during a medical emergency response.

Findings include:

1.a. The hospital's POC included:
* "Standardize emergency medical equipment across both campuses ... Consolidate equipment to be co-located across both campuses."
* "Review and update Policy 8.038 Code Blue surrounding equipment checklist and procedures to include ... Standardized checklist for all emergency medical equipment ... Procedures for ongoing maintenance of emergency medical equipment, including frequency of checks, list of checks and who is responsible ... Include Admissions processes for Emergency Medical Equipment management ... All staff will read and acknowledge updated Policy 8.038 ...
Non-nursing staff responsible to check emergency medical equipment will take 'Code Blue Medical Equipment Training.'"
* "Develop Code Blue Department procedures involving tracking and on-going maintenance of equipment ... [Oregon State Hospital] will identify process to track supplies in Code Blue carts/bags/cabinets ... Inventory has been created that has location, supplies in each location and expiration dates of supplies ... Each bag/cart will have a numbered pull tight lock that is tracked in the inventory and will be updated each time the lock is broken, and a new lock is issued."

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{A 093}	Continued From page 2 1.b. During a tour of Salem campus Flower 2 unit on 10/07/2024 beginning at approximately 1455 with a Director of Nursing (DNS), Program Director (PD) and Compliance Specialist (CS), observations included: * In the Exam Room, a Red Emergency Cart with six drawers and an intact red breakaway lock (#13125507) that "locked" all six drawers. * A clipboard with a checklist titled "Emergency Medical Equipment Checklist (Carts)", 8.038 - Attachment B, dated revised 06/2024 for "Month/Year: Oct 2024" was observed on top of the cart. The top portion of the checklist reflected "Location: [Flower 2 unit]" and "Every section MUST be completed. Notify management (or designee) of equipment problems." The checklist had a "Date" column with rows numbered 1-31 for circling "Y" (Yes) or "N" (No) for the following items each day of the month: - "[Automated External Defibrillator] shows green check" - "Red Emergency Cart Lock Present" - "Oxygen Tank [greater than or equal to] 1000 [pounds per square inch]" - "Suction Machine Plugged In, Tubing/Wand Present" - "Code Blue Signage Present and Intact" The checklist had spaces for recording "Comments (Corrective action must be noted for any 'N' responses)" for each day of the month. The checklist had spaces for recording a signature each day of the month. The checklist had spaces for recording "Code Blue Lock Number (ensure #'s match; if they are different, update on this sheet)" for each day of the month. The documentation on the checklist was incomplete and inconsistent, and did not provide assurance emergency supplies and	{A 093}		

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equipment were checked and would be available when needed. For example:
- The code blue lock number recorded for 10/01/2024, 10/02/2024, 10/03/2024, 10/04/2024, 10/05/2024 was "13125507".
- The comments for 10/05/2024 reflected "vitals [sphygmomanometer, an instrument for measuring blood pressure] broken". There was no documentation that reflected whether "management (or designee)" was notified about the broken sphygmomanometer," or that other actions had been taken to ensure it was functioning correctly when needed.
- On 10/06/2024, a checkmark was recorded in the space designated for "Code Blue Lock Number ..." No code blue lock number was not recorded for that date. It was not clear what the check mark meant and this was inconsistent with 10/01/2024, 10/02/2024, 10/03/2024, 10/04/2024, 10/05/2024 all of which had a lock number recorded.

* A "Code Blue Equipment Check Sheet" dated "Updated 6/23/2024" was observed on top of the cart. The check sheet included a list of items and a quantity for each item to be included in Drawer #s 1 through 6 of the Red Emergency Cart. For example:
- Drawer #1: Flashlight, quantity 1; Code Blue Tracking Sheet, quantity 5; Yankauer Suction tip and tubing, quantity 1 each; Pen light, quantity 2; Cut Down tool, quantity 1; Coaxial cable cutters, quantity 1; and Razor, quantity 1.
- Drawer #2: Nasal canula, quantity 2; Non-rebreather face mask; quantity 2; Blood Pressure cuff [Large/Extra Large], quantity 1 each; Stethoscope, quantity 1; and Pulse Oximeter, quantity 1.
- Drawer #3: 4 x 4 Sterile Gauze, quantity 4;

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Paper tape, quantity 1; Trauma Shears, quantity 1; Sterile tongue depressors, quantity 4; 3 [inch] roll gauze, quantity 2; 4 [inch] Coban, quantity 1, ABD (abdominal) pads, quantity 6; and Red bio hazard bag, quantity 2.
- Drawer #4: Gloves (Medium/Large), quantity 1 each.
- Drawer #5: No items or quantities were listed.
- Drawer #6: OB kit, quantity 1; AMBU (resuscitation) Bags Adult/Infant, quantity 1 each; and Emergency Med (medication) Kit with Narcan, quantity 1 box.

1.c. During a tour of Salem campus Leaf 3 unit on 10/08/2024 beginning at approximately 1130 with a Deputy Chief Nursing Officer (DCNO) and CS, observations included:
* In the Exam Room, a Red Emergency Cart with six drawers and an intact red breakaway lock similar to Finding 1.b. was observed. The red breakaway lock on the cart was #13125511.

* A clipboard with the same checklist titled "Emergency Medical Equipment Checklist (Carts)" dated revised 06/2024 in Finding 1.b. for "Month/Year: Oct 2024" was observed on top of the cart. The top portion of the checklist reflected "Location: [Leaf 3 unit]" and "Every section MUST be completed ..." The checklist had spaces for recording "Code Blue Lock Number ... " for each day of the month.
- The code blue lock number recorded for 10/01/2024 and 10/05/2024 was "13125511".
- The space for recording a code blue lock number for 10/02/2024 had a ditto mark. No code blue lock number was recorded for that date.
- The spaces for recording a code blue lock numbers for 10/03/2024 and 10/04/2024 were blank. No code blue lock numbers were recorded

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for those dates.
- The space for recording a code blue lock number for 10/06/2024 had two ditto marks. No code blue lock number was recorded for that date.
- The space for recording a code blue lock number for 10/07/2024 had a check mark. No code blue lock number was recorded for that date.

1.d. During a tour of Admissions Department (AD) at Salem campus on 10/08/2024 beginning at approximately 1345 with a DCNO, CS and other hospital staff, observations included:
* A Red Emergency Cart with six drawers and a red breakaway lock similar to Finding 1.b. was observed. The red breakaway lock on the cart was #13125537.

* A clipboard with the same checklist titled "Emergency Medical Equipment Checklist (Carts)", 8.038 - Attachment B, dated revised 06/2024 in Finding 1.b. for "Month/Year: Oct/2024" was observed on top of the cart. The top portion of the checklist reflected "Location: Admissions" and "Every section MUST be completed ..." The checklist had a "Date" column with rows numbered 1-31 for circling "Y" or "N" for the following items each day of the month:
- "[Automated External Defibrillator] shows green check"
- "Red Emergency Cart Lock Present"
- "Oxygen Tank [greater than or equal to] 1000 [pounds per square inch]"
- "Suction Machine Plugged In, Tubing/Wand Present"
- "Code Blue Signage Present and Intact"
The checklist had spaces for recording "Comments ..." for each day of the month.

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The checklist had spaces for recording a signature each day of the month.
The checklist had spaces for recording "Code Blue Lock Number ..." for each day of the month.
The checklist was incomplete and did not provide assurance emergency supplies and equipment were checked and would be available when needed. Examples included:
- For 10/05/2024 and 10/06/2024, "Y" and "N" were not circled or otherwise marked for "[Automated External Defibrillator] shows green check," "Red Emergency Cart Lock Present," "Oxygen Tank [greater than or equal to] 1000 [pounds per square inch]," "Suction Machine Plugged In, Tubing/Wand Present" and "Code Blue Signage Present and Intact." Further, the spaces for documenting signature were blank for those dates.
- The spaces for documenting comments were blank 10/01/2024, 10/02/2024, 10/03/2024, 10/04/2024, 10/05/2024, 10/06/2024, 10/07/2024 and 10/08/2024.
- The spaces for documenting a code blue lock number were blank 10/01/2024, 10/02/2024, 10/03/2024, 10/04/2024, 10/05/2024, 10/06/2024 and 10/07/2024.
- The only code blue lock number that was recorded was "13125537" on 10/08/2024. This was confirmed during an interview on 10/08/2024 with staff present at the time of the observation.

* A "Code Blue Equipment Check Sheet" dated "Updated 4/30/2024" was observed on top of the cart. The check sheet included a list of items and a quantity for each item to be included in Drawer #s 1 through 6 of the Red Emergency Cart. For example:
- Drawer #1: Code Blue Tracking Sheet, quantity 5; Flashlight, quantity 1; Yankauer Suction tip and

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tubing, quantity 1 each; Pen light, quantity 2; Cut Down tool, quantity 1; Coaxial cable cutters, quantity 1; and Razor, quantity 1.
- Drawer #2: Nasal canula, quantity 2; Non-rebreather face mask; quantity 2; Blood Pressure cuff [Large/Extra Large], quantity 1 each; Stethoscope, quantity 1; and Pulse Oximeter, quantity 1.
- Drawer #3: 4 x 4 Sterile Gauze, quantity 4; Paper tape, quantity 1; Scissors, quantity 1; Sterile tongue depressors, quantity 4; 3 [inch] roll gauze, quantity 2; 4 [inch] Coban, quantity 1, ABD pads, quantity 6; and Red bio hazard bag, quantity 2.
- Drawer #4: Gloves (Medium/Large), quantity 1 box each.
- Drawer #5: No items or quantities were listed.
- Drawer #6: OB kit, quantity 1; AMBU Bags Adult/Infant, quantity 1 each; and Emergency Med Kit, quantity 1 box".
The AD equipment check sheet was a different version compared to the equipment check sheet in Finding 1.b. For example:
- The AD equipment check sheet was dated "Updated 4/30/2024." The equipment check sheets in Findings 1.b. and 1.e. were dated "Updated 6/23/2024."
- The AD equipment check sheet reflected "Emergency Med Kit," quantity 1 box and did not not include Narcan. The equipment check sheet in Finding 1.b. reflected "Emergency Med Kit with Narcan," quantity 1 box.
- The AD equipment check sheet reflected "Scissors," quantity 1 which could be confused with office type scissors. The equipment check sheet in Finding 1.b. reflected "Trauma Shears," quantity 1 and did not include scissors.

1.e. During virtual tour using FaceTime of

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{A 093}	Continued From page 8 Junction City campus Mountain 3 unit on 10/08/2024 beginning at ~ 1430 with a DCNO, CS and other hospital staff, observations included: * Similar to the findings above, a Red Emergency Cart with six drawers was observed. * A "Code Blue Equipment Check Sheet" dated "Updated 6/23/2024" was observed on top of the cart. Similar to the equipment check sheet in Finding 1.b., it included a list of items and a quantity for each item to be included in Drawer #s 1 through 6. However, the items on the Mountain 3 unit equipment check sheet were inconsistent with the items on the equipment check sheets in Findings 1.b. and 1.d. For example: - The Mountain 3 unit equipment check sheet did not include an OB kit. The equipment check sheets in Findings 1.b. and 1.d. both included one OB kit. - The Mountain 3 unit equipment check sheet did not include an infant AMBU Bag. The equipment check sheet in Findings 1.b. and 1.d. included one infant AMBU bag. - In addition, the Mountain 3 unit equipment check sheet reflected Drawer #3 should have two "3 [inch] roll gauze." However, observation of the inside of Drawer #3 revealed there were no 3 inch rolls of gauze. This was confirmed during an interview on 10/08/2024 with staff present at the time of the observation.	{A 093}		

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{A 000}	INITIAL COMMENTS This report reflects the findings of the unannounced, onsite Federal Medicare certification revisit survey completed on 10/11/2024. The revisit survey was result of complaint investigation surveys for complaints OR50743, OR50765 and OR51018 that had concluded on 07/03/2024. During the revisit survey the hospital was evaluated for implementation of its Plan of Correction for the 07/03/2024 survey and for return to compliance with the Conditions of Participation (CoP). The hospital demonstrated it had implemented processes and systems to the extent that deficiencies at the Condition-level were determined to be corrected and it was back in substantial compliance with the following 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 482.41 - CoP: Physical Environment * CFR 482.60 - CoP: Special Provisions for Psychiatric Hospitals Standard-level deficiencies follow in this report.	{A 000}		
{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 patient care documentation, and review of the hospital's Plan	{A 144}		

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of Correction (POC), it was determined that the hospital failed to fully implement its POC in relation to the "Continuous Rounds, Census, and Milieu Management" (RCM) process it developed to ensure patient safety, and additionally failed to prevent the recurrence of patient possession of contraband and prohibited items:
* Nighttime weekend staff observed on video on three units on the hospital's two campuses revealed that RCM practices specified in the POC were not always in accordance with the POC and were inconsistent between staff and between units.
* Documentation by the Video Monitoring Team responsible for monitoring staff RCM practices by video in real time was not clear or complete.
* Contraband and prohibited items were found in patient rooms and an outdated version of the hospital's prohibited items list was posted in hospital units.

Findings include:

1.a. The hospital's POC reflected the "Nursing Protocol 2.020 [RCM] Management" was updated and an "RCM Administrative Directive" was issued in relation to the RCM process. The POC included the following direction:
"Administrative Directive requiring direct observation of viability checks: [sic] [Registered Nurse (RN)] is to observe the accuracy of the viability check by ensuring the staff member does the following:
o At the top of the hour, two staff must complete the Patient Unit Census and Status Flowsheet to verify the location and status of each patient. While doing so, if they observe a patient who is nonverbal or who is not up and moving about, both staff must verify two respirations. This will be

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{A 144}	Continued From page 2 done by observing the patient for no less than 10 seconds, watching for respirations (as evidenced by chest rise and fall) for a minimum of 2 respirations ... o If the patient is their bedroom and the door is closed, staff must look through the window to observe if the patient is awake, up/moving, or communicating with staff or peers. If the patient is laying down and they are not spontaneously verbal, staff must observe the patient for 10 seconds and visualize 2 respirations. If 2 respirations cannot be confirmed by both staff, staff must quietly open the door ... o The status of each patient must be documented on the Patient Census and Status Flowsheet, using the codes available on the flowsheet as soon as each patient check is completed. At the end of the round, after all patients have been checked, both staff must attest, via initials and signature." 1.b. Video recordings of weekend nighttime staff who conducted RCM rounds were reviewed on 10/10/2024 beginning at 0930 with numerous hospital staff that included the Quality Management Director (QMD), the Standards & Compliance Director (SCD), the Incident Response & System Investigation Director (IRSID), nursing leaders, unit managers, and others. Video recordings of all or parts of five RCM rounds that occurred on three hospital units from both campuses that were conducted by 10 RN, Licensed Practical Nurse (LPN), and Mental Health Technician (MHT) staff were reviewed. Observations revealed the rounds were not conducted in accordance with the POC. For example: * Video of RCM rounds on the Junction City campus Mountain 3 unit that began at ~ 0200 on	{A 144}		

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{A 144}	Continued From page 3 Sunday, 10/06/2024 revealed that the two MHTs did not conduct the patient checks together at the same time. Rather one did checks independently on the opposite side of the hall or at another room from the other. * During the Mountain 3 unit 0200 rounds, video showed, for patients for who staff had recorded on the RCM form that the patient was in their "Bedroom - Eyes Closed, [Respirations] Confirmed", that the lengths of each patient check by staff were insufficient. For example: In three rooms where one patient resided in each room, one of the two staff observed the patients for the required 10 seconds each while the other observed the patients for five to eight seconds each. For patient checks in four rooms where two patients resided, the length of observations of those two patients by both staff varied from ~ five seconds to 13 seconds, for observations that should have been 10 seconds for each patient. * Similar findings regarding the length of patient checks were observed in the video recordings of the Sunday, 10/06/2024 0300 rounds on Mountain 3 unit; the Monday, 10/07/2024 0200 and 0300 rounds on Leaf 3 unit; and the Sunday, 10/06/2024 2200 rounds on Butterfly 1 unit. * The video recordings additionally revealed that one of the two staff carried a clipboard with the RCM form on it. However, they were not observed to record anything on the form "as soon as each patient check is completed." Staff were observed to only stop and record an entry on the clipboard form for those patient checks that the RCM form showed the staff observed the patient to be awake at the time of the check. 1.c. During interview with staff at the time of the video reviews the findings related to the length of patient checks and documentation were	{A 144}		

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confirmed. Additionally, a nursing leader stated that staff were trained to conduct the rounds together, side by side.

2.a. The hospital's POC reflected that "Video monitoring team operates 24 hours per day to observe staff and patient activity in unit milieu, to ensure staff maintain situational awareness and diligent observation and monitoring of patient condition, location, and status."

2.b. Review of documentation on the "Milieu Safety Monitoring Log" completed by the video monitoring team reflected it did not clearly or completely capture the monitoring activities and the outcome of those observations. For example:
* An entry on the Junction City log was dated 10/05/2024 at 1357 for the Mountain 1 unit. The notation recorded was only "Viability completed on Mountain stack." Mountain "stack" referred to three hospital units: Mountain 1, Mountain 2, and Mountain 3. It was not clear what the times of the "viability" checks observed on each of those units were and of what rooms, or whether all viability checks were observed for all rooms on each of those units. Further, there was no indication as to whether the "viability" check rounds were conducted per the protocol and POC, including the length of the observations made by staff for each patient.
* An entry on the Junction City log was dated 10/06/2024 at 0600 for the Mountain 3 unit. The notation recorded was "viability checks was [sic] observed at 2200, 2300, 0000." It was not clear if the observation was of the full RCM rounds for each room at those times, and there was no indication as to whether the checks were conducted fully per protocol, including the length of observations.

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{A 144}	Continued From page 5 * Similar entries on the Junction City and Salem campus logs did not clearly reflect the times and extent of the rounds observed and the outcome. 3.a. The hospital's POC included that "[Oregon State Hospital] (OSH) has clear procedures/systems for investigation of incidents and adverse events that constitute potential abuse or neglect as defined by [Centers for Medicare & Medicaid Services] ... OSH recognizes that prior investigations did not prevent these instances of contraband and prohibited items, and that additional actions are required to identify and implement corrective actions to prevent the recurrence of contraband and prohibited items coming into patient possession. Thus, OSH is taking the actions identified in section one: The Quality Management Department will analyze options for selection, tracking, and monitoring of investigative findings, and implement these new collection tools, leveraging existing data analysis systems to incorporate investigative findings data. The Quality Management Department will identify the group responsible for inputting the investigatory findings data into an identified system and will identify the process for how the data will be analyzed in the current [Quality Assessment and Performance Improvement] plan. The [Performance System Steering Committee] will identify and will be responsible for implementing corrective action(s) to prevent recurrence ..." 3.b. An Administrative Directive dated 06/03/2024 reflected "This Administrative Directive ... modifies Oregon State Hospital policy number 8.044, 'Contraband and Prohibited Items' ... it is my directive that, effective June 5, 2024 ... The attached Prohibited Items List ... will replace the	{A 144}		

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existing list and now reflects that this list is not exclusive. As needs evolve, additional information regarding prohibited items will be shared. An item not being included on this list does not mean it is allowed, and all items entering patient access areas must follow appropriate procedure for acquisition and use."

3.c. The hospital's prohibited items list titled "Oregon State Hospital Patient/Property/Item Access List" dated 06/05/2024 reflected "... This list applies to all units, patients [sic] types and is not exclusive. Additional property restrictions may be set to support the safety and security of Oregon State Hospital patients and staff." Under "Contraband" it included "Drugs ... flammable liquids ... Ethanol (drinking alcohol) ..." Under "Prohibited Items: No Access Allowed" it included "Any item with ethyl, methyl, or isopropyl alcohol as the first or second ingredient ... Aromatherapy products (unless indicated on [Occupational Therapy] (OT) assessment and [Physician] ordered) ... Excess personal property - property which cannot be stored in the designated storage in the patient's room or personal storage space on the unit ... Gum (unless indicated on OT assessment and [Physician] ... Hair dye ... Items that are manipulated or altered into something other than original, intended use ... Items intended for the use of escape or elopement ... Non-OSH issued pens/pencils/markers (must be 'mini' length) ... Non-OSH issued coffee or tea ... Prescription or over-the-counter drugs, herbal supplements, or other supplements ..." Under "Tier 1: Checkout For Off-Unit Use, Specified Locations Only" included "...scented lotions ..."

3.d. During tour of the hospital with a Director of Nursing (DNS) and Compliance Specialist (CS)

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{A 144}	Continued From page 7 on 10/07/2024 beginning at approximately 1400 observations on the Anchors 1 unit included the following: * An "Oregon State Hospital Patient/Property/Item Access List" posted on the wall inside the Patient Belongings Room was dated 07/06/2022 and was not the current 06/05/2024 version reflected in Finding 3.c. * In Patient Room (PtRm) 147, piles of unfolded clothing and other items were observed overflowing from a laundry basket and paper bags onto the floor, and strewn on the floor in a cluttered and disorganized manner. This was not consistent with the hospital's prohibited items list in Finding 3.c. that included "Excess personal property - property which cannot be stored in the designated storage in the patient's room or personal storage space on the unit." * In PtRm 133: - A paper medicine cup with yellow, jelly-like substance inside. The cup had no information that indicated its contents and no dispensed or discard date. It was not clear what was inside the cup including whether the contents were on the hospital's prohibited items list. It was additionally not clear whether, if ingested, it could cause patient harm. - A single serving package of strawberry mango drink mix. - A paper cup containing dried flowers and other plants. There was no information that indicated whether, if ingested, those could cause patient harm. - A single serving carton of soy milk. - Ten paper drinking cups stacked together. The top cup contained dark brown/black liquid. It was	{A 144}		

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not clear what was inside the cup including whether the contents were on the hospital's prohibited items list. It was additionally not clear whether, if ingested, it could cause patient harm.
During interview on 10/07/2024 at the time of the observations the DNS stated the drink mix should be in the patient's "snack box" and should not be in the patient's room. The DNS stated the soy milk and dark brown/black liquid "shouldn't be in here."

* In PtRm 154:
- A small cup containing thick, yellow liquid with no information indicating the contents of the cup, dispense date, or discard date. It was not clear what was inside the cup including whether the contents were on the hospital's prohibited items list. It was additionally not clear whether, if ingested, it could cause patient harm.
- Two snack-size packages Honey Maid graham crackers.
During interview on 10/07/2024 at the time of the observations the DNS stated the small cup contained shampoo, should have been labeled, and confirmed it was not. The DNS stated there was "not supposed to be food items in the room."

3.e. During tour of the hospital with a DNS, Program Director and other hospital staff on 10/07/2024 beginning at approximately 1455 observations on the Flower 2 unit included the following:

* An "Oregon State Hospital Patient/Property/Item Access List" posted on the wall inside the unit was dated 07/06/2022 and was not the current 06/05/2024 version reflected in Finding 3.c.

* In PtRm 227:

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{A 144}	Continued From page 9 - An unopened packet of Splenda sweetener. - An unlabeled item that looked like a wrapped lollipop on a rigid stick that was approximately two to three inches long. - A standard length, rigid toothbrush. It was not clear whether this was permitted as observations in other patient rooms had short, non-standard length toothbrushes. During interview on 10/07/2024 staff present at the time of the observations stated Splenda was not permitted in patient rooms and they were not sure where the patient got the toothbrush. It was stated that the patient "probably" got it from the dentist. * In PtRm 229: - A paper cup containing freshly cut flowers. There was no information that indicated what type of flowers those were or whether, if ingested, could cause patient harm. - A paper cup containing dried flowers and other plants. There was no information that indicated what type of flowers those were or whether, if ingested, could cause patient harm. - Five single wrapped, unlabeled items that looked like salt water taffy. - An unopened packet of Splenda sweetener was observed under the mattress on the bed. During interview on 10/07/2024 staff present at the time of the observations stated they did not know where the cut flowers and plants came from. They stated the cut flowers and plants may have been from a sensory activity or from "outside". No further information was provided regarding the flowers and plants observed. * In PtRm 231: - A medicine cup with thick, white substance inside dated "10/5" and no information indicating	{A 144}		

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the contents of the cup. It was not clear what was inside the medicine cup including whether the contents were on the hospital's prohibited items list. It was additionally not clear whether, if ingested, it could cause patient harm.
- A medicine cup containing thick, yellow substance with no information indicating the contents of the cup, dispense date, or discard date. It was not clear what was inside the medicine cup including whether the contents were on the hospital's prohibited items list. This was confirmed with the DNS on 10/07/2024 at the time of the observations.

3.f. During tour of the hospital with a Deputy Chief Nursing Officer and CS on 10/08/2024 beginning at approximately 1130 observations on the Leaf 3 unit included the following:

* An "Oregon State Hospital Patient/Property/Item Access List" posted on the wall inside the unit was dated 07/06/2022 and was not the current 06/05/2024 version reflected in Finding 3.c.

* In PtRoom 324, single wrapped, unlabeled items that looked like hard candies were observed. It was not clear whether those were permitted in patient rooms as interview with hospital staff in Findings 3.d. reflected that food was not permitted in patient rooms.

3.g. The findings related to the outdated prohibited items list posted in hospital units; and contraband and prohibited items observed in patient rooms was presented at the exit conference on 10/11/2024. No additional information was provided by the hospital.

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{A 000}	INITIAL COMMENTS This report reflects the findings of the unannounced, onsite Federal Medicare certification revisit survey completed on 10/11/2024. The revisit survey was result of complaint investigation surveys for complaints OR48336, OR45197, OR37585 and OR31593 that had concluded on 03/04/2024. During the revisit survey the hospital was evaluated for implementation of its Plan of Correction for the 03/04/2024 survey and for return to compliance with the Conditions of Participation (CoP). The hospital demonstrated it had implemented processes and systems to the extent that deficiencies at the Condition-level were determined to be corrected and it was back in substantial compliance with the following CoPs: * CFR 482.12 - CoP: Governing Body * CFR 482.13 - CoP: Patient's Rights * CFR 482.21 - CoP: Quality Assessment and Performance Improvement * CFR 482.23 - CoP: Nursing Services Standard-level deficiencies follow in this report.	{A 000}		
{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 interviews, review of medical record documentation for 3 of 3 Code Blue events for two patients (Patients 1 and 2), review of policies and procedures (P&Ps), and review of the hospital's Plan of Correction (POC), it was determined that the hospital failed to fully	{A 144}		

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{A 144}	Continued From page 1 implement the P&Ps and POC in relation to Code Blue documentation and debrief. Findings include: 1.The "Policy Attachment" titled "Procedures A: Code Blue Medical Emergency Response" was dated 06/24/2024. It reflected that the "Recorder" was to "Complete the Code Blue Flowsheet" and after the event was to provide one of the triplicate copies to EMS, file one of the copies into the patient's medical record, and send the third one to the Chief of Medicine (COM). * Review of documentation for a Code Blue event that occurred on 10/05/2024 for Patient 1 revealed the absence of the required "Code Blue Flowsheet." It was not found in the medical record. * During interview at the time of the review on 10/08/2024 beginning at 1415, the Code Blue Registered Nurse (RN) stated they were unable to find the flowsheet and speculated that the triplicate form may have been sent with EMS to the acute care hospital. 2. The POC reflected the creation of a "Code Blue Review Form" for post Code Blue review of the event, response, and follow-up. On Page 2 of the form it included a section to "Describe the medical emergency and outcome (as well as any failures to follow procedure, e.g., failure to fill out code flowsheet, failure to notify legal guardian, and your response)." * Review of documentation for the Code Blue event that occurred on 10/05/2024 for Patient 1 reflected the "Code Blue Review Form" had been completed by the Code Blue RN on 10/06/2024. However, there was no indication and response to the omission in the medical record of the	{A 144}		

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{A 144}	Continued From page 2 "Code Blue Flowsheet" that could not be found, as described under Finding 1. 3. The POC reflected the creation of "... a Code Blue progress note template to be used in the electronic health record (EHR) ..." * During interview with the Code Blue RN at the time of the review on 10/08/2024 beginning at 1415 the EHR template was electronically viewed. It included the following fields that the RN was to complete for each Code Blue event. Those included "Respiratory: Cardiac/Circulatory: Neurological: Pain: Fracture/Threatened Limb: Intervention: RN or MD notified, if applicable (include name, date, and time of notification): Code Blue Called: Yes or No - Patient transferred to outside facility: Yes or No - Patient Emergency Contact notified, if applicable ..." * Review of documentation for three Code Blue events that occurred for Patient 1 on 10/05/2024 and for Patient 2 twice on 10/07/2024 revealed that the RNs did not use the "Code Blue progress note template" for those. RN progress notes about the code blue event had been recorded in the medical record, however, they did not include all of the information contained on the template. For example: In the progress note for Patient 1 who was found down on the floor information that was not documented included: Neurological, Pain, Fracture/Threatened Limb, MD name/date/time of notification. The note did reflect "Doctor notified" but not the time of notification/response. 4. The POC reflected "Each Code Blue event is reviewed and debriefed among the [RNs], Licensed Practical Nurses, Mental Health Therapy Technician classifications and Interdisciplinary Team at the following	{A 144}		

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{A 144}	Continued From page 3 interdisciplinary morning report." * Review of documentation for the three Code Blue events that occurred for Patient 1 on 10/05/2024 and for Patient 2 twice on 10/07/2024 revealed no indication that the debrief had been conducted the following morning. 5. During interview with the Code Blue RN and the COM on 10/08/2024 beginning at 1415 they confirmed the findings for Patients 1 and 2.	{A 144}		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 000}	INITIAL COMMENTS This report reflects the findings of the unannounced, onsite Federal Medicare certification revisit survey completed on 10/11/2024. The revisit survey was result of a complaint investigation survey for complaint OR44708 that had concluded on 10/05/2023. During the revisit survey the hospital was evaluated for implementation of its Plan of Correction for the 10/05/2023 survey and for return to compliance with the Conditions of Participation (COP). The hospital demonstrated it had implemented processes and systems to the extent that deficiencies at the Condition-level were determined to be corrected and it was back in substantial compliance with the following COPs: * CFR 482.12 - CoP Governing Body * CFR 482.13 - CoP Patient's Rights * CFR 482.21 - CoP Quality Assessment and Performance Improvement	{A 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.