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 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 for complaints OR48336, OR45197, OR37585, and OR31593. The survey was conducted onsite at the OSH-Salem main campus on hospital level-of-care units. It was initiated on 02/28/2024 and concluded with an exit conference on 03/14/2024.

The survey also included a patient sample from hospital level-of-care inpatient units at 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 hospital Condition of Participation for Patient's Rights, CFR 482.13.

The findings from the survey that follow in this report reflected that allegations in the four 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
* CFR 482.23 - CoP: Nursing Services

****
Hospital units referenced throughout this report are as follows:
AN1 - Anchors 1 unit @ OSH-Salem
AN3 - Anchors 3 unit @ OSH-Salem

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

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TR1 - Tree 1 unit @ OSH-Salem
TR3 - Tree 3 unit @ OSH-Salem
MN1, MN2, MN3 - Mountain 1, 2, 3 units @ OSH-JC

Hospital staff referenced throughout this report are as follows:
CFO/COO - Chief of Operations
COM - Chief of Medicine
CMO - Chief Medical Officer
CNO - Chief Nursing Officer
CFO/COO - Deputy Chief of Operations
DNS - Director of Nursing Services
DSC - Director of Standards and Compliance
DQM - Director of Quality Management
IRSI - Incident Response Systems Investigator
OSH Superintendent - Administrator OSH
PD - Program Director

Abbreviations and acronyms used throughout this report may include:
@ - at
# - number
1:1 - one-to-one observation
AC - Activities Coordinator
AL - Administrative Leave
c/o - complains of
CADM - Type of investigation report
CDC - Centers for Disease Control
CEO - Chief Executive Officer
CFR - Code of Federal Regulations
CIR - Critical Incident Review
CMS - Federal Centers for Medicare and Medicaid Services
comm - communication(s)
CoP - Condition of Participation
CT - Computerized Tomography
d/t - due to
DC- discontinue

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DHS- Oregon Department of Human Services
DND - Do Not Distribute
e.g. - for example
ED - Emergency Department
ES - Enhanced Supervision
EOC - Environment of Care
FYI - For your information
GEI - Guilty Except for Insanity
HCP - Health Care Personnel
HCRQI - Health Care Regulation and Quality Improvement
HI - Homicidal Ideation
HR - Human Resources
ICU - Intensive Care Unit
IDT - Interdisciplinary Team
IP - in-patient
IP - Infection Preventionist
LIP - Licensed Independent Practitioner
LOC - Level of Consciousness
LPN - Licensed Practical Nurse
MD - medical doctor, physician
mg - milligrams
MHT - Mental Health Technician/Therapist
MN - Mountain unit
NM - Nurse Manager
NMI - Notice of Mental Illness
NP - Nurse Practitioner
NS - Nurses Station
OAR - Oregon Administrative Rule
OHA - Oregon Health Authority
OQM - OSH Office of Quality Management
OSH - Oregon State Hospital
OSH-JC - Oregon State Hospital in Junction City, Oregon
OSH-JC Mountain units - OSH-JC licensed hospital inpatient units
OSH-Salem - Oregon State Hospital in Salem, Oregon
OSP - Oregon State Police

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OTIS - DHS/OHA Office of Training, Investigation and Safety
P&P, PP - policy(ies) and procedure(s)
PET - Program Executive Team
PHD - OHA Public Health Division
POD - Psychiatrist On Duty
PRN - as needed
PSRB - Psychiatric Security Review Boards
pt - patient
Pt2Pt - Patient to Patient
QAPI - Quality Assessment and Performance Improvement
Q15 - every 15 minutes
r/t - related to
RCA - Root Cause Analysis
RCM - Rounds, Census, Milieu
RN - Registered Nurse
SA - The CMS designated State Agency responsible for enforcement of the Federal hospital regulations. In Oregon that is the Public Health Division office of Health Care Regulation and Quality Improvement within the Oregon Health Authority.
SA - suicide attempt
SH - self harm
SI - suicidal ideation
(sic) - In a quote reflects the language, spelling or punctuation is recorded as in the original document.
SOM - CMS State Operations Manual
SRTF - Secure Residential Treatment Facility
Sup - supervisor
TCP - Treatment Care Plan
TMM/TXM - Treatment Mall Manager
TX - treatment
VAH - visual and auditory hallucinations
w/ - with
****

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A 043	Continued From page 4	A 043		
A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: ********** Based on observations, review of video recordings, interviews, review of incident and medical record documentation for 24 of 26 patients (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 ,19, 22, 23, 24, 25, and 26), review of investigation documentation, review of grievance documentation, review of P&Ps and review of other documentation it was determined that the governing body failed to ensure the provision of safe and appropriate care to patients in the hospital in a manner that complied with all Conditions of Participation. The cumulative effect of these systemic failures resulted in this Condition-level deficiency that represents a limited capacity on the part of the hospital to provide safe and adequate care. Findings include: 1. Refer to the findings cited at Condition Tag A-115 under CFR 482.13 - CoP: Patient's Rights that reflects that policies, procedures, and systems for the provision of safe care were not clear, complete, or implemented (Tag A-144); that identification of, investigations of, and response	A 043		

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A 043	Continued From page 5	A 043		

to, allegations of abuse, and 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 (Tag A-145); and that response to, investigation of, and follow-up to patient grievances related to safe care were not clear, complete or timely (Tag A-118).

2. Refer to the findings cited at Condition Tag A-263 under CFR 482.21 - CoP: Quality Assessment and Performance Improvement that reflects additionally that the hospital failed to ensure that incidents and adverse patient events were clearly identified, tracked, 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. Further, there was no process for systematic identification and tracking of negative outcomes to patients that involved patient injuries, ED visits, and hospitalizations in relation to incidents (Tag A-286).

3. Refer to the findings cited at Condition Tag A-385 under CFR 482.23 - CoP: Nursing Services that reflects additionally that the RN failed to supervise the nursing care for each patient to ensure the provision of safe and appropriate care that included prevention of patient to patient altercations and injuries, and sexual contact. RN failures included, but were not limited to: failure to ensure nursing staff appropriately supervised and observed patients to prevent incidents, failure to ensure investigations of incidents were complete and corrective actions were taken that prevented recurrence, and failure to ensure that response to grievances regarding

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A 043	Continued From page 6 patient safety were timely and appropriate (Tag A-395). **********	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: ********** Based on observations, review of video recordings, interviews, review of incident and medical record documentation for 24 of 26 patients (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 ,19, 22, 23, 24, 25, and 26), review of investigation documentation, review of grievance documentation, review of P&Ps and review of other documentation, it was determined that the hospital failed to ensure each patient's right to provision of care in a safe setting, the right to freedom from all forms of abuse and neglect, and the right to prompt and appropriate response to grievances. Those failures resulted in actual and potential physical and psychological harm to patients. The cumulative effect of these systemic failures resulted in this Condition-level deficiency that represents a limited capacity on the part of the hospital to provide safe and adequate care. Findings include: 1. Refer to the findings cited at Tag A-144 under CFR 482.13(c)(2) - Standard: Privacy and Safety that reflects that policies, procedures, and systems for the provision of safe care were not	A 115		

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A 115	Continued From page 7	A 115		

clear, complete, or implemented and resulted in the following:
* Failure to prevent patient to patient physical altercations and injuries.
* Failure to prevent patient to patient sexual contact and sexual assault.
* Failure to ensure staff carried out assigned duties related to all aspects of observation and supervision of patients.
* Failure to ensure TCPs and ES orders were followed.
* Failure to ensure door security and situational awareness practices that ensured patient safety.
* Failure to ensure all high risk patient care areas monitored by 24/7 security staff video monitoring were fully observable and did not include blind spots.
* Failure to ensure staff practices were in accordance with, and supported by, written and approved P&Ps for the following:
- Condom distribution to patients.
- Processing and tracking police reports filed on behalf of patients who had been assaulted by other patients.
- Security staff "access control" video monitoring
* Failure to ensure Code Blue responses were organized, appropriate, and documented.
* Failure to ensure staff training related to patient safety was current.

2. Refer to the findings cited at Tag A-145 under CFR 482.13(c)(3) - Standard: Privacy and Safety that reflects that identification of, investigations of, and response to, allegations of abuse, and 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.

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A 115	Continued From page 8 3. Refer to the findings cited at Tag A-118 under CFR 482.13(a)(2) - Standard: Patient Grievances that reflects that response to, investigation of, and follow-up to patient grievances related to safe care were not clear, complete or timely. **********	A 115		
A 118	PATIENT RIGHTS: GRIEVANCES CFR(s): 482.13(a)(2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. This STANDARD is not met as evidenced by: ********** Based on review of grievance documentation for 1 of 1 patient reviewed for grievances (Patient 11) it was determined that the hospital failed to ensure patients' rights were recognized, protected, and promoted in regards to patient grievances. Response to, investigation of, and follow-up to patient grievances were not clear, complete or timely. Findings include: 1. Review of patient grievance documentation filed by Patient 11 revealed the following: 1.a. A "Patient Grievance" form was signed and dated by Patient 11 on 08/13/2023 at 1932. At the top of the form Patient 11 had written in large letters "*Emergent*." The grievance was described as "[Patient 10] is continuing to provoke and instigate myself and other patients. [MHT] witnessed [Patient 10] provoking me as I walked back onto the unit at approx. 6:02 pm. Just now [Patient 10] lunged at [another patient]	A 118		

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with a raised fist attempting to intiate [sic] a violent interaction. Staff unwillingness to address this issue is putting staff and patient [sic] in harm's way ... emergency transfer [Patient 10] to another unit." The "For Staff use only" box reflected the "Date Received" was 08/14/2023.

The "Grievance Committee Response" reflected the "Date of Grievance Review" was 08/21/2023 and the response was "attached" to the form. The undated attachment contained one paragraph that reflected "IDT is aware of the issues that are happening between you and the described peer and have taken the necessary follow up. All follow up will be confidential to protect patient privacy. In the future please encourage peers who are having issues to reach out to staff or complete their own grievances so that we may follow up with them."

1.b. A second "Patient Grievance" form was signed and dated by Patient 11 on 08/13/2023 with no time. The grievance was described as "[Patient 10] has been increasing [their] aggressive behavior toward me and other patients. Flicking [another patient] and pushing through people. Just now in East TV Room I was grabbing a spoon after receiving my meal and [Patient 10] walked in from the air court and threw [their] shoulder into me ... Move [Patient 10] to another ward, My safety and the safety of the other patients is at risk." The "For Staff use only" box reflected the "Date Received" was 08/14/2023.

The "Grievance Committee Response" reflected the "Date of Grievance Review" was 08/21/2023 and the response was "attached" to the form. The undated attachment was identical to the one

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A 118	Continued From page 10	A 118		

described in the grievance above.

1.c. A third "Patient Grievance" form was signed and dated by Patient 11 on 08/16/2023 at 0950. The grievance was described as "I filed 2 grievances within the last 72 hours about [Patent 10's] continual aggressive behavior and [on 08/15/2023] in the milieu of Tree 1 [Patient 10] violently assaulted me by close fist strike to the left temple of my head. When I returned from the E.R. at approx 7 pm [Patient 10] was already out of seclusion. This morning in East Plaza at approx 9:15 [Patient 10] came out and began to attempt an altercation from afar telling staff '[Patient 11] can't be within 10 feet of me.' This is systemic supported abuse and violence." The "For Staff use only" box reflected the "Date Received" was 08/17/2023.

The "Grievance Committee Response" reflected the "Date of Grievance Review" was 08/29/2023 and the response was "The treatment team has reviewed the issues and resolved it. The two patients currently do not reside on the same unit. The IDT may not discuss patient treatment with you."

1.d. The fourth related "Patient Grievance" form was signed and dated by Patient 11 on 08/22/2023 at 1555. The grievance was described as "On, or about, August 15th at approximately 3:30PM I was assaulted by [Patient 10]. I do not believe the report has been forwarded to law enforcement and/or the Marion County DA for prosecution. The the [sic] documentation and proper reporting of this crime needs to be done immediately. If this violent assault is not reported, investigated, and charges are not filed I will hold each, and every, member

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of the Treatment Team, P.E.T, and all other relevant parties accountable both personally and professionally to the harm inflicted by this neglect. This will include each, and every licensee, who is charged with my care and treatment as a public servant of Oregon ... I still have not spoken with a detective, OSH security, or even been approached by a therapist to talk about, decompress, or process this attack for which I am the victim." The "For Staff use only" box reflected the "Date Received" was 08/23/2023.

The "Grievance Committee Response" reflected the "Date of Grievance Review" was 08/29/2023 and the response was "On 8/29 management called security to inquire about the police report regarding the assault. The police report was submitted by the unit on 8/15/23. Security stated that it had not yet been sent out to OSP for review. The detective who usually picks them up missed a week due to other obligations. It was stated the [detective] should return this week and will receive it by end of week sometime. Management asked if security was planning to follow up and they stated they don't typically check in after each report unless a patient requests it specifically as there are too many to keep up with at times according to security. Management has reach out to the IDT and the therapist that you are currently working with on 8/29 and let them know you would appreciate meeting to help you process/decompress regarding the incident."

2. In response to surveyor request for tracking information related to the police report that was filed, an internal OSH email, with an attachment, sent from the DOS dated 03/13/2024 at 0807 was provided. It included the following information:

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"Like most of our stuff we don't have a written protocol but the process is described below ... This was closed out by [detective name] without being assigned a case number due to not meeting prosecutorial guidelines. At the time the case was received, the unofficial protocol we were using was ... Incident occurs prompting a report made to OSP ... [unit staff] fills out an OSP reporting form and submits it to the Security Management email box. Form is received by Security and printed ... Printed form is maintained by Security Investigator until OSP makes a visit to OSH to collect these forms ... When OSP detectives come to OSH, the printed forms are handed over to the detectives ..."

3.a. The document attached to the 03/13/2024 email from the DOS was titled "Oregon State Hospital - Security Department Reporting of a crime" was reviewed. It included the following information:
* "Date of Incident: 08/15/2023"
* "Reported by: [NM identified in the incident report]"
* "Date/Time: 08/15/2023 at 1530"
* "Victim of Crime: [Patient 11]"
* "Suspect of Crime: [Patient 10]"
* "Summary of Incident: [Patient 11] was speaking to the Unit Administrator ... [Patient 10] walked up ... swung around the staff and punched [Patient 11] in the left eye ... eye immediately began to swell, become bruised ..."
* "Signature of person completing this report" that was followed by a signature.

The lower part of the form had two sections, one of which was for "Security Use Only" which contained the following:
* "Date Submitted:"

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A 118	Continued From page 13 * "Submitting Manager:" * "Reporting Manager Signature:" Those fields were blank and contained no entries. The last section of the form for "Dispatch Use Only" contained the following: * "Date Received:" * "Case Number:" Those fields were blank and contained no entries. 3.b. As of the date of the survey there was no documentation to reflect when that report had been received by the Security Department and whether or when it had been submitted to OSP. Nor was there evidence that Patient 11 had been updated as to the status of the report to OSP after the 08/29/2023 "Grievance Committee Response" for the 08/22/2023 grievance Patient 11 had filed. 4. Refer also to Finding 3 for Patient 11 cited at Tag A-144 under CFR 482.13(c)(2) - Standard: Privacy and Safety that reflects Patient 11 was assaulted and injured by Patient 10 on 08/15/2023 after submission of their grievances related to concerns about safety for themselves and others. **********	A 118		
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: ********** Based on observations, review of video recordings, interviews, review of incident and medical record documentation for 24 of 26	A 144		

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patients (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 ,19, 22, 23, 24, 25, and 26), review of investigation documentation, review of P&Ps and review of other 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 provide adequate observation, supervision and other preventive measures and precautions created an unsafe EOC that resulted in actual and potential physical, mental or emotional harm to patients. Deficient practices included:

* Failure to prevent patient to patient physical altercations and injuries.
* Failure to prevent patient to patient sexual contact and sexual assault.
* Failure to ensure staff carried out assigned duties related to all aspects of observation and supervision of patients.
* Failure to ensure TCPs and ES orders were followed.
* Failure to ensure door security and situational awareness practices that ensured patient safety.
* Failure to ensure all high risk patient care areas monitored by 24/7 security staff video monitoring were fully observable and did not include blind spots.
* Failure to ensure staff practices were in accordance with, and supported by, written and approved P&Ps for the following:
- Condom distribution to patients.
- Processing and tracking police reports filed on behalf of patients who had been assaulted by other patients.
- Security staff "access control" video monitoring
* Failure to ensure Code Blue responses were organized, appropriate, and documented.
* Failure to ensure staff training related to patient

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safety was current.
* Failure to ensure incident investigations were clear and complete to identify causes and to plan and implement corrective actions to prevent recurrence for the affected patient and other patients.

Findings include:

1.a. The P&P titled "Continuous Rounds, Census, and Milieu (RCM) Management" dated as 05/01/2023 was reviewed and included the following:
* "Nursing staff must perform continuous rounds focused on census and milieu management (RCM) at all times on each unit when patients are present."
* "RCM rounds and related verifications and observations are documented on the Unit Patient Census and Status Flowsheet, also known as the 'RCM Flowsheet.'"
* "The oncoming RN (or Lead LPN) must note each patient's status next to the patient's name on the RCM Flowsheet using the 'Daily Clinical Screening Status' codes found on the flowsheet."
* "For patients on Enhanced Supervision, both the type and level of supervision must be noted."
* 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."
* "RCM staff must maintain a continuous presence in the milieu, walking each hall and varying their routes and times in order to prevent any identifiable patterns. This activity must occur on all shifts."
* "RCM staff must not station themselves in the Bubble, at the Hub, or other unit location and

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must only access these areas for short periods of time (less than 5 minutes) to complete specific RCM-related tasks."
* "When not actively completing RCM-related observation rounds, RCM staff must remain in the milieu, therapeutically interacting with patients, facilitating positive social interactions, providing assistance to patients and co-workers, and intervening early to defuse tense or potentially dangerous situations."
* "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 potentially aggressive behaviors to staff or peers and intervening ... monitoring for potential sexual contact between patients and intervening ..."
* "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)."
* "RCM staff must maintain continuous possession of the RCM clipboard, flowsheet(s), and a two-way radio ...

1.b. The P&P titled "Procedure B: Environment Checks" dated as 06/07/2023 was reviewed and included the following:
* "To protect the safety of patients and staff, OSH staff are responsible to maintain the cleanliness and sanitation of patient care areas, including patient rooms. Environment checks may be conducted as often as necessary, and frequency may change depending on patient, unit, or treatment mall need ... Staff are encouraged to involve patients in maintaining cleanliness and sanitation of their rooms whenever possible ..."
* "OSH staff designated in these procedures are authorized to: Enter a patient's room to remove

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food and fluids (excluding water) ... Enter a patient's room to remove and dispose of garbage; Check to ensure state-issued bedding is clean ... Ensure dirty clothing is in a covered laundry basket ... During rounding or other environmental monitoring, dispose of patient sundry items which are unlabeled or past the listed expiration date ..."
* "Designated staff include; Nurses, including contracted nurse staff; Mental Health Technicians (MHT); Interdisciplinary team members (IDT); Clinical support staff ... Environmental Services staff."

1.c. The P&P titled "Enhanced Supervision" dated as 11/09/2017 was reviewed and included the following:
* "Oregon State Hospital (OSH) strives to promote and maintain the safety, health, and wellbeing of patients, in part by minimizing the occurrence of aggressive, suicidal, or self-destructive behavior. While persons who engage in such behavior often require a targeted increase in therapeutic interventions, which may include the increased presence of staff, this need must be weighed against the intrusion and isolation that such interventions may create. The least intrusive means of providing effective treatment must be used, with the goal of helping patients regain the ability to maintain safety toward self and others without the need for an increased staff presence."
* "The psychiatrist or psychiatric mental health nurse practitioner (PMHNP), using clinical input from other members of the interdisciplinary treatment team (IDT), must determine the type and level of enhanced supervision necessary to safeguard patients and staff. The IDT must collaboratively plan and implement therapeutic interventions to address dangerous,

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self-destructive, and/or suicidal behavior, or needs associated with medical illness."
* "The type of enhanced supervision indicates the primary behavior or condition that warrants more careful monitoring and/or intervention ... 'Behavior supervision' may be ordered to provide enhanced monitoring and intervention for patients who are at risk of engaging in dangerous behaviors. These behaviors may include harming others, elopement, sexual contact with peers, etc."
* "The level of enhanced supervision describes the frequency with which staff make contact with the patient being supervised. 1. "Unobtrusive supervision" means a staff member must be assigned to be aware of a patient's location and activities at all times, and have visual and, if the patient is awake and able, verbal contact with the patient at least three (3) times per hour, at irregular intervals, never more than 30 minutes apart. 2. "Close supervision" means a staff member must be assigned to be aware of a patient ' s location and activities at all times, and to have visual and, if the patient is awake and able, verbal contact with the patient at least five (5) times per hour, at irregular intervals, never more than 15 minutes apart. 3. "1:1 supervision" means a staff member must be assigned to monitor a patient's location and activities at all times. The assigned staff member must maintain constant visual contact and consistent physical proximity, as well as verbal contact while the patient is awake, within parameters specified by the physician/PMHNP order and as described on the Intervention Card. The psychiatrist or PMHNP must specify additional parameters, as appropriate, in the order. Supervision at staff ratios greater than 1:1 (2:1, etc.) means the same as 1:1 except that more than one staff person is assigned to monitor the

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A 144	Continued From page 19 patient. * "'Intervention card' means the document which assists staff working with any patient on 1:1 supervision and some patients on lower-level supervision. The Intervention Card includes the supervision order, the behavior(s) of concern, the hypothesis about the underlying reason for the behavior(s), and recommended interventions." * "Patient education handout means the document that is prepared for a patient who is placed on enhanced supervision. It provides information about the behavior of concern, any limitations on patient movement or property, and how often the patient can expect to interact with staff." * "Initial Response to Acute Safety Concern, Any HCP who becomes aware of a patient's unsafe, unpredictable, or suicidal behavior or deterioration in medical condition must immediately take measures to verify the safety of patients and others, and notify the registered nurse or licensed practical nurse (nurse). The nurse must: 1. Immediately assess the patient and implement necessary safety and security measures. 2. If there is a need to assess for enhanced supervision, immediately contact the psychiatrist or PMHNP responsible for the patient's care, or the Psychiatrist On Duty (POD). 3. When necessary, authorize temporary supervision and implement required documentation until the psychiatrist or PMHNP is available. 4. Document in a progress note the assessment of the patient, the specific behavior(s) and/or medical condition(s) that prompted intervention, the method of intervention, the patient's response to the intervention, and the reason this specific intervention was used. 5. Determine if a search of the patient's person or property may be necessary ..."	A 144		

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A 144	Continued From page 20 * "Initiation of enhanced supervision ... Behavioral or suicide/self-harm supervision must be ordered only following face-to-face assessment by a psychiatrist or PMHNP. When a behavioral or suicide/self-harm supervision is needed, the psychiatrist or PMHNP must determine the primary type of supervision, the level of supervision, and any other relevant therapeutic interventions to be utilized. Findings must be documented in a progress note." * "Reassessment of enhanced supervision a. If any patient is started on enhanced supervision by a covering psychiatrist or PMHNP, the patient must be reassessed by the attending psychiatrist or PMHNP the next business day, with the assessment documented in a progress note. b. If a patient remains on 1:1 or greater supervision for seven (7) consecutive days following the previous face-to-face assessment, the attending or covering psychiatrist or PMHNP or medical physician (in the case of medical supervision) must personally reassess the patient. This assessment must be documented in a progress note. If supervision continues to be deemed appropriate, a rationale for ongoing supervision and interventions to help the patient become safe must be documented. c. If a patient is on 1:1 or greater supervision for 14 consecutive days, the attending or covering psychiatrist or PMHNP or medical physician (in the case of medical supervision) must inform the supervisor, Chief Medical Officer (CMO), or designee. This discussion must include review of the treatment provided to the patient, and the patient ' s progress toward safety. The practitioner must document this discussion (including rationale for ongoing supervision, alternatives considered, and any change in interventions provided based on supervisor	A 144		

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review) in a progress note. This must be repeated at each consecutive 14 days the patient remains on 1:1 or greater supervision."
* "Discontinuation or change of enhanced supervision a. Only a psychiatrist or PMHNP may discontinue behavioral or suicide/self□harm supervision, and only following a face-to-face examination. This applies also to temporary supervision implemented by the nurse. b. Only a psychiatrist or PMHNP may change an order for behavioral or suicide/self-harm supervision. For significant changes (increase or decrease in level, change of type, or significant changes in parameters - for example, discontinuation of restriction to unit), a personal examination is required. For minor changes (for example, small modifications to allowed property), personal examination shall be at the discretion of the ordering practitioner."
* "Enhanced Supervision Orders 1. All orders for enhanced supervision must be entered into the electronic medical record, and must contain the following required elements:
a. Type of supervision
b. Level of supervision
c. Primary behavior(s) of concern
d. Time of day that supervision is required
e. Distance staff should remain from the patient while supervising
f. Allowed patient movement, particularly off unit
g. Allowed patient property"
* "The psychiatrist or PMHNP order may modify the default parameters for enhanced supervision.
a. Default parameters include:
i. Enhanced supervision level and type is around the clock (24 hours per day)
ii. Enhanced supervision is applicable in all areas, both on and off the unit
iii. A patient on enhanced supervision may attend

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and participate in most treatment mall classes and activities, cafeteria meals, quad time, visits, and religious services.
iv. Continuous visualization of the head, neck and hands of any patient on 1:1 or greater suicide/self-harm supervision is required, including during patient use of bathroom and shower.
v. For a patient on 1:1 or greater supervision, staff must remain approximately 2 arms' length from the patient (in the doorway, if the patient is in their bedroom)."

1.d. The P&P titled "Enhanced Supervision" dated as 02/28/2024 was reviewed and included the following:
* "This policy establishes guidelines for enhanced supervision at Oregon State Hospital (OSH). OSH strives to promote and maintain the safety, health, and wellbeing of patients by minimizing the occurrence of aggressive, suicidal, or self destructive behavior. This policy applies to all OSH staff."
* "The need for targeted increase in therapeutic intervention must be weighed against the intrusion and isolation that such interventions may create. The least intrusive means of providing effective treatment must be used, with the goal of helping patients regain the ability to maintain safety toward self and others without the need for an increased staff presence."
* "The psychiatrist or psychiatric mental health nurse practitioner (PMHNP), using clinical input from other members of the interdisciplinary treatment team (IDT), must determine the type and level of enhanced supervision necessary to safeguard patients and staff. The IDT must collaboratively plan and implement therapeutic interventions to address dangerous,

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self-destructive, and/or suicidal behavior, or needs associated with medical illness."
* "'Enhanced supervision' is careful monitoring and/or intervention characterized by types that indicate the primary behavior or condition and levels that describe the frequency with which staff contact the supervised patient ... 'Behavioral supervision' provides enhanced monitoring and intervention for patients who are at risk of engaging in dangerous behaviors including harming others, elopement, sexual contact with peers, etc. ... Level: 'Unobtrusive supervision' means a staff member must be assigned to be aware of a patient's location and activities at all times. Staff must have visual contact at least three (3) times per hour and, if the patient is awake and able, verbal contact with the patient at irregular intervals, never more than 30 minutes apart ... 'Close supervision' means a staff member must be assigned to be aware of a patient's location and activities at all times. Staff must have visual contact at least five (5) times per hour and, if the patient is awake able, verbal contact with the patient, at irregular intervals, never more than 15 minutes apart ... '1:1 supervision' means a staff member must be assigned to monitor a patient's location and activities at all times. The assigned staff member must maintain constant visual contact and consistent physical proximity, as well as verbal contact while the patient is awake, within parameters specified by the physician/PMHNP order and as described on the Intervention Card. The psychiatrist or PMHNP must specify additional parameters, as appropriate, in the order."
* "'Intervention card' is the document which assists staff working with any patient on supervision. The Intervention Card includes the

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supervision order, the behavior(s) of concern, the hypothesis about the underlying reason for the behavior(s), and recommended interventions."
* "'Patient education handout' is the document prepared for a patient who is placed on enhanced supervision, providing information about the behavior of concern, any limitations on patient movement or property, and how often the patient can expect to interact with staff."

1.e. The P&P titled "Use of Personal Portable Electronic Devices" dated as 09/30/2022 was reviewed and included the following:
* "The purpose of this protocol is to define expectations relative to the use of personal portable electronic devices by nursing staff, as well as by other staff when working in the capacity of nursing staff or under the supervision of unit nursing management, while on duty at Oregon State Hospital (OSH). The goal of this protocol is patient and staff safety."
* "Personal portable electronic devices (PPED)" means any personal, self-contained, easily carried by an individual electronic device that has the capacity to receive, record, collect, store, or transmit data or images. Types of devices include, but are not limited to: cellular phones, hand-held computers, book viewers, music players, games, watches, fitness trackers, headphones (including earbuds), and speakers."
* "Primary patient care area" means all on-ground areas in which patients may normally be expected to be present. Primary patient care areas, such as clinic and treatment mall rooms and dining halls, become secondary patient care areas outside of normal hours of operation."
* "Staff may not access or interact with PPED while on assignment in a patient care role or while working on a patient living unit. (Questions

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regarding the applicability of this protocol to a specific person or role must be directed to unit nursing management.)
1. All non-hospital issued PPED must be turned off or set on silent mode and safely stored, preferably in the employee's locker, during the work shift. Watches and fitness trackers may be worn but must be silenced.
2. Employees are encouraged to utilize the central staff phone in their assigned work area for emergency contacts.
3. If the employee chooses to carry their PPED on their person, the following rules apply.
a. The device (exclusive of fitness trackers and watches), must not be visible to a patient, regardless of the actual or anticipated position or posture of the staff. For example, a phone that extends above a pants' pocket, even if covered by a shirt or other garment, is not allowed.
b. The staff member must not answer, or otherwise interact with, the device in a primary patient care area or in the presence of patients.
c. The staff member must not leave a patient care assignment to answer, or otherwise interact with, the device without insuring adequate coverage during the staff 's absence.
* "Except as noted above, staff may only access and interact with PPED while on rest and meal breaks. This access and use must not occur in primary patient care areas (even when no patients are visible) or where it could cause disruption or distraction to other staff (such as unit chart rooms, medication rooms, etc.)."

1.f. A document titled "Attachment C Staff Prohibited Items" dated 07/06/2022 was reviewed and included the following:
* "The following items may be transported through patient care areas under secure

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possession of health care personnel (HCP), and must be stored in a secure, non-patient-care area (such as a break room or staff locker) as indicated in OSH Policy and Procedure 8.044, "Contraband and Prohibited Items".
These items may not be used in patient-care areas, even under the secure possession of HCP: glass, mirror or ceramic items; plastic bags or plastic wrap; personal toiletries (e.g., hair brushes, soaps, perfumes, deodorant, toothpaste, toothbrush, Aerosolized products); personal electronic devices not issued by OSH (e.g., cellphones, radios, MP3 players, cameras, or recording devices of any kind)."

1.g. The P&P titled "Sexual Activity Involving Patients" dated as 12/08/2022 was reviewed and included the following:
* "Oregon State Hospital (OSH) has the responsibility to take reasonable steps to discourage sexual contact between patients and to direct appropriate follow-up actions if sexual contact or sexual assault occurs. This policy establishes definitions of appropriate touch and inappropriate sexual behaviors for patients and expectations for staff response in the event of such behaviors."
* "Staff and patients are authorized to use appropriate touch; however, staff and patients must receive permission before touching another person. Even if permission is received, the other party may change their mind at any time, and the appropriate touch must stop immediately ... Staff must follow Procedures A if staff witness or receive reported allegations of a patient engaging in inappropriate sexual behaviors (other than sexual contact) with another person ... Staff must follow Procedures B if staff witness or receive reported allegations of a patient engaging in

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sexual contact with another person. Patient sexual contact is considered a reportable incident ..."
* "'Appropriate touch' includes, but is not limited to: Handshakes, Fist bumps, Touching a person's shoulder, Side hugs, and Any behavior normally associated with friendship or emotional support. 'Inappropriate sexual behaviors' include: Sexual contact, Intimate/inappropriate touching, Kissing, Extended hand holding, Full body hugs, Hugs from behind, Sexual conversations/statements, Going off alone with another patient to be more intimate, Other behaviors normally associated with sexual interactions or relationships, and/or Any sexual or dating behavior the interdisciplinary treatment team deems as contraindicated for recovery."
* "'Sexual assault' means an incident of sexual contact between patients where criminal activity is alleged to have occurred as defined by Oregon Criminal Code, including, but not limited to, non-consensual sexual intercourse or penetration, and those acts involving an alleged victim who lacks capacity to consent to sexual contact."

1.h. The P&P titled "Sexual Activity Involving Patients" dated as 02/16/2024 was reviewed and included the following:
* "'Appropriate touch' includes, but is not limited to:
1. Handshakes,
2. Fist bumps,
3. Touching a person's shoulder,
4. Side hugs, and
5. Any behavior normally associated with friendship or emotional support.
B. 'Inappropriate sexual behaviors' include:
1. Sexual contact,

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A 144	Continued From page 28 2. Intimate/inappropriate touching, 3. Kissing, 4. Extended hand holding, 5. Full body hugs, 6. Hugs from behind, 7. Sexual conversations/statements, 8. Going off alone with another patient to be more intimate, 9. Other behaviors normally associated with sexual interactions or relationships, and/or 10. Any sexual or dating behavior the interdisciplinary treatment team deems as contraindicated for recovery 1.i. The "Procedure B: Staff Response to Sexual Contact Involving Patients" dated as 02/16/2024 was reviewed and included the following: * "For witnessed sexual contact or upon receiving a report of alleged sexual contact: 1. Staff must notify the lead RN ... and a manager on site ... The lead RN or PNM must notify: a. The patient's psychiatrist/psychiatric mental health nurse practitioner (PMHNP) or Psychiatrist on Duty ... The unit Nurse Manager or program nurse manager (PNM) if after hours, OSH Security department, The Infection Prevention and Employee Health Department. Psychiatry staff must meet with all involved patients individually to assess immediate medical and psychological needs ... Psychiatry and nursing staff must collaborate to determine what environmental interventions are needed to limit contact between involved patients. This may include transfer ... Staff must report the incident ... Staff must document the incident and intervention in every involved patient's electronic medical record ..." 1.j. The "Procedure A: Staff Response to	A 144		

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Inappropriate Sexual Behaviors Involving Patients" dated as 12/08/2022 was reviewed and included the following:
* "For witnessed inappropriate sexual behaviors, staff must intervene to stop the inappropriate sexual behaviors. Appropriate interventions include, but are not limited to: 1. Instructing the individuals to stop and separate, 2. Call for additional staff for assistance ..."
* "For witnessed inappropriate sexual behaviors or alleged inappropriate sexual behaviors: 1. Staff must notify the lead RN of the incident (PNM if the incident occurs on an SRTF unit). 2. The lead RN may consult with the interdisciplinary team (IDT) and/or PNM to determine if room changes or other environmental interventions are needed to limit contact between the involved patients. 3. Staff must document the incident and intervention in every involved patient's electronic medical record ... 4. The IDT must meet to determine if further assessment of any involved patient to identify additional treatment needs is appropriate, or if treatment care plan updates are necessary ... Inappropriate sexual behaviors between a patient and staff must be reported."

1.k. The Procedure B: Staff Response to Inappropriate Sexual Behaviors Involving Patients" dated as 12/08/2022 was reviewed and included the following:
* "Following an incident of patient sexual contact, the IDT must: 1. Meet no later than the next business day, excluding weekends and holidays, to review and address the incident. Treatment care plan updates that may result from the IDT meeting must be made per OSH policy 6.011, "Treatment Care Planning."
2. Meet with all involved patients to assess any further psychological or medical needs and

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coordinate any recommended follow-up services ... If sexual contact occurs between patients that all involved patients describe as consensual, Psychology or Psychiatry staff will assess each involved patient for capacity to give consent and document the assessment in the electronic medical record ... If one or more involved patient does not describe the sexual contact as consensual, no assessment will occur. Instead, staff must follow OSH policy 8.019, 'Staff Response to Alleged Criminal Acts' ... Staff must follow OSH policy 8.019 if it is determined that a patient does not have capacity to consent, or a suspected sexual assault has occurred."

1.l. During interview with staff that included the DSC, the QMD and others on 02/28/2024 beginning at 1615 they stated that the policy definitions of sexual contact had been changed on 02/05/2024 to include what had been previously categorized as "intimate touching." Those "intimate touching" encounters between patients had not previously required that an incident report and an investigation be completed. As of the 02/05/2024 policy change those behaviors were considered to be "sexual contact" and would require an incident report and investigatory next steps.

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2. The following is regarding an incident involving Patient 22 and Patient 23.

2.a. During interview with staff that included the Superintendent, CNO, QMD, DSC, COM, CMO, DNS, and PD on 02/28/2024 beginning at ~ 1630 staff stated that on 02/10/2024 at ~ 1030 Patient 22 physically attacked Patient 23. They stated that the unwitnessed assault occurred without

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provocation in the AN1 air court and resulted in physical harm to Patient 23 that included LOC and a head laceration. When Patient 23 was found a Code Blue was called, 911 was called, and the patient was transported to the local acute care hospital for ED services. The following information was provided during the interview:
* Upon return from the ED later the day of the incident, Patient 23 was transferred to the OSH medical unit for care and monitoring.
* Security staff initiated video review immediately after the incident to determine what happened and who had assaulted Patient 23.
* When it was shown on video that Patient 22 was the aggressor, orders for 1:1 observation and for placement in seclusion were initiated for Patient 22 until they could be transferred to another unit.
* An Everbridge email notification was sent to hospital leadership staff on the day of the incident at 1117 to inform them that Patient 23 had been transported to the acute care hospital secondary to LOC and "contusion" over the left eye.
* On 02/12/2024 hospital leadership met to continue follow-up actions and initiate the formal investigation that was underway at the time of this survey.
* Video recordings of unit, patient, and staff activities prior to the event had been reviewed.
* Staff adherence to unit shift assignments had been evaluated.
* Medical records for Patient 22 and Patient 23 had been reviewed.
* Initial investigation findings included that RN and MHT staff assigned to be continually present in the milieu were not in the milieu at the time of the incident, that observation orders in place for Patient 23 had not been followed, and there was a lack of staff supervision to ensure assignments

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were followed.
* Initial actions taken included communications to all staff regarding their responsibilities to comply with unit assignments and to maintain continual presence on the milieu.
* Staff changes were made that included placement of employee staff on AL during the investigation, and termination of some agency staff contracts.

2.b. Review of Patient 23's medical record reflected that they sustained injuries and had subsequent hospitalizations that included:

* A "Patient Progress Note" written by an OSH MD on 02/10/2024 at 1250 included the following: "Writer got called about the code blue in AN-1 at around I 0:50 AM this morning. When I went to the unit, [Patient 23] was lying down in the air court area, with [their] face towards ground bleeding profusely from a laceration on the forehead. Pt was conscious and able to talk with staff but could not recollect what happened. Staff were able to reposition [the patient] with [their] face facing side ways and apply pressure on the lacerated wound to prevent further bleeding. Pt later stated that someone choked [them] from behind and [they were] unconscious for a moment. I've noticed a deep lacerated wound on the right side of [their] forehead approximately 8 cm x 4 cm. EMS arrived and applied pressure dressing on [the patient's] head ... sent to Salem Hospital ER for further evaluation and treatment."

* A local hospital ED encounter note for 02/10/2024 included the following: "The patient ... presents to the Salem Health Emergency Department with head, face and neck pain after being assaulted. Patient states that [they were]

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assaulted ... at the Oregon State Hospital states that [they were] choked and then thrown to the ground and [they] landed on the edge of concrete brick. [They state] that [they were] getting choked and then [they] felt like [they were] going to pass out and was thrown to the ground and does not remember what happened after that. Staff at the bedside were able to get video of this and did state that it was caught on camera and [Patient 21] was choked and thrown to the ground and [they] did have a loss of consciousness ... Patient has a large gaping X shaped laceration across [their] forehead extending over the bridge of the nose and down towards the right eye but does not involve the globe or the lid ... does have some swelling of the eyelid on the left that progressed throughout [their] stay here. Neck: ... does have tenderness over the anterior neck ... evaluated for facial laceration, headinjury, choking episode with neck pain. Ddx includes, but is not limited to: I have concerns for intracranial hemorrhage, skull fracture, facial bone fractures, airway or vascular injury of the neck secondary to choking episode ... ADMIT TO OBSERVATION: Yes, Time starts 1130 AM Disposition of the patient will be determined by the results of the ED workup as well as re-evaluation of the patient to determine adequate response to treatment ... PROCEDURE NOTE: LACERATION REPAIR Site: Forehead Length: 15 cm Laceration Type based on exam: complex Anesthesia was obtained with several cc of 1 % lidocaine with epinephrine. Prior to repair the laceration was thoroughly cleansed and irrigated per nursing protocol. The wound was examined prior to repair and no significant arterial, nerve or underlying tendon injury was noted. Foreign bodies were not appreciated. The area was prepped and draped in the usual sterile fashion. The site was then repaired with 4-0 gut

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utilizing several simple interrupted sutures and several short running sutures. Deep sutures were needed for good wound approximation. 2 deep sutures were placed. A dressing was placed over the site ... Extensive suture repair of the forehead laceration with good approximation and hemostasis." The ED note reflected that the patient had blood drawn for lab testing and underwent CT testing of the head, facial bones, and angio of the neck. The patient was discharged back to OSH on 02/10/2024.

* A "Patient Progress Note" written by an OSH MD on 02/10/2024 at 2240 included the following: "Pt was evaluated after [they] came back from Salem Hospital ... had the laceration sutured on the forehead. Pt had wound dressing in place. Pt was awake, alert and oriented ... calm and mentioned that a peer came from behind and strangulated [them]. Reports having pain while trying to open [their] mouth and difficulty chewing the food. Reports having moderate pain in [their] forehead ... left eye shut due to swelling. Speech was fluent with regular rate and volume. Fair insight and judgement per test situation."

* A "Patient Progress Note" written by an OSH MD on 02/11/2024 at 1657 included the following: "[Patient 23] ... earlier [today] ... had xl vomiting, received Zofran. No further vomiting. Reports head and neck pain, vision problems and stress related to the event ... reports [they] felt sudden neck pain (staff reported [the patient] was grabbed from the back and [their] neck was put in a choke hold), and [they] lost consciousness, fell on [their] face; [they have] no memories of the event ... Facial swelling, anxiety ... both eyelids are swollen and bruised, and bruises below the orbits. Left eye hard to ope, [sic] right eye is also

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somewhat shut but less severe ... TMJs are tender, only able to open [their] mouth about 4-5cm wide ... is a large, X-shaped suture on the forehead that extends to the glabella. Nasal base is swollen and tender, but air flows through both nostrils. Neck is anterior swollen somewhat. Decreased lateral rotation, only 30 deg to left and right ... There is a scant bruise on the right side of the neck ... Choking event, LOC, fall on face, facial contusion with sutures, orbital and neck soft tissue injuries. Anxiety related to the event. Suspected concussion ..."

* Patient 23 was transferred from the medical unit to TR3 unit on 02/13/2024.

* A "Patient Progress Note" written by an OSH NP on 02/14/2024 at 2144 included the following: "Pt said that [they are] still having nausea and is having some trouble eating ... waking up in pain ... vision is still blurry."

* A "Patient Progress Note" written by an OSH MD on 02/19/2024 at 1722 included the following: "Called by nursing staff due to patient showing worsening distress with frequent vomiting and severe persisting headache over the last hour without relief by various when necessary medications. Patient seen in [their] room ... appears to be in mild distress but notes that [their] vomiting has subsided for the moment. Given recent severe head injury and episode of choking after strangulation from peer last weekend, I discussed with nursing staff and we agreed that having [the patient] assessed in the emergency department was appropriate. Prepared paperwork and discussed with nursing staff ... patient was agreeable with the plan."

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* A "Patient Progress Note" written by an OSH MD on 02/20/2024 at 1633 included the following: " ER follow up, a. Urinary retention, could not urinate for them in ER. [Patient] was straight cathed for 800 ml. b. Still having significant HA. Now associated with nausea and vomiting. Loud noises make [their] head hurt more ... 1.Post concussion headache. Now with some associated nausea and vomiting. Zofran is controlling the nausea and decreasing the vomiting. But still has severe HA. CT did not show any hemorrhage intra and extra cranial ... 2.Laceration: seems to be healing well. No indication of infection. 3.Urine retention. Straight cathed for 800 ml in the ER. Still having issues today. Will need to have [patient] scanned and possible repeat scan. Also need to find out how much [they are] drinking -what [they are] vomiting. [Patient] may not be making as much urine if [they are] slightly dehydrated."

* A "Patient Progress Note" written by an OSH MD on 02/21/2024 at 1243 included the following: "1. Patient continuing to have urinary retention, feels like [they need] to urinate, but cannot make urine flow. When [they bear] down in [sic] push it out, [their] headache increases significantly ... NECK: Tenderness to palpation and rotation C2-4 on the right ... Assessment/Plan 1.Urinary retention since assault 2/10/24. Initially was able to urinate small amounts but required straining. Now cannot urinate even with straining. 2.Headaches: suspect post-concussion HA, but it definitely gets worse when [patient] strains. Craning CTs have been negative x2. Transfer to [Salem Hospital ED]. Spoke with [physician] in the ER. Requested evaluation of [the patient's] cervical spine and other evaluations if indicated."

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* A "Patient Progress Note" written by an OSH NP on 02/21/2024 at 1734 included the following: "On 2/20/24, ... met with pt following AM report. Pt was transported to ... ED on 2/19/24 ... Pt continues to report difficulty urinating, along with continued headache, N/V. Pt stated that [they are] currently experiencing 8/10 pain and that [they are] 'starting to feel really agitated' due to pain and continued external stimuli (routinely loud volume on unit, bright lights in hallway). Pt went on, 'I feel like I should be on [the medical unit]. I need a quiet place. I don't know why they didn't keep me there longer. It was a lot quieter.' PMHNP informed pt that [they] will complete an urgent transfer request to a medical unit and pt indicated understanding. Assessment/Plan: Consulted with clinic MD regarding pt status pre and post ED transport, noting continued urinary retention and post-concussive pain, dizziness, N/V. MD met with pt that afternoon for assessment (see MD note for details). PMHNP completed emergency transfer request for [medical unit]."

* A "Patient Progress Note" written by an OSH NP on 02/23/2024 at 1941 included the following: "On 2/21/24, PMHNP reassessed pt ... Pt reported continued urinary retention and after a bladder scan in clinic revealed approx 805 ml, unit NM assisted pt with straight cath which yielded approx 1050 ml. Clinic MD was immediately notified who subsequently sent pt back to Salem ED for imaging. Pt was sent back with indwelling catheter and notation of urinary retention without identifiable cause. Pt was referred to urology and neurology for flu. Transfer to [medical unit] was subsequently accepted ... Prior to transfer, around 1650 on 2/22/24, pt reported visualizing a blood clot in [their] catheter tube. PMHNP

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visualized an approx 0.5 mm size blood clot ... no further clots were observed, no change in output that might indicate a blockage ... Pt was transferred [to medical unit] following lunchtime on 2/23/24."

* A "Patient Progress Note" written by an OSH MD on 02/26/2024 at 1047 included the following: "[Patient] vomited this AM ... post concussion- improving, but has ongoing NV and HA ... Urinary retention- pulled out Foley this AM, start PRN bladder scanning and PRN straight cath, urology consult on 2/28. retention is likely related of stress because symptoms started about 10 days after [their] initial injury, [Patient] says [they feels] more relaxed now that [they're] back [on medical unit]."

* A "Patient Progress Note" written by an OSH MD on 02/28/2024 at 1452 included the following: "[Patient] returned from Urology eval ... had urinary retention temporarily last week, Foley was removed 2 days ago and bladder scan and straight cath PRN were ordered, but [patient] had normal urine since, no straight cath needed. The retention was likely situational, as [patient] admits, teh [sic] previous unit [they were] at was too stressful, and being on medical 1 : 1 watch caused more stress so [they] couldn't urinate."

* A "Patient Progress Note" written by an OSH MD on 03/02/2024 at 1616 included the following: "[Patient] was seen and evaluated on the unit after [they] requested to be seen for [their] headache. [Patient] reports experiencing 'the worst headache of [their] life' and nausea since waking up this morning. Symptoms did not resolve or improve after taking imitrex and pain medication. Denied experiencing shortness of

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breath, chest or abdominal pain, dizziness or sensation of the room spinning ... Given [patient's] recent history of head trauma and intensity of headache pain, new nausea and unsteady gait, ordered that [they] be transferred to Salem ED for head CT to rule out intracranial bleed. Spoke to Salem Health triage nurse ..."

* During interview with staff that included the CMO, DSC, QMD, and Deputy CNO on 03/04/2024 at 1100 they reported that Patient 23 had been transported to the Salem Hospital ED on 03/02/2024 and had been admitted as an inpatient to neurology with a fever of ~ 103 degrees and a possible diagnosis of "viral meningitis."

2.c.i. During tour of three Salem-campus hospital units (AN1, AN3, and TR1) on 02/28/2024 beginning at ~1515 observations were made:
* On AN1 the unit's NS, hallways, common areas, and air court were observed to be configured as follows: The main entry door onto the unit led into the West Hallway. Near the end of the West Hallway on the left was the Med Room window and after that the door into the Med Room. That was followed by a door into the main NS and "bubble." The "bubble" was a NS counter and area that was fully enclosed with see through material from the counter to the ceiling in the front and on both sides. The windows on each side of the "bubble" had a round area through which patients and staff could converse. Behind it, the bubble was connected to the rest of the NS and Med Room. Extending out from the NS at the end of the West Hallway were three other hallways, South, East, and North. In front of the NS was the "commons" space in which television and seating was provided for patients. There was an entry

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door into the commons from the East Hallway and an entry door into the commons from the South Hallway. Extending outward from the commons spaces toward the exterior of the building was the air court space. There was an entry into the air court from the East commons space and an entry into the air court from the South commons space. A description of the air court follows below.
* During the tours of AN1, AN3, and TR1 there were numerous staff observed in the milieu hallways and common areas. Staff were observed to interact with patients. Some staff were observed actively walking through the halls with clipboards. Other staff who were identified as 1:1 constant observers were observed to sit outside of patient rooms with clipboards.

2.c.ii. An undated "Video Timeline" document completed by hospital staff included the following "Scene description" that described the air court space in which Patient 23 was attacked: "The AN1 air-court is a 30' x 20' screened patio area, which faces east, along the east side of the unit. At either end of the air-court are entry doors, with one from the east commons room and one from the south commons room. Along the interior wall of the air-court are large windows which span approximately 3' off the floor to near the ceiling of both common rooms. The outer, mesh screen material, is heavy fencing spanning from approximately 1' from the floor to the ceiling. Along the base of the meshed screen was is a concrete curb-line. At the south wall line of the air-court is a mesh door to Quad [secured, walled outdoor space] ... Inside the air-court is plastic patio furniture which consists of plastic chairs and at times tables. The air-court and each commons room contain (1) surveillance camera each, which

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do have some blind spots areas."

2.d. Survey team review of video-recordings, without audio capability, revealed the following timeline of events on 02/10/2024 beginning at 1033:49 when Patient 23 entered the air court space where they were attacked:
~ 1033:49 Patient 23 entered the air court through the East Hall door with a beverage cup in one hand and a banana in the other hand.
~ 1034:15 Patient 23 positioned a chair and seated themselves to face south toward the outside of the air court. They sipped on beverage and ate the banana.
~ 1036:41 Patient 23 exited air court briefly through south commons door with banana peel in hand.
~ 1036:55 Patient 23 reentered air court without the banana peel in hand, sat down in south facing chair, resumed sipping beverage.
~ 1037:22 Patient 22 entered air court through south door, Patient 23 turned head toward Patient 22 momentarily then back to face south. Patient 22 walked around and periodically stood still in the space for the next ~ 52 seconds, then moved directly behind Patient 23.
~ 1038:14 Patient 22 lunged toward Patient 23 from behind, placed their arm around Patient 23's neck in a "chokehold" manner, and lifted Patient 23 to a standing position. Patient 23 initially struggled, reached both their arms up and behind their head and neck to attempt to release the grip of Patient 22. Patient 23's arms fell to their sides after 12 seconds and they stopped moving. Over the next 16 seconds Patient 23 maintained the "chokehold" while they also shook Patient 23's limp body which was lifted off the ground.
~ 1038:42 Patient 22 released the "chokehold" and threw Patient 23 toward the southwest corner

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of the air court onto the ground. Patient 23's motionless body was not clearly visible in the video recordings of the air court. Only a small portion of their body could be seen but not clearly.
~ 1038:47 Patient 22 calmly and without expression walked out of the air court through the South Hall door.
~ 1039:17 30 seconds after Patient 23 was thrown to the ground a third patient entered the air court through the East Hall door and eventually saw Patient 23 who continued to lie motionless on the ground in the corner of the air court.
~ 1039:23 That third patient exited the air court. (Seen on other camera views at that time the patient waved their arms in the air and appeared to yell for help, after which eight staff emerged from the West Hall side of the NS and hurried toward the air court.)
~ 1039:30 Multiple staff enter the air court and upon observation of Patient 23 on the ground some ran back out, after which numerous staff begin to rapidly respond to the air court, many of whom were observed on other camera views entering the unit through the unit's secure doors from other parts of the hospital.
~ 1041:47 Staff pushed the Code Cart into the air court.
~ 1042:21 By this time there were at least 16 individuals, if not more, in the air court. It was a crowded, disorganized, and chaotic scene and it was unclear what roles and tasks the various staff were carrying out.
~ 1054:08 EMS staff entered the air court with a gurney and equipment and assumed care of Patient 23.

It was shown on other camera views that after Patient 22 left the air court at 1038:47 they

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walked across the South Hallway into the activities room, then to the NS where they stood until staff were seen to rush from the NS toward the air court. After that they walked down East Hall and entered the East Hall door towards the air court. At 1040:22 they exited that space, reentered the East Hall corridor and walked toward their room.

2.e.i. Survey team review of video-recordings that began on 02/10/2024 at ~ 1000, prior to the time of the air court incident, revealed the times when staff left the fully enclosed NS. This excluded the staff persons assigned to constant 1:1 observation of a patient located on the North Hall. During interview with staff that included the CFO/COO, QMD, DSC, and IRSI at the time of the video review on 02/29/2024 beginning at 1030, they stated that staff assigned to constant 1:1 are not considered to be present on the milieu as their role and responsibility is to observe and focus all attention on the 1:1 patient. The video recordings showed that from ~ 1000 until ~ 1039:30, the time the third patient called for help upon finding Patient 23 on the ground, there was not a continual presence of any staff in the milieu. During the times below multiple patients were observed to wander throughout the halls, pace around the NS and Med Room, stand against the walls, sit on the floor, lay on the floor, talk on the patient phone, enter and exit common areas.

2.e.ii. Review of the "Day Shift" functional assignment sheet for 02/10/2024 reflected that from 1000 to 1100 MHT B was assigned to the "Environmentals" role/task. Video recordings showed the time MHT B was out of NS from 1000 to the time the third patient called for help in the air court was ~ 16 minutes, 26 seconds:

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~ 1000:00 visible inside NS.
~ 1005:05 left NS, walked down South Hall, then onto East Hall, then back in front of NS, reentered NS at 1021:00, ~ 16 minutes later.
~ 1027:14 left NS through West Hall door, walked into room with closed door on West Hall ~ 16 seconds later.
~ 1030:15 exited West Hall room, reentered NS across the hall at 1030:25, 10 seconds later.
~ 1039:32 left NS hurriedly toward air court.

2.e.iii. Review of the "Day Shift" functional assignment sheet for 02/10/2024 reflected that from 1000 to 1100 MHT C was assigned to the "RCM" role/task. Video recordings showed the time MHT C was out of NS from 1000 to the time the third patient called for help in the air court was ~ 10 minutes, 11 seconds:
~ 1000 appeared from East Hall, walked down South Hall, reentered NS ~ two minutes, 10 seconds later.
~ 1007:25 left NS, walked down South Hall, reentered NS ~ one minute, 11 seconds later.
~ 1010:07 left NS, walked down South Hall then East Hall, then approached MHT F and MHT H who were seated in chairs in the hall outside of the NS, reentered NS ~ three minutes, 14 seconds later.
~ 1014:04 left NS, walked down West Hall and entered through door into fourth room on left of hallway at 1014:13.
~ 1015:05 left West Hall room, walked across the hall into the NS, 14 seconds later.
~ 1015:30 left NS, walked down South Hall, reentered NS ~ one minute, 38 seconds later.
~ 1027:13 left NS, walked down South Hall then East Hall, returned NS at 1028:45, ~ one minute, 32 seconds later.
~ 1039:35 left NS hurriedly toward air court.

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2.e.iv. Review of the "Day Shift" functional assignment sheet for 02/10/2024 reflected that from 1000 to 1100 MHT D was assigned to the "Bubble" role/task. Video recordings showed the time MHT D was out of NS from 1000 to the time the third patient called for help in the air court was ~ four minutes, 22 seconds:
~ 1000:00 appeared from South Hall, walked into first room on the left on East Hall, stood outside of room with door open, reentered NS at 10:02:38.
~ 1011:45 left NS, stood directly outside of NS, reentered NS ~ 17 seconds later.
~ 1016:11 left NS, walked down South Hall, reentered NS ~ 38 seconds later.
~ 1017:37 left NS, walked down South Hall, reentered NS ~ 23 seconds later.
~ 1027:32 left NS, approached MHT F and MHT H who were seated outside of the NS, reentered NS ~ 17 seconds later at 1027:49.
~ 1039:30 left NS hurriedly toward air court.

2.e.v. Review of the "Day Shift" functional assignment sheet for 02/10/2024 reflected that from 1000 to 1100 LPN FF was assigned to the ""Meds" role/task. Video recordings showed the time LPN FF was out of NS from 1000 to the time the third patient called for help in the air court was ~ 1 minute, 32 seconds:
~ 0959:00 on North Hall stood near MHT H, who was seated in a chair outside of the NS.
~ 0959:54 entered NS after MHT F exited the NS and sat in a chair beside MHT H outside of the NS.
~ 1000:03 left NS, handed something to MHT C who was outside of NS, reentered NS at 1000:14, 11 seconds later.
~ 1001:53 left NS, walked down West Hall and

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entered through door into fourth room on left of hallway 15 seconds later.
~ 1017:45 left West Hall room, walked across the hall into the NS, 12 seconds later.
~ 1039:35 left NS hurriedly toward air court

2.e.vi. Review of the "Day Shift" functional assignment sheet for 02/10/2024 reflected that from 1000 to 1100 LPN GG was assigned to the "SSM" role/task. Video recordings showed the time LPN GG was out of NS from 1000 to time the third patient called for help in the air court was ~ five minutes, 40 seconds:
~ 1000:45 appeared from South Hall, walked down West Hall corridor and back, entered NS at 1001:46.
~ 1027:18 left NS, walked down West Hall observed to be checking room door handles, then walked down South Hall, then down East Hall, then approached MHT F and MHT H both seated in chairs near the NS on North Hall across from closed double doors. The three staff walked through the closed double doors further into the North Hall, then shortly thereafter reemerged back through the closed double doors to the location of the chairs.
~ 1031:12 reentered NS ~ three minutes, 54 seconds after leaving NS.
~ 1039:35 left NS hurriedly toward air court.

2.e.vii. Review of the "Day Shift" functional assignment sheet for 02/10/2024 reflected that from 1000 to 1100 MHT HH was assigned to the "Environmentals" role/task. Video recordings showed the time MHT HH was out of NS from 1000 to time the third patient called for help in the air court was ~ 17 minutes:
~ 1005:05 left NS, walked down South Hall, then onto East Hall, then back in front of NS, around

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the corner into the West Hall corridor, then reentered NS at 1022:00 ~ 17 minutes later.
~ 1039:32 left NS hurriedly toward air court.

2.e.viii. Review of the video recordings as identified earlier in this Tag reflected that at 1039:29 eight individuals emerged from the West Hall side of the nurses' station and hurried toward South Hall. The eight staff included those already described above in this finding and the following:
- RN A assigned to the role/task of "Lead ... RN Duties" on the "Day Shift" functional assignment sheet for 02/10/2024 from 0800 until 1400.
- RN K assigned to the role/task of "Milieu RN" on the "Day Shift" functional assignment sheet for 02/10/2024 from 0800 until 1100.

2.e.ix. Neither RN A nor RN K were observed on video to have been outside of the NS from 1000 until the time they responded to the call for help at 1039:29.

2.e.x. In addition, staff were observed to not practice door security and situational awareness. For example:
~ 1015:27 MHT C exited the West NS door and walked away with their back to the door while the door was partially open and a patient stood next to the door.
~ 1016:11 MHT D exited the West NS door and walked away with their back to the door while the door was fully open. They had walked onto the South hallway before the NS and closed.
~ 1027:13 MHT B exited the West NS door and walked away with their back to the door while the door was partially open and a patient walked behind them toward the door.
~ 1039:35 LPN GG was the last staff to exit the West NS door, they walked away with their back

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to the door while the door was partially open. A patient was seated immediately across the hall from the open door.
~ 1039:36 RN K exited the West NS/Med Room door into the hallway and walked away with their back to the door while the door was partially open. Two patients walked immediately behind RN K past the open NS/Med Room door
~ 1041:22 two staff exited the West NS door and hurriedly walk away in opposite directions with their backs to the nearly fully open door while two patients were across the hall and faced the open NS door. For two seconds their are no staff on that side of the NS between the two patients and the door as it closed.

2.e.xi. The video-recordings reflected there was lack of continual staff presence on the milieu for the purpose of continuous observation, monitoring, and supervision of patient behaviors and activities from 1000 until after Patient 23 was found on the ground by another patient. That included that all eight RN, LPN, and MHT staff assigned to be on the unit and who were not assigned to a 1:1 role were inside the NS from ~ 1031:12 until 1039:30, after the third patient called for help when they found Patient 23 on the ground. During the video review with staff that included the CFO/COO, QMD, DSC, and the IRSI on 12/29/2024 beginning at 1030 they confirmed that unit staff were not continually present in the milieu prior to the incident as required by the "functional" shift assignments and policies and procedures for staff assigned to Milieu RN, RCM, and SSM roles/tasks.

2.e.xii. Review of an undated "Dispositioned Staff information" summary included the following information about disposition of some staff

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present on the AN1 unit on the day of Patient 23's attack:
"The following staff were put on administrative leave because they were not following their assignment per the functional. All were assigned to be in the milieu at the time, but after camera review were in the chart room ... [RN A assigned to Lead RN Duties], [MHT B assigned to Environmentals], and [MHT C assigned to RCM] ..."
"[RN K assigned to Milieu RN] - continues to work. Was visible in medication room for the hour, covering the medication room."
"[MHT HH assigned to E] ... has been restricted from working patient care units."

2.f.i. During interview with the DOS on 02/29/2024 beginning at 1430 they stated there were ~ 1,083 cameras in use on the OSH-Salem campus. They indicated that there were three security staff positioned at three security monitoring stations in the hospital's "access control" office on a 24/7 basis. The responsibility of those staff was to continually monitor the live video camera feed from those ~ 1,083 cameras. The DOS stated that not all of those ~ 1,083 camera views could be observed at the same time. They stated that the monitor staff were "not omnipresent" but tended to focus on the milieus and activities of units or groups that were high acuity or high concern and as requested by specific units for particular reasons. They further stated that monitor staff watched for "visual cues" and "behaviors of staff and patients" that were unusual or unexpected. The DOS stated that there were times when monitor staff had observed a situation develop and called the unit to advise them and sometimes that had been before unit staff were aware of the situation. The

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DOS did not know whether the AN1 air court camera view had been monitored by "access control" monitor staff at the time Patient 22 attacked Patient 23. At ~ 1455 the DOS stated that there was no written procedure or protocol for how monitor staff were to decide which of the ~ 1,083 camera views to monitor and what they were to look for. They stated that all monitor staff were "legacy trained" by other staff.

2.f.ii. Additional review of video recording and still photo images of the air court was conducted on 03/14/2024 beginning at 1135 with the DSC and IRSI. During the review it was confirmed by those staff that the video camera view of the air court had a blind spot in the southwest corner where Patient 23 had been thrown and laid. A significant section of the air court where the southwest exterior air court wall met the brick building wall and formed a corner was not observable on video camera views. In the video recording, a very small portion of Patient 23's body could be discerned, however, was not clear.

2.f.iii. "Access control" monitor staff may have observed the attack had the air court camera been monitored at the time of the incident. However, had the air court camera been monitored after the attack while Patient 23 laid on the ground, there would have been no clear image to observe as the patient laid in the camera blind spot. Based on staff performance on that day as described, and on the blind spot in the camera view where Patient 23 was on the ground, it was unclear how long Patient 23 might have remained undetected in the corner of the air court.

2.g.i. During review of video recordings of staff

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presence and activity on the unit prior to Patient 23's attack from ~ 1000 until after staff responded to Patient 23 who had been found on the ground in the air court, observations were made related to a 1:1 constant supervision situation on the North Hall. During that previous review with hospital staff an individual seated in a chair outside of the NS was identified to be the patient who was the subject of 1:1 constant supervision as identified on the 02/10/2024 functional shift assignment sheet. The staff person assigned to provide the 1:1 constant supervision was identified as seated next to the patient.

However, during interview with staff that included the PD, DSC, NM, DNS and others on 04/01/2024 beginning at 1105, to clarify discrepancies related to staff shift assignments, staff present stated that the individual previously identified by other staff as a patient, was in fact an employee, MHT H. Staff stated that Patient 27 who required 1:1 constant supervision was roomed in a patient room on the section of the North Hall behind closed double doors. The North Hall closed double doors were across the hallway and several feet away from the NS door. The two individuals seated in chairs outside the NS door were MHT F and MHT H. Review of the "Day Shift" functional assignment sheet for 02/10/2024 reflected that from 1000 to 1100 MHT F was assigned to the "Constant 1" role/task and MHT H was assigned to the "North Hall Assist" role/task. The shift assignment sheet reflected there was one patient, Patient 27, identified to require 1:1 constant supervision.

Video recording captured the following:
~ 0959:52 MHT F left NS, seated self on chair on the left side of MHT H who was focused, head

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and shoulders and back fully slumped over toward their lap, on a reading or writing or drawing activity. Further, MHT H was wearing a "hoody" sweatshirt with the hood pulled over their head. The two sat in chairs on the North Hall outside the NS several feet away from closed double doors that led further into the North Hall where a patient was roomed. Each of the double doors had a narrow (few inches wide) rectangular window embedded into the top half of the door that was above the height of the chairs the two staff were seated in. In the seated position in the chairs, staff would not have been able to see through the narrow door windows several feet away into the North Hall to the patient's room on the left side of the corridor.
~ 1002:56 MHT F appeared to take item out of their sweatshirt pocket with left hand and began to focus on that item they held in their hands.
~ 1003:11 MHT F moved position so that the lighted face of a cell phone in their hand became clearly visible, they turned to their left away from MHT H so that their back was to MHT H, head and shoulders were slumped downward, and faced the wall that was to their immediate left.
~ 1008:06 MHT F slumped head, shoulders, back further downward with their back toward MHT H, their head was only partially visible above their back.
~ 1013:00 MHT F lifted head, turned slightly toward MHT H as MHT C approached the two.
~ 1013:17 MHT F turned back away from MHT H into previous position after MHT C reentered NS three seconds later.
~ 1030:11 MHT F had brief interaction with LPN GG who had approached, still turned with back to MHT H, MHT F held cell phone up with left hand so that the lighted face of the cell phone was clearly seen.

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There were ~ nine brief instances from 1000 to 1030 when MHT F moved their head or looked up toward the direction of MHT H, although their body position did not change. During that time period there were no occasions where MHT F stood up, approached the North Hall closed double doors, opened the doors, or looked through the narrow windows into that hall. MHT H's position with their head, shoulders, and back slumped fully over, almost as if folded in half, focused on activity in their lap, was primarily unchanged throughout the video. Periodically they would lift their head and shoulders up or turn toward MHT F for a moment. To that point there were no occasions where MHT H stood up, approached the North Hall closed double doors, opened the doors, or looked through the narrow windows into that hall.

~ 1030:15 MHT F rose from the chair during interaction with LPN GG who had approached.
~ 1030:41 MHT H rose from chair, then MHT F, MHT H, and LPN GG walked away from the space where they were seated and through the closed double doors further into the North Hall.
~ 1031:10 MHT F and LPN GG reentered the North Hall back through the closed double doors where MHT F and MHT H had been seated.
~ 1031:13 MHT H reentered the North Hall space.
~ 1031:20 MHT F resumed their previous position in the North Hall chair, slumped over, head down and toward the wall, back turned to MHT H.
~ 1034:58 MHT F lifted arm and lighted face of cell phone was visible.
~ 1036:14 MHT F momentarily lifted and turned head to the right.
~ 1039:27 MHT F momentarily lifted and turned head at which time a portion of the lighted face of

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cell phone was again visible.
~ 1039:30 Eight staff exited the NS and hurried toward the air court.
~ 1039:32 MHT F and MHT H stood up from their chairs, the entire lighted face of a cell phone was clearly visible in MHT F's right hand.
~ 1039:34 MHT F and MHT H walked away from the chairs they were seated in, with their backs toward the North Hall closed double doors. MHT was seen to place a cell phone with a fully lighted screen in their sweatshirt pocket, proceeded to walk around corner of NS and out of proximity and view of MHT H and the North Hall closed double doors.
~ 1039:47 MHT H turned head for a moment toward the North Hall closed double doors.
~ 1039:51 MHT F returned back to hallway where MHT H was located and neither of those staff looked toward the North Hall closed double doors.
~ 1040:17 MHT F entered NS and left MHT H in hallway.
~ 1040:24 MHT H faced back toward the North Hall closed double doors for a moment.
~ 1040:33 LPN GG left NS and stood next to MHT H in the hallway, both of them with their backs turned toward the North Hall closed double doors.
~ 1040:53 LPN GG turned briefly to face the North Hall closed double doors, then turned their back toward those again.
~ 1041:30 LPN GG turned briefly toward the closed double doors.
~ 1043:01 MHT H opened the NS door and partially entered the NS with their back toward the closed double doors and stood in the doorway for 20 seconds.
~ 1043:54 MHT H turned briefly toward the closed double doors.

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~ 1044:34 LPN GG reentered NS and left MHT H in hallway.
~ 1044:57 MHT H approached the closed double doors and looked through one of the narrow door windows for seven seconds, then proceeded to pace the hallway in front of those doors and appeared to periodically look through one of the door windows. MHT F, the assigned constant staff with 1:1 supervision responsibilities had not returned nor was any other staff present with MHT H at that time.
~ 1046:10 Another staff person not previously visible during the video review left NS and stood outside the NS door near MHT H in the hall, both of them had their backs toward the North Hall closed double doors, and were in those positions until 1050, the end of this video review.

2.g.ii. It was unclear how MHT F's activities would be considered as "1:1 constant" supervision, and how MHT H's activities would be considered "North Hall Assist" in any way. Both of those staff were intently focused on activities other than direct observation and supervision of Patient 27 who was behind closed doors in their room which was behind another set of closed doors several feet away from where the two MHTs sat. There were very few occasions where those two staff even looked momentarily in the direction of the closed double doors, and when seated it was unclear how much they could see through those double doors.

2.g.iii. An internal OSH email dated 02/14/2024 at 1057 had a "Subject" of "AN1: Staff Follow Up." It included the following information about disposition of some staff present on the AN1 unit on the day of Patient 23's attack: "Below are the names of the staff who were actively engaged in

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their functional assignment and feel there is no need for follow up. - MHT D - MHT F - MHT H."

2.h.i. Review of the hospital's internal investigation and follow-up documentation revealed a CADM report. The report had multiple dates that included a "CADM Meeting Date" of 02/15/2024 and a "CAT CADM Report Review Session" of 02/21/2024. Information on the report included:.
* "On Saturday, 2/10/24, at approximately 10:37 (according to the clock on the video review), [Patient 22] entered the air court on ANI. Prior to entering the air court, [they were] walking thought [sic] the milieu and looked down the halls and towards the bubble. [Patient 23] was sitting in the air court in a chair by the south hall entrance, with [their] back to the main space, looking out towards the quad towards the south, sipping a cup of hot beverage and acknowledged [Patient 22] entry to the air court. [Patient 22] was standing in the air court, to the back left behind [Patient 23] for approximately a minute. During this time, [Patient 22] was looking out of the air court towards the quad to the east, before slowing walking up behind [Patient 23] ... [Patient 22] was noticed to be looking through the windows of the air court towards the dayrooms and unit. At this time, it was noted that no staff were present in the milieu/dayroom area. [Patient 22] put [their] arm around [Patient 23's] neck in a "sleeper hold" at 10:38 ... applying pressure to the sides of [Patient 23's] neck. While holding [Patient 23] around the neck, [Patient 22] lifted [Patient 23] out of the chair and suspended [them] in the air, until it appears [they went] limp and [lost] consciousness ... continuing to hold [their] arm around [Patient 23's] neck, [Patient 22] proceeded to harshly shake [Patient 23] multiple

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times side to side. As [Patient 22] released the hold from around [Patient 23's] neck, [Patient 22] tossed [them] to the side towards the fencing of the air court. Total time of [Patient 23's] arm around [Patient 23's] neck, was 27 seconds (12 seconds until loss of consciousness and 15 seconds of continued carotid compression). [Patient 23] was laying on the ground of the air court for 34 seconds before another patient entered the air court from the east hall entrance. Upon finding [Patient 23] on the ground unconscious and bleeding, the other patient immediately called for assistance ... Code blue called ... EMS arrived ... [Patient 23] was sent to Salem hospital to receive medical care ... had a significant X-shaped stellate laceration for which [they] received multiple sutures at the hospital; approximately 7x7 cm laceration, with right eye closed and not able to be opened. During the code blue medical response by OSH staff, [Patient 23] was conscious and able to respond to questions by staff ... did not appear to recall specifics of the incident ... was sent to Salem Hospital for medical treatment. Upon [their] return, AP was [placed on the medical unit] for continued medical monitoring and to also provide separation from aggressor ... was transferred to TR3 on Monday, 2/12/24."

* "With video review at approximately 11:15, it was determined that [Patient 22] was the aggressor to [Patient 23]; due to lack of direct observation of the event, the aggressor was not known until video was reviewed ... was placed in seclusion at approximately 11:45. During the process of going to the seclusion room, [Patient 22] was noted to make statements [that they were] going to murder staff. Transfer request was submitted to have [Patient 22] moved to a gender specific unit because of concerns of potentially

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A 144	Continued From page 58 targeting additional [opposite gender] patients; ... transfer request approved 2/14/24. * "Chart review indicates that [Patient 22] was previously in seclusion for making threats towards murdering staff (2212 on 2/7/24) and released 2/9/24; no indication from documentation around threats towards other patients. 2/7/24 documentation does indicate making statements of 'I'm homicidal' and 'I feel like killing someone again, grab someone around the neck and strangle the fuck out of them', but does not indicate being towards other patients; following documentation indicates HI towards staff." * "During video review, it was noted that from approximately 10:30 to 10:38 (when patient who found [Patient 23] and they yelled for help) there were no staff in the east or south halls, in the activity rooms, or day rooms. Staff assigned to RCM, SSM and milieu RN were not present in the milieu. Three additional staff had assignments that have the expectation of having milieu presence." 2.h.ii. An undated document titled "Communication Timeline" reflected: "2/13/24: DNS/PD, communicated during AM Huddle 2/13/24: DNS/PD, had a bigger discussion at leadership meeting; team was asked to communicate to staff via huddles and newsletters 2/14/24 Debrief with An1 leadership during leadership meeting and discussed importance of presence in the milieu 2/14/24 talked during PET meeting about importance of staff being in the milieu and for all managers to help when on units and able 2/15/24: LH1 unit newsletter disseminated to unit staff 2/16/24: LH3 unit newsletter disseminated to unit	A 144		

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staff
AN1, AN2, AN3, LH1, LH2, LH3: Communicated in multiple huddles for all shifts following the incident regarding staff, bubble, and RCM/SSM expectations and being in the milieu. Continuing discussions regarding the email sent by program DNS outlining these expectations. This information was also collected into the unit newsletters and disseminated."

2.i. Survey team review of Patient 22's medical record, who was admitted to OSH on 11/09/2023, revealed that the TCP was not consistent with Patient 22 incident documentation related to aggressive behaviors nor LIP orders for ES. For example:

* 11/12/2023 incident documentation and an "Incident Review Form" signed and dated by unit leadership staff on 11/17/2023 reflected that Patient 22 had reportedly touched the buttocks and breast of an opposite gender staff person. Under "Safety and Risk Mitigation" was recorded "Enhanced Supervision" and "Staff were informed about event & to keep [opposite gender] staff/patients safe." However, there was no instruction as to how opposite gender patients were to be kept safe.

* The "Client Profile - Order Details" for "Order Type: Enhanced Supervision" specified:
- From 11/13/2023 at 1653 to 11/27/2023 at 1711 ES orders were in place for "Unobtrusive Suicide/Self Harm."

* The "10 Day TCP" post-admission dated 11/15/2023 included:
- "Since [admission] [Patient 22] has engaged in disorganized and intrusive behavior; e.g.,

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A 144	Continued From page 60 smacking a staffs [sic] bottom and grabbing [their] breast - "[Patient 22] will maintain safety toward self and others as evidenced by no documented incidents of self-harm, aggression, intrusiveness, touching others inappropriately, or unit disruption for 30 days ... Status: New [goal]." - "If [Patient 22] is intrusive to [their] peers / staff or engages in sexualized touching of others, staff will redirect [them] to [their] room, the sensory room, or different area of the unit to help maintain safety." - "Staff will maintain Enhanced Precautions on [Patient 22] to monitor for any aggression or intrusive behavior. Please refer to the Behavior Card for additional information." * The "30 Day IDT Meeting" TCP dated 12/05/2023 included: - " ... [Patient 22] has engaged in disorganized, intrusive, and unsanitary behavior; e.g., smacking a staffs [sic] bottom and grabbing [their] breast, playing with feces, ejaculate, etc., which has led to a seclusion even to maintain safety." - "[Patient 22] has engaged in disorganized behavior. [They have] been medication adherent and reports they are useful. [They have] not expressed any SI or gestures thus precautions was discontinued on 11/27." - "[Patient 22] will maintain safety toward self and others as evidenced by no documented incidents of self-harm, aggression, intrusiveness, touching others inappropriately, or unit disruption for 30 days ... Status: New [goal]." - "If [Patient 22] is intrusive to [their] peers / staff or engages in sexualized touching of others, staff will redirect [them] to [their] room, the sensory room, or different area of the unit to help maintain safety."	A 144		

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A 144	Continued From page 61 * ES orders and implementation was not consistent with the TCP. The "Client Profile - Order Details" for "Order Type: Enhanced Supervision" specified: - From 12/12/2023 at 0213 to 12/14/2023 at 1343 ES orders were in place for "Close Suicide." * The "Add Enhanced Supervision" TCP dated 12/14/2023 included: - " ...[Patient 22] has engaged in disorganized, intrusive, and unsanitary behavior; e.g., smacking a staffs [sic] bottom and grabbing [their] breast, playing with feces / ejaculate, etc., which has led to a seclusion even to maintain safety. [They have] engage [sic] in suicidal gestures; e.g., tying ripped up clothing around [their] neck." - "Added intervention around Enhanced Supervision." - "[Patient 22] will maintain safety toward self and others as evidenced by no documented incidents of self-harm, aggression, intrusiveness, touching others inappropriately, or unit disruption for 30 days ... Status: New [goal]." - "If [Patient 22] is intrusive to [their] peers / staff or engages in sexualized touching of others, staff will redirect [them] to [their] room, the sensory room, or different area of the unit to help maintain safety." - "Staff will maintain Enhanced Supervision on [Patient 22] to monitor for any self-harm comments or actions. Start Date: 12.14.2023" * The "30 Day TCP Review" TCP dated 01/02/2024 included: - "... [Patient 22] has engaged in disorganized, intrusive, and unsanitary behavior; e.g., smacking a staffs [sic] bottom, grabbing [their] breast, and playing with feces which has led to a seclusion	A 144		

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events to maintain safety."
- "[Patient 22] will maintain safety toward self and others as evidenced by no documented incidents of self-harm, aggression, intrusiveness, touching others inappropriately, or unit disruption for 30 days ... Status: Not Met, Continue."
- "If [Patient 22] is intrusive to [their] peers / staff or engages in sexualized touching of others, staff will redirect [them] to [their] room, the sensory room, or different area of the unit to help maintain safety."

* 01/03/2024 incident documentation, an "Incident Review Form" signed and dated by unit leadership staff on 01/12/2024, and a second "Incident Review Form" signed and dated by unit leadership staff on 02/09/2024 reflected that Patient 23 began to throw feces and urine out of their patient room, some of which was directed at staff. The incident resulted in time in a seclusion room for Patient 22.

* The "30 Day TCP Review" TCP dated 01/31/2024 included:
- "Since admission [Patient 22] has engaged in disorganized, intrusive, and unsanitary behavior ..."
- "[Patient 22] will maintain safety toward self and others as evidenced by no documented incidents of self-harm, aggression, intrusiveness, touching others inappropriately, or unit disruption for 30 days ... Status: Not Met, Continue."
- "If [Patient 22] is intrusive to [their] peers / staff or engages in sexualized touching of others, staff will redirect [them] to [their] room, the sensory room, or different area of the unit to help maintain safety."

* (The CADM Report referenced in the Finding

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above indicated that staff review of the patient's medical record revealed that on 02/07/2024, three days before they attacked and choked Patient 23, Patient 22 made "... statements of 'I'm homicidal' and 'I feel like killing someone again, grab someone around the neck and strangle the fuck out of them.'")

* The "Client Profile - Order Details" for "Order Type: Enhanced Supervision" reflected there were no other ES orders until after Patient 22 attacked Patient 23 on 02/10/2024, on which date Patient 22 was placed on "1:1 Behavioral" ES.

* The "Unscheduled Update" TCP dated 02/15/2024 included:
- "On 2-10-24 [Patient 22] very significantly assaulted a peer. [They were] placed on 1:1 Behavioral Precautions and is being transferred to a [gender specific] exclusive unit."
- "[Patient 22] will maintain safety toward self and others as evidenced by no documented incidents of self-harm, aggression, intrusiveness, touching others inappropriately, or unit disruption for 30 days ... Status: Not Met, Continue."
- "If [Patient 22] is becoming intrusive, agitated, or making threats towards others staff will attempt to provide distractions such as offering them space in a less stimulating area (their room, sensory room, or a different area of the unit) to maintain safety.
- "Staff will maintain Enhanced Precautions to monitor for any aggression and to promote safety, redirection, and attempts at regulation. Please refer to the Behavior Card and enhanced supervision sheet for additional information. Start Date: 02/15/2024."

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A 144	Continued From page 64 3. The following is regarding an incident involving Patient 10 and Patient 11. 3.a. Review of grievance and incident documentation revealed that Patient 11 was physically assaulted and injured by Patient 10 on 08/15/2023 after having conveyed to staff safety concerns and fear of Patient 10. The findings that follow reflect that: *Investigation of the incident was not clear or complete. *Patient 11 requested that criminal charges be filed against Patient 10, however there was no documentation to reflect when or whether that had been completed. *Responses to Patient 11's four related grievances pre- and post-incident were not timely or complete. 3.b. Incident documentation reflected that on 08/15/2023 at 1520 Patient 11 " ... was standing at the hub having a conversation with [the NM] when [Patient 10] walked behind [Patient 11] ... numerous times before [Patient 11] verbalized [their] concern of [Patient 10] being behind [them]. [Patient 10] responded and punched [Patient 11] in the eye/nose. [MHT] put [themselves] between [Patient 10] and [Patient 11] and then [Patient 10] walked off towards [their] room. [Patient 11] did not retaliate to this assault physically but exclaimed verbally that [they were] upset. From the nursing station, I called a code green over the walkie talkie and brought paper towels for [Patient 11] to catch the blood from [their] nose while [a staff person] helped redirect nearby patients. [RN] and [NM] walked [Patient 10] to the [seclusion room] where [they] spent nearly two hours deescalating while [Patient 11] was helped with getting ice for [their]	A 144		

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injury. [Patient 11] then went to the emergency room to have [their] injury looked at per [their] request."

3.c. Review of patient grievance documentation filed by Patient 11 revealed the following:

*A "Patient Grievance" form was signed and dated by Patient 11 on 08/13/2023 at 1932. At the top of the form Patient 11 had written in large letters "*Emergent*." The grievance was described as "[Patient 10] is continuing to provoke and instigate myself and other patients. [MHT] witnessed [Patient 10] provoking me as I walked back onto the unit at approx. 6:02 pm. Just now [Patient 10] lunged at [another patient] with a raised fist attempting to intiate [sic] a violent interaction. Staff unwillingness to address this issue is putting staff and patient [sic] in harm's way ... emergency transfer [Patient 10] to another unit." The "For Staff use only" box reflected the "Date Received" was 08/14/2023, the day prior to the assault.

The "Grievance Committee Response" reflected the "Date of Grievance Review" was 08/21/2023 and the response was "attached" to the form. The undated attachment contained one paragraph that reflected "IDT is aware of the issues that are happening between you and the described peer and have taken the necessary follow up. All follow up will be confidential to protect patient privacy. In the future please encourage peers who are having issues to reach out to staff or complete their own grievances so that we may follow up with them."

*A second "Patient Grievance" form was signed and dated by Patient 11 on 08/13/2023 with no

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time. The grievance was described as "[Patient 10] has been increasing [their] aggressive behavior toward me and other patients. Flicking [another patient] and pushing through people. Just now in East TV Room I was grabbing a spoon after receiving my meal and [Patient 10] walked in from the air court and threw [their] shoulder into me ... Move [Patient 10] to another ward, My safety and the safety of the other patients is at risk." The "For Staff use only" box reflected the "Date Received" was 08/14/2023, the day prior to the assault.

The "Grievance Committee Response" reflected the "Date of Grievance Review" was 08/21/2023 and the response was "attached" to the form. The undated attachment was identical to the one described in the grievance above.

*A third "Patient Grievance" form was signed and dated by Patient 11 on 08/16/2023 at 0950. The grievance was described as "I filed 2 grievances within the last 72 hours about [Patent 10's] continual aggressive behavior and [on 08/15/2023] in the milieu of Tree 1 [Patient 10] violently assaulted me by close fist strike to the left temple of my head. When I returned from the E.R. at approx 7 pm [Patient 10] was already out of seclusion. This morning in East Plaza at approx 9:15 [Patient 10] came out and began to attempt an altercation from afar telling staff '[Patient 11] can't be within 10 feet of me.' This is systemic supported abuse and violence." The "For Staff use only" box reflected the "Date Received" was 08/17/2023.

The "Grievance Committee Response" reflected the "Date of Grievance Review" was 08/29/2023 and the response was "The treatment team has

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reviewed the issues and resolved it. The two patients currently do not reside on the same unit. The IDT may not discuss patient treatment with you."

*The fourth related "Patient Grievance" form was signed and dated by Patient 11 on 08/22/2023 at 1555. The grievance was described as "On, or about, August 15th at approximately 3:30PM I was assaulted by [Patient 10]. I do not believe the report has been forwarded to law enforcement and/or the Marion County DA for prosecution. The the [sic] documentation and proper reporting of this crime needs to be done immediately. If this violent assault is not reported, investigated, and charges are not filed I will hold each, and every, member of the Treatment Team, P.E.T, and all other relevant parties accountable both personally and professionally to the harm inflicted by this neglect. This will include each, and every licensee, who is charged with my care and treatment as a public servant of Oregon ... I still have not spoken with a detective, OSH security, or even been approached by a therapist to talk about, decompress, or process this attack for which I am the victim." The "For Staff use only" box reflected the "Date Received" was 08/23/2023.

The "Grievance Committee Response" reflected the "Date of Grievance Review" was 08/29/2023 and the response was "On 8/29 management called security to inquire about the police report regarding the assault. The police report was submitted by the unit on 8/15/23. Security stated that it had not yet been sent out to OSP for review. The detective who usually picks them up missed a week due to other obligations. It was stated the [detective] should return this week and

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will receive it by end of week sometime. Management asked if security was planning to follow up and they stated they don't typically check in after each report unless a patient requests it specifically as there are too many to keep up with at times according to security. Management has reach out to the IDT and the therapist that you are currently working with on 8/29 and let them know you would appreciate meeting to help you process/decompress regarding the incident."

3.d.i. In response to surveyor request for tracking information related to the police report that was filed, an internal OSH email, with an attachment, sent from the DOS dated 03/13/2024 at 0807 was provided. It included the following information: "Like most of our stuff we don't have a written protocol but the process is described below ... This was closed out by [detective name] without being assigned a case number due to not meeting prosecutorial guidelines. At the time the case was received, the unofficial protocol we were using was ... Incident occurs prompting a report made to OSP ... [unit staff] fills out an OSP reporting form and submits it to the Security Management email box. Form is received by Security and printed ... Printed form is maintained by Security Investigator until OSP makes a visit to OSH to collect these forms ... When OSP detectives come to OSH, the printed forms are handed over to the detectives ..."

3.d.ii. The document attached to the 03/13/2024 email from the DOS was titled "Oregon State Hospital - Security Department Reporting of a crime" was reviewed. It included the following information:
* "Date of Incident: 08/15/2023"

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* "Reported by: [NM identified in the incident report]"
* "Date/Time: 08/15/2023 at 1530"
* "Victim of Crime: [Patient 11]"
* "Suspect of Crime: [Patient 10]"
* "Summary of Incident: [Patient 11] was speaking to the Unit Administrator ... [Patient 10] walked up ... swung around the staff and punched [Patient 11] in the left eye ... eye immediately began to swell, become bruised ..."
* "Signature of person completing this report" that was followed by a signature.

The lower part of the form had two sections, one of which was for "Security Use Only" which contained the following:
* "Date Submitted:"
* "Submitting Manager:"
* "Reporting Manager Signature:"
Those fields were blank and contained no entries.

The last section of the form for "Dispatch Use Only" contained the following:
* "Date Received:"
* "Case Number:"
Those fields were blank and contained no entries.

3.d.iii. As of the date of the survey there was no documentation to reflect when that report had been received by the Security Department and whether or when it had been submitted to OSP.

3.e. An incident investigation form titled "Incident Review Form" was signed and dated by unit leadership staff on 08/21/2023. It summarized the incident, and under "Safety and Risk Mitigation" was recorded "Follow-up with Victims(s)," "Incident Debrief," "Security/OSP Contacted," and "After the provider met with [Patient 10] [they]

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agreed to maintain 10 ft distance between [them] and [Patient 11]. [Patient 10] also agreed to remain in [their] hallway and avoid [Patient 11's] hall. A police report was filed on [Patient 11's] behalf. On 08/17/2023 [Patient 10] was moved to another unit due to the incident."

The "Incident Review Form" completed six days after the incident did not reflect an investigation of the incident. For example, under the sections "What factors contributed to the incident and how did you investigate those factors?" and "Assessment" and "Clinical Interventions" there was no indication of medical record or document review for the following:
* Identification and evaluation of Patient 11's injuries.
* Relevant TCP goals and interventions for both patients in place and implemented.
* Evaluation of any enhanced supervision orders for either patient.
* History of aggression for either patient.
* History of conflict between those two patients.
* Lack of response to the three related grievances Patient 11 had filed on 08/13/2023 and 08/16/2023.
* Status of the "police report was filed on [Patient 11's behalf]." As of the date unit leadership staff signed the form that had not been processed.

3.f. During interview at the time of the review with staff that included the DNS, PD, and QMD on 03/07/2024 beginning at 1220 no additional information was provided.

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4. The following is regarding an incident involving Patient 3.

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4.a. An "Office of Quality Management" investigation document was signed by an OQM investigator and reflected an "END REPORT" date of 06/24/2022 at 1133. The report reflected that "On 6/3/2022 [Patient 3] had taken a urine analysis (UA) at the Oregon State Hospital (OSH) clinic. The clinician relayed to nursing staff that [Patient 3] had spermatozoon identified in the UA. Nursing staff notified the program director who relayed the finding to the OSH Superintended [sic] along with information [Patient 3] was on 1: 1 constant supervision for more than a week leading up to the UA ... [Patient 3] was at OSH starting 5-20-2022 and was placed in 1:1 supervision with directions to maintain line of sight visual of [Patient 3] when [they were] out of [their] room."

The 15-page report concluded that "The findings of this investigation did not identify a staff or patient having the opportunity to engage in sex with [Patient 3]. There have been no allegations made by [Patient 3] of a sexual encounter at OSH and this investigation concluded the origination of the spermatozoon was not isolated to the time of [Patient 3's admission to OSH."

However, it was unclear how the investigation conclusion that no sexual contact between Patient 3 (who themself could not be the source of the sperm) and another individual had occurred between Patient 3's admission on 05/20/2022 and 06/03/2022, the date the urine specimen had been obtained.

4.b. The OQM report reflected the following findings related to Patient 3's impaired cognition, confusion, and lack of reliability to provide credible information on their own behalf. Patient

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3's behaviors and mental state reflected they were a vulnerable person. For example: "I was informed the clinician had told nursing staff they attempted to speak with [Patient 3] and [they were] extremely dysregulated and difficult to comprehend ... I [reviewed] patient progress notes which showed the patient was highly dysregulated upon [their] initial entry to the hospital on 5-20-2022. [They were] placed on 1:1 at 1551 on that date. Per [OQM Investigator's] supplement a Psychiatry Admission Assessment stated: Patient was put on close observation 1:1 (behavioral) at 1551 by unit attending [PMHNP] who noted in the order that the patient 'is attempting to enter peer's [sic] rooms, grabbing staff's [sic] badges, combative, disorganized.' In review of Psychiatry General Note dated 6/3/2022 I found: ... [Patient 3] reports feeling confused, 'I want to go home', and when asked if [they] knew where [they were they] stated 'This is confusing to me why did the floors change?'. When told that [they were] at Oregon state [sic] Hospital, [they] responded 'No, no, no'. [They] stated 'One minute I'm supposed to be running out of here, next walking, but ... ' and didn't finish [their] statement, [they] stared off. I received a lab report from [their] urine that was collected this morning which showed Spermatazoa [sic] positive. I asked [Patient 3] if [they] could recall anyone having any type of sexual contact with [them] while [they were] either here or at jail prior to coming here. [They] stated "Not that I've known". When asked if [they] remembered coming into the hospital or being in jail, [they] responded 'bits and pieces'. [Patient 3] remains disorganized and confused. 'This is a joke, right? Tell me this is a joke' when questions asked of [them] ... 6/3/22- [Patient 3] remains grossly disorganized and confused, however there is noted improvement in [their]

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speech, responding to questions a little better this week. [They continue] to report feeling confused and unaware of their surroundings, denying that [they are] at OSH. When discussing [their] urine sample with positive spermatazoa [sic], [they report] that [they are] unaware of anyone having any type of sexual encounter with [them] while here at OSH or at jail. [They] stated 'Not that I've known' ... [Patient 3] also believes that I am related to [their] fiance's [relative] (I am not). [They] did not believe me when I told [them] otherwise."

4.c. The OQM report reflected that "This investigation revealed the age of the spermatozoon was not limited to 72-hours ... An approximate origination date or time was not able to be concluded by the laboratory staff. The laboratory staff confirmed the single cell was the only one [they] observed in the sample. [They] also stated the cell could have been many days, or even weeks old ... I was informed this collection was one where [Patient 3] did not have the area cleaned around the urinary tract exit prior to collection ... I contacted [OSH Lab Director] with some clarifying questions ... I was informed the spermatozoon was detected during magnification on a slide. I was advised [they] only saw one and it was non-viable. I was advised the lack of viability presented indications the cell single spermatozoon was not from a recent encounter. The window of time was 72 hours to possible 12 or more days old. I asked how the spermatozoon would get into a ... urine collection. I was advised [sic] would have been washed from the body into the urine at the time of collection. I asked if the presence of a single cell provided any information. I was advised that [Lab Director] suspected [they] would have seen more

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if the encounter was recent, but [they] could not provide a professional opinion on that matter."

Review of the UA report reflected it was "Collected" on 06/03/2022 at 0931 and "Received" in the lab on 06/03/2022 at 0955. The "Urine Source" was "Clean Catch, Mid-Stream." The report identified "A" or abnormal results that included the "Urine Appearance ... WBC ... Epithelial Cells ... and Bacteria." An abnormal result was also identified for "Spermatozoa" as "Observed." There was no information on the report that identified the quantity or quality of the observed sperm. The report also included a statement "Contamination present. Reorder and submit clean catch specimen if clinically indicated."

The OQM report stated that OSH staff were "not able" to conclude the origination date of the sperm, they stated the age "could have been" days or weeks, referred to "possible" time frames, and stated they "could not" provide a professional opinion. There was no indication in the OQM report that an evaluation of the sperm was conducted by a pathologist or other forensic or subject matter professional who had expertise to date the sperm age more conclusively.

4.d. The OQM report also reflected:
*"More than 48-hours of video was reviewed during this investigation. Video showed staff performed the enhanced supervision as required in the orders and each time [Patient 3] entered another patient's room staff were directly responsive and prevented any chance of a sexual encounter. There was not an observed window of opportunity for a sexual encounter between [Patient 3] and [opposite-gender] staff or peers."

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* "[OQM Director at that time] requested we focus the review of video surrounding the time that would be 72-hours prior to the collection of the UA. Specifically, we were to cover 24-hours prior through 24-hours after that time. This placed the review window from 5-30-22 at 0900 hours through 6-1-22 at 0900 hours (48-hours)."
* "[Patient 3] had entered peers' rooms 5-21-22 at about 1326 hrs, 5-22-22 at about 2110 hrs, and 5-24-22 at about 0755 hrs. I requested additional video authorization from [OSH Superintendent] for these three events ... reviewed ... each time the patient entered another patient's room staff were quick to redirect the patient and there was no realistic change [sic] that sexual activity happened between [Patient 3] and other [sic] individual during the three events."

It was unclear why video for only the specified 48 hours and three other short time periods were reviewed.

4.e. The OQM report lacked identification or reference to the fact that Patient 3 had two occurrences of seclusion since their admission on 05/20/2022. Those occurrences were not identified or evaluated as part of the investigation. Review of seclusion documentation reflected the following:

*Review of an "Emergency Seclusion or Restraint Review" form reflected that Patient 3 was placed in seclusion on 05/20/2022 with a start time at 1105 and seclusion end time was 1208. The "Emergency Seclusion or Restraint Flowsheet" form reflected that four same-gender staff conducted and documented all seclusion observations and tasks recorded on 05/20/2022 at 1105, 1120, 1135, 1150, 1200, 1206, and 1208.

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Additional tasks were recorded at 1215 and 1225 as Patient 3 declined to leave the seclusion room at 1208 and remained in the room with the door unlocked at until 1225.

*Review of an "Emergency Seclusion or Restraint Review" form reflected that Patient 3 was placed in seclusion on 05/25/2022 with a start time at 0940 and seclusion end time was 1340. The "Emergency Seclusion or Restraint Flowsheet" form reflected that three opposite-gender staff conducted and documentation the seclusion observations and tasks recorded on 05/25/2022 from 0955 through 1330 as follows:
-Staff JJ recorded seclusion observation entries at 0955, 1010, 1025 1040, and 1055.
-Staff KK recorded seclusion observation entries at 1110, 1125, and 1140.
-Staff LL recorded seclusion observation entries at 1200, 1215, 1230, and 1245.
-Staff JJ recorded seclusion observation entries at 1300, 1315, and 1330.
"Comments" written by those staff included "hitting floor ... mumbling ... tearful ... sitting by door ... confused demeanor ... unpredictable ... praying or talking to unseen others ... standing in the restroom ... trembling hands"

4.f. During interview at the time of the review with staff that included the NM, IRSI, PD, and QMD on 03/07/2024 beginning at 1045 no additional information was provided.
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5. The following is regarding an incident involving Patient 1 and Patient 2.

5.a. Incident documentation reflected that on 05/20/2021 at 1915 there was a physical

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altercation between two patients on Mountain 3 at JC. The document reflected, "I was in the personal belongings room at 1915, getting a water for a client. I heard a loud thud near me and then a client shouting 'staff.' I ran over to the activity room and saw [Patient 1] on top of [Patient 2] punching [them] in the face. [Staff] approached the two, yelling 'hey' while pushing [Patient 1] off of [Patient 2] ... [Patient 2] was bleeding from the nose and tried sitting up ... Two nurses asked [Patient 2] if [they were] ok, and [they] responded with 'what happened?' and 'where am I?' ... [Staff] then was asked to take [Patient 2] to the emergency room where we found out that [their] nose was broken."

5.b. There was no documentation of an investigation of this incident to prevent recurrence.

5.c. During interview on 03/07/2024 at 1311 with DNS-JC, PD-JC and other staff, they confirmed there was no investigation documentation for this incident.

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6. The following is regarding an incident involving Patient 4 and Patient 9.

6.a. Review of incident documentation for Patient 4 reflected that on 02/20/2024 "While on 1:1, [Patient 4] was seen exiting room at 1417 ... nurse asked pt 'want to go to the air court since you're covered up, for some fresh air.' Pt responded 'yeah.' Pt came near doorway leading into TV room as [they] took [their] glasses off [their] face, nurse asked staff to notify RN in chartroom as this is a known pre-curser, [Patient] started to stare at [Patient 9], once nurse noted

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the tense moments between peers, nurse attempted to verbally de-escalate situation by suggesting 'everyone get going' to there [sic] own space ... [Patient 4] then proceeded to follow [Patient 9] into the TV room an [sic] initiate a physical altercation by posturing and putting [their] hands up, both [Patient 9] and [Patient 4] began to exchange punches ..." The report did not reflect whether [Patient 4] sustained any injuries.

6.b. Incident documentation for Patient 9 reflected that on 02/20/2024 at 1419 "[Patient 9] was the victim ... [Patient 4] ... initiated the physical aggression." The report did not reflect whether [Patient 9] sustained any injuries.

6.c. Review of an "Enhanced Supervision Intervention Card" for Patient 4 dated 01/24/2024 reflected the following orders and direction in place at the time of the 02/20/2024 incident:
*"Patient is on a 1:1 [Behavioral Precautions]: Hx of assaults peers and staff unprovoked due to Paranoia, AH, PTSD, with hyperarousal and hypervigilance. Be within hearing distance when out of room to hear conversation [they have] with other peers. Pt historically has assaulted more peers between 1500 and 0700."
*"There is concern for occurrence of assaults after restrictions are lifted, so while [Patient 4] is progressing currently, it is important to still be very vigilant and monitoring for any precursors - paranoia, darting glares with repeated return stares to a person, dissociating/zoning out/not aware of environment."
*"Primary Behavior(s) of concern: Primary Behavior(s) of concern: paranoid delusions, significant physical aggression and assault. There is concern that when restrictions are lifted,

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assaults follow shortly after, so still very important to be vigilant."
*"Significant history of aggression and assaults on peers and staff. History of assaults typically occurring in afternoons and evenings. Can be triggered/ can target new people on unit, patients and staff. When paranoia is worsened, there is an increased risk of assaults ... It is important to be vigilant ..."
*"Hallucinations/Delusions warning signs: Ask for support from other staff in the area. Reality check pt when intensely staring or preoccupied with individuals or a situation. Narrate the situation actually occurring. Example, "[Patient 4], this is [insert name], they are doing rounds to make sure that everyone is doing ok.", "That patient is just walking down the hall for exercise, is there something you're worried about with that person?"

6.d. "Incident Review Form" investigation documentation signed and dated 03/11/2024 was not clear. For example, it did not reflect that the incident had been thoroughly reviewed to determine whether staff had been "vigilant," repeated multiple times as a priority on the ES Card. It did not reflect evaluation of whether staff had carried out all interventions as directed timely and appropriately. Further, the form reflected in conclusion that "Is this a recurring incident for individual ...? Yes," and "What (if any) additional actions were needed?" to which the response was "None needed." It was not clear how that determination was made.

6.e. Documentation of incidents that occurred prior to the 02/20/2024 incident reflected that Patient 4 was the aggressor on those occurrences:

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A 144	Continued From page 80 *On 08/07/2023 at 2128 Patient 4 entered Patient 5's room and pushed Patient 5 who sustained a "bump on the back of [their] head" as result of hitting the ground during the assault. On the way to the seclusion room after that Patient 4 "turned into the TV room and punched [Patient 6] causing [them] to have a "bleeding nose." The "Incident Review Form" investigation signed and dated on 08/18/2023 only described injuries to the patient's involved and did not describe an investigation to identify whether, for example, TCP interventions in place had been carried out or were effective, nor did it describe actions planned to prevent recurrence. *On 09/14/2023 at 1810 Patient 4 "entered [Patient 7's] room, started punching [them] twice hitting [Patient 7] on the head x 1 and torso x 1. [Patient 7] sustained a small bump and redness to [their] left temple but refused further assessment ... When [Patient 4] went into locked seclusion [they] ... told staff in the ante room, 'why are you putting me in here, I only punched a black kid that's all and started giggling' ..." The "Incident Review Form" investigation signed and dated 09/22/2023 did not reflect, for example, that the patient's TCP interventions or history with people of color had been reviewed, nor did it describe what actions were planned to prevent recurrence. There was no reference on the ES orders described above related to patients of color. *On 10/01/2023 at 2030 in the hall Patient 4 "hit [Patient 8] in the face with a closed fist." 6.f. During interview with staff that included the DSC and PD on 03/13/2024 at ~ 1030 they confirmed the findings related to Patient 4 and stated that the hospital was "actively working on investigation gaps."	A 144		

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7. The following is regarding an incident involving Patient 24 and Patient 25.

7.a. Review of incident documentation reflected that on 02/21/2024 at 1930 on FW1 unit Patient 25 "approached the hub where I was sitting and without being prompted stated, 'I hope there isn't [sic] any cameras in the sensory room'. I asked [them] why and [they] replied, 'Because I don't want anyone to talk to me about what happened'. I asked [them] what happened, and [they replied, 'Sex.'. I asked with who [sic], and [they] responded, '[Patient 24]', referring to another patient on the unit."

Incident documentation also reflected that video review was conducted and showed that Patient 24 was in the sensory room, that Patient 25 entered the sensory room, that Patient 24 turned out the lights, and that at 1854 the patients engaged in sexual intercourse, and that they then left the room. The report reflected that security staff found an open condom wrapper in the sensory room and although Patient 24's room was searched security staff, Patient 24 reported to them that they had flushed the condom. In addition, "Patient 25 was placed on a 1:1 when out of room for [their] safety. Since [they] had reported to another staff member that [they were] coerced into sex ... both [patients'] clothing was collected by security and [Patient 25] was sent to Salem Health ED for a sexual assault exam. Infection prevention was notified of sexual contact, per protocol ... Security later reported to this [NM] that on the way to the ED [Patient 25] was remarkig [sic] that [they] hoped this would get [their] charges dismissed. It was also reported

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that once [Patient 25] realized [they] could not submit to a sexual assault exam anonymously, [they] declined the exam and was subsequently transferred back to OSH."

7.b. Review of Patient 25's "Transfer TCP Review" TCP dated 01/26/2024, in place at the time of the 02/21/2024 sexual incident reflected the following:
* "RN/Staff will ... redirect any unsafe and/or inappropriate behaviors (specifically being victimized by peers)."
* Patient 25 had been transferred to FW1 unit on 01/25/2024.
* Since transfer to that unit on 01/25/2024 Patient 25 "appeared to be a victim of [an opposite-gender patient's] hypersexual behaviors ..."

7.c. A CADM investigation report with a "CADM Meeting Date" of 02/28/2024 included the following information:
* The CADM concluded that "No significant gaps in care or treatment identified."
* "Video review: Video showed [Patient 25] and [Patient 24] engaged in conversations from 1700 until the incident ... Throughout the video that was reviewed they were very close in conversation in both the hall, activity room, and aircourt."
*"Per [physician] there was an exchange of $2 and [Patient 24] gave a card to [Patient 25] 'I (heart shape) you'."
* It reflected that "There are 2 chart notes indicating that [Patient 25] saw condoms being handed out to [opposite-gender] patients and [Patient 25] asked staff, 'Why are you handing out condoms. Does this mean we should be getting busy?' and another time, 'Because you give out

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condoms here, it makes people think about sex.' On 2/18 condoms were given to [another patient] ... [they] showed them to [Patient 25] who then came to the property room to ask the above question. Staff educated both of them that these were not for peer to peer use and that we do not permit sexual contact."
*It reflected that "Neither patient needed capacity assessment based on clinical opine/consult between [OSH physicians]. [Patient 25] continues to be easily influenced by [other patients] and demonstrates ambivalence as part of [their] psychotic disorder. If a capacity evaluation were to be performed, [Patient 25] would not meet criteria for informed consent based on [their] inability to clearly and consistently make a rational decision."

The CADM did not reflect that Patient 25's TCP had been reviewed. It didn't identify as part of the investigation that the TCP referenced that Patient 25 had "appeared to be a victim" of another patient's sexual behaviors the month prior, nor did it reflect review of incident documentation for that event.

The CADM reflected that Patient 25 was a vulnerable person who was easily influenced, would not meet criteria for informed consent, and was unable to consistently make rational decisions. It also identified that Patient 25 had interpreted the distribution of condoms to patients as permissive of sexual intercourse. However, it reflected that Patient 24 and Patient 25 were in close proximity and conversation during the ~ two hours prior to the occurrence and there was no indication that the TCP instruction to "redirect any unsafe and/or inappropriate behaviors (specifically being victimized by peers)" had been

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followed.

7.d. During interview with staff that included the DSC, PD, and NM on 03/13/2024 beginning at 1145 the NM stated that condoms were made available to patients for "self care" and provided at the NS to anyone who asked regardless of gender. The NM stated the RNs and LPNs were supposed to inform the patients that the condoms were for self-care use.

7.e. In response to a request for the hospital's policies and procedures related to condom distribution, in an email from the DSC received on 03/14/2024 at 1217 they wrote that "We do not have a policy/procedure/protocol for the distribution of condoms."

It was unclear why the hospital would engage in the practice of condom distribution to any patient who asked without a written policy and procedure that ensured the protection and safety of all patients. There was no evidence in the CADM that review of relevant policies and procedures had been conducted.

7.f. It was unclear how the CADM investigation concluded for this incident that "there were no significant gaps in care or treatment."
****

8. The following is regarding an incident involving Patient 25 and Patient 26.

8.a. Incident documentation reflected that on 02/22/2024 at 0830 while staff were speaking with Patient 24 about the sexual encounter with Patient 25, described in the finding above, that occurred on 02/21/2024 Patient 24 stated that

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Patient 25 "also had sex with a patient who was previously on FW1, [Patient 26]."

8.b. Review of Patient 25's "Transfer TCP Review" TCP dated 01/26/2024, in place at the time of the 02/21/2024 sexual incident reflected the following:
* "RN/Staff will ... redirect any unsafe and/or inappropriate behaviors (specifically being victimized by peers)."
* Patient 25 had been transferred to a new unit, FW1, on 01/25/2024.
* That since transfer to that unit on 01/25/2024 Patient 25 "appeared to be a victim of [an opposite-gender patient's] hypersexual behaviors ..."

8.c. There was no indication that prior to 02/22/2024 an incident report had been initiated or an investigation conducted into the reported sexual contact incident between Patient 25 and Patient 26 that occurred on either 01/25/2024 or 01/26/2024 on FW1 unit.
****

9. Similar findings related to patient to patient incidents that resulted in injuries to patients and for which investigations were unclear and incomplete were identified for the following incidents reviewed:
* Incidents for which Patient 14 was the aggressor on 12/25/2023 that involved Patient 11, on 12/29/2023 that involved Patient 15, and on 12/31/2023 that involved Patient 16.
* Incidents for which Patient 17 was the aggressor on 12/27/2023 that involved Patient 19, and on 02/04/2024 that involved Patient 18.
* An Incident for which Patient 12 was the aggressor on 08/17/2023 that involved Patient 13.

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10.a. Review of the incident log revealed no Pt2Pt incidents on AN1 from 02/11/2024 through the date of the survey. Review of the log reflected that hospital-wide the number of Pt2Pt incidents had declined from 55 in August 2023 to 29 in February 2024.

10.b. Review of the incident log reflected that from 08/01/2024 through 01/31/2024 there were one or two "sexual contact" incidents per month hospital-wide at both the OSH-Salem and OSH-JC. For the month of February 2024 the number of "sexual contact" incidents increased to seven. For the first part of the month of March 2024, from 03/01/2023 through 03/10/2023, the number was four.

10.c. During interview with staff that included the CMO, DSC, QMD, and Deputy CNO on Monday 03/04/2024 at 1100 they reported that over the weekend on 03/02/2024 there had been a patient to patient altercation on MTN3 that resulted in transfer of one of those patients to the ED, and on 03/03/2024 on LF2 a patient to patient altercation that involved multiple patients resulted in injury to one of those patients.

****

11.a. The P&P titled "Code Blue Medical Emergency" dated as 07/01/2020 was reviewed and reflected the following:
* "A physician, nurse practitioner (NP), or registered nurse (RN) must assess the person to determine whether an emergency medical condition exists ..."
* "Team Captain ... Assign roles and responsibilities ... Unless the physician, NP or RN has determined the person cannot be safely

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moved, direct moving them to the nearest medical staging area. When the person experiencing a medical emergency is a patient, document in the electronic health record (EHR)."
* "Physician/NP/RN ... Assess the person to determine whether they are experiencing an emergency medical condition ... Determine whether an ambulance is needed to transport the person to the nearest acute-care facility ... Communicate essential information to responding EMTs ... If the Code Blue is for a patient, a. Notify the receiving emergency department of the patient's clinical history. b. Complete a summary of the Code Blue event in the EHR. c. Contact authorized primary contacts via telephone."
* "Recorder ... Complete the Code Blue Flowsheet."
* "Crowd Control Monitor ... Maintain safety of the scene and milieu as necessary ... Verify essential personnel have access to the scene, person, and emergency equipment ... Request the Communicator cancel responders when sufficient responders have arrived at the scene ... Assist with transporting the person ..."

11.b. During video review of the assault on Patient 23 that occurred on 02/10/2024, the footage revealed that at one time, there were approximately 16 people that responded to the code blue and it is unclear what roles or involvement each person had since the "Code Blue Flowsheet" only has the space for "Team captain" and "Recorder." The form lacked information on who performed an assessment on Patient 23 and what physician/NP or RN were present to fill this role. The form also lacked information regarding Patient 23's emergency contact being notified.
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A 144	Continued From page 88 12.a. The P&P titled "Training and Competency Requirements" dated as 09/01/2023 was reviewed and reflected "RN, LPN, and MHT position requirements ... Current Cardiopulmonary Resuscitation (CPR) certification ... Current 'Anaphylaxis Education and Epinephrine Auto-Injector Pen Training' Competency ... Annual requirements for all nursing staff ... In addition to all applicable training requirements listed previously, all nursing staff assigned to patient care units must also participate in Code Green Drills at a frequency of once every two months." 12.b. Staff training related to nursing staff requirements was not complete for all staff. Review of employee training documentation reflected the following: - RN W with hire date 01/27/2019 reflected no evidence of current Code Green Drill training as required by hospital policy. - MHT Z with hire date 07/09/2023 reflected no evidence of current Code Green Drill training as required by hospital policy. - MHTT DD with hire date 12/05/2022 reflected no evidence of current Code Green Drill training as required by hospital policy - RN A with hire date 01/14/2024 reflected no evidence of current Anaphylaxis Education and Epinephrine Auto-Injector Pen Training competency as required by hospital policy. - MHT B with hire date 03/03/2024 reflected no evidence of current Anaphylaxis/Epinephrine Pen training competency. There was no evidence of current Anaphylaxis/Epinephrine Pen training competency for several employees including but not limited to:	A 144		

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A 144	Continued From page 89 - MHT C with hire date 03/10/2024 - MHT D with hire date 12/26/2021 - MHT2 E with hire date 12/08/2019 - MHT F with hire date 09/11/2022 - MHT H with hire date 02/28/2022 - RN L with hire date 01/27/2019 - RN M with hire date 01/27/2019 - MHT N with hire date 01/27/2019 - MHT O with hire date 01/27/2019 - LPN S with hire date 06/27/2021 - MHT2 T with hire date 08/25/2019 . 12.c. During interview on 03/07/2024 starting at 1030 with the QM, DSE, SC, CS and other staff members, they confirmed the records lacked "Anaphylaxis Education and Epinephrine Auto-Injector Pen Training" competency and "Code Green Drill" training for the above staff. 12.d. An email dated 03/18/2024 at 0624 from the QM reflected "I did find the training for one staff member in column J. I plan to verify the remaining today as well." No additional documentation was received. **********	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 medical record documentation for 24 of 26 patients (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11,	A 145		

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A 145	Continued From page 90	A 145		

12, 13, 14, 15, 16, 17, 18 ,19, 22, 23, 24, 25, and 26), review of investigation documentation, review of grievance documentation, review of P&Ps and review of other documentation it was determined that the hospital failed to fully develop and implement clear P&Ps that ensured each patient's right to be free from all forms of abuse and neglect. Identification of, investigations of, and response to, allegations of abuse, and 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.

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.

Findings include:
1.a. The P&P titled "Incident Reporting" dated as revised 02/05/2024 was reviewed and included the following:
* "OSH staff must accurately report incidents in accordance with this policy. In response, OSH must conduct thorough investigations, prepare reports showing the tracking and trending of data, and implement and monitor corrective or preventative actions."
* "Any of the following reportable incidents must be reported ... Code Blue ... ER visit or admission of a patient ... Physical aggression toward patients, staff, or visitors resulting in any degree of injury ... Sexual contact and inappropriate sexual behaviors between patients or with a patient ... Sexual crimes or an inappropriate sexual behavior ..."

1.b. The P&P titled "Procedure A: Reporting an Incident" dated as 02/05/2024 was reviewed and included the following:
* "Unless otherwise noted in this policy, every staff who witnesses a reportable incident must complete a separate incident report for each person involved in the reportable incident within one business day of the reportable event. For example, in a patient-to-patient aggression incident where a staff member is injured, three incident reports would be required to be submitted by each person that witnessed the reportable incident - one for each patient involved and one for the injured staff."

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A 145	Continued From page 92 * "For reportable incidents involving patients (i.e. incident reports with patients listed as "subject") an RN must assess the involved patient(s), when it is safe to do so, and document in the Progress Note. This assessment should consider elements appropriate to the nature of the incident, such as physical and psychological safety, access to prohibited items, and risk for recurrence." * "Each incident report must identify the reporting staff ' s location at the time of the incident." * "If the incident report includes information from another source, the reporting staff must provide the name of the outside source and indicate if they were a witness or an involved party." 1.c. The P&P titled "Procedure B: Incident Report Response" dated as 02/05/2024 was reviewed and included the following: * "The Incident Review Form must include: a. A brief summary of the incident (reference all incident reports describing the incident); b. A description of factors which contributed to the incident; and c. Actions taken or planned to respond to the incident, including but not limited to patient assessment and documentation in the patient medical record. d. Description of how OSH will prevent the event from reoccurring." 2. Refer to the incident investigation findings cited at Tag A-144 under CFR 482.13(c)(2), Standard: Privacy and Safety. Those findings reflect the hospital's failure to ensure investigations of incidents/events that reflected potential neglect were clear, complete, and accurate to prevent recurrence for those patients who experienced actual and potential harm, and for other patients. **********	A 145		
A 263	QAPI	A 263		

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A 263	Continued From page 93 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: ********** Based on observations, review of video recordings, interviews, review of incident and medical record documentation for 24 of 26 patients (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 ,19, 22, 23, 24, 25, and 26), review of investigation documentation, review of grievance documentation, review of P&Ps and review of other documentation it was determined that the hospital failed to ensure that the QAPI program was effective to ensure the provision of safe and appropriate care to patients in the hospital. 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.	A 263		

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A 263	Continued From page 94 Findings include: 1. Refer to the findings cited at Condition Tag A-115 under CFR 482.13 - CoP: Patient's Rights that reflects that policies, procedures, and systems for the provision of safe care were not clear, complete, or implemented (Tag A-144); that identification of, investigations of, and response to, allegations of abuse, and 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 (Tag A-145); and that response to, investigation of, and follow-up to patient grievances related to safe care were not clear, complete or timely (Tag A-118). 2. Refer to the findings cited at Tag A-286 under CFR 482.21(a), (c)(2), (e)(3) - Standard: Patient Safety that reflects the hospital failed to ensure that incidents and adverse patient events were clearly identified, tracked, 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. Further, there was no process for systematic identification and tracking of negative outcomes to patients that involved patient injuries, ED visits, and hospitalizations in relation to incidents. **********	A 263		
A 286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited	A 286		

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A 286	Continued From page 95 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: **********	A 286		

Based on observations, review of video recordings, interviews, review of incident and medical record documentation for 24 of 26 patients (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 ,19, 22, 23, 24, 25, and 26), review of investigation documentation, review of grievance documentation, review of P&Ps and review of other documentation it was determined that the hospital failed to ensure that incidents and adverse patient events were clearly identified, tracked, investigated and analyzed. Further, the hospital failed to plan and implement corrective actions to prevent recurrence of those, to promote learning throughout the hospital, and to establish clear expectations for patient safety.

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A 286	Continued From page 96	A 286		

Findings include:

1. Refer to the findings cited at Tag A-144 under CFR 482.13(c)(2) - Standard: Privacy and Safety that reflects that policies, procedures, and systems for the provision of safe care were not clear, complete, or implemented and resulted in the following:
* Failure to prevent patient to patient physical altercations and injuries.
* Failure to prevent patient to patient sexual contact and sexual assault.
* Failure to ensure staff carried out assigned duties related to all aspects of observation and supervision of patients.
* Failure to ensure TCPs and ES orders were followed.
* Failure to ensure door security and situational awareness practices that ensured patient safety.
* Failure to ensure all high risk patient care areas monitored by 24/7 security staff video monitoring were fully observable and did not include blind spots.
* Failure to ensure staff practices were in accordance with, and supported by, written and approved P&Ps for the following:
- Condom distribution to patients.
- Processing and tracking police reports filed on behalf of patients who had been assaulted by other patients.
- Security staff "access control" video monitoring
* Failure to ensure Code Blue responses were organized, appropriate, and documented.
* Failure to ensure staff training related to patient safety was current.

2. Refer to the findings cited at Tag A-145 under CFR 482.13(c)(3) - Standard: Privacy and Safety

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A 286	Continued From page 97 that reflects that identification of, investigations of, and response to, allegations of abuse, and 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. 3. Refer to the findings cited at Tag A-118 under CFR 482.13(a)(2) - Standard: Patient Grievances that reflects that response to, investigation of, and follow-up to patient grievances related to safe care were not clear, complete or timely. 4. During interviews with staff that included the DSC, QMD, and CMO about the patient incident log on 02/28/2024 and 03/04/2024 they indicated that the hospital had no process for systematic identification and tracking of outcomes to patients that involved patient injuries, ED visits, and hospitalizations in relation to incidents. They stated that information about patient injuries sustained and ED/hospital visits was only identifiable in individual patient incident reports or individual patient medical records. **********	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: ********** Based on observations, review of video recordings, interviews, review of incident and medical record documentation for 24 of 26	A 385		

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patients (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 ,19, 22, 23, 24, 25, and 26), review of investigation documentation, review of grievance documentation, review of P&Ps and review of other documentation it was determined that the hospital failed to ensure that nursing services were organized and managed to ensure the provision of safe and appropriate care to each patient in the hospital.

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

Findings include:

1. Refer to the findings cited at Condition Tag A-115 under CFR 482.13 - CoP: Patient's Rights that reflects that policies, procedures, and systems for the provision of safe care were not clear, complete, or implemented (Tag A-144); that identification of, investigations of, and response to, allegations of abuse, and 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 (Tag A-145); and that response to, investigation of, and follow-up to patient grievances related to safe care were not clear, complete or timely (Tag A-118).

2. Refer to the findings cited at Tag A-395 under CFR 482.23(b)(3) - Standard: RN Supervision of Nursing Care that reflects an RN failed to supervise the nursing care for each patient to ensure the provision of safe and appropriate care that included prevention of patient to patient altercations and injuries, and sexual contact. RN

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A 385	Continued From page 99 failures included, but were not limited to: failure to ensure nursing staff appropriately supervised and observed patients to prevent incidents, failure to ensure investigations of incidents were complete and corrective actions were taken that prevented recurrence, and failure to ensure that response to grievances regarding patient safety were timely and appropriate. **********	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 medical record documentation for 24 of 26 patients (Patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 ,19, 22, 23, 24, 25, and 26), review of investigation documentation, review of grievance documentation, review of P&Ps and review of other documentation it was determined that the RN failed to supervise the nursing care for each patient to ensure the provision of safe and appropriate care. Findings include: 1. Refer to the findings cited at Tag A-144 under CFR 482.13(c)(2) - Standard: Privacy and Safety that reflects that policies, procedures, and systems for the provision of safe care were not clear, complete, or implemented and resulted in the following: * Failure to prevent patient to patient physical	A 395		

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altercations and injuries.
* Failure to prevent patient to patient sexual contact and sexual assault.
* Failure to ensure staff carried out assigned duties related to all aspects of observation and supervision of patients.
* Failure to ensure TCPs and ES orders were followed.
* Failure to ensure door security and situational awareness practices that ensured patient safety.
* Failure to ensure all high risk patient care areas monitored by 24/7 security staff video monitoring were fully observable and did not include blind spots.
* Failure to ensure staff practices were in accordance with, and supported by, written and approved P&Ps for the following:
- Condom distribution to patients.
- Processing and tracking police reports filed on behalf of patients who had been assaulted by other patients.
- Security staff "access control" video monitoring
* Failure to ensure Code Blue responses were organized, appropriate, and documented.
* Failure to ensure staff training related to patient safety was current.

2. Refer to the findings cited at Tag A-145 under CFR 482.13(c)(3) - Standard: Privacy and Safety that reflects that identification of, investigations of, and response to, allegations of abuse, and 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. Investigations of the majority of incidents were conducted primarily by hospital nursing and other clinical staff. Exceptions included investigations of incidents that resulted in significant or serious

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A 395	Continued From page 101 harm. 3. Refer to the findings cited at Tag A-118 under CFR 482.13(a)(2) - Standard: Patient Grievances that reflects that response to, investigation of, and follow-up to patient grievances related to safe care were not clear, complete or timely. Patient grievance response and follow-up was conducted primarily by hospital nursing and other clinical staff. **********	A 395		