OSH Gap Analysis & Action Plan

	Priority	Title/Finding	Description/Plan	Discussion/Recommendation	Status	Start Date	Next Update	End Date	Hospital Oversight	Chartis Oversight	Comments
1		**GOVERNING BODY CHAPTER**				09/23/24		03/31/25			
2		**OBSERVATION: Escalation of Clinical Concerns/Oversight by Governing Body**	**There appears to be a lack of transparency with leadership about significant events that occur within the facility. Lack of immediate escalation of clinical concerns from front line staff to leadership for oversight/awareness.**	**Recommend daily brief executive leadership and RM/Quality discussion of significant events occurring in prior 24 hours. Conduct daily via Teams meeting with AOC call to AOC on weekends by house supervisor if significant event occurs.**	**Complete**	**09/23/24**		**10/04/24**	**Dr. Sara Walker**	**Kim Wilson**	**Radar initiated on 9/24 and continues daily.**
3		**OBSERVATION: Quality, Safety, and Oversight**	**Lack of a formal process for escalating clinical concerns to leadership for oversight and accountability**	**Accountability is critical for effective quality and monitoring processes in hospitals. Strengthening oversight mechanisms can foster a culture of responsibility, enhance patient safety, and ensure that staff are held accountable for their actions, ultimately leading to better care outcomes. Recommend implementing QSOC to oversee significant events and to help expedite solutions.**	**Complete**	**09/23/24**		**10/04/24**	**Dr. Sara Walker**	**Kim Wilson**	**Initial QSOC on 10/1 and will be weekly until organization has addressed significant ongoing events and can transition to a monthly or quarterly cadence as appropriate.**
4		**Policy/Process Alignment, Simplification and Streamlining**				12/03/24		03/31/25			
5		*OBSERVATION: Incident Management Policy*	*The policy states "Every staff who witnesses a reportable incident must promptly report the incident in the electronic OSH incident reporting system by the end of the staff's current shift, but if not possible, by the end of their next scheduled shift." The act of having every employee enter an incident report is redundant and does not add value to the incident reporting process. Security reports are usually from a different point of view than clinical staff reports. -The incident reporting policy also includes the following must be reported, "Atypical seclusion and/or restraint, including hard shield use (Code Purple). Only reporting "Atypical restraint and/or seclustion" is subjective and misleading insinuating a "typical" restraint is a normal patient care intervention.*	*We recommend that the staff member with the most information typically enters the incident report with the names of all staff involved. The subsequent incident review and investigation is when employees are interviewed for information as needed. Entering multiple incident reports takes staff out of direct patient care and is an undue burden on both the front and back end when reports need to be reconciled and bundled. One report is needed to capture an incident with the investigation taking place outside of the immediate timeframe. What must be captured fully is the incident within the patient's medical record and immediate measures undertaken. -All seclusion and restraint incidents should be reported for incident review, data tracking and trending.*	*In Progress*	*12/04/24*	*12/12/24*	*01/06/25*	*Aisha Krebs, Rodney Wolverton*	*asmedley@chartis.com*	*Policy review and revision is underway regarding the incident managment system changes, the next meeting will be with Rodney, Jim, Scott and Caroline (policy) 12/11/24. The S&R event addition will be deferred until the RLDatix rollout Feb/March 2025 due to the inability to add a S&R event that is not "atypical" in the current system.*
6		OBSERVATION: Hospital Wide Policy Management Process	Process for identifying, reviewing, and approving policies would benefit from a well-defined structure. All departments identify duplicative/repetitive policies. Outdated policies currently available in the electronic repository could cause confusion and erroneous information. -Upon unit staff interviews, policies were viewed as "too long to read", "the process doesn't work", "policies are hard to find and in different places" "policy is developed without staff input."	Recommend implementing policy management processes, updating current policies, and retiring outdated policies. -Restructure the committee process and define department responsibilities for policy management. -The Incident Management policies and Seclusion and Restraint policy revisions are a priority for the organization.	In Progress	12/04/24		03/07/25	Toni Gyatso	Kim Wilson	Weekly meetings are underway with the policy team.
7		OBSERVATION: Policy/Process Implementation	Front line staff observed in interviews that there is a disconnect between what is in the policy, what the education team is training to, and what is actually happening on the front line. There is the perception that a process will be updated, but the education team is still teaching to the old policy/process, which creates confusion on the front line.	Develop streamlined process to educate to and communicate about policy and process changes to ensure front-line awareness and capabilities to execute	Pending	12/04/24		03/31/25	Toni Gyatso	Kim Wilson	
8		OBSERVATION: Overly Complex Core Set of Patient Care Policies, Processes, and Guidelines	Review and identify patient care policies benefiting from simplification to eliminate redundancy and overly complex process requirements. Direct care staff interviewed, as a whole, felt policies were too long and complicated, were often difficult to locate, and may not correlate to actual practice and processes	Need to review and revise approximately 8-10 core policies to match documentation and align with enhanced practice	Pending	12/03/24		02/24/25			
9		**OBSERVATION: Governing Body**	**Upon senior and executive leadership interviews, not all were clear on the composition of leaders and responsibilities of the Governing Body.**	**The governing body is responsible for the conduct of the hospital that includes the quality of care provided to patients. We recommend a Governing Body education presentation to leadership staff (Dept. Chiefs, Board/Exec Team) to ensure full understanding of the governing body's responsibilities and to update the New Emloyee Orientation training on this topic.**	**In Progress**	**12/03/24**		**12/13/24**		**Kim Wilson**	**A meeting is scheduled for the second week of December even though this is a "moderate" priority finding. Ann will meet with Learning Services the 2nd week also to review/recommend revisions to the OSH NEO education.**
10		OBSERVATION: Leadership Role in Oversight and Decision-Making	During interviews, individuals across all levels of the organization (senior leaders, to mid-level leaders, and front-line) spoke of significant leadership involvement in all aspects of organizational decision making. This has created a perception that decisions can only be made at the top, which has felt disempowering to middle level and front-line leaders and is felt to be inefficient and insufficiently involve front line perspective (and engage them) in problem-solving. Front line leaders report that even when they are asked to think independently and problem solve, they are second-guessed.	Create the structures that empower appropriate groups to make decisions (see Committee section), incorporating front line perspective. Utilize team structure (units and PETs) to enable local problem solving and sharing. Leadership should have clear visibility into decision-making, but function more in escalation and oversight role. (Specific issues for revision include the patient transfer process).	Pending	11/19/24		01/10/25		Kim Wilson	Initial review of gap analysis governing body findings was held during a meeting with OSH executive team on 11/19.
11		OBSERVATION: Opportunities for Improvement in the Hospital's Reporting Structure	The hospital organizational chart is very heavily weighted on the CFO/COO with clinically-driven reporting departments that should be assigned under the clinical umbrella or functioning independently outside of operations and finance. Also, the hospital administrator at the Junction City Campus is an executive leader with no direct reports. Specifically, the quality department reports to COO/CFO, which is less typical than reporting directly to Superintendent/CEO. This risks limiting scope and influence of department as it relates to oversight of quality defined broadly across the organization.	Our recommendation is to clearly delineate the regulatory oversight of the organization as a function separate from operations and finance through the establishment of a Chief Quality Officer with direct reporting oversight of quality and performance improvement, adverse event management, safety/risk management, compliance, data analysis and sub-departments of patient advocacy/rights/experience and policy management. Any area that potentially affects patient care, including the management of the physical environment, should be viewed through the lens of patient care, quality and safety to reduce the potential for conflict in resolving issues; this includes the ability to escalate considerations to leadership.	Pending	11/19/24		01/10/25		Kim Wilson	Discussions underway 12/24.
12		OBSERVATION: Clinical Team Structure and Accountability Variabilities	Upon staff interviews and observations: PETs and Unit teams are in place, and some efforts have been made to standardize processes (e.g., unit morning report template) but the processes within these teams and the overall effectiveness of these teams is not consistent. PET leader engagement and oversight/support of the Unit teams is also variable (e.g., some PET leaders consistently attend Unit morning report across their program, and others do not). In addition, organizational quality and safety priorities are not consistently aligned and translated into goals for the PETs and Units, and there are limited structures in place to ensure executive visibility into (and create accountability for) team performance. This also limits executive ability to identify and remove barriers that cannot be mitigated locally.	Reconnect teams to organizational priorities (defined as part of QAPI and overall organizational goal-setting) by cascading annual organizational goals to PET and Unit teams. Clarify roles, responsibilities, and expectations for PET leaders as it relates to engagement, support and oversight of Unit teams. Create bidirectional information flow so that senior leaders can have visibility into PET and Unit team performance on organizational goals and teams are able to efficiently escalate concerns and issues to leadership.	Pending	11/19/24		01/10/25			
13		OBSERVATION: Complaints/Grievance	Grievance Program is very decentralized, with multiple Unit Grievance Committees. Four Unit Grievance Logs were reviewed. On all unit logs, completion dates were missing, and it was difficult to assess if the prescribed grievance process dates were met. The grievance logs were not standardized. Staff vocalized difficulty managing grievances and felt unsupported. Ombudsman staff will not have situational awareness of the grievances until everything is completed, as they are not involved in the daily processing of grievances. The current policy is very prescriptive and has added requirements that are not typical of CMS. The ombudsman sends data to Standards and Compliance, but we cannot assess leadership oversight.	As best practice, we recommend reviewing the grievance program processes, which may include: -Standardizing Unit Grievance Log. -Review existing policy to streamline processes. The Chartis model policy was sent to the Ombudsman for review. -Ensure the executive staff and board annually document the review of the grievance program for leadership oversight. -Centralizing Grievance Program and Grievance Committee It's understood this is likely a larger project that will require additional staff but we continue to recommend as a future state.	Pending	11/19/24		01/10/25			

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14		OBSERVATION: Creating and Maintaining a Culture of Safety and Quality	2024 AHRQ Safety culture survey results suggest opportunities to strengthen safety culture, particularly as it pertains to communication, hospital management support for safety, and response to error. 2023 was the first year of the survey, and there were improvements in several domains, but a notable decline in "response to error." In interviews with Safety team leadership, who manages safety culture survey results, the focus to date has been on workplace safety. There is an acknowledgement of the opportunity to improve safety culture more broadly along the elements measured in the survey. In interviews with mid-level leaders and front-line leaders, there was an expressed desire to see senior leaders "out on the units" more frequently. In conversations with front-line staff and front-line leaders, there was the perception this would help reinforce senior leadership connection to reality of front-line experience.	Create a process to increase the transparency surrounding adverse events, including a distribution plan that provides caregivers at all levels with event details at a level such that they could find relatability to the event and adjust their work practices. Share data widely on organizational performance against goals, including aggregate harm numbers. Formalize safety/leader walk-rounds and include standard scripting and a data collection process.	Pending	11/19/24		01/10/25			
15		**Contracted Services**				11/19/24		01/08/25			
16		OBSERVATION: Evaluation of Contracted Services	The governing body must assess the services furnished provided under contract, identify quality and performance problems, implement appropriate corrective or improvement activities, and to ensure the monitoring and sustainability of those corrective or improvement activities. There was an extensive list of contracted services provided but there's no evidence of evaluation of services being provided. Per CMS, the hospital must have a mechanism to evaluate the quality of each contracted service and ensures that each contracted service is provided in a safe and effective manner. For example, it's extremely common for a hospital to review over-reads from radiologist (contracted staff) as this is a performance measure that should be reviewed from a quality perspective.	Review the list of contracted services and ensure all are integrated into the QAPI plan and that governing body has assessed and reviewed all metrics related to performance for each.	Pending	11/19/24	12/04/24	01/08/25	Aisha Krebs, Nate Gillard	Ann Smedley	The Chartis model QAPI Plan was introduced to the Quality Team 12/4/24. Contract services will be listed as a QAPI indicator within the 2025 Plan.
17		OBSERVATION: List of Contracted Services	Per CMS, the hospital must maintain a list of all contracted services, including the scope and nature of the services provided. The list of contracted services that was provided did not have a scope or nature of services being provided which made it difficult to determine what type of services were being provided.	Update the list of contracted services and ensure that there is a delineation of contractor responsibility.	Pending	11/19/24	12/04/24	01/08/25	Aisha Krebs, Nate Gillard	Ann Smedley	The Chartis model QAPI Plan was introduced to the Quality Team 12/4/24. Contract services will be listed as a QAPI indicator within the 2025 Plan.
18		OBSERVATION: Integration of Contracted Services into QAPI	Clinical contracted services must be integrated into the hospital-wide QAPI program.	Ensure all contracted clinical services are reviewed for the quality of those services provided and is integrated into the hospital-wide QAPI program.	Pending	11/19/24	12/04/24	01/08/25	Aisha Krebs, Nate Gillard	Ann Smedley	The Chartis model QAPI Plan was introduced to the Quality Team 12/4/24. Contract services will be listed as a QAPI indicator within the 2025 Plan.
19		**Committee Management, Agenda, Presentation**				11/19/24		01/10/25			
20		OBSERVATION: Effectively Functioning Committee Meetings	There doesn't appear to be a consistent process managing committee meeting content, agendas or a consistent way of presenting information.	Establish method to standardize committee presentations. Committee presentations to include aggregated data, with substantive analysis to provide committee with clear picture of issue magnitude, direction, variability and rate of issue - thus allowing committee to problem solve and authorize actions	Pending	11/19/24		01/10/25			
21		OBSERVATION: Committee Organization	The hospital has approximately 45-50 committees with no clear process for establishing committees per leadership interviews and feedback is that many are redundant and ineffectively managed. Committees do not report up through tiered committee structure, which can contribute to inefficiencies and hinder decision-making and execution.	Overall, current and new committees need to be assessed and realigned into the appropriate reporting structure to ensure activities are captured and reported as necessary to the Governing Body. The assessment includes a review of duplicative functions and actions.	Pending	11/19/24		01/10/25			
22		Committee membership	Committees do not always have broad, interdisciplinary membership composed of decision-makers empowered to speak for their disciplines. This can slow decision-making and lead to re-work. For example, within the operations reporting structure, department such as Facilities, Safety, and Security can feel siloed and without a "seat at the table" when it comes to setting strategy/best practice (e.g., as part of interdisciplinary standing committees)	Evaluate committee membership to ensure appropriate representation across key stakeholders and that members are empowered to make recommendations and decisions.	Pending	11/19/24		01/10/25			
23		Committee information flow	Committee initiatives do not seamlessly flow into front line teams for execution, as there is not a consistent and clear process for communicating best practice approaches to front line teams, with closed loop follow up on execution. Process described as more ad-hoc.	Develop process to organize initiatives coming out of committees and communicate in clear, consistent way to PETs and Unit teams.	Pending	11/19/24		01/10/25			
24		**INFECTION PREVENTION CHAPTER**				11/20/24		02/04/25			
25		**Infection Prevention and Control-Patient Care Areas**				11/20/24		02/03/25			
26		***OBSERVATION: Medical Clinic HLD of reusable instruments***	***Several instruments in peel packs had visible staining that either represents bioburden or rust. These instruments included alligator clamps, scissors, and hemostats and were found in sterilizing room and in a clinic exam room. Forceps and hemostats were noted to be hinged, therefore not sterilized in an open position. Staff responsible for high level disinfection appeared unclear on the proper process for disinfection and did not appear to be following policy. At present, infection prevention doesn't appear to have consistent involvement in this process (education or tracer activity).***	***Discussed process with the Dentist assigned to the clinic. He provides the staff education on HLD in the clinics. Recommend inclusion of IP and immediate review of the reprocessing process policy and procedures, review manufacturers' instructions, reprocess instruments or removal from service, and ensure staff are appropriately trained. Deficiencies noted during rounding were corrected in real-time by staff and education was initiated for staff performing HLD and will be followed up on an ongoing basis.***	***Complete***	***11/20/24***	***12/13/24***	***12/06/24***	***Dr. Sara Walker, Justin Ririe***	***Ann Smedley***	***11/20/24: Initial meeting with Justin and Dr. Hennan. Annual autoclave training completed with the Dentist/clinic today. 12/4: Dr. Hennan will get us an update for next week from Justin. They don't want to move to disposeable and have already initiated education on HLD. As of 12/6, collected all instruments and resterilized or destroyed. Created an inventory with check in/check out process. Education provided to all involved staff. Will update protocols based on manufacturers IFU.***
27		**OBSERVATION: Improper storage of patient supplies.**	**Both Medical and Dental Clinics had patient supplies stored on the floor. Storing supplies on the floor can expose them to contamination. -In the Medical Clinic clean utility room, linen was stored on a shelf system that did not have a solid bottom. -3 new mattresses were stored standing on the floor in the linen room in a Harbours unit.**	**Recommend observation of storage rooms during weekly environment of care rounds to identify non-compliance with the storing of patient supplies. Educate staff to proper storage of patient supplies.**	**Complete**	**11/20/24**		**12/06/24**	**Justin Ririe**	**asmedley@chartis.com**	**All identified deficiencies corrected**
28		**OBSERVATION: Improper storage of Linen**	**Hospital Linen in the Medical Clinic was stored on countertops or with other patient supplies.**	**Linen should be kept in a clean, enclosed cupboard or on a covered cart. Recommend observation of linen storage during weekly environment of care rounds to ensure linen is stored appropriately. Educate staff on the proper storage of linen.**	**Complete**	**11/20/24**		**12/06/24**	**Justin Ririe**	**asmedley@chartis.com**	**All identified deficiencies corrected**
29		OBSERVATION: Shelving Storage	Medical Clinic: Patient supplies were stored on shelves that were not solid. Storing supplies too close to the floor can make it difficult to clean, and can cause items to splash when the floor is cleaned.	Recommend adding solid bottoms to supply shelves to protect from contamination and cleaning products.	In Progress	11/20/24		02/03/25	Justin Ririe	asmedley@chartis.com	
30		**OBSERVATION: Items located in splash zones**	**Towels, equipment, paper documents, and unsecured sharps containers were found in splash zones throughout the medical clinic.**	**A splash zone is an area around a sink in which contamination could occur, to objects within that space, from the splash associated with handwashing or other activity being done in the sink. CMS defines the splash zone as a 3-foot radius around a sink. Recommend observing splash zones during the weekly environment of care rounds to ensure splash zones are clear. Educate staff to Splash Zones.**	**Complete**	**11/20/24**		**12/06/24**	**Justin Ririe**	**asmedley@chartis.com**	**All identified deficiencies corrected**
31		**OBSERVATION: Broken exposed concrete**	**During rounds in Dental Clinic Op Room 1, a hole was found, exposing broken concrete in a patient care procedural area.**	**Broken concrete floors in hospitals can be a safety hazard and an infection control issue that may negatively impact the health of patients and staff. Educate staff to report flooring issues as soon as observed. Ensure flooring is properly repaired.**	**Complete**	**11/20/24**		**12/06/24**	**Justin Ririe**	**asmedley@chartis.com**	

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32		OBSERVATION: Damaged patient items	During rounds in Radiology, the radiology table's pad was appeared stained and a patient positioner was torn.	Damaged positioners can allow bodily fluids to leak into the foam core, posing a risk of infection to patients. Soiled patient pad also poses a risk of infection. Educate staff on the importance of cleaning and ensuring equipment is operational. Recommend regularly inspecting patient positioners and pads for signs of damage, such as tears, cuts, punctures, abrasions, and staining.	Complete	11/20/24		12/06/24	Justin Ririe	asmedley@chartis.com	
33		**Infection Control Program Design**				11/20/24		02/04/25		asmedley@chartis.com	
34		OBSERVATION: Resources dedicated to support the program	There is an opportunity to evaluate the program staffing. There are three Infection Prevention RNs and an administrative assistant that support the program for the Salem and Junction City campuses. Each IP RN covers 10-11 units with each having a census of 23-25 patients and are responsible for oversight and administration of all staff vaccinations.	-Benchmark against like organizations to ensure the program is being supported by enough resources to perform required program surveillance and reactive infection control as well as proactive work, such as proactive tracing of high-risk processes more frequently and participating regularly in environmental rounds. -Evaluate opportunities to utilize nursing students to support staff vaccination efforts.	Pending	11/20/24		02/04/25	Justin Ririe	asmedley@chartis.com	
35		OBSERVATION: Governing body appointment of the infection preventionist/infection control professional(s) responsible for the IP&C program	It is unclear how the governing body approves/approved the current IP nurses being hired into their roles.	Their needs to be clear documentation that the governing body approves of the infection preventionists, and their appointments are based on recommendations of medical staff leadership and nursing leadership. This could be accomplished via documentation in Infection Control Committee minutes of the appointments being approved by that group and then filtering up to the executive team for review/approval.	Pending	11/20/24		02/04/25	Aisha Krebs	asmedley@chartis.com	
36		OBSERVATION: Infection control plan alignment with QAPI	It is unclear if the governing body is ensuring the CMS requirements that issues identified by the IC program and antibiotic use issues are being addressed in collaboration with hospital QAPI leadership.	Determine current state and ensure for these programs in 2025 that there is coordination between the IC program, antibiotic stewardship program, and QAPI leadership in conjunction with the medical staff, nursing services and pharmacy services leaders.	Pending	11/20/24		02/04/25	Aisha Krebs	asmedley@chartis.com	The Chartis model QAPI Plan was introduced to the Quality Team 12/4/24. IC will be incorporated into the QAPI indicator list for 2025.
37		OBSERVATION: Infection prevention control professionals/infection preventionist responsibilities.	The Infection Control Committee is led by a physician, not the Infection Preventionists or the Chief of Medicine. Through interviews and policy review, it is understood that the COM oversees the IP&C program.	Evaluate the current meeting membership and leadership to ensure that infection control professionals are fulfilling the CMS requirements related to IP responsibilities, ownership, and documentation of the program.	Pending	11/20/24		02/04/25	Aisha Krebs, Kristi Hennan	asmedley@chartis.com	
38		**Food Preparation, Storage and Safety**				11/20/24		01/28/25			
39		**Infection Control Issues: Main Kitchen**				11/20/24		01/28/25			
40		OBSERVATION: Expired Non-Critical Supplies	Springs and Trails kitchens: burn spray in first aid cabinets expired 8/2024, each cabinet had a few bottles, all expired. Process explained for cabinet checks was that Safety staff check the cabinets every month.	Expired burn spray has the potential to be ineffective in treating burns if staff needed for first aid. Recommend that the expired bottles are removed and replaced. Reinforce with Safety that cabinets are being checked per the established process or that a process is established and followed. Monitor for compliance.	Complete	11/20/24		12/06/24			Deficiencies corrected.
41		**Infection Control Issues: Satellite Kitchens**				11/20/24		01/28/25			
42		OBSERVATION: Clean vs. Dirty	In the Springs satellite kitchen, paper goods are being stored under the ice/water machine. Also, at the time of survey, the drip container for the ice/water machine had standing water; there should be a process for emptying the container after meals or at some other regular interval. In general, the storage of clean supplies should be such that the risk of contamination is minimized to the extent possible. There should also be a process for managing any manual water collection devices (drip trays, etc.) to ensure that the risks associated with waterborne contaminants are minimized.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Complete	11/20/24		12/06/24		asmedley@chartis.com	Deficiencies corrected.
43		OBSERVATION: Dusty Fans	Trails: two fans in this kitchen were both significantly dusty and blowing in areas where clean items/food are stored.	Ensure fans are cleaned per the established process and frequency. Monitor for compliance.	Complete	11/20/24		01/28/25		asmedley@chartis.com	Initial meeting held with FNS. Cleaned and added to mock survey report
44		OBSERVATION: Wet Pans	Trails: clean pans stacked together for storage were wet	Ensure pans/containers are dried completely before storing or store in a manner that allows for drying vs. water collection. Monitor for compliance.	Complete	11/20/24		01/28/25		asmedley@chartis.com	Initial meeting held with FNS. Education provided. Will monitor for ongoing compliance.
45		*OBSERVATION: Microwave Cleaning*	*In the Kirkbride Cafe dining area, there was a microwave oven in need of cleaning. Any "common use" appliances should be maintained on a regular basis to ensure appropriate cleanliness, etc.*	*Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.*	*In Progress*	*11/20/24*	*12/13/24*	*12/20/24*		*asmedley@chartis.com*	*Initial meeting held with FNS.Still being worked on to establish ongoing cleanliness*
46		**Storage Issues: Kitchen**				**11/20/24**		12/06/24			
47		OBSERVATION: Shelving Storage	Main Kitchen: Shelves in refrigerators and in production did not have solid bottoms. Storing food items and kitchen supplies too close to the floor can make it difficult to clean, and can cause items to splash when the floor is cleaned. Junction City Kitchen: The majority of kitchen racks did not have solid bottoms.	Recommend adding solid bottoms to supply shelves to protect from contamination and cleaning products. Monitor for compliance	Complete	11/20/24		12/06/24		asmedley@chartis.com	All are now solid bottoms except in freezers where it isn't necessary.
48		OBSERVATION: Food Storage	Kirkbride: cardboard box of buns was sitting on dishwashing sink area counter	Recommend that kitchen staff ensure food is put away and not stored in cleaning area.	Complete	11/20/24	11/20/24	12/06/24		asmedley@chartis.com	Corrected during the kitchen tour
49		**Overall Sanitation: Kitchen**				**11/20/24**		12/06/24			
50		OBSERVATION: Sanitizer Use	Harbors Kitchen: Staff could not verbalize the use of surface sanitizer. Main Kitchen: The posted process for checking the sanitizer's effectiveness was for bleach. The product had been changed to an ECOLab product. The process was not updated, and staff could not speak to the manufacturer's instructions for use and the frequency of changing surface sanitizer	Recommend reviewing and updating sanitizer processes. The frequency at which you should change Ecolab quat sanitizer depends on the type of container it's in: Third sink sanitizer and red sanitizer pails: Replace the solution when it's visibly dirty, when it tests below the food-contact sanitizing concentration range, or every four hours. Monitor for compliance	Complete	11/20/24		12/06/24		asmedley@chartis.com	Added to protocol and had staff sign off. Updated signage for cleaning material
51		OBSERVATION: Unrefrigerated food	On Mountain 1 unit at Junction City, there were multiple clam shells (food trays) that had been delivered for breakfast but left out on the counter and not refrigerated. The refrigerator log also had missing elements for temperature monitoring.	Recommend continued education for staff to ensure food is refrigerated per policy	Complete	11/20/24		12/06/24		asmedley@chartis.com	Unit educated
52		*OBSERVATION: Staff Food*	*Main Kitchen: Although in a separate tray, staff food was found in the same refrigerator as patient food.* *Kirkbride: Staff drink on counter of dishwashing sink-didn't appear to be a designated staff drink area.*	*Main Kitchen: Recommend providing a small staff refrigerator for staff items to prevent the comingling of staff and patient food items. Monitor for compliance.* *Kirkbride: Ensure process for staff drinks is in place and followed.*	*In Progress*	*11/20/24*	*12/13/24*	*12/20/24*		*asmedley@chartis.com*	*In process to purchase items to correct. Educated staff on proper staff drink storage*
53		OBSERVATION: Temperature Probe	Main Kitchen: The temperature probe for the Rational Oven was heavily soiled and had food residue. The staff reported that the process is for the probe to be wiped with approved cleaner after and before each use.	Recommend continued education of staff on temperature probe cleaning. Monitor for compliance.	Complete	11/20/24		12/06/24		asmedley@chartis.com	Responded in the moment and educated staff

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54		**OBSERVATION: Expired food item**	**Main Kitchen: Potato pearls that were in production had an expiration date of September 2024. Removed immediately by dietary staff.** **Springs: blueberries dated as use by 10/22 observed on 10/23.** **Trails: Cinnamon container above stove not dated with open date/any date.** **Kirkbride: large plastic bins storing rice and flour contained food that appeared to be out of date. Rice container was labeled as use by 7/1/24 and flour was dated as use by 4/1/24. Smaller round plastic bins had inconsistent dating noted-some dates with open date, not labeled, or dated with 'dc' date and thickener appeared to be dated as 'dc' on 4/24** **Valley Cafe Junction City: There were multiple items found throughout the kitchen in various areas that were expired or had no labeled use by date. Examples included expired cheese with a use by date of 10/13 (current date was 10/23). There were eggs, multiple containers, apples, etc. that had no use by date or labels for expiration. The current process is to label trays with expiration dates for all items on the tray but there were several trays missing these stickers."**	**Noted observations were corrected at the time of rounding. Continue educating staff on the importance of adhering to expiration dates. For the plastic containers used for storing dry goods, decide on a dating system and stick to it. Monitor for compliance.**	**Complete**	**11/20/24**		**12/06/24**		**asmedley@chartis.com**	**Reviewed dating protocol and reviewed with all production. Weekly date reviews instituted. On both campuses.**
55		**PATIENT RIGHTS CHAPTER**				12/02/24		03/31/25			
56		**(Care in a Safe Setting)**				12/02/24		03/31/25			
57		OBSERVATION: Sharps Management	There's currently an inconsistent sharps management process in the organization which is leading to patient safety concerns. This is evidenced by multiple findings and incident reports within multiple areas of the organization.	There needs to be a consistent, standardized process for identifying, labeling, and tracking sharps within the organization. A physician has been identified as is currently leading this initiative related to an active RCA.	In Progress	12/02/24		02/04/25	Tom Anhalt	Ann Smedley	This will primarily be addressed through QSOC as related to the Sharps RCA. The RCA actions will address sharps hospital-wide. The PI team also started a Sharps Management project.
58		OBSERVATION: Contraband Management	Reviewed and discussed Contraband Policy with the Director of Security. The current Policy is dated 2017. The plan has not been updated in 7 years, although five administrative directives have been issued. According to organizational policy 1.001 Policy System at Oregon State Hospital, each active policy system document must be formally reviewed and evaluated at least every three years, or more frequently if required by external regulation. Upon use of OWL to access Contraband policy, there were several outdated patient property/item access lists. A draft policy is in process and Chartis will work with OSH to streamline.	The Joint Commission recommends that policies and procedures be reviewed and updated regularly, typically at least every three years. However, they should also be updated whenever there are changes in regulations, standards, or practices that affect patient care or safety. It's important for organizations to have a systematic approach to policy review to ensure compliance and best practices.	In Progress	12/02/24		02/04/25	Jim Aguilar, Scott Jeter	Kim Wilson	Policy is in final development. Education and rollout plan will need review prior to policy signature.
59		*OBSERVATION: Restraint or seclusion. Per CMS, all patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.*	*The frequency and duration of seclusion and restraint at OSH is higher than in comparable hospitals. The factors are complex and likely vary from unit to unit, but it is necessary to implement policies and practices to bring the number of seclusion and restraint events and their duration into line with the average of similar facilities.*	*The shift to a nearly exclusive forensic patient population has contributed to an increase in violent events. Staff have responded by increasing the use of seclusion and restraint as a treatment method at the expense of other possible interventions requiring intensive training and the investment of capital and social resources by the Oregon Health Authority. The culture of safety needs to be addressed in many areas and across all disciplines. The following recommendations could reduce the incidence of seclusion and restraint. -Unit and senior leadership need to be present to work alongside nursing staff as behavior plans are enacted when patients are released from seclusion -Daily Radar meeting: Days in extended seclusion should be added to the Radar agenda -Top of agenda discussion regarding those in seclusion for unit daily reports -Top of agenda for weekly PET meetings with treatment actions determined and added to the treatment plan -PET and executive leadership daily rounds -Incident reporting: All S&R events should be reported, not just when injuries occur or a hands on event occurs. -Continued development of aggressive medication management -Dedicate a behavioral specialist to the seclusion patients, who manages plan and coaches staff -Consider a ""seclusion team"" comprised of all disciplines to focus efforts with patients in extended seclusion -Daily patient assessments by each discipline -Enhance onboarding for inexperienced staff and ongoing staff development -Allow patients to stay in their room versus the seclusion room post incidents when safe to do so -Utilize the single North Hall program for the most severely ill and aggressive patient(s) as determined and consider requesting legislative investment in capital improvements to expand such access, including new, purpose-built facilities. -Implement unit groups and activities for the acute units by other disciplines for patients who do not attend the treatment mall -Individual activities for the acute units -Redesign staffing model and 15-minute checks, which may require legislative support for increased staffing or union acceptance of a new nursing schedule (such as 12 hour days). -Include patients in violence reduction efforts, possibly using the 'interrupter' model applied to community violence -Expand incentive programs for safe behavior -Include direct care staff in violence re-education efforts*	*In Progress*	*12/03/24*	*12/10/24*	*03/31/25*	*Dr. Bell, Llindsey Sande*	*Ann Smedley*	*12/3 - Had initial team meeting with Dr. Bell, Lindsey, Nate, and laid out initial plan for addressing all of these issues. 12/5 - 2nd meeting including Katie H. regarding the project plan. SBAR will be presented in QSOC 12/10/24 for approval to initiate.*
60		*OBSERVATION: Delays in Care (Care in a Safe Setting)*	*On 10/19, a patient at the Junction City campus experienced a choking episode, requiring the Heimlich maneuver to be performed. On the same day, a provider noted in their progress notes the patient should be on a modified diet order and would order a swallow evaluation. On 10/23, unit staff were asked if the evaluation had been completed. They were unaware and indicated they would have to call the medical clinic to determine if it had been scheduled. Medical clinic staff were interviewed and indicated they had received the order on 10/21 but they didn't have a speech pathologist onsite and had emailed the order to the Salem campus. As of 10/23, they had not been notified if the swallow evaluation had been scheduled. They indicated it would be scheduled by the Salm SP and results would be emailed to the ordering provider. On 10/30, staff at Salem campus called to determine if the swallow evaluation had been completed but it had not been completed yet.*	*Evaluate current process for medical clinic referrals/Avatar capabilities to see if other options exist for documenting referrals. Ensure nursing staff and clinical team members have an accepted path to escalate clinical concerns with delays in care and to follow-up on outstanding orders. Currently there doesn't seem to be a clear outstanding order worklist. It's recommended the practice at both campuses be reviewed to determine best practice for ensuriing treatments occur timely. Chartis is actively working actively with medical clinics on this initiative.*	*In Progress*	*12/04/24*	*12/13/24*	*01/31/25*	*Christopher Raikes, Dr. Sara Walker, Kristi Hennan*	*Kim Wilson*	*12/4 - Had initial meetings with Dr. Hennan, Toni, Nate related to finding. Issue: Purchasing Issue: Conflicting policy Issue: Different practice at JC/Salem Issue: Clinics have different reporting structures - not consistent practice Issue: Discuss with IT getting referrals built Issue: Getting nursing to document relevant info about calling in referrals (dates/times) so that it appears in medical record Issue: Doesn't appear to be a solid pending worklist order list for providers/nursing to review for outstanding items*
61		*OBSERVATION: Patient Monitoring (Care in a Safe Setting)*	*On 10/19, a patient at the Junction City campus experienced a choking episode, requiring the Heimlich maneuver to be performed. The patient had existing orders requiring that 1:1 close observation occur when the patient was in the dining hall eating as this patient has been known to choke on his food and requires coaching from staff. On 10/19, the patient was in the activity room eating, unsupervised, and choked on his food, requiring back thrusts and the Heimlich maneuver. Staff didn't appear to follow provider orders to monitor the patient while eating.*	*Staff indicated that the patient was eating outside of his normal area which is why he wasn't being observed 1:1 during his meal. There needs to be more awareness of the precautions within the unit and understanding that these precautions are inclusive to any location within the organization. Working with leadership to get education out to staff and providers.*	*In Progress*	*12/04/24*	*12/10/24*	*12/31/24*	*Christopher Raikes, Nikki Mobley*	*Kim Wilson*	*12/4 - Working with Katie to get SBAR education created for QSOC presentation next Tuesday.*

	Priority	Title/Finding	Description/Plan	Discussion/Recommendation	Status	Start Date	Next Update	End Date	Hospital Oversight	Chartis Oversight	Comments
62		*OBSERVATION: Patient Observation Practices Staff Interviews - Patient Observation and Environmental Checks*	*One hour viability checks are not the standard of care in most psychiatric hospitals. As completed now, 2 person viability checks (and 3 with the nurse involved) do not decrease the chance of adverse events or in finding a non-viable patient. Environmental checks are also completed hourly which is typically only done with oncoming-offgoing staff twice daily in other psychiatric hospitals.* *-MHTs are removed from direct patient care and observation to document in the electronic record. Often, such notes may be conflictual with nursing or provider documentation, inaccurate or unprofessional.*	*- A review and revision of patient observation practices with recommendation of 15-minute observation checks for all acute units with 30 minute observation checks for less acute patient units. The rationale is to increase patient monitoring and engagement to avoid or capture adverse events such as assaults, falls, and medical events. 15-minute checks will eliminate enhanced observation and likely decrease the need for some 1:1 interventions.* *-Reinstate patient engagement education using the Lighthouse staffing model with unit staff.* *- Revise environmental check times to oncoming-offgoing staff only (3 times daily).* *-We recommend stopping the practice of MHT documentation which removes the staff from direct patient care. Their role is valuable regarding patient care in a safe setting; value is not added within the medical record by having a non-licensed staff document notes.*	*Pending*	*12/04/24*	*12/13/24*	*01/31/25*	*Christopher Raikes, Llindsey Sande, Nikki Mobley*	*Ann Smedley*	*12/4 - Met with Nate, Katie, Chris, Toni and Chartis. Nursing ready to initiate q15" checks. Stopping daily documentation for MHTs to be considered. Chartis to review documentation requirements for RNs. SBAR to be completed by Katie for the next QSOC. Observation checks align with S&R plans.*
63		OBSERVATION: CMS 2567-RCM (Continuous Rounds, Census, and Milieu Management) and Contraband (Care in a Safe Setting)	Failure to implement the Plan of Correction related to "Continuous Rounds, Census, and Milieu Management" (RCM) process to ensure patient safety and failure to prevent the recurrence of patient possession of contraband and prohibited items. 1. RCM (Continuous Rounds, Census, and Milieu Management) Process -Video of the RCM process at both campuses was reviewed. 10/6/24 0200 checks didn't show the two MHTs conducting the patient checks together at the same time as required by the hospital's process. -Night shift staff across several units didn't always observe patient respirations, when required per the process, for as long as required (10 seconds). -Staff didn't document on the RCM form as soon as each patient check was completed, as required by the process. 2. Video Monitoring Team Documentation on the "Milieu Safety Monitoring Log" - Junction City log on 10/5 had an entry for the Mountain 1 unit that said, "Viability completed on mountain stack". This entry didn't provide enough clarity about the times that viability checks were completed on Mountain 1, 2 and 3 units, which rooms, or at what time the checks were done. The length of patient observations by staff, as required by the process, was also not included. -Junction City lob on 10/6 had an entry at 0600 for Mountain 3 unit that stated the viability checks were observed at 2200, 2300, 0000, but any additional details about the viability checks was missing. -Similar entries on the Junction City and Salem campus logs lacked clear times and extent of the viability checks and outcomes. 3. Contraband and Prohibited Items -Tour of Anchors 1, Flowers 2, and Leaf 3 units at Salem resulted in finding the previous OSH "Patient/Property/Item Access List" posted (dated 7/6/22) instead of the recent version (6/5/24) called out in the latest Administrative Directive to the policy. -Patient rooms on Anchors 1, Flower 2, and Leaf 3 were found to contain items or conditions inconsistent with the process/list, such as laundry and items strewn across the floor, cups with unknown substances inside, drink mix packages, food, sweetener packets, candy, standard length rigid toothbrush, fresh and dry flowers,	Write POC	Pending						This is being addressed in the changes to be implemented with patient monitoring.
64		OBSERVATION: List of Prohibited Items (Care in a Safe Setting)	At Junction City, there was a list of prohibited items hanging on Mountain 1 that had not been updated since 2022. This was a prior CMS finding. **See above. This finding indicates that the list had still not been updated since the CMS exist on 10/11.	Get updated list of prohibited items pushed out to all units and remove old signs.	Pending						
65		OBSERVATION: Lack of Physical Intervention Training for All Disciplines (also noted under Learning Services)	Per CMS and TJC, the hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population. Only nursing and security staff are trained in physical intervention practices even though treatment services and clinical staff all interact with patients. This does not allow for immediate physical intervention in all cases for violent and self-destructive behaviors.	It's best practice to begin incorporating all clinical disciplines in the NEO and periodic training for physical intervention skills versus the current training of only "high contact" patient care staff (nursing and security).	Pending						
66		*OBSERVATION: Lack of Incident Reporting for Restraint and Seclusion*	*Per the Incident Reporting policy, not all restraint and seclusion events are documented in an incident report unless "atypical" with a patient or staff injury. As best practice, it's recommended all restraint and seclusion events be tracked through incident reporting so that events cannot be discussed in the daily incident review meeting for tracking and trending.*	*Hospital policies for restraint and seclusion and adverse event reporting need to be reviewed and revised to ensure all adverse events are captured appropriately with subsequent staff education.*	*Pending*	*12/03/24*	*12/12/24*	*01/08/25*	*Llindsey Sande, Rodney Wolverton*	*asmedley@chartis.com*	*Included in the S&R initial meeting with Lindsey and Dr. Bell. This will likely be moved as an action until Feb/March when RLDatix reporting system is implemented due to the categorizaion withing the current system but may warrent further discussion.*
67		OBSERVATION: OSH Key Inventory (Care in a Safe Setting): As of 10/23, there are currently 16 sets of keys that can not be accounted for.	Staff provided a list of 16 different sets of keys that are currently missing and can't be accounted for. Some of these have been missing since January 2024. There was no indication staff knew who had originally checked the keys out as they were not "tagged". Verified with security leadership that they are aware of the situation.	There needs to be a reconciliation of lost keys. Re-evaluate the process for checking out keys to the organization and determine if a better process exists for not only checking out the keys, but also tracking their whereabouts.	Pending						
68		OBSERVATION: Monitoring Checked Out Items by Patient (Care in a Safe Setting)	At Junction City it was noted that staff are not adequately logging items that are checked out by patients. On Mountain 1, there was a patient belongings room with 4 clipboards on the wall. These logs were reviewed and found to have multiple missing entries showing where items had been returned. In one instance, a patient had checked out 5+ IPods and there was no documentations showing that any of them had been returned. This was also found with DVD players, DVDs, CD's, etc. Interviewed staff about this process indicated, "We are very deficient in signing in/out items".	Review policies/procedures or guidelines to the inventory practice related to these items. Staff felt strongly some of these items (ipods) should not be inventoried and didn't feel these posed patient safety issues. However, other items, such as CD's have been shown to be very dangerous and can be easily broken and used as a weapon. This entire process should be reviewed to determine which items truly need to be logged so that they organization can move toward compliance.	Pending						
69		OBSERVATION: Monitoring Ligature Risk (Care in a Safe Setting)	At Junction City, it was noted that two patients had checked out items considered to be ligatures (TED hose and an ankle brace). Per nursing leadership, staff are responsible for monitoring these patients 3 times an hour to ensure the items accounted for. During observations, it was noted that the MHT rounded on the patient with an ankle brace but did not open his closed door and lay eyes on the ankle brace. The patients legs were covered by blankets so it wasn't possible to observe the brace without interacting with the patient. At both campuses, there's an inconsistent process for provider orders, purchase, and risk identification for items brought onto units. The organization is currently not in compliance with the published PRA (Product Risk Assessment) process and there's evidence of staff purchasing items and bringing into the organization without using documented policies/procedures. This has posed patient safety concerns and needs to be addressed.	Review the process for these ligature/environmental checks to determine if the current process is effective in managing patient safety concerns. Review policy/protocols and ensure staff are aware of expectations. Monitor for compliance. Review process for ensuring any item that enters a patient care area has been properly vetted.	Pending						
70		OBSERVATION: Incident Management after Unwanted Touching (Care in a Safe Setting)	During record review, it was noted that a 32 year old male had been inappropriately touched in a sexual manner on 10/3 by a female patient on the same unit. There was a very robust note in the record about this. A note by the psychiatrist on 10/4 at 0600 indicated that both patients were found together in the activity room. When psychiatry interviewed the male patient, he indicated he felt he had been victimized but declined to press charges against the patient. At 1600 on 10/4, the male patient was moved to another unit as a protection intervention. It was unclear by documentation or during interview why it took almost 24 hours to re-house either patient. One staff (care plan treatment specialist) indicated it was likely due to the female patient being a known aggressor and would likely do the same thing to another patient if she were moved. The following day the female patient was transported to Salem campus to an all female unit.	It's felt this was more of a documentation issue, rather than intervention, howevr, there needs to be documented action to ensure we are protecting patients from further unwanted assaults/actions or being placed in compromising position. Review policy/procedures for these types of incidents and educate staff to expectations for protecting patients and documenting interventions.	Pending						
71		OBSERVATION: Admission Patient Rights Paper Documents	Upon admission, staff will sign that a patient was unable to sign forms. There is no process for forms to be reviewed once the patient is stable and able to do so. Also, if the patient signs, it is not clear if the form is reviewed with the patient since no staff signature was found.	A form revision is recommended to state the form was reviewed with the patient by the staff member who signs the form. The reason for patient non-signature should be noted. A process should be implemented for a patient review post admission if the patient was "unable to sign" versus "refused to sign".	Pending						

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72		OBSERVATION: Important Message from Medicare	An Important Message from Medicare (IM), must be provided to the patient within 2 days of admission. The IM is to be signed and dated by the patient to acknowledge receipt. Furthermore, 42 CFR 405.1205(c) requires that hospitals present a copy of the signed IM in advance of the patient's discharge, but not more than two calendar days before the patient's discharge.	No clear process exists for providing the IM to patients, and there is minimal compliance described with presenting a copy in advance of discharge. Along with the recommended review and updating of the UR plan, with clear elements required for UR, it is recommended to include the IM requirement and monitor for compliance.	Pending						This was moved from UR to Patient Rights.
73		OBSERVATION: Patient Medical Products Authorization	The medical product review committee has a backlog of 129 products. Multiple committees have to approve of medical supplies/devices ordered by a physician and by the time of approval, the patient has developed additional medical problems or has been discharged. This would be considered a patient rights violation and patient neglect.	Specific patient medical devices should be ordered and assessed by the clinical team for any necessary mitigation prior to patient use. Individual items do not need to be a committee driven activity. New products to be stocked can go through a committee vetting process.	Pending						
74		OBSERVATION: Missing Provider Orders (Care in a Safe Setting)	On 10/19, a patient at the Junction City campus experienced a choking episode, requiring the Heimlich maneuver to be performed. On the same day, a provider noted in their progress notes the patient should be on a modified diet order and would order a swallow evaluation. The modified diet order wasn't placed until 2 days later when the nutritionist read the provider progress notes. The provider failed to update the order and nursing staff failed to notify the provider or request an order be placed for the modification.	There needs to be coordination of care to ensure that patient's needs are being addressed timely. While the provider failed to modify the order, nursing staff should have escalated a concern about the patient's current dietary modification/monitoring to the provider to ensure the patient was safe.	Pending						
75		OBSERVATION: CMS 2567-Code Blue Events	-Code Blue event occurred on 10/5/24, but there was no "Code Blue Flowsheet" found in the patient's medical record. -Code Blue Review Form for the above-mentioned patient's event did not include indication and response to the omission in the medical record of the "Code Blue Flowsheet". -Code Blue progress note template that was part of the hospital's plan of correction was not used by nurses to document, per the new process, after three Code Blue events that were reviewed. RN documented in progress notes for these events, but didn't use the template and not all the information from the template was included in the three progress notes. -The plan of correction required the team to debrief on Code Blue events at the following morning interdisciplinary morning report, but for the three Code Blue events reviewed, there was no indication that a debrief had been conducted.	Write POC - see Code Blue Recommendations	Pending						
76		OBSERVATION: Patient Rights Forms Upon Admission	Patients do not always sign all patient rights forms at the time of admission. There is no process to review the forms with the patient post admission. The staff do not sign as a witness when the patient signs which gives the impression that the forms were not explained to the patient.	Develop process to ensure the patient rights forms are signed.	Pending						
77		**PHARMACEUTICAL SERVICES/MEDICATION MANAGEMENT**				11/20/24		01/31/25			
78		OBSERVATION: Medication Variances	There are a considerable amount of medication variances for OSH. As of September 2024, there have been 757 medication variances with 60 reaching the level of high alert or wrong medication/wrong patient. There have been 112 identified medication diversions, 71 medication errors, and 245 medications found outside of the medication room.	While P&T does review this data, there doesn't appear to be strong system-level improvement efforts to identify root causes or identify sustainable solutions. There's no current performance improvement initiatives around these medication variances. Recommend working on long-term solutions system wide to address these issues including assigning appropriate accountabilities and identifying root causes.	In Progress	11/20/24		01/31/25	Kevin Haley	Kim Wilson	11/20/24: Initial meeting with Kevin and Amber from pharmacy services and Katie from nursing.
79		OBSERVATION: Medication Administration	The Medication Variance Committee continues to review reports of patients receiving the wrong medications. For example, a full morning medication pass being given to the wrong patient is becoming a more frequent issue. Concerns that following best practices for safe administration, including using two patient identifiers, is not part of the culture. - A unit RN was questioned regarding medication administration outside of the medication room. He stated, "two staff, me and one other." He indicated scanning the medication and the bar code on the patient's picture in the medication room and then finding the patient for administration. The RN did not indicate name, date of birth, or taking picture to validate.	Recommend action to be taken regarding training/re-training and accountability related to the Medication Administration protocol requirements. Monitor for compliance.	In Progress	11/20/24		01/31/25	CHRISTI SCHOENBORN, Nikki Mobley	Kim Wilson	11/20/24: Initial meeting with Kevin and Amber from pharmacy services and Katie from nursing.
80		OBSERVATION: Adverse Medication Events and Medication Errors	Adverse medication events are believed to be underreported and are not traditionally reported, but rather identified in roundabout ways, picking up on possible events in discussions, in meetings, etc. versus reported by unit staff. Medication errors are not reported via the incident reporting system, but rather are supposed to be reported by filling out a form from the 'I' drive and emailing to a specific email inbox. (Medication Errors protocol).	Re-evaluate current medication error reporting protocol/process to determine opportunity for aligning to incident reporting system in order to minimize separate event reporting workflows. Educate patient care staff on what constitutes an adverse medication event. Reinforce the process (current or revised, if changed) and monitor for compliance.	Pending	11/20/24		01/31/25	Dr. Sara Walker, Kevin Haley	Kim Wilson	
81		OBSERVATION: Medication Order Entry	A custom form was built in Avatar that is a blank template that only includes the required medication order elements. Meds are free entered by the ordering provider, not selected from a formulary drop down formulary for providers to select from. This process works at Junction City where there is a lower census, patient acuity, order volume. Formulary available in spreadsheet on the OWL which is inefficient and not effective in preventing errors. There are approximately 300 orders received every day at Salem, resulting in an estimated 25 hours a day of Pharmacists reviewing and transcribing the orders. This practice is not logical and is preventing pharmacy from being involved in a multitude of other clinical pharmacy initiatives (medication errors, investigating diversions, reviewing medication regimens, medication reconciliation, etc.)	Implement CPOE that includes selection of medications on formulary that is available in the medical record. Monitor for compliance. This should be a top priority for safety within the organization.	In Progress	11/20/24		01/31/25	Dr. Bell, Kevin Haley	Kim Wilson	12/5 - Initial meetings held with both pharmacy and IT. Will work towards resolution on this soon.
82		OBSERVATION: Medication Regimen and Expiring Medication Orders	Medication regimen review is primarily driven by Pharmacy and is a reactive versus proactive process. Clinical pharmacists spend hours every week running reports and reviewing expiring medications. Pharmacy delivers a med rec form to the ordering provider, form is signed and scanned back to Pharmacy	Consider developing a structured process for medication regimen review, including monitoring medication order expiration dates, that includes the IDT and is provider driven.	Pending	11/20/24		01/31/25		Kim Wilson	
83		OBSERVATION: Therapeutic Duplication	Several examples identified during record reviews of randomly selected patient records across multiple units: 1. Patient 1-orders for Klonopin 0.25mg po QD PRN anxiety, Benadryl 50mg po Q6H PRN sleep/anxiety, and Vistaril 50mg po Q6H PRN for moderate anxiety. Patient received all three PRN medications regularly the week of 10/21/24 and often administered at the same time. 2. Patient 2-orders for Klonopin 1mg po Q6H PRN anxiety/panic attack and Benadryl 50mg po Q6H PRN anxiety. 3. Patient 3-orders for Propranolol 40mg po QD PRN tremor/anxiety, Cogentin 1mg po QD PRN EPS symptoms, and Klonopin 1mg po Q8H PRN severe anxiety. Tremors are an EPS symptom, so patient could receive Propranolol or Cogentin without clear directions in the orders, and Propranolol order is not clear on giving for mild/mod/severe anxiety with the Klonopin specifying severe anxiety. 4. Patient 4-orders for Haldol 10mg po QD PRN psychosis and Haldol 5 mg po QD PRN for psychosis with no other administration directions, such as to give together, to give each for a different level of psychosis, etc. Patient also has Neurontin 100mg po Q6H PRN for anxiety association with pain and Ativan 2mg po Q6H PRN for severe anxiety, resulting in no clear instructions for if Neurontin is intended to be given for mild, mod or severe anxiety in addition to the Ativan. 5. Patient 5-orders for Klonopin 1mg po Q6H PRN for anxiety and Vistaril 50mg po Q6H PRN mild/moderate anxiety, resulting in no clear instructions for when to give one versus the other.	Using different indication wording such as 'anxiety' for one medication and 'sleep/anxiety' for another medication ordered for the same patient does not clearly direct nursing which medication to select if the patient is exhibiting anxiety. While there is a Pharmacy process in place to review each medication order that is place, opportunities exist to 1) ensure that a patient's collective PRN orders and any new orders are reviewed to determine duplication is avoided and 2) for physicians to provide clear direction for PRN medications, such as "give before 'x', 'give first', '1st line', '2nd line'. Recommend collaboration between Pharmacy, Medical Staff, and Nursing to ensure that medication orders are clear and accurate for all members of the patient care team involved in medication management. In scenarios where the intent in ordering multiple medications for anxiety, tremors, psychosis, etc. is that medications be administered together and the organizations policy allows for these orders, the pharmacy preparing the medication and the staff administering the medication need to have clear guidance provided. Monitor for compliance.	Pending	11/20/24		01/31/25		Kim Wilson	
84		OBSERVATION: Security Involvement in Missing Meds	Security has initiated a tracking process of unsecured medications and taken ownership of this initiative. Security has, in general, no jurisdiction over medications within a hospital. Pharmacy and nursing owns the distribution, storage and administration of medications.	This policy/procedure needs to be reviewed to determine the best process going forward and identify a root cause for the issue.	Pending					Kim Wilson	
85		**FOOD AND DIETETIC SERVICES**				11/20/24		01/28/25			

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86		**Overall Safety: Kitchen**			In Progress	11/20/24		01/28/25	Karen Jamieson	asmedley@chartis.com	11/20. Initial meeting with Kent Hunter to discuss the high and moderate risk findings.
87		OBSERVATION: Sharps Storage	Kirkbride: sharp utensil storage case in dry storage room was not following established procedures. Some removed items did not have the staff tag hanging in the utensil spot	Recommend reinforcement and monitoring the established process.	In Progress	11/20/24		01/28/25	Karen Jamieson, Tom Anhalt	asmedley@chartis.com	Need to verify with Food and Nutrition Services that the sharps policy is being followed prior to patient's returning to work in the kitchen. The sharps PI project is underway related to the November RCA.
88		OBSERVATION: Slip Hazard-Water on Floor	Springs kitchen: Oven with workorder placed on 10/17 was observed on 10/23 to still be emitting steam from the top (as per work order) and to be leaking water from the front onto the floor and puddling.	Recommend that a wet floor sign is used when water is present on floor; consider using a container to catch water if needed, until the work order is completed and that work order is completed as soon as possible to eliminate the slip hazard.	Pending	11/20/24		01/28/25	Karen Jamieson	asmedley@chartis.com	
89		**Food Temperature Log Accuracy**									
90		OBSERVATION: Temperature Log Checks	The Main Kitchen Temperature Log was missing all temperatures for October 7, 2024, for the entire day. Springs kitchen: Red Book of logs had missing checks for at least one or more days for every log that was present. Valley Cafe Temp Logs - Junction City Campus: Multiple missing refrigerator logs for 10/3, 10/8, 10/16. There were also multiple entries that were out of range without documented actions. The kitchen manager acknowledged he had not followed-up yet with staff about the missing entries and temperature excursions. There was also an area for staff to initial who had completed the temperature checks and approximately 75% of these area on the form was blank. Nursing Station (Mountain 1) - Junction City - Patient nourishment refrigerator with multiple missing dates showing temperature audits.	Continue educating staff on the importance of documenting refrigeration and freezer temperatures. Monitor for compliance. Reinforce the "Red Book" logging in Springs. Every other kitchen appears to be completing logs consistently. Monitor for compliance.	Pending				Karen Jamieson	asmedley@chartis.com	
91		**PHYSICAL ENVIRONMENT/LIFE SAFETY/EMERGENCY MANAGEMENT**				11/19/24		01/31/25			
92		**Environment of Care**	High Level Recommendations for EOC	Overall recommendations for management of the physical environment are: -Coordination of Stewardship of the Environment / Staff Roles & Responsibilities – the environment "lives" at point of care/service – it's the finders versus fixers dynamic -Integration of Physical Environment into mainstream operations (this has started, but there are additional opportunities), particularly when there are plans to change how the environment is to be used -Risk Assessment / QAPI – this is the sustainability quotient, if you will – more effective management of data coming out of the physical environment will help the hospital make better decisions.	In Progress	11/19/24		01/31/25	Chris Stewart, Karen Jamieson		11/20/24: Overview meeting with Chris, Joe, Seth, and Steve Mac. All high and moderate risk findings were discussed.
93		**Fire Safety Management**				11/20/24		01/31/25	Joe McQuillin, Karen Jamieson		
94		**Fire Response Plan**				11/20/24		01/31/25			
95		**OBSERVATION: Implementation of Fire Response Plan, including planning for, and drilling of, evacuation of SRTF units, in accordance with Oregon licensing statute(s). The elements of the program were submitted as part of a plan of correction to the state.**	**The inclusion of provisions for, and the testing of, evacuation is outlined in the Oregon Administrative Rules, Division 35, which covers Residential Treatment Facilities and Residential Treatment Homes for Adults With Mental Health Disorders, Section 309-035-0145 Safety.**	**It is recommended that the updating of Fire Response Plan be completed as soon as possible and the implementation of the program of evacuation for the SRTF units be expedited to ensure not only compliance, but the safety of the patients being provided care, treatment and services. 12/6: Initial drill has been completed.**	**Complete**	**11/20/24**		**01/31/25**	**Joe McQuillin, Karen Jamieson**		**1st drill done last week (week of 11/10)**
96		**Minimization of Fire Risks**				11/20/24		01/31/25			
97		OBSERVATION: In the Salem lab break room, there is an appliance (panini press) for which cooking oil is being applied to the surface. There is no K-Type fire extinguisher located in the space. Also, there are several other heat producing appliances (toaster oven, pressure cooker, crock pots) that can be left on and unattended - there is no smoke detector in the room.	Cooking appliances, particularly those that use oil as a cooking medium, require additional protections because of the potential for fire/smoke events that are not immediately discernible or could overwhelm a space before it can be extinguished. As a point of information, some municipalities require the use of a commercial-grade ventilation system for appliances that use oil as a cooking medium.	If the panini press continues to be used, it is recommended that a K-Type fire extinguisher (designed for the extinguishment of grease/oil fires) be installed in the area. Also, it is recommended that a smoke detector (either a battery-powered single-station or one wired into the fire alarm system) be installed to ensure appropriate notification in the event of a fire / smoke event. Finally, it is recommended that the organization consult with their property insurer to determine if this represents a condition that the insurer would decline to cover in the event of damage, etc.	Pending	11/20/24		01/31/25			
98		**Life Safety Systems Inspection, Testing & Maintenance**				11/20/24		01/31/25			
99		**Sprinkler Systems Components**				11/20/24		01/31/25			
100		OBSERVATION: The 5-year standpipe test for the Junction City campus was due in July 2024.	The inspection, testing & maintenance (ITM) vendor did not facilitate the completion of the 5-year standpipe test for the Junction City campus.	It is recommended that the organization establish a clear process for closing out any ITM activities, including a meeting with facilities leadership to review the results, particularly any deficiencies identified during the activity, thus ensuring that all required activities are performed per applicable frequencies, etc.	Pending	11/20/24		01/31/25			
101		OBSERVATION: Section 3 of the Junction City NFPA 25 summary report was not completed	The inspection, testing & maintenance (ITM) vendor did not facilitate the completion of the NFPA 25 summary report.	It is recommended that the organization establish a clear process for closing out any ITM activities, including a meeting with facilities leadership to review the results, particularly any deficiencies identified during the activity, thus ensuring that all required activities are performed per applicable frequencies, etc.	Pending						
102		**Kitchen Fire Suppression System**				11/20/24		01/31/25			
103		OBSERVATION: No documentation of monthly owners inspection of kitchen fire suppression systems equipment per NFPA 17 at each site.	There was no documentation to validate that fire suppression system in the kitchen is undergoing monthly inspections as required by NFPA 17-2009 11.2 / NFPA 17A 2009 7.2. At a minimum, this inspection includes verification of the following: a) the extinguishing system is in its proper location; b) the manual actuators are unobstructed; c) the tamper indicators and seals are intact d)the maintenance tag or certificate is in place; e) no obvious physical damage or condition exists that might prevent operation; f) the pressure gauge(s), if provided, is in operable range; g) the nozzle blow-off caps are intact and undamaged; h) the hood, duct, and protected cooking appliances have not been replaced, modified, or relocated;	It is recommended that the inspection process as outlined be implemented; typically, this activity can be performed during the monthly kitchen fire extinguisher inspection process.	Pending	11/20/24		01/31/25			
104		OBSERVATION: Issues identified during semi-annual inspection of system - closing loop on corrective actions / timeframe	From a practical standpoint, to be in strict compliance with the CMS "rules" regarding corrective actions, any corrective actions that are not completed within 60 days of the identification of the deficiency would be considered non-compliant relative to the timeframe for completion.	It is recommended that the organization establish a clear process for closing out any ITM activities, including a meeting with facilities leadership to review the results, particularly any deficiencies identified during the activity, thus ensuring that all required activities are performed per applicable frequencies, etc.	Pending	11/20/24		01/31/25			
105		**Fire Extinguishers (monthly)**				11/20/24		01/31/25			

	Priority	Title/Finding	Description/Plan	Discussion/Recommendation	Status	Start Date	Next Update	End Date	Hospital Oversight	Chartis Oversight	Comments
106		OBSERVATION: Documentation does not clearly demonstrate that each fire extinguisher in the facility is being inspected on a monthly basis. There is no evidence of an inventory list of fire extinguishers by location.	EC.02.03.05 EP 28 requires (among other things) an inventory of applicable devices; in the absence of an inventory (and a fair amount of variation from month to month when it comes to device counts), it is almost impossible to demonstrate that each device is being inspected.	The expectation of regulatory agencies is for the organization to be able to clearly demonstrate that each device is appropriately inspected. To that end, it is recommended that an inventory of devices, by location, be created to ensure each fire extinguisher is inspected and/or maintained in accordance with NFPA 10 Standard for Portable Fire Extinguishers	Pending	11/20/24		01/31/25			
107		**Fire Extinguishers (annual)**				11/20/24		01/31/25			
108		OBSERVATION: Documentation of annual fire extinguisher testing does not clearly demonstrate that each fire extinguisher in the Salem facility is being tested on an annual basis. Vendor documentation provides a vague accounting of variances of the total number of fie extinguishers tested with an indication that some are removed from service, but there is no specific accounting of the type, etc. of extinguishers removed from service.	EC.02.03.05 EP 28 requires (among other things) an inventory of applicable devices; in the absence of an inventory (and a fair amount of variation from year to year when it comes to device counts), it is almost impossible to demonstrate that each device is being inspected.	The expectation of regulatory agencies is for the organization to be able to clearly demonstrate that each device is appropriately inspected. To that end, it is recommended that an inventory of devices, by location, be created to ensure each fire extinguisher is inspected and/or maintained in accordance with NFPA 10 Standard for Portable Fire Extinguishers	Pending	11/20/24		01/31/25			
109		**Fire Drills**				11/20/24		01/31/25			
110		OBSERVATION: Fire drills are not consistently conducted in accordance with the scheduling requirements outlined by Joint Commission; quarterly fire drills on each shift must be performed every 3 months (+/- 10 days); for example, in the Trails Building, the swing shift fire drills were performed in February and April, and the overnight shift drills were performed in March, April & September.	Fire Drills must be scheduled and conducted in accordance with the Joint Commission's Interpretive Guidance related to the CMS requirements for fire drills. The details of the Interpretive Guidance can be found here: https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/physical-enviroment/opsig-2021-1-1.pdf	It is recommended that the organization create a schedule at the beginning of each year, in accordance with the information contained in the Joint Commission Interpretive Guidance, and adhere to that schedule once it is reviewed for compliance.	Pending	11/20/24		01/31/25			
111		**Medical Equipment Management**				11/20/24		01/31/25			
112		**Central Supply Acquisition**				11/20/24		01/31/25			
113		OBSERVATION: There's an unclear process for ordering outside medical equipment/supplies	Per policy 4.012, the medical clinic must use an open purchase order to obtain equipment. Presently, it appears that units are responsible for researching medical equipment and submitting RFPs to obtain the equipment, often by personnel who may not have the skillset required to obtain items that could pose a ligature risk to patients.	It's recommended that the process for medical equipment acquisition be reviewed to ensure patient safety elements are at the forefront of the process. Highly recommend moving to a "central supply" acquisition and distribution method as this is very standard across the nation and would standardize purchasing practice.	In Progress	11/20/24		01/31/25	Dr. Sara Walker		11/20: Discussed all high risk and moderate risk findings with facility staff although not the leads in this area.
114		**Laboratory Equipment**									
115		OBSERVATION: In the Lab, a filter for the analyzer water system indicates on the filter that is to be changed every 120 days, but the practice has been to change it every 6 months.	Any excursion from the manufacturer Instructions For Use (which includes labels on the product/device/equipment) must be supported by either a risk assessment that provides evidence of a commensurate level if safety, etc. or permission to do so from the manufacturer, preferably in writing.	It is recommended that the device manufacturer be contacted to close the loop on the appropriate cadence for filter replacement, etc.	Pending						
116		**Emergency Equipment**				11/20/24		01/31/25			
117		OBSERVATION: Emergency equipment log in Kirkbride Cafe dining area not completed on Oct. 7 & Oct. 10; there were similar gaps in emergency equipment logs throughout the organization.	Daily logs are expected to be completed at the prescribed frequency.	It is recommended that the process for the daily checks of emergency equipment be reviewed to ensure reliability and sustainability.	Pending	11/20/24		01/31/25			
118		**Low-Risk Medical Equipment**				11/20/24		01/31/25			
119		OBSERVATION: In the clinic area at Junction City, there was a lab analyzer in the soiled utility room that was past due for preventive maintenance.	All equipment is expected to maintained in accordance with manufacturer recommendations at the frequency prescribed by the organization.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24		01/31/25			
120		**Utility Systems Management**				11/20/24		01/31/25			
121		**Utility Systems Equipment**				11/20/24		01/31/25			
122		**Utility Systems Infection Control**				11/20/24		01/31/25			
123		**OBSERVATION: In a break room in the clinic area at Junction City, there was an ice machine that contained flammable/explosive refrigerant; the ice machine was not approved for use or otherwise inspected by the Facilities Department prior to initial use.**	**In general, appliances containing flammable or explosive components are not permitted in healthcare occupancies.**	**Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.**	**Complete**	**11/20/24**		**11/20/24**	**Chris Stewart, Karen Jamieson**	**Kim Wilson**	**Reviewed 11/20. The ice machine(s) was removed.**
124		OBSERVATION: Unused HVAC filters stored in CUP outside of original containers risking contamination	HVAC filters stored uncovered are at increased risk for contamination.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24		01/31/25			
125		OBSERVATION: In the Springs satellite kitchen, there were some drain lines going into a floor drain without an air gap.	Drain lines associated with food services-related equipment must have a minimum of a once-inch air gap between the drain line discharge and the floor drain.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24		01/31/25			
126		**HVAC Systems - Management of Environment**				11/20/24		01/31/25			
127		OBSERVATION: In the autoclave room servicing the dental clinic, there are clean and soiled processes being conducted in the space. The current airflow in the room appears not to be supportive of the separation of clean/soiled.	While the use of mixed process (clean / soiled) is generally discouraged, when circumstances dictate that design, etc. the airflow in the space should be from clean to soiled to limit the potential for cross-contamination.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24		01/31/25			
128		**Electrical Equipment**				11/20/24		01/31/25			
129		OBSERVATION: On the Lighthouse 1st floor break room, there were several appliances (coffee maker, toaster, popcorn maker) that were not in compliance with organizational standard for such devices.	The design and construction of electrical appliances are specified through the Facilities department.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24		01/31/25			
130		OBSERVATION: In the Lab & Pharmacy areas, there are power strips that are not hospital grade devices; also, some of these devices are located on the floor and on top of counter surfaces.	NFPA 70 / NFPA 99 outline the specifications regarding the types of arrangements in which power strips may be used; the OSH Facilities Department facilitates compliance with those specifications.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24					

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131		OBSERVATION: In the Junction City clinic area break room, there was a refrigerator and a microwave plugged into a power strip. Appliances are not permitted to use power strips as permanent wiring.	NFPA 70 / NFPA 99 outline the specifications regarding the types of arrangements in which power strips may be used; the OSH Facilities Department facilitates compliance with those specifications.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24					
132		OBSERVATION: In the soiled linen holding room by the loading dock, there was an unattended cart positioned directly in front of an electrical shutoff switch; the switch is labeled with sign indicating that it should not be blocked.	Electrical controls, including panels and switches, must be completely unobstructed at all times.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24					
133		OBSERVATION: In the satellite kitchens, materials and equipment are being stored in front of electrical panels. The area in front of electrical panels must be completely clear at all times.	Electrical controls, including panels and switches, must be completely unobstructed at all times.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24					
134		OBSERVATION: In the Bridges satellite kitchen, the electrical panel schedule (panel LP-NN-1E) did not reflect the status of the breakers contained in the panel; breakers #12 & #33 are labeled as "spare" and are in the "on" position.	The National Electric Code NFPA 70, as interpreted by various accreditation organizations, requires breakers to be appropriately labeled.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24					
135		**Elevator Equipment**									
136		OBSERVATION: Elevator equipment adjacent to loading dock - semiannual inspection documentation indicated a 7+ month period between inspections (February 2024 - September 2024); Oregon State code specifies a period of no greater than 6 months between inspections. This was noted in elevator machine rooms throughout the organization, including Junction City.	All scheduled inspection, testing & maintenance activities are expected to be performed at the cadence specified by the Authority Having Jurisdiction with the most strict requirements.	It is recommended that the organization contact the applicable vendor to solicit a plan for ensuring ongoing compliance with the state regulations.	Pending						
137		**Emergency Power Supply Inspection, Testing & Maintenance**				11/20/24		01/31/25			
138		OBSERVATION: At Junction City, the documentation of the testing of the Emergency Power Supply System equipment does not clearly indicate that the transfer switch for the fire pump is being tested each month as required.	NFPA 110 Standard for Emergency & Standby Power Supply Systems requires the testing of each automatic transfer switch on a monthly basis.	It is recommended that a process be implemented (including applicable) documentation) to test the fire pump transfer switch on a monthly basis.	Pending	11/20/24		01/31/25			
139		OBSERVATION: The weekly generator inspection documentation has a key for indicating whether or not issues are encountered during the inspection process; staff completing the documentation is not using the values outlined in the key.	There is an expectation that all documentation would be completed in accordance with the applicable internal and/or external standard of practice.	It is recommended that either the documentation process be modified to comply with the internal standard, or the documentation modified to reflect current practice.	Pending	11/20/24		01/31/25			
140		**Medical Gas & Vacuum Systems**				11/20/24					
141		OBSERVATION: In the main gas cylinder storage room, there were 5 "H" cylinders that were not secured in accordance with NFPA 99; NFPA 99 requires the cylinders to be individually secured.	NFPA 99-2012 requires compressed gas cylinders to be individually secured when stored or in use.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24					
142		OBSERVATION: In the main gas cylinder storage room, there is a quantity of combustible signage placed on the gate separating the medical gas manifold equipment from the cylinders stored for patient use. Due to the amount of positive pressure gases stored in this space, combustible materials must be located at least 5 feet away from the stored cylinders.	NFPA 99-2012 requires combustibles to be located at least 5 feet away from stored gas (20 feet if the space is not provided with automatic fire sprinkler protection).	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24					
143		OBSERVATION: In the Central Utility Plant at Junction City, there was an unsecured compressed gas cylinder.	NFPA 99-2012 requires compressed gas cylinders to be individually secured when stored or in use.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24					
144		OBSERVATION: In the Kitchen at Junction City, the carbon dioxide cylinders are stored in a group of 4; NFPA 99 requires such cylinders to be individually secured.	NFPA 99-2012 requires compressed gas cylinders to be individually secured when stored or in use.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24					
145		**Physical Environment**				11/20/24		01/31/25			
146		**Management of Physical Environment**				11/20/24		01/31/25			
147		OBSERVATION: Unauthorized Field Modifications / Introduction of Non-Approved Equipment, etc.	A common thread throughout this survey, as well as through recent organizational experiences, both internal and relative to other external reviews, is the presence of equipment, supplies, etc. that are being introduced into the environment (including the patient environment) without being reviewed or otherwise approved for use. Ongoing issues with the appropriate use of power strips, as well as the appropriate management of sharps are clear examples of the need for a robust process for the management of materials that could represent a danger to patients and/or staff.	Minimally, it is recommended that the use of any equipment, supplies, etc. be clearly reviewed and approved by the internal Authority Having Jurisdiction (manager, supervisor, etc.), including the replacement of items that have gone missing or were damaged, to ensure appropriate safety is maintained at all times.	Pending	11/20/24		01/31/25	Chris Stewart, Karen Jamieson		Reviewed 11/20 with facilities.
148		OBSERVATION: Coordination of Stewardship	The current level of focus on conditions in the physical environment, particularly as a function of the environment's impact on infection control and prevention, calls for a greater degree of coordination amongst the primary participants. While there is no specific dictate or requirement relating to the circumstances under which infection control risk assessments must be conducted or risk management strategies implemented, there is a clear charge to each healthcare organization to provide a safe environment for the delivery of care.	Based on the results of this survey, the proliferation of damaged wall and flooring surfaces, and other environmental "imperfections" would indicate that the current management of this process does not provide enough of a "safety net" to serve the organization and its mission of continuous survey readiness. At this point, the administration of the survey process is clearly aimed at the removal of the "final" barriers between "clinical" and "non-clinical" functions in hospitals. The survey process is based on a clear sense/ understanding that the entire hospital staff is engaged in patient care, regardless of their role in that care. The organization's that fare the best during survey are the organization's that have been able to grow the culture in a direction that results in a truly seamless management of the environment as the outer "ring" of the patient care continuum. Each staff member is a care giver; each staff member is a steward of the physical environment.	Pending	11/20/24		01/31/25			

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149		OBSERVATION: QAPI / Risk Assessment	The management of the physical environment is, at its heart, a performance improvement undertaking. As support for hardwiring ongoing sustained improvement, a process for the proactive risk assessment of conditions in the physical environment is essential. As an example, the "next" assessment would use the current slate of findings from this readiness visit to extrapolate the identification of additional risks in the physical environment. For all intents and purposes, it is impossible to provide a physical environment that is completely risk free, so the key focus becomes one of identification of risks, prioritizing the resolution of those risks that can be resolved (immediate and long-term), and to develop strategies for managing those risks that are going to require resource planning and allocation over an extended period of time. The goal of the process is to ensure that the organization can articulate the appropriate management of these risks - and to be able to provide data (occurrence reporting, etc.) to support the determination of that level of safety. By establishing a feedback loop for the management of risk allows the organization to fully integrate past actions into the improvement continuum.	While it is recognized that the organization has made, and continues to make, improvements over time, what is important is not to lose sight of the hardwiring of processes that are designed to sustain those improvements. The physical plant is traditionally not considered a revenue generating concern, but the impact of ongoing maintenance of the physical environment on the delivery of excellent patient care has never been scrutinized more closely. It is of critical importance to develop and implement strategies that allow for those tasked with maintaining the physical environment to focus on those tasks, utilizing point of care / point of service staff to the fullest extent in the identifying of "imperfections" in the environment.	Pending	11/20/24		01/31/25			
150		OBSERVATION: Staff Roles & Responsibilities	During the facility tours, there was a number of what would nominally be characterized as "blemishes", that while minor in nature individually, in the aggregate communicate a less-than-effective process for managing the environment. The published requirements for safety surveillance rounds are aimed at ensuring that there is an ongoing, effective process for managing the physical environment, with the intent of the standards being for all staff at point of care/point of service, to proactively manage those conditions. There is no expectation for front line staff to correct the conditions, but there is an expectation that deficiencies and opportunities will be communicated in a timely fashion to the appropriate parties for resolution.	As noted in this report, there were a number of conditions, particularly those relating to the management of environmental conditions in the patient care environments that could have, if the actual survey were to have occurred today, resulted in significant findings under the Physical Environment and Infection Control Conditions of Participation. It is of critical importance that the organization's resources be brought to bear in order to implement any necessary corrective measures to ensure patients are not put at risk without protection.	Pending	11/20/24		01/31/25			
151		**EOC Infection Control**				11/20/24		01/31/25			
152		**OBSERVATION: In a number of locations in the Loading Dock area, there were expired containers of sanitizing wipes. These were discarded when identified.**	**Products must be used in accordance with the manufacturer Instructions For Use, inclusive of expiration dates.**	**Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.**	**Complete**	**11/20/24**		**11/20/24**			**The wipes were discarded during the tour**
153		OBSERVATION: In the Lab area, a janitor closet has been converted to storage; most of the stored items appear to be clean and the room is under negative pressure to the adjacent space. Clean storage is to be under positive pressure in relation to adjacent spaces.	The FGI Guidelines for the Design & Construction of Health Care Facilities, through its adoption of ASHRAE 170 Standard for Healthcare Ventilation provides design specifications for various types of applications. Clean storage should be located in a space that is under positive pressure in relation to adjacent spaces.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24		01/31/25			
154		OBSERVATION: Tables and chairs stored in soiled linen holding room near loading dock; no clear process for ensuring appropriate separation of clean and soiled or for disinfecting the stored items before use.	In general, mixing of clean and soiled holding is discouraged unless there is a clear and sustainable process for ensuring that contaminated items in storage are cleaned before being returned to service.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending						
155		**Space Committee**				11/20/24		01/31/25			
156		OBSERVATION: Change of Use in Physical Environment	At present, there is minimal process for monitoring any change of use in the physical environment. There are various codes and regulations that must be considered when evaluating an change of use in a space. For example, converting spaces to storage must ensure that appropriate air pressure relationships are maintained, etc.	Many organizations have found the establishment of a space committee to review change of use requests to be an effective means of ensuring that the environment being changed is designed and/or configured to support the new use.	Pending	11/20/24		01/31/25			
157		**Emergency Management**				11/20/24		01/31/25			
158		Hazard Vulnerability Analysis				11/20/24		01/31/25			
159		OBSERVATION: Availability of Hazard Vulnerability Analysis (HVA) documentation	There were no copies of record HVA's immediately available for review/evaluation. This documentation was requested as part of the survey agenda provided to the organization.	It is recommended that all critical Emergency Management documentation (after-action reports, HVA, etc.) be maintained in a manner which facilitates the provision of said materials in real time to surveyors.	In Progress	11/20/24		01/31/25	Chris Stewart, Karen Jamieson		
160		Staff education / competencies				11/20/24		01/31/25			
161		OBSERVATION: Emergency Exercise Planning	Anecdotally, the organization tends to conduct emergency response exercises that relate to weather.	Ensure that the hospital conducts emergency response exercises based on the hospital's prioritized hazards based on the HVA.	Pending	11/20/24		01/31/25			
162		After-action reports / evaluations				11/20/24		01/31/25			
163		OBSERVATION: Availability of after-action reports / evaluations	There were no after-action reports or other emergency exercise documentation immediately available for review/evaluation. This documentation was requested as part of the survey agenda provided to the organization.	It is recommended that all critical Emergency Management documentation (after-action reports, HVA, etc.) be maintained in a manner which facilitates the provision of said materials in real time to surveyors.	Pending	11/20/24		01/31/25			
164		Emergency Response activations (actual / exercise)				11/20/24		01/31/25			
165		OBSERVATION: Compliance with applicable standards for the conduction of emergency response activations/exercises)	In the absence of after-action reports or other documentation of performance relative to emergency response activations / exercises, there is no evidence that the organization is in compliance with the applicable requirements for emergency management drills, etc.	It is recommended that all critical Emergency Management documentation (after-action reports, HVA, etc.) be maintained in a manner which facilitates the provision of said materials in real time to surveyors.	Pending	11/20/24		01/31/25			
166		Emergency Management Program				11/20/24		01/31/25			
167		OBSERVATION: Testing of Emergency Communications Equipment	Joint Commission requirement (EM.12.02.01 EP 6) outlines the requirements for the testing of alternative communications systems; there was no available evidence that these systems are being tested.	It is recommended that the testing of communications systems components be included in the program for response activation/exercise evaluations.	Pending	11/20/24		01/31/25			
168		OBSERVATION: Management of Volunteers	The provisions in the Emergency Management program for the management of volunteer practitioners appears to be in opposition with internal policy (OSH Policy 5.018) that indicates volunteers do not provide care to patients.	In general, CMS/TJC require the existence of a means of managing volunteer practitioners during an emergency (declining the use of volunteers during emergencies is not allowed), so it is recommended that internal policy OSH 5.018 be modified to provide a framework for the use of volunteer practitioners during an emergency.	Pending						
169		OBSERVATION: Identification of Patient Populations	Joint Commission requirement (EM.12.01.01 EP 2) outlines the requirement for the identification of at-risk patient populations that would be managed during an emergency. There was no available evidence that at-risk patient populations have been identified as a function of the emergency management program.	It is recommended that all critical Emergency Management documentation (after-action reports, HVA, etc.) be maintained in a manner which facilitates the provision of said materials in real time to surveyors.	Pending						
170		Regulatory Survey Etiquette									
171		OBSERVATION: Inaccurate / inappropriate survey findings	Making use of subject matter experts for to manage survey deficiencies in real time.	It is recommended that internal subject matter experts be identified to respond in real time to questions asked by surveyors that are not clearly "known" by the survey escorts. As a practical example, it is likely that there would have significantly fewer issues relative to medical equipment had a representative from Bio-Med been involved in the conversation with the surveyor as the surveyor was requesting evidence of activities for certain pieces of equipment (manual blood pressure cuffs, otoscopes) that are not indicated by the manufacturer IFUs.	Pending						
172		**Safety Management**				11/20/24		01/31/25			
173		**General Safety**				01/30/25		01/31/25			

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174		OBSERVATION: Storage of liquids	OBSERVATION: In a storage room on Anchors, there is a sign posted indicating that liquids are to be stored on bottom shelves per Joint Commission. There were liquids stored in this room that were not stored on a bottom shelf.	There is no specific regulatory requirement in this regard; it should be considered a good practice, but it is recommended that the sign be removed if compliance is not sustainable.	Pending	01/30/25		01/31/25			
175		**Risk Assessments**				01/30/25		01/31/25			
176		OBSERVATION: Protection of high-risk spaces	OBSERVATION: In Junction City, the door to the Welcome Center does not self-close and lock; Joint Commission requires areas in which there are harm risks to be protected by self-closing, self-securing doors.	It is recommended that the Welcome Center be equipped with a self-closing / self-securing door.	Pending	01/30/25		01/31/25			
177		**Patient Environmental Checks**				11/20/24		01/31/25			
178		OBSERVATION: Effectiveness of Environmental Checks	Inconsistent identification of risk conditions.	It is recommended that the patient environmental check process be evaluated as a function of the Environment of Care management program.	Pending	11/20/24		01/31/25			
179		**Policy - No food in patient rooms**				11/20/24		01/31/25			
180		OBSERVATION: Food found in patient rooms	During various rounding activities, instances of food being found in patient rooms in violation of policy.	It is recommended that the organization consider an FMEA relative to the "movement" of food by patients to their rooms.	Pending	11/20/24		01/31/25			
181		**Inventory Lists in Storage Rooms/Spaces**				11/20/24		01/31/25			
182		OBSERVATION: In a number of storage rooms throughout the organization, there are inventory lists, presumably of the stored contents. In general, these inventory lists are not dated.	While there is no dictate or regulation regarding the provision and/or management of inventory lists, when it comes to the management of materials that could pose a risk to patients, there is a value in being able to identify some sort of timeframe in which the inventory list was created.	It is recommended that the organization implement a process for managing inventories that includes the date of the inventory list's creation / revision and perhaps indicate an individual that could be contacted in the event there is a concern, etc.	Pending	11/20/24		01/31/25			
183		**Security Management**				11/20/24		01/31/25			
184		**Workplace Violence Program**				11/20/24		01/31/25			
185		OBSERVATION: Worksite Analysis	Annual worksite analysis related to the WPV program for 2023 does not include analysis of inpatient areas/units.	Ensure that the 2024 analysis is comprehensive and expands beyond evaluating risks in external areas, including analysis of inpatient areas/units.	Pending	11/20/24		01/31/25			
186		OBSERVATION: WPV incident review	Disconnect between the WPV committee and other leaders in how WPV events are reviewed. Some are reviewed by one group and others are reviewed by another group, resulting in a lack of insight into all WPV events by the WPV committee and ability to inform the WPV program, educational, etc. gaps..	Streamline safety event process, including WPV event review. Ensure WPV committee is aware of all events, including level 2 or 3 WPV events.	Pending	11/20/24		01/31/25			
187		OBSERVATION: WPV Prevention & Management	OSH has a commitment to health equity and anti-racism, but per interviews with front line staff, this commitment can feel hollow when racism is tolerated on the front lines (patient to staff (Type 2 WPV), patient to patient (Type 2 WPV), and even staff to staff (Type 3 WPV)). It was learned in senior leadership interviews that a DEI manager starting soon, with DEI team, and anti-racism training is planned.	Leadership has validated strongly that racism is not tolerated and understand this is an ongoing challenge. Will work with organization to manage incidents of racism and other equity concerns, provide training and support where needed (initial training planned), and create accountability for managing incidents according to organizational policy.	Pending	11/20/24		01/31/25			
188		**Hazardous Materials and Waste Management**				11/20/24		01/31/25			
189		**HazMat Safety**				11/20/24		01/31/25			
190		OBSERVATION: Sharps Container not secured	In the Medical Clinic, in a clean storage area, a sharps container with sharps was stored by a sink and could have easily been knocked over.	OSHA requires that Containers for disposable sharps must be closable (that is, have a lid, flap, door, or other means of closing the container), and they must be kept upright to keep the sharps and any liquids from spilling out of the container. Recommend securing sharps containers as needed.	Pending	11/20/24		01/31/25			
191		**Hazardous Materials Exposure Response**				11/20/24		01/31/25			
192		OBSERVATION: Understanding eyewash station use timeframe	Kitchen leaders were unable to speak to the need for eye flushing at eyewash stations for 15 or more minutes (depending on the information contained in the product Safety Data Sheet). OSHA refers to ANSI Z358.1-2014, eyewash stations must be connected to a supply of flushing fluid to produce the required spray pattern for a minimum period of 15 minutes, at 1.5 liters per minute (0.4 gallons per minute).	Recommend review of chemicals being used in the kitchen environment(s) to determine response to occupational exposures to eyes. Emergency eyewash equipment is required for occupational exposure to any chemicals identified as injurious (typically, caustic or corrosive materials) to eyes. Subsequent to evaluation of products, recommend leadership ensures staff education on kitchen safety, including the use of eyewash stations, particularly as it relates to the use of injurious chemical products. Consider adding a visual reminder to eyewash signs that are posted near each eyewash station.	Pending	11/20/24		01/31/25			
193		OBSERVATION: Main kitchen is using liquid bleach for laundering kitchen towels; the nearest available eyewash station requires navigating two doors, but may be more than 10 seconds of travel time.	The pouring of liquid bleach is a significant risk for occupational exposure to a corrosive / injurious material, which requires immediate (within 10 seconds of unimpeded travel) access to emergency eyewash equipment capable of providing at least 15 minutes of flushing fluid.	It is recommended that the chemical supplier be consulted to determine if there is an effective safe substitute for liquid bleach; if the liquid bleach cannot be replaced, then consider reconfiguring the laundry area to accommodate an emergency eyewash station.	Pending	11/20/24		01/31/25			
194		OBSERVATION: At Junction City, the caps for the eyewash station on the Kitchen EVS closet were not in place.	The caps on the eyewash station protect the eyewash from contamination, which could result in additional contamination of an individual's eyes.	Provide education to applicable staff; monitor for ongoing compliance.	Pending	11/20/24		01/31/25			
195		**Labeling of secondary containers**				11/20/24		11/20/24			
196		**OBSERVATION: In the Kirkbride Cafe kitchen area, there was an unlabeled squirt bottle containing a blue liquid. The bottle was removed from service during the survey.**	**The OSHA Hazard Communications standard requires that all secondary containers be labeled in accordance with the information contained on the original container. See for detail: https://www.osha.gov/Publications/OSHA3636.pdf**	**Provide education to applicable staff; monitor for ongoing compliance.**	**Complete**	**11/20/24**		**11/20/24**			
197		OBSERVATION: In the Central Utility Plant at Junction City, there was a pump sprayer with a pink-colored liquid with no secondary label.	The OSHA Hazard Communications standard requires that all secondary containers be labeled in accordance with the information contained on the original container. See for detail: https://www.osha.gov/Publications/OSHA3636.pdf	Provide education to applicable staff; monitor for ongoing compliance.	Pending						
198		**Life Safety Code Compliance**				11/19/24		01/31/25			
199		**Fire Rated Barriers**				11/20/24		01/31/25			
200		OBSERVATION: In several 1st floor Telecomm rooms, there were incompletely sealed vertical penetrations.	NFPA 101-2012 requires penetrations to be completely sealed in accordance with the requirements for a rated assembly as prescribed by the firestopping manufacturer.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24		01/31/25			
201		OBSERVATION: In the Telecomm room adjacent to the Lab / Pharmacy spaces, there were incompletely sealed vertical penetrations.	NFPA 101-2012 requires penetrations to be completely sealed in accordance with the requirements for a rated assembly as prescribed by the firestopping manufacturer.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24		01/31/25			
202		**Smoke Barriers**				11/20/24		01/31/25			
203		OBSERVATION: In the Lab, there is a network cable that has been run up through the suspended ceiling and back down again, resulting in gaps in the ceiling membrane.	NFPA 101-2012 requires ceiling membranes to be maintained in a manner that ensures they are resistant to the passage of smoke and/or heat.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24		01/31/25			

	Priority	Title/Finding	Description/Plan	Discussion/Recommendation	Status	Start Date	Next Update	End Date	Hospital Oversight	Chartis Oversight	Comments
204		OBSERVATION: At Junction City, there is a break area on the first floor that is open to the corridor; the space is not under direct supervision nor is it protected by an electrically supervised smoke detection system.	NFPA 101-2012 requires unsupervised spaces open to the corridor to be provided with automatic smoke detection.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24		01/31/25			
205		**Fire Alarm System**				11/20/24		01/31/25			
206		OBSERVATION: In a number of spaces, there were gaps around penetrations through suspended ceiling; ceiling membranes are to be maintained in manner that resists the passage of heat and/or smoke.	NFPA 101-2012 requires ceiling membranes to be maintained in a manner that ensures they are resistant to the passage of smoke and/or heat.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24		01/31/25			
207		**Fire Suppression System**				11/20/24		01/31/25			
208		OBSERVATION: In the Kirkbride Cafe kitchen area, the two section of the hood vent above the deep fryer were not properly in place; there were gaps at the top of the sections.	NFPA 96 stipulates the elements required to be appropriately maintained for kitchen fire suppression and ventilation systems equipment.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24		01/31/25			
209		OBSERVATION: In each of the satellite kitchens, materials and equipment are stored in front of the actuators for the fire suppression systems. This area in front of this equipment must be completely clear at all times.	NFPA 96 stipulates the elements required to be appropriately maintained for kitchen fire suppression and ventilation systems equipment.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24		01/31/25			
210		OBSERVATION: In several locations at the Junction City site, including the kitchen area, there were sprinkler heads with fibrous or other materials.	NFPA 13 & NFPA 25 prohibit the presence of any foreign materials on sprinkler heads, sprinkler piping or any other component of the automatic sprinkler system.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24		01/31/25			
211		OBSERVATION: In the automatic transfer switch gear room at Junction City, there was network cabling resting on sprinkler piping; also, there was a J-hook tie-wrapped to sprinkler pipe.	NFPA 13 & NFPA 25 prohibit the presence of any foreign materials on sprinkler heads, sprinkler piping or any other component of the automatic sprinkler system.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending	11/20/24		01/31/25			
212		OBSERVATION: In the soiled linen holding room near the loading dock, there was fibrous matter on several sprinkler heads.	NFPA 13 & NFPA 25 prohibit the presence of any foreign materials on sprinkler heads, sprinkler piping or any other component of the automatic sprinkler system.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending						
213		OBSERVATION: In the Environmental Services laundry processing area, there was a power cord draped against a sprinkler pipe.	NFPA 13 & NFPA 25 prohibit the presence of any foreign materials on sprinkler heads, sprinkler piping or any other component of the automatic sprinkler system.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending						
214		OBSERVATION: Inventory of spare sprinkler heads not posted in each location in which spare heads are stored per NFPA 25; this was noted in Salem and in Junction City.	NFPA 25 - 6.2.9.7.1* The (inventory) list shall include the following: (1) Sprinkler identification number (SIN) if equipped; or the manufacturer, model, orifice, deflector type, thermal sensitivity, and pressure rating; (2) General description; (3) Quantity of each sprinkler type contained in the cabinet; (4) Issue or revision date of the inventory list	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending						
215		OBSERVATION: In the main warehouse, there is a fire extinguisher cabinet that is installed above the height required under NFPA 10;	NFPA 10 requires the handle of the extinguisher to be no more than 60 inches above the finished floor; the handle for the extinguisher in question is approximately 62 inches above the floor.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending						
216		**OBSERVATION: In the main kitchen, there was a blow-off nozzle above the steam kettles that was not properly in place; this was corrected during the survey.**	**NFPA 96 stipulates the elements required to be appropriately maintained for kitchen fire suppression and ventilation systems equipment.**	**Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.**	**Complete**	**11/20/24**		**11/20/24**			
217		OBSERVATION: In the Kirkbride Cafe kitchen area, there was fibrous material on a sprinkler head; this was also noted in several locations in the main kitchen.	NFPA 13 & NFPA 25 prohibit the presence of any foreign materials on sprinkler heads, sprinkler piping or any other component of the automatic sprinkler system.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending						
218		OBSERVATION: In the main production kitchen, there were two sprinkler heads behind the steam kettles that appear to be corroded.	NFPA 13 & NFPA 25 prohibit the presence of any foreign materials on sprinkler heads, sprinkler piping or any other component of the automatic sprinkler system.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending						
219		**Statement of Conditions**									
220		OBSERVATION: The Facilities Building is not in strict compliance with the requirements of the Life Safety Code for a healthcare occupancy.	From a practical standpoint, it is best to limit the spaces that are "surveyable" by Joint Commission to the extent possible. At this point, only Healthcare & Ambulatory Healthcare occupancies are subject to survey by TJC.	Consider identifying the Facilities Building as a Business Occupancy, as well as any other areas in which patient care/services are not provided - upper floors of Kirkbride, warehouse/distribution kitchen, etc.	Pending						
221		**Integrity of Egress**				11/19/24		**11/19/24**			
222		OBSERVATION: In the main warehouse space, there are materials and equipment positioned such that a clear path of egress is not consistently maintained.	NFPA 101-2012 requires the maintenance of a clear path to exit doors at all times.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending						
223		OBSERVATION: In the dental procedure area of the clinic, there is an exit sign that does not provide direction to the path of egress.	Exit signs must be positioned and arranged to provide clear indication of the path of egress.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending						
224		**OBSERVATION: Egress from walk-in refrigerator/freezer assembly.**	**In reviewing the egress from the walk-in refrigerator / freezer assembly in the production kitchen by a fire protection engineer, it was determined that the current arrangement is in compliance with NFPA 101-2012 Life Safety Code**	**None needed.**	**Complete**	**11/19/24**	**11/19/24**	**11/19/24**			
225		**Hazardous Locations**									
226		OBSERVATION: In the Salem Clinic area, there is a storage room larger than 50 square feet in area that does not have a self-closing & latching door (the door closer has been removed).	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.		Pending						
227		**Barrier Doors**									
228		OBSERVATION: In the Kirkbride satellite kitchen the door to storage room C01-169 was being held open with an unauthorized holdback device; this was also noted in the main production kitchen. NFPA 80-2010 5.2.13.3 prohibits the blocking or wedging of doors in the open position.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.		Pending						
229		**Building Services**									
230		Shredder Bins									

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231		OBSERVATION: Confidential document collection bins with capacity greater than 32 gallons are located in areas that do not meet the requirements of NFPA 101-2012 Life Safety Code for containers of that volume.	Any containers greater than 32 gallons in capacity must be stored in a location that meets the requirements for a hazardous location as defined by the Life Safety Code.	Manage corrective actions through work order process; provide education to staff as applicable; monitor for ongoing compliance.	Pending						
232		**MEDICAL RECORDS**				12/03/24		01/31/25			
233		**Information Technology Services:**				12/03/24		01/31/25			
234		OBSERVATION: Change Management Process for EHR Changes	The current process for change management appears to be cumbersome and not conducive to effective change processes. At present, there are over 180 open tickets related to IT processes. If it's anticipated that the request will take <20 hours, it's kept at the local team level to complete. If it's anticipated the request will take >40 hours, it's pushed to CAG to determine a priority level. The new change request process map has over 75 process points, likely contributing to the inefficient processes. The Technology Change Request Prioritization Scorecard used by CAG ranks the change request with a possible 435 possible points, in addition to requiring a text descriptor and impact statement. This exercise of scoring the request appears extremely time consuming and is again, likely contributing to delays as these requests are dependent on CAG meeting.	Recommend a deep dive into the change management process to evaluate for simplification. Overall, there should be an EHR governance committee that evaluates the content of the EHR and approves revisions to content. However, the governance committee process should not be so difficult that it creates delays. Recommend reviewing the CAG process and determining if it's necessary or can be combined with another committee or eliminated.	In Progress	12/03/24		01/31/25	Karen Jamieson, kristy Bouchie	Kim Wilson	
235		OBSERVATION: EHR Upgrade	There are multiple issues within the organization that are attributed to an outdated version of Avatar. Currently, the update to avatar is slated for Quarter 1 of 2026. IT is currently under the impression Avatar will require a complete rebuild of new content when it's upgraded in 2026, which does seem unusual compared to how many modern EHR systems operate. Most EHR platforms are designed with backward compatibility and upgrade paths in mind. Typically, updates to these systems—whether they involve software, security, or features—are made in a way that doesn't disrupt or require a complete rebuild of patient records, workflows, or customizations that have been built into the system.	Would like to validate with the EHR vendor directly and discuss transition issues that may occur with the upgrade. If there are issues with adding content to the existing EHR platform, it's recommended OSH push to move to the newer version so address multiple findings/issues mentioned within this report - especially as it relates to pharmacy and nursing/provider documentation.	In Progress	12/03/24		01/31/25	Karen Jamieson, kristy Bouchie	Kim Wilson	
236		OBSERVATION: Utilization of Informatics Nurses	In general, clinical informatics (CI) nurses are used throughout organizations to help bridge the gap between clinical staff and IT staff. They generally help with building forms and providing insight in how best to use the EHR to it's fullest potential, keeping clinical workflows in mind. Currently, CI are being used to answer the help desk, manage the Avatar community, ensure staff can access Avatar, perform regression testing, and perform user acceptance testing. All of these tasks can be performed by someone other than a nurse. Currently, the builders in Avatar are non-clinical and require business resources to help them make decisions because they are unclear of clinical workflow, process, etc.	It's recommended that the role of the CI be restructured to allow them to function as a true informatics nurse. This would give them the ability to build as the current builders are not clinical. This could drastically help with the speed of building in Avatar and provide clinical consultation from the CI staff.	In Progress	12/03/24		01/31/25	Karen Jamieson, kristy Bouchie	Kim Wilson	
237		OBSERVATION: Two different versions of admission H&P	Reviewed patient admission H&P. Two different versions exist when looking at a completed H&P, and either can be printed from Avatar, depending on what is selected. For example, version one of the neurological cranial nerve assessment for the patient states "Negative: intact cranial nerves II-XII" and version two lists the specifics for each individual cranial nerve assessed by the provider.	Two different versions of the same H&P can be viewed and printed (in/from Avatar) and potentially provided to surveyors, for a medical record request, etc. Recommend reconciling this, especially since the nurse practitioner described only documenting once and at that, documenting the complete assessment version. 12.3 - Email Amanda the patient info for further review.	Pending	12/03/24		12/31/24	Karen Jamieson, kristy Bouchie	Kim Wilson	
238		OBSERVATION: HIPAA (Emailing patient inquiries and records)	In the medical clinics, there's no standardized process for staff on floors communicating or requesting for medical providers to assess a patient or provide consultation. As a workaround to Avatar, staff have developed distribution lists in Outlook and nurses are being asked to email patient information, including why they are requesting patient evaluation, to this email group. The clinic will then email back to the requesting nurse follow-up information. It's unclear if any of this information is recorded in the actual EHR. Additionally, the medical clinic could be replying to an email address of an agency staff who won't be back to the hospital for months (or ever) with instructions for follow-up. There are concerns with having all of this PHI in email and concerns with breakdown in process as a result of this workaround.	Evaluate why referrals can't be built into Avatar and discontinue the use of work emails as a means of discussing patient information and care coordination. Per IT 12/3, there's a solution in place for this but it's being held up due to a quarterly update. It's being built.....current ETA April 2025. Need to loop in Medical Records Services to understand the HIPAA issues and discontinue the use of distribution lists.	Pending						
239		OBSERVATION: Discrepancies in the medical record	While reviewing records of patients who had medical appointment outings in October, it was noted that discrepancies existed between times when patient was documented on the "Medical Trip Slips-Survey Readiness" log sheet as being out of the hospital and times when nursing progress or treatment plan notes indicated the patient was present: -Patient 1 had an outing 10/3 from 1230 to 1430, according to the trip slips log. Treatment plan note on 10/3 at 1420, when patient was off the unit/out of building, stated "no, declined" for client participation in the plan discussion and again on at least page 2 of 8, it was documented that the patient "chose not to participate" in the plan discussion. -Patient 2 had an outing 10/2 1500 to 2100 per trip slips log. RN progress note on this day (10/2) is timed for 2030 and mentions patient's appointment and patient's state after returning, but according to the log time, the patient was still off the unit for another 30 minutes. -Patient 3 had an outing 10/2 0645 to 1045 per trip slips log. RN progress note was documented at 1021, while patient was supposed to still be at the appointment, and there was no mention of the appointment. -Patient 4 had an outing 10/3 0745 to 0945 per trip slips log. RN progress note was documented at 0910, while patient was supposed to still be at the appointment.	Ensure patient movement to and from the hospital is accurately being reflected on the trip slips log times. Nursing progress notes that include patient assessment details should not be timed for when the patient is not present on the unit, should be documented in real-time, or should indicate that the details were assessed earlier in the shift when patient was present, if nurses are documenting later. Treatment plan notes should be documented in real-time to accurately reflect patient's participation or declination versus potentially indicating a discussion that took place without the patient.	Pending						
240		OBSERVATION: Incomplete medical records	In review of 7 of 10 records of patients who had medical appointment outings during October, there was no mention in the nursing progress notes about the patient's outing or behavior/physical state before or after the patient returned.	Records should be complete and include details such as patients' activities, including leaving the unit/hospital for appointments.	Pending						
241		OBSERVATION: HIPAA (Medical records in open view)	In the medical clinic at Junction City, there were numerous patient order forms sitting out on the counter of the medical clinic office in open view. Some were surgical orders, physical therapy orders, etc. Staff indicated the orders were there because they hadn't had time to take them up to the floors to place in the medical records	Remind staff about HIPAA regulations and protecting patient information.	Pending						
242		OBSERVATION: Access to Medical Records (timely)	In the medical clinic at Junction City, there were numerous patient order forms sitting out on the counter of the medical clinic office in open view. Some were surgical orders, physical therapy orders, etc. Staff indicated the orders were there because they hadn't had time to take them up to the floors to place in the medical records. Per CMS, all information, including practitioners orders, must be available in the medical record to provide appropriate care.	Determine the process for ensuring all paper orders and placed in the paper medical record at the time they are written or soon thereafter.	Pending						
243		OBSERVATION: Verbal Orders	As of 10/30, there are currently 206 verbal orders that have not been authenticated by a provider. Some of these orders date back to 11/2023 and many are several months old. Currently, medical records does not audit or track verbal orders unless it's within the first 10 days of admit or at discharge. Per medical records manager, they have recently developed a process to "void" old orders that haven't been signed. It's unclear what this process looks like and if new orders are received. Additionally, medical records doesn't currently have access to any report that would show them a list of verbal orders that are unsigned.	Recommend reviewing the process for validating verbal orders and capturing co-signature. Ensure medical records staff have access to necessary reports in medical record. This has been an ongoing finding with CMS/TJC.	Pending						
244		OBSERVATION: Access to medical records upon request	Requested access to a list of patients who had been transferred to Salem hospital for any medical procedures, ED visits, etc. for the past month on 10/29.	Records should be readily available upon request and shouldn't take 24+ hours to receive. There should be reports built or logs in place that track patients leaving the building to transfer to the hospital. This is a common request during survey and something the hospital should be able to produce on demand.	Pending						

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245		OBSERVATION: Medical Records Legibility & Authentication	All entries in the medical record must be legible. Orders, progress notes, nursing notes, or other entries in the medical record that are not legible may be misread or misinterpreted and may lead to medical errors or other adverse patient events. There's currently no audits, evaluation of legibility, or evaluation of completeness (date/time/author authentication) occuring with the exception of admission and discharge documentation.	There needs to be a process to ensure all entries in the medical record are legible and date/timed and authenticated. There needs to be a process to flag entries with missing elements (dates/times, etc.) and flag legibility issues for correction.	Pending						
246		RECOMMENDATION: Printing Labs	Labs are currently being printed and placed in physician bins on nursing units so that providers can "authenticate" the lab results. Medical records was under the impression this was a regulatory requirement.	It's recommended this practice be reviewed to determine why staff feel they need to print labs. If there's no valid reason, it's recommended this practice stop.	Pending						
247		**QAPI CHAPTER**				11/21/24		01/31/25			
248		*OBSERVATION: QAPI Program*	*Current QAPI and quality improvement plans are challenging to assess. There was no evaluation of the 2023 QAPI Plan nor evidence of the approval by the governing body (OHA Director) of the 2024 QAPI Plan. A key indicator inventory of the organizational and departmental measures was provided but is lacking inclusion from all services (i.e. staffing, supply chain, operations, etc.). A 2023 "Fundamentals Map" of strategies, outcomes (and measures), and processes (and measures) was provided. The governing body (OHA Director) does not formally approve the Fundamentals Map / priorities. Leadership has begun to give quarterly performance reports to the OHA Director. Executive meeting minutes capturing the challenges and leadership responses to these challenges were not available.*	*Recommendations:* *-Organizational Leadership should establish key indicators that are clear, measurable goals and enhance data collection methods for accurate performance monitoring.* *-Develop a key indicator inventory list that represents quality and safety indicators that reflect the care provided organizationally and across all departments. Key indicator list could begin with mandatory measures outlined by State, CMS, and/or TJC.* *-Regular monitoring of key indicator progress will facilitate timely adjustments while balancing short-term and long-term goals, ensuring sustainability.* *-Implement action meeting minutes for the Exec Team and/or Performance System Steering Committee to ensure a record of the critical outcomes of the meetings, including the actions taken and responsibilities assigned.* *- To address the challenges of the current quality improvement plan, engaging stakeholders, including staff and patients, is crucial for fostering collaboration and buy-in. The plan should be flexible to adapt to feedback and changing circumstances, supported by a robust communication strategy. Adequate resources must be allocated, and staff training on quality improvement methodologies should be provided. Finally, fostering a culture that embraces change can enhance the effectiveness of improvement efforts.* *-Organizational priorities, goals, and metrics should cascade to accountable committees (who are empowered to set strategy and initiate work for key priorities) and to accountable clinical teams (PETs and Unit teams), with regular monitoring and good executive visibility into committee and team progress against goals.*	*In Progress*	*11/21/24*	*12/12/24*	*01/09/25*	*Aisha Krebs*	*Ann Smedley*	*Initial meeting 11/21/24: Aisha, Nate, Bob. Discussion regarding how to implement a hospital-wide data driven quality program that does not "step on" departments that are not currently a part of the quality program. The executive team's core function is to manage the quality continuum across the hospital. The RCA management and process needs overhaul, historically too detailed and cumbersome.* *Discussion regarding indicators and PI projects. Lack of fidelity to hospital processes, committees, leadership meetings.* *Proactive changes are uncomfortable and will be vital through change management. 12/4/24 - meeting with the QAPI Team regarding the quality department functions, the model QAPI Plan, Indicators and projects for 2025.*
249		OBSERVATION: RCA Process and ACA Processes	The process for significant event review and analysis is cumbersome and overly redundant.	-Review current process to identify where revisions should be made. -Identify differences between RCA and ACA and when each should be used for specific events. -Review RCA and ACA process to identify where changes are needed to increase depth and output. -Educate Risk/Quality/Compliance and Leadership Staff on new methodologies.	In Progress	11/21/24		01/31/25	Aisha Krebs, Rodney Wolverton	asmedley@chartis.com	Initial meeting 11/21/24: Dr. Duran, Fletcher, Rebecca, Pamela. Questions regarding the scope of work and detailed analysis. Guardrails needed around contributory causes. A review of current RCA with recommendations to summarize key findings versus all details imbedded in the report. 12/4 - Additional feedback was provided to Dr. Duran and Fletcher regarding the current sharps RCA report.
250		Performance Improvement									
251		*OBSERVATION: Focusing Analysis on Patient Safety Issues and Sustainable Actions*	*Projects are not always focused on patient safety and sustainability, and sometimes projects are informally initiated outside of a formal process.*	*Review current incidents (and output from prior 6 month review) and review prior indicator monitoring outcomes and incorporate pertinent indicators and/or outliers from previous monitoring plans to ensure focus remains on patient safety and sustainability*	*In Progress*	*01/08/25*	*12/12/24*	*01/08/25*	*Aisha Krebs, Nate Gillard*	*asmedley@chartis.com*	*Ongoing iterations continue during incident management meetings to improve the process. 12/4 - meeting with the QAPI Team regarding the quality department functions, the model QAPI Plan, Indicators and projects for 2025.*
252		*OBSERVATION: Prioritizing Improvement Issues to Remediate Patient Safety Vulnerabilities*	*Performance Improvement projects are not all based on facility performance or incorporated into the QAPI plan.*	*QAPI program should be revised to focus on facility performance on multiple levels (i.e., trends in adverse events, facility specific indicators monitored, issues arising from monitoring).* *PI projects to be selected analysis of IR trends, themes and categories of significant events will be included in PI project selection in tandem with routine indicator outcome data.*	*In Progress*	*12/04/24*	*12/12/24*	*01/09/25*	*Aisha Krebs, Nate Gillard*	*asmedley@chartis.com*	*12/4 - meeting with the QAPI Team regarding the quality department functions, the model QAPI Plan, Indicators and projects for 2025..*
253		*OBSERVATION: Data and Dashboarding*	*Interviews with data/analytics and PSSC leaders indicate that the performance team monitors a wide range of performance metrics and uses weekly PSSC meetings to manage metrics that are out of "control" in partnership with measure leaders.* *Leaders observed that their data analysts are spending much of their time on data preparation as opposed to try analytics to drive insights.* *There is not a true organizational "dashboard" of key measures, nor is data routinely available in dashboard format at the middle level of the organization or at the unit level for unit teams/PETs.*	*Develop organizational "dashboard" of key measures that is readily accessible and reviewed regularly by senior leadership.* *Create cascading dashboards that deliver data on these key measures to mid-level and front-line teams (PETs and units).*	*In Progress*	*12/04/24*	*12/12/24*	*01/09/25*	*Aisha Krebs, Nate Gillard*	*asmedley@chartis.com*	*12/4 - meeting with the QAPI Team regarding the quality department functions, the model QAPI Plan, Indicators and projects for 2025.*
254		OBSERVATION: Communication and Change Management Gaps	Per staff and leadership interviews, the organization has been reactive instead of proactive in response to events and CMS requirements. The "why" for changes is not communicated effectively. Front line perspective is not consistently incorporated into response, leading to backtracking and re-work when new processes meet with front line "reality" and have to be pulled back and reworked. -General communication and communication of change does not fully reach all staff as the primary mode of communication is via email.	Develop a face-face communication strategy that accompanies new processes as well as general communication (e.g., staff huddles, staff meetings, hand-off report, morning report). Develop processes to consistently integrate front-line perspective into new initiative/process development (and iterate quickly when feedback received).	Pending						
255		OBSERVATION: Organization tracking of PI projects and monitoring persistence of changes.	No formal organization tracking of PI projects or to monitor persistence of changes. Formal performance Improvement management process to needs to be implemented to track all PI projects throughout the organization.	PI projects, once selected will be managed through project management work plans and reported through QSOC until completion. Output from PI team improvements will be monitored through the rapid cycle improvement process and care facilitation process (at the elbow staff (real time) mentoring and teaching)	Pending						
256		**NURSING SERVICES CHAPTER**				11/20/24		01/10/25			
257		OBSERVATION: Exceeding Ordered Dose	Multiple examples noted in medical record review in which Tylenol 3000mg per Q24 Hour max dose was exceeded. For example, a patient had Tylenol 650 mg oral solution ordered q4hrs po prn for pain and received 3250mg on 10/25/24.	Recommend that there is an alert in the eMAR to the RN if a dose about to be administered would result in the patient exceeding the ordered daily dose.	Pending	11/20/24		01/10/25			11/20 Initial meeting with Catie, Lindsey, and Nikki about the nursing and special provisions for psych findings.
258		OBSERVATION: Administration and Reassessment of PRN (as needed) medications	One record review revealed a patient had received multiple prn medications (pain, other medical, and psychiatric) the evening shift prior without reassessment of effectiveness. Another record showed prn zyprexa 10mg ordered every 6 hours administered 1-1.5 hours too soon 3 times within 1 week. Time frames exist in the current policy for differing drug classes for prn effectiveness results (1 hour, 4 hours, or 12 hours).	Recommend further review to determine if this is an isolated incident or if more education is necessary for staff. -A review and revision, as necessary, of the PRN Administration Policy should occur.	Pending	11/20/24		01/10/25			
259		OBSERVATION: Fall Prevention Program	At present, the current fall prevention policy and associated EHR documentation appears overly complex and doesn't appear to be followed.	Recommend simplifying the falls policy and documentation to help come into compliance. Sample policy provided on 10/29 to Nursing leadership/Quality. Recommend reviewing/updating current fall prevention policy and revising the current fall prevention documentation to be more streamlined to help with compliance and to meet the needs of the patients and staff.	In Progress	11/20/24		01/10/25			

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260		OBSERVATION: Nursing Assessments (Medical)	Per CMS/TJC, there should be initial and ongoing nursing assessments as defined by the organization as to the scope and criteria for assessment and reassessment. In several records, there was inconsistent physical assessments documented when medical conditions were known to be present. There was no indication the patient wasn't assessed, however, due to lack of documentation, it was difficult to determine patient progress/status.	Recommend evaluating process for documenting physiological assessment in Avatar along with progress notes to allow for documentation of changes in pt condition.	Pending	11/20/24		01/10/25			12/4/24 - Initial discussion with Chris and Katie regarding RN assessment documentation vs MHT documentation.
261		OBSERVATION: Assessment Post Fall	Multiple charts were reviewed in which falls were documented. However, there was lack of evidence of a post-fall assessment as required per policy in multiple instances.	Review fall policy and determine opportunities for streamlining documentation and process. A sample falls policy has been provided to the organization.	Pending	11/20/24		01/10/25			
262		OBSERVATION: Medications given without evidence of ordered indication	1. Patient with orders for PRN Haldol 5mg po Q6H prn psychotic agitation and Ativan 0.5mg Q8H prn severe anxiety. Per staff, patient stood in line, awaiting his morning medications. He was compliant with scheduled meds. Requested for his prn Ativan and Haldol. Patient able to communicate needs, follow commands and make requests. No s/s of acute distress noted. 2. Patient received Aripiprazole (prn for psychosis) and Hydroxyzine (prn for mild anxiety) at 1023. No comments in eMAR as to indication/behavior resulting in the prn med administrations at that time. The RN note for this day was entered on swing shift, no note from day shift to relay behaviors, and swing shift RN note didn't include any comments as to behaviors earlier in the day or on swing shift related to this.	According to 'Medication - Administration of PRN' Nursing Services Department Protocol #2.070, "A nurse may administer any authorized prescriber-ordered PRN medication based on the patient's relevant complaint or observable changes in behavior or condition.". This protocol also requires the RN to assess the patient's current status and to consider non-pharmacological interventions prior to PRN medications. CMS and TJC require a complete medical record for each patient, which includes nursing notes and proper documentation of patient assessments and medication administration actions taken and their outcomes. Recommend monitoring for documentation that supports medications administered and education, as appropriate, to nurses who are not documenting this information in the medical record.	Pending	11/20/24		01/10/25			
263		**SPECIAL PROVISIONS APPLY TO PSYCH**				11/20/24		01/10/25			
264		OBSERVATION: Nursing Unit Staffing Model	In early 2024, a staffing model was trialed with the goal of increasing patient engagement to decrease assaultive behaviors and adverse events. Upon data review, code greens and seclusion events decreased, 1:1 staff to patient orders were eliminated and time in seclusion decreased. Upon staff interviews, the general consensus found the model to be helpful but there still lacked sufficient activities and groups from disciplines outside of nursing for the acute patient population and the support expected waned from the initial time of implementation.	It is recommended to implement the staffing model in the Harbor units along with initiation of 15-minute patient observation/wellness checks. Each hall can have 1 MHT assigned for the checks which can further increase engagement through visual/verbal interactions to preempt potential problems. - The environmental check is recommended to occur at the change of shift with off-going and on-coming staff. - Unit group activities should be reassessed and added to the daily schedule. -A priority needs to be placed on staff assignments to improve the continuity of patient care.	Pending	11/20/24		01/10/25			
265		OBSERVATION: Nursing Staffing Office	The Staffing Office provides for centralized nursing department scheduling. The daily process is as follows: A Nurse Manager reviews patient acuity on each unit. A set of acuity questions are scored with the scores then entered manually on an Excel spreadsheet for tracking and scheduling purposes by the staffing office. The Excel sheet calculates minimum staffing numbers and skill mixes for each unit. Administrative staff must then take those numbers and use them alongside the daily API information and manually count to ensure the number of staff and skill mix within API equals the Excel tracking sheet. Actual staff numbers and skill mixes are manually recorded in Excel for each shift three times daily to provide documentation of minimum staffing and skill mix for compliance with the staffing plan. - Any change in the schedule needs to be reconciled by the staffing office in each employee's timesheet to ensure accuracy of time and attendance (OT, late arrival, left early, no-show, etc.) - The staffing office covers all call-offs daily (20-30%) that includes non-delivered time and late-cancel, or self-cancel shifts previously picked up which increases the burden on the staffing office. The staffing office notifies staff via phone, text, and email which is time consuming as well as an inequitable distribution of shifts and overtime since most staff are not aware of open shifts but may be willing to work. - Staff utilize the API time and attendance, staffing and scheduling application via computer to address time discrepancies, verify schedules, and approve timecards. Unit staff must leave direct care for computer access. - The Staffing Office has an influx of calls daily to provide scheduling information to registry and float staff.	It is recommended to update the API system to include modules that incorporate the Patient Classifications System, OpenShift Notification, Mobile Application, and Outcomes Analytics. An upgraded system will significantly decrease staff time with an efficient computerized tracking system that contains all necessary components for staffing a large hospital system as well as providing employee satisfaction across the nursing department.	Pending	11/20/24		01/10/25			
266		OBSERVATION: Nursing Department Shift Scheduling	The nursing department experiences a high rate of vacancies for nurses, approximately 40+ for RNs and 80+ for LPNs. Also, an extremely high percent of non-delivered staffing, approximately 5000 hours per week due to various leave types and call-offs. There are also up to 30 1:1 (staff to patient ratio) shifts to cover daily. It is understood the nursing department has proposed 12 hours shifts and the Department of Administrative Services has not approved the staffing model change for nurses and mental health technicians due to the 4 hours of non-direct care time each week or 8 hours per pay period. The nursing department has developed a plan for education purposes that can be either on-site or off-site for staff education and development. Throughout the gap analysis assessment, consistent team-driven patient care practices were found to be deficient. Unit staff did not receive consistent messaging and hand-off shift to shift. A lack of time for staff development and education was a frequent theme during interviews throughout the organization. -This can create team communication and hand-off problems when not all staff work the same shifts. Continuity of patient care may be compromised.	For patient care needs, 12 hour shifts typically lend to team development and consistent patient care. Staff satisfaction is higher as it has been generally found preferable to work 3 shifts per week with the opportunity to work overtime and still have days off than working 4 or 5 days per week and, recruitment and retention of staff is typically higher in hospitals that work 12-hour schedules. This will also decrease daily numbers of staff and allow for positions to improve treatment mall attendance and float RNs for meal breaks, etc. It is recommended the Governing Body approve initiation of the 12-hour shifts and address any concerns as raised by the approving OHA department to expedite approval. Although staffing has generally improved since the pandemic, additional change is necessary to recruit and retain staff to meet this vulnerable patient population basic psychiatric and medical care needs.	Pending	11/20/24		01/10/25			
267		OBSERVATION: Interdisciplinary Treatment Plans	Generally, the treatment plans reviewed were not individualized with specific groups and interventions. Patients attend groups of their choosing in the treatment mall without a specific focus that correlates to their problems and goals of treatment. CMS expects modalities to be specifically described.	Specific groups and the focus of those groups should be indicated as interventions on the plan of care.	Pending	11/20/24		01/10/25			
268		OBSERVATION: Active Treatment	It is understood the Jurisdictional Treatment Program is scheduled to go into effect in April 2025; however, that is dependent upon many factors including segregating units according to legal status as possible. Active treatment consists of groups and activities as facilitated by multiple disciplines with individual focus which is to be reflected in the patient treatment plan of care. Currently, active treatment is not occurring on each unit daily for those who do not attend the mall groups or those too acute to participate. Although there is not a set number of hours for active groups per CMS regulations, partial hospital programs are required to provide four licensed groups/day. Inpatient hospitalization should at least match four groups/day since a higher level of care. Groups can be provided by licensed social workers and therapists, nurses, dieticians, pharmacists, psychologists and occupational, recreation, physical, music and art therapists. Active treatment is expected to occur seven days/week. Treatment Mall staff currently facilitate the group model of active treatment. In a review of group notes from different units and different levels of acuity, very few group notes are documented. For example, one record had 5 group notes in one week, another with 2 group notes in one week, and 0 group notes in 1 record on an acute unit. Social workers do not currently facilitate groups. Prior to the pandemic, unit social workers facilitated 2 groups each week. Reasons provided included remote work, staff leaving due to the pandemic, and a change in responsibilities due to increasing patient discharges. Currently, social workers work 4, 10-hour shifts or 5, 8-hour shifts with one day of remote work. The Director stated the department is almost fully-staffed at this time. There exists a gap in unit staff knowledge of their role in active treatment and group facilitation. Also, upon staff interviews, many stated there seems to be a belief that treatment can't start until "the meds kick in" versus engaging the patient from the time of admission.	Until the Jurisdictional Treatment Program comes into fruition, we recommend that each Program Executive Team (PET) assess and determine on-unit schedules for patient population appropriateness and according to individual treatment plans to ensure patient engagement and decrease idle time througout the day and into the evening. The hospital promotes a group model of treatment which needs to be prioritized. -Specific treatment mall groups should be assigned to patients according to their treatment plan. Rosters need to be initiated and group notes documented for every group attended. Group services can be tailored to the Civil/GEI and Aid and Assist population (for example, an admission unit with groups occuring in the unit or other specific locations). -We also recommend reviewing treatment mall, social work and psychology positions to add part-time and pool weekend staffing to increase and facilitate weekend groups and activities to include on-unit groups for the acute units. -Treatment services should be included in new employee orientation to discuss the model of treatment and the role of nurses and mental health technicians in helping patients engage in active treatment.	Pending	11/20/24		01/10/25			

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269		OBSERVATION: Treatment Mall Staffing	Upon multiple unit staff interviews, there seems to be staffing issues regarding duties and communication pertaining to the number of staff needed during mall hours and unit staff responsibilities.	A review of how the treatment mall is staffed with a reconciliation as to what is appropriate for nursing staff unit and mall responsibilities.	Pending	11/20/24		01/10/25			
270		OBSERVATION: Learning Services	The learning services department is a comprehensive program although there are certain elements that can be improved to increase staff learning in specific areas. -Employee compliance is not 100% for "Safe Together" training and competency validation for physical intervention for all required departments. -Clinical staff (other than nursing and security), do not receive physical intervention training as training is determined by low-moderate-high patient contact. -There is an gap in knowledge with first-time, inexperienced nursing staff (both for nurses and mental health techs) according to direct care staff and leadership interviews. There was a feeling that new hires, and especially new graduates, could benefit from additonal support. -Although medical assessment education has been added for nurses as of June 2024, the content is not as comprehensive as needed. Currently, the education is offered at new employee orientation and annually. -Per staff interviews, processes taught "per policy" during orientation do not follow current practice changes due to a lag in the approval process. -In interviews, front-line staff observed that new nurses and MHTs can often be placed on challenging units and don't feel they have enough training. Staff felt there could be a more supportive culture from experienced staff.	There are currently 13 Nurse Educators in the department and their primary role is classroom education. It is recommended their teaching environment be expanded to care facilitation (at the elbow, real-time coaching) with staff at the unit level. Through assigned unit rounds, nurse educators can assist staff by means of "in the moment" education; also, to their develop role as an added resource for managers who need additional teaching assistance with noted staff deficiencies in assessment, documentation, or patient engagement. -Engage experienced providers, nurses, and MHTs to assist with new employee orientation with ongoing mentoring support. -Establish a preceptorship program. -Additional learning through just in time huddles and real-time care facilitation at the unit level by educators, managers, and leaders as well as formal classroom and experiential/scenario-based teaching is recommended. Seven "code blue" nursing positions were recently approved that could be assigned for this purpose. -As several nurses interviewed stated, in differing ways, they are a "psychiatric nurse" and not as confident regarding medical problems. We recommend an increase in the frequency of nursing education related to recognition of medical decline and emergency assessment of the psychiatric patient. Often, having a family nurse practitioner or physician teaching a class is typically beneficial as well as team building. -Review and validate opportunities to enhance on-boarding, training, and placement processes for new staff to balance care needs with imperative to ensure staff set up for success in new roles. -It is recommended that employees should not be allowed to work if required trainings (e.g. "Safe Together" verbal/physical patient interventions) are not met at the time of NEO or as assigned periodically or annually. We recommend all employees with patient care interactions (clinical staff) must be proficient and able to assist in verbal and physical altercations. All clinical staff are recommended to participate in code green drills as a skill and team-building exercise. Skilled clinical patient engagement is crucial in decreasing overall workplace violence. -A former model of the MHT lead (discontinued approximately 5 years ago) is recommended to help mentor and guide unit MHT staff to improve patient engagement and de-escalation skills with the goal of decreasing physical intervention. A merit-based versus seniority-based designation is recommended for this position if possible, as interpersonal and leadership skills are required. -Treatment services should be included in NEO for nursing staff to better understand their role and responsibilities in the group model of care. -Although a long-term recommendation, a specific space for a training facility is recommended.	Pending	11/20/24		01/10/25			
271		OBSERVATION: Psychological and Social Work Staffing	There are currently no positions specific to substance use counseling services although substance use disorders are prevalent in the psychiatric population.	We recommend that substance use counselors be added to the repertoire of services for patient assessment needs, group facilitation, and individual counseling as needed.	Pending						
272		**HUMAN RESOURCES**				11/21/24		01/31/25			
273		OBSERVATION: Progressive Discipline	The process for counseling staff is largely governed by HR policies and the employee union, making it challenging for supervisors across all disciplines to hold employees accountable for their performance. Supervisors can only address an initial concern; after that, HR is responsible for issuing a letter of expectation, followed by a letter of reprimand if necessary. Employees have the right to grieve or appeal any disciplinary actions through the union. If the situation escalates, the Department of Administrative Services (DAS) may become involved, and ultimately, the Department of Justice (DOJ) could step in. This complex process is a result of staff "owning" their position after the trial service period. The DOJ appears to take a cautious approach when dealing with employees, but does not extend the same level of caution when it comes to direct patient care and the provision of care in a safe setting. During interviews with unit staff, supervisors, and leadership, it was communicated that supervisors struggle to effectively address and escalate performance issues due to the burdensome HR process. Supervisors expressed frustration with HR personnel, noting that the HR process lacks fairness and consistency in handling discipline, with the ability for HR or other entity to overturn decisions at any stage. Supervisors state they cannot hold staff accountable for patient care, even within the trial period, due to the current process. There was also dissatisfaction voiced regarding what was seen as "staff entitlement" and the abuse of the ADA system. Another concern expressed is the lengthy investigation process related to workplace abuse, harassment, and discrimination. Either staff are home for months pending the investigation outcome or continue to work aside the team member in which there have been problems. These issues negatively affect team dynamics and ultimately patient care. The general consensus is that underperforming and unsafe employees are neither disciplined effectively nor managed out of the organization, which has a detrimental impact on staff morale and the overall culture of safety.	This complex, multifaceted issue requires attention at a level beyond the hospital as it involves the state government system. However, it must be addressed somewhat urgently due to its negative impact on the entire organization. HR personnel are typically expected to support supervisors in applying Just Culture principles and integrating these practices into daily operations. While this is a challenging process, leadership must take responsibility for holding staff accountable for their performance and ensure adherence to the established performance management process. -As an immediate measure, managers need to be educated regarding the disciplinary process and utilize the 6 month and 1 year probation periods to terminate employees who do not meet basic job position requirements. -There should be a non-punitive performance improvement pathway designed to support employees to improved performance by addressing any deficits in knowledge, skills, and abilities, etc. This may still result in termination if the employee is unable to meet basic minimum job requirements. There should also be a separate progressive discipline pathway designed to correct behavioral issues, with defined triggers and responses to create accountability. This approach is consistent with Just Culture and is designed to improve employee performance while strengthening safety culture. -Safeguards/criteria should be developed to ensure that HR actions are consistent with Just Culture and that employees are not being "punished" for system issues or for occasional, expected human errors that are below the established threshold of acceptability for their particular role. At the same time, the organization must be committed to accountability for job performance, with underperformers identified and supportive performance pathways or progressive discipline pathways initiated as appropriate given the nature of the performance deficit.	Pending	11/21/24		01/31/25	billy.j.martin@oha.oregon.gov, Karen Jamieson		11.21.24 Initial Meeting: Jennifer Midkiff, Billy Martin, Justin Ririe, Aisha Krebs, Nate Gillan HR shared that they cannot control the length of OTIS investigations. Discrimination-based issues are outside of OSH control. TJC HR Chapter briefly discussed, this will be sent to Billy and Jennifer. Updated wording from 'finding' to 'observation'
274		OBSERVATION: HR File Management/HR Session	HR file management was found to be highly disorganized, making it difficult to locate all requested documents. While it's common for some documents/forms to be housed outside of the HR file, there appeared to be a multitude of documents that reside in different locations/software programs including: -Background checks -Employee health records (expected) -Annual Evaluations -Competencies -Education -Certifications -Job Descriptions This made it extremely difficult to validate staff performance, responsibilities, orientation, qualifications, etc. Names were provided to OSH staff days prior to the HR session yet the only individuals who were prepared to review records were Provider Credentialing/Peer Review. No one from Nursing Services, Background Checks, or Employee Health were present for the HR session and had to be called down, delaying the session 30-45 minutes. Additionally, none of the files for Unit Administrators, Occupational Therapist, Treatment Care Plan Specialists, Resource Coordinator, Security, Infection Prevention, OS and Investigative Manager files were not provided as requested. No Junction City files were provided either. Overall, the HR Session file review was not optimal and needs to be reviewed for better efficiency. Considering advance notice was given multiple times about the areas to be covered during the session, there should have been a more organized effort to have files and staff available.	There needs to be an organized method for HR file review. It's recommended the HR files should be more organized and managed through standardized processes to ensure consistency, improve efficiency, and maintain compliance with regulatory and organizational standards. Recommend a comprehensive review of roles/responsibilities and organizational structure to determine best path forward as processes appear very siloed.	Pending	11/21/24		01/31/25			Discussed that the information lives in different places and OSH is already considering how to consolidate (i.e. using Workday for some)

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275		OBSERVATION: Staff Evaluations	Per TJC, the hospital evaluates staff based on performance expectations that reflect their job responsibilities and evaluates staff performance once every three years or more frequently as required by hospital policy. Currently, OSH policy requires quarterly performance reviews per the HR Director. There are no incentives for employee performance and as stated under progressive discipline, poor performance is not routinely addressed. Quarterly performance reviews were not consistently completed for the staff reviewed. One Director of Nursing was found without any evaluations in workday since being hired (multiple years). Additionally, OSH is performing quarterly evaluations that are not structured or standardized, nor are they merit-based. Performance evaluations have no goals, objectives, employee expectations, etc. Many appeared to be copy/pasted verbatim from employee to employee. There are no incentives for employee performance in providing high quality patient care.	Considering that evaluations are not merit-based, it's recommended the process of quarterly performance evaluations be reviewed as these are only required every three years (minimally) by TJC. It's unclear how quarterly evaluations are adding value for the employee and it is a time-consuming exercise for managers and supervisors.	Pending	11/21/24		01/31/25	billy.j.martin@oha.oregon.gov, Karen Jamieson		Discussed that OSH has since shared that the quarterly performance reviews are a requirement that comes from the Governor.
276		OBSERVATION: Criminal Background Checks	Oregon Department of Human Services mandates that employees of OHA must have a criminal background check prior to employment. Additionally, CMS suggests that any person with a record of abuse or neglect should not be hired or retained as employee. During HR file review, it was noted that a staff member was hired as an RN in 2020 without evidence of a background check. There's also evidence that employee's with known records of past patient abuse have been re-hired due to mandates as a result of arbitration.	It's recommended that a comprehensive review of employee background checks occur to ensure they are completed prior to hire. Additionally, while OHA has rules/regulations around employee grievances, it's important to remember that federally, CMS has rules/regulations that require hospitals to keep patient's safe from anyone who has a history of abuse/neglect. It's suggested that further conversations happen on this topic to identify and opportunities for improvement.	Pending	11/21/24		01/31/25			Updated wording of the last statement in the finding from being a DOJ mandate to resulting from arbitration.
277		OBSERVATION: Employee Health Files	As part of the HR file review process, it was requested 3+ times that someone from employee health be available to provide proof of vaccinations. No one from employee health (3 invites) arrived during the 1.5 hour session so this portion of the gap could not be completed.	N/A - not reviewed	Pending	11/21/24		01/31/25			Discussed need to ensure backups for this process so that when key people are out of the office, someone else has access to the information to be able to provide.
278		OBSERVATION: Job Descriptions	In one LPN job description, there was a requirement that the employee participate in code green drills every other month. There was no evidence in the HR file of this requirement and upon reviewing online training, there were gaps in which the staff had not participated every other month.	It's recommended this requirement be removed from the LPN job description and that a review of all job descriptions occur to ensure these type of granular details are not included.	Pending						Frontline leaders can and do update job descriptions and it is believed that there are many variations in existence.
279		**EMERGENCY SERVICES**									
280		OBSERVATION: CMS 2567-Medical Emergency Supplies and Equipment	From the 2567 dated 10/11/24, the hospital failed to ensure that medical emergency supplies and equipment processes were managed and documented consistently to ensure availability of necessary items during a medical emergency response. 1. Emergency Medical Equipment Checklist in Flower 2 unit noted the sphygmomanometer was not working on 10/5/24, but no escalation or corrective action was documented. 2. Emergency Medical Equipment Checklist in Flower 2 unit had the "code blue lock" number recorded on some days of the month but on 10/6/24 there was a checkmark placed in that space, which was inconsistent with the other days. 3. Emergency Medical Equipment Checklist in Leaf 3 unit showed inconsistencies with marking the daily "code blue lock" numbers. Some days had a number entered, some days a ditto mark or checkmark was used, and some days, the space was left blank. 4. Emergency Medical Equipment Checklist in the Admissions Department (Salem) showed inconsistencies with several missing instances of circling or marking the daily defibrillator, oxygen, emergency lock, suction machine, and signage checks, and some dates had blank signature spaces (not signed). 5. The Code Blue Equipment Check Sheet, a list of supplies/equipment that should be in the Red Emergency Cart, on top of the cart in the Admissions Department (Salem) was a version from April 2024, but the version seen in the previous departments was dated for June 2024. The Admissions Department check sheet didn't include items required on the unit versions of the check sheet, such as Narcan, trauma shears (AD version listed "scissors"). 6. The Code Blue Equipment Check Sheet in Mountain 3 unit in Junction City was observed to be present, but to be a different list than the one seen in Salem units or the Salem Admissions Department. The Junction City equipment check sheet didn't list an OB kit or infant AMBU bag. 7. Red Emergency Cart on Mountain 3 units at Junction City had no 3in. rolls of gauze in drawer #3, but the check sheet indicated there should be two.	Ensure that the Emergency Medical Equipment Checklists in use have been standardized and simplified and that the policy related to the use of the checklist and check sheets is being followed. If the patient population at Junction City warrants having a different checklist and/or supply list, such as not needing the OB kit or infant AMBU bag, then this needs to be indicated in the policy so it is clear to surveyor's that there is a difference between the supplies and lists at each campus. Monitor for compliance.	Pending						
281		OBSERVATION: Code Blue	The Code Blue policy states, "If the situation appears to be life threatening or life altering to the person, staff must call a Code Blue." Per staff interviews and observations, "Code Blue" is called for any type of medical problem that staff feel require an immediate response.	We recommend implementing a Rapid Response Code to distinguish a true Code Blue emergency from other urgent situations. Differentiating these responses can help ensure that resources and staff are appropriately allocated based on the specific needs of each situation. Structure suggested: Rapid Response vs. Code Blue Differentiation: Clearly define the criteria for each type of response. A Rapid Response Code could be used for cases that require immediate clinical attention but don't yet meet the threshold for full resuscitation efforts. Code Blue would then be reserved specifically for instances of cardiac or respiratory arrest where CPR and advanced life support are required. Staff Assignments and Training: Nursing and medical staff should be assigned roles within either Rapid Response or Code Blue protocols, depending on their expertise and the needs of each unit. Staff should receive regular training on both types of codes to maintain readiness and awareness of specific protocols. Communication Protocols: Ensure all staff are well-versed in communication protocols to avoid confusion during deployment. Differentiating the calls (such as "Rapid Response Team to Room X" versus "Code Blue in Room X") can make it clear to all personnel the urgency and type of response required. Evaluation and Debriefing: After each response, conduct a debrief to evaluate response times, the appropriateness of the code called, and any opportunities for improving the protocol. This approach should help maximize patient outcomes by ensuring that each response type is staffed appropriately and handled with the specific urgency required.	Pending						
282		**UTILIZATION REVIEW**				11/21/24		01/31/25			
283		OBSERVATION: Delivery of Medically Unnecessary Decision Letters	Written notification of this final determination must be sent to the attending physician, the patient (or next of kin), the facility administrator, and the single State agency (in the case of Medicaid) no later than 2 days after such final determination and in no event later than 3 working days after the end of the assigned extended stay period.	Recommend ensuring the written notification that final determination is being delivered as required, is 1) understood as a requirement, 2) is part of the UR plan, and 3) is being monitoring for compliance.	Pending	11/21/24		01/31/25			Initial meeting 11/21- Have experienced challenges in determining who should deliver the letters. Have considered Patient Financial Services delivering as part of IDT meeting. Patient Financial Services would benefit from clinical support when letters being delivered. Key considerations include that patient population has changed to predominately forensic and there are some newer staff in PFS.

	Priority	Title/Finding	Description/Plan	Discussion/Recommendation	Status	Start Date	Next Update	End Date	Hospital Oversight	Chartis Oversight	Comments
284		OBSERVATION: Not reviewing outliers	Hospitals need review only cases that they reasonably assume to be outlier cases based on extended length of stay and/or on extraordinarily high costs. They don't feel they have the knowledge to understand exactly what they should be looking for or how to get the data. Provider turnover for UR committee is also a contributing factor to lack of understanding of committee purpose.	Education for UR committee regarding roles/responsibilities, what information they should be looking for and how to get this data. Evaluate committee members and create contingency plans to account for turnover and to support ongoing leadership of the group and guidance on purpose. Review and update the hospital's UR plan to ensure that cases reasonably assumed to be outliers are being reviewed.	Pending	11/21/24		01/31/25			
285		OBSERVATION: Not reviewing professional services	The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of Professional services furnished including drugs and biologicals.	Review and update the hospital's UR plan to ensure that Medicare and Medicaid patients, with respect to the medical necessity of professional services furnished including drugs and biologicals, are reviewed.	Pending	11/21/24		01/31/25			
286		**MEDICAL STAFF SERVICES**									
287		OBSERVATION: Medical Staff Peer Review	Per interviews and review of materials provided, there are peer review committees are in place for the clinical disciplines. There is regular quality review for all providers as part of OPPE as well as review of referred cases. -Interviews suggest that there is not a clearly documented, transparent set of criteria for what types of cases are automatically referred for peer review (e.g., particular types of care/process deviations or particular outcomes). -Interviews with medical staff leadership and medical staff office staff suggest that behavioral and interpersonal issues have been a challenge for MAPS to address, and most behavioral issues are handled through HR, which MAPS does not have insight into.	-Objective, transparent criteria should be in place for identifying cases for peer review (Rate, Rule, Review criteria). -Aggregated data on number of cases reviewed, findings, and actions should be tracked. -Clear standards should exist for what issues are managed through MAPS peer review process vs delegated to HR, and some closed loop process should exist so that MAPS can be assured that delegated performance management is effective (within bounds of what can be shared legally).	Pending						
288		OBSERVATION: Advance Practice Professionals - Admission and Discharge Summary	CMS hospital regulations permit licensed practitioners (e.g., nurse practitioners) as allowed by the State, to admit patients to a hospital. CMS regulations also require that Medicare and Medicaid patients admitted by APPs be under the care of an MD/DO. Evidence of being under the care of an MD/DO must be in the patient's medical record. If a hospital allows APPs to admit and care for patients, the governing body and medical staff must establish policies and bylaws to ensure that the requirements are met. The MD/DO may delegate writing the discharge summary to APPs.The MD/DO responsible for the patient during his/her hospital stay must co-authenticate and date the discharge summary to verify its content.	It is recommended that the Bylaws be reviewed and revised if necessary regarding the admission and discharge summary documentation to ensure compliance with the CMS SOM.	Pending						
289		OBSERVATION: Medical Staff Service Need	The absence of Electroconvulsive Therapy (ECT) services is not a regulatory deficiency; however, it is considered a valuable treatment option that is difficult for OSH patients to access. Discussions are reportedly underway with the local medical center, as patients currently must be transferred to the University Hospital in Portland, which only accepts non-violent patients. This poses a challenge, as those needing ECT often include violent individuals with medication-resistant schizophrenia, severe psychosis, etc.	Given the highly acute and medication-resistant segment of population at OSH, we recommend actively pursuing a contract with the local medical center while also exploring the option of establishing ECT services directly at OSH. Providing ECT onsite would be preferable and highly beneficial for both patients and staff.	Pending						
290		**OBSERVATIONS:**									
291		Medical Clinic-Radiology	A barrier to patient care is the lack of transport employees. Due to fewer transporters, imaging staff assist with transporting patients or travel to units to perform portable exams. This results in fewer imaging exams that can be performed each day, or exams being performed in the department later in the day, which results in delayed reports.	Recommend evaluating transport staffing compared with average historical patient transport requests to determine if there is an opportunity to align staffing and testing needs.	Pending						
292		Medical Clinic-Avatar SOAP Notes	There is no SOAP template in Avatar that includes the required elements per their clinic protocol for the notes. Some physicians create their own Word templates that can be opened on their computer, updated and saved with details for each patient, and copied/pasted into Avatar to document clinic visit notes. There is also glitching of the system that has been escalated and is known internally and by Avatar. Signed and completed notes can and have been completely deleted from the system.	Build and share with physicians a SOAP template for Avatar that includes all the required elements per the clinics written protocol for notes.	Pending						
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295		**POSITIVE FINDINGS**									
296		REVIEWED: Glucometer Medical Clinic	Utilizing Accucheck. Controls labeled with opened and expiration dates. Controls within date range. Performing daily QC and cleaning afterwards.	N/A							
297		REVIEWED: Medical Clinic SOAP Notes	Medical Clinic Protocol 1.017: Medical Clinic Provider Documentation Standards outlines the protocol for completing SOAP notes, including note contents and timing for completion.	N/A							
298		REVIEWED: Treatment Plan Initial Meeting	Observed the 10-day treatment plan meeting with a new patient. Present in-person: PNP, Psychologist, Social Worker, and RN, via teams: Treatment Plan Specialist.	N/A							
299		REVIEWED: Medical Staff Credentialing	Reviewed the credentialing files for two dentists, a psychiatrist and a medical doctor. The required documents were found in each physician's files. OPPE and FPPE data was also reviewed and found to be complete and compliant.	N/A							
300		REVIEWED: Initial Intake Assessment	Observed four patient initial intake assessments. No deficiencies noted.	N/A							
301		REVIEWED: Meal Delivery	Observed meal delivery on Butterfly 1 and subsequent storage of food for a patient who didn't eat lunch yet. No deficiencies noted.	N/A							
302		OBSERVATION: Physical Environment Management	Committed core group of individuals (Facilities, Safety, Compliance)	N/A							
303		OBSERVATION: Physical Environment Management	Relatively well-maintained facilities (which is mostly a by-product of the team charged with managing the environment)	N/A							
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