STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	380007	A. BUILDING _____ B. WING _____	C 04/20/2020

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LEGACY EMANUEL MEDICAL CENTER	**2801 N GANTENBEIN AVENUE PORTLAND, OR 97227**

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A 000	INITIAL COMMENTS This report reflects the findings of the unannounced complaint investigation survey of complaint #s OR21405 and OR21531 initiated onsite on 10/14/2019 at the Legacy Emanuel Medical Center's (LEMC) off-campus satellite behavioral health inpatient and outpatient facility, the Unity Center for Behavioral Health (UCBH). A second unannounced, onsite investigation was initiated on 03/03/2020 in response to complaint # OR22358. This report reflects the findings from the combined investigation surveys that were concluded offsite on 04/20/2020. The allegations contained in complaint #s OR21405, OR21531 and OR22358 were substantiated. LEMC UCBH was evaluated for compliance with the Condition of Participation for Patient's Rights, CFR 482.13. The findings from the survey reflected its limited capacity to provide safe and adequate care as the following Condition-Level deficiencies were identified: * CFR 482.12 - CoP Governing Body * CFR 482.13 - CoP Patient's Rights * CFR 482.21 - CoP Quality Assessment and Performance Improvement * CFR 482.23 - CoP Nursing Services Abbreviations and Acronyms used throughout this report: 4-point restraints - physical restraints applied to a person on both wrists and both ankles ACC - Accreditation & Clinical Compliance staff AMR - American Medical Response, Inc., a medical transportation company	A 000		

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

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A 000	Continued From page 1	A 000		

ANM - Assistant Nurse Manager
AOC - Administrator on Call
AVH - Auditory & Visual Hallucinations
approx - approximately
BAL - Blood Alcohol Level
BH - Behavioral Health
BHT - Behavioral Health Therapist
BHU - Behavioral Health Unit
bx - behavior
CHIERS - A sobering station
C-SSRS - Columbia Suicide Severity Rating Scale
CFR - Code of Federal Regulations
CIS - Crisis Intervention Specialist
cm - centimeter
CMO - Chief Medical Officer
CMS - Federal Centers for Medicare and Medicaid Services
CN - Charge Nurse
CNO - Chief Nursing Officer
CoP - Condition of Participation
Code Gray - Response to threatening or assaultive behaviors
CoP - Condition of Participation
CRN - Charge RN
CTW - Criminal Trespass Warning
d/c - discharge
DOS - Director of Services
DPSST - State of Oregon Department of Public Safety Standards and Training
DS - Director of Services
DSS - Director of Safety & Security
d/t - due to
ED - Emergency Department
EDMD - Emergency Department physician
EHR - Electronic Health Record
EMT - Emergency Medical Technician
EOC - Environment of Care
EOMI - Extraocular Movements Intact

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A 000	Continued From page 2	A 000		

f/u - follow-up
HCRQI - Health Care Regulation and Quality Improvement
HI - Homicidal Ideation
HS - House Supervisor
h/o - history of
IM - Intramuscular
JC - Joint Commission
L - Left
Lac - Laceration
LEMC - Legacy Emanuel Medical Center
LGSMC - Legacy Good Samaritan Medical Center
LH - Legacy Health
LIMS - Legacy Internal Medicine Services
LIP - Licensed Independent Practitioner
LSO - Legacy Security Staff
MOAB - Management of Aggressive Behavior Training
NM - Nurse Manager
NMI - Notice of Mental Illness
NP - Nurse Practitioner
OHA - Oregon Health Authority
P&P - Policy and Procedure
PAS - Patient Access Staff
PES - Psychiatric Emergency Service
PESMD - PES Medical Director
POCT - Point of Care Testing
PPB - Portland Police Bureau
PPO - Portland Police Officer
PRN - As needed
PSA - Patient Safety Alert
Pt, pt - Patient
PTA - Prior to Arrival or Prior to Admission
PTSD - Post Traumatic Stress Disorder
Q, q - Every
QAPI - Quality Assessment Performance Improvement
QI&CCM - Quality Improvement and Clinical

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A 000	Continued From page 3 Compliance Manager Quiet Team - Unknown QR - Quiet Room R - Right RN - Registered Nurse RM - Risk Manager sxs - signs & symptoms S&S - Safety and Security SA - State Agency that conducts CMS survey and certification activities. In Oregon that is the Oregon Health Authority, Public Health, Health Care Regulation and Quality Improvement. SA - Suicide Attempt SBIRT - Screening, Brief Intervention and Referral to Treatment. A tool for identifying risk behaviors and providing appropriate intervention. SI - Suicidal Ideations SLM - Self Learning Module SM - Security Manager SS - Security Supervisor SSO - Safety & Security Officer TJC - Joint Commission UCBH - Unity Center for Behavioral Health UCBHP - President of UCBH UDS - Urine Drug Screen UTA - Unable to Assess VIW - Unknown VPU - Vice President Unity VSD - Violent Self Destructive XR - X-Ray	A 000		
A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the	A 043		

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A 043	Continued From page 4 functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on observations, review of recorded video footage, interviews, email communications, review of incident and medical record documentation for 21 of 21 psychiatric patients (Patients 1 through 21), review of training records for 5 of 14 staff (Staff Q, K, L, M and W), review of policies and procedures, review of building floor plans and other documentation related to safety and physical environment risk, it was determined that the governing body failed to ensure the provision of safe and appropriate care to patients in the hospital that complied with the Conditions of Participation. Staff failures to prevent patient access to unsafe items, failures to prevent elopement, failures to provide supervision, failures to appropriately manage behaviors and prevent unnecessary restraint use, and failures to protect patient privacy resulted in actual and potential harm to patients, and investigations to ensure such incidents did not recur were not timely or complete. This Condition-level deficiency represents a limited capacity on the part of the hospital to provide safe and adequate care and is a repeat deficiency previously cited on surveys completed on 08/08/2019, 07/30/2018 and 05/22/2018. Findings include: 1. Refer to the findings cited under Tag A115, CFR 482.13 - CoP Patient's Rights.	A 043	Compliance with A043 will be achieved on or before 10/10/20 through implementation of the plans of corrections related to patient rights, nursing services, maintenance of the physical environment, and integration of plans in the QAPI program Unity's leadership team will be responsible for overseeing implementation of the plans of correction for all cited deficiencies to ensure the provision of safe and appropriate care for patients in the hospital. Unity leadership, including the Chief Nursing Officer and President will have insight to ongoing improvement activities through attendance and participation at Unity's monthly Quality Council meetings. The President is ultimately responsible for A043. Refer to Tags A115, A263, A385, A701 for plans of correction related to patient rights, the QAPI program, nursing services, and building maintenance.	

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A 043	Continued From page 5 2. Refer to the findings cited under TagA263, CFR 482.21 - CoP Quality Assessment and Performance Improvement. 3. Refer to the findings cited under TagA385, CFR 482.23 - CoP Nursing Services. 4. Refer to the findings cited under TagA701, CFR 482.41(a) - Standard: Buildings.	A 043		
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on observations, review of recorded video footage, interviews, email communications, review of incident and medical record documentation for 21 of 21 psychiatric patients (Patients 1 through 21), review of training records for 5 of 14 staff (Staff Q, K, L, M and W), review of policies and procedures, review of building floor plans and other documentation related to safety and physical environment risk, it was determined that the hospital failed to fully develop and implement policies and procedures that ensured that patients' rights to safe care, freedom from abuse and neglect, freedom from restraint, and privacy and dignity were recognized, protected and promoted. As a result, patients experienced actual and potential harm: * Patients were allowed access to unsafe items. Those incidents included a case where an inpatient was provided with unsafe items which the patient used to attempt suicide, and two cases where patients removed smoke detectors from the ceiling in the secure unit.	A 115	Compliance with A115 will be achieved on or before 10/10/20 through implementation of plans of correction related to patient rights. This includes corrective actions that will be taken to ensure the patients' rights to safe care, freedom from abuse and neglect, freedom from restraint, as well as the recognition, protection and promotion of patient privacy and dignity. The Chief Nursing Officer is ultimately responsible for A115. Refer to Tags A143, A144, A145, A154, A199, A701 for plans of correction related to privacy, safe care, freedom from abuse and neglect, freedom from restraint and seclusion, training to manage patient behaviors, and building maintenance.	

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A 115	Continued From page 6 * Patients were not protected from elopement from secure units and the secure facility. Those incidents included two cases where inpatients were allowed to elope from the secure facility. * Patients were not supervised and observed to ensure safety. Two patients were allowed to engage in sexual intercourse and other sexual acts on the floor of a locked bathroom in the emergency services unit. * A patient was not protected from the use of unnecessary restraint and seclusion. * Patients were not afforded auditory and visual privacy during the provision of care that included one case where a video recording of an inpatient was posted on Facebook by another inpatient who was allowed to use a cell phone with a camera without supervision. * Investigations of and response to patient incidents were not timely or complete to prevent recurrence of similar events. This Condition-level deficiency represents a limited capacity on the part of the hospital to provide safe and adequate care and is a repeat deficiency previously cited on surveys completed on 08/08/2019, 10/05/2018, 07/30/2018 and 05/22/2018. Findings include: 1. Refer to the findings cited under Tags A143, A144 and A145, CFR 482.13(c) - Standard: Privacy and Safety. Those findings reflect that hospital's failure to ensure all patients were afforded personal privacy, safe care and freedom from abuse and neglect. 2. Refer to the findings cited under Tag A154, CFR 482.13(e) - Standard: Restraint or seclusion.	A 115		

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A 115	Continued From page 7 Those findings reflect the hospital's failure to ensure all patients were afforded freedom from restraints. 3. Refer to the findings cited under Tag A199, CFR 482.13(f) - Standard: Restraint or seclusion: Staff training requirements. Those findings reflect the hospital's failure to ensure all staff completed training to identify, prevent and manage patient behaviors. 4. Refer to the findings cited under Tag A701, CFR 482.41(a) - Standard: Buildings. Those findings reflect the hospital's failure to ensure the building was maintained for the safety and well-being of the patients.	A 115		
A 143	PATIENT RIGHTS: PERSONAL PRIVACY CFR(s): 482.13(c)(1) The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Based on observations, interviews, review of incident and medical record documentation for 2 of 2 psychiatric patients for who privacy concerns were identified (Patients 7 and 13) and review of policies and procedures it was determined that the hospital failed to fully develop and implement policies and procedures that ensured that patients' rights to privacy were recognized, protected and promoted as follows: * Patients were allowed unsupervised and unmonitored possession of cell phones with no provisions to ensure photographic images were not taken of other patients and posted to social media or other Internet sites. A video recording of an inpatient in the safety suite was filmed by another inpatient and posted on Facebook.	A 143		

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A 143	Continued From page 8 * ED triage, exams and care were provided in chairs in the open corridor directly in front of the ED triage area without provisions for auditory or visual privacy, and where other patients, hospital staff, non-hospital personnel and visitors would wait or pass through. Findings include: 1. The P&P titled "Patient Rights and Responsibilities" dated as last revised "05/17" included the following: * "To assure that patients receiving health care services at any Legacy facility and their families are treated with dignity and respect ... Legacy Health (Legacy) recognizes and respects the dignity and individuality of each person admitted to or treated within our facilities. All members of our workforce (employees, volunteers, medical staff, residents, students, contracted personnel and vendors) are expected to provide considerate and respectful care, meeting the cultural, spiritual, emotional, and personal dignity needs of each individual patient and their family." * "Patient's have the right to personal privacy and safety in accordance with state and federal law and Legacy policies." * "Legacy provides for environmental privacy ... The environment is created to provide for auditory, visual and olfactory privacy and comfort." 2. The P&P titled "Use of Electronic Equipment on Adult Psychiatric Units" dated as last reviewed "Dec 2016" included the following information: * "Personal Devices:" - "On Inpatient ADULT Units ... Personal electronic equipment including cell phones,	A 143	The following actions will ensure that patients' rights to privacy are recognized, protected, and promoted. The Chief Nursing Officer is ultimately responsible for A143:	

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A 143	Continued From page 9 tablets and laptops may be used, monitored by staff in accordance with written guidelines communicated to the patient." - "On Inpatient PEDIATRIC/ADOLESCENT Units ... No use of personal electronic equipment in the PES (sic) will be allowed." * "Hospital Owned Devices, including but not limited to headphones, computers, MP3 players, DVD players:" - "Use of personal electronics may be permitted at staff discretion or Charge RN discretion with assessment for confidentiality (Internet access, camera), safety and communication to the team on a case by case basis." - "Patients will agree to the following milieu rules regarding personal cell phone/computer use: The use of electronic devices will not interfere with the prescribed milieu activities ... Electronic devices are used in the patient's room, not in public areas such as dining rooms or hallways ... Electronic devices should not be utilized in groups or after 10 pm ... Electronic devices must be returned to the staff by 10 pm for recharging ... Personal devices will not be shared with other patients." - "Personal devices will not be used to take pictures." - "The staff assigned to a patient during a designated shift is responsible for the check-out of electronics and for the general oversight of the patient and equipment." The P&P was not clear. For example: - It reflected that on the "PEDIATRIC/ADOLESCENT Units" patients were not allowed use of personal electronic equipment but it unclearly referenced the "PES." - Under "Hospital Owned Devices" it was unclear whether the hospital owned cell phones and	A 143	**Procedure & Process for Implementation (Cell Phones)** To ensure photographic images are not taken of patients, patient access to all personal electronic devices with image capture capabilities (cell phone, tablet, laptop, etc.) will be restricted, unless monitored by staff. The following Policies and Procedures will be updated to reflect change: - Use of Electronic Equipment on Adult Psychiatric Units - Management of Personal Belongings and Potentially Unsafe Items Behavioral Health Therapists, RNs, Behavioral Health Assistants, Counseling & Therapy Staff, Care Management Staff, LIP, Patient Access, and Security will receive education on the revised electronics use process. **Monitoring Plan** In-room belongings will be inspected to ensure that patients do not have unsupervised access to personal electronic devices with image capture capabilities for 30 patients per month. The target for compliance is 90% per month for 3 consecutive months. During monitoring, instances of non-compliance will be reviewed with the leadership team to identify trends and education opportunities. Auditing will continue until 90% compliance has been achieved for 3 consecutive months.	

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A 143	Continued From page 10 cameras that would be checked out to patients. - It did not reflect how and when staff were to monitor cell phone and camera use except for "general oversight." 3. The P&P titled "Management of Personal Belongings and Potentially Unsafe Items" dated as last revised "Sep 2018" was reviewed. It included the following information: * "Items fall into four categories: never, supervised, group only, and unmonitored. Appendix A includes examples of items which will be deemed as never available, available only in a therapeutic group setting, available under supervision, and unmonitored." * The Appendix A "Never" column included: - Phone chargers * The Appendix A "Unmonitored" column included: - Cell phones This P&P was not consistent with the P&P identified under Finding 2 above in relation to monitoring of patient cell phone use. 4. Incident documentation received on 10/15/2019 reflected that on 10/10/2019 on Unit 2 Patient 9 was allowed possession of cell/smart phone, video recorded Patient 7 in the safety suite and posted those images on Facebook. The documentation revealed no evidence of follow-up or investigation at that time. Additional incident documentation received on 10/28/2019 reflected "work done on file." The documentation reflected that Patient 9 "was the patient doing the recording of [Patient 7]. It was a Facebook live stream. [Another] patient showed the RN writer the video on [his/her] own Facebook feed, as [he/she] is now 'friends' with [Patient 9]. The video was taken	A 143	**Incorporation Into QAPI Program** Ongoing monitoring of supervised electronic device use with image capture capabilities will be conducted for 30 patients per quarter. The target for compliance is 90% per quarter. During monitoring, instances of non-compliance will be reviewed with the leadership team to identify trends and education opportunities. Results will be shared at monthly Quality Council meetings. Policies are reviewed and updated at least every three years and/or with regulatory updates. Upon hire, Behavioral Health Therapists, RNs, Behavioral Health Assistants, Counseling & Therapy Staff, Care Management Staff, LIP, Patient Access, and Security will receive education on the revised process. **Completion Date** 10/10/2020 **Responsible Party** Chief Nursing Officer	

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A 143	Continued From page 11 of [Patient 7] through a door. [Patient 9] is noted on the video that [he/she] was 'recording this conversation; this is live right now' ... [Patient 9] is admitted with a diagnosis of bipolar, manic episode. [He/she] is on an NMI, presenting as delusional, manic, disorganized, and psychotic. [He/she] has been irritable, demanding, impulsive, and intrusive. [He/she] has been tech and cyber focused since admission. In the afternoon of this day, [Patient 9] had [his/her] technology access restricted due to calling the Secret Service." The investigation was not timely or complete and did not conclude that Patient 7's privacy rights had been allowed to be violated. In fact, the incident documentation noted that although Patient 9's behaviors towards Patient 7 were intrusive and unacceptable, and that Patient 9 was on a NMI and experiencing demanding, impulsive and intrusive behaviors, Patient 9's cell phone was not "restricted" until he/she called the Secret Service. Further, "[Patient 9] was increasingly agitated and not accepting of [his/her] limitations initially. Once [he/she] was reassured that [he/she] would be able to have minimal supervised use of phone/Internet, [he/she] was more agreeable." Refer to the findings for Patient 7 described in Tag A144 of this report that reflect he/she had attempted suicide with zip ties on 10/06/2019. 5. During tour with Staff CC on 10/15/2019 beginning at 1500 the following observations were made: * Patients on Unit 5 who were not in their rooms and were in the milieu were observed in possession of cell phones with cameras contrary	A 143	Refer to Tag A144 for plan of correction on complete and timely investigations.	

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A 143	Continued From page 12 to the P&P under Finding 2. * Patients on Unit 2 who were not in their rooms and were in the milieu were observed in possession of cell phones with cameras contrary to the P&P under Finding 2. * Posters/signs affixed to the walls on those units and throughout the facility reflected "Items that are NOT PERMITTED inside Unity Center." Other language on the poster reflected "Certain items ... are not permitted within our secure areas for everyone's safety. If you have those items and cannot send them home, notify staff so that we may secure them or provide off-unit lockers." Under that wording there were eight images of items over each of which a large X was placed. The first image was of a cell phone. Wording under the image of the cell phone with an X over it was: "cell phone* cords (including headphones and chargers)" The * was explained at the bottom of the poster and reflected *Exceptions may be made please notify the patient treatment team." * During interview with Staff CC during the tour he/she stated that patients could have camera phones "unless they are inappropriate." The poster was not consistent with the P&Ps identified under Findings 2 and 3 above in relation to cell phones on patient care units. 6. Refer to the findings for Patient 13 described in Tag A154 of this report regarding the location of the patient's triage and examination in the ED. The ED record for Patient 13 reflected that on 11/26/2019 at 1536 "Patient roomed in ED To room PES TR1" for triage and examination. When the patient returned to the ED triage area later that day on 11/26/2019 at 1816 the ED	A 143	**Procedure & Process for Implementation (Triage)** In order to ensure patient privacy in the triage area, Room #P-161 was repurposed into a private triage interview room to allow for auditory and visual privacy for patients during triage. The building plans were updated accordingly on 8/31/20. PES Staff including: Behavioral Health Therapists, RNs, Behavioral Health Assistants, Counseling & Therapy Staff, Care Management Staff, and LIPs will receive education on use of the new triage room.	

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A 143	Continued From page 13 record reflected "Patient roomed in ED To room PES TR1." However, review of recorded video footage at both of those times reflected the medical record was inaccurate as the video showed that Patient 13 was triaged and examined and administered care in the open corridor in front of the triage nurses station without any auditory or visual privacy. Patient 13 was not "roomed in" to a triage or exam room. During interview with the BHT Q on 03/05/2020 at approximately 1630 with the CNO, the PES NM and ACC1 present he/she stated that there were no triage rooms in the ED Triage area and those present concurred. An explanation was provided that for the EPIC EHR they have to select a room for the medical record so they select "Roomed in TR1" or "Roomed in TR2" or "Roomed in TR3," and that if they need privacy during triage or examination they use a vacant seclusion/hold room.	A 143	**Monitoring Plan** Use of the triage room during the triage interview process will be observed for 30 PES patients per month. The target for compliance is 90% per month for 3 consecutive months. During monitoring, instances of non-compliance will be reviewed with the leadership team to identify trends and education opportunities. Auditing will continue until 90% compliance has been achieved for 3 consecutive months. **Incorporation Into QAPI Program** Ongoing monitoring of use of the triage room during the triage interview process will be observed for 30 PES patients per quarter. The target for compliance is 90% per quarter. During monitoring, instances of non-compliance will be reviewed with the leadership team to identify trends and education opportunities. Results will be shared at monthly Quality Council meetings. Upon hire PES Staff including: Behavioral Health Therapists, RNs, Behavioral Health Assistants, Counseling & Therapy Staff, Care Management Staff, and LIPs will receive education on use of the new triage room. **Completion Date** 10/10/2020 **Responsible Party** Chief Nursing Officer	
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on observations, review of recorded video footage, interviews, email communications, review of incident and medical record documentation for 21 of 21 psychiatric patients (Patients 1 through 21), review of training records for 5 of 14 staff (Staff Q, K, L, M and W), review of policies and procedures, review of building floor plans and other documentation related to safety and physical environment risk, it was determined that the hospital failed to fully develop and implement policies and procedures that	A 144	--- The following actions will ensure that patients' rights to safe care are recognized, protected, and promoted. The Chief Nursing Officer is ultimately responsible for A144.:	

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ensured that patients' rights to safe care were recognized, protected and promoted, and patients experienced actual and potential harm:
* Patients were allowed access to unsafe items. Those incidents included a case where an inpatient was provided with unsafe items which the patient used to attempt suicide, and two cases where patients removed smoke detectors from the ceiling in the secure unit.
* Patients were not protected from elopement from secure units and the secure facility. Those incidents included two cases where inpatients were allowed to elope from the secure facility.
* Patients were not supervised and observed to ensure safety. Two patients were allowed to engage in sexual intercourse and other sexual acts on the floor of a locked bathroom in the emergency services unit.
* A patient was not protected from the use of unnecessary restraint and seclusion.
* Investigations of and response to patient incidents were not timely or complete to prevent recurrence of similar events.

This is a repeat deficiency cited previously on surveys completed on 08/08/2019, 10/05/2018, 07/30/2018 and 05/22/2018.

Findings include:

1. The P&P titled "Patient Rights and Responsibilities" dated as last revised "05/17" included the following:
* "To assure that patients receiving health care services at any Legacy facility and their families are treated with dignity and respect ... Legacy Health (Legacy) recognizes and respects the dignity and individuality of each person admitted to or treated within our facilities. All members of

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A 144	Continued From page 15 our workforce (employees, volunteers, medical staff, residents, students, contracted personnel and vendors) are expected to provide considerate and respectful care, meeting the cultural, spiritual, emotional, and personal dignity needs of each individual patient and their family." * "Patient's have the right to personal privacy and safety in accordance with state and federal law and Legacy policies." * "Safety of the environment of care is a primary focus for all Legacy staff. Periodic education in environmental safety, equipment management, infection control and physical security is a requirement. Drills, auditing and monitoring are carried out on a routine basis to ensure that staff awareness is high and response is appropriate." * "Staff are trained in the identification of abuse , neglect or harassment of patients and processes are in place to ensure timely reporting and response ..." * "Patients have the right to be free from all forms of abuse and harassment." * "Patients have the right to be free from restraint or seclusion and corporal punishment. Legacy protects the right of patients to be free of restraint or seclusion when restraint or seclusion is not indicated for the protection of the patient's health or the safety of the patient, staff or others." 2. The P&P titled "Management of Personal Belongings and Potentially Unsafe Items" dated as last revised "Sep 2018" was reviewed. It included the following information: * "To assure patient safety by defining a process to identify and restrict patient access to personal belongings and potentially unsafe items in the care milieu." * "Patients may be allowed to wear their own clothing and to retain possession of personal	A 144		

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A 144	Continued From page 16 items except when items pose a threat to safety." * "KEY POINT: Patients at risk for suicide during hospitalization may have additional personal belongings limitations." * "Items fall into four categories: never, supervised, group only, and unmonitored. Appendix A includes examples of items which will be deemed as never available, available only in a therapeutic group setting, available under supervision, and unmonitored." * "Personal belongings that pose a safety risk such as items with straps will only be made available to patients upon their request and under direct supervision." * "Environmental safety checks will be conducted twice daily on patient care areas. The environmental safety check includes an examination of all patient rooms and communal living areas for potentially unsafe items." * "Appendix A: Items which a patient may NEVER have access to while hospitalized are items that are illegal, weapons, items that are intentionally hard and sharp or easily turned into a cutting implement when broken, flammable items, and items that are easily used for strangulation ... This is not a comprehensive list ..." * The Appendix A "Never" column contained: - Weapons or drugs - Backpacks and purses with long straps - Smoking materials or lighters - Belts, cords, or shoelaces - Alcohol products - Aerosol products - Intentionally sharp items (knives, non-electric razors, metal nail files) - Heavy boots with steel toes - Phone chargers - Plastic bags - Paracord survival bracelets	A 144		

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A 144	Continued From page 17 - Golf pencils - Clothes hangers * The Appendix A "Therapeutic Group" column for those "items that are used in the presence and direction of therapeutic and recreation staff " included: - Long pens, pencils, paintbrushes * The Appendix A "Supervised (direct observation)" column included: - Grooming supplies and nail polish - Breakable or short string for jewelry * The Appendix A "Unmonitored" column included: - Hygiene items (ex. toothbrush, toothpaste, shampoo) - Cell phones - Hair picks - Scrubs/clothes - Radio/DVD player - Patient computers - Jewelry - Linen and bedding Appendix A did not clearly or consistently classify "unsafe items." For example: - The "Never" column included "... purses with long straps" but did not define "long" and what length of strap would not be considered unsafe. - The "Unmonitored" column included "jewelry" which is a general, broad category that includes items with pins, cords, plastic string, beads and other small items, sharp edges, etc. - The "Unmonitored" column included "Hygiene items ... hair picks" that were items that could be made of metal or be broken with resulting sharp edges. - The "Unmonitored" column included "Radio/DVD player ... Patient computers" that were items that may have cords.	A 144	**Procedure & Process for Implementation (Unsafe Items - Policy)** The Management of Personal Belongings and Potentially Unsafe Items Policy will be updated to include the following changes: - Clarification of length of unsafe purse straps - Further define safe jewelry types - Clarification that all electronic devices provided to patients are cordless. - Clarification of safe scrubs/clothes types. *Note 1 – Risk Assessment of hair picks was completed and deemed safe. *Note 2 – Only cordless items are distributed to patients including radio/DVD players as per risk assessment process. *Note 3 – Risk assessment of patient computers completed. All computers are monitored. **Monitoring Plan/ Incorporation Into QAPI Program** Refer to section labeled: Unsafe Items – Environmental Risk Assessment Process and Access to Unsafe Items **Completion Date** 10/10/2020 **Responsible Party** Chief Nursing Officer	

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- The "Unmonitored" column included "Scrubs/clothes" that were items that may include straps and strings and cords.

3.a. During interview on 10/14/2019 beginning at 1600 the LEMC UCBHP stated that in regards to Patient 7 there had been "a significant incident last Sunday," on 10/06/2019, at the LEMC UCBH.

On 10/14/2019 beginning at 1640 the UCBHP, Unit 5 NM, RM, PESMD, DOS, Interim UCBHP, and the QI&CCM were interviewed and the following information was provided:
* On admission during the past week Patient 7 had verbalized threats to harm him/herself, had thoughts of suicide and was on hourly observation checks.
* At approximately 0600 on Unit 5 a BHT was doing hourly observation rounds and found Patient 7 in his/her room bathroom with multiple zip ties interconnected around his/her neck. The patient was still talking and directed the BHT to a suicide note in the room.
* An RN responded and removed the zip ties with trauma scissors.
* The patient was evaluated by the PES provider and transferred to LGSMC ED for evaluation.
* Patient 7 returned from the ED later that day with no new orders.
* The patient was transferred to another adult inpatient unit at UCBH, was on 1:1 observation for two to three days and was currently on Q15m observation checks.
* Zip ties were used at LEMC UCBH on pants and shoes to replace patient's belts and shoelaces.
* The patient had obtained zip ties and had connected four of them together to create a ligature around his/her neck.

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A 144	Continued From page 19 * The patient reported that he/she used the zip ties that were on his/her pants. * The UCBHP and the PESMD reported to UCBH that day to address the incident. * Actions taken included elimination of the use of zip ties completely in the facility, staff education and addition of zip ties as a ligature risk to the physical environment risk assessment. * None of the zip ties used or removed from the facility were kept, no pictures of the zip ties were taken nor was there a physical description of them including the length. * However, the RM disclosed that, unknown to the rest of the team present, that he/she did have one or more of the zip ties in his/her possession. Observation on 10/14/2019 of two zip ties provided by the RM revealed they were 6 and 1/4 inches long and were off white in color. 3.b. The medical record of Patient 7 was reviewed and reflected that he/she presented to the LEMC UCBH PES on 09/16/2019 and was admitted as an inpatient on 09/19/2019. The CMO, the UCBHP, Interim UCBHP, Unit 5 NM, QI&CCM and the ACC2 were present during the medical record review and provided the following information: * Patient 7 had no "serious" SAs in the past. * Patient 7 was assessed every day for suicidality. * The patient had a fantasy about hanging him/herself from a bridge. * Patient 7 was "not seriously trying to kill [him/herself]" during this incident. * The patient had "totally regressed" as result of the incident. He/she had "turned a corner with that event" and would "probably" go to the State psychiatric hospital from UCBH.	A 144		

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A 144	Continued From page 20 * P&Ps require that RNs document the C-SSRS about each patient's suicide risk at least once every shift. * P&Ps require that LIPs document a suicide risk evaluation for each patient at least once every day. The medical record included the following information: * On 09/19/2019 at 1705 the psychiatrist's "Psychiatry Inpatient Admission Attending Initial Evaluation" reflected that Patient 7 was a "low risk of suicidal behavior while in the hospital." * On 09/20/2019 at 1321 an order for "Observation Frequency ... Hourly Rounding" was initiated. * On 10/01/2019 at 0808 the psychiatrist's "Psychiatry Attending Daily Inpatient Progress Note" reflected that Patient 7 was a "low risk of suicidal behavior while in the hospital." * On 10/01/2019 at 1108 an RN documented on the C-SSRS that the patient stated he/she had suicidal thoughts. * On 10/01/2019 at 2338 an RN documented on the C-SSRS that the patient stated he/she had suicidal thoughts. * On 10/02/2019 at 1657 the psychiatrist's "Psychiatry Attending Daily Inpatient Progress Note" reflected that Patient 7 was a "low risk of suicidal behavior while in the hospital." * On 10/03/2019 at 2018 the psychiatrist's "Psychiatry Attending Daily Inpatient Progress Note" reflected that Patient 7 was a "low risk of suicidal behavior while in the hospital." * On 10/04/2019 at 0941 and again at 0947 an RN documented on the C-SSRS that the patient stated he/she had suicidal thoughts and at 1009 the RN documented that he/she notified the LIP	A 144		

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A 144	Continued From page 21 and the "LIP Response" was "Monitor." * On 10/04/2019 at 1840 an RN progress note reflected that the patient "Endorsed not wanting to live and SI with plans outside of the hospital. Provider informed." * On 10/04/2019 at 1841 the psychiatrist's "Psychiatry Attending Daily Inpatient Progress Note" reflected that Patient 7 was a "low risk of suicidal behavior while in the hospital." * On 10/04/2019 at 2205 an RN documented on the C-SSRS that the patient stated he/she had suicidal thoughts. * On 10/05/2019 at 0155 an RN progress note reflected, "Assumed care at 1930 ... Endorses SI, continues to verbalize [he/she] dreams of jumping off the steel (sic) bridge ..." * On 10/05/2019 at 1045 an RN documented on the C-SSRS that the patient stated he/she had suicidal thoughts. * On 10/05/2019 at 1102 an RN progress note reflected, "Thought content - Suicidal ideation ... [He/she] continues to endorse SI consistent with past assessment stating that [he/she] can't see how [his/her] life can improve and stating that [he/she] 'might as well jump off a bridge.'" * There was no documentation to reflect the LIP was notified of the SI Patient 7 expressed on 10/04/2019 at 2205 or on 10/05/2019 at 0155 and at 1102. * On 10/05/2019 at 1324 the psychiatrist's "Attending Weekend Cross-Cover Note" reflected that Patient 7 was a "low risk of suicidal behavior while in the hospital." * On 10/05/2019 at 2304 an RN progress notes reflected "At around 0458, [Patient 7] came to nursing station and reported SI with no plan and intent ... On call provider notified, no order received." * On 10/06/2019 at 0458 an RN documented on	A 144		

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A 144	Continued From page 22 the C-SSRS that the patient stated he/she had suicidal thoughts and at 0504 the RN documented that he/she reported that to the LIP and no orders were received. * On 10/06/2019 at 0520 an RN progress note reflected, "Pt requested to speak to the CRN at approximately 0500 ... When asked about SI pt stated 'I don't want to kill myself here, you guys are smarter than that. I just want to know what I have to do to be transferred to a place that tell (sic) me about assisted suicide which is legal in Oregon." * On 10/06/2019 at 0600 an RN progress note reflected, "Pt has been monitoring, (sic) during 6:00am round, patient hands a note to staff asking [his/her parent] be call (sic) about wanting to attempt suicide. This writer when (sic) to check patient and found pt in (sic) sitting on the toilet with zip tie around [his/her] neck. The writer cut off the zip tie. Patient was not unconscious, VSS, no respiratory distress ... Patient transported to Good Sam around 6:33am by ... EMTs." * On 10/06/2019 at 0610 a physician progress note reflected, "I was called earlier on shift (but had not yet documented) that pt had ongoing SI. I was previously aware of the pt from prior stays in PES and have known that [he/she] often has SI, discussed with nursing staff and agreed no additional supervision appeared warranted. Called to floor at approximately 0600 due to pt suicide attempt. Per nursing, pt had been in the bathroom on the toilet, hands visible, stating [he/she] was suicidal. Nursing staff reported concerns that [his/her] suicidality seemed to be increasing and when they promptly returned to check in on [him/her he/she] had tied zipties (sic) around [his/her] neck and was purple/blue. [He/she] fell to the floor and hit [his/her] head, zipties (sic) cut and reperfused. VSS. I was called	A 144		

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A 144	Continued From page 23 promptly and arrived on the floor with pt conversant, lying on the floor, appeared tremulous but alert ... pupils equally round, EOMI, no abrasions or lacerations ... Given that pt was found cyanotic and hit [his/her] head when falling forward during the attempt, though [he/she] appears neurologically intact [he/she] is withdrawn, called Legacy Good Sam and elected to transfer for medical clearance." * On 10/06/2019 at 0800 the psychiatrist's "Psychiatric Attending Inpatient Discharge Summary" reflected that Patient 7 was "at high risk of imminent suicide." * A "Clinical Photo" of Patient 7's "Suicide note" was dated as entered into the EHR on 10/06/2019 at 0856. The note stated, "Please call my [parent] at [phone number] promptly at 9:00 am to inform [him/her] of my hopefully successful suicide attempt. All my love to ... [Patient 7's signature] 10-6-2019 @ 5:47 am." * A LGSMC ED RN progress note dated 10/06/2019 at 0703 reflected that Patient 7 had a "Red line on throat from zip tie ..." Patient 7 was examined, medically cleared and returned to LEMC UCBH to continue his/her inpatient admission. * On 10/06/2019 at 1651 the psychiatrist's "Psychiatric Inpatient Admission Evaluation" after Patient 7's return to UCBH reflected that he/she "is at extreme risk of suicidal behavior while in the hospital, and necessary hospital precautions at this time should include 1:1 within 10 feet and safety interventions as per orders." 3.c. Incident documentation reflected that on 10/06/2019 on Unit 5 Patient 7 made a "Suicide Attempt." The documentation reflected "... during 6:00am round, patient hands a note to staff asking [his/her parent] be called about wanting to	A 144		

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A 144	Continued From page 24 attempt suicide. This writer when (sic) to check patient and found pt in (sic) sitting on the toilet with zip tie around [his/her] neck. The writer cut off the zip tie. Patient was not unconscious, VSS, no respiratory distress ... Patient transported to Good Sam around 6:33am by ... EMTs." The only follow-up or investigation documentation was "Linked this iCare to iCare [#] which will be primary iCare. Please refer to [iCare #] for full investigation follow up. Closing this iCare." Incident documentation linked to the documentation referenced immediately above reflected that on 10/06/2019 on Unit 5 Patient 7 made a "Suicide Attempt." The documentation reflected: "upon (sic) doing 0600 hr rounds. (sic) when (sic) entered room this staff noted pt. to be in the bathroom with the curtain open. staff (sic) spoke with pt. asked how [he/she] was and approached the bathroom door. staff (sic) was able to visualize pt. was naked and sitting on the toilet. Pt. had both hands clearly visible in [his/her] lap and was speaking to staff in full sentences. Pt. stated 'you really suck at your job. I'm fine.' staff (sic) asked if pt needed anything and [he/she] stated 'no.' as (sic) staff was leaving the room pt. stated 'there is a note on the desk'. Staff turned around and found the note. The note was a suicide not. Pt. was still talking at staff. Staff took note directly to pt's RN. RN and staff returned to pt. room to find pt. had a chain of zip ties around [his/her] neck. staff (sic) yelled for help and attempted to relieve pressure of ties until they could be cut. pt.(sic) ties were cut. Pt. fell from toilet to bathroom floor. security (sic) called Code M and Dr and nursing supervisor notified. vitals (sic) obtained." Documentation dated 10/08/2019 reflected that	A 144		

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A 144	Continued From page 25 "Investigation started ... 10.06.19" and was "Immediate safety plan: Assessment and securement of zip ties throughout the units. Communication to staff during staff huddles and bedboard that only Charge RNs are authorized to provide and apply zip ties. Communication included proper process of applying and cutting off excess 'tail' on zip tie. Meeting scheduled for 10.09.19 to decide on longer term solution." There was no other investigation documentation that included, but was not limited to: how and why the patient had the zip ties, whether those were allowed items and whether they had been evaluated as part of the physical environment risk assessment, what the "process of applying and cutting off excess 'tail'" meant and whether that "process" was described in a written policy and procedure for use of zip ties, or whether a written policy and procedure for use of zip ties existed. A separate document titled "Action Plan Unsafe Items in Patient Care Area's/Facility (sic)" and dated as "Date Action Plan Ready to Launch: 10/06/2019" and "Date all Actions (sic) Plan are Complete: 12/06/2019 (sic)" and "Last Update 10/10/19." The "Action Plan" contained 13 rows with an action item in each row. Six (6) of those were identified as "Complete" and the others were "In-process." One of the actions was "Leadership team meet (sic) to discuss safety of zip ties at Unity. Determinded (sic) not appropriate for our environment. Recommended removal of all zip ties from facility ... [Due Date] 10/6/2019 ... [Status and Date] Complete 10/06/2019." However, the next action item was "Staff Communication on need to eliminate use of zip ties ... [Due Date] 10/9/2019 ... [Status and Date]	A 144		

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A 144	Continued From page 26	A 144		

Complete 10/09/2019," three days after it was decided that all zip ties would be removed."

Twenty-nine undated forms titled "Legacy Health Patient Safety Conversation Zip Tie Use at Unity" were provided. The forms contained the following language "The use of zip ties in the behavioral health setting poses a potential ligature risk if not used in a supervised manner. Patients can link ties together which creates even greater risk. Patient can stockpile zip ties without rigorous practices in place to control access. At Unity 8-inch white zip ties are used as an alternative to belts for holding up pants and instead of shoelaces to keep shoes on. Background - The use of zip ties across Unity is not consistent. Not all units are using zip ties; some units have moved to the use of wristbands for the same purpose. Access to zip ties is not restricted to specific individuals. The process for applying zip ties is not consistent across all staff who may have access to zip ties. Short-term immediate change - Zip ties will be placed in one centralized location on each unit where they are in use and stored in a locking drawer inside the nurse's station. Charge Nurses will be the only staff member to access and apply the zip ties if needed to keep patient clothing secure. We have chosen to restrict the use of zip ties as a short-term safety measure until a long-term decision can be made with a broader group regarding this ligature risk. Charge nurses shall assess the need and risk for each patient. Zip ties will be physically applied by the charge nurse and made as small as possible with all ends cut off so no tail is hanging." At the bottom of the form were rows and columns of staff names, signatures and dates signed.

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A 144	Continued From page 27 Although the "Action Plan" document reflected a decision to eliminate use of zip ties was made on 10/06/2019, the "Patient Safety ... Zip Tie Use ..." forms that described a process for continuing to use zip ties were signed by approximately 167 staff and dated on 10/06/2019, 10/07/2019, 10/08/2019, 10/09/2019, 10/10/2019 and 10/16/2019. For signatures of approximately 40 staff there was no date recorded so it was unclear when they received the information. 3.d. The undated "Ongoing BH Environmental Risk Assessment and Mitigation Plan" addressed unsafe areas and items and included the following: * "'No tie' shoelace substitutes (Image B43). Evaluated to be a risk when multiple rubber pieces are tied together ... Unit 2 ... Remove from units ... Completion Date 9/18/2018." * "zip ties ... 5, 1E, 1W ... Date identified 10/6/2019 ... remove use of zip ties across Unity ... Educate nursing to use wristbands in lie (sic) of zip ties ... Completion Date 10/9/2019." Although the risk assessment reflected that on 09/14/2018, over a year prior to the Patient 7 incident, similar "no tie" substitutes for shoelaces had been identified to have the potential to be attached together to form a ligature, the zip ties were not similarly evaluated and on 10/06/2019 Patient 7 was provided the zip ties to use as a belt. After Patient 7 had attached multiple zip ties together to fashion a ligature and attempt suicide the zip ties were added to the risk assessment. However, the zip ties entry on the risk assessment was not clear as it reflected that all zip ties were removed on 10/09/2019 whereas the "... Zip Tie Use at Unity" form, identified under Finding 3.e. above, reflected zip ties were stored	A 144		

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A 144	Continued From page 28 on units for use by charge nurses. An internal UCBH email memo dated 10/09/2019 at 1647 titled "Important Notice of Practice Change at Unity ..." related to a change in the use of zip ties, was reviewed. It reflected that the "no tie" shoelace substitutes referred to in item #135 of the risk assessment as removed from units on 09/14/2018, were in fact found on a unit on 10/09/2019. The memo reflected, "Additional unsafe item - 'no tie shoelaces': When rounding on the units this morning, 'no tie shoelaces' were found on one of the units ... 'No tie shoelaces' have ... deemed to be unsafe. If 'no tie shoelaces' are found, please remove and notify leadership." In addition, the "wristbands" referenced on the "Legacy Health Patient Safety Conversation Zip Tie Use at Unity" form in use on some units to replace belts and shoelaces, and on the zip tie entry on the physical environment risk assessment, were not addressed on the risk assessment to determine if those had been evaluated for safety and how risk of forming a ligature from multiple "wristbands" would be prevented. 3.e. Although Patient 7 had increasingly expressed suicidal thoughts staff provided him/her with zip ties that he/she used to create a ligature with which he/she attempted suicide. Although a similar item used as a shoelace substitute had been evaluated as a part of the environmental risk assessment to be unsafe, the zip ties were put into service without such an evaluation. The incident resulted in physical and mental harm for the patient as he/she fell and hit his/her head on the floor and was transferred to another hospital's ED for evaluation where red	A 144		

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A 144	Continued From page 29 ligature marks around his/her neck were identified. Upon return to UCBH his/her behaviors escalated, psychiatric condition worsened and suicide risk increased resulting in increased suicide precautions. 4.a. The undated "Ongoing BH Environmental Risk Assessment and Mitigation Plan" addressed other unsafe items that included: * "Toothbrushes ... All units ... All patient rooms ... Items are allowed unmonitored unless an elevated or extreme risk has been identified by staff or provider ... Completion Date 5/20/2018." * "Nail polish ... All units ... Kept at nurse's station ... Nail polish will be only used with staff supervision (direct line of sight) ... Completion Date 5/20/2018." * "Other writing utensils (examples: colored pencils, gel pens) ... Group rooms ... Other writing utensils will only be used with staff supervision during groups ... Completion Date 5/20/2018." * "Paintbrushes ... All units ... All rooms ... Paintbrushes will be removed from general milieu and only used during groups ... Completion Date 5/20/2018." * "Writing Utensils used by staff ... All areas ... Staff writing utensils will be kept in their possession while in patient accessible areas ... Completion Date 5/20/2018." * "pillow was found with a plastic bag covering it ... Unit 6 ... verify all of the pillows in all of the rooms to make sure we had not left any other plastic cover (sic) ... Completion Date 9/3/2018." * "Shower caps can present risk for suffocation ... All units ... Remove from units ... Completion Date 9/14/2018" * "apples in stretchy plastic bags ... All units ... 2/15/2019 ... evaluate options for delivery of apples ... Completion Date 4/1/2019 ... Changed	A 144	**Procedure & Process for Implementation (Unsafe Items – Environmental Risk Assessment Process and Access to Unsafe Items)** Wristbands and uncaged smoke detectors will be assessed and added to the environmental risk assessment. The safety of apple plastic bags will be clarified on the environmental risk assessment. The Management of Personal Belongings and Potentially Unsafe Items Policy will be updated to include a formal process to assess new items including staff education and placement on the environmental risk assessment. The process will require all new items to go through an initial risk assessment conducted by the clinical leadership team and documented on the environmental risk assessment. Results of risk assessment that impact clinical practice or patient care will be shared with staff to incorporate into practice accordingly. When information is communicated to staff, the date of implementation will be included. Note: It was noted that the ongoing environmental risk assessment is “undated”. The risk assessment document is a “living document” and the date of each risk-assessed item is included next to each item. In order to address any potential drift in practice resulting in patients obtaining unsafe items, staff will be re-educated on changes in the Management of Personal Belongings and Potentially Unsafe Items Policy and the expectation to screen patients and patient	

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A 144	Continued From page 30 to new vendor with non stretchy plastic for apples." It was not clear whether the non stretchy plastic used by the new vendor had been evaluated for safety. 4.b. Incident documentation reflected that on 08/01/2019 on Unit 6 Patient 21 "obtained a piece of paintbrush while in unit classroom and refused to give it to staff. Pt used metal paintbrush piece to superficially scratch L wrist and L thigh." Follow-up documentation dated 08/02/2019 reflected that "... patent will now only be allowed to use all plastic paint brushes and staff will double check classroom for potentially unsafe items before entering with pt ... Just Culture findings: Paint brushes are allowed to be used with 1:1 supervision and patient had not taken one apart previously, staff followed protocol correctly." However, there was no investigation to confirm that staff followed protocol as there was no information about how the patient "obtained" the metal piece of paintbrush and how the patient was being supervised at the time he/she "obtained" the metal piece of paintbrush. It was unclear how the patient could have "obtained" the unsafe item while being directly supervised 1:1. Incident documentation reflected that on 08/05/2019 on Unit 6 Patient 21 had a second incident that involved a paintbrush. The documentation reflected "Accidentally broke a paintbrush in the classroom and later took a small piece of metal from the paintbrush. Returned to room and superficially self-harmed on lateral aspect of right calf and left forearm." Follow-up documentation dated 08/07/2019 reflected "Human error - staff forgot about metal on paint brush restriction, not a repetitive error ... Provider orders followed: no, paintbrush with metal given	A 144	clothing in triage, upon admission, and when indicated by staff clinical judgement. Behavioral Health Therapists, RNs, Behavioral Health Assistance, Counseling & Therapy Staff, Care Management Staff, LIPs, and Patient Access Staff will receive education on the Management of Personal Belongings and Potentially Unsafe Items Policy/Procedure and Environmental Risk Assessment processes. Facilities staff will receive education on the Environmental Risk Assessment processes. **Monitoring:** In-room belongings will be inspected to ensure that patients do not have unsafe items for 30 patients per month. The target for compliance is 90% per month for 3 consecutive months. During monitoring, instances of non-compliance will be reviewed with the leadership team to identify trends and education opportunities. Auditing will continue until 90% compliance has been achieved for 3 consecutive months. **Incorporation Into QAPI Program** Ongoing monitoring of unsafe items will be conducted for 30 patients per quarter. The target for compliance is 90% per quarter. During monitoring, instances of non-compliance will be reviewed with the leadership team to identify trends and education opportunities. Results will be shared at monthly Quality Council meetings. Policies are reviewed and updated at least every three years and/or with regulatory updates.	

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A 144	Continued From page 31 ... Standard of care followed: yes ... Repeated event: yes ... No failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. No reasonable belief that neglect occurred." As on 08/01/2019 there was no information to reflect an investigation into the level and quality of supervision of the patient that allowed him/her conceal a metal piece of the paintbrush having "accidentally" broken it in the classroom while under 1:1 supervision. It was unclear how the "Standard of care" was determined to be followed and how it was determined that no neglect occurred when the patient had been allowed to access an unsafe item, the same unsafe item used for self-harm twice in a four-day period. 4.c. Incident documentation reflected that on 08/17/2019 on Unit 1E Patient 1 was found with a bag of marijuana and a lighter. The documentation reflected that "Investigation started: 9/3/19" and "Investigation status: complete" on 09/03/2019. However, the investigation was not timely nor complete and did not conclude how the patient in a secure unit came to be in possession of drugs and a lighter, both of which a patient is to "NEVER" have in their possession according to the P&P related to unsafe items. There was no deficient practice identified and no actions taken to prevent recurrence. 4.d. Incident documentation reflected that on 08/18/2019 on Unit 1E Patient 2 was found with a lighter, marijuana and an " I cigarette stick" and the patient's room "smelled like 'weed.'" The documentation reflected that "Investigation started: 9/5/19" and "Investigation status: complete" on 09/06/2019. However, the	A 144	Upon hire Behavioral Health Therapists, RNs, Behavioral Health Assistants, Counseling & Therapy Staff, Care Management Staff, LIPs, and Patient Access staff will receive education on the Management of Personal Belongings and Potentially Unsafe Items Policy/Procedure and the Environmental Risk Assessment process. Upon hire, Facilities staff will receive education on the Environmental Risk Assessment processes. **Procedure & Process for Implementation (Investigations)** To ensure timely and complete investigations, the Investigation Reporting template will be updated to include: • Root Cause Identified • Actions taken to prevent recurrence, including dates In addition to ensuring a complete investigation as described above, when there is sexual contact between two patients, the investigation template will include: • If patient has been coerced or manipulated • Physical exam findings, when indicated	

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A 144	Continued From page 32 investigation was not timely or complete and did not conclude how the patient in a secure unit came to be in possession of a lighter, marijuana and an "I cigarette stick," items a patient is to "NEVER" have in their possession according to the P&P related to unsafe items. There was no deficient practice identified and no actions taken to prevent recurrence. 4.e. Incident documentation reflected that on 09/05/2019 on Unit 2 Patient 3 was found to have matches and marijuana and his/her room "smelled of marijuana." The documentation reflected that the "Investigation started: 9/5/19" and "Investigation status: complete" on 09/19/2019. However, the investigation was not timely or complete and did not conclude how the patient in a secure unit came to be in possession of drugs and matches, items a patient is to "NEVER" have in their possession according to the P&P related to unsafe items. There was no deficient practice identified and no actions taken to prevent recurrence. 4.f. Incident documentation reflected that on 09/07/2019 on Unit 2 Patient 4 was found with "containers of Pringles that have metal bottoms and pt had placed glass bottles of nail polish under potato chips. Pt also noted to have a 1 liter bottle of Pepsi, an entire bag of cereal, and big plastic bag of candy. Pt. was placed in seclusion soon after discovery d/t inability to remain safe and escalating bx. Staff need to be more aware of what they give patients. Pt could have fashioned weapons with the items that staff members allowed this patient to have and could have seriously injured someone." The documentation reflected that "Investigation started: 09/20/19" and "Investigation status: complete" on 09/20/2019.	A 144	Nurse managers will be re-educated on the expectations of a complete investigation, as well as required timeframes to complete an investigation. Nurse managers will be educated on the changes made to the investigation templates. **Monitoring Plan** Auditing of 30 ICAREs per month will be conducted to ensure that the Incident Report Summary template is completed for each Incident Report. The target for compliance is 90% per month for 3 consecutive months. During monitoring, instances of non-compliance will be reviewed with the leadership team to identify trends and education opportunities. Auditing will continue until 90% compliance has been achieved for 3 consecutive months. **Incorporation Into QAPI Program** The leadership team will review 30 ICAREs per quarter to ensure that the Incident Report Summary template is completed for each ICARE. The target for compliance is 90% per quarter. During monitoring, instances of non-compliance will be reviewed with the leadership team to identify trends and education opportunities. Results will be shared at monthly Quality Council meetings. Nurse managers will receive education on the revised template upon hire. **Completion Date** 10/10/2020 **Responsible Party** Chief Nursing Officer	

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However, the investigation was not timely or complete and although video footage reviewed reflected the patient's possession of those items it did not clearly conclude how he/she came to be in possession of them, including items a patient is to "NEVER" have in their possession and items patients may only have under direct supervision, according to the P&P related to unsafe items. There was no deficient practice identified and no actions taken to prevent recurrence.

4.g. Incident documentation reflected that on 09/08/2019 on Unit 2 Patient 5 was found with a lighter and writing pen in his/her room. The documentation reflected that "Investigation started: 09/20/19" and "Investigation status: complete" on 09/20/2019. However, the investigation was not timely or complete and did not clearly conclude how the patient in a secure unit came to be in possession of a lighter and a writing pen, items a patient was to "NEVER" have in their possession according to the P&P related to unsafe items. There was no deficient practice identified and no actions taken to prevent recurrence, except for "Implemented a full search on each return to the unit." However, it was not clear if that had not occurred previously and not clear when that was to be "implemented."

Incident documentation reflected that on 10/06/2019 on Unit 2 Patient 5, the same patient in the incident above found with a lighter, "was caught smoking in [his/her] room after [his/her visitor] brought [him/her] the lighter and the cigarettes." Incident documentation received on 10/15/2019 contained no other information and reflected no evidence of follow-up and investigation into how the patient had possession of items a patient is to "NEVER" have in their

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possession according to the P&P related to unsafe items. There was no deficient practice identified and no actions taken to prevent recurrence.

4.h. Incident documentation reflected that on 10/03/2019 on Unit 1W Patient 6 was found with a "large plastic bag of candy" in his/her room. Incident documentation received on 10/15/2019 contained no other information and reflected no evidence of follow-up and investigation into how the patient had possession of a plastic bag, an item a patient is to "NEVER" have in their possession according to the P&P related to unsafe items. There was no deficient practice identified and no actions taken to prevent recurrence.

4.i. Incident documentation received on 10/15/2019 reflected that on 10/12/2019 on Unit 6 Patient 8's "assigned nurse" gave the patient a pencil sharpener that contained three separate blades to "use alone in room." A staff member observed that occur and "immediately" intervened in the patient's room and removed the item. The documentation further reflected that "later staff was seen given (sic) same patient pencil sharpener to use to (sic) extended time and said [he/she] is monitoring. It should not be on unit at all. (Definitely NOT FOR PATIENT USE ALONE, but should not be on unit at all. (sic)" The documentation reflected, "Investigation started: 10/14/19." However, the conclusion was not clear as it reflected, "Staff needing coaching around unsafe items ... No video evidence of unsafe item reaching patient nor of attempt to provide to patient ... no unsafe item reached pt nor was pt harmed ... Standard of care followed." There was no explanation or investigation into the significant

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discrepancy between the incident as recorded by the observer of the incident versus the video footage review. In addition, the only action taken was documented on 10/15/2019 and was not clear as it reflected only "may need reminder unit wide about small pencil sharpeners."

4.j. Incident documentation reflected that on 12/02/2019 on the PES unit Patient 14 "used bra to strangle [self]." There was no other description of the incident. Documentation dated 12/04/2019 reflected that "Investigation started ... 12/3/19" and that a video review was done that showed the patient "covered completely with blanket for a total of 12 minutes. Staff then uncover patient and quickly remove bra." The investigation was not clear or complete and did not describe how the bra was positioned or how it was used and around what part of the body, nor did it identify that the P&P related to personal belongings directed that those items "... with straps will only be made available to patients upon their request and under direct supervision." Generally, bras have straps and there was no indication in the documentation that the bra used was strapless. Further, although the patient was allowed to have an unsafe item with which he/she used to harm him/herself, the investigation reflected that "Standard of Care followed ... Yes."

4.k. Incident documentation reflected that on 12/10/2019 on the PES unit Patient 15 "swallowed a pen." There was no other description of the incident or the outcome to the patient until a note recorded on 12/11/2019 that reflected "Investigation started ... 12/11/2019." Although a video review was conducted it is unclear what the review was trying to determine. The events were unclear and there was no

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indication of an attempt to determine how the patient got the pen, what type of pen, how staff knew he/she swallowed a pen and whether the patient was experiencing a change of condition. The documentation reflected the patient was transferred to another hospital by ambulance for evaluation and treatment and the only related documentation was "See attachment of XR image showing pen in stomach." Although the patient was allowed access to a pen and swallowed it, an item considered unsafe in accordance with the P&P and the environment risk assessment, the investigation reflected "Standard of Care followed ... Yes ... No failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. No reasonable belief that neglect occurred." Further, it was unclear how staff made determinations about the amount of supervision patients required, although it was reflected to be a subjective decision, as the documentation reflected "Repeated event ... Yes ... Pt did not seem to require 1:1 monitoring before event."

4.l. Incident documentation reflected that on 01/13/2020 on the PES unit Patient 16 and his/her "peer" were "suspected" of accessing and dismantling a smoke detector in the PES patient bathroom. This was identified as result of a "smoke detector malfunction called out to security in room P-101a ... in PES ... patient bathroom smoke detector found to be missing ... smoke detector not immediately found ... found in bathroom trash ..." The only follow-up documentation was recorded on 01/22/2020 as was: "Contributing factors: highly agitated patient in seclusion. Patient condition: stabilized in PES, no injury to staff/patients. Mitigation plan: President is consulting with facilities staff to look

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at potential changes to this item. Consider restraints for patient who is unable to maintain safety in seclusion." There was no other documentation.

There was no investigation that included a clear description of where the smoke detector was - in the PES patient bathroom or in a seclusion room, There was no investigation of how the patient was able to access the smoke detector, how long the patient had been allowed to be in the bathroom, there was no video review and no evaluation to determine whether patient supervision was provided appropriately. Further, staff determined that to prevent patient access to the smoke detectors they should "consider restraints" when the facility is prohibited from using restraints for their convenience or as a substitute for providing a safe environment.

The LEMC UCBH satellite location architectural firm's "State Review First Floor Plan ... Construction Documents" dated 11/08/2016 showed that the PES bathroom P-101A was located in direct view of the PES nurse's station.

A patient was able to access a smoke detector that should have been secured and tamper resistant in the psychiatric unit. That item had the potential for a patient to use it as an unsafe item to harm self or others, and the removal of a smoke detector put all patients at risk for harm from fire. However, the only documented follow-up did not occur until 01/22/2020, after a second smoke detector incident occurred on 01/18/2020.

4.m. Incident documentation reflected that on 01/18/2020 on the PES unit Patient 17 "While in

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[bathroom] of [hold room 2] patient removed smoke detector from ceiling." This was the second incident in five days. The only follow-up documentation was recorded on 02/05/2020, 18 days later, and was: "Contributing factors: patient toileting independently in hold room. Patient condition: stable, no injury. Mitigation plan: ICARE reviewed at clinical huddle and facilities aware of issue. Just Culture findings: n/a." There was no other documentation or investigation, to include, how the patient was able to remove the smoke detector, and why this patient who was in a Hold Room was able to use the bathroom, unmonitored, long enough to remove a smoke detector. The failure of staff to monitor the patient's activities created the potential for harm to Patient 17 and all other patients as described in the incident immediately above that occurred on 01/13/2020.

The LEMC UCBH satellite location architectural firm's "State Review First Floor Plan ... Construction Documents" dated 11/08/2016 reflected that there were four patient bathrooms attached to four Hold Rooms in the PES. It was unclear which one was Hold Room 2.

4.n. The undated "Ongoing BH Environmental Risk Assessment and Mitigation Plan" addressed smoke detectors as unsafe items and reflected:
* "Smoke detector cage could be used as ligature ... all units ... Breakaway test demonstrated the mesh cage is a ligature risk. Team tested the smoke detector and deemed it to be safe without the cage ... Remove all of the mesh smoke detector cages from patient rooms and patient bathrooms ... Completion Date 9/17/2018."
* "Smoke Detector Mesh Cover P 162 and P 163 ... PES triage ... P 162 and P 163 ... immediate

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A 144	Continued From page 39 removal of mesh covers by facilities ... Completion Date 10/4/2018." There were no additional or updated entries related to smoke detectors on the environmental risk assessment. 5.a. Incident documentation reflected that on 10/12/2019 at 1850 Patient 11 from Unit 1E "eloped from the garden area via roof next to the solarium." The incident documentation received on 10/15/2019 was not complete and did not include an investigation to identify all causes and deficient practices. However, a separate document titled "Action Plan" was provided. The action plan reflected that several actions had been identified and were in process that included the following actions dated as "Completed" on 10/14/2019: * "Debrief of critical patient incident/event at facility." * "Gardens Closed Until environmental careassessment (sic) of area complete and plan for garden use developed." * "Review and revise current Unity Elopement Policy." 5.b. During interview with staff that included the UCBHP, CMO, a NM and ACC2 on 10/15/2019 at approximately 1645 the following information was provided: * Patient 11 had been admitted to LEMC UCBH on a "14-day diversion." * On 10/12/2019 at approximately 1830 the patient was outside in the South Garden with a group and eloped over the roof. * Staff in the garden saw him/her on the roof but didn't see him/her get on the roof and lost sight of him/her as he/she ran across the roof.	A 144		

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A 144	Continued From page 40 * Policy requires there be two staff in the garden with patients. * There should have been three (3) staff at that time as one of the patients was 1:1 observation. * Patient 11 had not returned to the facility as of 10/15/2019. * The family had been in contact with Patient 11. 5.c. Recorded video footage from four cameras views in the South Garden and a camera view from the hospital interior, during the timeframe when Patient 11 eloped on 10/12/2019, was reviewed on 10/25/2019 beginning at approximately 1540 with the CNO, Interim UCBHP and the QI&CCM. The video revealed the following: The external garden camera views showed: * The four camera views in the South garden did not capture all corners and areas in the garden. There were blind spots in which Patient 11 and others were not in view at all times. * Daylight was diminishing in the garden at that time. * There were two entrances/exits from the building into the garden. A North door from an interior corridor and a door from the 1East Solarium. * At 1835 a group of individuals entered the South Garden through the North entrance/exit door. Initially during the first minute, 12 patients, an RN and two BHTs, identified by staff present during the review, were observed. One of the staff persons initially carried a blanket or sheet out with him/her, was observed to wrap that around his/her shoulders and body and remained wrapped up in the blanket or sheet through the majority of the video reviewed. * After the group had entered the garden, multiple	A 144		

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A 144	Continued From page 41 individuals were observed coming and going through the 1East door during the video recording. * The staff members proceeded to the south end of the garden, barely visible in the camera views and furthest from the North and 1East doors. * At 1837 Patient 11 was observed to move in the direction near the North door. Patient 11 remained in that area for the duration of the video recording. He/she moved in and out of a blind spot in that area on multiple occasions but was never observed in any other area of the garden. No staff members were observed to approach or engage with the patient during the video recording. * One of the staff members walked casually around a circular garden path multiple times with another person. The staff person carried a cup of beverage with one hand and had his/her other hand in a pocket. Although he/she passed near where Patient 11 was standing he/she did not engage with the patient. * At 1840, the only time Patient 11 moved away from the area near the North door, he/she was observed to move towards the 1East door, look and wave in the direction of the camera in which he/she was in view, and climb onto and stand on a bench near the 1East wall and door. * At 1842 Patient 11 was observed to move in the direction of the North door area again and into a blind spot. * At 1847 a partial view of Patient 11 was visualized briefly in the area of the North door. * At 1850 a partial view of Patient 11 was again visualized briefly in the area of the North door. * At 1852 Patient 11 was observed standing in full view in a corner immediately next to the North door and adjacent to the 1East Solarium wall and roof. The patient was not visualized again.	A 144		

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A 144	Continued From page 42 * At 1853 staff and patients began to move in the direction of the North door. * At 1856 SSOs were observed to enter the garden. The interior camera showed: * At 1857 Patient 11 was in a basement corridor inside the hospital, he/she opened a door and exited to the outside of the building. According to online sunset times, on 10/12/2019 sunset was at 1816. During the video recording staff and patients were observed to be casual and informal. There were no organized activities observed to occur. Some patients were observed to walk in circles around the garden path and some were observed shooting baskets at a basketball hoop. Some patients and staff were not observed due to blind spots in the camera views. The staff person wearing the blanket was observed to be seated on a bench near the south end of the garden. The only staff person who entered the proximity of Patient 11 during the entire recording was the staff person who walked in circles with another person. 5.d. During tour of the South Garden on 10/15/2019 at 1715 with staff that included the UCBHP and the CMO the following information was provided: * During daytime hours seven (7) days a week counseling staff conducts organized group garden visits as therapeutic activities. * After hours and on weekends RN and BHT staff take patients in groups to the garden, there are no P&Ps for that and those are not organized, therapeutic activities.	A 144		

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A 144	Continued From page 43 * The garden visit during which Patient 11 eloped was at 1830 with a group of patients accompanied by RN and BHT staff and was not an organized, therapeutic activity. * There were no counseling staff present during that garden visit. * The courtyard has been closed since the elopement and other mitigation/corrective actions are in process and being planned. 5.e. The P&P titled "Counseling and Therapy: Therapeutic Group Guidelines" dated as last reviewed "Sep 2018" included the following: * "To describe processes associated with patient use of the therapeutic garden." * "Therapeutic garden group - The therapeutic garden at Unity will offer access to the outdoors and exercise for patients admitted to the hospital. The garden will provide: ... Natural daylight... Places for family to visit ... A safe and secure, non-institutional environment ... Scheduled and programmed activities daily." * "Counseling and Therapy staff will establish garden usage times to allow all units access to the outdoors daily." * "The garden schedule will be posted on the unit daily schedule and at the entry to the garden. Each floor has designated times for use of North and South garden. Therapy staff will communicate with charge nurses to discuss patient safety and garden pass orders." * "Patients will be transported to the garden with a minimum of 2 staff." * "The minimum staff to patient ratio will be maintained at one staff per five patients, however a minimum of 2 staff will be present at all times when patients are in the garden." * "Staff will monitor the garden during patient use by standing in designated zones to enable	A 144	**Procedure & Process for Implementation (Elopement- Garden)** Garden Policies and Procedures will be updated to address: • Garden use after hours (garden use is restricted to daylight hours), on weekends, and when there are no organized, therapeutic activities. • Presence of counseling and therapy staff. Behavioral Health Therapists, RNs, Behavioral Health Assistants, Counseling & Therapy Staff, Care Management Staff, and LIPs will receive education on the revised policies. **Monitoring Plan** 10 Garden outings per month will be observed to ensure compliance with the new policy and procedure. The target for compliance is 90% per month for 3 consecutive months. During monitoring, instances of non-compliance will be reviewed with the leadership team to identify trends and education opportunities. Auditing will continue until 90% compliance has been achieved for 3 consecutive months. **Incorporation Into QAPI Program** Ongoing monitoring of 10 garden outings will be conducted per quarter. The target for compliance is 90% per quarter. During monitoring, instances of non-compliance will be reviewed with the leadership team to identify trends and education opportunities. Results will be shared at monthly Quality Council meetings. Policies are reviewed and updated at least every three years and/or with regulatory updates.	

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A 144	Continued From page 44 visualization of the garden at all times." * "Patients' ordered level of observation will be maintained while they are in the garden." The P&P: * Reflected that the garden was a place "for family to visit" but it did not provide any other direction related to its use by "family." * Did not specify the "designated zones to enable visualization ..." in either the North or South garden. There were no P&Ps for use of the "therapeutic garden" by nursing staff or for any reason other than use by counseling and therapy staff as a therapeutic activity. 5.f. The P&P titled "Safe Transportation of Patients and Prevention of Elopement" dated as last reviewed "May 2018" included the following: * "To describe the process of safe transportation of patients within the facility ... Prevention of elopement from unit, garden or building." * "Responsible Staff: All staff, contractors with assigned badge access." * "Transportation of patients ... Off unit groups - refer to Therapeutic Group Guidelines." * "Prevention of elopement. When moving through a locked door, all staff and service providers with badge access will ensure door is clear of patients prior to opening and stay until door is completely closed. Therapeutic Group Guidelines will be followed for patients using the garden." There were no other P&Ps to address the prevention of elopement from secured units and the secure facility that included monitoring activity of patients at risk for elopement, those who were	A 144	Upon hire Behavioral Health Therapists, RNs, Behavioral Health Assistants, Counseling & Therapy Staff, Care Management Staff, and LIPs will receive education on the garden policies and procedures. **Completion Date** 10/10/2020 **Responsible Party** Chief Nursing Officer **Procedure & Process for Implementation (Elopement – Doors)** The Safe Transportation of Patients and Prevention of Elopement Policy and Procedure will be updated to reflect: • Risk factors for elopement, including exit-seeking behaviors • Clear and systematic door security measures to be used by all staff, including specific techniques for door security • What to do if a patient follows staff to a doorway, or "rushes" an open doorway All staff and contractors with badge access will receive education on the policy changes.	

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A 144	Continued From page 45 "exit-seeking" and who located themselves near exit doors; and that included clear and systematic door security measures to be used by all staff to "ensure door is clear of patients prior to opening and stay until door is completely closed." 6.a. Incident documentation reflected that on 08/14/2019 on Unit 2 Patient 10 "stood right at the nursing station and kept following anyone existing (sic) the door. [He/she] rush (sic) staff at the door and tried to push [his/her] way through." Patient 10 was described in the follow-up documentation as a "severe elopement risk." Incident documentation reflected that on 08/16/2019 on Unit 2 Patient 10 was "following the food cart that was passing Room 214 on its way out to the interior staff hallway. I told the patient that [he/she] needed to step away from the doors, but [he/she] was not able to redirect and went straight through the doors. I immediately put myself in front of [Patient 10] outside the doors. I kept telling [him/her] to go back, attempted to call for help, and was trying to push [him/her] back while [he/she] was pushing [his/her] weight toward me ... Approximately 10 to 20 seconds later, [Patient 10] was calmly able to walk back to the milieu and safety suite ..." There was no follow-up documentation until 08/30/2019 which reflected, "Investigation status: complete." The documentation reflected "[Patient 10] is extremely exit seeking ... [He/she] is very attentive to people coming/going on the unit and notices patterns to take advantage of ... Video review ... [Patient 10] was walking in the hall with another patient, following the dietary staff and food cart. The nurse writing the report noted [Patient 10's] behavior and walked to [his/her] location in the hallways. [The nurse] positioned	A 144	**Monitoring Plan** 30 observational audits of staff entering/exiting doorways will be conductd per month. The target for compliance is 90% per month for 3 consecutive months. During monitoring, instances of non-compliance will be reviewed with the leadership team to identify trends and education opportunities. Auditing will continue until 90% compliance has been achieved for 3 consecutive months. **Incorporation Into QAPI Program** Ongoing monitoring entering/exiting doorways will be conducted for 30 patients per quarter. The target for compliance is 90% per quarter. During monitoring, instances of non-compliance will be reviewed with the leadership team to identify trends and education opportunities. Results will be shared at monthly Quality Council meetings. Policies are reviewed and updated at least every three years and/or with regulatory updates. Upon hire all staff and contractors with badge access will receive education on the elopement process. **Completion Date** 10/10/2020 **Responsible Party** Chief Nursing Officer	

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A 144	Continued From page 46 [him/herself] between [Patient 10] and the food cart while the staff exited with the cart. As the door was shutting, [Patient 10] rushed the opening and the RN was unable to prevent [Patient 10] exiting into the secure hallway behind the unit ..." The "Mitigation plan" was "[Patient 10] has high alerts in [his/her] chart. There are high elopement area signs posted on all entrance/exit signs for the unit. Staff is oriented to who [Patient 10] is and what [his/her] behaviors are and what language [he/she] may try to use seeking exit." The investigation was not timely or complete and did not identify deficient practices related to door security and P&Ps to prevent elopement, specifically that "When moving through a locked door, all staff and service providers with badge access will ensure door is clear of patients prior to opening and stay until door is completely closed." Although the P&P was incomplete and did not specify techniques for the door security, the dietary staff failed to ensure the door was clear of patients prior to opening and allowed an opportunity for Patient 10 to elope. There were no actions identified related to the staff failure to prevent recurrence. Seven days later, on 08/23/2019, incident documentation related to Patient 10 reflected that on Unit 2 at approximately 1820 staff "noticed that a shoe was holding the stair case door was (sic) open ... I requested an (sic) head count, it was right on the 1815 rounds and we noticed that must be [Patient 10] missing ... Few minutes later [Patient 10's parent] called and stated that [Patient 10] was at 2nd and Wiedler (sic) ... police went to the [hotel at 2nd and Weidler] and found the patient ... patient brought back to the unit ..."	A 144		

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Incident documentation reflected that "Investigation started: 8/23/19" and there was no documentation to reflect that the investigation had been completed. The documentation consisted of an attachment titled "Elopement timeline: 8/23/19" and a "General ... Review" dated 08/26/2019.

The "Elopement timeline: 8/23/19" reflected that a video review was conducted however, the description of the video observations are unclearly recorded in relation to the "shoe" that "was holding the stair case door ... open" and there was no summary that referenced the video observations to provide a clear narrative of the events, except that it involved dietary staff entering and exiting the unit with a food cart.

The "General ... Review" dated 08/26/2019 reflected, "Per email correspondence with food and nutrition manager on Aug. 30, 2019, all staff were trained on elopement procedures and elopement procedures was added to new employee orientation." In addition to the lack of specificity about what "elopement procedures" staff were trained to; it was noted that the 08/26/2019 note was recorded four days prior to the 08/30/2019 "email correspondence" the note referenced.

The investigation was not timely or complete and did not identify the deficient practice(s) that led to Patient 10's successful elopement from the secure facility, just seven days after Patient 10's elopement from the secure unit, to ensure that appropriate actions to prevent recurrence were planned and taken.

6.b. Incident documentation provided on

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A 144	Continued From page 48 10/25/2019 reflected that on 10/21/2019 Patient 12 exited the secure Unit 5 and "was seen to enter the [staff breakroom]. Pt appeared somewhat confused and was returned to the unit by this staff and MHT ... The unit was apparently having a code when Pt was able to get out. Unit charge nurse was informed and stated Pt was supposed to be on a one on one, but they do not have the staff to provide this today. Staff were urged to keep a closer eye on pt regardless." Documentation reflected, "Investigation started: 10/21/19" and "Investigation status: Post event mitigation plan present." Investigation documentation identified deficient practices that included: "Short staffed," lack of a dedicated staff person to carry out the physician 1:1 observation order and "Human error." The investigation included review of video that showed when two RNs exited Unit 5 the patient "grabs ahold of door before it fully shuts." Although the documentation reflected "Standard of care followed: no, our standard practice is to stay with all doors leading to and from patient care areas until the door is fully closed/locked," there was no evidence in the "Post event mitigation plan" that staff were counseled and re-educated to that process. However, as noted in this report previously, the P&P that "When moving through a locked door, all staff and service providers with badge access will ensure door is clear of patients prior to opening and stay until door is completely closed" does not specify a clear technique for staff to use to ensure that. 6.c. Incident documentation reflected that on 01/15/2020 on the PES unit Patient 20 "ran out exit into sally port, staff able to bring pt back into milieu." There was no documentation of an	A 144		

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investigation to determine how the patient was able to get out of the locked, secure unit into the sally port. There was no evidence that video had been reviewed or staff interviewed to identify how staff failed to ensure that "When moving through a locked door, all staff and service providers with badge access will ensure door is clear of patients prior to opening and stay until door is completely closed" to prevent patients from exiting the secure unit. The only other documentation was related to the patient's placement in seclusion as a result of staff allowing him/her to exit the secure unit and his/her continued elopement risk.

7. Incident documentation recorded on four separate reports described sexual intercourse and oral sex between Patient 18 and Patient 19 that occurred in the PES on 01/16/2020.

* The documentation reflected that on 01/16/2020 Patient 18 was "found in bathroom with [Patient 19]. Pt was sitting on bathroom floor with pants off and [Patient 19] was kneeling in front of patient with pants down ... [Patient 18] states they had consensual sexual intercourse and that [Patient 19] performed [oral sex] on [him/her]. [Patient 18] states 'I felt like [he/she] needed it'. [Patient 18] reports small amount of blood and requests a pad. Pt states [him/her] and [Patient 19] have been talking this morning. [Patient 18] was sitting at table near bathroom and [Patient 19] was let in to bathroom by staff. [Patient 19] then opened bathroom door and invited [Patient 18] inside."

* The documentation on 01/16/2020 reflected that Patient 19 "does not appear to have insight to why this is problematic in this environment. [Patient 19] declined to go to seclusion but was

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A 144	Continued From page 50 ultimately cooperative walked to seclusion with security and basic escort. Pt took oral medication voluntarily ..." In response to a question on the report template "What type of unsafe behavior did the patient do that required intervention?" staff recorded "Other unsafe behaviors requiring intervention." In response to the question "What physical contact occurred?" staff recorded "Staff initiated physical contact with patient due to unsafe behaviors." * Additional documentation recorded on 01/16/2020 reflected SSOs reviewed video and observed that Patient 19 was "allowed by staff to enter [the shower room] at 1022," Patient 18 entered the shower room at 1023, two staff members "removed [Patient 19]" at 1044 and Patient 18 "exited" at 1054. There was no documentation to reflect what the video showed about where staff members were and what they were doing that allowed Patient 18 to enter the shower room unobserved. * A note recorded on 01/16/2020 reflected "This event report to [Adult Protective Services] 1/16/20 at 1420. * "Follow-up Notes" recorded on 01/17/2020 reflected, "Contributing factors: [Patient 19] entered bathroom and invited [Patient 18] to join [him/her]. Upon interview of patients, they both engaged in planning of this connection in the bathroom. MD determined both patients met capacity for consensual contact. Patient condition: stable, no injury. Mitigation plan: Patient monitored per standard of care. Encourage BHA presence in area around shower and calming rooms. Just Culture findings: n/a."	A 144		

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A 144	Continued From page 51 * On 01/21/2020 documentation was recorded as: "Immediately after being informed of this issue, I directed one of the security officers who responded to [document the incident]. I then ... reviewed video ... I also spoke with [PES Manager] later to ensure [he/she] had been informed of this incident." * On 01/28/2020 at 0930 documentation recorded reflected, "Follow-up Notes" reflected, "Contributing factors: patients made plan to connect in shower prior to event, per RN interview. Medical Director deemed patients able to consent. Patient condition: stable, no injuries, RNs and medical team followed up with both patients. Mitigation plan: PES BHA and staff were engaged in patient care in various zones throughout time [Patient 19] opened door and [Patient 18] entered room with [Patient 19]. BHAs alerted RN at next q 15 minute observation and staff immediately responded to locate patients. Just Culture findings: BHAs on floor were all engaged in patient care duties at time of event. PES staff member was not in immediate zone of restroom/shower at time [Patient 19] opened door. Coaching provided 1/24/20." * On 01/28/2020 at 1017 documentation recorded reflected "Follow-up Notes ... had sex with peer in bathroom; need to separate patients." The documentation consisted of an evaluation of whether seclusion documentation for Patient 19 had been completed. * The LEMC UCBH satellite location architectural firm's "State Review First Floor Plan ... Construction Documents" dated 11/08/2016 was reviewed. The floor plan revealed that there were five "Toilet" rooms in the main PES patient care	A 144		

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A 144	Continued From page 52 area that were identified with room numbers P-101A, P-111, P-117, P118 and P119. There was one "Shower" room identified with room number P-120. All six of those rooms were in direct view of the PES nurse's stations. * An investigation of this potential sexual abuse incident was not timely or complete. It did not identify what specific room the event occured in as some entries referred to the room as a bathroom and other entries referred to the room as a shower room. The documentation did not clearly reflect whether the patients were being appropriately supervised and how both patients were allowed to be in the bathroom or shower room at the same time when all bathroom and shower rooms were in direct view of the nurse's stations. The documentation did not identify where staff were at the time and what staff were doing. It did not reflect whether either one of the patients may have been manipulated or coerced in some way. There was no documentation of a physical exam to determine whether there were injuries as one of the patients reported he/she was bleeding. The conclusion that this incident was "consensual" was unclear and not consistent with some of the immediate actions taken such as the placement of Patient 19 into seclusion and the report of the incident to APS. Further, the mitigation plan minimized the incident as the only action was to "encourage" staff "presence around the shower and calming rooms." The hospital is responsible to ensure that patients are free from abuse and neglect, including sexual abuse. Patients' abilities to consent to sexual acts does not relieve the hospital of its responsibility to protect patients, particularly vulnerable populations such as psychiatric patients, from	A 144	Note: This event was reported to APS in accordance with APS reporting requirements. APS did not substantiate abuse/neglect. **Procedure & Process for Implementation- (Supervision)** To prevent recurrence, bathroom doors in the PES will be monitored by staff when in use by patients. PES Behavioral Health Therapists, RNs, Behavioral Health Assistants, Counseling & Therapy Staff, Care Management Staff, and LIPs, will receive education on the revised process. **Monitoring Plan** 30 observational audits will be conducted to ensure staff monitor bathroom doors in PES when in use by patients. The target for compliance is 90% per month for 3 consecutive months. During monitoring, instances of non-compliance will be reviewed with the leadership team to identify trends and education opportunities. Auditing will continue until 90% compliance has been achieved for 3 consecutive months. **Incorporation Into QAPI Program** 30 observations of bathroom door monitoring will be conducted each quarter. The target for compliance is 90% per quarter. During monitoring, instances of non-compliance will be reviewed with the leadership team to identify trends and education opportunities. Results will be shared at monthly Quality Council meetings	

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A 144	Continued From page 53 unsafe situations such as unprotected sex with strangers on the floor of a bathroom or shower room. Patient 18 and Patient 19 are both victims of the neglect by staff that allowed this sexual abuse to occur in a room in the psychiatric ED that was in direct view of the nurses's station. This investigation was not complete and there was no assurance that such an incident would not recur. 8. Refer to the findings cited under Tag A154, CFR 482.13(e) - Standard: Restraint or seclusion. Those findings reflect the hospital's failure to ensure all patients were afforded freedom from restraints and seclusion. Refer also to the findings cited under Tag A199, CFR 482.13(f) - Standard: Restraint or seclusion: Staff training requirements. Those findings reflect the hospital's failure to ensure all staff completed training to identify, prevent and manage patient behaviors safely.	A 144	Upon hire PES Behavioral Health Therapists, RNs, Behavioral Health Assistants, Counseling & Therapy Staff, Care Management Staff, and LIPs will receive education on the bathroom door monitoring process. **Completion Date** 10/10/2020 **Responsible Party** Chief Nursing Officer Refer to Tag A154 and A199 for plans of correction related to restraint use.	
A 145	PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT CFR(s): 482.13(c)(3) The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on observations, review of recorded video footage, interviews, email communications, review of incident and medical record documentation for 21 of 21 psychiatric patients (Patients 1 through 21), review of training records for 5 of 14 staff (Staff Q, K, L, M and W), review of policies and procedures, review of building floor plans and other documentation related to	A 145	Compliance with A145 will be achieved on or before 10/10/20 through implementation of plans of correction related to patient rights. This includes corrective actions that will be taken to ensure the patients' rights to freedom from abuse and neglect. The Chief Nursing Officer is ultimately responsible for A145. Refer to Tags A143, A144, A154 for plans of correction related to privacy, safe care, and freedom from restraints or seclusion.	

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safety and physical environment risk, it was determined that the hospital failed to fully develop and implement policies and procedures that ensured that patients' rights to freedom from abuse and neglect were recognized, protected and promoted as follows:
* Staff failures to prevent patient access to unsafe items, failures to prevent elopement, failures to provide supervision, failures to appropriately manage behaviors and prevent unnecessary restraint use, and failures to protect patient privacy resulted in actual and potential harm to patients. Investigations of, and response to, those incidents of actual or potential abuse or neglect were not timely or complete to ensure those did not recur.

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

Further, the CMS Interpretive Guideline reflects that components necessary for effective abuse protection include, but are not limited to:
o Prevent.
o Identify. The hospital creates and maintains a proactive approach to identify events and occurrences that may constitute or contribute to abuse and neglect.
o Investigate. The hospital ensures, in a timely

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A 145	Continued From page 55 and thorough manner, objective investigation of all allegations of abuse, neglect or mistreatment. o Report/Respond. The hospital must assure that any incidents of abuse, neglect or harassment are reported and analyzed, and the appropriate corrective, remedial or disciplinary action occurs, in accordance with applicable local, State, or Federal law. This is a repeat deficiency previously cited on surveys completed on 08/08/2019, 10/31/2018, 10/05/2018, 07/30/2018 and 05/22/2018. Findings include: 1. Refer to the findings cited under Tags A143 and A144, CFR 482.13(c) - Standard: Privacy and Safety, and Tag A154, CFR 482.13(e) - Standard: Restraint or seclusion. Those findings reflect the hospital's failure to conduct timely and complete investigations of incidents of actual and potential abuse and neglect to prevent recurrence.	A 145		
A 154	USE OF RESTRAINT OR SECLUSION CFR(s): 482.13(e) Patient Rights: Restraint or Seclusion. 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. This STANDARD is not met as evidenced by: Based on review of recorded video footage,	A 154		

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A 154	Continued From page 56 interviews, email communications, review of incident and medical record documentation for 1 of 1 psychiatric patient who was physically and chemically restrained and secluded (Patient 13), review of training records for 5 of 14 staff (Staff Q, K, L, M and W) and review of policies and procedures, it was determined that the hospital failed to fully develop and implement policies and procedures that ensured that patients' rights to freedom from restraint and seclusion were recognized, protected and promoted as follows: * While in the ED Patient 13 experienced a change of condition in relation to behaviors that were not managed appropriately in accordance with P&Ps, by staff who did not have required training. The patient's condition was allowed to worsen and resulted in the use of multiple forms of physical restraint, including handcuffs, and chemical restraints and seclusion. According to staff, the patient's PTSD was triggered during the encounter and his/her mental health condition continued to deteriorate. The patient also experienced physical change of condition and injury. Patient 13 was subsequently admitted as an inpatient at UCBH for three months, court-committed and transferred to OSH at the end of February 2020. Findings include: 1. On 03/03/2020 beginning at approximately 0945 an ED encounter for Patient 13 was discussed during interview with the LEMC UCBH President, the CNO, the CMO, ACC1 and ACC2 and the following information was provided: * Patient 13 was well known to hospital staff and had a history of methamphetamine/drug use and mental illness. * Staff stated that LEMC UCBH is licensed as a	A 154		

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A 154	Continued From page 57 psychiatric hospital and "meth intoxication is not an appropriate reason for hospitalization." * Patient 13 presented to the hospital ED three (3) times in 18 hours on 11/25/2019 and 11/26/2019. * On 11/26/2019, during the third ED visit, the decision was made to send the patient to CHIERS. * CHIERS is a "Sobering station" to which patients are transferred for intoxication issues. * Staff called CHIERS transportation line, "waited several hours" and were "then told [CHIERS] didn't have a driver" and were directed to call PPB. * "Typically," a secure van is used to pick up patients for transport to CHIERS. When a van isn't available PPOs transport patients. * Patient 13 "became combative" when staff moved him/her from the triage area to the lobby to wait for secure transport. * SSO's were "present as escorts." * When the patient went out the front doors and started "kicking cars" SSOs "put [Patient 13] in handcuffs for [his/her] safety" and placed him/her in the ambulance bay. * UCBH staff do not "put hands on" patients that are not in the building or not in the lobby. * Staff stated "we don't engage, we call Project Respond" or another agency for encounters that are outside of the building when assistance is needed. * UCBH has a "zone map protocol" that describes how staff are to respond in the lobby and outside of the building - "It's our policy." * There is a process for SSOs to notify PPB when they use handcuffs on an individual. * It was not known if SSOs called PPB on that day for Patient 13. * PPO's did arrive, but it was not known how long	A 154		

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A 154	Continued From page 58 Patient 13 was outside before they were on scene, "maybe 45 minutes." * When Patient 13 was outside with PPOs the ED provider on duty requested a second opinion and the CMO and the EDMD responded and determined the patient did meet mental health criteria, placed him/her on an NMI and directed the patient be brought back into the hospital. * At the conclusion of that third ED encounter Patient 13 was admitted to LEMC UCBH as an inpatient, had a three-month hospitalization, and was transferred to the Oregon State Hospital on 02/27/2020. * Incident reports were filed about the encounter, a "process review" of the encounter was done and there were discussions and follow-up, but there was "no investigation" and they were unsure if there was recorded video footage of any of the encounter. 2. During interview on 03/03/2020 beginning at 1415 the SS and DSS were interviewed. The UCBHP, the CNO, and the ACC1 were present. The following information was provided: * Patient 13 "committed a crime" of "harassment" when he/she "put [his/her] hands on someone unlawfully." * Patient 13 "hit the RN and spit on them." * PPOs did not charge the patient with a crime. * Legacy SSOs are certified by DPSST as "Security Officers." * The SSOs carry handcuffs and "never use on patients unless they've committed a crime." * When they "arrest a person who's committed a crime" they can handcuff the person. * The SSOs carry out "arrest by private person" also referred to as "citizen's arrest." * There are no restrictions or limitations as to the locations on hospital property where SSOs can	A 154		

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"arrest" and handcuff patients, the only restrictions are related to the "situation."
* The SS and DSS were asked if UCBH patients on inpatient units exhibited behaviors similar to those it was reported Patient 13 exhibited, would those patients be arrested and handcuffed . The SS stated that they would "if it was safe to do that" but they "wouldn't go blazing in."
* It was "rare" and "out of the ordinary" for an inpatient to be "arrested" by SSOs.
* Patient 13 was "arrested" and handcuffed for the behaviors he/she exhibited because he/she "wasn't a patient any longer."
* The SS stated that it was "not necessarily" the case that only discharged patients could be "arrested."
* The UCBHP added that they were "not clear amongst ourselves" what happened.
* The UCBHP stated that the clinical staff has physical boundaries on the hospital property where they can intervene for a patient.
* Staff "didn't want [Patient 13] walking off into the street" and wanted to "hold [him/her] until PPOs arrived."
* Clinical staff boundaries are defined on the "zone map."
* SSOs boundaries are all areas on the hospital's property.
* SSOs "wear two hats, security versus safety" and operate under their safety hat as support to clinical staff.
* "No smoking on campus" is allowed at UCBH, but patients smoke in front of the entrance doors.

3.a. The "Zone Map protocol" described as "our policy" was reviewed. The document was one-page and was untitled and undated. Approximately 3/4 of the page contained a floor-plan image of the LEMC UCBH interior main

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LEGACY EMANUEL MEDICAL CENTER	2801 N GANTENBEIN AVENUE PORTLAND, OR 97227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 154	Continued From page 60 lobby/waiting room (highlighted pink in color), the exterior sidewalks in front of the lobby/waiting area and the ambulance bay (highlighted blue in color) and the parking lot in front of the facility (highlighted purple in color). At the bottom of the page, under the image were three columns. The first column had a header of "Lobby Zone: Pink - What you can do:" and under that was the following: * "Encourage them to come in and assess the situation/condition" * "Use De-Escalation skills to meet person's needs/meet the needs of our space" * "Have the patient check in for a new or worsened condition if recently discharged [Patient Access Staff]" * "Bring someone back for triage and evaluation either willing or unwillingly (Call LIP immediately)" * "Document what you have done: Have staff create a visit, SSO you can chart if not registered [Patient Access Staff]" * "Call Security for criminal activity" The second column had a header of "Front of building Zone: Blue - What you can do:" and under that was the following: * "Encourage someone to come inside for care" * "Document your encounter with them" * "Bring someone inside for triage care, if they are: Currently checking in Discharged within the past 12 hours" * "Meet the threshold of Good Samaritan laws: offers legal protection to people who give reasonable assistance to those who are, or they believe to be injured, ill in peril, or otherwise incapacitated." * "Stop intervention and consider 911 before	A 154		

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A 154	Continued From page 61 Code Grey" * "Call Security for criminal activity" The third column had a header of "Parking lot Zone: Purple - What you can do:" and under that was the following: * "Encourage someone to come inside for care" * "Call 911 if medical care is needed and the person is unwilling/able to come inside" * "Call Project Respond via 503-998-4888 is (sic) someone needs a possible hold to come inside" * "Call CHEIRS (sic) for sobering if needed" * "Call Security for criminal activity" * "Who can do these things? House Supervisor-Lead CIS and/or Provider Unity Leadership" On 03/12/2020 at 1330 follow-up email communication from ACC1 regarding the date the "Zone Map" was effective reflected the map "is a guideline. Originated in early July." The information further reflected that "Staff were assigned an online learning module SLM" and that there was "no" other written P&P for the "Zone Map" information. 3.b. The SLM training content titled "[UCBH] Legacy Emanuel Intervention Zones" was dated "August 2019" and consisted of 26 slides. It contained the following information for staff: * "People experiencing a behavioral health crisis are often mistaken for individuals engaged in intentional deviancy when presenting to healthcare facilities for help ... When healthcare facilities make this mistake, people who should be in the hospital could end up losing access to the mental health treatment they need." * "The following groups collaborate within	A 154		

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A 154	Continued From page 62 Intervention Zones to produce the best possible outcome for everyone presenting to Unity: Patient Access Staff - Security Staff Officers ... Nursing ... Providers." * "Parking Lot Zone ... Recommended Interventions: Encourage the individual to check in to receive care ... In the event of a behavioral emergency and the individual is unable or unwilling to enter and may require a legal hold, call Project Respond ... If the individual appears to be intoxicated, call CHEIRS ... If the individual is engaged in concerning behavior (ie: breaking into a car in the parking lot), call Security ... Staff should call Security if the individual is actively engaging in unsafe behaviors to self or other ... Follow the intervention zone guidelines for the Parking Lot whenever an individual is present in that zone, regardless of how they arrived there..." * "Front of Building Zone ... Recommended Interventions: Encourage the individual to enter inside for care ... If the individual is clearly engaged in criminal activity (ie: breaking into a car in the parking lot), call Security ... Clinicians should consider the following when assessing the need for assessment: Is the patient currently checked in? Was this patient recently hospitalized? If the answer to these questions is 'yes', it is likely that the patient would benefit from triage assessment." * "Lobby Zone ... Recommended Interventions: Encourage them to come in and assess the situaton/condition ... Recommend patient check in for a new or worsened condition if recently discharged ... Use De-Escalation skills to maintain safety while addressing the individuals (sic) needs. If you believe the patient is escalating, notify Nursing Supervisor and PES Clinicians immediately ... The Nursing Supervisor and other PES CRN, CIS and Providers present	A 154		

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A 154	Continued From page 63 will determine if the individual requires assessment and should be escorted to triage (either voluntarily or involuntarily) ... Immediately call Security for criminal activity or if the individual present unsafe behaviors to self or others ..." * "Roles and Responsibilities within Intervention Zones" included for "Security" to "Encourage individual to check in for assessment" and "Coordinate with team & support safety" in all three zones. * "KEY POINT: Going 'Hands-on' - It is better to spend more time and resources on de-escalation if doing so prevents going 'hands-on' ... Going 'Hands-on' is a form of physical restraint, and should only be used as a last resort ... NEVER go hands-on alone and without a Code Team in place (follow Code Gray process) ... In the Parking Lot Zone (Purple): DO NOT initiate 'hands-on.' In the Front of Building Zone (Blue) AND Lobby Zone (Pink): a team may initiate 'hands-on' in the event of an extreme risk to safety." The training contained unclear information, including, but not limited to: * There was no information to reflect how staff would discern at that moment if an "individual appears to be intoxicated" versus having a "behavioral emergency." * There was no information to discern the difference between "concerning behavior" exhibited in the parking lot zone versus "criminal activity" exhibited in the front of the building zone for which security staff were to be called, particularly when the example for both was "breaking into a car in the parking lot." 4.a. The P&P titled "Patient Rights and Responsibilities" dated as last revised "05/17"	A 154		

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A 154	Continued From page 64 included the following: * "To assure that patients receiving health care services at any Legacy facility and their families are treated with dignity and respect ... Legacy Health (Legacy) recognizes and respects the dignity and individuality of each person admitted to or treated within our facilities. All members of our workforce (employees, volunteers, medical staff, residents, students, contracted personnel and vendors) are expected to provide considerate and respectful care, meeting the cultural, spiritual, emotional, and personal dignity needs of each individual patient and their family." * "Patients have the right to be free from all forms of abuse and harassment." * "Patients have the right to be free from restraint or seclusion and corporal punishment. Legacy protects the right of patients to be free of restraint or seclusion when restraint or seclusion is not indicated for the protection of the patient's health or the safety of the patient, staff or others." 4.b. The P&P titled "Restraint and Seclusion for Patient Safety" dated as last reviewed "Nov 2018" included the following: * "Purpose: To provide regulatory requirements regarding appropriate restraint and seclusion use within the hospital and Emergency Department for the medical well-being of any patient. To the (sic) protect the patient's health and safety and preserve his or her dignity regardless of patient type or location. To define a procedure for the use of restraint and seclusion that focuses on the least restrictive approach." * "Restraint - Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely ... A drug or medication used as a restriction to	A 154		

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A 154	Continued From page 65 manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition." * "Restraint Exclusions ... The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices applied by non-hospital employed or contracted law enforcement officials ..." * "The patient has the right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff. A restraint can only be used if needed to improve the patient's well-being or in emergency situations if needed to ensure the patient's physical safety or safety of others. In either case, restraint or seclusion is only used when less restrictive interventions have been determined to be ineffective based on clinical justification." * "Restraint or seclusion may be used when less restrictive means have been attempted and would not be effective to protect the physical safety of patients, staff members or others. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate safety of the patient, staff members, or others." * "Each episode of restraint or seclusion (regardless of restraint category) shall be initiated: Upon the order of the LIP who is responsible for the patient, or by a registered nurse, if necessary to protect the patient, staff members or others from harm, provided that an order is immediately obtained from a LIP responsible for the care of the patient." 4.c. The P&P titled "Emergency - Use of Force" dated as last reviewed "07/19" included the	A 154		

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A 154	Continued From page 66 following: * "It is the policy of Legacy Health to accomplish its security responsibilities with reasonable reliance on the use of force. The use of force is a matter of critical concern, both to the public and to the law enforcement community. Security Officers, and other Legacy staff, are involved daily in numerous and varied interactions, that when warranted may use reasonable force in carrying out their duties. This is especially true with respect to overcoming resistance while engaged in security and staff protection duties ." * "All staff should be aware that patients are there for treatment not punishment. Accordingly, it is essential that they understand the importance of de-escalation interventions in any situation. Absent an imminent threat that requires immediate use of force, MOAB, verbal de-escalation, and other interventions must be utilized in such situations before force is applied." * "KEYPOINT: This policy applies to Legacy Health Safety/Security Officers in the performance of their job duties, while involved in a law enforcement action, such as making a private person's arrest or if it is necessary to use self-defense techniques to protect themselves or others from injury or death. All other situations requiring the use of force to control a patient, such as assisting medical/clinical staff with the application of restraints, will be performed under the supervisor of a medical or clinical staff member." * "Factors Used to Determine the Reasonableness of Force ... These factors include, but are not limited to: a. Immediacy and severity of the threat to Officers	A 154		

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A 154	Continued From page 67 or others. b. The conduct of the individual being confronted, as reasonably perceived by the Officer at the time ... h. The availability of other options and their possible effectiveness. i. Seriousness of the suspected offense or reason for contact with the individual ... k. Potential for injury to Officers, suspects and others. l. Whether the person appears to be resisting, attempting to evade arrest by flight or is attacking the Officer ... n. The apparent need for immediate control of the subject or a prompt resolution of the situation. o. Whether the conduct of the individual being confronted no longer reasonably appears to pose an imminent threat to the Officer or others. p. Prior contacts with the subject or awareness of any propensity for violence. q. Whether and to what extent that approved strategies and interventions (MOAB, verbal de-escalation, Trauma Informed Care) (sic) were employed prior. r. Any other exigent circumstances." * "Handcuffs shall not be used to restrain any patient unless that patient has committed a crime and is being placed under a lawful arrest by the Safety/Security Officer." * "Any use of force by Legacy Security staff shall be documented promptly, completely and accurately in Report Exec. Legacy staff may also document the incident in ICARE. The actions or condition, which made the use of physical force necessary and a detailed description of the physical force used ..."	A 154		

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A 154	Continued From page 68 4.d. The P&P titled "Facilities & Safety Behavior Management" dated as last revised "08/19" included the following: * "Inappropriate behavior is defined as acting in ways contrary to a safe, healing environment and includes, but is not limited to: 1. Public intoxication or having a strong odor of an alcoholic beverage 2. Verbal or physical threats as well as threatening gestures 3. Acts of violence 4. Use of abusive or inappropriate language ... 6. Refusal to comply with any Legacy Health policy i.e.: tobacco free campus, visiting hours, image capturing, etc ..." * "Persons may be escorted off Legacy Health property, criminally trespassed or arrested from Legacy Health property if they are: 1. Committing a crime including but not limited to: theft, robbery, burglary, assault, trespass, possession of alcohol, unlawful possession of a controlled substance (including paraphernalia), and possession of a weapon of any kind, disorderly conduct, criminal mischief, harassment, menacing, recklessly endangering, OR intimidation. Persons may be placed under Private Persons Arrest (also known as a Citizen Arrest) if they are observed committing a criminal act on Legacy property. In all instances, individuals arrested for committing a criminal act will receive a written CTW. 2. Creating a disturbance. 3. Without valid business: a) Loitering anywhere on property b) Removing refuse from waste containers c) Panhandling or soliciting 4. Acting in ways contrary to the best interest of the facility.	A 154		

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A 154	Continued From page 69 5. In violation of the Solicitation, Distribution and Posting policy ... 6. Unsanitary, visibly filthy, or having an offensive odor. (sic) Refusal to consent or comply to a search of belongings or property." * "KEY POINT: Verbal criminal trespass warnings (CTW's) are not enforceable and will not be issued in lieu of a written CTW." * "Criminal Trespass Procedure ... 1. Security Officers issuing a written CTW will state: You are prohibited from coming onto the property or premises of any Legacy Health Property at any time except in order to receive emergency medical care. Entry upon the premises for any other reason without permission from the Legacy Security Department may result in your arrest for criminal trespass. Oregon (ORS 164.245) - Criminal Trespass in the second degree occurs when a person enters or remains unlawfully in or upon the premises. This is a misdemeanor ... A copy of this notice will remain on file. 2. The Safety & Security Officer issuing a CTW is required to document the incident in a Security report. They are also required to fill out the 'comments section' and retain the yellow copy of the CTW. This will include the applicable report number, specific behaviors that resulted in the CTW, and the Safety/Security Officer's name. A photo of the individual should be taken and added to the report whenever possible. The Safety & Security Officer will attempt to give the top (white) copy of (sic) the Offender and read aloud the warning on the back. The Safety and Security Officer will advise the subject of the various	A 154		

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A 154	Continued From page 70 Legacy properties, i.e., Emanuel, Randall Children's Hospital, Good Samaritan, Holladay Park, Meridian Park, Salmon Creek, Mt Hood, Unity Center, Silverton, Woodburn Health Center, and Legacy Medical Group Clinics and Labs." * The "Facilities & Safety Behavior Management" P&P concluded with a section of policies unrelated to behavior management that reflected "Safe Environment to Address Allergies and Asthma - Latex free environment ... Fragrance free environment ..." It was unclear if "persons" who violated those policies were to be "criminally trespassed or arrested" in accordance with the procedures above. 4.e. The P&P titled "Psychiatric Emergency Services (PES) Standard of Care" dated as last reviewed "Sep 2018" including the following: * "Purpose: To establish a standardized, consistent nursing practice for the care of all patients being assessed and treated in the Psychiatric Emergency Service (PES)." * "Expected Patient Outcomes: ... Provision of a safe environment that maintains patient dignity and privacy, and incorporates emotional support ..." * "Disposition (Determined by LIP) - For all disposition types, except discharge home or self-care: ... Reassess patient within approximately one hour of disposition." * "Discharge: ... All patients will receive discharge education and printed After-Visit Summary (AVS) pertinent to their diagnosis or condition. Patients will receive written discharge instructions; staff will validate patient/family understanding of instructions." 4.f. The P&P titled "Unity Center for Behavioral	A 154		

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A 154	Continued From page 71 Health: Scope of Service for Psychiatric Emergency Services (PES)" dated as last reviewed "Jul 2018" included the following: * "The PES care team in (sic) utilizes evidenced based practice, specifically, Trauma Informed Care to care for patients with mental health problems." * "Harm Reduction Specialist: Registered nurses who specialize in the prevention of aggressive behaviors, verbal de-escalation and management of agitation." * "Patients may come to the PES by ambulance or police transport, or may present requesting treatment at the PES entrance admission area ... In compliance with LH Policy ... PES LIPs will perform a Medical Screening Examination for every patient presenting to the PES for care..." * "Criteria for admission: The PES admits for care those patients who: i. Are displaying symptoms of a psychiatric diagnosis ii. Are experiencing an acute psychiatric crisis iii. Have co-occurring substance use disorders ..." * "Psychiatric emergency services may include up to 23 hours of triage and assessment, observations and supervision, crisis stabilization, crisis intervention, crisis counseling, case management, medication management, safety planning, lethal means counseling, and mobilization of peer and family support and community resources." 5.a. Review of the ED medical record of Patient 13 reflected that he/she arrived at the LEMC UCBH PES at 1501 on 11/26/2019. The medical record contained the following timed entries on 11/26/2019: * 1501 - "Patient arrived in ED."	A 154		

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A 154	Continued From page 72 * 1501 - "Arrival Complaint" was "eval." * 1517 by NP U - "Patient Care Initiated." * 1531 by NP U - "Patient Evaluation." * 1536 by BHT Q - "Patient roomed in ED to room PES TR1." * 1536 by BHT Q - "ED Triage Notes - Pt is marginally cooperative with triage. Mood and affect are euphoric. [He/she] appears distracted by internal stimulus. One bag of belongings are gathered and stored. Vital signs are WNL." * 1538 by BHT Q - "Vitals Assessment - Re-assess Vitals?: Yes ... Vital Signs ... Heart Rate: 110 ... BP: 141/93 ..." * 1538 by CIS N - "Follow up/Handoff - Seven Day Follow Up/Warm Handoff - Follow up scheduled within 7 days of discharge: Refused." * 1538 by NP U - "Patient Evaluation." * 1538 by NP U - "Discharge Disposition Selected - ED Disposition set to Discharge." * 1539 by CIS N - "AVS Printed - ED After Visit Summary." * 1539 - The "Aftercare Recommendations" were printed and the documentation reflected "Thank you for coming into Unity today: It was a pleasure working with you. You met with a social worker today and the following recommendations were given: Take all Medications as prescribed. Abstain from alcohol use and illicit/illegal substances (including marijuana). Eat healthy diet and get adequate sleep. Follow up with getting a therapist. Use coping skills -- take a walk, read, notice nature. ASK FOR HELP WHEN NEEDED. SET BOUNDARIES WITH OTHERS. TAKE CARE OF YOURSELF - LET OTHERS DO FOR THEMSELVES." There was no documentation in the discharge instructions that reflected the patient was being transported to CHIERS, a sobering station, for detox, by police. * 1540 by RN P - "Triage Start - Triage Start *	A 154		

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A 154	Continued From page 73 Triage Start: Triage Start." * 1540 by RN P - "SBIRT Screening." * 1540 by RN P - "Triage Started." * 1540 by RN P - "SBIRT Due." * 1540 by RN P - "Triage Started." * 1540 by RN P - "Chief Complaints Updated - + Psychiatric Evaluation." * 1540 by RN P - "ED Triage Notes - Pt vol walk in from lobby. Made inapropriate (sic) comments and inappropriately touched a female staff member in the lobby. Pt hostile with this writer and this writer disengaged from interview with patient. Patient seen earlier today in triage. Reports SI." * 1600 by RN P - "ED - Pain assessment ... " * 1601 by RN P - "Psych Mental Status Assessment ... Reported Mood: Unremarkable ... Affect and Mood: Inapproprpiate (sic) to situation - Behavior: Not directable ... Thought process: Flight of ideas - Thought Content: Delusions - Hallucinations: UTA ... Confused ..." * 1602 by RN P - "Psych Safety/History ... Have you wished you were dead, or wish to fall asleep and not wake up?" Yes ... Have you had any thoughts of killing yourself?" Yes * 1603 by RN P - "Apply Acuity Triage Complete Patient Acuity: 2 - Emergency ... PES Levels: 3 - Semi-Urgent." * 1603 by RN P - "Risk Assessments Infection Control ... Communicable Disease ... Functional Screen ... Nutritional Screen ..." * 1603 by RN P - "Triage Completed." * 1604 by RN P - "WilsonSims Fall Risk Assessment ..." * 1604 by RN P - "SBIRT Adult Drug and Alcohol Screening ..." * 1604 by RN P - "ED Infection Screening." * 1604 by RN P - "SBIRT Complete." * 1605 by PAS - "Registration Completed."	A 154		

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A 154	Continued From page 74 * 1620 by RN P - "ED Notes - Patient left triage angry and spat towards this writer. Patient making several threats of harm towards this writer and others. Made a swing at this writer and at one other staff on the way out the (sic) building. Patient escorted by security off the property ." * 1647 by RN P - "Care Handoff - Care Handoff Report given to: Patient went home." * 1647 by RN P - "ED Patient Services Coordination - Psych Care Coordination * Psychiatry Care Coordination by: Social Worker ..." * 1648 by RN P - "Departure Condition: Stable ... Departure Mode: By self." * 1656 by RN P - "Patient discharged." * 1843 - A "Psychiatric ED Initial Evaluation" was authenticated and electronically "filed" by NP U. The documentation reflected "[Patient 13] ... with history of psychosis, paranoid schizophrenia who returned to PES voluntarily walk (sic) presenting with psychosis and self reported drug/alcohol use. [He/she] was seen by this provider in triage few hours ago when [he/she] presented seeking help with shower, was d/c with bus pass and food from triage. BAL at that time was 0.057 and [he/she] endorsed using 'ice' PTA. On assessment in triage with CIS, notes nothing has changed since last d/c. Actively responding to internal stim with inappropriate smile while talking to self. Denies SI/HI. Unable to elaborate why [he/she] returned to PES. Will d/c to CHIERS for sobering." The evaluation included "Past Psychiatric History" that reflected "Previous suicide attempts: Yes ... endorses multiple attempts most recent 1 month ago [he/she] laid in the street ... Patient reports schizoaffective Disorder, PTSD ..."	A 154		

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A 154	Continued From page 75 The evaluation included "Social History" that included the following assessment information: "Number of children ... Year of education ... Highest education level ... Occupational History ... Financial resource strain ... Food insecurity Worry ... Food Insecurity Inability ... Transportation Needs Medical ... Transportation Needs Non-medical ... Sexual activity ... Physical activity days per week ... Physical activity minutes per session ... Stress ... Talks on phone ... Gets together ... Attends religious service ... Active member of club or organization ... Attends meetings of clubs or organization ... Relationship status ... Other Topics Concern ..." The entry recorded for each of those assessment fields was "Not on file." The evaluation included "Review of Systems" that reflected the patient was "Positive for behavioral problems and hallucinations." The evaluation included "Mental Status Exam" that reflected the patient was "... unkempt ... Poor eye contact, uncooperative and bizarre ... mostly mumbling ... Affect: Inappropriate and bizarre ... Thought process: Disorganized ... Thought Content: Auditory hallucinations and visual hallucinations ... Issues with attention/concentration ... Insight: Poor ... Judgement: Poor." The evaluation included "Provider assessment based on evaluation ... [Patient 13] presents as intoxicated and psychotic actively responding to internal stimuli. Not presenting with any acute safety concern or acute psychiatric sxs (psychoitc (sic) sxs appeared to be at [his/her] baseline) that warrants PES level of care. Will d/c to CHIERS	A 154		

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for sobering ... I have reviewed the CSSR-S and based on my safety assessment of this patient, I believe the patient is at low risk of suicidal behavior while in the Psychiatric Emergency Services, due to lack of SI ... Based on my evaluation, this patient is not at risk of acts of violence in the Psychiatric Emergency Services. Patient denies thoughts, intent, or plan for harming others, did not express levels of agitation or aggression that places others at risk ... This patient is not determined to be at imminent risk of harm to self or others or unable to care for self if discharged, due to lack of SI/HI."

The evaluation included "PES Progress: 1800 Writer was informed that pt refusing to leave with the police who came to bring him to CHIERS. Writer arrived on scene, pt was sitting in the ambulance bay surrounded by three police officer (sic) and three security staff, refusing to leave the property. Pt continued to not engaged (sic) when writer attempted to assess [him/her]. Police refused to go hands on [him/her] as [he/she] is in a private property. Leadership got involved who decided to place pt on an NMI and bring pt back to PES."

The evaluation concluded "Disposition and Follow-Up Plan: Discharge to Outpatient Level of Care: ED Note routed to provider: yes ..."

* 2048 - A PES Care Management Triage/Brief Assessment" was authenticated and electronically "filed" by the CIS N. The documentation reflected "Treatment team learned that [Patient 13] had assaulted Patient Access staff by hitting [him/her] in the rear end. CIS and BHT went to bring [patient] back to triage to be assessed for the second time today. [Patient] was

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A 154	Continued From page 77 laughing to [him/herself], smoking a cigarette and declining to come in while [he/she] was smoking. Charge RN was walking by and CIS requested assistance escorting [patient] into triage. [Patient] tried to contact RN with [his/her] lit cigarette. {he/she] was redirected to put out the cigarette and be escorted back to triage which [he/she] was able to do. CIS, RN and NP met with [patient] in triage to complete assessment. [Patient] was unable to report any significant change in [his/her] safety concern or psychiatric needs since [his/her] last presentation 2 hours prior where [he/she] had denied SI/HI/AVH access to firearms. [He/she] continued to endorse being intoxicated. [He/she] was informed that [he/she] would be discharging to CHIERS. [He/she] was displeased with this and made it known. [He/she] then endorsed vague passive SI in the context of being discharged to CHIERS. [He/she] waited in triage for non-emergency police to transport [him/her] to CHIERS as the CHIERS drivers were not operating today." The assessment included "Disposition/Plan" that reflected '[Patient 13] to discharge to non-emergency police and be escorted to CHIERS for sobering with recommendations to follow up with substance use services and PCP services in the community. After an hour, it was determined that [he/she] would need to wait in the lobby for police due to acuity of triage unit. After [patient] had been waiting patiently in triage for almost an hour, [he/she] became agitated and annoyed when [he/she] was being taken to the lobby. [He/she] tried to spit at the RN escorting him to the lobby. BHT and CIS followed to assist RN in crisis management. BHT followed RN and [patient] outside where [patient] hit BHT in the hand and was posturing and throwing punches at	A 154		

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staff. CIS called police who had been dispatched. Security team escorted [patient] up the ambulance driveway to take [him/her] off property when [he/she] became uncooperative and needed to be taken to the ground and handcuffed. CIS informed them that police were en route. Police arrived and were in disagreement with Unity plan for [Patient 13]. They disregarded Security's stance that [Patient 13] should be arrested for assaulting three staff members. They disregarded CIS and NP's assessment and [Patient 13's] admission that [he/she] was intoxicated on stimulants. They disregard (sic) request for [patient] to be transported to CHIERS for sobering, stating that it is against the law to remove a person from private property to transport him to CHIERS. [Patient 13] declines to leave Unity property. CIS and NP disengage and leave House Supervisor and PES Medical Director to manage the situation with police and security."

The assessment included an "Addictions Screening" entry recorded on 11/26/2019 at 2023 that reflected "Substance Use - Substance Used #1 Methamphetamines reported using 'ice,' UTA further - Substance #1 Last Used Today, per [his/her] report. No UDS obtained."

The assessment included a "BH Mental Status" entry recorded on 11/26/2019 at 2020 that reflected the patient was "Dirty; Disheveled ... Stooped ... Restless; Brisk; Uncoordinated ... Gestures; Grimaces ... Posturing laughing to self, smiling inappropriately ... Angry; Argumentative; Negative; Threatening ... Overly dramatic ... Poor boundaries; Impulsive ... Thought Content Suicidal Ideation in the context of discharge to CHIERS ... Insight Poor ... Judgement Poor ..."

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A 154	Continued From page 79 * The ED record documentation was incomplete, inaccurate and did not clearly reflect the patient's course through the ED visit. Examples include, but are not limited to: - The record reflected the evaluation of the patient's condition and decision-making occurred during a two-minute period that began at 1536 and was completed by 1538 when the disposition was identified as "discharge" and discharge instructions were printed at 1539. - Triage, a process that determines the priority in which patients will be evaluated, was "started" at 1540 after the evaluation and the decision to discharge was made, yet the RN continued to document patient assessments up through 1604. - The patient's SIs were not described and there was no documentation to reflect how the conclusion was drawn that the SIs were "in the context of discharge to CHIERs." - The record contained no orders for labs or other diagnostic tests during this encounter to evaluate whether Patient 13 was intoxicated or under the influence of drugs. - The "Aftercare Recommendations" reflected that the patient was being discharged home, but in fact Patient 13 was being transferred by PPOs to CHIERS, a sobering station. - At 1647 the RN documented the "Patient went home" and at 1648 the RN documented "Departure Condition: Stable ... Departure Mode: By self." Neither of those statements were accurate. 5.b. The ED record from the patient's prior ED encounter earlier the same day did reflect that a breath alcohol test was obtained during that visit. That result was obtained on 11/26/2019 at 1309 and was "POCT Alcohol Breath Test - ED	A 154		

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A 154	Continued From page 80 Resulted ... Abnormal Result.....0.057 ! (Ref Range: 0.000)." The CDC Alcohol and Public Health online webpage, dated as last reviewed 01/15/2020, reflected "All states in the United States have adopted 0.08% (80 mg/dL) as the legal limit for operating a motor vehicle." 5.c. Patient 13's ED medical record reflected that another ED encounter was generated on 11/26/2019 at 1816, after the patient was placed on an NMI and returned to the ED. The record included the following timed entries: * 1816 - "Patient arrived in ED" * 1816 - "Patient roomed in ED To room PES TR1" * 1818 - "Orders Placed.....(Geodon) injection 20 mg ... (Ativan) injection 2 mg .... Urine Drug Panel ED .... Notice of Mental Illness Hold" * 1822 by RN V - "Medication Given.....(Geodon) injection 20 mg..... IntraMuscular; Comment: per verbal report and chart review IM's administered in emergency situation per ordering LIP ... Medication Given ... (Ativan) injection 2 mg ... IntraMuscular; Comment: per verbal report and chart review IM's administered in emergency situation per ordering LIP." * 1825 by RN R - "pt (sic) visited PES three times in 24 hours. Pt engaged in several behaviors that place pt at risk of harm to self or others. Pt kicked car in parking lot (sic) Pt escorted from parking lot to lobby, lunged at and attempted to extinguish cigarette on writer, when writer use (sic) firm voice to redirect pt threw cup at writer (sic) pt (sic) grabbed buttocks of person registering pt to PES.	A 154		

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A 154	Continued From page 81 Pt attempted to spit and physically assault triage RN (sic) pt (sic) hit triage BHT (sic) Disposition made for pt and every attempt was made for pt to remain in triage until appropriate transport arrived. Pt was moved and remained with security in ambulance bay. Pt was self dialoguing, removed clothes and was found unable to redirect. As additional provider team and nursing were consulting on pt and determining next steps. Portland PD arrived and was (sic) now with pt and Legacy Security. Portland PD called Project Respond. Pt declined to return back to PES. Medics arrived and attempted to engage with pt. Pt threw orange juice on medic. Medics assisted staff to move pt to gurney and then transported pt to triage. while (sic) in triage(sic) pt (sic) was combative (sic) pt (sic) spit on medics (sic) pt (sic) yelling at staff (sic) unable (sic) to redirect (sic) unable (sic) plan for safety (sic) pt placed on NMI, was provided emergent medication, moved to HR 3." * 1825 by RN P - Seclusion documentation was initiated and continued through the ED encounter. * 1857 by RN P - Pt. [brought in by] AMR from ambulance bay. Patient in 4 point restraints and spitting at AMR and Unity staff. AMR placed spit sock on patient and turned gurney towards the wall. Pt had lighter in [his/her] hand and was refusing to give it to AMR staff and security was called for assistance. Patient was given involuntary medications on the gurney in restraints. Patient wheeled into hold room and remained on gurney for several minutes with staff supervision. Patient began to calm down and restraints and clothing was removed by security	A 154		

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staff. Patient left in hold room and door was closed. Pt agitated and yelling at staff through the door."
* 2225 by RN V - "Pt does not rouse toverbal stim ..."
* 11/27/2019 at 0135 - "Medication Given ... (Geodon) injection 20 mg ... IntraMuscular; Comment: 2 RN verification ... Medication Given ... (Ativan) injection 2 mg ... IntraMuscular; Comment: 2 RN verification"
* 11/27/2019 at 0200 - "Patient escalated. Was still disrobed and then with urine and feces incontinence. Patient yelling, unintelligibly, with loud roars, sounds, words unable to understand ... Pounding. Would not step back and sit down, and patient needing more medication. Security had to enter room and go hands on as patient aggressively at door, not redirecting. IM administered ..."
* 11/27/2109 at 0200 a urine specimen for a drug screen was obtained.
* 11/27/2019 at 0221 "[Urine] Drug Panel ED Resulted -Abnormal Result - Collected: 11/27/2019 0130 ... Final Result." The results reflected "Not Detected" for the following drugs: "Amphetamine/Methamphetamine ... Barbiturates ... Cocaine ... Heroin ... MDMA/MDA ... Methadone ... Hydrocodone/Morphine ... Oxycodone/Oxymorphone ... PCP ... TCA ..." The results reflected "[Presumptive] Detect ng/ml!" for "Benzodiazepines" and for "Marijuana Metabolites." The results also reflected "Drug Test Disclaimer ED: PRESUMPTIVE (Results are to be used for medical/treatment purposes only. The results given are presumptive. Confirmation testing is available upon request."
* 11/27/2019 at 1030 - "Vital Signs ... Pulse Rate: 108 ... BP: 160/95 ..."
* 11/27/2019 at 1530 by an RN - "Remains

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A 154	Continued From page 83 disorganized, garbled speech, difficult to understand ... Yelled out unintelligibly and made loud, irritable grunts multiple times ..." * 11/27/2019 at 1700 - "Vital Signs ... Heart Rate: 99 ... BP: 177/108! ..." * 11/27/2019 at 1717 - "Seclusion: Discontinued," approximately 23 hours after seclusion was initiated it was discontinued in the ED and the patient was transferred to an inpatient unit. * 11/27/2019 at 1723 - "Assessment ... BP elevated ... Extremity, Right Upper: Injury/trauma; Swelling" and "Extremity, Left Upper: Injury/trauma: Swelling" * 11/27/2019 at 1723 - "Care Handoff Report given to: Floor ([Staff name], unit 5)" * 11/27/2019 at 1725 - Orders to continue seclusion on the inpatient unit were received. In regards to the urine drug test result that detected Benzodiazepines, that result was consistent with the administration of Ativan, a Benzodiazepines, by staff. In regards to the entry on 11/27/2019 at 1030 that reflected the patient's vital signs were elevated, the next vital signs were not taken until 1700. At 1700 the vitals signs were elevated further and there was no documentation in the record to reflect that those were reported or followed up on. In regards to the entry on 11/27/2019 at 1723 related to "injury/trauma", prior to that time ongoing and numerous entries in the ED record reflected "no sign of injury." 6.a. Review of a "Security Report" with an "Incident Discovered/Called In 11/26/2019 at 1625 and an "Incident Occurred Date 11/26/2019 at 1900" was reviewed. It was "Prepared By"	A 154		

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A 154	Continued From page 84 SSO M and "Submitted" on 11/26/2019 at 2223. The "Narrative Text" included the following information: "On [11/26/2019] at approximately 1625, a panic alarm was pulled in the lobby for a discharged patient, [Patient 13] ... Upon being discharged, while in the lobby, [Patient 13] began to punch and spit at [RN D]. [BHT Q] and I quickly rushed to the lobby due to [BHT Q] seeing [Patient 13] spitting at the RN. [BHT Q] and I tried escorting [Patient 13] out of the lobby and off property. As we helped [Patient 13], [he/she] began to use vulgar language and then attempted to strike [BHT Q] and myself multiple times. I even tried telling [Patient 13] that if he/she kept trying to punch at me, I would have no other option but to place [him/her] in handcuffs and call police. [SSO F and SSO G] then responded to the panic alarm, came to assist with [Patient 13] with walking off property. While walking up the ambulance drive way, [Patient 13] was still agitated and kicked someone's car. That is when [SSO G] decided to place [Patient 13] in handcuffs. [SSO F] and I quickly obtained arms and assisted [Patient 13] to the ground SSO handcuffs could be placed on. Handcuffs were placed by me [SSO A]. Once handcuffs were placed on, [Patient 13] was placed in the ambulance bay were (sic) [he/she] was seated until PPB was contacted. [Two PPOs were] first to show ... [SSO G] informed Police what had happened with [Patient 13]. Stating that [he/she] had attempted to punch at Staff and Security multiple times, spat on staff, struck a vehicle, and was Trespassed. Police then requested that Security remove the handcuffs, handcuffs were then removed by me. [BHT Q] was then brought to speak with PPB about placing charges against [Patient 13], [he/she] then agreed to pressing charges. Report #[19-xxxxxx] ... PPB then	A 154		

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requested to speak with Staff about [Patient 13] and why they were discharging [him/her]. [NP U, CIS N and a Nursing Supervisor] began talking to [PO] on why [Patient 13] was being discharged. Police then stated they don't have enough criteria to take [Patient 13] into custody ... [Physician M] then made a decision to place [Patient 13] on a hold. AMR was then called by PPB to help place [Patient 13] on a gurney. [Patient 13] then got agitated and threw an orange juice at one of the AMR Staff. PPB and [I, SSO M] assisted AMR put [Patient 13] on the gurney where restraints were placed on. [Patient 13] was then taken into triage where [he/she] was given a shot of medication. The IM was given by [RN R]. After the IM was given, [Patient 13] was then placed in hold room 3. A debrief was then held to place comments and concerns."

6.b. During interview with the SS on 03/04/2020 beginning at 1335 a copy of the CTW issued to Patient 13 when SSOs arrested and handcuffed him/her as required by the P&P above was requested. At that time the SS stated that a CTW "may not have been" issued.

On 03/04/2020 at approximately 1500 a 3.5 inch by 5.5 inch document titled "Contact Report" was provided and reviewed. This form was referred to as the CTW. The name of Patient 13 was written on the form, the "Date of Contact" was recorded as 04/12/2019, the "Time" was blank, the "Location" was recorded as "Unity." The card contained the following information in the following fields:
* "Sex" - "[specific gender type]"
* "Race" - "[specific race type]"
* "[Height]" - "N/A"
* "[Weight]" - "N/A"

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A 154	Continued From page 86 * "Hair/Length" - "None" * "Eyes" - Either "U/A" or "N/A" * "Comments" - There were none * "Trespass Warning Notice Given?" - "Yes" was checked There was no information on the Contact Report to reflect why the report was written and what events had transpired on 04/12/2019 the date it was issued, nor was there any information relevant to the events that occurred on 11/26/2019. The back of the card contained pre-printed language that reflected, "Criminal Trespass Warning - You are prohibited from coming onto the property or premises of any Legacy Health Property at any time except in order to receive emergency medical care. Entry upon the premises for any other reason without permission from the Legacy Security Department may result in your arrest for criminal trespass. Oregon (ORS 164.245) - Criminal Trespass in the second degree occurs when a person enters or remains unlawfully in or upon the premises. This is a misdemeanor ... This notice may be rescinded only by written notice from an officer of Legacy Safety and Security Services and will remain on file." During interview with the SS on 03/04/2020 about the CTW provided he/she stated that anyone who is handcuffed by SSOs is "arrested" and "gets trespassed." He/she stated that a "Criminal Trespass Warning" in accordance with the P&P was not issued on 11/26/2019 "because [Patient 13] had already been banned" and the one last given would have remained in effect. The SS confirmed that the 04/12/2019 "Contact Report" or CTW did not reflect the events of that date and	A 154		

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A 154	Continued From page 87 stated that he/she did not know the circumstances that led to the 04/12/2019 CTW and was unsure if Patient 13 had been handcuffed at that date. 6.c. A report titled "Safety/Security" for "Escalated Person" was dated on 11/26/2019. It contained "General Information about the ... Event" that was an identical "copy and paste" of the note written by RN R at 1825 recorded under Finding 12 above. The documentation reflected: "pt (sic) visited PES three times in 24 hours. Pt engaged in several behaviors that place pt at risk of harm to self or others. Pt kicked car in parking lot (sic) Pt escorted from parking lot to lobby, lunged at and attempted to extinguish cigarette on writer, when writer use (sic) firm voice to redirect pt threw cup at writer (sic) pt (sic) grabbed buttocks of person registering pt to PES. Pt attempted to spit and physically assault triage RN (sic) pt (sic) hit triage BHT (sic) Disposition made for pt and every attempt was made for pt to remain in triage until appropriate transport arrived. Pt was moved and remained with security in ambulance bay. Pt was self dialoguing, removed clothes and was found unable to redirect. As additional provider team and nursing were consulting on pt and determining next steps. Portland PD arrived and was (sic) now with pt and Legacy Security. Portland PD called Project Respond. Pt declined to return back to PES. Medics arrived and attempted to engage with pt. Pt threw orange juice on medic. Medics assisted staff to move pt to gurney and then transported pt to triage. while (sic) in triage(sic)	A 154		

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A 154	Continued From page 88 pt (sic) was combative (sic) pt (sic) spit on medics (sic) pt (sic) yelling at staff (sic) unable (sic) to redirect (sic) unable (sic) plan for safety (sic) pt placed on NMI, was provided emergent medication, moved to HR 3." The report further reflected the following: "What type of unsafe behavior did the patient do that required intervention." The response recorded was "Violence towards staff" "Was there physical contact between the patient, peers, and/or staff?" The response recorded was "Yes" "What physical contact occurred?" The response recorded was "Patient initiated physical contact with staff" "Was Emergency Medication Administered?" The response recorded was "Yes" "Voluntarily or Involuntarily?" The response recorded was "Involuntarily" The only "Follow-up Notes" on the report were dated 12/02/2019 and 01/02/2020. On 12/02/2019 "Follow-up Notes" were recorded as "sent email to RN writing [report] to get names of staff involved for VIW f/u and support." On 01/02/2020, 37 days after the incident, "Follow-up Notes" were recorded as: "Contributing factors: patient with hx of violence presented multiple times to Unity PES in 24 hours Patient condition: stable, no injury. BHT reports filing police report for assault by patient Mitigation plan: PES Medical Director intervened to assist patient with return to services in PES. PES RN staff involved attended debriefing	A 154		

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A 154	Continued From page 89 11/26/19 along with members of Unity leadership and multidisciplinary team members. On-going discussion of best practice to assist patients in substance-induced crisis with violence behavior in PES. VIW process complete with staff involved. Just Culture findings: n/a" An untitled, undated and unauthenticated attachment to the report reflected: "The ... stated [he/she] had recently used substances. Otherwise, [he/she] was assessed to be at [his/her] baseline. It was determined that [he/she] should go to CHIERS to detox. The patient appeared agreeable to wait for transport ... waited in the triage area for approximately 45 minutes without issue. The triage area started to get busy with other patients, so this patient was escorted to the lobby to continue to wait for transport to CHIERS. While the patient was being escorted to the lobby, [he/she] quickly escalated and became aggressive towards three staff members. [He/she] grabbed and spit on a staff person, punched a nurse, and continued to raise [his/her] fists in attempt to strike a security guard. [He/she] then ran outside and began kicking cars. Security engaged with the patient and eventually placed him in handcuffs due to [his/her] assaultive behavior. Security waited with the patient in the ambulance bay for approximately 5 minutes until the non-emergency police transport arrived. When police arrived, the handcuffs were removed. The patient was accompanied by Unity staff the entire time that [he/she] was in the ambulance bay ... Upon arrival, the police indicated that they would not transport the patient to CHIERS. They believed the patient needed mental health treatment. The patient continued to be reassessed by nursing and a provider, who	A 154		

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reiterated that they believed [he/she] needed detox treatment. Over the next 1.5 hours, police and Unity staff had ongoing discussions to develop a plan for this patient. Eventually, the medical director of PES assessed the patient and determined that [he/she] should be admitted to the PES, as [his/her] behavior had decompensated. While in the ambulance bay, the patient was asked to put on [his/her] warm clothing but refused. [He/she] was offered blankets by nursing staff." The report reflected, "As a result of this incident, the following areas of opportunity have been identified: Staff will be re-educated on Legacy's Chain of Command policy, and Unity's escalation plan will be updated "to involve providers earlier in the series of escalations. An algorithm will be developed for patients who present to PES multiple times within a short timeframe. This will include consideration to involve different staff members in the patient 's care, to provide a 'fresh set of eyes.' Unity Leadership scheduled a meeting with the Portland Police Bureau to discuss this case and identify opportunities for better partnership."

On 03/12/2020 at 1330 follow-up email communication from ACC1 regarding the purpose, date, origin and author of the untitled, undated attachment reflected "Response to TJC Office of Quality and Patient Safety Inquiry, received 12/12/19, responded 12/30, closed by TJC 2/6/20 with no further follow up." In addition, the follow-up email communication regarding the discussion and outcome of the "debriefing 11/26/19" reflected "Informal debrief, no notes taken."

6.d. A report titled "Restraints" for "Seclusion" was dated 11/26/2019. It contained "General

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A 154	Continued From page 91 Information about the ... Event" that was an identical "copy and paste" of the "General Information ... about the Event" recorded under Finding 15 above, and of the note written by RN R at 1825 recorded under Finding 12 above. The report further reflected the following: "Were there any injuries?" The response recorded was "No" "Was any property damaged?" The response recorded was "Yes" "What property was damaged and how?" The response recorded was "pt kicked car in parking lot" "What type of unsafe behavior did the patient do that required intervention?" The response recorded was "Other unsafe behaviors requiring intervention" "Was there physical contact between the patient, peers, and/or staff?" The response recorded was "Yes" "What physical contact occurred?" The response recorded was "Patient initiated physical contact with staff" "Was Emergency Medication Administered?" The response recorded was "Yes" "Voluntarily or Involuntarily?" The response recorded was "Involuntarily" The only "Follow-up Note" on the report was dated 12/01/2019 and reflected: "Contributing factors: alcohol use disorder, unspecified psychosis Patient condition: extreme agitation, combative, threatening, requiring hands-on intervention Care plan opened: yes/no ... NA Flowsheet: ..." The "Flowsheet" entries recorded were related to required seclusion documentation once seclusion	A 154		

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A 154	Continued From page 92 had been initiated. On 03/12/2020 at 1330 follow-up email communication from ACC1 regarding the entries that "property was damaged" and "pt kicked car in parking lot" reflected "No property damage occurred, but there was an attempt/potential for damage." In addition, the follow-up email communication regarding whether injuries to Patient 13's feet had resulted from kicking a car with bare feet hard enough for the car to sustain damage reflected "There was no damage sustained to the car. There was an attempt. No patient injury noted." The report only addressed the seclusion that occurred after the physical take-down, handcuffing and 4-point physical restraints while strapped with two cross-body straps on a gurney. The report was inaccurate where it indicated there was property damage and did not reflect the extent of damage to the car that resulted from the patient kicking the car with his/her bare feet in 40-degree weather. 7.a. During interview on 03/05/2020 beginning at 1235 the ACC1 stated that the RM had confirmed that morning, on 03/05/2020, that while escorting Patient 13 through the sally port between the ED Triage and the main lobby the BHT Q had been "struck in the face" by Patient 13 and had "pressed charges" against Patient 13. During that interview the CNO stated that Patient 13 had "hit" RN P in the sally port, but that had not been captured on video, and had "hit" BHT Q in the face while in the main lobby. 7.b. RN P was interviewed on 03/05/2020 beginning at 1330 and provided the following	A 154		

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A 154	Continued From page 93 information: * The RN stated he/she didn't recall what the discharge plan for Patient 13 was when he/she was discharged from the ED. The RN stated, "I think [he/she] was waiting for a taxi or whoever picked [him/her] up." * Patient 13 was "grimacing" and "posturing" at the RN when they moved through the sally port from the ED Triage area into the main lobby and waiting area. * The RN stated that he/she didn't recall being spat at by Patient 13 but other staff told the RN that the patient had "spat at me" and "I was told [he/she] took a swing at me." * The RN P stated that "No, [Patient 13] did not make physical contact with me." * "I think [Patient 13] hit [BHT Q] in the hand on the outside of the hand." The RN stated, "I feel I did see that but not 100% sure." * Patient 13's clothing and shoes "would have been in the bag I was holding and handed to patient in the lobby." * The RN stated that "normally" patients would change into their clothes and put on shoes in the lobby restroom or waiting area. * The triage notes written by RN P and dated 11/26/2019 at 1620 was reviewed with RN P. The notes reflected that the "patient spat ... and made threats of harm ... Reports SI ..." RN P stated he/she didn't recall being spat, didn't recall the threats of harm and didn't remember the patient's reports of SI. * RN P stated that after escorting Patient 13 into the lobby/waiting area he/she was not involved with or had observations of Patient 13 until after he/she was brought back into the ED Triage area on a gurney. * RN P indicated that he/she might have gone out to the ambulance bay to report to staff out there	A 154		

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that Patient 13 "might have swung at [BHT Q]."
* Inside the ED Triage area Patient 13 "spat towards ambulance personnel" and they turned the gurney towards the wall.
* Patient 13 had a lighter in his/her pocket which they tried to get out of the patient's hand.
* The RN stated he/she didn't recall who was involved in decision making but that ED MD took over the process and decided to medicate the patient in the ED Triage while he/she was on the gurney.
* After the medication was administered the patient was wheeled on the gurney into a hold room and "20 to 25 minutes" passed before Patient 13 was removed from the gurney and the restraints released.
* The RN stated they kept the hold room door open to observe the patient to determine when to remove the restraints.

7.c. SSO L was interviewed on 03/05/2020 beginning at 1410 and provided the following information:
* SSO L responded to a call from the main lobby that a patient was "assaulting staff."
* SSO L first encountered Patient 13 outside of the building where he/she was being escorted off property.
* Patient 13 was "screaming, yelling and kicking a vehicle" in the parking lot.
* He/she was informed that Patient 13 had "spat on an RN" and "hit a tech in the arm."
* There were "multiple victims in the lobby saying [Patient 13] assaulted them."
* They "wanted to take control of [his/her] arms and help get [him/her] off property."
* Patient 13 "began fighting really hard" and they had "no other option but to take [him/her] to ground and place [him/her] under arrest ... for

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harassment, trespass and vandalizing a vehicle."
* When SSO L and SSO K "grabbed" Patient 13's arms he/she "started kicking, biting, spitting" and "hurt us."
* "All of us" placed Patient 13 "on the ground as best as we could as safely as we could."
* "All of us" was SSO L, SSO K, SSO M, and "I think" SSO T was there too.
* Two SSO's each had an arm, one SSO had the legs and SSO K or M placed the handcuffs, "I don't recall 100%."
* SSO L was asked how many times Patient 13 kicked the car to which he/she responded that Patient 13 kicked the car "one time."

7.d. CIS N was interviewed on 03/05/2020 beginning at 1435 and again on 03/16/2020 beginning at 1330 and provided the following information:
* Patient 13 arrived at the hospital and went outside to have a cigarette before he/she was seen in ED Triage.
* CIS N and BHTQ went outside to get Patient 13 for triage and he/she came in voluntarily.
* Before the patient came inside, CIS N observed that Patient 13 "waved [his/her] arm at RN R, who was walking outside, with the lit cigarette" in his/her hand. CIS N stated this was a "gesture" and the patient was not trying to attack the RN with the cigarette.
* During the triage process Patient 13 demonstrated no change in presentation than the prior ED visit earlier that same day.
* They were not planning to discharge Patient 13 to the community but instead to CHIERS. Patient 13 "grumbled about that."
* CIS N called non-emergency PPB to request transport to CHIERS as CHIERS secure transport was not available that day.

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A 154	Continued From page 96 * Patient 13 waited for PPO transport in the ED Triage area for about an hour and "was calm during that time." * The "acuity" of the ED triage was increasing so they wanted Patient 13 to move to the main lobby to wait for transport. * As RN P was escorting Patient 13 through the sally port into the main lobby and waiting area it "looked like he spat on the RN." * BHT Q had said that he/she saw RN P being spat on by Patient 13. * CIS N stated the patient was "shadow boxing," and described that the patient was "leaning back" in a boxing type stance with his/her arms in the air and was "not directing punches at staff." * CIS N "saw [Patient 13] shadow boxing with [BHT Q]. * He/she didn't know who escorted the patient outside. * CIS N called PPB to check on status of transport and went back outside to report to staff who were outside with the patient that PPOs were en route to the hospital. * SSOs had Patient 13 on the ground. * CIS N "immediately left" the scene to go back inside. * CIS N stated that sometime later when he/she learned that Patient 13 was still at the hospital he/she was "very surprised." * He/she learned that the PPOs wouldn't take or arrest the patient. * CIS N went out to the ambulance bay where the patient was at that time. * The CIS stated "[Patient 13] looked worse off ... had history of PTSD." * He/she stated that "PTSD trauma was triggered by security and police." * "[Patient 13] was sitting with handcuffs on and struggling in a way that [he/she] was not when	A 154		

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A 154	Continued From page 97 [he/she] was in triage." 7.e. SSO K was interviewed on 03/05/2020 beginning at 1510 and provided the following information: * SSO K heard the "panic alarm" go off in the main lobby and responded to that area. * When the SSO arrived he/she saw Patient 13, SSO M and BHT Q outside of the building and Patient 13 was "squaring up" and "raising [his/her] fists." * During the process of walking the patient off the hospital property the patient was "squaring up," "decided to commit a crime" by kicking a car. * In addition, "[SSO M] stated that [RN P] and another staff person were assaulted." * SSO L, the "lead" SSO, directed that the patient be placed in handcuffs. * The SSOs grabbed the patient and placed him/her on the stomach with hands behind the back. * After they "had [Patient 13] on the ground SSO M placed cuffs on [him/her]." * The wrist cuffs were "double locked." * Patient 13 was "helped to [his/her] feet" and taken to the ambulance bay. * PPOs arrived and requested that the handcuffs be removed. * PPOs called Project Response and AMR for assistance. * Staff and PPOs attempted to help the patient into warmer clothing, but Patient 13 started to swear and threw some of his/her belongings. * An AMR ambulance staff person reported that the patient threw a juice box at him/her. * SSO K left the scene in the ambulance bay to do work in the nearby security office. * When SSO K observed Patient 13 in the "4 point restraints" he/she assumed it was due to	A 154		

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A 154	Continued From page 98 the "assault on AMR staff" when the patient threw a juice box. * SSO's responded to a second "panic alarm" set off when triage staff reported that the patient, still restrained on the gurney, had a lighter and tried to set a blanket on fire. SSO K did not see the lighter. * Staff held the patient down so that medication could be administered. * He/she did not recall anything about the application or use of spit hoods. * SSO K helped staff assist the patient into the hold room. The gurney was wheeled up to the hold room door, the restraints were released, and the patient walked into the hold room. SSO K stated the patient was not on the gurney and not in restraints in the hold room. 7.f. On 03/05/2020 beginning at 1600 the PAS S who was observed in the video to be seated at the main lobby desk at the time Patient 13 and RN P exited the ED triage area was interviewed and provided the following information: * PAS S's first interaction with Patient 13 during that ED visit was after Patient 13 had originally arrived at the ED. * He/she approached Patient 13 where the patient was seated in the lobby waiting area and sat next to him/her to have the patient sign the patient's rights form. * Patient 13 stared at the PAS S's breasts then "poked" the breasts with his/her finger twice. * The PAS S stated that when he/she got up to walk away Patient 13 "poked" the PAS S's bottom with his/her finger twice. * PPOs were seated nearby and did not intervene. * He/she reported the inappropriate behavior to his/her supervisor.	A 154		

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A 154	Continued From page 99 * After PAS S reviewed the documentation made about the encounter in the EPIC FLAG feature of the medical record he/she asked the supervisor to change how the behavior was recorded as it reflected Patient 13 had "groped" the PAS S. PAS S stated there was "no grope." * He/she stated that later when Patient 13 and RN P entered the lobby/waiting area from the ED triage area Patient 13 did not hit RN P and recalled that he/she made a comment to that effect to RN P at that time. * He/she observed the interaction between Patient 13 and BHT Q and stated that the BHT Q "caught [Patient 13's] hand" when Patient 13 was making punching gestures at the BHT. * In relation to Patient 13, the PAS S stated "don't hold it against [him/her]." 7.g. SSO M, the "Lead" SSO, was interviewed on 03/05/2020 beginning at 1630 and provided the following information: * SSO M stated that as Patient 13 was walking out of the ED Triage area into the main lobby the patient started spitting and throwing punches and staff set off the "panic alarm." * Patient 13 "was being violent punching at [BHT Q] and me." * SSO M, SSO K and SSO L were "trying to walk him off" the property when Patient 13 kicked a car and was handcuffed. * SSOs "tried to maintain control" but the patient "was resisting" SSO "as quick as possible" they put him/her on the ground on his/her stomach. * The handcuffs were removed "shortly" after PPOs arrived on the scene. * SSO M didn't know the time AMR arrived to assist and he/she "stood by and observed." * SSO M, PPOs and AMR staff assisted Patient	A 154		

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13 onto his/her feet and placed him/her on the gurney inside the ambulance bay.
* Patient 13 "was not struggling or fighting during this time."
* SSO M applied one of the extremity restraints and AMR staff applied the other three restraints and the gurney halter and strap seat belts.
* SSO M followed the gurney back into the ED Triage area and then "cleared it" and left the area.
* He/she did not recall the panic alarm sounding, anything about a lighter or anything about the application or use of spit hoods.
* SSO M did state he/she was there when the patient was wheeled to the hold room but did not recall how the patient got into the hold room.

7.h. NP U was interviewed on 03/16/2020 beginning at 1245 and provided the following information:
* NP U had seen Patient 13 three (3) times in 24 hours and described ED encounters with the patient that occurred late the night before on 11/25/2019 and earlier in the day on 11/26/2019.
* NP U stated that "clinical judgement was involved in all three presentations."
* Patient 13 was "disorganized this time" and "sharing that [he/she] used [methamphetamines]."
* Patient 13 was "not engaging with the assessment" so the decision was made to send him/her to CHIERS.
* The CIS called PPB for transport to CHIERS.
* Pt waited in triage and then needed to be moved to the lobby to wait.
* NP U didn't observe Patient 13 until about an hour later in the ambulance bay.
* Patient 13 didn't respond to NP U's questions, refused to move and refused to change into other clothes.

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* PPOs had a different impression of Patient 13's situation and hospital leadership became involved.
* In regards to the entries in the ED medical record that Patient 13 had expressed SIs NP U stated that "I believe [Patient 13] was endorsing SI in the context of wanting to stay to have [his/her] basic needs met." NP U stated, "I believe it was passive and at [his/her] baseline." NP U indicated that the patient didn't have a plan nor intent and was not an imminent danger to self.

7.i. BHT Q was interviewed on 03/16/2020 beginning at 1400 and provided the following information:
* Patient 13 was triaged in the corridor in front of the ED Triage desk.
* Patient 13 "was not cooperative or willing to be involved in [his/her] care so was discharged."
* Patient 13 "had to be escorted out of the lobby" and "was out of control with patients in the lobby."
* BHT Q was watching the video monitors, saw Patient 13 "ramping up" and so responded to the lobby.
* When in the lobby BHT Q "deflected [Patient 13's] attempts to strike me" and he/she "shielded other patients" from Patient 13.
* Patient 13 "just glanced me ... didn't hit anyone ... swung at me ... deflected with my hand ... didn't connect ... grazed my hand ..."
* BHT Q stated that Patient 13 made "minimal contact" with his/her hand and he/she didn't have any pain or injury and "it wasn't anything I was concerned about."
* BHT Q and a SSO escorted the patient outside "without anyone getting hurt."
* The BHT came back into the hospital and the SSO's took over with Patient 13 outside.
* BHT Q saw the patient again when he/she was

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brought back in restraints to ED Triage.
* He/she "thought [Patient 13] walked back in" and didn't recall the patient was brought in on a gurney.
* BHT Q also stated that the patient was spitting while he/she was on the gurney and "had something in [his/her] hand we had to take away."
* BHT Q did not witness Patient 13 outside kicking the car or the SSO's taking the patient to the ground and handcuffing him/her. BHT Q stated, "I was coming in when that was happening."
* A video screen shot from 11/26/2019 at 1625 in the hospital's parking lot was reviewed with BHT Q. It showed Patient 13 on the ground held down by SSO's with BHT Q standing within a few feet of the situation. BHT Q stated, "at one point I went back out to see what was happening."
* BHT Q stated "I don't remember pressing charges" against Patient 13.

8. During interview with the DSS, SS and the UCBHP on 03/03/2020 beginning at 1415 it was stated that there was no video of Patient 13's ED encounter as video lasted for 30 days unless it was saved. They stated that there were video "screen shots" that had been captured and saved and those were provided for review.

During interview on 03/04/2020 at 1130 the President and the CNO disclosed that recorded video footage of the encounter of Patient 13 on 11/26/2019 had been located. That video footage was reviewed on 03/04/2020 beginning at 1140 with the CNO, ACC1, RM and SS. During interview with those staff at the time of the review it was stated that the video footage was from six (6) interior and exterior cameras. During the review it was revealed that there was no video

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saved of the reported assault by Patient 13 on BHT Q nor of events immediately preceding that in the lobby, and there was no video of the events that occurred outside, including of the behaviors that Patient 13 exhibited that led SSOs to physically take-down and handcuff him/her. The lack of that video was confirmed again on 03/04/2020 at the conclusion of the video review.

The video, with no audio capability, and video screen shots during the times when video had not been saved, revealed the following timeline on 11/26/2019:

* 1451 - Video screen shot identified as "Lobby South Patient Access ... Camera 1" showed Patient 13 standing in front of and facing the main lobby desk. The patient was facing a staff person who stood behind the desk looking directly at the patient and the patient was pointing the direction of the lobby windows. The patient was fully clothed in shoes, blue jeans, a dark long-sleeved jacket and a gray hooded shirt or other shirt was hanging around his/her neck and down the back.

* 1535 - Video screen shot identified as "PES Triage Nurses Station Right Corridor ... Camera 2" showed Patient 13 was sitting on a chair in the ED Triage corridor facing the nurse's station. There were individuals in the shot who faced the patient and were identified as BHT Q, CIS N, RN P and NP U. The patient was wearing a sleeveless shirt, knee length shorts and no shoes or socks or other items.

Video footage from interior cameras:
* 1536 - Patient 13 was seated in a chair in the corridor in front of the ED Triage nurse's station desk with three individuals seated or standing

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A 154	Continued From page 104 and facing the patient. The patient and the staff were observed to verbalize periodically. * 1557 - Patient 13 was seated in the same chair without staff interaction. The patient was observed to exhibit no physical behaviors nor verbalizations * Patient 13 was observed to remain seated in the same chair without exhibited behaviors while activity in the ED Triage area occurred and staff , patients and other individuals were observed to come and go directly in front of and around the patient. * 1619 - RN P and CIS N approached Patient 13 while he/she was seated in the chair and a verbal exchange occurred. * 1621 - RN P entered the main lobby and waiting area through doors from the ED Triage area followed by Patient 13. The RN was holding a clear bag of items in his/her hand. * 1622 - RN P and Patient 13 were observed to be a few feet apart and facing each other while Patient 13 was observed with a boxing-like stance, making boxing-like gestures with his/her arms towards the RN's back and then as the RN turned and faced him/her. There was no observation that RN P was struck or hit by Patient 13. PAS S was observed seated at the main lobby desk and faced Patient 13 and RN P. * 1622 - BHT Q and an SSO were observed to enter the main lobby and waiting area from the ED Triage area behind Patient 13 and RN P. During the review staff stated that there was no video footage saved to show the events that followed in the lobby/waiting area inside the building and of the physical take-down and handcuffing of Patient 13 outside the building. The following video screen shots captured still images during that time as follows:	A 154		

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A 154	Continued From page 105 * 1622 and 19 seconds - Video screen shot identified as "Lobby North Patient Access ... Camera 1" showed Patient 13 and BHT Q to be facing each other on the other side of the main lobby desk near the main entrance doors. In the shot, BHT Q had both arms extended towards the patient and the patient had both knees bent, one arm extended toward the BHT and the other arm bent at the elbow at his/her side. * 1622 and 22 seconds - Video screen shot identified as "Lobby North Entry Door ... Camera 2" showed Patient 13 walk through the main lobby entrance/exit door towards the outside of the building followed by a SSO and BHT Q. * 1624 and 21 seconds - Video screen shot identified as "EXT East Lot Viewing South ... Camera 1" showed Patient 13 stood near the rear driver's side of a red, four-door sedan parked parallel to the ambulance driveway. The patient was observed to be wearing the sleeveless shirt, shorts and no shoes or socks as described in an earlier video screen shot. Approximately five individuals are observed to be several feet behind the patient. * 1625 and 54 seconds - The next video screen shot identified as "EXT East Roof PTZ," one (1) minute and 33 seconds later, revealed that Patient 13 was face down on the ground a few feet in front of the red sedan. One SSO was standing over the patient while two other, and possibly three, SSOs were bent or crouched over the patient. CIS N and BHT Q were observed to stand at the scene within a few feet of the situation.	A 154		

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A 154	Continued From page 106 * 1626 and 52 seconds - The next video screen shot identified as "A Turn" showed a partial view of the inside of the ambulance bay. An AMR ambulance was parked partially inside the ambulance bay. BHT Q and CIS N were observed to be standing in the bay, and Patient 13 and another individual were observed to be standing next to the amblance bay wall. Video footage from exterior cameras - View from parking lot towards the hospital's ambulance bay: * 1628 - An AMR ambulance parked in the ambulance bay drove out of the bay and away from hospital to reveal Patient 13 on the ground in the SW corner of the bay with multiple SSOs standing around him/her. * 1634 - Patient 13 was observed to be sitting on the ground in the corner with his/her knees up to his/her chest. The patient's arms, legs and feet are observed to be uncovered as described in previous screen shots. Three individuals including at least two of whom are PPOs are observed to approach the exterior entry of the ambulance bay. * 1653 - During the previous minutes other PPOs arrived on scene. Approximately seven SSOs and PPOs were observed in the ambulance bay standing and moving around while Patient 13 remained seated on the ground in the SW corner of the bay. * 1709 - Patient 13 continued to remain on the ground in the ambulance bay. * 1715 - An AMR ambulance arrived and backed into the ambulance bay. * 1738 - During the previous 23 minutes multiple police vehicles and officers arrived on scene. The AMR ambulance pulled out of the ambulance bay and drove away from the hospital to reveal that Patient 13 remained on the ground in the SW corner of the bay with approximately seven (7)	A 154		

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A 154	Continued From page 107 individuals that included hospital clinical staff standing around him/her. * 1744 - Patient 13 continued to remain on the ground in the ambulance bay. * 1801 - An AMR ambulance arrived and backed into the ambulance bay. * 1811 - The back doors of the ambulance were opened. * 1815 - Behind the ambulance a partial view of a gurney was seen being wheeled into the hospital by individuals from the ambulance bay. Video footage from interior cameras: * 1815 - Patient 13 was observed on a gurney being wheeled back into the ED Triage area from the ambulance bay by AMR ambulance staff and SSOs. * A harness-like safety belt was strapped across the patient's shoulders and chest and abdomen to the gurney. A second gurney safety belt was strapped across the patient's knees. A blue restraint was observed around each of the patient's wrists and a red restraint was observed around each of the patient's ankles. Patient 13 was seated calmly and did not exhibit any behaviors. * Notably, the following events are only partially captured on video as the position of the gurney and the patient's head and most of his/her body are directly underneath the video camera head located on the ceiling in front of the ED Triage nurse's station desk. * 1815 - An AMR ambulance staff person recoiled as if something had been thrown at him/her and Patient 13's legs are observed to be moving and struggling in the ankle restraints. * 1816 - A person was observed to approach the patient on the gurney with a surgical face mask. * 1819 - An AMR ambulance staff person was	A 154		

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A 154	Continued From page 108 observed to enter the ED Triage area carrying a spit hood and approached the patient on the gurney with the spit hood. * 1819 - RN P and RN R were positioned behind the ED Triage nurses' station desk engaged in interaction with each other and other staff , and were performing tasks on a counter-top that were not clearly identifiable. * 1820 - Two AMR ambulance staff are observed to physically hold the patient down on the gurney while he/she struggled in the restraints and straps. * 1820 - BHT Q approached the patient with a towel and the AMR staff applied a spit hood. * RN P approached the patient on the gurney with something small and white in his/her hand that was not identifiable on the video. * 1821 - Five (5) SSOs are observed to enter the ED Triage nurse's station area through the ambulance bay door and approach the gurney. * 1824 - Multiple SSOs and AMR staff are crouched over the patient, holding him/her down while RN R approached Patient 13 with a medication syringe. * 1826 - Patient 13, restrained to the gurney, was wheeled in front of the ED Triage desk through double doors into the seclusion/hold room area. Approximately 11 individuals were pushing or following the gurney. The screen shots and video footage reflected that Patient 13 was removed from the building by staff at 1622 and returned into the building restrained to a gurney at 1815, approximately two hours later. 9. On 03/12/2020 at 1330 follow-up email communications from ACC1 were provided regarding the following:	A 154		

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A 154	Continued From page 109 * Regarding the use of "spit hoods" on Patient 13, the information reflected there was "No Policy or Procedure on Spit Hoods. Spit Hood was applied by AMR in this situation." * Regarding other P&Ps related to roles of ED staff, police, ambulance agencies and secure transport agencies in managing medical, psychiatric and other emergencies, the information reflected "There are no other P&Ps." * Regarding P&Ps, protocols or directions related to staff encounters with "Project Respond," the information reflected there was "No Policy or Procedure for Project Respond." * Regarding time of arrival and documentation about Project Respond's activities referenced in Patient 13's medical record, the information reflected the "PPB requested Project Respond. PPB requested Project Respond leave." 10. To summarize the failures identified in the findings above that led to the restraint and seclusion of Patient 13: 10.a. Patient 13 was triaged and a MSE conducted concurrently by the RN, BHT, NP an CIS in the corridor in front of the nurse's station with no visual or auditory privacy allowed for the processes. The triage and MSE lasted approximately two minutes before a discharge disposition was made. 10.b. The patient expressed SI on two occasions during the encounter that was not described, nor clearly and objectively addressed. The SI was determined to be "in the context of going to CHIERS" but there was no explanation for what that meant. 10.c. The decision to transfer the patient to	A 154	The following actions will ensure that patients' rights freedom from restraint and seclusion are recognized, protected, and promoted: **Procedure & Process for Implementation (Triage Algorithm)** The identified root of cause of the incident was that the patient was evaluated by the same provider on 3 separate occasions within 24 hours, making it difficult to readily identify changes in the patient's condition. To address this, an algorithm will be developed for patients who present to PES more than once within a 24-hour timeframe. This algorithm will require the care team to involve different staff members and providers in the patient's care, providing for a "fresh set of eyes", while making a determination on patient disposition.	

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A 154	Continued From page 110 CHIERS, a sobering station, was made without any diagnostic testing during the encounter to confirm whether the patient was intoxicated or under the influence of drugs. 10.d. Patient 13 was waiting for a hospital arranged secure transfer to another setting for continuing care. He/she had not been discharged to home or self-care and never left the ED or the hospital's premises. Patient 13 continued to be a patient and the responsibility of the hospital until he/she was transported off the premises to the other care setting. 10.e. Patient 13 sat calmly, without aggressive behaviors, for 45 minutes in the corridor in front of the nurse's station. When RN P directed the patient to wait for the transfer to CHIERS in the lobby/waiting area and began to escort him/her from the ED Triage area into the lobby the patient began to exhibit a change of condition in relation to his/her behaviors. The patient began to "shadow box" at staff and while in the lobby "grazed" the hand of BHT Q. Staff decided that Patient 13 was to be escorted out of the hospital. Staff failed to follow the "Intervention Zones" criteria and SLM training for the Lobby Zone that stated about patients: "Encourage them to come in and assess the situaton/condition ... Recommend patient check in for a new or worsened condition if recently discharged ... Use De-Escalation skills to maintain safety while addressing the individuals (sic) needs. If you believe the patient is escalating, notify Nursing Supervisor and PES Clinicians immediately ... The Nursing Supervisor and other PES CRN, CIS and Providers present will determine if the individual requires	A 154	Unity Leadership identified an alternative location in PES for discharged patients to stay when they are awaiting transport by police services, to minimize the potential for patient escalation. These patients will no longer be escorted to the lobby. PES Staff including Behavioral Health Therapists, RNs, Behavioral Health Assistants, Counseling & Therapy Staff, Care Management Staff, LIP, Patient Access, and Security will receive education on the Triage algorithm. **Monitoring Plan** 10 audits will be conducted per month to assess use of the triage algorithm for patients who are triaged in PES more than once within a 24 hour period. The target for compliance is 90% per month for 3 consecutive months. During monitoring, instances of non-compliance will be reviewed with the leadership team to identify trends and education opportunities. Auditing will continue until 90% compliance has been achieved for 3 consecutive months. **Incorporation Into QAPI Program** 10 audits will be conducted per quarter to assess use of the triage algorithm for patients who are triaged in PES more than once within a 24 hour period. The target for compliance is 90% per quarter. During monitoring, instances of non-compliance will be reviewed with the leadership team to identify trends and education opportunities. Results will be shared at monthly Quality Council meetings. Upon hire, PES Staff including Behavioral Health Therapists, RNs, Behavioral Health Assistants,	

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A 154	Continued From page 111 assessment and should be escorted to triage (either voluntarily or involuntarily)." Had staff followed the guidance the use of multiple types of restraint and seclusion may have been prevented. 10.f. Patient 13 continued to exhibit a change in condition while being escorted through the parking lot by SSOs, although video of that part of the encounter was not provided. SSOs' actions were influenced by inaccurate and exaggerated information about the "assaults" to clinical staff by Patient 13. For example: The patient was accused of "groping" a staff person, intentionally trying to burn an RN with a cigarette, hitting another RN and hitting a BHT. Those events were not accurately characterized based on the interviews with staff and the review of video. In the parking lot, when the patient kicked a car, one time, with his/her bare foot, multiple SSOs conducted a physical take-down to the ground and handcuffed and "arrested" the patient. Documentation after the incident reflected that Patient 13 caused "property damage" when he/she kicked the car. However, the patient had no shoes or socks on and to have kicked a car hard enough, with one kick, to cause damage to the car would have likely resulted in significant injuries to Patient 13's foot. Such injuries were not identified or clearly assessed for. Staff decided that Patient 13 was to be physically forced to the ground and handcuffed. Staff failed to follow the "Intervention Zones" criteria and SLM training for the Parking Lot Zone that stated about patients: "Encourage the individual to check in to receive care ... Call the Nursing Supervisor ... Do not go hands on ..." and "KEY POINT: Going 'Hands-on' - It is better to spend	A 154	Counseling & Therapy Staff, Care Management Staff, LIP, Patient Access, and Security will receive education on the Triage algorithm. **Completion Date** 10/10/2020 **Responsible Party** Chief Nursing Officer **Procedure & Process for Implementation (Private Persons Arrest)** Unity Safety/Security Officers will no longer make the decision to use Private Person's Powers of Arrest (ORS 133.225) for any crime where Legacy Health is the victim, unless first receiving approval from the Security Manager, Security Director or VP of Facility Operations. This includes, but is not limited to, the crimes of trespassing, theft and criminal mischief. In these instances, Security staff will first notify the Clinical Team to intervene and assess the person's potential need for clinical care. The Behavior Management Policy will be updated to reflect these changes. Safety/Security Officers received education on this change on 6/28/20, 6/29/20, and 9/1/20. **Monitoring Plan** 30 security reports will be audited per month to ensure compliance with the new process. The target for compliance is 90% per month for 3 consecutive months. During monitoring,	

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A 154	Continued From page 112 more time and resources on de-escalation if doing so prevents going 'hands-on' ... Going 'Hands-on' is a form of physical restraint, and should only be used as a last resort ... NEVER go hands-on alone and without a Code Team in place (follow Code Gray process) ... In the Parking Lot Zone (Purple): DO NOT initiate 'hands-on.'" Contrary to that direction, staff did initiate "hands-on" in the Parking Lot Zone and did so without "a Code Team in place (follow Code Gray process)." Had staff followed the guidance the use of multiple types of restraint and seclusion may have been prevented. 10.g. After Patient 13 was handcuffed, staff decided to seclude him/her in the corner of the ambulance bay for nearly two hours. The patient was surrounded by numerous SSOs and PPOs while hospital staff debated with PPOs about the patient's mental health status. Staff failed to follow the "Intervention Zones" criteria and SLM training for the "Front of Building Zone," that included the ambulance bay, that stated about patients: "Encourage the individual to enter inside for care ... Clinicians should consider the following when assessing the need for assessment: Is the patient currently checked in? Was this patient recently hospitalized? If the answer to these questions is 'yes', it is likely that the patient would benefit from triage assessment." Instead staff engaged in a debate with PPOs about whether the behaviors the patient exhibited were criminal and were grounds for PPOs to arrest the patient or whether those behaviors demonstrated a change in condition and a "mental health crisis." Had staff followed the guidance the use of multiple types of restraint and seclusion may have been prevented.	A 154	instances of non-compliance will be reviewed with the security leadership team to identify trends and education opportunities. Auditing will continue until 90% compliance has been achieved for 3 consecutive months. **Incorporation Into QAPI Program** 30 security report audits will be conducted per quarter to ensure compliance with the Private Person's arrest process change. The target for compliance is 90% per quarter. During monitoring, instances of non-compliance will be reviewed with the security leadership team to identify trends and education opportunities. Results will be shared at monthly Environment of Care and Quality Council meetings. Policies are reviewed and updated at least every three years and/or with regulatory updates. Upon hire, Security Officers will receive education on the revised process. **Completion Date** 10/10/2020 **Responsible Party** Security Manager	

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A 154	Continued From page 113 Further, while secluded in the ambulance bay the patient was clothed in a sleeveless shirt and shorts and was wearing no shoes or socks. According to an online past weather summary the low temperature on 11/26/2019 in Portland, Oregon was 41 degrees and the high temperature on that date was 44 degrees. 10.h. Patient 13 was strapped to a gurney and placed in 4-point restraints by non-hospital staff for transport from the ambulance bay into the ED triage area although there was no evidence that his/her behaviors warranted that level of physical restraint and there was no evidence that other interventions had been taken to prevent the use of restraints. 10.i. Other care providers who were not LEMC staff placed the patient in restraints. It was unclear why hospital staff deferred the care of Patient 13 to non-hospital staff and there were no P&Ps to support that decision. 10.j. Upon return to the ED Triage area Patient 13 was chemically restrained with IM medication and placed in a seclusion room while in 4-point restraints. After the physical restraints were removed, the patient remained in seclusion in the ED Triage area for 23 hours until he/she was transferred to an inpatient unit where seclusion continued. 10.k. Patient 13's medical record reflected that in addition to the deterioration of his/her mental health condition, he/she experienced an increasingly elevated BP to 177/108 and "injury/trauma" to both upper extremities. Neither of those changes of condition were addressed or	A 154		

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A 154	Continued From page 114 assessed by ED nursing staff. 10.l. An investigation of Patient 13's ED encounter had not been conducted by the hospital and the failures, inaccuracies and inconsistencies identified during the SA investigation had not been identified or addressed. There was no evidence that the hospital had evaluated staffs' actions and inactions and attempted to determine whether the use of forced physical restraint to the ground, handcuffs, 4-point physical restraints, seclusion and chemical restraints could have been prevented, and identified opportunities to prevent such events from recurring. 10.m. Further, the only individuals that demonstrated consideration for Patient 13's dignity during for the encounter were: - A PAS staff person who, in accordance with the Patient's Rights P&P that all LEMC staff members "provide considerate and respectful care, meeting the cultural, spiritual, emotional, and personal dignity needs of each individual patient," stated about Patient 13 "don't hold it against [him/her]" and who insisted that inaccurate and exaggerated documentation in the medical record about Patient 13's inappropriate touching be corrected. - PPOs, who upon arrival to the scene in the ambulance bay, directed staff to remove the handcuffs and refused to arrest Patient 13 based on their assessment that the patient was having a "mental health crisis." 11. Refer to Tag A199 that reflects the failure to ensure that 5 of 14 staff had completed training to identify, prevent and manage patient behaviors in accordance with hospital P&Ps. Four of those five	A 154		

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A 154	Continued From page 115 staff persons were involved in the incident involving Patient 13 on 11/26/2019: BHT Q, SSO K, SSO L and SSO M.	A 154		
A 199	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(f)(2) Training content. The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following: (i) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion. This STANDARD is not met as evidenced by: Based on email communications, review of training records for 1 of 7 clinical staff (BHT Q) and 4 of 7 S&S staff (SSOs K, L, M and W) and policies and procedures it was determined that hospital staff failed to complete training in techniques to identify, prevent and manage patients' aggressive behaviors in accordance with policies and procedures to ensure patients' rights to receive safe care by trained staff. Findings include: 1. The P&P titled "Workplace Violence Prevention & Response" dated as last reviewed "07/19" included the following: * "This policy applies to all people present on Legacy Health (Legacy) property. This includes but is not limited to employees, physicians, patients, visitors, leased office staff, contractors,	A 199		

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A 199	Continued From page 116 and suppliers." * "Workplace Violence - An act of aggression, regardless of the source, directed towards persons at work or on duty and ranges from offensive or threatening language to homicide . Workplace violence includes but is not limited to any physical assault, emotional or verbal abuse or threatening, harassing or coercive behavior in the work setting that causes physical or emotional harm. It includes disruptive behaviors, threatening behaviors and violent behavior. - Disruptive behaviors - Yelling, using profanity, waving arms or fists, verbally abusing others. - Threatening behavior - includes physical actions short of actual contact or injury (moving aggressively into another's personal space), general oral or written threats to people or property ('You better watch your back.' 'I'll get you.'), and implied threats ('You'll be Sorry.' 'This isn't over.'). - Violent behavior - includes any physical assault, with or without weapons; behavior a reasonable person would interpret as being potentially violent (throwing things, pounding one's fist on a desk or door, or destroying property), or specific threats to inflict physical harm (a threat to shoot a specific person: 'I'm going to shoot you,')." * "All Legacy employees will complete training on how to recognize, prevent and/or respond to workplace violence. Training requirements will be based on assessed level of risk in the assigned work area ... High Risk and Extreme High Risk - MOAB Lecture and Physical Training - 8 hours. For employees who are high risk of encountering patients, family visitors or employees that exhibit aggressive or violent behavior. Required of staff that are assigned to work in the following areas: Extreme High Risk * Security * Behavioral Health * Emergency Department ... The participant will	A 199		

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A 199	Continued From page 117 learn strategies and techniques to recognize and reduce aggressive behavior and to avoid physical harm as well as how to manage physical confrontations through demonstration of skills to safely approach, escort, direct to prone, and control individuals using reasonable force that minimizes injury." * "New hires in these departments would be assigned upon hire with required completion within 90 days." * "Ongoing Training ... Extreme High Risk ... recurring training of the MOAB lecture and Physical training should occur every two years ... consists of the MOAB SLM followed by the 4-hour Physical Skills class ... completion of the annual 4-hour Code Gray: Safe Management of Behavioral Escalation training, followed by the MOAB 4-hour Physical Skills." 2. The training records report dated 04/16/2020 for BHT Q with a hire date in 1999 contained no documentation to reflect that he/she had received the ongoing MOAB training described in the P&P for the time period requested, 01/01/2016 to current date. BHT Q was involved with Patient 13 on 11/26/2019 as described in Tag A154 of this report. On 04/20/2020 at 1702 follow-up email communication from ACC1 confirmed that BHT Q had worked in BH at LEMC prior to working at UCBH, and had "worked as a behavioral health therapist throughout [his/her] Legacy tenure. The expiration date for [BHT's] MOAB was entered incorrectly into the education monitoring database. This was discovered in early March 2020 ... the next available class which was in March 2020 ... was canceled due to COVID."	A 199		

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A 199	Continued From page 118 It was unclear how the lack of MOAB training for a staff person in an "Extreme High Risk" department was not detected and identified by the BHT's supervisors and colleagues and the BHT him/herself over the four-year period for which the training records were requested. 3. The training records report dated 04/16/2020 for SSO K with a hire date of 10/31/2016 reflected he/she received eight hours of MOAB lecture and physical skills training on 11/13/2016 and on 01/20/2017. On 01/10/2019 he/she completed a MOAB lecture module. SSO K completed another MOAB SLM on 10/15/2019. On 11/30/2019 he/she completed a "MOAB Training 4 hour Skills Class Session" and the MOAB "SLM (4 Hour Skills Class) Curriculum." That was not until two years and ten months after the initial training, and four days after he/she was involved with Patient 13 as described in Tag A154 of this report. 4. The training records report dated 04/16/2020 for SSO L with a hire date of 08/20/2012 reflected he/she received eight hours of MOAB lecture and physical skills training on 12/30/2016. On 10/27/2019, not until two years and ten months after the initial training did he/she complete a MOAB SLM. He/she completed the MOAB "SLM (4 Hour Skills Class) Curriculum" three months later on 01/30/2020. That was more than three years after the initial training and two months after he/she was involved with Patient 13 on 11/26/2019 as described in Tag A154 of this report. 5. The training records report dated 04/16/2020 for SSO M with a hire date of 07/17/2017 reflected he/she received eight hours of MOAB lecture and physical skills training on 07/25/2017.	A 199	The following steps will be taken to ensure hospital staff complete training in techniques to identify, prevent, and manage aggressive patient behaviors in accordance with policies and procedures to ensure patients' rights to receive safe care by trained staff: **Procedure & Process for Implementation** A one-time audit of physical skills de-escalation training for required employees will be conducted to ensure that that training has been completed within the past 2 years. If gaps are identified, employees will be scheduled for the next available physical skills de-escalation training. Note: Some trainings are currently delayed due to COVID-19.	

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A 199	Continued From page 119 He/she completed a MOAB lecture on 08/28/2018 and a MOAB SLM on 10/15/2019. SSO M completed the MOAB "SLM (4 Hour Skills Class) Curriculum" three months later on 01/10/2020. That was approximately two years and six months after the initial training and two months after he/she was involved with Patient 13 on 11/26/2019 as described in Tag A154 of this report. 6. The training records report dated 04/16/2020 for SSO W with a hire date of 05/15/2017 reflected he/she received eight hours of MOAB lecture and physical skills training on 05/19/2017. The only MOAB training received since that time was the "SLM (4 Hour Skills Class) Curriculum" on 12/09/2019, two years and seven months after the initial training. It was not clear if that was the required SLM or the required physical skills class. 7. MOAB course descriptions reflected that the MOAB "SLM (4 Hour Skills Class) Curriculum" was a "module" during which "the learner will: Describe Legacy's work ... Review Legacy's policies ... Describe techniques that can be used ... Recognize bullying and strategies ..." There was no indication in the course description that physical skills were physically practiced and demonstrated. Although in additional email communication from ACC1 on 04/21/2020 at 1216 he/she indicated that the course was a physical skills class in which the MOAB techniques were demonstrated and practiced, the training records reviewed did not clearly reflect that information.	A 199	For future de-escalation training validation: RN Managers and Assistant RN Managers, as well as Security Managers and Supervisors, will use a dual verification process to verify that de-escalation training is completed within defined timeframes. This process will be conducted during each employee's annual review. RN managers and assistant RN managers, as well as Security Managers and Supervisors, will receive education on the revised process. **Monitoring Plan** 10 employee de-escalation education records will be audited per month to ensure de-escalation training is conducted within defined timeframes. The target for compliance is 100% for three consecutive months. **Incorporation Into QAPI Program** Ongoing monitoring of 10 employee de-escalation education records will be audited per quarter with 100% compliance. During monitoring, instances of non-compliance will be reviewed with the leadership team to identify trends and education opportunities. Results will be shared at monthly Quality Council meetings. Upon hire RN managers and assistant RN managers, as well as Security Managers and Supervisors, will receive education on the revised process. **Completion Date** 10/10/2020 **Responsible Party** Chief Nursing Officer	
A 263	QAPI CFR(s): 482.21	A 263		

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A 263	Continued From page 120 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on observations, review of recorded video footage, interviews, email communications, review of incident and medical record documentation for 21 of 21 psychiatric patients (Patients 1 through 21), review of training records for 5 of 14 staff (Staff Q, K, L, M and W), review of policies and procedures, review of building floor plans and other documentation related to safety and physical environment risk it was determined that the hospital failed to develop, implement, and maintain an effective QAPI program to ensure the provision of safe care and the recognition, promotion and protection of patients' rights. Staff failures to prevent patient access to unsafe items, failures to prevent elopement, failures to provide supervision, failures to appropriately manage behaviors and prevent unnecessary restraint use, and failures to protect patient	A 263	Compliance with A263 will be achieved on or before 10/10/20 through implementation of plans of correction related to patient rights, nursing services, and building maintenance. This includes corrective actions that will be taken to maintain an effective QAPI program, which ensures provision of safe care and the recognition, promotion, and protection of patients' rights. The Chief Nursing Officer is ultimately responsible for A263. Refer to Tags A115, A385, A701 for plans of correction related to patient rights, nursing services, and building maintenance.	

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A 263	Continued From page 121 privacy resulted in actual and potential harm to patients, and investigations to ensure such incidents did not recur were not timely or complete. This Condition-level deficiency represents a limited capacity on the part of the hospital to provide safe and adequate care and is a repeat deficiency previously cited on surveys completed on 08/08/2019, 07/30/2018 and 05/22/2018. Findings include: 1. Refer to the findings cited under Tag A115, CFR 482.13 - CoP Patient's Rights. 2. Refer to the findings cited under TagA385, CFR 482.23 - CoP Nursing Services. 3. Refer to the findings cited under TagA701, CFR 482.41(a) - Standard: Buildings.	A 263		
A 385	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observations, review of recorded video footage, interviews, email communications, review of incident and medical record documentation for 21 of 21 psychiatric patients (Patients 1 through 21), review of training records for 5 of 14 staff (Staff Q, K, L, M and W), review of policies and procedures and other documentation related to safety and physical	A 385	Compliance with A385 will be achieved on or before 10/10/20 through implementation of plans of correction related to patient rights, and nursing supervision. This includes corrective actions that will be taken to ensure that nursing services are provided in a manner that ensures the provision of safe care and the recognition, promotion, and protection of patients' rights. The Chief Nursing Officer is ultimately responsible for A385. Refer to Tags A115 & A395 for plans of correction related to patient rights and nursing supervision of the care provided to each patient.	

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A 385	Continued From page 122 environment risk, it was determined that the hospital failed to fully develop and implement policies and procedures that ensured that nursing services were provided in a manner that ensured the provision of safe care and the recognition, promotion and protection of patients' rights. Staff failures to prevent patient access to unsafe items, failures to prevent elopement, failures to provide supervision, failures to appropriately manage behaviors and prevent unnecessary restraint use, and failures to protect patient privacy resulted in actual and potential harm to patients, and investigations to ensure such incidents did not recur were not timely or complete. This Condition-level deficiency represents a limited capacity on the part of the hospital to provide safe and adequate care and is a repeat deficiency previously cited on surveys completed on 07/30/2018 and 05/22/2018. Findings include: 1. Refer to the findings cited under Tag A395, CFR 482.23(b) - Standard: Delivery of care, RN supervision and evaluation. Those findings reflect the hospital's failure to ensure an RN was responsible to supervise and evaluate the care provided to each patient. 2. Refer to the findings cited under Tag A115, CFR 482.13 - CoP Patient's Rights.	A 385		
A 395	RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate	A 395		

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A 395	Continued From page 123 the nursing care for each patient. This STANDARD is not met as evidenced by: Based on observations, review of recorded video footage, interviews, email communications, review of incident and medical record documentation for 21 of 21 psychiatric patients (Patients 1 through 21), review of training records for 5 of 14 staff (Staff Q, K, L, M and W), review of policies and procedures and other documentation related to safety and physical environment risk, it was determined that the hospital failed to fully develop and implement policies and procedures that ensured that an RN was responsible for the supervision and evaluation of each patient to ensure the provision of safe care and the recognition, promotion and protection of patients' rights. This is a repeat deficiency previously cited on surveys completed on 08/08/2019, 10/31/2018, 10/05/2018, 07/30/2018 and 05/22/2018. Findings include: 1. Refer to the findings cited under Tags A143, A144 and A145, CFR 482.13(c) - Standard: Privacy and Safety. Those findings reflect the RNs' failures to supervise and evaluate the provision of services provided to each patient to ensure personal privacy, safe care and freedom from abuse and neglect. 2. Refer to the findings cited under Tag A154, CFR 482.13(e) - Standard: Restraint or seclusion. Those findings reflect the RNs' failures to supervise and evaluate the provision of services provided to each patient to ensure freedom from restraints and seclusion.	A 395	Compliance with A395 will be achieved on or before 10/10/20 through implementation of plans of correction related to patient rights, and nursing supervision. This includes corrective actions that will be taken to ensure that supervision of nursing services is provided in a manner that ensures the provision of safe care and the recognition, promotion, and protection of patients' rights. The Chief Nursing Officer is ultimately responsible for A395. Refer to Tags A143, A144, A145, A154 for plans of correction related to privacy, safe care, freedom from abuse and neglect, and freedom from restraint and seclusion.	

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A 701	MAINTENANCE OF PHYSICAL PLANT CFR(s): 482.41(a) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on review of recorded video footage, interviews, review of incident and medical record documentation for 3 of 21 psychiatric patients (Patients 13, 16 and 17), review of building floor plans and other documentation related to safety and physical environment risk, it was determined that the hospital failed to ensure the physical plant environment was maintained to ensure the safety and well-being of patients: * Smoke detectors in the PES were not tamper resistant and on two occasions patients were allowed to remove them from the ceilings in patient bathrooms. * Although the ED had designated triage and exam rooms, ED triage, exams and care were provided to patients in chairs in the open corridor directly in front of the ED triage area without provisions for auditory or visual privacy. This is a repeat deficiency cited previously on surveys completed on 10/05/2018, 07/30/2018 and 05/22/2018. Findings include: 1.a. Incident documentation reflected that on 01/13/2020 a patient accessed and dismantled a smoke detector from the ceiling in the PES patient bathroom with room number P-101A. The smoke detector was not immediately found and was later located in the trash. There was no follow-up documentation that reflected correction	A 701		

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A 701	Continued From page 125 or mitigation of a smoke detector that was removable by a patient and was not tamper-resistant. 1.b. Incident documentation reflected that on 01/18/2020, five days later, another patient accessed and removed a smoke detector from the ceiling in the PES patient bathroom of "Hold Room 2." Incident investigation documentation recorded 02/05/2020, 18 days later, referenced corrective actions only as: "ICARE reviewed at clinical huddle and facilities aware of issue." There was no other documentation. 1.c. The undated "Ongoing BH Environmental Risk Assessment and Mitigation Plan" included smoke detectors and reflected: * "Smoke detector cage could be used as ligature ... all units ... Breakaway test demonstrated the mesh cage is a ligature risk. Team tested the smoke detector and deemed it to be safe without the cage ... Remove all of the mesh smoke detector cages from patient rooms and patient bathrooms ... Completion Date 9/17/2018." * "Smoke Detector Mesh Cover P 162 and P 163 ... PES triage ... P 162 and P 163 ... immediate removal of mesh covers by facilities ... Completion Date 10/4/2018." There were no additional or updated entries related to smoke detectors on the environmental risk assessment to reflect that once the protective "cages" or "covers" were removed the smoke detectors had been evaluated for safety and tamper-resistance. 1.d. Hospital building construction OARs for Psychiatric Patient Care Units and Rooms included OARs 335-535-0061(6) and (6)(v),	A 701	Note: Smoke detector cages were previously identified as a ligature risk, and as such, the cages were removed. The uncaged smoke detectors are on a supervised system which alerts nursing and facilities if the detector is not working (ex: device malfunction, patient interference, etc). In the two cases referenced in this report, the smoke detector supervised system notified staff of compromised smoke detectors, and staff followed the appropriate process to intervene to ensure patient safety and notify facilities. Compliance with A701 will be achieved on or before 10/10/20 through implementation of corrective action plans related to patient rights to privacy and right receive care in a safe setting. The Chief Nursing Officer is ultimately responsible for A 701. Refer to Tag A144 for the plan of correction to include uncaged smoke detectors on the environmental risk assessment, including education to Facilities staff on the environmental risk assessment process when changes are made to the environment. Refer to Tag A143 for the plan of correction related to the new triage process, ensuring auditory and visual patient privacy.	

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Patient and Staff Safety Features. Those OARs, in effect at the time LEMC UCBH was licensed, required:
* "(6) Patient and staff safety features, security and safety devices shall not, to the extent practicable, be presented in a manner to attract or invite tampering by patients. Design, finishes and furnishings shall be designed and installed to minimize the opportunity for patients to cause injury to themselves or others. Special design considerations for prevention of self-injury and injury to staff and others shall include:"
* "(6)(v) All devices attached to walls, ceilings and floors and all door and window hardware shall be tamper resistant and be securely fastened with tamper proof screws."

1.e. Refer to the findings for Patients 16 and 17 described in Tag A144 of this report regarding the tampering and removal of smoke detectors in PES patient bathrooms.

2.a. The ED record for Patient 13 reflected that on 11/26/2019 at 1536 "Patient roomed in ED To room PES TR1" for triage and examination. The patient returned to the ED triage area later that day on 11/26/2019 at 1816 and the ED record again reflected "Patient roomed in ED To room PES TR1." However, review of recorded video footage at both of those times showed that Patient 13 was triaged and examined and administered care in the open corridor in front of the triage nurses station and was not in a triage room.

2.b. During interview with the BHT Q on 03/05/2020 at approximately 1630 with the CNO, the PES NM and ACC1 present he/she stated that there were no triage rooms in the ED Triage

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area and those present concurred. An explanation was provided that for the EPIC EHR they have to select a room for the medical record so they select "Roomed in TR1" or "Roomed in TR2" or "Roomed in TR3," and that if they need privacy during triage or examination they use a vacant seclusion/hold room.

2.c. The LEMC UCBH satellite location architectural firm's "State Review First Floor Plan ... Construction Documents" dated 11/08/2016 was reviewed. These building plans were approved by the SA prior to licensure of the satellite on 01/26/2017. The plans revealed that the ED was designed to include the following rooms in the patient triage area:
* A dedicated "Triage" room identified as room number P-155.
* A "Triage/Hold" room identified as room number P-166, and with an attached "Triage Toilet" room identified as room number P-156A.
* A "Triage/Hold" room identified as room number E-142.
* A dedicated "Exam" room identified as P-161.
* Two other dedicated "Hold" rooms identified as P-158 and P-159.

Although the building was built with dedicated triage and exam rooms, those had not been maintained to be used as designed and intended to ensure the privacy and well-being of patients.

2.d. Refer to the findings for Patient 13 described in Tag A154 of this report regarding the location of the patient's triage and examination in the ED.