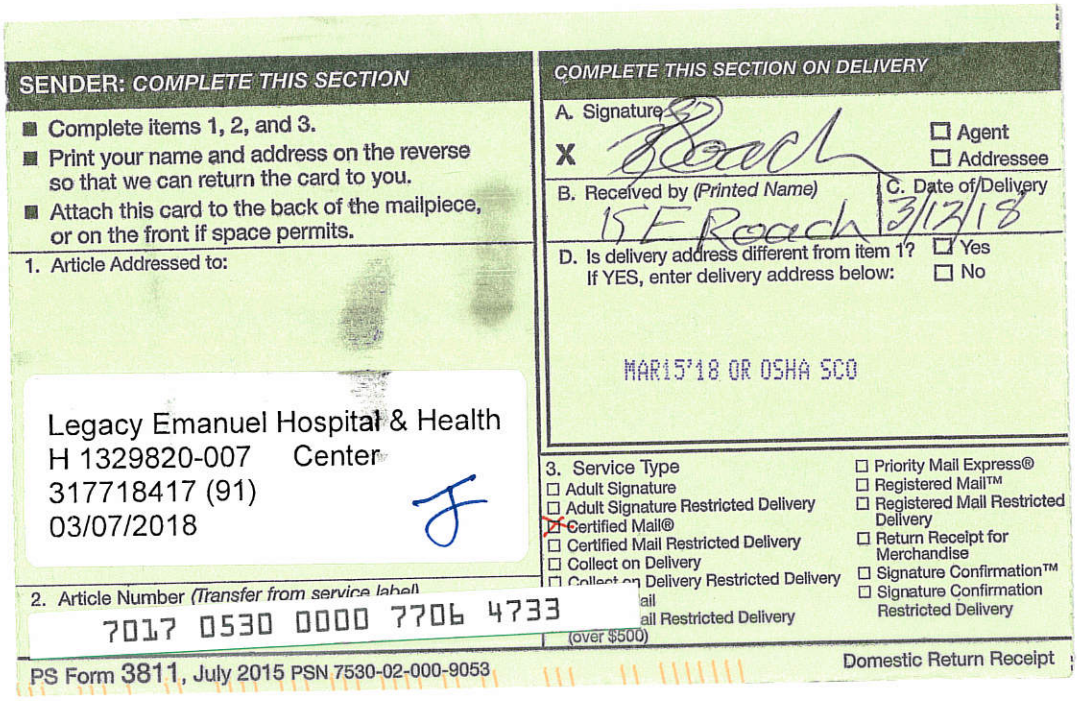

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Legacy Emanuel Hospital & Health Center
H 1329820-007
317718417 (91)
03/07/2018

2. Article Number *(Transfer from service label)*
7017 0530 0000 7706 4733

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X E Roach ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* 15 E Roach
C. Date of Delivery 3/13/18

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

MAR15'18 OR OSHA SCO

3. Service Type
- ☐ Adult Signature
- ☐ Adult Signature Restricted Delivery
- ☒ Certified Mail®
- ☐ Certified Mail Restricted Delivery
- ☐ Collect on Delivery
- ☐ Collect on Delivery Restricted Delivery
- ☐ ail
- ☐ ail Restricted Delivery (over $500)
- ☐ Priority Mail Express®
- ☐ Registered Mail™
- ☐ Registered Mail Restricted Delivery
- ☐ Return Receipt for Merchandise
- ☐ Signature Confirmation™
- ☐ Signature Confirmation Restricted Delivery

PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

Oregon Department of Consumer and Business Services
Oregon Occupational Safety and Health Division (Oregon OSHA)
16760 SW Upper Boones Ferry Rd, Suite 200
Tigard, OR 97224
Phone: 503-229-5910

Citation and Notification of Penalty

To:
George J Brown, President
Legacy Emanuel Hospital & Health Center
1919 NW Lovejoy St
Portland, OR 97209

Inspection Site:
1225 NE 2nd Ave
Portland, OR 97232

Inspection Number: 317718417(91)
Inspection Date(s): 09/28/2017-02/23/2018
Issuance Date: 03/07/2018
Optional Rpt Num: A2637-038-17
Employer ID No: 1329820-007

The violation(s) described in this Citation and Notification of Penalty is (are) alleged to have occurred on or about the day(s) the inspection was made unless otherwise indicated.

In the interest of assuring a safe and healthy workplace, the Oregon Occupational Safety and Health Division (Oregon OSHA) conducted an inspection at a workplace under your control. During this inspection, violations of the Oregon Safe Employment Act and occupational health and/or safety rules were found.

This citation lists the violations and a date by which they must be corrected. If you are not able to correct the violations by the correction date, you must apply for an extension of the correction date by following the instructions outlined later in this citation. Oregon laws require that under certain conditions violations of occupational safety and health rules carry a civil penalty. If penalties have been assessed on this citation, they have been computed in conformity with Oregon Administrative Rules, Chapter 437, Division 1. If you want to appeal this citation, file your request for hearing within 30 calendar days as outlined on the next page. If you choose not to appeal this citation, it becomes a final order 30 calendar days after receiving it. You must abate the violations referred to in this Citation by the dates listed, and pay the proposed penalties.

An effective Safety and Health program not only assures the correction of cited violations, it also requires actions to prevent violations from recurring. Through continued cooperation of employers, employees and Oregon OSHA, a safe and healthful workplace for all Oregon employees can be achieved.

Michael D. Wood, Administrator
Oregon OSHA

Posting - The law requires that a copy of this Citation and Notification of Penalty be posted immediately in a prominent place at or near the location of the violation(s) cited herein, or, if it is not practicable because of the nature of the employer's operations, where it will be readily observable by all affected employees. This Citation must remain posted until the violation(s) cited has (have) been abated, or for 3 working days (excluding weekends and holidays), whichever is longer.

Penalty PAYMENT - Penalties are due 20 days after the citation becomes final order (which is 30 days after receipt of this citation, unless appealed). Either make your check or money order payable to "Department of Consumer & Business Services (DCBS)", and mail to **DCBS, Fiscal Services Section, PO Box 14610, Salem OR 97309-0445,** or pay online at http://osha.oregon.gov/rules/enf/Pages/citations.aspx#req. Please include the Inspection Number on the remittance and return a copy of the invoice with payment. Oregon OSHA does not agree to any restrictions or conditions or endorsements put on any check or money order for less than the full amount due, and will cash the check or money order as if they do not exist.

Employer APPEAL Rights - To appeal a citation, you must clearly state in writing that you are requesting a hearing on the citation and specify the alleged violation(s) contested and the grounds upon which you consider the citation, proposed penalty(ies), or correction period to be unlawful. The request for an appeal must be filed within **30** calendar days of receipt of the citation. You can file an appeal in writing or on-line at http://osha.oregon.gov/rules/enf/Pages/citations.aspx#req. An appeal is considered filed on the date of the postmark, if mailed, or on the date of receipt if transmitted by other means. If mailed, the appeal letter should be sent to: **Oregon OSHA, PO Box 14480, Salem OR 97309-0405.**

A request for an informal conference alone is not an appeal of a citation, and any unresolved issues discussed at an informal conference will not be forwarded for appeal unless there is a timely request for hearing filed. **If you do not request a hearing within the required time frame, this citation will become a final order that is not subject to review by any agency or court.**

IMPORTANT NOTE: Appealing a serious violation or the reasonableness of the correction date does not automatically extend the correction date. You may apply for an extension of the correction date through Oregon OSHA or request an expedited hearing on the issue of the correction date with the Workers' Compensation Board Hearings Division (Oregon Revised Statute 654.078(6)).

Letter of Corrective Action - You are required to complete and mail the enclosed Letter of Corrective Action to the appropriate field office on or before the latest correction date on the citation. Please provide a detailed explanation and supporting documentation (if necessary), such as drawings or photographs of corrected violations, purchase or work orders, air sampling results, etc.

EXTENSION of Correction Date - To apply for an extension for correcting a violation, go online to submit a written request to http://osha.oregon.gov/rules/enf/Pages/citations.aspx#req, or submit a written request to the **office listed on the "Letter of Corrective Action"** and include:

(1) Employer name and address.
(2) The location of the place of employment.
(3) The inspection number and optional report number.
(4) The violation number for which the extension is sought.
(5) The reason for the request.
(6) All available interim steps being taken to safeguard employees against the cited hazard during the requested extended correction period.
(7) The date by which you propose to complete the correction.
(8) A statement that a copy of the request for extension has been posted as required by OAR 437-001-0275(2)(d) and (j) or for at least 10 days, whichever is longer; and, if appropriate, provided to the authorized representative of affected employees; and, certification of the date upon which the posting or service was made.

Your request must be postmarked or received by the Department no later than the correction date of the violation for which the extension is sought.

Employer Discrimination Unlawful - The law prohibits discrimination by an employer against an employee for filing a complaint or for exercising any rights under this Act. An employee who believes that he/she has been discriminated against may file a complaint with the Bureau of Labor & Industries (BOLI) no later than 90 days after the discrimination occurred.

Notice to Employees - The law gives an employee or his/her representative the opportunity to object to any abatement date set for a violation if he/she believes the date is unreasonable. The objection letter must be mailed to Oregon OSHA and postmarked within 30 calendar days of the receipt by the employer of this Citation and Notification of Penalty.

Adopting Federal Rules by Reference - Whenever federal rules have been adopted by reference, the federal rule number has been noted in the citation. If information is needed regarding the Oregon standard, contact the Oregon OSHA field office addressed at the top of the first page of this citation.

Posting on the Internet - Federal OSHA publishes information on all inspections and citation activity on the Internet under the provisions of the Electronic Freedom of Information Act. The information related to your inspection will be available not sooner than 30 calendar days after the Citation Issuance Date. You are encouraged to review the information concerning your establishment at www.osha.gov. If you have any dispute with the accuracy of the information displayed, please contact this office.

If you would like to discuss this citation, call the Oregon OSHA office in your area:

Portland	503-229-5910	Salem	503-378-3274	Medford	541-776-6030
Eugene	541-686-7562	Bend	541-388-6066		

Citation and Notification of Penalty

Optional Rpt Num: A2637-038-17

Company Name: Legacy Emanuel Hospital & Health Center

Inspection Site: 1225 NE 2nd Ave Portland, OR 97232

The alleged violations below have been grouped because they involve similar or related hazards that may increase the potential for illness and/or injury.

Citation 1 Item 1a Type of Violation: **Serious**

OAR 437-001-0760(3)(a): The employer did not investigate or cause to be investigated every lost time injury that workers suffered in connection with their employment, to determine the means that should be taken to prevent recurrence:

a) There were three lost time injuries recorded on the OSHA 300 log for 2017. The employer provided records of the accident investigation. Two of the incidents were not evaluated. This is inconsistent with the company policy. The section of the accident investigation regarding actions taken by the manager and what should be done to prevent recurrence was not completed.

Date by Which Violation Must be Abated:	03/16/2018
Proposed Penalty:	$1,250.00

Citation 1 Item 1b Type of Violation: **Serious**

OAR 437-001-0765(8): The safety committee did not evaluate all accident and incident investigations and make recommendations for ways to prevent similar events from occurring:

a) The safety committee did not evaluate lost time injury incidents, recordable injuries, or incidents on the assault log to make recommendations for ways to prevent similar events from occurring. Unity did not have a safety committee member present on the committee until May. The safety committee minutes noted a number of incidents at Unity beginning in April but recommendations were not made and specifics of the incidents were not discussed. Additionally, the number of incidents reflected on the minutes do not correspond to the number of incidents on the assault log or OSHA 300 log.

Date by Which Violation Must be Abated:	03/16/2018
Proposed Penalty:	$0.00

Citation 1 Item 2 Type of Violation: **Serious**

ORS 654.416(1): The record of assaults committed against employees did not include the requirements of subsections (a) through (i) of this section:

a) The assault log did not include a description of the assaultive behavior as mild, major, severe, or death; the number of employees in the immediate area of the assault when it occurred; or a description of the actions taken by the employees and the employer in response to the assault.

Date by Which Violation Must be Abated:	03/16/2018
Proposed Penalty:	$300.00

Citation 2 Item 3 Type of Violation: **Other than Serious**

OAR 437-001-0706(3): The health care employer did not use the Health Care Assualt Log, or equivalent, to record assaults:

a) The employer did not record all assaults on their assault log. A lost time injury assault was not listed on the assault log. There were eight recordable assaults on the OSHA 300 log that were not listed on the assault log. The assault log is generated from the VIW reports from security and does not include assaults reported through icare.

OR IN THE ALTERNATIVE

OAR 437-001-0700(14)(b): Health care employers as defined in ORS 654.412 did not record assaults against employees on the Health Care Assault Log (See OAR 437-001-0706):

a) The employer did not record all assaults on their assault log. A lost time injury assault was not listed on the assault log. There were 8 recordable assaults on the OSHA 300 log that were not listed on the assault log. The assault log is generated from the VIW reports from security and does not include assaults reported through icare.

Date by Which Violation Must be Abated:	03/16/2018
Proposed Penalty:	$100.00

Total Proposed Penalty:	**$1,650.00**

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

OREGON OSHA INSPECTION SUPPLEMENT

1. IMIS no.: 317718417 2. Opt rpt no.: A2637-038 -17 3. Emp. no.: 1329820-007

4. Date:	Time on site:	Time out:	Travel time:
9.28.17	9:10 AM	11:30 am	1.0
10.12.17	745 am		1.0
12.20.17	840 am	900 pm	1.0
2.23.18	10:45 am		1.0

5. Total inspection time: _____ 6. Legal entity: ☑ Corporation ☐ Partnership ☐ Sole

7. Legal name: ~~Unity Center for Behavioral Health~~ Legacy Emanuel Hospital & Health Center

8. DBA: Unity Center for Behavioral Health E-mail: _____

9. Phone: _____ Cell/fax: _____

10. Site address: 1225 NE 2nd Ave ; Portland OR 97232

11. Mailing address: 1919 NW Lovejoy St, Portland OR 97209

12. Employed in establishment:	Covered by inspection:	Employed in Oregon:	13. Statewide average DART:
450	450		

14. OSHA 300 Logs:

Not open for 1 year yet (partial provided)

	year _____		year _____		year _____	
	H	I	H	I	H	I
Hours worked each year:						
DART rate:						

Formula: H + I x 200,000 ÷ hours worked = DART rate

15. Type of operation: hospital 16. SIC: _____ 17. NAICS: 622110

18. Management representatives: (see list) see list for closing

	Title	Opening	Insp.	Closing
Chris Farentinos	VP	☑	☐	☐
Angela Heckathorn	EHS mgr	☑	☐	☑
Rn. Caitlin Henneveck	Asst Nurse Mgr	☑	☐	☐
Linda Jones	Chief Nursing officer	☑	☐	☐
Rebecca Moreland				

19. Employee representatives:

	Title			
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

20. Photos taken: (Yes) No Video: Yes No Audio: _____ (# of tapes)

21. Workers' comp. insurance carrier: Self-insured Number: _____

22. Union name/address: —

23. Does employer lease any employees? Yes No Leasing co. name: contractors Travelers —

24. Citation copies: Legacy
ATTN: Chris Farentinos

MAR 1 '18 OR OSHA SCO

COMPLIANCE OFFICER: Lindey Patterson DATE: 2-23-18

Print name

440-1254 (9/12/COM)

Department of Consumer and Business Services

Oregon Occupational Safety and Health Division

Notice of Alleged Safety or Health Hazards

WED SEP 13, 2017 04:29			Complaint Number	209426886
Establishment Name	Unknown			
Site Address	1125 NE 2nd Ave, Portland, OR 97232			
	Site Phone	503-944-8000	Site FAX	
Mailing Address	Unknown, Unknown, XX 99999			
	Mail Phone		Mail FAX	
Management Official	Dr. Miller, Medical Director		Telephone	
Type Of Business	Psychiatric Treatment Facility		Ownership	PRIVATE SECTOR
Primary NAIC	999999 - UNKNOWN			

HAZARD DESCRIPTION/LOCATION. Describe briefly the hazard(s) which you believe exists. Include the approximate number of employees exposed to or threatened by each hazard. Specify the particular building or worksite where the alleged violation exists.

DESCRIPTION:

Item No: 1

Treatment models used for psychiatric patients expose employees to assaults resulting in serious injuries. Over 500 assaults and incidents have occurred since the facility opened 7 months ago. Dozens of employees have suffered lost time injuries.

Location:

1125 NE 2nd Avenue, Portland

Unknown

WED SEP 13, 2017 04:29 PM
Complaint No. 209426886

Has this condition been brought to the attention of:	Employer
Please Indicate Your Desire: The Undersigned believes that a violation of an Occupational Safety or Health Standard exists which is a job safety or health hazard at the establishment named on this form.	My name may be revealed to Employer A, Employee

Complainant Name	ANONYMOUS	Telephone	
Address(Street, City, State, Zip)			
Signature		Date	

If you are an authorized representative of employees affected by this complaint, please state the name of the organization that you represent and your title.

Organization Name: Your Title:

OFFICIAL USE ONLY:

Identification	Reporting ID	1054191	Previous Activity	0	Opt Numbe	0	
	Establishment Name Change? ☐ Yes ☐ No		Site Address Change? ☐ Yes ☐ No	Employer ID 8902364		City Code	County Code
Receipt Information	Received By F9199 SMITH		Send OSHA-7? ☐ Yes ☐ No	Date: 09/13/2017 Time: 04:29 PM		Supervisor Assigned Q2473	
Industry & Ownership	A. Private Sector PRIVATE SECTOR						
Complaint Evaluation	Evaluated By Q2473 Is this a Valid Complaint? Yes Formality INFORMAL Migrant Farmworker Camp?		Subject/Severity Other Than Serious				
Send Letter	Type				Date Letter Sent	Date Response Sent	
Received Letter	Type			Date Letter	Evaluation	Abatement Date	
Complaint Action	Inspection Planned? Yes		If Yes Priority: Other Than Serious		If No Reason:		
	Transfer To (Name)				Transfer Date		
	Transfer To Category						
Optional Information	Type	ID	Value				
Close Complaint							

COMMENTS

MAR 1'18 OR OSHA SCD

Oregon
Kate Brown, Governor

Department of Consumer and Business Services
Oregon Occupational Safety & Health Division (OR-OSHA)
350 Winter St. NE, Room 430
PO Box 14480, Salem, OR 97309-0405
Phone: (503)378-3272
Toll Free: 1-800-922-2689
Fax: (503)947-7461
osha.oregon.gov

February 27, 2018

CONFIDENTIAL
Information
has been removed

Subject: Inspection No: 317718417
Optional Report No: A2637-038-17
Date of Inspection: 09/28/2017

In response to your complaint concerning safety and/or health hazards at Legacy Emanuel Hospital & Health Center, the Oregon Occupational Safety and Health Administration conducted an inspection. The results of our investigation of your complaint are as follows:

Item: Treatment models used for psychiatric patients expose employees to assaults resulting in serious injuries. Over 500 assaults and incidents have occurred since the facility opened 7 months ago. Dozens of employees have suffered lost time injuries.

Findings: At the time of the inspection the facility had been opened less than a year. It was determined that hundreds of assaults occurred and were logged into the assault log. Assaults were reported in a variety of different manners. The majority of assaults were reported through security (which completes VIW reports) and ICARES. There were only three lost time injuries on the OSHA 300 log. Two of the lost time injuries were not investigated to prevent recurrence. Oregon OSHA does not have jurisdiction over any type of treatment or treatment model used during patient care. Citations were issued for this item.

If you would like a copy of the citation, please call (503) 378-3272 and ask for the Records Management Unit.

We appreciate your concern regarding safety and health conditions at this workplace. Should you feel that your complaint was not adequately evaluated by Oregon OSHA, you may request that the Administrator review the matter by writing to:

Michael D. Wood, Administrator
Oregon Occupational Safety and Health Division
PO Box 14480
Salem, OR 97309-0405

If we may be of further assistance, please contact us.

Sincerely,

Penny Wolf-McCormick
Health Enforcement Manager/Industrial Hygienist
PENNY.L.WOLF-MCCORMICK@oregon.gov
Oregon OSHA Portland Field Office
Durham Plaza
16760 SW Upper Boones Ferry Rd Ste 200
Tigard OR 97224
503-229-5910

209426886 thompspl

Oregon Department of Consumer & Business Services

OR-OSHA DIVISION
INDEX OF VIOLATIONS: SEVERITY, PROBABILITY & DOCUMENTATION

For Inpection Number 317718417

Questions?
Contact
Andrew Gawne
(503) 947-7192

Establishment Legacy Emanuel Hospital & Health Center **Optional Report** A2637 - 038-17

AVD Item No	01 - 001a	Violation Type #	Serious	Final Penalty	1,250.00	Days to Correct	7	Sign C/W Pg #	

Rule No	OAR 437-001-0760(3)(a): The employer did not investigate or cause to be investigated every lost time injury that workers suffered in connection with their employment, to determine the means that should be taken to prevent recurrence:
Variable Language	a) There were three lost time injuries recorded on the OSHA 300 log for 2017. The employer provided records of the accident investigation. Two of the incidents were not evaluated. This is inconsistent with the company policy. The section of the accident investigation regarding actions taken by the manager and what should be done to prevent recurrence was not completed.
Employer Knowledge Pg	72, 96, 130, 133, 139, 143-147, 159, 160, 227-228
Violation Pg #	72, 96, 130, 133, 139, 143-147, 159, 160, 227-228 (66-67)
Probability & Justification	High: Two lost time injuries were not evaluated by management. The facility had 24 recordable assaults and hundreds of assaults that did not result in lost time. If evaluated, it is possible that some of the assaults could have been avoided.
Severity	Serious: Fracture to the chest, contusion

AVD Item No	01 - 001b	Violation Type #	Serious	Final Penalty	1,250.00	Days to Correct	7	Sign C/W Pg #	

Rule No	OAR 437-001-0765(8): The safety committee did not evaluate all accident and incident investigations and make recommendations for ways to prevent similar events from occurring:
Variable Language	a) The safety committee did not evaluate lost time injury incidents, recordable injuries, or incidents on the assault log to make recommendations for ways to prevent similar events from occurring. Unity did not have a safety committee member present on the committee until May. The safety committee minutes noted a number of incidents at Unity beginning in April but recommendations were not made and specifics of the incidents were not discussed. Additionally, the number of incidents reflected on the minutes do not correspond to the number of incidents on the assault log or OSHA 300 log.
Employer Knowledge Pg	9, 13, 14, 27, 63, 64, 72, 73, 76, 79, 96-99, 107, 130-131, 133-135, 139, 159, 197, 223-244, 249
Violation Pg #	9, 13, 14, 27, 63, 64, 72, 73, 76, 79, 96-99, 107, 130-131, 133-135, 139, 159, 197, 223-244, 249 (64, 69, 76)

Establishment Legacy Emanuel Hospital & Health Center **Optional Report** A2637 - 038-17

Probability & Justification	High: The number of incidents listed on the minutes did not correlate to incidents on the OSHA 300 log or the assault log. Two lost time injuries were not evaluated by management. Therefore, the safety committee would not have had an investigation in order to make recommendations. The facility had 24 recordable assaults and hundreds of assaults that did not result in lost time. If evaluated, it is possible that some of the assaults could have been avoided.
Severity	Serious: Assaults resulted in fractured ribs, contusions, fractured foot; Other assaults involved in contusions, strains, abrasions to the hand, head contusion, concussion

AVD Item No 01 - 002 **Violation Type #** Serious **Final Penalty** 300.00 **Days to Correct** 7 **Sign C/W Pg #**

Rule No	ORS 654.416(1): The record of assaults committed against employees did not include the requirements of subsections (a) through (i) of this section:
Variable Language	a) The assault log did not include a description of the assaultive behavior as mild, major, severe, or death; the number of employees in the immediate area of the assault when it occurred; or a description of the actions taken by the employees and the employer in response to the assault.
Employer Knowledge Pg	9, 74, 82, 96, 98, 99, 129, 156, 231, 250-252
Violation Pg #	9, 74, 82, 96, 98, 99, 129, 156, 231, 250-252
Probability & Justification	Low: There were 298 entries on the assault log. For all 298 entries the cases were not logged correctly. It is important that employees/employer is provided all required information in order to make corrective actions.
Severity	Serious: Assaults include fractures, concussions, contusions

AVD Item No 02 - 003 **Violation Type #** Other than Serious **Final Penalty** 100.00 **Days to Correct** 7 **Sign C/W Pg #**

Rule No	OAR 437-001-0706(3): The health care employer did not use the Health Care Assualt Log, or equivalent, to record assaults:
Variable Language	a) The employer did not record all assaults on their assault log. A lost time injury assault was not listed on the assault log. There were 8 recordable assaults on the OSHA 300 log that were not listed on the assault log. The assault log is generated from the VIW reports from security and does not include assaults reported through icare.

Establishment Legacy Emanuel Hospital & Health Center **Optional Report** A2637 - 038-17

Employer Knowledge Pg	74, 82, 96, 98-99, 107, 130-131, 133-136, 139, 159, 197, 227, 229, 231, 233, 235, 237
Violation Pg #	74, 82, 96, 98-99, 107, 130-131, 133-136, 139, 159, 197, 227, 229, 231, 233, 235, 237 (82)
Probability & Justification	Low: Injuries may have been minimized or prevented if the assaults were logged and incidents investigated. The facility has patients who have been at the facility multiple times.
Severity	OTS:Injuries such as concussions, contusions, and fractures

Company Name: Legacy Emanuel Hospital & Health Center
Inspection Number: 317718417
Optional Report Number: A2637-038-17

Opening Conference:
A complaint health inspection was opened on September 28, 2017 at Unity Center for Behavioral Health located at 1225 NE 2nd Ave, Portland. The opening conference was conducted with Angela Heckathorn (Environment of Care Manager) and others. See list in file. Employees were not union represented. The company was self-insured.

Complaint: Treatment models used for psychiatric patients exposure employees to assaults resulting in serious injuries. Over 500 assaults and incidents have occurred since the facility opened 7 months ago. Dozens of employees have suffered lost time injuries.

Employees began working at Unity on January 31, 2017 and the complaint was made mid September 2017. The OSHA 300 log for 2017 listed 30 recordable injuries from March 11, 2017 to September 8, 2017. Twenty three were assault related.

Company Information:
Unity Center for Behavioral Health was a 24-hour psychiatric hospital providing mental and behavioral health emergency services for adults and adolescents. It was a partnership between Adventist Health, Legacy Health, Kaiser Permanente, and OHSU. They employ approximately 450 people. Unity has been opened since January 31, 2017.

Walk Around:
Unity shares a building with Legacy Laboratory. Unity is located on part of the 1st and 2nd floors, and the 5th and 6th floors. The inspection was focused on the issue of assaults. There were cameras throughout the facility. All patient areas were secured and doors must be opened with an electronic badge reader. Heavy furniture was recommended for behavioral health units. A specification sheet for a chair was provided, and weighed 55 lbs. See more on this below. Cameras were located in all patient rooms. The facility had centrax, which is similar to GPS for people.

All units (1E, 1W, 2, 5 and 6) were similar in their design; the charting station was enclosed in glass with an open nursing station which was monitored with cameras. All units were secure, an electronic badge reader was required to enter and exit the room. Additionally there were corridors in which you were unable to open the next door without the door behind you being secured. Units 1E, 1W, 2, 5 and 6 had heavy furniture. This furniture was recommended for hospital and behavioral units. The weight of the furniture discouraged patients from throwing the chairs. There were no recorded incidents on the assault log about throwing furniture.

The employer visited several behavioral health facilities in order to determine what worked and the amenities they wanted at the facility. A concern of employees was the open nurses' station. When asked how they chose the design the employer explained that they included both designs of enclosed glass documentation/charting station and an open nurses' station. This allowed

employees to have the protection of the glass enclosure and an area to escape to in an emergency. Additionally, the open nurses' station impressed a level of comfort and caring for patients.

1st floor:
Triage unit- 4 seclusion rooms. Large desk and 2 triage rooms
Psychiatric Emergency Services (PES): calming room, dark ambiance, recliners, open nurses' station, and enclosed charting station. Both the nurses' station and the charting room were videoed and views of the cameras were available.
1E- 22 patient rooms, hold rooms, attached to the garden
1W- TV enclosed in Plexiglas, heavy chairs and tables
2nd floor: 17 patient rooms.
5th floor: 22 patient rooms.
6th floor: Adolescent floor.

Employee Interviews:

- Initially interviews consisted of discussing the complaint and asking questions with regards to workplace violence. Programs, training, and getting a general idea of how things work at Unity. Additional interviews discussed the complaint, but also concentrated more on specific incidents, injuries, or assaults.
- It was established early on that employees were either for, or against the treatment model. Employees were told that OR-OSHA does not have jurisdiction over the type of care a patient does or does not receive. The focus of the inspection was on the employee. Many employees explained that their patient's type of care was directly related to the patient acting out and assaulting employees.
- It was determined from the OSHA 300 log that there were 3 work related lost time injuries in March 2017.
- **Culture:** Unity was a new facility with employees from at least 4 other hospital organizations. Employees admitted to receiving training in workplace violence. Employees claimed they were not going to report assaults such as being punched or slapped in the face as it was not a serious injury in their opinion. Other employees claimed they would not report the assault because they would save their write up for when they need it. Some employees believed that each time an icare was written it was placed in the employee file and was seen as a negative action. It made the employees look like complainers. Some employees felt that because they did not notice any changes when a co-worker was assaulted that nothing would change so why report it. The employer's policy is to report all workplace violence incidents and the policy provides definitions and examples of workplace violence including: violent behavior that includes any physical assault. A few employees stated that they realize where they work and it was dangerous, and it's OK to get hurt.
- **Equipment:** Employees spoke about several changes or additions to the facility. The most requested piece of equipment was panic buttons. The only panic button is at the front desk in admitting. Employees stressed the need for the panic buttons due to the inconsistent reliability of the voceras. Employees requested additions of seclusion rooms, and relocation of the safety suite on the 5th floor closer to the nurses' station, because it was at the end of the hall. Additional requests of employees included reduction of the

noise in the unit that can trigger other patients, ensuring that cameras were working properly, and reducing the bright lights which are over stimulating to the patients.

- **Security:** Employees indicated that they were responsible for writing violence in the workplace (VIW reports) and these seemed to correspond to the assault log. Employees asked for more training with the health care staff and the role of security. A few employees felt that there was a lack of understanding of the role of security, but security was the first called to de-escalate patients. Employees asked for additional training in behavioral health education and hands-on tactics.
- **Staffing:** Employees were concerned with the staffing levels at the facility. Encouraging the employer to staff to acuity of the patient, not patient count. Determine how many patients really need one on one, or a two on one observation. Add more staff to the milieu. Employees were concerned with the number of employees assaulted; extra staff is needed in all areas to count for those that are off on medical leave, or have quit the organization. A float pool or on-call staff may solve those issues.
- **Treatment Model:** Employees need clearer rules on the treatment model and how to implement it. More specific guidelines for violent behavior were needed. Employees would like examples and specific scenarios. There seems to be differences in the timeliness in handling escalated patients between shifts and floors. Employees were concerned that patients were not receiving treatment from physicians soon enough to keep the patient from escalating, potentially causing harm to others. Some patients benefited from more attention, but time is spent with higher acuity patients.
- **Training:** Employees would benefit from additional training on when to call a Code Grey, and how to handle codes. A Code Grey was a hospital emergency code for a combative person (Combative or abusive behavior by patients, families, visitors, staff or physicians). Develop protocols for when and how to conduct a debrief/critical incident. Additional training on de-escalation was requested. Provide training amongst the care staff and security on the roles/responsibilities of each group, especially during a code. Additional training on what to do during a code grey. If employees are not part of the code, what are the responsibilities of the staff watching? Can they help without interfering? Increase education and training for security. Inventory patient's belongings. Develop protocols for what items are acceptable, what items aren't?
- **Vocera:** Vocera was a wearable, communication device. The vocera eliminates the need for an employee to be at/near a telephone or paged overhead. To activate the vocera, press the button and state "Call (name of employee or group). For example, to summon security an employee presses the button, and states "call security". If working properly, the vocera will restate, "calling security" and the call is routed to security and they are dispatched. The vocera devices were shared amongst the staff and were supposed to stay on each floor. Signs were posted near the badging area, as a reminder, to leave the devices on the unit. Sometimes employees forgot they were hanging around their neck and were taken home. Employees were required to wear voceras but it was not enforced. Employees claim that there were not enough for each employee on shift. Additional concerns regarding the voceras were that they do not understand what the employee was saying and this was not a good way to alert someone in an emergency. This was proved during an interview with an employee. The employee attempted to call someone to let them know they were in an interview. The vocera did not understand. The employee repeated the statement at least two more times then left the interview to respond in

person. This occurred in a quiet room with only the employee speaking. Employees complained that on the floors especially if it was loud, the vocera does not understand. In order to activate the vocera, employees need use of their hands. When being choked, this function was not available. Employees encourage the installation of panic buttons. Employees asked that training be conducted on how soon to activate the vocera to call for help.

IH Information Request:
Current OSHA 300 Log: The facility is less than a year old. The current log was provided. The first entry on the log was March 11th. However, the first entry on the assault log was February 1, 2017. The statewide average for this industry is 8.5.

Workplace Violence: The facility provided a Workplace Violence Prevention policy and a Code Grey policy. An assault log was provided via email. The assault log record did not include a description of the assaultive behavior as mild, major, severe, or death; a number of employees in the immediate area of the assault when it occurred; or a description of the actions taken by the employees and the employer in response to the assault. It was extremely difficult to determine the name and job title of the assaulted employee, and identification of the physical injury as it was embedded in the narrative text.

The facility has at least two ways in which an employee can report an assault. The first is when a code grey is called security will complete a VIW report or an incident report. If security is not notified, employees complete an icare report. The icare report is not an assault only report. Employees can complete icares for medical errors, incidents that involve restraint, falls, professional conduct matters related to physicians, and patient related matters. It is not solely based on assaults to employees. Based on the various reporting systems and large deviation in the number of assaults the inspector does not believe that the employer is 1) aware of how many employees are being assaulted or that 2) they are investigating each assault to prevent it from reoccurring. This is shown in the table below. Notice that this table does not include the icare reports. Additionally, there were at least 8 assaults listed on the OSHA 300 log that were not listed on the assault log.

	# of assaults listed on 300 log	# of entries on the assault log	# of incidents on the safety committee minutes	Rate of security reports for physical contact events (by unit) per month	Was a Unity representative present at the safety committee?
February	None	41	Nothing Listed		No
March	5	38	12		No
April	4	41	14	47.04	No
May	4	52	17	58.37	Yes
June	3	38	10	42.66	Yes
July	2	31	Nothing Listed	28.33	Yes
August	3	30	Nothing Listed	35.35	Yes
September	3	27	Nothing Listed		

The Patient & Staff Injury Workgroup was set up in order to trend falls, assaults, and icares. The first meeting was held in September and the group began looking at data in November.

Several articles were provided on reducing restraints and seclusion in patient care and on the trauma informed care model. The majority of the articles focused on patient care and why the trauma informed care model works. Oregon OSHA is not in the business of patient care but staff safety while providing patient care. It certainly can be taken from one of the articles that if patients were provided a calming environment, employees were trained and practiced de-escalation, and the culture of employees accepted the use of alternatives to restraints and seclusions. These changes could minimize injuries to staff.
A policy from the Oregon Health Authority was provided on Trauma Informed Services but it was patient focused.

Safety Committee: Safety committee minutes were provided from February 2017 through November 2017. During this time, the safety committee was made up of representatives from Legacy Research Institute, Legacy Laboratory and Unity. These three entities were connected, part of the same campus, and originally had one safety committee.

Patients were transferred to Unity January 31, 2017 and opened their doors for new patients on February 2, 2017. Unity did not have a representative on the safety committee until May 2017. The three time loss injuries occurred in March and there were no Unity representatives on the committee at that time. The safety committee meeting minutes stated the number of assaults at the facility but the safety committee did not evaluate the investigations and make recommendations to prevent similar events from occurring. After approximately 8 months of practicing that model, it was recognized the combined safety committee was not working well. In December 2017 the facility intended to revise the structure and have three separate committees and 1 campus committee. They intended to start the Unity safety committee in January 2018.

An interview was conducted with the Employee Health Nurse who was listed as person responsible on the safety committee meeting minutes. She stated that she was not a representative for Unity she is a representative for Employee Health and attends all Legacy safety committee meetings. Her job is report injuries. She was responsible for tracking icare reports.

Employer Knowledge:

- The employer was fully aware that workplace violence was a concern. Unity was exclusively a mental and behavioral emergency hospital for adults and adolescents.
- The employer operates another hospital and was required to have a safety committee, have meetings, and investigate lost time injuries.
- The employer was aware of the assault log as they have completed this form at another hospital.

Additional Information: There were three confidential files. The complainant's interview was placed in one file. The assault log provided by the employer via email was copied to a disc and placed in another. The third file contained confidential interviews provided by others. The assault log and some of the information provided by others contained patient names and contained dates of birth.

Closing Conference:
A closing conference was held on February 23, 2018. All items on the closing conference checklist were covered. See list of attendees in the file.

The proposed violations for this inspection are as follows:

1-1a) 437-001-0760 (3)(a)- The employer did not investigate every lost time injury. H/S $1250

- There were three lost time injuries recorded on the OSHA 300 log for 2017. The employer provided the records for the accident investigations. Two of the incidents were not evaluated. This is not consistent with their policy, per the Environment of Care Manager.
- Of the two incidents the sections regarding the actions taken by the manager and what should be done to prevent recurrence was not completed.
- An interview was conducted with one employee who suffered a lost time injury. The person stated during this interview that he was not involved in the accident investigation, and as far as he knows, the accident investigation did not take place.
- The other employee whose paperwork was not completed was not interviewed as he left the organization in July.

1-1b) 437-001-0765 (8)- The safety committee did not evaluate all accident and incident investigations and make recommendations for ways to prevent similar events from occurring.

- The safety committee minutes were provided from February 1, 2017 through November 1, 2017. Unity accepted current patients from Legacy Emanuel at the end of January, and opened their doors for new patients February 2nd. The members present at the safety committee were majority from Legacy Laboratory and Legacy Research. Unity did not have a member present until May. The lost time injuries occurred in March, and there were no Unity representatives on the committee in March.
- The February minutes list 14 attendees; none from Unity. This is understandable as the facility had been opened for one day. The notes reflect that someone would look into asking Unity about the safety committee.
- The March minutes list 19 attendees; none from Unity. The notes reflect that Unity will not have their own safety committee.
- The April minutes list 19 attendees; none from Unity. The notes reflect that Unity had 12 assaults, 4___, 1 burn, 3 communicable diseases; and 3 BBFE. The action taken would be followed up internally through Unity. (An interview was conducted with the Employee Health nurse present at the meeting who could not recall what word(s) should be listed after the number 4. She believed it to be Workplace Violence Incidents. BBFE were bloodborne pathogen incidents.)
- The May minutes list 15 attendees, one from Unity. The notes reflect that Unity had 14

incidents. No action listed.

- The June minutes list 20 attendees; one from Unity. The notes reflect that workplace violence is an issue in Unity; most solutions have been reactive instead of proactive. No action listed.
- The July minutes list 12 attendees; one from Unity. The notes reflect that a violence task force was started to help with problems. May had 17 and June had 10 incidents. No action listed. (The May minutes lists 14 incidents not 17).
- The August minutes list 20 attendees; two from Unity. The notes do not reflect any injuries at Unity.
- The September minutes list 12 attendees; one from Unity. The notes reflect no incidents.
- An interview was conducted with a safety committee member who stated the nurse reports on icares. Significant events are evaluated, and she is not part of the full investigation. The Employee Health nurse provides the information, but the safety committee does not go into depth. She is not involved in looking at the assault logs.
- Based on the various reporting systems and large deviation in the number of assaults, the inspector does not believe that the employer is 1) aware of how many employees are being assaulted or 2) they are investigating each assault to prevent it from reoccurring. Because the employer is not investigating, the safety committee would not receive the investigations and therefore would not be able to make recommendations from the reports.

1-2) ORS 654.416(1) – A health care employer shall maintain a record of assaults committed against the employees that occur on the premises and the log shall include: (e) a description of the assaultive behavior; (h) number of employees in the immediate area of the assault when it occurred, or (i) a description of actions taken by the employees and the health care provide in response to the assault. L/S $300

- There were 299 incidents listed on the assault log. All 299 incidents did not include the aforementioned criteria.
- The assault log record did not include a description of the assaultive behavior as mild, major, severe, or death; a number of employees in the immediate area of the assault when it occurred; or a description of the actions taken by the employees and the employer in response to the assault.

2-3) 437-001-0706 (3)- The health care employer did not use the Health Care Assault log to record assaults or in the alternative 437-001-0700 (14)(b)- Health care employer must record assaults against employees on the Health Care Assault Log. L/OTS $500

- A lost time injury assault was not listed on the assault log.
- There were 8 recordable assaults on the OSHA 300 log that were not listed on the assault log.
- The assault log is generated from the VIW reports and does not include assaults reported through icare. Therefore, all assaults on employees are not recorded on the assault log.