This report reflects the findings of the unannounced complaint investigation survey, #OR14492, initiated onsite at the Legacy Emanuel Medical Center's off-campus satellite behavioral health inpatient and outpatient facility, the Unity Center for Behavioral Health, on 04/26/2018. The survey was discontinued on 04/27/2018 as a result of the provider's refusal to permit surveyors to remove requested photocopied documents from the premises. The survey was continued onsite at UCBH on 05/15/2018 and concluded on 05/22/2018. Between 04/27/2018 and 05/15/2018 additional concerns related to patient's rights in the UCBH Center were submitted to the SA. Those were incorporated into the investigation once it resumed on 05/15/2018.

The UCBH was evaluated for compliance with the Condition of Participation for Patient's Rights, CFR 482.13.

The allegations in complaint #OR14492 were substantiated.

On 05/18/2018 at 1725 surveyors informed the hospital it was determined that an immediate jeopardy (IJ) situation existed. During the survey observations, interviews, review of medical records and incident/event investigation documentation, review of training documentation in staff personnel records, and review of policies and procedures revealed numerous hazards in the physical environment, a lack of patient supervision, and lack of clear protocols for response to medical emergencies. Documentation reviewed reflected hazards...
A 000

Continued From page 1

observed during the survey had resulted in actual harm, patient attempts at self-harm, and suicide attempts.

* Hazards identified include items observed on units during the survey and referenced in documentation reviewed. Some examples are:
Pencils and pens; Rigid plastic utensils; Shaving razors; and Ligature items such as cords, pillow covers, scrub pants, blankets, string.

* Hazards included ligature risk areas observed in the physical environment: Top end of piano hinges on patient bathroom doors where the top end of doors had been cut down/modified to create a sloping surface; Significant gaps associated with door closure and hold open mechanisms on double doors to "safety suites;" Gaps between the mounted surface of vertical and horizontal grab bars and the wall in some bathrooms.

* There was a lack of systems for visual observation and supervision of patients when in high risk or vulnerable areas, or when engaging in high risk or vulnerable activities. Some examples are: The majority of patient rooms observed had significant "blind spots" in camera views, including at the locations of the modified bathroom doors where ligature risks were identified; Blind spots in camera views of the locations of "safety suite" doors where ligature risks were identified; Successful patient elopements occurred from the garden area during a "supervised" garden visit, while being escorted by multiple staff in a group of patients from the garden back to the unit, when a patient followed a vendor provided with badge access off the patient unit and all the way out of the facility; A patient with a history of cutting was provided a shaving razor to use while "supervised" in the shower and during the shower cut him/herself numerous
A 000

Continued From page 2

* There was a lack of clear processes and supplies/equipment for responding to urgent and emergency patient conditions: There was no written protocol for response to those situations that identified who was to respond and what the roles of responders were, and staff interviews revealed inconsistent understandings of those processes; Supplies/equipment were inconsistently stored, available, and maintained from unit to unit, and staff could not readily identify what items were available and where those were located (those included O2 E-tanks, blood glucose meters, ligature cutting devices, and dressing supplies).

On 05/21/2018 at 1000 the hospital submitted a written plan outlining actions taken to remove the IJ situation. On 05/21/2018 at 1655 the plan was resubmitted with additional information. On 05/22/2018 at 0945 the plan was resubmitted with final clarifications. On 05/22/2018 at 1600 during the survey exit conference the hospital was informed that the IJ was removed. Actions taken included:

* Risk assessment of unsafe items on patient units was conducted and unsafe items removed on 05/19/2018 and 05/20/2018.
* Rigid plastic utensil dispensers mounted on patient units were removed on 05/19/2018.
* Door closures on "safety suite" doors were removed on 05/19/2018.
* Gaps associated with grab bars in patient bathroom were caulked on 05/19/2018;
* Patient bathroom doors were locked beginning 05/21/2018, unless in use by patients under supervision of staff present in the patient bedroom, until long-term correction plan developed.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 380007

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED
C 05/22/2018

NAME OF PROVIDER OR SUPPLIER
LEGACY EMANUEL MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
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 000 Continued From page 3
* Twice daily environmental safety rounds, including ligature risks and unsafe items, were implemented.
* Policies and protocols for elopement prevention and safe transportation of patients were developed and implemented.
* Patient monitoring policies and protocols were revised to address “blind-spots” and to distinguish between in-person and camera monitoring, in relation to hourly checks, every 15 minute checks, and constant observation.
* A requirement was implemented that the un-enclosed section of the nurses’ station on each unit, open to the milieu, be staffed at all times.
* Code M carts for medical emergency response were purchased, stocked and deployed to all units on 05/21/2018.
* The Code M policy was revised to reflect roles and responsibilities of team members, and a Code M cart daily checklist was developed and implemented on 05/21/2018 to ensure required supplies present in cart and not expired.
* Training of all staff at each shift change was implemented for the following: Safe transportation and prevention of elopement; Changes in unsafe items policy and rounding; Standards in care and monitoring; Bathroom door safety plan; and Code M roles, responsibilities, initiation and criteria.

Although the hospital mitigated the IJ, the findings from this survey reflect 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
A000 Continued From page 4

* CFR 482.41 - CoP Physical Environment

Abbreviations and Acronyms used throughout this report:

ACC - Accreditation & Clinical Compliance
AD - Advance Directives
ADLs - Activities of Daily Living
AED - Automated External Defibrillator
AMR - American Medical Response ambulance
Ambu bag - A manual resuscitator
ANM - Assistant Nurse Manager
AOC - Administrator on Call
approx - approximately
BHT - Behavioral Health Therapist
BHU - Behavioral Health Unit
BLS - Basic Life Support
CHT - Unknown
CFR - Code of Federal Regulations
cm - centimeter
CMS - Federal Centers for Medicare and Medicaid Services
CN - Charge Nurse
CNA - Certified Nursing Assistant
CoP - Condition of Participation
Code Gray - Response to threatening or assaultive behaviors
Code M - Response to urgent and emergency medical conditions
Code Silver - Response to weapons, active shooter, etc.
CoP - Condition of Participation
COTA - Certified Occupational Therapy Assistant
DS - Director of Services
DSS - Director of Safety/Security
d/t - due to
DPCS = Director of Patient Care Services
ED - Emergency Department
EHRR - Electronic Health Record
A 000 Continued From page 5

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| A 000 | Continued From page 5

- EKG - Electrocardiogram
- EOC - Environment of Care
- EOCC - Environment of Care Committee
- FDA - U.S. Food and Drug Administration
- FM - Facilities Manager
- Good Sam - Legacy Good Samaritan Medical Center
- HCRQI - Health Care Regulation and Quality Improvement
- HH - Hold
- HS - House Supervisor
- h/o - history of
- IJ - Immediate Jeopardy
- IM - Important Message From Medicare
- JC - The Joint Commission
- L - Left
- Lac - Laceration
- LEMC - Legacy Emanuel Medical Center
- LH - Legacy Health
- LIMS - Legacy Internal Medicine Services
- LIP - Licensed Independent Practitioner
- LSO - Legacy Security Staff
- MAR - Medication Administration Record
- meds - Medications
- mg - milligram
- mtg - Meeting
- NA - Nursing Administration
- NM - Nurse Manager
- OHA - Oregon Health Authority
- OHSU - Oregon Health & Science University Hospital
- OT - Occupational Therapist
- O2 - Oxygen
- NP - Nurse Practitioner
- PES - Psychiatric Emergency Service
- PRN - As needed
- PSA - Patient Safety Alert
- Pt - Patient
- Q, q - Every
### Legacy Emanuel Medical Center

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:** Legacy Emanuel Medical Center

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 2801 N Gantenbein Avenue
PORTLAND, OR 97227

**ID** 380007

**DATE SURVEY COMPLETED:** 05/22/2018

**MULTIPLE CONSTRUCTION B. WING _____________________________**

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<td>AAPI - Quality Assessment Performance Improvement</td>
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<td>QIO - Quality Improvement Organization</td>
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<td>QR - Quiet Room</td>
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<td>RLQ - Right Lower Quadrant</td>
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<td>RN - Registered Nurse</td>
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<td>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.</td>
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<td>SLM - Self Learning Module</td>
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<td>SM - Security Manager</td>
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<td>UCBH - Unity Center for Behavioral Health</td>
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<td>UM - Utilization Management</td>
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<td>VPU - Vice President Unity</td>
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<td>VPFO - Vice President Facilities Operations</td>
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<td>VSD - Violent Self Destructive</td>
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<td>A043</td>
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<td>GOVERNING BODY</td>
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</table>

There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ...

This CONDITION is not met as evidenced by:

Based on observations, interviews, review of medical record and other documentation for 4 of
Continued From page 7

4 patients who experienced restraint or seclusion (Patients 1, 9, 19, and 31), review of event and medical record documentation for 23 of 23 patients who experienced actual or alleged abuse or neglect (Patients 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 22, 23, 24, 26, 31, and 32), review of medical record documentation for 3 of 3 patients reviewed for conformance with physician orders, review of grievance documentation for 7 of 12 patients selected from the grievance log, (Patients 33, 34, 35, 37, 38, 42, and 43), review of training documentation for 22 of 22 staff (Staff 1 - 22), review of policies and procedures, and review of 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.

This Condition-level deficiency represents a limited capacity on the part of the hospital to provide safe and adequate care.

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 Tag A263, CFR 482.21 - CoP Quality Assessment and Performance Improvement.

3. Refer to the findings cited under Tag A385, CFR 482.23 - CoP Nursing Services.

4. Refer to the findings cited under Tag A700, CFR 482.41 - CoP Physical Environment
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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A hospital must protect and promote each patient's rights.

This CONDITION is not met as evidenced by:

Based on observations, interviews, review of medical record and other documentation for 4 of 4 patients who experienced restraint or seclusion (Patients 1, 9, 19, and 31), review of event and medical record documentation for 23 of 23 patients who experienced actual or alleged abuse or neglect (Patients 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 22, 23, 24, 26, 31, and 32), review of grievance documentation for 7 of 12 patients selected from the grievance log, (Patients 33, 34, 35, 37, 38, 42, and 43), review of training documentation for 22 of 22 staff (Staff 1 - 22), review of policies and procedures, and review of 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 patient's rights were recognized, protected and promoted as follows:

* Patients were not provided care in a safe physical environment that had been assessed for ligature and other risks.
* Physical environment and security measures to prevent patients from inappropriate departure, or elopement, from the secured facility were not effective.
* Patients were not supervised when in high risk areas or during high-risk activities.
* Response to urgent and emergent medical conditions was inconsistent.
* Investigations of and response to actual or alleged abuse or neglect were not timely or
A 115  Continued From page 9 complete.
   * Restraint and seclusion requirements were not met for those patients who experienced restraint or seclusion.
   * Restraints and seclusion were not implemented by staff who met the restraint and seclusion training requirements.
   * Response to patient's complaints and grievances were not timely or complete.
   * Patients were not informed of their rights as required.
   * Medicare beneficiaries did not receive IMs as required.
   * Patients did not received AD information as required.

This Condition-level deficiency represents a limited capacity on the part of the hospital to provide safe and adequate care.

Findings include:

1. Refer to the findings cited under Tags A144 and A145, CFR 482.13(c) - Standard: Privacy and Safety. Those findings reflect that hospital's failure to ensure the provision of care in a safe setting, appropriate supervision, consistent response to urgent and emergent medical conditions, and failure to ensure that allegations of abuse and neglect were thoroughly investigated in a timely manner as required.

2. Refer to the findings cited under Tags A168 and A175, CFR 482.13(e) - Standard: Restraint or seclusion. Those findings reflect the hospital's failure to ensure restraints and seclusion were implemented, assessed, and monitored as required.
3. Refer to the findings cited under Tags A196, A202 and A206, CFR 482.13(f) - Standard: Restraint or seclusion: Staff training requirements. Those findings reflect the hospital's failure to ensure that staff participating in restraint or seclusion received appropriate training and demonstrated competency as required.

4. Refer to the findings cited under Tags A117 and A123, CFR 482.13(a) - Standard: Notice of Rights. Those findings reflect the hospital's failure to inform patient's of their rights as a hospital patient and as a Medicare beneficiary; and failure to ensure that responses to patient's complaints and grievances were timely and complete.

5. Refer to the findings cited under Tag A132, CFR 482.13(b) - Standard: Exercise of Rights. Those findings reflect the hospital's failure to ensure patient's received AD information as required.

A 117 PATIENT RIGHTS: NOTICE OF RIGHTS CFR(s): 482.13(a)(1)

A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.

This STANDARD is not met as evidenced by:
Based on interview and documentation in 2 of 2 medical records of inpatient Medicare beneficiaries reviewed for the “Important Message from Medicare” (Patients 19 and 31), review of policies and procedures, review of patient brochures, and and review of the CMS website, it was determined the hospital failed to
### Legacy Emanuel Medical Center

**Statement of Deficiencies and Plan of Correction**

- **Provider/Supplier/CLIA Identification Number:** 380007

**Summary Statement of Deficiencies**

<table>
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<tr>
<th>(X4) ID Prefix Tag</th>
<th>(X4) ID Prefix Tag</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) Completion Date</th>
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<td>A 117</td>
<td>A 117</td>
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</table>

#### Findings include:

1. A policy and procedure titled "Patient Rights and Responsibilities" dated last revised "05/17" was reviewed and reflected "...Patients will be provided a copy of the Statement of Patient Rights and Responsibilities" The policy contained a list of patient rights. However, the policy and procedure was not fully developed as it did not include the following patients right required by these regulations at CFR 482.13(c)(3): "The patient has the right to be free from all forms of abuse or harassment."

2. An undated patient brochure provided to patients titled "Patient rights and responsibilities" was reviewed. The patient brochure did not include the patients right to be free of harassment nor specify the right to be free from "all forms of abuse."

3. Regarding the "Important Message from Medicare" (IM) form, the policy and procedure titled "Patient Rights and Responsibilities" in finding 1 above reflected "...Legacy provides the Important Message from Medicare about Your
A 117 Continued From page 12

Rights' to patients in accordance with Medicare guidelines...Legacy will provide notice to the patient when discharge is pending and coordinate the hospital's existing mechanisms for utilization review notice and referral to Quality Improvement Organization (QIO) for Medicare beneficiary concerns. The hospital informs all Medicare beneficiaries of their right to appeal premature discharge and file a grievance with their QIO...

The policy was not fully developed to include the requirement that the form be provided to the patient within 2 days of admission, and signed and dated by the patient to acknowledge receipt; and that the hospital present a copy of the signed IM in advance of the patient's discharge, but no more than 2 calendar days before the patient's discharge.

4. The policy and procedure titled "Utilization Management Plan" dated last revised "07/17" was reviewed and reflected "RN case managers provide Medicare beneficiaries with the Important Message from Medicare prior to discharge per CMS requirements. When a patient appeals his or her discharge UM RNs manage the process and document the outcome." The policy did not include the requirement that the IM form be provided to the patient within 2 days of admission, and signed and dated by the patient to acknowledge receipt; and that the hospital present a copy of the signed IM in advance of the patient's discharge, but no more than 2 calendar days before the patient's discharge.

5. Review of the "CMS.gov" webpage titled "Hospital Discharge Appeal Notices" stipulated that an "Updated Important Message from Medicare Form" was effective "60 days from June 29, 2017." The updated form was identified as...
### SUMMARY STATEMENT OF DEFICIENCIES

**A 117** Continued From page 13  
"Form CMS-R-193 (Exp. 03/31/2020)."

6. The medical record of Patient 31 was reviewed and reflected the patient was an inpatient Medicare beneficiary admitted on 04/19/2018 at 1706. The record contained copies of two IM forms, one signed and dated by the patient on 04/20/2018 at 1208, and the other signed and dated by the patient's representative on 04/20/2018 at 1613. Both of the IM forms used were form "CMS-R-193 (approved 07/10) 271956 (7/14)", which was a version prior to the updated version identified in the paragraph above. The record reflected the patient was discharged on 05/17/2018 at 0743. The record contained no documentation reflecting the hospital presented the patient or patient's representative a copy of the signed IM in advance of the patient's discharge. This was confirmed with the DPCS on 05/19/2018 at 1215.

7. The medical record of Patient 19 was reviewed and reflected the patient was an inpatient Medicare beneficiary admitted on 04/25/2018 at 0246 and discharged on 05/21/2018 at 0945. The record contained a copy of an IM form signed by the patient. The form was not dated by the patient or timed. The record lacked documentation reflecting the patient signed and dated the form within 2 days of admission. The record contained a second copy of an IM form signed by the patient and dated prior to discharge on 05/21/2018 at 0820. However, both of the IM forms used reflected they were form "CMS-R-193 (approved 07/10) 271956 (7/14)", which was a prior version to the updated version.

### PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION

**A 123**

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**A 117**

**A 123**
A 123 Continued From page 14
CFR(s): 482.13(a)(2)(iii)

At a minimum:
In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.

This STANDARD is not met as evidenced by:
Based on interview, review of grievance documentation for 7 of 12 patients selected from the grievance log (Patients 33, 34, 35, 37, 38, 42 and 43), review of event documentation for actual and alleged abuse and neglect, review of training documentation for 16 of 16 staff reviewed for complaint/grievance training (Employees 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 17, 18, 19, 21 and 22), and review of policies and procedures, it was determined that the hospital failed to implement its grievance policies and procedures as follows:
* A written grievance notice that contained the required elements including the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion was not provided to each patient/patient representative.
* All events requiring the implementation of the grievance process were not identified.

Findings include:

1. The hospital policy and procedure titled "Managing Patient's Complaints and Grievances" dated as last revised "07/17" reflected "Grievances are investigated and managed by..."
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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LEGACY EMANUEL MEDICAL CENTER

2801 N GANTENBEIN AVENUE
PORTLAND, OR  97227

A 123 Continued From page 15
the affected Unit, Department or Service Manager or Director. It is advisable to partner with a Patient Relations Specialist to assure compliance with timelines, the content of the mandatory response letter and documentation of the grievance...Grievances will be investigated and managed within a reasonable time period determined by the complexity of the grievance and the investigation and decision-making required. If the grievance cannot be resolved, or if the investigation is not or will not be completed within seven (7) days, the hospital should inform (verbally or in writing) the patient or the patient's representative that the hospital is still working to resolve the grievance and that the hospital will follow-up with a written response within thirty (30) days...When a final resolution has been reached, a written response will be provided to the patient/designated representative. The written response will include...Name of the hospital contact person. This will be the person signing the letter, unless otherwise noted...Steps taken on behalf of the patient to investigate the grievance...Results of the investigation...Completion date, which is the date of the written response unless otherwise noted."

The policy and procedure also addressed processing of abuse and neglect complaints and grievances. It reflected "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 is considered a form of abuse is defined as a failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." The policy's "Specific
A 123 Continued From page 16

Circumstances” section followed the "Grievance" section and included the following: "Statements of concern that describe allegations of abuse or neglect, which may include various including but not limited to actions (sic) alleged to be sexual in nature, including inappropriate touch, should be escalated up the management chain which will evaluate the allegation in collaboration with the following: Risk Management, Legal Services, Employee Relations and medical Staff Leadership, as applicable. These cases will be evaluated for application of the "Guideline for Investigation and Evaluation of Reports of Inappropriate Behavior or Abuse involving Patients and occurring with a Legacy Facility or Campus."

2. Patient 43: Grievance/complaint report documentation for the patient was reviewed and reflected it was submitted by the patient's representative. The "Date Complaint Received" was 05/11/2018. The "Initial Complaint Description" was "Concern regarding seclusion event after patient threatened to self-harm with a plastic spoon." There was no documentation reflecting the hospital contacted the patient or patient's representative either verbally or in writing after 05/11/2018, including no documentation reflecting a written notice of follow-up investigation and resolution submitted to the patient or patient's representative.

3. Patient 38: Grievance/complaint report documentation for the patient was reviewed and reflected the "Date Complaint Received" was 12/15/2017. The "Initial Complaint Description" section reflected "Glasses disappeared' and shower chair is missing." There was no documentation reflecting a written notice of
### Statement of Deficiencies and Plan of Correction

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<td>follow-up investigation and resolution was submitted to the patient.</td>
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<td>4.</td>
<td>Patient 35: Grievance/complaint report documentation for the patient was reviewed and reflected the &quot;Date Complaint Received&quot; was 06/02/2017. The &quot;Initial Complaint Description&quot; section reflected complaints including racial discrimination and &quot;poor staffing&quot;. A written response from the hospital dated 06/09/2017, submitted to the patient in response to the grievance, was reviewed and did not contain the steps taken on behalf of the patient to investigate the grievance or the results of the grievance process.</td>
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<td>5.</td>
<td>Patient 35: Grievance/complaint report documentation for the patient was reviewed and reflected he/she submitted another complaint. The &quot;Date Complaint Received&quot; was 06/12/2017. The &quot;Initial Complaint Description&quot; section reflected &quot;Reports of racism, alleges someone put blood or a bloody tissue on [his/her] floor, being denied access to [his/her] hair dryer, [he/she] is not receiving medical care for [his/her] foot pain.&quot; A written response from the hospital dated 07/05/2017, submitted to the patient in response to the grievance, was reviewed and did not contain the steps taken on behalf of the patient to investigate the grievance or the results of the grievance process.</td>
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<td>6.</td>
<td>Patient 34: Grievance/complaint report documentation for the patient was reviewed and reflected it was submitted to the hospital by the patient's representative. The &quot;Date Complaint Received&quot; was 05/18/2017 and the &quot;Initial Complaint Description&quot; section reflected &quot;Complainant alleges [patient] is not getting</td>
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B. Wing _____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

LEGACY EMANUEL MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
2801 N GANTENBEIN AVENUE
PORTLAND, OR 97227

B. WING _____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

A 123 Continued From page 18
proper care, specified that nurses are not providing PRNs, patient is having 'brain shakes' from lack of Klonopin, and does not have a physician." A written response from the hospital dated 07/05/2017, submitted to the patient's representative in response to the grievance, was reviewed and did not contain the steps taken on behalf of the patient to investigate the grievance or the results of the grievance process.

7. Patient 37: Grievance/complaint report documentation for the patient was reviewed and reflected the "Date Complaint Received" was 10/10/2017. The "Initial Complaint Description" section reflected "Unclean room, lack of response to accidental injury, staff's preoccupation with rules and not enforcing the rules." A written response from the hospital dated 11/06/2017, submitted to the patient in response to the grievance, was reviewed and did not contain the steps taken on behalf of the patient to investigate the grievance or the results of the grievance process.

8. Patient 42: Grievance/complaint report documentation for the patient was reviewed and reflected the "Date Complaint Received" was 03/16/2018. The "Initial Complaint Description" reflected "[Patient's representative] reports that patient was discharged without glasses and that unit staff informed [patient's representative] that another patient had taken them." A written response from the hospital dated 03/27/2018, submitted to the patient's representative in response to the grievance, was reviewed and did not contain the steps taken on behalf of the patient to investigate the grievance.

9. Patient 33: Grievance/complaint report
### SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<td>documentation for the patient was reviewed and reflected the &quot;Date Complaint Received&quot; was 05/15/2017. The &quot;Initial Complaint Description&quot; reflected &quot;I am writing you regarding some lost belongings. I was transferred to unity...I was received at the front door intake along with two bags of belongings. I am not from the Portland area...I had a bag with 2 pairs of new pajamas, 3 bras, 4 pairs socks, 3 blouses, 3 pairs leggings, 1 new pair sandals. The second bag contained shampoo, conditioner, 1 leave in conditioner, 1 tube argon oil...1 body wash, 1 tube crest pro white, 1 new tooth brush, 1 bottle lotion...thank you so much for youre (sic) attention to this matter.&quot; A written response from the hospital dated 05/25/2017, submitted to the patient in response to the grievance, was reviewed and did not contain the steps taken on behalf of the patient to investigate the grievance or the results of the grievance process.</td>
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<td>10. Findings 1-8 were confirmed with the QIC on 05/22/2018 at 1000 during review of the grievance documentation.</td>
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<td>11. Review of training documentation for 16 of 16 staff reviewed for complaint/grievance training (Employees 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 17, 18, 19, 21 and 22) reflected they lacked training related to the hospital's complaint/grievance process. Those staff included RNs, BHTs, SSOs and &quot;Folktime&quot; contract staff.</td>
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<td>12. An interview was conducted on 05/16/2018 at approximately 1110 with the DPCS regarding staff training related to the hospital's complaint/grievance process. The DPCS stated he/she was not aware of any documented complaint/grievance training provided to staff.</td>
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### Legacy Emanuel Medical Center

**Streets Address, City, State, Zip Code**

2801 N Gantenbein Avenue

PORTLAND, OR 97227

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**Summary Statement of Deficiencies**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

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13. Refer to the findings cited under Tag A145, CFR 482.13(c) - Standard: Privacy and Safety. Those findings reflect that hospital's failure to ensure events of actual and alleged abuse and neglect additionally met the grievance requirements and its own policies.

A 132 PATIENT RIGHTS: INFORMED DECISION

CFR(s): 482.13(b)(3)

The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part (Definition), §489.102 of this part (Requirements for providers), and §489.104 of this part (Effective dates).

This STANDARD is not met as evidenced by:

Based on interview, documentation in 4 of 4 medical records of patients reviewed for advance directives (Patients 1, 9, 19 and 31), and review of policies and procedures, it was determined that the hospital failed to implement its policies and procedures to ensure each patient's right to formulate an advanced directive for healthcare as follows:

* Patients were not asked if they had an advance directive at the time of admission; and patients who did not have an advance directive were not offered advance directive information as required by hospital policy.

Findings include:

1. The policy and procedure titled "Advanced Directive For Healthcare" dated as reviewed "10/15" was reviewed. It stipulated that:
"Procedure for Administration of Advance Directives...All patients will be given information on their right to execute an advance directive at the time of admission to the hospital. If the patient does not have a written advance directive, a blank advance directive will be offered to the patient...Upon admission, all patients 18 years of age or older admitted to Legacy hospital will be asked if they have an advance directive for healthcare. The presence or absence of an advance directive will be recorded in the medical record...

2. The medical record of Patient 19 was reviewed and reflected he/she was admitted to the hospital on 04/25/2018 at 0246. The "Documents" section reflected "Advance/Healthcare Directive...Patient Informed..." However, there was no documentation reflecting the patient was asked if he/she had an advance directive at the time of admission as required by hospital policy. The patient was discharged on 05/21/2018.

3. The medical record of Patient 9 was reviewed and reflected he/she was admitted to the hospital on 12/19/2017 at 1259. There was no documentation reflecting the patient was asked if he/she had an advanced directive at the time of admission as required by hospital policy. The patient was discharged on 01/03/2018.

4. Findings 2 and 3 were confirmed during review of the medical records for Patients 9 and 19 with the NA and ANM on 05/21/2018 at approximately 1300.

5. The medical record of Patient 31 was reviewed and reflected he/she was admitted to the hospital on 04/19/2018 at 1706. There was no...
A 132 Continued From page 22
documentation reflecting the patient was asked if
he/she had an advance directive at the time of
admission. The RN notes dated 04/23/2017 at
1500 reflected “Advance Directive...No, patient
does not have an advance directive for
healthcare treatment.” There was no
documentation reflecting the reason the advance
directive was not addressed until 4 days after the
patient was admitted. There was no
documentation reflecting the patient was asked if
he/she had an advanced directive at the time of
admission as required by hospital policy. The
patient was discharged on 05/17/2017. These
findings were confirmed during review of the
medical record with the DPCS and ANM on
05/17/2018 at approximately 1200.

6. The medical record of Patient 1 was reviewed
and reflected the patient was admitted on
03/05/2017 at 1437. On 03/06/2017 at 1618
information recorded on the “All Flowsheet Data”
reflected “...No, patient does not have advance
directive for healthcare treatment.” There was no
documentation reflecting the patient was offered
a blank advance directive as required by hospital
policy. The patient was discharged on
05/04/2017. These findings were confirmed
during review of the medical record with the
DPCS on 05/16/2018 at approximately 1700.

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, interviews, review of
event and medical record documentation for 23 of
## SUMMARY STATEMENT OF DEFICIENCIES

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| A 144 | Continued From page 23 | 23 patients who experienced actual or alleged abuse or neglect (Patients 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 22, 23, 24, 26, 31, and 32), review of Code M documentation, review of training documentation for 22 of 22 staff (Staff 1 - 22), review of policies and procedures, and review of 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 the patients' rights to receive care in a safe setting as follows:

* The physical environment contained ligature risks that created the potential for patient harm.
* The physical environment contained blind spots that created the opportunity for patient self-harm or suicide without immediate detection.
* The physical environment contained unsafe items that had resulted in actual and potential patient harm.
* Physical environment and security measures to prevent patients from inappropriate departure, or elopement, from the secured facility were not effective.
* Patients were not supervised when in high risk areas or during high-risk activities.
* Response to urgent and emergent medical conditions was inconsistent.
* All staff had not received training as required by the CFR or by hospital policy.

Findings include:

1. Policies and procedures related to safety and physical environment risk were not clear or fully developed. For example:

* The policy and procedure titled "Security Management Plan" dated as last reviewed |
A 144  Continued From page 24

"04/17" reflected "The Security Program is designed to manage the security risks the environment of Legacy Health presents to patients, staff, and visitors. The program is designed to assure identification of general and high security risks, minimize the risk of personal injury or property loss and to develop effective response procedures. The program is applied to all facilities owned or leased and operated by Legacy Health...Assessment of risks to identify potential problems is key to reducing crime, injury, and other incidents...Training hospital staff is critical. Staff is trained to recognize and report either potential or actual incidents to ensure a timely response. Staff in sensitive areas are trained about the protective measures designed for those areas and their responsibilities to assist in protection of patients...

* The policy and procedure titled "Access Control to Sensitive Areas" dated as last revised "04/17" stipulated that "Sensitive areas within Legacy Health (LH) will be identified and access to those areas will be controlled and/or monitored...The following areas within Legacy Health are considered sensitive. Access to any of the following areas will be controlled and monitored by the personnel assigned to work in those areas. Access may be granted by the approval of the department manager or designee of the sensitive area. Only authorized personnel have door codes, keys or LH ID Badge (Proximity card) access." Specific areas such as Family Birth Center and the Emergency Department were specified on the list of departments. The list did not include, nor did the policy address, access control for the hospital's psychiatric services department, UCBH.
A 144 Continued From page 25

* The policy and procedure for "Adult Psychiatric Services" titled - Elopement" dated as last revised "Dec 2016" reflected that "Upon discovering that a psychiatric patient has eloped, the following actions will be taken immediately..." The policy and procedure did not include elopement prevention measures.

* The policy and procedure titled "General RN Station Guideline" dated as last reviewed "Jan 2017" stipulated "Every staff member is expected to wear a Vocera badge while on duty...Staff are expected to be in the open nurse's station as much as possible...Class rooms and group rooms should be monitored by staff when opened for client use...There are cameras in all patient rooms, hallways and other areas/rooms used by patients. The cameras in each room are linked to monitors located in the nurse's station on that unit. These monitors have settings that allow staff to automatically scan from room to room. The cameras and monitors DO NOT take the place of personal viewing and interacting with the patient but serve as an added tool to help staff maintain a safe environment and assist patient when help is needed." The policy did not specify what "as much as possible" meant in terms of staff presence at the open nurse's station; it did not specify what "should" and "monitored" meant in terms of class rooms and group rooms; and it did not provide direction related to when in-person observation was required versus camera monitoring.

* The policy and procedure titled "Patient Supervision Requirements by Room" dated as last reviewed "Jan 2017" reflected it's purpose was "To outline expectations of patient supervision by staff." The policy stipulated the
Continued From page 26 following: "Nourishment rooms will remain locked at all times. Only Unity staff will be allowed access into the nourishment rooms. Staff will provide supervision if a patient is in the nourishment room. Enclosed dining rooms will be monitored at all times. Enclosed dining rooms will be open at staff discretion and supervised by staff. Open dining areas will be monitored at all times. Group rooms will be monitored at all times. Group rooms that are not in direct line-of-sight of nurse station will remain locked and not in use without a staff member present. 2nd floor Group Room 1 can be used by patients without staff in room due to line of sight from staff desk. 2nd floor Group Room 2 will be locked when not supervised by staff." The policy did not specify what "monitored" and "supervised" meant, or how would staff monitor and supervise.

* The policy and procedure titled "Guideline for Close Supervision" dated as last reviewed "Dec 2017" defined:
- "Constant Observation: Defined as 1:1 staff supervision and is related to severe behavioral, emotional and cognitive problems that result in the patient being a danger to themselves and other. The periods of support and observation are constant and require that an experienced member of the staff be within arm's length of the patient at all times or in direct line of sight;" and
- "Intermittent Observation: Defined as 1:2 - 1:4 staff supervision and is related to patient behaviors that are intrusive enough to require intervention on a frequent basis, or frequent re-direction, or patients at risk for self-harm that require frequent support and observation by an experienced member of the staff with a specific assessment or observation parameter including every 15 minute checks."
A 144 Continued From page 27

The policy was not clear as although the definitions clearly reflected that the patient's behaviors "required" the increased level of observation the "Implementation" section indicated that the enhanced observation levels were to be "considered." There was "Criteria for considering constant observation" and "Criteria for considering intermittent observation" reflecting that there were no actual requirements for such as described in the definitions.

2. Structural physical environment hazards and risks had not been identified or mitigated:

* The policy and procedure titled "Safety Management Plan" dated as last reviewed "05/17" reflected its scope was to "describe the activities conducted to design, implement, monitor, and manage the safety program to reduce the risk of injury for patients, staff and visitors to Legacy Health and to assure compliance with applicable codes and regulations." The policy described related processes that included:
  - "Risk Assessment Process. Risk assessments are conducted on an as needed basis involving subject matter experts from the EOCC as appropriate. Risk assessments are conducted to aid in: Creating new or revised safety policies and procedures. Improvising safety orientation and education programs. Helping to define safety performance monitoring, and indicators. Determination of utility system inspection frequency. The organization uses the risks and hazards identified to select and implement changes in procedures and controls to assure the lowest potential for adverse impact on the safety and health of patients, staff, and visitors. Those risks and hazards found during the assessment..."
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| A 144             | Continued From page 28 process are addressed with proper controls, procedures, and training to reduce the risks." - "Hazard Surveillance Rounds and Analyses. Legacy Health conducts regular hazard surveillance rounds or analyses to identify and evaluate employee, visitor and patient environmental deficiencies, hazards, and unsafe practices, security deficiencies, hazardous materials and wastes practices, fire safety problems, medical equipment issues, access to utility system elements, staff knowledge and other issues. A pre-use hazard analyses shall be completed for any significant change in operations or procedure. Hazard Surveillance Rounds are conducted quarterly in all areas where patients are treated, monitored, housed or served; including in-patient and outpatient patient care areas." - "Orientation, Training & Education. All staff must attend new employee orientation within 30 days of hire. New employee orientation addresses key issues and objectives of all seven areas of the EOC including the role each area and staff play in the overall Legacy Health Safety Program. Employees also receive departmental safety orientation at their respective work areas regarding hazards and their responsibilities to patient, visitors and co-workers. In addition, all staff participates in annual, mandatory education regarding the Environment of Care." * The policy and procedure titled "Environmental Risk Mitigation Plan" dated as last reviewed "Jan 2017" reflected its purpose was "To define the assessment, intervention, and monitoring to reduce environmental risk for patient and staff safety." It identified five (5) risk areas that included: "Blind Sport in Camera or 180 Degree Mirror
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Continued From page 29

View...The open nursing stations on the unit provide staff with an opportunity to continually be present in the milieu to observe patients and identify when a door might be blocking patient visualization...At a minimum, staff round hourly on all patients. All patient rooms are video monitored from the nursing station. If a patient is unable to be redirected from the blind spot to ensure safe monitoring the patient’s bathroom door will be locked.

"Ligature Points - Patient Bathroom Door/Adjoining Door for Safety Suites (Pediatric)...All patient will be assessed for suicide risk at the time of admission...All patient rooms and patient care areas, except bathrooms, are monitored by video camera...Patients have individualized Suicide Precaution Care Plan, which may include: Visually inspecting in person by staff no less than every fifteen minutes...Locking the bathroom door. Staff will remain in line of sight of the patient at all times. 1:1 staffing. Placement in hardened room that has piano hinges on bathroom door..."

"Psychiatric Emergency Services (PES)...Blind Spots Staff at the desk can visualized patients via camera in the area. Additionally 2 behavioral health assistants will be out in the milieu at all times. One will be located in the area behind the pillars."

* Undated documents titled "Risk Mitigation Plan" were provided as "Environmental Risk Assessments" for each inpatient unit; Unit 1E, Unit 1W, Unit 2, Unit 5, and Unit 6. The plans were not dated nor was the origin or author(s) identified. The documents contained two columns for each unit. Column 1 was titled "Environmental Risk" and Column 2 was titled "Risk Mitigation Plan." The "Environmental Risks" identified were...
### A 144

Continued From page 30 incompletely documented and included, but were not limited to:

- "Bathroom doors for patient rooms # (enter numbers) provide ligature points in the hinges and top of door." There were no room numbers identified.
- "Blind spots when bathroom doors are open; difficulty visualizing from cameras." There were no specific locations of bathrooms identified.
- "Blind spots when some of the room doors are open swing out in corridor; difficulty visualizing from camera." There were no room numbers for the locations identified as "some."
- "Safety suites have a door that connects both rooms is flush with the frame." This description was not clear.
- "Rooms (enter #) have patient desk that provide ligature points." There were no room numbers entered.

During interview with the DPCS on 04/26/2018 at 1430 he/she stated that the "Unity Leadership Team" had developed the plans and confirmed that there were no dates "in the system" to reflect when the plans had been generated. He/she believed that the plans were in place at the time of a JC survey in early 2017 where findings resulted in the modification or "cut-down" of patient room bathroom doors throughout the facility. He/she confirmed there were no other physical environment risk assessments specific to UCBH. During interview with the FM on 04/26/2018 at 1545 he/she stated that he/she was "not familiar" with the "Risk Mitigation Plans" document and had not been involved in its development. He/she confirmed there were no other physical environment risk assessments specific to the BHU. During further interview with the DPCS on 04/27/2018 at 1120 he/she...
## Legacy Emanuel Medical Center

### Name of Provider or Supplier

**2801 N Gantenbein Avenue**  
**Portland, OR 97227**

### Statement of Deficiencies and Plan of Correction

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<td>confirmed that the “Risk Mitigation Plans” had not been revised or modified since the JC survey visit in April of 2017. He/she confirmed that the modification of the patient bathroom doors had occurred after the JC visit and was not reflected in the plans.</td>
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* The form titled "Legacy Health - Hazard Surveillance Survey Program" was dated as revised "07/2017." The form contained nine (9) sections, for 45 various aspects of environmental safety. There were no aspects of the EOC identified specific and relevant to a BHU including for example: ligature risk areas, visual "blind spots," unsafe items that could be used as weapons against others, or unsafe items that could be used by patients to harm themselves or to attempt suicide.

* During tour of Unit 2 with the Unit NMs and the VPU on 04/26/2018 beginning at 1130, and later that day with the VPFO and the FM at 1440, gaps between the mounted surfaces of the horizontal and vertical grab bars and the wall were observed in patient bathrooms. In patient bathrooms S205 and S215, gaps were observed on both horizontal and vertical grab bars. In the seclusion room bathroom, S225, a gap was observed on the vertical grab bar. Some of the gaps were approximately 1/8 inch, wide enough that 14 pieces of notebook paper could pass through, or fabric or elastic or string or cord could pass through, and therefore they created a ligature risk.

* During tour of Unit 5 with the CN, the VPFO, and the FM on 04/26/2018 at 1505, grab bar gaps described in Unit 2 finding above that created a ligature risk were observed in the bathroom.
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shared between two seclusion rooms H1 and H2 located outside of the locked unit. During interview with the CN at that time he/she stated that the patients placed in those seclusion rooms are clothed in scrubs that have elastic waistbands. He/she further stated that while the seclusion rooms are monitored by cameras from inside the locked unit, the bathroom is not.

* During tour of Unit 5 with the CN, the VPFO, and the FM on 04/26/2018 at 1530 the lockable double doors to two "safety suites" that contained multiple patient rooms were observed to have door closure and hold open mechanisms that included rigid metal bars that protruded from the doors and gaps between metal pieces. Those bars and gaps created ligature risks. During this observation staff attempted to observe the "safety suite" doors of the "safety suite" located furthest away from the nurse's station using the camera views at the nurse's station. The attempt to locate the specific view was in excess of 15 minutes, ultimately a camera view from within the "safety suite" that showed the doors from inside the suite was found, and a view of the outside of the "safety suite doors" was located but the images were dark and barely visible. The "safety suite" attempted to be observed by camera could also not be observed by direct visual observation from most of the nurse's station area. During interview with an RN at the time of the observation he/she stated that staff do not routinely monitor that hall. During interview with the VPFO and the FM at the time of the observations they stated that those door closure and hold open mechanisms were not of a "breakaway" type that would fail if significant weight was exerted on them, and they confirmed that they had not been identified as part of a physical environment risk assessment.
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* During tour of Unit 5 on 05/15/2018 at 1215 the floors of seclusion rooms H1 and H2 were observed to have thick metal rings mounted into recessed metal mountings in the floor for the purpose of tying of restraints. The rings were mounted in such a way so that they were moveable in their mounting and could be vertically positioned so the top of the ring was flush with the floor or extended slightly above the level of the floor. During interview with staff at the time of the observation they reported that Patient 9 had harmed him/herself by banging his/her head on those metal rings while in seclusion.

* During further tour of Unit 5 with the ANM, the DPCS, and ACC on 05/15/2018 at 1610 the lockable double doors to two "safety suites" that contained multiple patient rooms were observed to have door closure and hold open mechanisms that included rigid metal bars that protruded from the doors and gaps between metal pieces of greater than 1/8 inch. Those bars and gaps created ligature risks as described in the observation above on 04/26/2018. Staff were again asked to find the camera views of the "safety suite" doors and were unable to. An RN stated "No, I can't pull that hall up." The ANM stated "They can't view it."

* During tour of Unit 6 on 05/17/2018 beginning at 1600 the following observations were made:
  - Camera views observed on the monitors at the nurse's station revealed that the cameras did not provide for visualization and observation of all areas/corners in 20 of the 22 patient rooms on the unit. The areas that could not be visualized included the corner of the room underneath the camera and/or the area of the room where the
A 144

Continued From page 34

bathroom door, window to the outside, and bench under the window were located. This was the case in Rooms 601, 602, 603, 604, 605, 606, 607, 608, 609, 611, 612, 614, 615, 616, 617, 618, 619, 620, 621, and 622.

- In those rooms where the room door was located on the opposite side of the room from the area of the room where the bathroom door, window to the outside, and bench under the window were located, that area could also not be visualized in person at the door room entry. To visualize that area in its entirety an individual would be required to enter the room completely and walk to the other side of room.

* In room 605 on 05/17/2018 at 1620 during demonstration of "blind spots" a surveyor stood in the corner of the room directly under the camera and could not be visualized at the camera monitors; a surveyor stood in the area of the room where the bathroom door, window to the outside, and bench under the window were located and could not be visualized at the camera monitors or at the room door entrance; and a surveyor stood on top of the bench under the window, affixed one end of a lanyard to the top of the bathroom door piano hinge and the other around his/her neck and could not be visualized at the camera monitors or at the room door entrance. In that "blind spot" an individual could successfully step off the window bench without detection, or attempt self-harm in other ways without detection. During interview at the time of the observations the RN stated "that's a ligature risk."

* Refer to the the deficiency cited under Tag A145, CFR 482.13(c), Standard: Privacy and Safety, for findings that reflect patients
### A 144

**Continued From page 35**

A 144 experienced harm as a result of structural hazards in the physical environment and lack of patient supervision.

3. Unsafe items in the environment had not been identified or mitigated:

* The policy and procedure titled "Unity Adult Inpatient Psychiatric Services Standard of Care" dated as last reviewed "Aug 2017" reflected that "Interventions" to be implemented for patients included "Assure safe environment: Remove potentially harmful items. Check new patients for contraband; check patients returning from pass for contraband. Inform all visitors of restrictions and monitor all items being brought onto unit. Monitor for elopement risk if condition or legal status warrants."

* The policy and procedure titled "Personal effect, unsafe items, and searches on adult psychiatric unit" dated as last revised "Dec 2016" reflected: "Patients shall be allowed to wear their own clothing and to retain possession of personal items except when this poses a threat to safety. Any item which is deemed to present a danger will be removed using minimal, but necessary, intervention: Initial search of all patient clothing and personal effects shall be made upon admission and return from passes...Upon admission and return from passes, patients will be required to disrobe to allow clothing to be searched, or to change into hospital clothing for safety reasons...Items which pose an obvious threat to safety will be declared as unsafe items...Unsafe items and other items will be retained by staff in a secure storage area for the duration of hospitalization. Unsafe items, which a patient may never use, will be separated and
A 144 Continued From page 36
placed in a labeled envelope...Prescription medications not sent home with patients's family/representative will be itemized, separated, and stored in the unit unsafe items storage designated for the patient...Unsafe belongings and valuables will be stored in a secure area to maintain safety...The following items are considered unsafe items: Weapons...Boots...heavy shoes...Drug products including prescription and non-prescription...Sharp items such a razors...Plastic bags...cords including drawstrings...Pens and long pencils are not allowed. Paper and short pencils, short pens or felt markers will be provided upon request..."

* Multiple policies and procedures related to the use and management of weapons on the BHU were inconsistent and unclear:
- The policy and procedure titled "Weapons Policy" dated as last revised "11/16" reflected "Legacy does not allow the introduction of certain weapons, as defined herein, on Legacy property. Individuals in possession of these weapons will surrender them to Safety/Security for safekeeping or remove them from the property...The possession of a firearm or any other instrument that may be used as a dangerous weapon, while on legacy property is prohibited. A dangerous weapon is defined as any weapon, device, instrument, material or substance which, under the circumstances in which it is used, attempted to be used or threatened to be used, is readily capable of causing death or serious physical injury. Exceptions to this Policy are as follows: a. sworn law enforcement officers on or off duty and who are not patients b. a member of the military when engaged in the performance of duty c. armored car couriers in the performance of their..."
A 144  Continued From page 37  
job duties KEY POINT: Weapons are not allowed on the Behavioral Health units.”

- The policy and procedure titled “Visitor Behavior Management” dated as last revised “01/17” reflected that “Dangerous weapons of any kind are not permitted on Legacy property, with the following exceptions: a. Sworn Law Enforcement Officers who are not patients. b. On-duty Military Personnel in the performance of their duties. c. Armored car couriers in the performance of their job duties. d. Legacy Safety/Security personnel with permission of Safety/Security Leadership. Weapons can be in the form of pocket knives, pepper foam, handcuffs, or others as approved.”

- The policy and procedure for the "Legacy Security Department" titled "Dress Code/Uniform Standards" dated as effective 06/01/2016 and revised on 05/07/2018 reflected that SSOs were issued a "Pepper gel pouch" for carrying Pepper gel. In addition, although there were no provisions in this policy, and it was contradictory to the "Weapons Policy,” during interview with ACC on 05/22/2018 at 1120, he/she stated that prior to the policy revision of 05/07/2018 SSOs were permitted to carry knives in UCBH and prior to that revision the policy had not included provisions for that. The ACC stated that SSOs are no longer permitted to carry knives and the current policy doesn't reflect how knives should be managed.

- The policy and procedure titled "Use of Force" dated as last as originated "9/91" and last reviewed “3/2018” reflected its purpose was “To provide guidelines for the use of physical force by Legacy Safety/Security Offices during the performance of their duties.” The policy defined “Levels of Force” to include "Physical Control" and “Serious Physical Contact.” In the definitions of both of those levels was the statement that OC
### Legacy Emanuel Medical Center

**Summary Statement of Deficiencies**

Each deficiency must be preceded by full regulatory or LSC identifying information.

<table>
<thead>
<tr>
<th>Event ID</th>
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<th>Completion Date</th>
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<tbody>
<tr>
<td>A 144</td>
<td>380007</td>
<td>05/20/2018</td>
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</tbody>
</table>

#### A 144 Continued From page 38

Pepper foam may be used. The policy further reflected "Prior to the use of OC Pepper Foam, the subject(s) will be warned that if the action warranting the use of such ins not stopped, the foam will be used." According to the "Weapons" policy pepper foam was prohibited to be carried on the BHU.

* During tour of Unit 2 on 04/26/2018 at approximately 1130 a basket of pens and markers was observed on a table in the center of the patient milieu.

* During a second tour of Unit 2 on 05/15/2018 beginning at 1540 the following observations were made:
  - In the "safety suite" area a large piece of wood, approximately 1 ft. by 2 ft., with unfinished edges was observed screwed into a wall between two patient rooms. During interview with staff at that time they stated that the wood was covering the space where a recessed metal fire extinguisher cabinet had been located. They stated that a patient had kicked the metal door of the cabinet in, broke the door off, accessed the fire extinguisher and used it as a weapon.
  - At the part of the nurses's station open to the milieu three water bottles and two cups of pens and markers were observed to be accessible to patients who might reach over the counter. During interview with staff at that time they stated that long pens and markers were not permitted except when directly supervised by staff. They stated that short "bendy" pens and short "golf" pencils were ok for patient use.

* During a third tour of Unit 2 on 05/17/2018 beginning at 1650 the following observations were made:
### A 144

Continued From page 39

- A cup of pens and markers were observed on a table in the center of the patient milieu.
- A cup of "Jolly Rancher" hard candies were observed on the counter next to the sink in the patient milieu.

*During tour of Unit 5 on 04/26/2018 at 1150 in the “TV room,” T526, it was observed there were numerous cabinets with lock hardware on the doors. At the time of the observation there was a patient in the room and no staff in attendance with the patient. At that time a cabinet was found to be unlocked and contained miscellaneous items including a heavy, zippered plastic bag. During interview with the CN on 04/26/2018 at 1520 he/she stated that the cabinets in the TV room T526 were to be "locked at all times unless items were being taken out of the cabinets by the OTs."

* During a second tour of Unit 5 on 4/26/2018 beginning at 1550 the following observations were made:
  - Three commercial type coffee carafes with grab handles at the top of the carafe were observed located on the counter of the section of the nurses’ station open to the milieu. The carafes were labeled as coffee and "hot water." Those carafes were accessible to patients who might reach over the countertop.

* During a third tour of Unit 5 on 05/15/2018 beginning at 1610 the following observations were made:
  - In the open patient kitchen area three commercial type coffee carafes with grab handles at the top of the carafe were observed located on the counter of the section of the nurses’ station open to the milieu. The carafes were labeled as...
### Statement of Deficiencies and Plan of Correction

**Legacy Emanuel Medical Center**

**Street Address, City, State, Zip Code:**
2801 N Gantenbein Avenue, Portland, OR 97227

**Provider/Supplier/CLIA Identification Number:**
380007

**Date Survey Completed:**
05/22/2018

<table>
<thead>
<tr>
<th>ID</th>
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<th>Summary Statement of Deficiencies</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>A 144</td>
<td>Continued From page 40 A 44</td>
<td>- A plastic fork dispenser and a plastic spoon dispenser were observed mounted to the wall in the open patient kitchen area. Those utensils were rigid black plastic material and had potential to be used as weapons or for self-harm. - A long, rigid pen was observed on the counter of the nurse's station open to the patient milieu. - Numerous cords and cables were observed at the nurse's station open to the milieu and at the patient computer desk located on the outside of the nurse's station. * During tour of Unit 1W on 05/15/2018 beginning at 1700 the following observations were made: - In the open patient kitchen area three commercial type coffee carafes with grab handles at the top of the carafe were observed located on the counter of the section of the nurses’ station open to the milieu. The carafes were labeled as coffee and &quot;hot water.&quot; - A plastic fork dispenser and a plastic spoon dispenser were observed mounted to the wall in the open patient kitchen area. Those utensils were rigid black plastic material and had potential to be used as weapons or for self-harm. - The refrigerator and the drawers and cabinets in the open patient kitchen area had lock hardware installed but were unlocked. - A blue plastic bin of approximately 20 long and short had pencils were observed on top of the counter at the open nurse’s station and were easily accessible to patients. - A three shelf mobile cart was positioned inside the section of the nurses's station open to the milieu. The shelves were cluttered and completely full of layers of items and materials such as numerous pairs of shoes - some with laces, containers of disinfectant wipes, &quot;Cleaner&quot;,</td>
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**Event ID:** O63T11

**Facility ID:** 380007

**If continuation sheet Page:** 41 of 105
### Legacy Emanuel Medical Center

**Name of Provider or Supplier:**

**Street Address, City, State, Zip Code:**
2801 N Gantenbein Avenue
PORTLAND, OR  97227

### Summary Statement of Deficiencies

**Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information**

<table>
<thead>
<tr>
<th>ID</th>
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<th>TAG</th>
<th>Provider's Plan of Correction</th>
<th>(Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
</tr>
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<tbody>
<tr>
<td>A 144</td>
<td>Continued From page 41</td>
<td>pens/markers, a box of &quot;Better, Cheddar&quot; crackers, items with cords, disposable gloves etc. The items on the cart were accessible to patients.</td>
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- A mobile apparatus on which a vital signs machine and an open basket for storage was mounted was observed with numerous objects, and cords and cables protruding and dangling from various parts of the apparatus. The apparatus was positioned inside the section of the nurse's station open to the milieu and was accessible to patients.
- Numerous cords and cables were observed at the nurse's station open to the milieu and at the patient computer desk located on the outside of the nurse's station.

* During interview with the DPCS on 05/15/2018 at 1710 regarding the findings on Unit 1W he/she stated that there was an "informal risk assessment" and clinical judgement used on each unit to decide about whether cabinets, drawers, and refrigerators are kept locked or unlocked.

* During tour of Unit 6 on 05/17/2018 beginning at 1550 the following observations were made:
- A box was observed on top of the open nurse's station counter that contained three "golf" pencils.
- Numerous items were stored at the part of the nurse's station open to the milieu including a box full of with pencils and markers and multiple containers of personal hygiene supplies such as lotions, deodorants, and mouthwash. These items were easily accessible to patients.
- A mobile Dinamap apparatus that contained a vital signs machine and two trays compartments for storage was observed with numerous objects, and cords and cables protruding and dangling from various parts of the apparatus. The
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<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>A 144</td>
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<td>Continued From page 42 apparatus was positioned just inside the section of the nurse's station open to the milieu next to the swinging half-door and was easily accessible to patients. - Two holes were observed in the wall in unlocked and vacant patient room 605. Pieces of broken, hard plaster were observed within the compartment in the wall that had been created by the broken wall. Staff present during the observation stated that a patient had kicked the hole in the wall. * Documentation in the medical record of Patient 18, who was admitted to Unit 2 on 02/22/2018, included a physician's noted dated 03/26/2018 at 1551 that reflected &quot;Wound of right breast Overview: 12/20/17 Patient has delusions that the space behind [his/her] right breast is a 'treasure chest.' [He/she] has a h/o self injury (cutting, biting, burning) since [he/she] was 5 yo with multiple inpatient psych hospitalizations. [He/she] states that [he/she] created the space behind [his/her] right breast by cutting it and then started storing foreign objects in there that would give [him/her] strength/power (rocks, papers, shells, plastic, earrings, beads). Operated on at PHSW 12/11/17 for a foreign object that got infected - it was removed and a wound vac placed. - Transferred to Unity Was found to have foreign object by US GSH - surgery removed 2 pieces of plastic Challenge healing...Patient is...very focused on some self-harm behaviors and her pocket or which [he/she] refers to as [his/her] 'magical pocket' which is actually a pocket in the skin of [his/her] abdominal wall which is infected and needs to be kept clean and allowed to drain so that [he/she] does not have a more serious infection develop and continues to be localized to [his/her] abdominal wall. On my interview this</td>
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<td>morning [he/she] showed me a pencil and [he/she] asked that [he/she] put a pencil into [his/her] 'magical pocket.' I took a pencil and informed [his/her] nursing staff that [he/she] was trying to use the pencils to put them into [his/her] pocket as a mechanism of self injury. [He/she] has very limited insight into this issue and wants beads...</td>
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<td>* An RN progress note in Patient 18's medical record dated 03/26/2018 at 1702 reflected that Patient 18 &quot;...admitted that [he/she] did stick a pencil partway down into the wound on the medial end. [He/she] agreed to give up the pencil.&quot;</td>
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<td>* A COTA progress note in Patient 18's medical record dated 03/27/2018 at 1448 reflected that Patient 18 &quot;Worked on...beading task - during work with beads, pt was closely observed...After completing beaded bracelet, this staff deferred to RN, who allowed pt to wear bracelet out of group.&quot; There was no documentation by the COTA to reflect that the number of beads provided to the patient were accounted for at the end of the project when beads were known to be an unsafe item for Patient 18. Further there was no documentation by RN to reflect a risk assessment related to the patient's possession of the beaded bracelet when beads were known to be an unsafe item for Patient 18.</td>
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<td>* An RN progress note in Patient 18's medical record dated 03/28/2018 at 2210 reflected &quot;Pt came to the nurses station at 1935 and told staff that [he/she] had put a golf pencil (sharpened without an eraser) into [his/her] chest at approx 1500. [Physician] paged at 1940. No response so [physician] paged again. [Second physician] notified. Then [third physician] came to unit 2 at 2035...saw pt. And placed pt on a HH, as pt was also demanding discharge...Pt to be transferred to OHSU ED for removal of pencil, which pt...&quot;</td>
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## Legacy Emanuel Medical Center

**Name of Provider or Supplier:**

**Street Address, City, State, Zip Code:**

2801 N Gantenbein Avenue  
PORTLAND, OR  97227

### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information.

<table>
<thead>
<tr>
<th>ID</th>
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<th>Summary Statement of Deficiencies</th>
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states [he/she] punctured through skin and did not put the pencil in existing wound. Writer visualized wound and could see end of pencil on far L end of wound under R breast. New gauze applied as it was wet and not intact...Bracelets removed from pt..." There was no documentation to reflect how the patient had possession of a pencils on multiple occasions when such items were known to be unsafe for Patient 18. Further, although the written policy under finding 1 in this deficiency identified pencils as an unsafe item, pencils were observed in the physical environment during the survey.  
* Refer to the the deficiency cited under Tag A145, CFR 482.13(c), Standard: Privacy and Security, for findings that reflect other patients experienced harm as a result of unsafe items in the physical environment and lack of patient supervision.  
4. Clear written protocols, and equipment and supply availability, were not ensured for response to urgent or emergency medical conditions:  
* The policy and procedure titled "Medical Emergency and Urgent Medical Response" dated as last reviewed "Feb 2017" reflected that all Unity clinical staff were required to maintain BLS certification. It further outlined "Initiation Criteria" and "Implementation" for "Medical Emergencies (Code M)" and for "Urgent Medical Issues." In a Code M situation the policy directed the "Patient Care RN" to dial Legacy Security "Or initiates Vocera communication by calling Code M." The policy generally referred to "participants," "responders," and "patient care team" but did not clearly specify where those individuals were coming from in the facility or what the roles would...
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be when multiple individuals responded. In addition, the policy and procedure did not specify what equipment and supplies were available, where they were located, and how they would be transported to the patient's location to ensure appropriate and immediate assessment and interventions.

* The policy and procedure titled "Emergency Codes Policy" dated as last reviewed "11/17" reflected its purpose was "To provide uniform and timely response to defined emergency situations." The policy defined 12 "Codes" of which "Code M" was not listed. The "Codes" listed in the policy included "Code Green: Patient or visitor injury/illness." The "Code Green" designation was not consistent with the "Code M" designation identified in the policy above.

* The policy and procedure titled "General RN Station Guideline" dated as last reviewed "Jan 2017" stipulated "Every staff member is expected to wear a Vocera badge while on duty... 'Do not disturb' should only be used if in a meeting and be limited as it restricts calls from other staff." However, during interview with the Unit 2 NMs and the VPU on 04/26/2018 at approximately 1215 they stated that for the first few months of 2017 it was discovered that there were not enough Vocera devices to ensure that all Unit staff would have one as other departments began using the devices on hand. They stated that 50 or 60 additional devices were ordered and there had been no complaints since then that there were not enough for Unit staff. A Purchase Order to the Vocera Communications company dated 03/01/2017 validated the NMs and VPU interview as it reflected that 50 devices were ordered to be delivered on 05/01/2017.
<table>
<thead>
<tr>
<th>ID</th>
<th>NAME OF PROVIDER OR SUPPLIER</th>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
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<tbody>
<tr>
<td>A144</td>
<td>LEGACY EMANUEL MEDICAL CENTER</td>
<td>2801 N GANTENBEIN AVENUE PORTLAND, OR 97227</td>
</tr>
</tbody>
</table>

### Statement of Deficiencies and Plan of Correction

- **ID**: A144

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
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</table>
| *The policy and procedure titled “Glucose Testing using the Nova StatStrip Glucose Meter” dated as last reviewed “Nov 2016” reflected the following:*
| StatStrip GLU-Test Strips (100 per box)...Once opened, good for 180 days or until the expiration date on vial, whichever comes first."
| StatStrip GLU Control level 1...Once opened, stable up to three months or until the expiration date on vial, whichever comes first."
| StatStrip GLU Control level 3...Once opened, stable up to three months or until the expiration date on vial, whichever comes first.“ |

* During tour of the Unit 2 nurse's station on 04/26/2018 at approximately 1130 one portable, emergency O2 tank was observed available for patient use. The O2 gauge reflected the tank had between 900 and 1000 psi of O2 remaining, less than half of the volume of the tank. During interview with the Unit 2 NMs and CN at the time of the observation they stated there were no written policies or protocols for use and maintenance of the O2 tanks on the units, that included the minimum amount of O2 that should be contained in a tank to ensure an adequate volume was available for an emergency.

* During a second tour of the Unit 2 nurse's station on 05/15/2018 beginning at at 1510 the following observations were made:*
| - One portable, emergency O2 tank was observed available for patient use. The O2 gauge reflected the tank has less than 1000 psi of O2 remaining. During interview the the CN at the time of the observation he/she stated that the tank volume shouldn't be much lower than 1000 psi. The tank had an O2 mask and a NC attached to it. He/she confirmed that there was no written...
### Legacy Emanuel Medical Center

**STREET ADDRESS, CITY, STATE, ZIP CODE**

2801 N Gantenbein Avenue  
Portland, OR 97227

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#### Summary Statement of Deficiencies

**Event ID:** 63T11  
**Facility ID:** 380007  
**If continuation sheet Page:** 48 of 105

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- Two blood glucose check kits were observed. In one kit the "Control Level 1" bottle and the "Control Level 3" bottle had handwritten discard dates of 09/17/2018 recorded on the bottles' labels. In the second kit the "Control Level 1" bottle and the "Control Level 3" bottle had handwritten discard dates of 07/15/2018 recorded on the bottles' labels. In those kits two open bottles of "Test Strips" were observed. The "open" and "discard" dates on each bottle were blank.

- A pair of metal cutting shears were observed hanging in a plastic bag taped to a wall. Attached to the plastic bag was a crumpled and torn piece of paper that had in handwriting: "for cutting through sheets, blankets, etc." During interview with the CN at that time he/she described those as ligature cutters and it was confirmed that there were no polices and procedures for use and maintenance of those.

- A bottle of hydrogen peroxide and multiple bottles of sterile water for irrigation were observed to be open and partially full. There was no indication on those containers of the date opened to determine whether efficacy or sterility was ensured.

* During interview with the Unit 2 CN on 05/15/2018 at 1515 he/she stated that someone brings the O2, an ambubag, the AED, sometimes the EKG from PES, and "someone grabs" the blood glucose check device. He/she stated that in the event of a Code M for patient bleeding or hemorrhage they would "grab a towel" and would "send someone to supply closet" or get supplies out of wound care stock at nurses's station. He/she stated that if there is a ligature situation someone brings the ligature cutter. He/she stated
Continued From page 48

that when a Code M is called in addition to the HS and medical providers, other staff from other floors respond but there is not a standardized written protocol for what those staff do.

* During tour of Unit 5 on 04/26/2018 beginning at 1120 the NM and CN stated that Code M supplies were not located together in one area, and that some were kept at the nurse's station and others were in the clean supply room located of of the locked unit.
  - One roll of gauze was observed at the nurse's station.
  - The portable, emergency O2 tank was observed with an O2 mask attached to it.

* During a second tour of the Unit 5 nurses's station on 05/15/2018 beginning at 1610 the following observations were made:
  - One portable, emergency O2 tank was observed. Attached to the tank were two O2 masks.
  - There were no ligature sheers like those observed on Unit 2. RN staff interviewed at the time stated there were no "cut-down sheers" but they found trauma scissors that were available.

* During interview with the Unit 5 ANM on 05/15/2018 at 1630 he/she stated stated that for a Code M the equipment and supplies brought to the scene "depend on what's going on." He/she stated that usually the "nurse on the scene makes the decision" and that when its discovered that something specific is needed they'll have "runners" get what is needed. Staff present during the interview stated that there are responders from each unit of the UCBH and there are "almost too many people."
## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

### PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

380007

### MULTIPLE CONSTRUCTION

A. BUILDING _____________________________

B. WING _____________________________

### DATE SURVEY COMPLETED

05/22/2018

### PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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* During tour of Unit 1W on 05/15/2018 at 1655 the following observations were made:
  - The portable, emergency O2 tank had a NC attached to it.
  - The blood glucose kit "Control Level 1" bottle and the "Control Level 3" bottle had labels with a space for the bottle's "discard date." There was no "discard date" recorded on either bottle. In addition, two open bottles of "Test Strips" were observed. The "open" and "discard" dates on each bottle were blank.

* During tour of Unit 6 on 05/17/2018 at 1016 three RNs were asked and did not know where the portable, emergency O2 tank was located. A BHT was asked and stated it was in the med room, however, there was no O2 tank observed in the med room. A fourth RN reported the O2 tank was in the clean supply room, located off the locked unit.

* Documentation of a Code M event that occurred on 02/21/2018 reflected that Patient 18 was found in his/her bedroom to be confused and O2 sat level at that time reflected his/her O2 was in the "40s" on room air. O2 was applied via a NC and then a simple mask. The Code M follow-up documentation reflected that staff needed a nonrebreather mask to apply to the patient but none were available. There was no documentation of resolution of the mask availability concern. During interview with the DPCS at the time of the review on 05/21/2018 at 1440 he/she stated that the masks were available at the time of the Code M but staff didn't know where they were.

5. Committees and groups responsible for patient safety were not effective:
A 144 Continued From page 50

* During interview with the Unit 2 NMs and the VPU on 04/26/2018 at approximately 1230 the VPU described the organization of the UCBH’s safety reviews, including the Quarterly Safety Summit, The Monthly Safety Workgroup, the Monthly Safety Committee, and the bimonthly Leadership Council. He/she stated that any staff member of UCBH may attend the summit and committee meetings and that concerns about ligature risk areas had not been raised during those meetings.

* Review of meeting minutes for the safety related committees and workgroups reflected those were not effective as those groups had not identified significant physical environment risks on patient units such as ligature risks identified during the survey, and they had not ensured timely follow-up and implementation of actions to mitigate those risks that were identified.

* Review of “Safety Committee” meeting minutes dated 01/23/2018 reflected the following:
- “Agenda Topic...Safety Rounding...Safety committee will conduct quarterly safety rounds on units at Unity and then report back with findings. Plan to reduce any safety concerns will be discussed with action plan.” Minutes reviewed dated 02/20/1028, 03/08/2018, and 04/12/2018 included no further references to safety rounds.
- “Agenda Topic...Contraband All floors...We need to have a better system when going through pt belongings. Contraband is still ending up on the units.” Under “Action Items” the minutes reflected “Contraband” was identified, but the space for “person responsible” and "due date" was blank. The subject of Contraband was not addressed in minutes reviewed dated 02/20/2018
A 144 Continued From page 51 and 03/08/2018. Minutes dated 04/12/2018 reflected "Unit 1E...Visitors are bringing in unsafe items. Staff needs to know how to identify unsafe items. Unit 5...Visitors need to empty their pockets before coming on the unit. Patients being admitted to the 5th floor have had unsafe items on them. Please careful belongings search and pt should be wanded after changing into scrubs.

* Review of "Safety Committee" meeting minutes dated 02/20/2018 reflected the following:
- "Agenda Topic...Unit 5 Safety Concerns as well as hospital wide concerns...concerns for open RN stations...concerns would be taken to leadership meetings for further discussion and action plan."
- Under "Action Items" the minutes reflected "Unit 5 concerns...will take to Safety summit...due date: 3/2018." Review of "Safety Summit Minutes" dated 03/22/2018 lacked documentation to reflect that the subject of safety concerning "open RN stations" on the units had been addressed. In addition, there was no follow-up documented in Safety Committee meeting minutes dated 03/08/2018 and 04/12/2018.
  - "Agenda Topic...unsafe items...discussed a list of unsafe items on the units including: Golf pencils; hardcover books; boomboxes; and scissors...discussed adding concerns to unsafe item list that is being revisited." Under "Action Items" the minutes reflected "Unsafe items. Committee to review list and look for evidence based data to support...due date: 3/2018." The 03/08/2018 Safety Committee meeting minutes reflected that "The safety workgroup will review the unsafe items list and literature...create standardized process for the check out of items deemed unsafe...share the unsafe items list with safety group next meeting." There were no "Action Items" or "due dates" identified for...
A 144 Continued From page 52
"unsafe items." The 04/12/2018 Safety Committee meeting minutes reflected that "Visitors are bringing in unsafe items. Staff needs to know how to identify unsafe items." Under "Action Items" the minutes reflected "Unsafe items list...Person Responsible: Safety workgroup...due date: May." "Safety Workgroup Minutes" dated 04/16/2018 reflected this meeting was "the first safety workgroup." There was no documentation in the minutes to reflect that the "Safety Workgroup" addressed the identification and prevention of unsafe items on the patient units as planned in the 03/08/2018 Safety Committee meeting.
- "Agenda Topic...Concern for checking meds, RN to follow protocol for checking mouth to make sure pt swallowed the pills."
Under "Action Items" the minutes reflected "Cheeking meds...Nurse education on 6th...due date: 3/2018." The was no documentation of follow-up in the 03/08/2018 Safety Committee meeting minutes.
- "Agenda Topic...Blind spots in rooms have been detected." There were no "Action Items" related to "blind spots" documented in the minutes.

* Review of "Safety Committee" meeting minutes dated 03/08/2018 reflected the following:
- "Agenda Topic...There are multiple blind spots in the seclusion rooms. Needs a method to view in ante room...will reach out to milestone for computer/camera set up." Under "Action Items" the minutes reflected "Seclusion room blind spots...due date: Follow up for April mtg." The 04/12/2018 Safety Committee meeting minutes only addressed "Seclusion room blind spots" under "Action Items" with a "due date" of "Follow up for May mtg."
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>* Review of &quot;Leadership Meeting&quot; minutes dated 01/03/2018 reflected the following:</td>
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<td>- &quot;Subject...Review Unity risk mitigation...Carried over to next meeting.&quot; The 01/17/2018 &quot;Leadership Council&quot; minutes under &quot;Subject&quot; reflected &quot;Review Unity risk mitigation plan...each RN Manager to update the risk mitigation plan to ensure it is a current living document as we move forward. Timescale - one month. Plan will be reviewed regularly at Leadership meetings. Once updated...will meet with ACC to review the risk mitigation plan to ensure it complies with regulatory requirements.&quot; Under &quot;Action steps&quot; the minutes reflected &quot;...each RN Manager to update the risk mitigation plan to ensure it is a current living document as we move forward.&quot; The &quot;Unity Risk Mitigation Plan 12 4&quot; was electronically embedded in the minutes. A printed copy provided reflected the plan to be as described under finding 2 in this deficiency. &quot;Leadership&quot; minutes dated 02/07/2018, 02/21/2018, 03/07/2018, 03/21/2018, 04/04/2018, and 04/18/2018 to reflect that the &quot;Unity Risk Mitigation Plan&quot; had been reviewed and addressed as planned in the 01/17/2018 &quot;Leadership&quot; meeting.</td>
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<td>* Review of &quot;Leadership Meeting&quot; minutes dated 03/21/2018 reflected the following:</td>
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<td>- &quot;Subject...Discharging patients with weapons. Carried over to next meeting.&quot;</td>
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<td>* Review of &quot;Leadership Meeting&quot; minutes dated 04/04/2018 reflected the following:</td>
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<td>- &quot;Subject...Discharging patients with weapons. Carried over to next meeting.&quot;</td>
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<td>6. Staff training related to identification of hazards and risks in the EOC and for response to urgent</td>
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Continued From page 54
and emergency medical conditions had not been provided:

* The policy and procedure titled "Safety Management Plan" dated last reviewed "05/17" reflected "All staff must attend new employee orientation within 30 days of hire. New employee orientation addresses key issues and objectives of all seven areas of EOC including the role each area and staff play in the overall Legacy Health Safety Program. Employees also receive departmental safety orientation at their respective work areas regarding hazards and their responsibilities to patients, visitors and co-workers. In addition, all staff participates in annual, mandatory education regarding the Environment of Care..."

Review of employee training documentation for EOC reflected the following:
- Employee 1 (SSO) with hire date 08/21/2000 reflected no evidence of annual EOC training.
- Employee 4 (SSO) with hire date 07/17/2017 reflected no evidence of training on hire.
- Employee 21 ("Folktime" contract staff) with hire date 11/01/2016 reflected no evidence of EOC training on hire or annually.
- Employee 22 ("Folktime" contract staff) with hire date 02/02/2018 reflected no evidence of EOC training on hire.

On 05/16/2018 at approximately 0935, during review of training documentation with the SM, he/she confirmed Employees 1 and 4 lacked EOC training.
On 05/16/2018 at 1315, during review of training documentation with the DS, he/she confirmed Employees 21 and 22 lacked EOC training.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<td>380007</td>
<td>A. BUILDING _____________________________</td>
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#### NAME OF PROVIDER OR SUPPLIER

**LEGACY EMMANUEL MEDICAL CENTER**

#### STREET ADDRESS, CITY, STATE, ZIP CODE

2801 N GANTENBEIN AVENUE
PORTLAND, OR 97227

#### SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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- Documentation of employee training records reviewed reflected employees had not received training for identification of environmental risk factors and mitigation to ensure patients were protected from self-harm or causing harm to other patients. The following employees did not receive such training:
  - Employee 1 (SSO) with hire date 08/21/2000.
  - Employee 2 (SSO) with hire date 02/20/2017.
  - Employee 3 (SSO) with hire date 05/08/2017.
  - Employee 4 (SSO) with hire date 07/17/2017.
  - Employee 5 (SSO) with hire date 09/05/2017.
  - Employee 6 (SSO) with hire date 10/16/2017.
  - Employee 7 (SSO) with hire date 01/16/2017.
  - Employee 8 (SSO) with hire date 01/08/2018.
  - Employee 9 (BHT) with hire date 01/02/2017.
  - Employee 10 (BHT I) with hire date 07/09/2012.
  - Employee 11 (BHT) with hire date 01/31/2017.
  - Employee 12 (BHT) with hire date 11/06/2017
  - Employee 13 (RN) with hire date 05/05/1988.
  - Employee 14 (RN) with hire date 10/24/2011.
  - Employee 15 (RN) with hire date 01/31/2017.
  - Employee 16 (RN) with hire date 01/31/2017.
  - Employee 17 (RN) with hire date 07/10/2017.
  - Employee 18 (RN) with hire date 11/13/2017.
  - Employee 20 (RN) with hire date 01/08/2018.

On 05/16/2018 at 1105 the DPCS stated he/she didn't know of any documentation of training related to identification of environmental risk factors and mitigation.

- Review of the undated "Code Responses" training module reflected it included training related to the following: "Initiating and safely implementing the various processes, roles, responsibilities and mechanics involved in Code Gray, the Quiet Team, Code Silver and Code M."

During interview with DPCS on 05/26/2018 at...
### Summary Statement of Deficiencies

**Continued From page 56**

1355, he/she stated "Code Responses" training was required on hire and annually for all staff who worked in clinical areas.

Review of employee training documentation for the "Code Responses" module reflected the following staff records had no evidence of the training on hire or annually:

- Employee 1 (SSO) with hire date 08/21/2000.
- Employee 2 (SSO) with hire date 02/20/2017.
- Employee 8 (SSO) with hire date 01/08/2018.
- Employee 10 (BHT I) with hire date 07/09/2012.
- Employee 12 (BHT) with hire date 11/06/2017.
- Employee 19 (RN) with hire date 11/27/2017.
- Employee 21 ("Folktime" contract staff) with hire date 11/01/2016.
- Employee 22 ("Folktime" contract staff) with hire date 02/02/2018.

On 04/27/2018 at approximately 1120, during review of training documentation with the SS, he/she confirmed Employee 8 lacked "Code Responses" training.

On 05/16/2018 at approximately 0935, during review of training documentation with the SM, he/she confirmed Employees 1 and 2 lacked "Code Responses" training.

On 05/16/2018 at approximately 1245, during review of training documentation with the DS, he/she confirmed Employees 21 and 22 lacked "Code Responses" training.
## Statement of Deficiencies and Plan of Correction

- **Provider/Supplier/CLIA Identification Number:** 380007
- **Multiple Construction:**
  - A. Building:  
  - B. Wing:  
- **Date Survey Completed:** 05/22/2018

### Legacy Emanuel Medical Center

**Address:**
- **Street Address:** 2801 N Gantenbein Avenue
- **City:** Portland
- **State:** OR
- **Zip Code:** 97227

### Summary Statement of Deficiencies

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*Event ID: O63T11  Facility ID: 380007  If continuation sheet Page 58 of 105*
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 380007

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ____________________________
B. WING ________________________________

(X3) DATE SURVEY COMPLETED C 05/22/2018

NAME OF PROVIDER OR SUPPLIER

LEGACY EMANUEL MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
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

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<td>PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT CFR(s): 482.13(c)(3)</td>
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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, interviews, review of medical record and other event documentation for 23 of 23 patients who experienced actual or alleged abuse or neglect (Patients 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 22, 23, 24, 26, 31, and 32), and review of policies and procedures, it was determined that the hospital failed to fully develop and implement policies and procedures that ensured patients' rights to be free from all forms of abuse, including neglect, as all components of an effective abuse prevention program were not evident, including complete investigations of, and responses to, actual and alleged abuse and neglect.

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:
### PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 380007 |
| (X3) DATE SURVEY COMPLETED | 05/22/2018 |

#### NAME OF PROVIDER OR SUPPLIER

| LEGACY EMANUEL MEDICAL CENTER |
| STREET ADDRESS, CITY, STATE, ZIP CODE |
| 2601 N GANTENBEIN AVENUE |
| PORTLAND, OR  97227 |

#### SUMMARY STATEMENT OF DEFICIENCIES

| ID | PREFIX | TAG |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
| (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |

#### PROVIDER'S PLAN OF CORRECTION

| ID | PREFIX | TAG | (X5) COMPLETION DATE |
| (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |

**A 145**

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- Prevent.
- Identify. The hospital creates and maintains a proactive approach to identify events and occurrences that may constitute or contribute to abuse and neglect.
- Investigate. The hospital ensures, in a timely and thorough manner, objective investigation of all allegations of abuse, neglect or mistreatment.
- 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.

Findings include:

1. Policies and procedures for abuse protection, including investigation of allegations of all forms of abuse, neglect, and harassment were difficult to identify as there was no one overlying policy for this purpose. Procedures for aspects of abuse protection and investigation were incorporated into several policies and procedures as follows:

   * The policy and procedure titled "Patient Rights and Responsibilities" dated last revised "05/17" stipulated that "Patients have the right to be free from physical or mental abuse..." The policy did not include the patient's right to be free from "all forms of abuse or harassment" as required by this regulation. There were no policies and procedures that identified what steps the hospital would take to protect and promote the patients' right to be free from all forms of abuse or harassment.

   * The policy and procedure titled "Managing Patient's Complaints and Grievances" dated last...
A 145

Continued From page 60

revised "07/17" addressed processing of abuse and neglect complaints and grievances. It reflected "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 is considered a form of abuse is defined as a failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." The policy's "Specific Circumstances" section followed the "Grievance" section and included the following: "Statements of concern that describe allegations of abuse or neglect, which may include various including but not limited to actions (sic) alleged to be sexual in nature, including inappropriate touch, should be escalated up the management chain which will evaluate the allegation in collaboration with the following: Risk Management, Legal Services, Employee Relations and medical Staff Leadership, as applicable. These cases will be evaluated for application of the "Guideline for Investigation and Evaluation of Reports of Inappropriate Behavior or Abuse involving Patients and occurring with a Legacy Facility or Campus." The policy and procedure stipulated that "Grievances will be investigated and managed within a reasonable time period determined by the complexity of the grievance and the investigation and decision-making required. If the grievance cannot be resolved, or if the investigation is not or will not be completed within seven (7) days, the hospital should inform (verbally or in writing) the patient or the patient's representative that the hospital is still working to resolved the grievance and that the hospital will follow-up with a written response within thirty (30) days. When a final resolution has
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<td>Continued From page 61 been reached, a written response will be provided to the patient/designated representative. The written response will include...Name of the hospital contact person...Steps taken on behalf of the patient to investigate the grievance...Results of the investigation...Completion date, which is the date of the written response unless otherwise noted.&quot;</td>
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The "Guideline for Investigation and Evaluation of Reports of Inappropriate Behavior or Abuse involving Patients and occurring with a Legacy Facility or Campus" document referred to in the above policy and procedure was provided as a two part document titled "Phase 1 Investigation Guidelines - Reports of Inappropriate Behavior, Misconduct, Excessive Force or Abuse" identified with number "2018-0315," and "Reports of Inappropriate Behavior, Excessive Force or Abuse - Investigation Guidelines Phase 2" identified with number "2018-0206." The guidelines reflected "Inappropriate Behaviors Response Checklist for all Legacy Health staff & physicians. What do I do if a patient or family member approaches me to report another Legacy staff person or physician has engaged in inappropriate behaviors? All Legacy staff have a role in ensuring patient safety. The following will help you know what to report to your supervisor or the manager of the care area." The guidelines continued with language that reflected the guidelines were intended for investigations when allegations of patient abuse were made against Legacy health staff.

* The policy and procedure titled "Patient, Visitor, and Employee Incident Reporting" dated as last revised "07/17" reflected its objectives included "To provide a mechanism for reporting and
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
LEGACY EMANUEL MEDICAL CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
2801 N GANTENBEIN AVENUE
PORTLAND, OR 97227

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| A 145 | Continued From page 62 documenting incidents inconsistent with the routine operations of the facility or care of a patient. To support the review of incidents for risk management, patient safety and improvement opportunities..." The policy and procedure defined "Adverse event" as "An untoward, undesirable, and usually unanticipated event caused by patient care, treatment or services..." and "Incident" as "Any event, which may involve: (a.) actual injury or potential injury to an individual...Examples of incidents to report are those with or without a negative impact, including but not limited to: Safety concerns including Near Misses and Good Catches - Patient Injury - Treatment delays - Medication related incidents - Falls or burns - Equipment or products - Allegations of abuse, neglect, or misconduct..."
| A 145 | | | | | | | | |

The policy and procedure further described the processes for the next steps when an adverse event or incident was identified:
- The staff member "Submits a PSA, as soon as possible, preferably before the end of the shift...If a patient is seriously injured and you know or suspect it was related to a medical error, contact Legacy Risk Management during business hours...or the Nursing Supervisor or AOC after hours."
- The Manager of the patient unit "Receives an email notice when a PSA is submitted. Will assure review of the issue reported and will initiate the collection of additional relevant information, from anyone or any source who may have pertinent information...The Manager will investigate and document the investigation and actions taken to resolve the event. The Manager may take a variety of actions including reporting the issue up the change of command. Based on the investigation the Manager will change the"
### Legacy Emanuel Medical Center

**Street Address:** 2801 N Gantenbein Avenue  
**City, State, Zip Code:** Portland, OR, 97227

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**Continued From page 63**

- Report status from NEW to OPEN, within 72 hours of the incident and The Manager will assure the event is resolved and the status change to CLOSED within 2 weeks."
- Legacy Clinical Risk Management "Received email notice of the report and reviews events based on the type of the event and severity, generally events of severity 7 or above. May partner with responsible Managers, Medical Directors, and other Clinical and Administrative leaders to investigate events to fulfill various responsibilities as described in Considerations and Interventions."
- The "Considerations and Interventions" section of the policy procedure reflected "Events should be evaluated to determine appropriate next steps which include but are not limited to the following: Disclosure (see 100.76 Communication of Errors, Adverse Events and Unanticipated Outcomes). Critical Incident Notification...Root Cause Analysis and possible regulatory reporting of Serious Safety Events...Billing Implications..."

* A document titled "Managing Unanticipated Outcomes" dated "Sept 2016" included steps to be taken under the following headings: "Clinical Care...Get help...Are others at risk?...Save involved equipment, supplies, medication, videotapes...Notify your chain of command...Support the team...Don't speculate about error or cause, allow time for analysis...Contact Risk Management...What to Say, Now and Later...Epic Medical Record Documentation...I Care..." The last item directed staff to "Complete an ICare (Patient Safety Alert). If severity 7 or above, also notify Risk Management..."

* The undated document titled "ICARE Severity
A 145 Continued From page 64

Level" reflected the severity level designations assigned to each PSA generated. There were ten (10) severity levels:
1. Safety Environment. Unsafe practices, conditions, or circumstances that could cause an adverse event...
2. Near Miss/Good Catch. Event could cause an adverse event but did not include the patient (i.e. error caught prior to reaching the patient)
3. No Harm - Reached Patient - No Increased Monitoring...
4. No Harm - Reached Patient - Increased Monitoring...
5. Harm - Temporary - No Treatment...
6. Harm - Temporary - Minor Treatment...
7. Harm - Temporary - Major Treatment...
8. Harm - Permanent...
9. Harm - Near Death Event...
10. Death. Event may have contributed to death."

2. Event and medical record documentation for allegations of abuse and neglect, as defined in this CFR, were reviewed and reflected that investigations and responses were not complete for the following patients:
* Allegations of abuse or assault by other patients or staff for Patients 2, 18, 22, 24, and 31.
* Allegations of neglect resulting in suicide attempts for Patients 3, 6, 7, 10, 11, 12, 13, 15, 16, 20, 22, and 32. Some of those attempts were in "blind spots."
* Allegations of neglect resulting in actual, or potential for, self-harm for Patients 5, 7, 9, 14, 18, and 19. Some of the self-harm was affected with unsafe items that included pens, pencils, shaving razors, "unidentified" sharps, handsoap.
* Allegations of neglect resulting in patient acquiring weapons, and items used as weapons, for Patient 31. Those items included a knife, a
A 145

Continued From page 65
modified rigid plastic spoon, a fire extinguisher.

* Allegations of neglect resulting in unauthorized
departure from the facility, or elopement, for
Patients 4, 23 and 26.
Examples include, but are not limited to:

* Documentation of an allegation of patient
neglect that resulted in sexual assault of Patient 2
was reviewed with the DPCS on 04/27/2018 at
1130. During interview at the time of the review
the DPCS confirmed that the assault took place
on Unit 2 on 03/09/2017 when Patient 1 entered
Patient 2's room 201, within the "safety suite"
immediately adjacent to the nurse's station, and
was observed on the camera monitor to be
removing Patient 2's clothing while Patient 2 was
on his/her bed sleeping. Staff intervened, stopped
the assault, and Patient 1 was "secluded" in
another room. The documentation reviewed
lacked investigation and resolution of the
following aspects of the assault and related
circumstances:
- How Patient 1 had come to be in Patient 2's
room 201 within the "safety suite" without
detection.
- Why SSOs who responded to the scene were
not informed that the nature of the assault was
sexual.
- Why the patient's call light was found to be
"muted" at the nurse's station terminal.
- Had the allegation been managed as a
grievance and was grievance correspondence
provided to Patient 2.
Further the documentation unclearly categorized
the severity level of this sexual assault as "No
Harm."

* Documentation of an allegation of patient
neglect that resulted in suicide attempt by Patient
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| A145 | Continued From page 66 | 7 was reviewed with the DPCS on 05/22/2018 at 1030. During interview at the time of the review the DPCS confirmed that the event took place on 12/04/2017 on Unit 5. An RN progress note in the medical record dated 12/04/2017 at 2027 reflected that "at 1904 patient was found with [his/her] scrub pants wrapped around [his/her] neck, two knots were untied from [his/her] neck...Patient placed on suicide precautions." There was no further information in the medical record about the event. Nor was investigation documentation of the event complete. That documentation reflected only that follow-up was needed and a question raised by a reviewer about whether paper scrubs should have been used for the patient prior to the incident. The documentation reviewed lacked investigation and resolution of the following aspects of the attempted suicide:
   - Where did this attempt occur?
   - Had required monitoring for the patient been carried out prior to the event?
   - How had the patient fashioned the ligatures without staff detection?
   - Had the allegation been managed as a grievance and was grievance correspondence provided to Patient 7?
   Further the documentation unclearly categorized the severity level of this suicide attempt as "No Harm."
   * Documentation in the medical record of Patient 7 revealed an allegation of patient neglect that resulted in Patient 7 accessing and using an unsafe item to inflict injury on him/herself. During interview at the time of the review the DPCS confirmed that event took place on 12/05/2017 on Unit 5. A BHT progress note dated 12/05/2017 at 0513 reflected "Patient was found to be digging at
A 145 Continued From page 67

[his/her] wound with a plastic pen. Patient on Q15 min checks. All unsafe items were removed from patient room." There was no further documentation until an RN progress note dated 12/05/2017 at 0820 that reflected "Assumed care of pt at 1930 [on 12/04/2017]. At approx 2130, Pt was digging at [his/her] wound with a plastic pen. Staff performed room sweep and patient was cooperative with giving back items and refraining from further harm." There was no further documentation about this event until later that evening an LIP progress note dated 12/05/2017 at 1929 that reflected the following: "Self inflicted stab wound to RLQ 11/08 w exacto knife [approximately] 6 cm that [he/she] reopened 11/17 w pencil and contaminated with feces. Surgical exploration for concern of sepsis Emanuel 11/19...12/4 PM [he/she] was reportedly seen with pen probing [his/her] wound and told staff [he/she] put feces in the wound..." The documentation reviewed lacked investigation and resolution of the following aspects of the self-harm event:
- How the patient was able to harm him/herself on 12/04/2017 at 2130 when he/she was placed on suicide precautions on 12/04/2017 at 1904 secondary to suicide attempt, per the finding for Patient 7 above.
- How the patient acquired a pen known to be an unsafe item for this patient and was able to inflict self-harm without detection by staff when he/she had been placed on suicide precautions.
- What the other unsafe items found in his/her room were and how those were allowed to be in his/her possession when he/she had been placed on suicide precautions.

The DPCS confirmed on 05/22/2018 at 1035 that the event was not entered into a PSA or iCare as required by policy. The DPCS confirmed at that
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<th>PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
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<tr>
<td>380007</td>
<td>A. BUILDING _____________________________</td>
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<td>B. WING _____________________________</td>
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**DATE SURVEY COMPLETED**

| C | 05/22/2018 |

**NAME OF PROVIDER OR SUPPLIER**

LEGACY EMANUEL MEDICAL CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

2801 N GANTENBEIN AVENUE
PORTLAND, OR  97227

<table>
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<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>A 145</td>
<td>Continued From page 68 time there was no documentation of an investigation of this event. * Documentation of an allegation of patient neglect that resulted in the assault of Patient 18 by another patient was reviewed with the DPCS on 05/21/2018 at 1430. During interview at the time of the review the DPCS confirmed that the event took place on 01/29/2018 on Unit 2. An unidentified patient was found in Patient 18's room 201, within the &quot;safety suite&quot; immediately adjacent to the nurse's station, to be examining Patient 18's wound. Patient 18 had two wounds located under his/her breasts that were self-inflicted, tunneling wounds, and chronic in nature from continuous self-manipulation. The only follow-up documentation reflected that the reviewer found no documentation in Patient 18's medical record about the event, no interview with the patient, and no evidence that the event had been reported to the HS as the intrusive patient was examining the wound in Patient 18's breast area. There was no other documentation of an investigation and resolution of this event that included the following considerations: - How the unidentified patient came to be in Patient 18's room within the &quot;safety suite&quot; without detection by staff. - What was the extent of the &quot;examination&quot; by the unidentified patient? - Who was the unidentified patient and did his/her behaviors require monitoring that had not been carried out? - Had the allegation been managed as a grievance and was grievance correspondence provided to Patient 18. Further the documentation categorized this assault as a &quot;breach of privacy&quot; versus more accurately as assault.</td>
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A 145 Continued From page 69

* Documentation of an allegation of patient neglect that resulted in the Patient 18 accessing and using unsafe items to inflict injury on him/herself was reviewed with the DPS on 05/21/2018 at 1500. During interview at the time of the review the DPCS confirmed that the event took place on 03/28/2018 on Unit 2. Patient 18 had two wounds located under his/her breasts that were self-inflicted, tunneling wounds, and chronic in nature from continuous self-manipulation. The patient had extensive history of placing items inside the tunneling wounds to inflict self-harm. On this date Patient 18 punctured his/her skin to insert a "golf pencil" near one of the existing wounds and only the end of the pencil could be visualized. The patient was subsequently transferred to another hospital for surgical intervention. The only follow-up documentation was that all processes were followed and the investigation was closed. There was no other documentation of an investigation and resolution of this event that included the following considerations:
- How did Patient 18 have possession of the golf pencil when it was identified as an unsafe item in policy, and when Patient 18 was known to use such items for self-harm.
- Had the allegation been managed as a grievance and was grievance correspondence provided to Patient 18.

Further the documentation categorized this as a "skin/tissue event" versus more accurately as self-harm or self-inflicted injury.

* Documentation of an allegation of patient neglect that resulted in Patient 26’s unauthorized departure or elopement from the facility was reviewed. The documentation reflected that the
patient exited Unit 6 on 03/28/2018 through multiple secure doors with an office machine vendor. Although the documentation reflected follow-up actions related to vendor secure door access, the investigation did not clearly address the failure of staff to supervise and observe patients on the unit that created the opportunity for the patient to walk off the unit, and through multiple other secure doors, undetected by staff. The only documentation of follow-up related to staff supervision was a note that staff needed to be more aware of their surroundings. Further the documentation unclearly categorized the severity level of this successful elopement as "No Harm."

* Documentation of an allegation of patient neglect that resulted in Patient 31 fashioning a weapon that had the potential to be used to inflict injury on him/herself or on others was reviewed with the DPCS on 05/21/2018 at 1400. During interview at the time of the review the DPCS confirmed that the event took place on 05/7/2018 on Unit 2. Patient 31 was observed in his/her patient room 201, in the "safety suite" immediately adjacent to the nurse's station, wielding a weapon made from a rigid black plastic spoon that he/she had broken in half lengthwise. This situation was first identified by SSOs who were reviewing Patient 31's room from a remote area off of the unit secondary to Patient 31's history of behaviors that included an event on 05/02/2018 during which Patient 31 broke a utensil dispenser off of the wall in the patient kitchen area and barricaded him/herself in the day room. SSO staff notified Unit 2 by telephone of their observations on 05/07/2018. SSOs and unit staff responded and were able to retrieve the weapon from Patient 31 without further incident.
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<td>There was no documentation of an investigation and resolution of this event that included the following considerations:</td>
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<td>- How Patient 31 had possession of the plastic utensil, had fashioned a weapon from it, and concealed it in his/her room within the &quot;safety suite&quot; without detection of staff on the unit.</td>
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<tr>
<th>A 168</th>
<th>PATIENT RIGHTS: RESTRAINT OR SECLUSION</th>
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<tr>
<td>CFR(s): 482.13(e)(5)</td>
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<td>The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.</td>
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| This STANDARD is not met as evidenced by: |
| Based on interview, documentation reviewed in the medical records of 2 of 4 patients (Patient 9 and 19) who were physically restrained for violent or self destructive behaviors, and review of policies and procedures, it was determined the hospital failed to ensure the use of physical restraints were in accordance with physician or other LIP orders as required by hospital policies and procedures as follows: |
| * Physical restraints (physical/manual holds) of patients were used without a physician or other LIP order; and |
| * Physician orders for physical restraints of patients did not include the type of restraint device or method used in accordance with hospital policy. |

Findings include:
A 168 Continued From page 72

1. The policy and procedure titled “Restraint and Seclusion for Patient Safety” dated as revised “Sept 2017” stipulated the following: The “Definitions” section reflected “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...” The “Procedure” section reflected “…Initiation: Each episode of restraint or seclusion (regardless of restraint category) shall be initiated...Upon the order of the (sic) provider 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 licensed independent practitioner responsible for the care of the patient...Provider Order: an order for restraint will include...Indication for use of restraint or seclusion...Type of restraint device or method to be utilized...Length of time order is applicable“.

2. The medical record of Patient 9 was reviewed and reflected the patient was admitted on 12/19/2017 at 1259. The “Reason for Admission” was "intentional overdose."  
* An RN note dated 12/26/2017 at 2000 reflected “1900...Staff in [nurse] station monitoring camera saw pt had an item in hand. This staff & security entered room, pt initially resisted, but handed this staff 2 screws removed from [his/her] bedframe...Pt declined to contract for safety, banged hard on wall & window, was yelling/crying. Pt declined walk with this staff & security to QR for seclusion. Security instructed to take parts & pt resisted. Pt was held by 4 security as this staff retrieved restraint chair. When restraint chair was in room pt agreed to walk with hands on escort to...
A 168 Continued From page 73

QR...Seclusion initiated at 1915...

* The RN note dated 12/26/17 at 2048 reflected "Assumed care of pt at 1930...Pt continued to escalate in seclusion room by banging head on D-rings on floor...Pt required 5-point restraints (chest band utilized) for safety, which were placed at 1945...LIMS arrived on site to assess pt..."

* A telephone order for "Restraints Violent Self Destructive Adult..." dated 12/26/2017 at 2022 and electronically signed by the physician on 12/27/2017 at 0837 reflected "Frequency: Continuous X 4 Hours 12/26/2017 2022 - 4 Hours...Order comments: Seclusion at 1915 Restraint at 1945 Restraint type: Restraint and Seclusion Reason for restraints: threatening/inflicting harm to self and threatening/inflicting harm to others". The orders were incomplete as they did not reflect the type of restraint. There was no documentation to reflect the RN communicated the lack of information in the orders to the physician. Further, there was no physician or other LIP order for the physical restraint (physical hold) by 4 security staff.

3. The medical record of Patient 19 was reviewed and reflected the patient was admitted on 04/25/2018 at 0246 for diagnoses of "Obsessive compulsive disorder, severe and refractory; Major depressive disorder, recurrent; Borderline personality organization."

* The Therapist notes dated 05/10/18 at 2046 reflected: "...approx 20:25...Pt...suddenly began punching [his/her] right eye...staff summoned help...Two staff engaged in manual restraint and, as Pt was unable to control [his/her] impulse to self-harm, a third staff applied waist restraints at approx 20:30...Pt remained calm...Approx 22:00, staff opted to remove restraints..." The patient was discharged on 05/21/2018 at 0945.
The record contained no physician order for the "manual" (physical) restraint by 2 staff or the "waist restraints."

4. Findings 1 and 2 were confirmed with the NA and ANM on 05/21/2018 at 1300 during review of the medical records for Patients 9 and 19. With regard to the physician order for restraint, in finding 1, the ANM stated the orders did not include the specific type of restraint that was ordered. The ANM stated "I can't discern what type of restraint it was from the order."

**PATIENT RIGHTS: RESTRAINT OR SECLUSION**

CFR(s): 482.13(e)(10)

The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy.

This STANDARD is not met as evidenced by:

Based on interview, documentation reviewed in the medical record of 4 of 4 patients (Patient 1, 9, 19, and 31) who were physically restrained and/or placed in seclusion by hospital staff, and review of policies and procedures, it was determined the hospital failed to ensure ongoing assessment and monitoring of patients who were in physical restraints and/or seclusion in accordance with hospital policies and procedures as follows:

* Patients with violent or self-destructive behaviors were not assessed and monitored when restraints and seclusion were used in accordance with hospital policies and procedures.
A. BUILDING _____________________________
B. WING _____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
380007

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED
C
05/22/2018

NAME OF PROVIDER OR SUPPLIER

LEGACY EMANUEL MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
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

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Findings include:

1. The policy and procedure titled "Restraint and Seclusion for Patient Safety" dated last revised "Sept 2017" was reviewed. It stipulated:
   * "F. Implementation...7. Explain to the patient and/or family...purpose of restraint or seclusion, including discontinuation criteria...rationale for type of restraint selection...expected duration of use of restraint or seclusion...frequency of staff monitoring...purpose of ongoing attempts to orient patient to safety issues...Legacy Health Philosophy Regarding Use of Restraint and Seclusion (Attachment #1)."
   * "G. Restraint and Seclusion Assessment and Monitoring: 1. Non-Behavioral or Non-Violent Behavior: The RN will assess the patient every 2 hours to address patient specific needs which may include... The behavior exhibited by the patient indicating the need for restraint or seclusion...Status of restraint (device type and # of points)...Signs of any injury associated with applying restraint or seclusion...Nutrition and hydration needs...Circulation and range of motion in extremities...Elimination needs...Vitals signs...Physical and psychological status and comfort; and...Readiness for discontinuing restraint use.
   * "2. Violent or Self-Destructive Behavior...All violent or self-destructive restraint shall be assessed Q2 hours as set forth in 1 above....Additionally, all VSD patients shall be monitored every 15 minutes to evaluate...Safety, psychological & emotional status, comfort, and signs of injury from restraint and/or seclusion."
   * "3. Simultaneous Restraint and Seclusion: Patients who are simultaneously restrained and secluded shall be continuously monitored through...Face-to-face observation by clinical staff..."
A 175 Continued From page 76

members; or...Remote observation by clinical staff members located near the patient who are viewing a simultaneous video image and audio signal of the patient..."

* "1. Documentation will be completed in the medical record and include the following...time restraints initiated and baseline assessment of observed behavior(s) necessitating restraint...length of order (i.e. 12 hrs.)...considerations or use of alternatives attempted...clinical justification for restraints...patient and/or family communication provided (as described in F.7. above)...Family notification (where applicable)...restraint device applied...restraint use assessment, monitoring and interventions (as outlined in G.1. and G.2. above)...additional documentation as patient condition warrants."

* The "Definitions" section reflected "...Restraint Event...The time from application to discontinuation of restraints."

2. The policy and procedure titled "Use of Restraint and Seclusion" dated last revised "Jan 2018" was reviewed. It stipulated:

* "1. If patient requires restraint and/or seclusion...

* "b. Perform an assessment of focused biopsychosocial condition of patient, skin integrity, circulation, respiratory function, and ROM, physical and psychological status and comfort, and document findings."

* "c. Observe the criteria in (b) above and also:  patient response, any signs of injury associated with restraint/seclusion use and need for continued restraint/seclusion, type of restraint, and maintenance of dignity and privacy, readiness for discontinuation of restraint or seclusion, as follows...Immediately after..."
A 175 Continued From page 77

Implementation of any restraint or seclusion...Violent or Self Destructive (VSD) Behaviors: Patients in restraint or seclusion or VSD for behaviors will be monitored every 15 minutes to evaluate safety, psychological & emotional status, comfort and signs of injury from restraint and/or seclusion; in addition to the Q 2 hour monitoring required for all restraint or seclusion events..."

* "d. Check patient approximately every 2 hours and PRN; offer assistance with ADLs and toileting/elimination approximately every 2 hours."
* "e. Evaluate and provide for nutrition/hydration, hygiene, body alignment, emotional support/reassurance, comfort prior to implementation and approximately Q 2 hrs."
* "f. Release restraint approximately Q 2 hours to assess patient and provide ROM and ADLs as appropriate and re-restrain only when necessary."
* "g. Modify the Interdisciplinary Plan of Care with identified risks and interventions as appropriate..."
* "k. Document the following for all episodes of restraint or seclusion in the appropriate nursing documentation flow sheet in the electronic health record (EHR)...type of restraint device(s) each shift, and with any changes to number of type of device(s)...alternative interventions attempted...time of initiation and discontinuance of restraint/seclusion, as indicated..."
* "l. Document the following findings approximately every 2 hours and with changes...Specific observed behaviors necessitating restraint and or seclusion...Recognition of signs of readiness for restraint discontinuation...Assessment data and interventions provided..."
A 175 Continued From page 78
03/05/2017 at 1437 with a diagnosis of psychosis. The record reflected the following:
* The flowsheet notes dated 03/08/2017 at 1545 reflected seclusion was initiated. The record reflected the patient was aggressive, threatening harm, and impulsive.
* An RN assessment for seclusion on the "Restraint/Seclusion Monitoring Q 2 Hours" flowsheet dated 03/08/2017 at 1750 reflected the patient continued in seclusion. There was no assessment or monitoring of the patient's physical status and no vital signs, and the only information recorded about the patient's comfort was an entry on a Q 15 Minutes monitoring flowsheet that read "Physical Comfort...Self Ambulatory". The next RN "Restraint/Seclusion Monitoring Q 2 Hours" assessment was at 2030, 2 hours and 40 minutes later. It reflected the patient continued in seclusion. There was no assessment or monitoring of the patient's physical status and no vital signs, and the only information recorded about the patient's comfort was an entry on a Q15 Minutes monitoring flowsheet that read "Physical Comfort...Self Ambulatory".
* RN notes filed 03/09/2017 at 0721 reflected "Seclusion ended [03/09/2017] 0525."
* The patient was discharged on 05/04/2017.

4. The medical record of Patient 31 was reviewed and reflected the patient was admitted on 4/19/2018 at 1706 with a diagnosis of "psych problem". The record reflected the following:
* The flowsheet notes dated 04/19/2018 at 1800 reflected the patient was aggressive, threatening harm, impulsive, and had poor safety judgment; and seclusion was initiated at 1800.
* The initial RN assessment for seclusion on the
## A 175

**Summary Statement of Deficiencies**

- **Restraint/Seclusion Monitoring Q 2 Hours**
  - Flowsheet dated 04/19/2018 at 1800 reflected no assessment or monitoring of the patient's physical status.
  - Next RN assessment for seclusion on the flowsheet dated 04/19/2018 at 2000 reflected no assessment or monitoring of the patient's physical status and no vital signs.
  - With regard to monitoring of the patient's vitals, the record reflected vital signs were collected on 04/19/2018 at 1705. The next vital signs were not recorded until 04/20/2018 at 0846, more than 14 hours after seclusion was initiated.
  - The flowsheet notes dated 04/19/2018 at 2008 reflected seclusion was discontinued.
  - The RN notes dated 04/21/2018 at 0311 reflected "...[04/20/2018] at 2045...Pt up to nurse's station and stated to staff, 'I'm gonna leave or someone is gonna die tonight'...Pt then observed by staff waving a knife inside of seclusion room. Pt threatened to harm self with knife...Knife retrieved by staff. Seclusion ended 2245, after pt able to maintain safety..."
  - The initial RN assessment for seclusion dated 04/20/2018 at 2104 on the "Restraint/Seclusion Monitoring Q 2 Hours" flowsheet reflected no assessment or monitoring of the patient's physical status, nutrition needs, elimination needs, or vital signs upon initiation of seclusion nor at any time during the seclusion event.
  - With regard to vitals signs, the record reflected vital signs were collected on 04/20/2018 at 0846. The next set of vital signs were not recorded until 04/21/2018 at 1040, more than 13 hours after seclusion was initiated.
  - The patient was discharged on 05/17/2018.

**Provider's Plan of Correction**

- Cross-referenced to the appropriate deficiency.
### Statement of Deficiencies and Plan of Correction

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<th>Summary Statement of Deficiencies</th>
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<th>Tag</th>
<th>Provider's Plan of Correction</th>
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<td>A 175</td>
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#### 5. The medical record of Patient 19 was reviewed and reflected the patient was admitted on 4/25/2018 at 0246 with diagnoses including "Obsessive compulsive disorder...Major depressive disorder, recurrent; Borderline personality organization."

* The RN notes dated 05/10/2018 at 1058 and "Filed" on 05/11/2018 at 1011 reflected "Patient...continues to be on 1:1 safety observation for self harm. Patient was placed in wrist restraints (sic) from 1050-1125 after [he/she] was unable to stop pressing on [his/her] wound..."

There was no documentation reflecting an initial RN assessment of the restraints and no documentation of Q15 minute patient monitoring during the restraint event in accordance with hospital policy.

* The "Violent and Self-Destructive Restraint" flowsheet documentation dated reflected right and left soft wrist restraints and "Lap/Waist" restraints were initiated 05/11/2018 at 1445 and discontinued on 05/11/2018 at 1630. There was no RN initial assessment including no assessment of the patient's physical status, circulation, skin condition, range of motion, nutrition and hydration needs, elimination needs and vital signs.

* With regard to vital signs, the record reflected vital signs were collected on 05/11/2018 at 1002, prior to restraint initiation at 1445. The next set of vital signs were recorded on 05/12/2018 at 0924, almost 24 hours later.

* The patient was discharged on 05/21/2018 at 0820.

#### 6. The medical record of Patient 9 was reviewed and reflected the patient was admitted on 12/19/2017 at 1259. The "Reason for Admission"
Continued From page 81
was "intentional overdose."
* RN notes on 12/26/2017 at 2000 reflected
"1900: Pt standing on sink in room, poured water
on floor throughout room. Staff & 4 security
entered room...instructed...to get off sink. Pt
decided to contract for safety, banged hard on
wall & window, was yelling/crying...Seclusion
initiated at 1915. [At] 1945: Pt ambulatory in
locked QR. Staff observed large quantity of blood
on pt & floor. Staff entered room & pt appeared to
have self-inflicted wound to forehead from D-ring
in QR."
* RN notes on 12/26/2017 at 2048 reflected "...pt
was noted to have been placed in seclusion...Pt
continued to escalate in seclusion room by
banging head on D-rings on floor, bleeding
laceration to forehead noted. Pt required 5-point
restraints (chest band utilized) for safety, which
were placed at 1945...LIMS arrived on site to
assess pt...and recommended for transfer to
LEMC for suturing...AMR arrived at 2030 to
transfer pt."
* There was no documentation reflecting an initial
RN assessment of the seclusion event beginning
on 12/26/2017 at 1915.
* There was no documentation reflecting an initial
RN assessment of the restraint event that
consisted of simultaneous 5-point restraints and
seclusion beginning on 12/26/2017 at 1945,
including no assessment and monitoring of
circulation, range of motion, repositioning,
nutrition and hydration needs, elimination needs,
and readiness for discontinuation.

7. An interview was conducted with the DPCS on
05/16/2018 at 1700 during review of the medical
record of Patient 1. The DPCS confirmed the
record lacked documentation reflecting the RN
assessed and monitored the patient as identified
### A 175

Continued From page 82 in finding 3 above.

8. An interview was conducted with the DPCS and ANM on 05/17/2018 at 1200 during review of the medical record of Patient 31. The DPCS confirmed the record lacked documentation reflecting the RN assessed and monitored the patient as identified in finding 4 above.

9. An interview was conducted with the ANM and NA on 05/21/2018 at 1300 during review of the medical records for Patients 9 and 19. The ANM and NA confirmed the records lacked documentation reflecting the patients were assessed and monitored as identified in findings 5 and 6 above.

### A 196

**PATIENT RIGHTS: RESTRAINT OR SECLUSION**

CFR(s): 482.13(f)(1)

Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion-

- (i) Before performing any of the actions specified in this paragraph;
- (ii) As part of orientation; and
- (iii) Subsequently on a periodic basis consistent with hospital policy.

This STANDARD is not met as evidenced by:

Based on interview, review of restraint training documentation for 12 of 20 hospital staff (Employees 1, 2, 3, 4, 5, 6, 7, 8, 10, 12, 13 and 19), review of policies and procedures, and review of other documentation it was determined that the hospital failed to ensure staff were...
LEGACY EMANUEL MEDICAL CENTER

<table>
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<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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</table>
| ID TAG             | A 196 Continued From page 83 trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care of patients in restraint in accordance with hospital policies and procedures and as part of orientation:  
* Staff were not trained in the use of restraints and seclusion during orientation; and  
* Staff were not trained annually in the use of restraints and seclusion in accordance with hospital policy.  

Findings include:

1. Refer to the deficiency cited at Tag A202, CFR 482.13(f) Patient Rights: Restraint or Seclusion. That deficiency reflects the hospital's failure to ensure staff were trained in the use of restraints and seclusion during orientation and annually in accordance with hospital policies and procedures.

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<th>ID PREFIX TAG</th>
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</table>
| ID TAG        | A 202 PATIENT RIGHTS: RESTRAINT OR SECLUSION  
CFR(s): 482.13(f)(2)(iv)  
[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:]  
(iv) The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia).  

This STANDARD is not met as evidenced by:  
Based on interview, review of training documentation for 12 of 20 hospital staff
Continued From page 84

(Employees 1, 2, 3, 4, 5, 6, 7, 8, 10, 12, 13 and 19), review of policies and procedures, and review of other documentation it was determined that the hospital failed to fully develop and implement its restraint and seclusion policies and procedures to ensure staff were trained and demonstrated knowledge in the use of restraints and seclusion in the following areas:
* Staff were not trained or were not trained timely in the use of restraints and seclusion; and
* Staff were not trained in the safe application and use of all types of restraints used in the hospital.

Findings include:

1. The policy and procedure titled “Restraint and Seclusion for Patient Safety" dated last revised "Sept 2017" was reviewed. It stipulated: "Patients have the right to safe implementation of restraint or seclusion by trained staff. Hospital and medical staff shall receive focused education as appropriate to perform assigned duties under this policy. Such education shall take place upon hire, prior to the new staff member being asked to implement the provisions of this policy and shall be repeated annually...Staff Education (sic) (may vary by department and clinical position)...Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion...The use of nonphysical intervention skills...Choosing the least restrictive intervention based on an individualized assessment of the patient's medical or behavioral status or condition...The safe application and use of all types of restraint or seclusion used in the hospital, including education in how to recognize and respond to signs of physical and psychological distress (for example, positional
### A 202 Continued From page 85

asphyxia)...Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary...Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including, but not limited to: respiratory and circulatory status, skin integrity, and vital signs; and...The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including periodic re-certification."

The policy was not clear related to ensuring staff training included demonstrated knowledge (competency), including frequency of competencies. The policy did not include a process for ensuring staff would be trained and demonstrate knowledge (competency) of all restraint types used in the hospital.

2. The policy and procedure titled "Employee Mandatory Education" dated last revised "8/17" was reviewed. The "Purpose" section reflected "To define mandatory education; to describe employees responsibility to meet mandatory education requirements; and to identify leadership's responsibility to provide opportunities to meet mandatory education requirements in order to ensure competence, compliance, employee and patient safety." It further reflected "...Whenever staff receives mandatory education at the department level using an established curriculum, a copy of that specific curriculum will be retained by the manager for seven years and, if required by policy, forwarded to the designated departments..." Attachment #1 to the policy reflected the "Required Frequency" for "Use of restraints" education was "Upon hire and annually" for "Clinical staff with direct patient care."
3. Annual SLM training titled "Restraint and Seclusion for Patient Safety" dated "March 2012/January 2013 (Original January 2004, Updated January 2008)" was reviewed. The "Restraint Type" section contained an example of EHR drop down menu with a list of restraint types that included "Mitt Secured R...Mitt Secured L...Soft Restraint R Wrist...Soft Restraint L Wrist...Soft Restraint R Ankle...Soft Restraint L Ankle...Roll Best...Vest/Jacket...Chest...Wheelchair Belt Loop...Other(Comment)." Another section in the module reflected "This section includes instructions for specific types of restraint...Note: the following types are listed as examples. You will need to be familiar with all devices used in your department. Refer to manufacturer instructions as needed." This was followed by information related to seclusion and 3 types of restraints, "waist or vest restraint", "limb restraint," "Posey Double Padded, Double Security Mitts".

4. Review of restraint competency checklists that were used reflected they were inconsistent and it was unclear if they were intended to address all types of restraints and seclusion used at the hospital. Examples include:

* A "Restraint Training Checklist C.N.A./CHT/Technician" form dated "CPS 04.10.2017" was reviewed. The checklist included information about the following restraint types: "limb holder", "crisscross vest", "soft belt", "padded mitts", and "violent restraint devices (neoprene, locking, leather)."

* A "Restraint Training Checklist RN" form dated "CPS 04.11.2017" was reviewed. The checklist included information about the following restraint...
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING _____________________________
B. WING _____________________________

(OMB No. 0938-0391)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

LEGACY EMANUEL MEDICAL CENTER

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<td>A 202</td>
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5. Review of employee training documentation reflected the following:

* Employee 1 (SSO) with hire date 08/21/2000 reflected no evidence of annual restraint education or demonstrated restraint competency.
* Employee 2 (SSO) with hire date 02/20/2017 reflected no evidence of restraint education or demonstrated restraint competency, including on hire or annually.
* Employee 3 (SSO) with hire date 05/08/2017 reflected no evidence of demonstrated restraint competency, including on hire or annually.
* Employee 4 (SSO) with hire date 07/17/2017 reflected no evidence of demonstrated restraint competency, including on hire.
* Employee 5 (SSO) with hire date 09/05/2017 reflected no evidence of demonstrated restraint competency, including on hire.
* Employee 10 (BHT I) with hire date 07/09/2012 reflected restraint competency was not completed until 04/30/2018.
* Employee 12 (BHT I) with hire date 11/06/2017 reflected restraint competency was not completed until 04/18/2018, 6 months after he/she was hired. There was no documentation reflecting restraint competency completed on hire.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 380007

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED 05/22/2018

NAME OF PROVIDER OR SUPPLIER

LEGACY EMANUEL MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
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)

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<td>A 202</td>
<td>Continued From page 88</td>
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<td>* Employee 19 (RN) with hire date 11/27/2017 reflected no evidence of demonstrated restraint competency, including on hire.</td>
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<td>Similar findings were identified related to lack of demonstrated restraint competency on hire and/or annually for Employee 6 (SSO) with hire date 10/16/2017; Employee 7 (SSO) with hire date 01/16/2017; Employee 8 (SSO) with hire date 01/08/2018; and Employee 13 (RN) with hire date 05/05/1988.</td>
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<td>6. Training documentation for Employees 1-7 was reviewed on 05/16/2018 at 0925 with the SM. During the review, the SM confirmed the lack of restraint training and demonstrated restraint competency for Employees 1-7.</td>
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<td>7. Training documentation for Employee 8 was reviewed on 04/27/2018 at 1120 with the DSS and the SS. The SS confirmed SSO staff participate in application of restraints. The SSO stated all SSO staff were required to complete online restraint training and restraints competency on hire and annually. The SS confirmed Employee 8's training documentation lacked evidence of demonstrated restraint competency on hire.</td>
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<td>8. During interview on 04/27/2018 at 1035 the NM stated BHTs participate in restraint application.</td>
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<td>9. During interview with DPCS on 04/30/2018 at 1155, he/she stated restraint competencies should be completed within 90 days of hire. He/she confirmed Employee 10's training documentation lacked evidence of timely restraint competency on hire.</td>
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<tr>
<td>10. Training documentation for Employee 13 was reviewed on 04/27/2018 at 1000; and for Employee 12 on 05/16/2018 at 1130 with the NM. He/she confirmed training documentation for Employees 12 and 13 lacked evidence of restraint competency completed.</td>
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<td>11. Training documentation for Employee 19 was reviewed on 05/16/2018 at 1040 with the ANM. He/she confirmed training documentation for Employee 19 lacked evidence of restraint competency completed.</td>
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<td>12. During interview with the DPCS on 05/16/2018 at 1530 he/she stated the hospital did not have documentation that identified all types of restraints used at the hospital. He/she provided a document that reflected the following: &quot;5/16/18, OHA Survey...There is not a Legacy list that outlines specific restraints that can or can't be used clinically. The requirement is that the restraints must be FDA approved. Restraints used at Unity are usually locking neoprene limb restraints, but other types may be used. Per the Restraint and Seclusion SLM, &quot;You (staff) will need to be familiar with all devices used in your department. Refer to manufacturer instructions as needed.&quot; Due to the lack of information related to the types of restraints used at the facility, there was no assurance staff were provided appropriate training in all types of restraint or seclusion used. PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(f)(2)(vii)</td>
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[The hospital must require appropriate staff to]
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<td>A 206</td>
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have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:

(vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

This STANDARD is not met as evidenced by:

Based on interview, review of documentation in 20 of 20 personnel files reviewed for restraint and seclusion training (Employees 1-20), and review of policies and procedures, it was determined that the hospital failed to implement its restraint and seclusion policies and procedures to ensure staff were trained and demonstrated knowledge in the use of first aid techniques and CPR.

Findings include:

1. The policy and procedure titled "Restraint and Seclusion for Patient Safety" dated last revised "Sept 2017" was reviewed. It stipulated:
   "Education and Training...education shall take place upon hire, prior to the new staff member being asked to implement the provisions of this policy and shall be repeated annually...Staff EducationContent (sic)...The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic re-certification."

2. The policy and procedure titled "Employee Mandatory Education" dated last revised "8/17" was reviewed. Attachment #1 to the policy reflected the "Required Frequency" for BLS was "Verification upon hire and bi-annually" for "Personnel with direct patient contact in patient..."
Continued From page 91

care and diagnostic areas."

3. Review of employee training documentation for first aid techniques training related to patients who were restrained or secluded, including appropriate first aid required if a restrained or secluded patient was in distress or injured, reflected no evidence of the training for the following employees:

Employee 1 (SSO) with hire date 08/21/2000.
Employee 2 (SSO) with hire date 02/20/2017.
Employee 3 (SSO) with hire date 05/08/2017.
Employee 4 (SSO) with hire date 07/17/2017.
Employee 5 (SSO) with hire date 09/05/2017.
Employee 6 (SSO) with hire date 10/16/2017.
Employee 7 (SSO) with hire date 01/16/2017.
Employee 8 (SSO) with hire date 01/08/2018.
Employee 9 (BHT) with hire date 01/02/2017.
Employee 10 (BHT I) with hire date 07/09/2012.
Employee 11 (BHT) with hire date 01/31/2017.
Employee 12 (BHT) with hire date 11/06/2017.
Employee 13 (RN) with hire date 05/05/1988.
Employee 14 (RN) with hire date 10/24/2011.
Employee 15 (RN) with hire date 01/31/2017.
Employee 16 (RN) with hire date 01/31/2017.
Employee 17 (RN) with hire date 07/10/2017.
Employee 18 (RN) with hire date 11/13/2017.
Employee 19 (RN) with hire date 11/27/2017.
Employee 20 (RN) with hire date 01/08/2018.

4. An interview was conducted with ANM on 05/16/2018 at 1115. With regard to first aid training related to restrained or secluded patients, he/she stated "That's not something we have training specifically for."

5. Review of employee training documentation for CPR certification reflected the following:

* Employee 4 (SSO) reflected no evidence of
A 206 Continued From page 92

CPR certification.

* Employee 7 (SSO) reflected BLS certification with date expired "12/2017." There was no evidence of current BLS certification.

6. An interview was conducted with the SM on 05/16/2018 at approximately 0925. He/she confirmed the lack of current CPR certification for Employees 4 and 7.

A 263 QAPI CFR(s): 482.21

The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.

The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.

The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

This CONDITION is not met as evidenced by:
Based on observations, interviews, review of medical record and other documentation for 4 of 4 patients who experienced restraint or seclusion (Patients 1, 9, 19, and 31), review of event and medical record documentation for 23 of 23 patients who experienced actual or alleged abuse or neglect (Patients 2, 3, 4, 5, 6, 7, 9, 10, 11, 12,
| A263 | Continued From page 93  
13, 14, 15, 16, 18, 19, 20, 22, 23, 24, 26, 31, and 32), review of medical record documentation for 3 of 3 patients reviewed for conformance with physician orders, review of grievance documentation for 7 of 12 patients selected from the grievance log, (Patients 33, 34, 35, 37, 38, 42, and 43), review of training documentation for 22 of 22 staff (Staff 1 - 22), review of policies and procedures, and review of 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 and appropriate care to patients in the hospital that complied with the Conditions of Participation.  
This Condition-level deficiency represents a limited capacity on the part of the hospital to provide safe and adequate care.  
Findings include:  
1. Refer to the findings cited under Tag A043, CFR 482.12 - CoP Governing Body.  
2. Refer to the findings cited under Tag A115, CFR 482.13 - CoP Patient's Rights.  
3. Refer to the findings cited under Tag A385, CFR 482.23 - CoP Nursing Services.  
4. Refer to the findings cited under Tag A700, CFR 482.41 - CoP Physical Environment NURSING SERVICES CFR(s): 482.23  
The hospital must have an organized nursing service that provides 24-hour nursing services. | A263 | A385 |
### SUMMARY STATEMENT OF DEFICIENCIES

#### EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION

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<tr>
<td>A 385</td>
<td>Continued From page 94</td>
<td>The nursing services must be furnished or supervised by a registered nurse.</td>
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<td>This CONDITION is not met as evidenced by: Based on observations, interviews, review of medical record and other documentation for 4 of 4 patients who experienced restraint or seclusion (Patients 1, 9, 19, and 31), review of event and medical record documentation for 23 of 23 patients who experienced actual or alleged abuse or neglect (Patients 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 22, 23, 24, 26, 31, and 32), review of medical record documentation for 3 of 3 patients reviewed for conformance with physician orders, review of training documentation for 8 of 8 RNs (Staff 13, 14, 15, 16, 17, 18, 19, and 20), and review of policies and procedures, it was determined that the hospital failed to fully develop and implement policies and procedures that ensured that nursing services were provided in a safe and appropriate manner as follows: * Patients were not provided care in a safe environment. * Patients were not supervised when in high risk areas or during high-risk activities. * Response to urgent and emergent medical conditions was inconsistent. * Patient conditions, changes in patient condition, and patients in restraints or seclusion were not assessed. * Drugs, restraints and other interventions were not administered in accordance with physician orders.</td>
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<td>This Condition-level deficiency represents a limited capacity on the part of the hospital to provide safe and adequate care.</td>
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A 385 Continued From page 95

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 ensure that patient's conditions were assessed, that patients were monitored, and that physician's orders were implemented.

2. Refer to the findings cited under Tag A405, CFR 482.23(c) - Standard: Preparation and Administration of Drugs. Those findings reflect the hospital's failure to ensure that drugs were administered in accordance with physician's orders.

A 395 RN SUPERVISION OF NURSING CARE
CFR(s): 482.23(b)(3)

A registered nurse must supervise and evaluate the nursing care for each patient.

This STANDARD is not met as evidenced by:
Based on observations, interviews, review of medical record and other documentation for 4 of 4 patients who experienced restraint or seclusion (Patients 1, 9, 19, and 31), review of event and medical record documentation for 23 of 23 patients who experienced actual or alleged abuse or neglect (Patients 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 22, 23, 24, 26, 31, and 32), review of medical record documentation for 2 of 2 patients reviewed for conformance with physician orders, review of training documentation for 8 of 8 RNs (Staff 13, 14, 15, 16, 17, 18, 19, and 20), and review of policies and procedures, it was determined that the hospital failed to fully develop and implement policies and
### SUMMARY STATEMENT OF DEFICIENCIES

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<td>A395</td>
<td>Continued From page 96 procedures that ensured that the RN supervised and evaluated the care of patient to ensure the provision of safe and appropriate care:</td>
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<td>* Patient conditions, changes in patient condition, and patients in restraints or seclusion were not assessed.</td>
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<td>* Patients were not supervised when in high risk areas or during high-risk activities.</td>
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<td>* Response to urgent and emergent medical conditions was inconsistent.</td>
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<td>* Restraints and other interventions were not administered in accordance with physician orders.</td>
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<td>Findings include:</td>
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<td>1. Refer to the findings cited under Tag A115, CFR 482.13 - CoP: Patient's Rights. Those findings reflect the hospital's failure to ensure nursing staff provided appropriate supervision of patients in high risk areas or during high-risk activities; failure to ensure consistent response to urgent and emergent medical conditions; failure to ensure that patient's conditions, changes in patient's conditions and patients in restraints or seclusion were assessed; and failure to ensure restraint and seclusion was in accordance with physician orders.</td>
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<td>2. The policy and procedure titled &quot;Unity Adult Inpatient Psychiatric Services Standard of Care&quot; dated last reviewed &quot;Aug 2017&quot; was reviewed. It stipulated: &quot;Interventions: The RN coordinates the interdisciplinary plan of care and applies the nursing process...Complete initial biopsy nursing assessment within approximately four (4) hours of admission...Initiate/individualize plan of care within approximately eight (8) hours of admission, review plan every 24 hours, and modify plan as necessary. &quot;</td>
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| Event ID: O63T11 | Facility ID: 380007 | If continuation sheet Page 97 of 105 |
### Statement of Deficiencies and Plan of Correction

#### Legacy Emanuel Medical Center

- **Provider/Supplier/CLIA Identification Number:** 380007
- **Date Survey Completed:** 05/22/2018

#### Summary Statement of Deficiencies

<table>
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<tr>
<th>ID</th>
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**Continued From page 97**

Patient condition warrants...Reassess...response to treatment, and relevant major body systems, with a maximum duration of approximately (12) hours between observations as warranted by patient's condition, nursing judgment, and current or potential problems...Observe skin risk on admission and at any time the patient's nutritional status, activity, or mobility indicates and/or changes negatively due to change in condition or due to medical interventions..."

The policy and procedure reflected broad language related to "observing" skin risk but no information related to assessment and management of skin conditions, including but not limited to skin injuries related to violent or self-destructive behaviors. This was confirmed during interview on 05/21/2018 at 1550 with the ANM and NA. The ANM and NA stated there were no other policies and procedures related to assessment of patient skin conditions.

3. The medical record of Patient 9 was reviewed and reflected the patient was admitted on 12/19/2017 at 1259. The "Reason for Admission" was "intentional overdose."

* RN notes on 12/26/2017 at 2048 reflected "...pt was noted to have been placed in seclusion...Pt continued to escalate in seclusion room by banging head on D-rings on floor, bleeding laceration to forehead noted...LIMS arrived on site to assess pt...and recommended for transfer to LEMC for suturing..."

* The record reflected the patient was transferred to LGSC ED on 12/26/2017 at 2030 for treatment of the self-inflicted forehead laceration.

* The ED Physician "Discharge Instructions" dated 12/26/2017 at 2209 reflected the following: "Special Instructions...Sutures out in 7..."
## SUMMARY STATEMENT OF DEFICIENCIES

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<tr>
<td>A 395</td>
<td>Continued From page 98 days...Wash the wounds once a day with mild soap and water, then apply a small amount of topical antibacterial ointment (Neosporin), and then cover with a bandage...&quot; * The record reflected the patient was readmitted to UCBH on 12/26/2017 at 2357. * An LIP note dated 12/27/17 at 1400 reflected &quot;[Patient] Up on ward...Forehead sutures clean, dry, hematoma area almost completely resolved from initial incident last night...Sutures can be removed 1/2/2017.&quot; * An RN note dated 01/01/2018 at 0310 reflected &quot;...Around 0100 the patient became agitated, and began to kick the bathroom door. [He/she] was observed...pulling stitches on [his/her] forehead with a comb...[patient] began to bang [his/her] head against the bathroom door...the patient was agreeable to wearing the mitts, but as this writer left the room, the patient threw the mitts off and went back to head banging....The MD assessed the patient and ordered nursing to clean the wound and cover with steri-strips...&quot; * The patient was discharged on 01/03/2018 at 1523. There was no documentation reflecting the RN assessed the patient's forehead skin conditions between 12/27/2017 and 01/03/2018, a period of 8 days. There was no documentation reflecting the RN provided wound care as reflected in the ED &quot;Discharge Instructions&quot; 12/26/2017 and LIP note 12/27/2017; or that the RN provided wound care in accordance with physician orders reflected in the RN note 01/01/2018. There was additionally no care plan based on assessment of the patient's individualized wound care needs. An interview was conducted with the ANM and NA on 05/21/2018 at 1300 during review of the medical record of Patient 9. The ANM confirmed...</td>
<td>A 395</td>
<td>05/22/2018</td>
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</table>
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**X1** PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 380007

**X2** MULTIPLE CONSTRUCTION
- A. BUILDING _____________________________
- B. WING _____________________________

**X3** DATE SURVEY COMPLETED

| C | 05/22/2018 |

### NAME OF PROVIDER OR SUPPLIER

**LEGACY EMANUEL MEDICAL CENTER**

<table>
<thead>
<tr>
<th>X4</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>X5</th>
<th>COMPLETION DATE</th>
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<tr>
<td>A 395</td>
<td>Continued From page 99</td>
<td>the record lacked documentation reflecting the RN assessed, monitored and provided treatment to the patient's skin conditions. The ANM and NA stated that wounds should be assessed and documented once per shift. Regarding the patient's skin conditions, the ANM stated &quot;There's no care plan for that.&quot;</td>
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<td>4. Documentation in the medical record of Patient 30 reflected he/she had been admitted to Unit 1W on 04/03/2018 and was found expired in his/her room on 05/07/2018 at approximately 0730. The medical record contained LIP orders for PT and OT evaluations dated 04/13/2018 at 1447. However, those orders were not carried out timely as the PT evaluation was not conducted until 04/23/2018 at 0936 and the OT evaluation was not conducted until 04/23/2018 at 1015, ten days after the orders were written. The medical record also included RN and BHT progress notes dated 05/01/2018 at 0912, 05/01/2018 at 1314, 05/01/2018 at 1359, 05/02/2018 at 1447, 05/02/2018 at 1855 and 05/03/2018 at 1830 that reflected the patient was experiencing difficulty swallowing fluids. A nutrition consult note by the RD dated 05/02/2018 at 1431 reflected that a SLP consult was needed. An order for a &quot;SLP Clinical Swallow Evaluation&quot; was written on 05/02/2018 at 1436. However, there was no documentation to reflect that the order was implemented and there was no evidence in the medical record of the provision of SLP services.</td>
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<tr>
<td>A 405</td>
<td>ADMINISTRATION OF DRUGS</td>
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<td>CFR(s): 482.23(c)(1), (c)(1)(i) &amp; (c)(2)</td>
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<td>(1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or...</td>
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<td>ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
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<tr>
<td>A 405</td>
<td>Continued From page 100 practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice.</td>
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<td>(i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations.</td>
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<td>(2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on interview, review of medical record or other event documentation for 2 of 2 patients reviewed for medication administration (Patients 12 and 18), it was determined that the hospital failed to ensure that drugs were administered in accordance with physician's orders and facility policies.</td>
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Findings include:

1. The policy and procedure titled “Medications: Administration” dated as originated “Mar 1997” and last revised “Apr 2018” reflected it's purpose included “To describe a safe process for medication administration.” The policy stipulated: “Medications are administered in accordance with the orders of a prescriber who is responsible for the patient's care and in accordance with law, regulation and hospital standards...Key Point:|
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**LEGACY EMANUEL MEDICAL CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

2801 N GANTENBEIN AVENUE
PORTLAND, OR 97227

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
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**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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Continued From page 101

Patients with psychiatric history, or those with history of medication non-adherence will be closely observed for behaviors such as cheeking, palming, or regurgitation of medications.

2. Documentation in the medical record of Patient 18 reflected a physician’s order dated 03/04/2018 for diazepam (Valium) tablet 2 mg. three times daily prn "do not give after 1800." Documentation on the MAR reflected the drug was given prn 100 times and the order was not carried out as written on the following occasions:

- 03/15/2018 2 mg given at 1824
- 03/19/2018 2 mg given at 1803
- 03/21/2018 2 mg given at 1805
- 03/23/2018 2 mg given at 1805
- 03/26/2018 2 mg given four times at 0421, 0930, 1500, and 1830
- 03/27/2018 2 mg given at 1825
- 03/30/2018 2 mg given at 2313
- 04/01/2018 2 mg given at 1815
- 04/06/2018 2 mg given at 2009
- 04/09/2018 2 mg given at 1946
- 04/10/2018 2 mg given at 1959
- 04/11/2018 2 mg given at 2345

On 04/12/2018 the dosage was decreased to administer 1 mg three times daily prn "do not give after 1800." Documentation on the MAR reflected the drug was given prn 30 times and the order was not carried out as written on the following occasions:

- 04/14/2018 1 mg given at 1806
- 04/16/2018 1 mg given at 1810
- 04/18/2018 1 mg given at 1815
- 04/19/2018 1 mg given at 1836.

Further, the orders were incomplete as they did not reflect specific reasons to administer the
A 405

Continued From page 102

anti-anxiety drug, nor did they specify the frequency of prn administration. There was no documentation to reflect the RN communicated the lack of information in the orders to the physician.

3. Documentation of an event categorized as suicide attempt by Patient 12 that occurred on 12/31/2017 on Unit 6 was reviewed. The documentation reflected that the patient was observed to attempt to conceal oral medications under his/her tongue during medication administration by nursing staff on 12/31/2017. As a result, staff searched patient's room and found 24 pills on a counter under a hat. Those pills were identified as 14 count Prozac 20mg; 4 count trazodone 50mg; 4 count minipress 1mg; and 2 count minipress 2mg. The documentation reflected that patient stated he/she intended to overdose on them. Nursing staff failed to “closely observe” this psychiatric patient in a way to ensure that medications were successfully administered and that would prevent the patient from hoarding 24 pills. However, follow-up documentation by the reviewer of this event unclearly reflected that staff followed proper protocols.

A 700

PHYSICAL ENVIRONMENT

CFR(s): 482.41

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

This CONDITION is not met as evidenced by:
Based on observations, interviews, review of
Continued From page 103
event and medical record documentation for 23 of 23 patients who experienced actual or alleged abuse or neglect (Patients 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 22, 23, 24, 26, 31, and 32), review of training documentation for 22 of 22 staff (Staff 1 - 22), review of policies and procedures, and review of 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 the physical environment was arranged and maintained for the safety of patients.* Patients were not provided care in a safe physical environment that had been assessed for ligature and other risks.
* Physical environment and security measures to prevent patients from inappropriate departure, or elopement, from the secured facility were not effective.

This Condition-level deficiency represents a limited capacity on the part of the hospital to provide safe and adequate care.

Findings include:

1. Refer to the findings cited under Tag A701, CFR 482.41(a) - Standard: Buildings. Those findings reflect the hospital's failure to assess the environment for ligature and other risks, and failure to ensure appropriate measures were implemented to prevent patient elopement.

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
### Statement of Deficiencies and Plan of Correction

#### (X1) Provider/Supplier/CLIA Identification Number:

<table>
<thead>
<tr>
<th>ID</th>
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<tbody>
<tr>
<td>380007</td>
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</table>

#### (X2) Multiple Construction

- **A. Building:**
- **B. Wing:**

#### (X3) Date Survey Completed

| C | 05/22/2018 |

#### (X4) ID Prefix Tag

<table>
<thead>
<tr>
<th>ID Prefix</th>
<th>Tag</th>
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</thead>
</table>

#### (X5) Completion Date

#### Name of Provider or Supplier

**Legacy Emanuel Medical Center**

#### Street Address, City, State, Zip Code

2801 N Gantenbein Avenue
PORTLAND, OR 97227

### Summary Statement of Deficiencies

#### (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)

<table>
<thead>
<tr>
<th>ID Prefix</th>
<th>Tag</th>
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#### (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)

### Provider's Plan of Correction

- **A 701 Continued From page 104**

This **STANDARD** is not met as evidenced by:

Based on observations, interviews, review of event and medical record documentation for 23 of 23 patients who experienced actual or alleged abuse or neglect (Patients 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 22, 23, 24, 26, 31, and 32), review of training documentation for 22 of 22 staff (Staff 1 - 22), review of policies and procedures, and review of 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 the physical environment was arranged and maintained for the safety of patients as follows:

- *Patients were not provided care in a safe physical environment that had been assessed for ligature and other risks.*
- *Physical environment and security measures to prevent patients from inappropriate departure, or elopement, from the secured facility were not effective.*

Findings include:

Refer to the findings cited under Tag A115, CFR 482.13 - CoP: Patient's Rights. Those findings reflect the hospital's failure to ensure the provision of care in a safe physical environment.