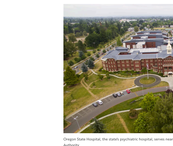

Oregon State Hospital, the state's psychiatric hospital, serves nearly 600 patients at its main Salem campus. Credit: Oregon Health Authority

GOVERNMENT & POLITICS

‘It’s broken.’ Safety concerns at Oregon State Hospital raised months prior to death of Lane County man

BY BEN BOTKIN
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Seven months before the March death of a Lane County resident at Oregon State Hospital, Oregon Health Authority Director Sejal Hathi huddled with nearly a dozen hospital staff, many of them managers, with a request: provide candid feedback.

By then, the authority’s psychiatric hospital already had faced violations connected to three patient deaths in less than a year.

In November 2023, a patient died in a seclusion room, where staff placed him after he complained of breathing difficulties. In April 2024, another patient died the same day he arrived from the Douglas County Jail. Inspectors found medical staff neglected to check that patient’s vitals when he arrived. In May 2024, another patient died of a suspected fentanyl overdose.

At the Aug. 15, 2024, gathering, Hathi heard from seasoned veterans of the state’s psychiatric hospital. They told Hathi the hospital had a culture of retaliation, a lack of accountability and a widespread inability to follow existing rules and protocols, according to a recording of the 53-minute meeting obtained by Lookout Eugene-Springfield.

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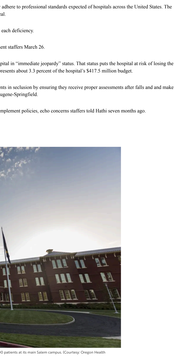
The state health authority runs the hospital, which provides mental health services from a main campus in Salem with capacity for up to 558 patients as well as a satellite campus in Junction City that houses up to 145 patients. The majority of the hospital’s patients go there for court-ordered mental health care so they can assist their attorneys with their defense against pending court charges from throughout Oregon, including Lane County. The hospital’s stays are limited to three months for misdemeanors and up to a year for serious violent felonies.

As of March 31, 47 Lane County residents were in the hospital for court-ordered treatment necessary to defend against criminal charges, state data show. That’s 12.3 percent of the hospital’s 382 patients facing charges and on court-ordered treatment, That’s the third-highest rate and number of patients.

The recording, done surreptitiously and verified by Lookout Eugene-Springfield, offers a window into the inner turmoil at Oregon State Hospital and the battles administrators and staff face as they try to enact reforms and provide the best care possible to some of the state’s most vulnerable people.

At that meeting, Hathi said the hospital’s situation is serious.



Dr. Sejal Hathi, director of the Oregon Health Authority. (Courtesy: Oregon Health Authority)

“I would be disappointed and surprised if you can’t see why I’m here when you’re painting such a dire picture,” Hathi told concerned staffers. “I’m here because clearly the hospital needs more attention, and there are a lot of challenges and it’s broken and status quo is not working.”

The hospital’s newest pressure points drive those concerns home. This week, federal inspectors and accreditation surveyors faulted the hospital’s care and inability to follow rules and emergency protocols after the death of a 25-year-old Lane County man March 18.

The latest death at Oregon State Hospital

The patient who died in seclusion at the hospital was Kenneth Haas.

In the aftermath, impacts of the death still ripple through the hospital, and administrators are scrambling to correct problems. Federal inspectors and surveyors with the Joint Commission, a nonprofit national accreditation body for more than 22,000 health care organizations, both found failures in separate reviews of the death.

“The hospital’s medical emergency response to the patient’s loss of consciousness was not timely or effective,” an inspector wrote in a preliminary report for the federal Centers for Medicare & Medicaid Services, released Wednesday to Lookout Eugene-Springfield.

The heavily redacted report said Haas was in a locked seclusion room with an unlocked bathroom and the one staffer assigned for constant observation had been insufficient to respond to his multiple falls.

Surveyors with the Joint Commission found similarly serious conditions.

The facility failed to provide a safe environment for Haas and its leadership failed to effectively implement policies and procedures, the Joint Commission wrote in a March 26 notice to Dr. Sara Walker, the hospital’s interim superintendent.

The commission said it made a preliminary decision to revoke its accreditation of the state hospital after finding conditions that pose a “serious threat” to public or patient health and safety. The hospital has a chance to correct the problems and return to good standing in the weeks ahead and has assembled teams to address the findings.

Those are:

- The hospital failed to provide a safe environment for a patient in seclusion;
- Leadership failed to implement effective policies for patients;
- “No evidence” was found that the hospital’s emergency response to Haas followed policies and procedures.

“The response was not immediate and the emergency communication process was not followed,” the commission said in its letter, which came after a two-day review at the hospital, March 24-25.

The commission’s accreditation is an industry standard for hospitals, demonstrating they adhere to professional standards expected of hospitals across the United States. The state hospital touts that accreditation on its website, with the Joint Commission’s gold seal.

Amber Shoebridge, a spokesperson for the hospital, said teams were assigned to address each deficiency.

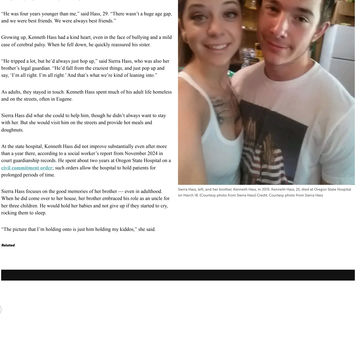
The commission will make a follow-up visit by April 17, according to an email Walker sent staffers March 26.

Separately, the federal Centers for Medicare & Medicaid Services (CMS) placed the hospital in “immediate jeopardy” status. That status puts the hospital at risk of losing the federal CMS funding it receives unless it corrects the problems. That federal funding represents about 3.3 percent of the hospital’s $417.5 million budget.

The federal agency found immediate action is needed the hospital can safeguard patients in seclusion by ensuring they receive proper assessments after falls and and make timely responses during emergencies, Walker wrote in the email, obtained by Lookout Eugene-Springfield.

The commission’s findings, including the hospital leadership’s inability to successfully implement policies, echo concerns staffers told Hathi seven months ago.

‘Sheer helplessness’



Oregon State Hospital, the state's psychiatric hospital, serves nearly 600 patients at its main Salem campus. (Courtesy: Oregon Health Authority) Credit: Oregon Health Authority

Hathi’s August meeting, also listed on her calendar, gave employees a chance to vent and speak frankly with her behind closed doors.

Walker, the hospital’s interim superintendent then and now, was not present.

Hospital spokesperson Shoebridge confirmed the meeting had been held and did not dispute the veracity of the statements by Hathi or the hospital staffers at the meeting, when asked by Lookout Eugene-Springfield. Hathi did not make herself available for an interview and staff members did not reply when contacted for comment.

The employees, who introduced themselves at the start of the meeting, work in a variety of settings including admissions, quality control, security and patient programs.

In the meeting, a number of them spoke in stark terms about low morale and their concerns about the hospital’s culture. What follows is a snapshot of their discussion.

“Many of us would say we’ve never experienced this level of darkness here, and that’s just sheer helplessness at this level,” said Anthony Cornell, director at the hospital’s Archways program, which teaches patients about the court system.

James Aguilar, the security director, told those assembled that the hospital repeatedly fails to follow the rules.

“We have a culture in this hospital and folks that don’t follow the rules, right?” Aguilar said. “We have an audit after audit that comes through and says, ‘You don’t need any more rules. You just need to have the people follow the stuff that you have.’”

Aguilar, a former Salem police officer, was surprised when he learned about the lax attitude towards rules.

“I came from a law enforcement side where, like, the rules are the rules,” he said. “And I got here, and I found out the rules are here, but they’re not really rules, because nobody has to follow them.”

Staffers expressed concerns about the blowback they face if they try to make improvements, or simply remind people to use common sense and be careful, such as when responding to emergencies.

“Retaliation is alive and well in this organization,” said Heidi Scott, a program director. “If you speak out, or if you rub people the wrong way, something will happen. And it could be that you’re just publicly shamed because you said, ‘Please don’t run. That’s not a safe manner to respond.’”

Past efforts to bolster accountability failed, said Aisha Krebs, director of quality management.

“The management system has been unsuccessful so many times in achieving accountability that it’s created apathy, quite frankly,” Krebs said. “So it’s very difficult.”

After hearing from the staff, Hathi told the group she informed Walker that the status quo is “unacceptable” and is pushing for improvements.

“I continue to ask for a plan and don’t receive a plan,” Hathi said.

This week, hospital officials offered no update on the status of that plan. Shoebridge, the hospital spokesperson, was unable to answer questions about whether Hathi ever received that plan, or what the plan entailed, saying she lacked context.

Since that meeting, the hospital continued to push for improvements, Shoebridge said.

In September 2024, the health authority contracted with The Charis Group, a health care regulatory advisory firm, to develop quality improvement plans after repeated violations impacting patient health and safety. That contract will cost Oregon taxpayers at least $1.7 million, records show.

“Still, significant work remains,” Shoebridge said. “Dr. Hathi remains confident in (Oregon State Hospital) leadership and staff to advance this work and continue to improve the quality and safety of care.”

For the latest patient to die unexpectedly, that work comes too late.

A patient’s life

Kenneth Haas died at Oregon State Hospital without his family by his side.

His sister, Sierra Haas, never wanted it that way, even after he fell on hard times and struggled with mental health challenges as an adult.

Haas, who lives in Springfield, prefers to remember the good times, like when the two grew up together, mostly in Cottage Grove.

“He was four years younger than me,” said Haas, 29. “There wasn’t a huge age gap, and we were best friends. We were always best friends.”

Growing up, Kenneth Haas had a kind heart, even in the face of bullying and a mild case of cerebral palsy. When he fell down, he quickly reassured his sister.

“He tripped a lot, but he’d always just brush up,” said Sierra Haas, who was also her brother’s legal guardian. “He’d fall from the craziest things, and just pop up and say, ‘I’m all right. I’m all right.’ And that’s what we’re kind of leaning into.”

As adults, they stayed in touch. Kenneth Haas spent much of his adult life homeless and on the streets, often in Eugene.

Sierra Haas did what she could to help him, though he didn’t always want to stay with her. But she would visit him on the streets and provide hot meals and doughnuts.

At the state hospital, Kenneth Haas did not improve substantially even after more than a year there, according to a social worker’s report from November 2024 in court guardianship records. He spent about two years at Oregon State Hospital on a civil commitment order; such orders allow the hospital to hold patients for prolonged periods of time.

Sierra Haas, left, and her brother, Kenneth Haas, in 2015. Kenneth Haas, 25, died at Oregon State Hospital on March 18. (Courtesy photo from Sierra Haas) Credit: Courtesy photo from Sierra Haas

Sierra Haas focuses on the good memories of her brother — even in adulthood. When he did come over to her house, her brother embraced his role as an uncle for her three children. He would hold her babies and not give up if they started to cry, rocking them to sleep.

“The picture that I’m holding onto is just him holding my kiddos,” she said.

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