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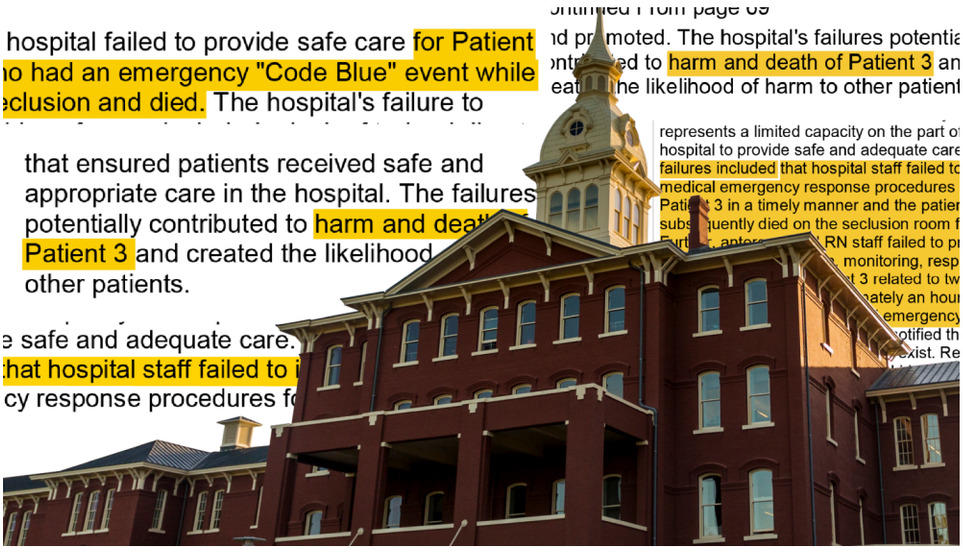


Credit: Photo: Oregon State Hospital. Illustration: Annie Aguiar

GOVERNMENT & POLITICS

‘Harm and death’: Report shows how Oregon State Hospital failed a Lane County patient

BY **BEN BOTKIN**
June 24, 2025

Federal inspectors linked repeated failures at Oregon State Hospital to the March 18 death of a patient in a locked seclusion room. When the hospital released the report, it censored those failures from the public’s view, an unredacted version obtained by Lookout Eugene-Springfield shows.

QuickTake:

'Harm and death': Report shows how Oregon State Hospital failed a Lane County patient

About 13 Minutes

1x

Everlit

Shortly before he died the night of March 18, Kenneth Hass fell and hit his head in a locked seclusion room at Oregon State Hospital. It was the third time in the space of about an hour he had fallen.

A hospital staffer assigned to watch him saw the fall and notified the unit's registered nurse. As the minutes ticked by, more hospital workers, including the psychiatrist on duty, gathered in an observation room and a hallway and watched as the patient, a 25-year-old from Lane County, lay motionless on the floor. More than four minutes passed before a nurse checked his pulse, a report shows. He had none. Compressions followed, but to no avail.

Hass died alone on the bathroom floor of a locked seclusion room, a space intended for patients to be closely observed for their health and safety. The hospital's delayed emergency response and other failures to provide safe care, both for Hass and other patients, are detailed in a report compiled by the federal Centers for Medicare & Medicaid Services.

The findings shed light on systemic flaws at the hospital in its care and treatment of patients and repeated breakdowns in how workers are trained to respond to crises in an institution responsible for the care of Oregon's most vulnerable residents.

The Oregon State Hospital, run by the Oregon Health Authority, is required to provide mental health care for patients from across the state, many of them people who need treatment so they can aid lawyers in their defense against criminal charges. The hospital's main Salem campus, where Hass died, can hold up to 558 patients. The satellite campus in Junction City has capacity for up to 145 patients.

The death has brought renewed attention to the state hospital, an institution with a record of failing patients. Earlier this month, a federal judge found the hospital in contempt for its failure to efficiently admit patients so they can get treatment necessary to face charges.

And inspectors have flagged failures with other deaths at the state hospital in the last two years. In November 2023, a patient died in a seclusion room, where staff moved him after he complained of breathing difficulties. In April 2024, another patient died the same day he arrived from the Douglas County Jail. Inspectors determined medical staff neglected to check his vitals when he arrived.

Hass' death is different in at least two significant ways. For one, Gov. Tina Kotek replaced the hospital's interim superintendent, Dr. Sara Walker, after learning details about the death.

There's also less transparency. Unlike previously released reports about deaths, Oregon Health Authority officials redacted many details about how, specifically, the hospital failed the patient. Citing patient privacy regulations, the agency stripped the report of details about its failures surrounding the death, including the delayed response to check on him.

Lookout Eugene-Springfield obtained an unredacted copy of the 242-page report and verified its findings with multiple sources. The unredacted account retraces the events that led to Hass' death — and offers a broader window into the pain of those who suffer unresolved mental health challenges.

Redacted

> that ensured patients received safe and appropriate care in the hospital. The failures potentially contributed to [redacted] and created the likelihood of harm to other patients.

Unredacted

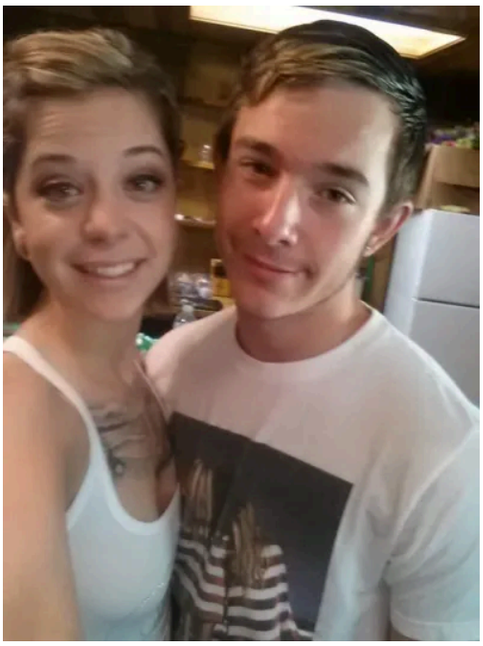
> that ensured patients received safe and appropriate care in the hospital. The failures potentially contributed to harm and death of Patient 3 and created the likelihood of harm to other patients.

'Patient 3'

The unredacted report does not identify Hass or other patients by name.

Instead, he is listed as Patient 3.

His sister and legal guardian when he died, Sierra Hass of Springfield, has confirmed his death at the hospital. As an adult, he sometimes was homeless, often in Eugene.



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

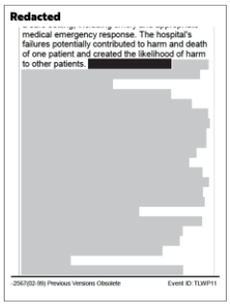
"It's definitely been hard," Hass said. "I lost my best friend."

By the night of March 18, Hass already had a history of falls at the hospital. A staffer was assigned to constantly observe him from an anteroom and immediately notify others of potential harm.

Hass was classified as a high fall risk and spent months in seclusion rooms, which staff seldom cleaned. Court guardianship records show he had lived there more than two years on a civil commitment order. When he died, he had no pending criminal charges.

In the span of about an hour — from 9:32 p.m. to 10:34 p.m. — he fell three times in the seclusion room's bathroom, the report found.

After the third fall, he died.



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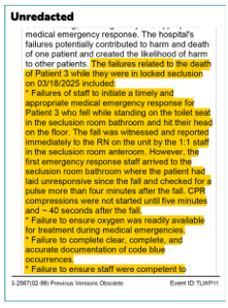
medical emergency response. The hospital's failures potentially contributed to harm and death of one patient and created the likelihood of harm to other patients. [redacted]



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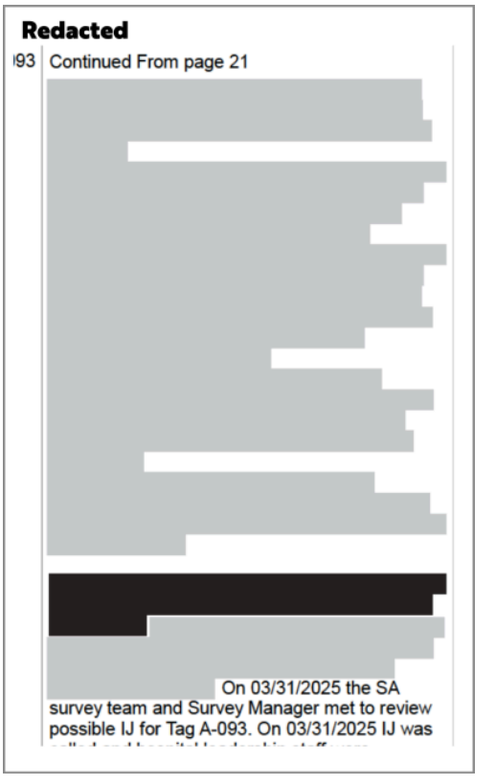
medical emergency response. The hospital's failures potentially contributed to harm and death of one patient and created the likelihood of harm to other patients. The failures related to the death of Patient 3 while they were in locked seclusion on 03/18/2025 included:
* Failures of staff to initiate a timely and appropriate medical emergency response for Patient 3 who fell while standing on the toilet seat in the seclusion room bathroom and hit their head on the floor. The fall was witnessed and reported immediately to the RN on the unit by the 1:1 staff in the seclusion room anteroom. However, the first emergency response staff arrived to the seclusion room bathroom where the patient had laid unresponsive since the fall and checked for a pulse more than four minutes after the fall. CPR compressions were not started until five minutes and ~ 40 seconds after the fall.
* Failure to ensure oxygen was readily available for treatment during medical emergencies.
* Failure to complete clear, complete, and accurate documentation of code blue occurrences.
* Failure to ensure staff were competent to



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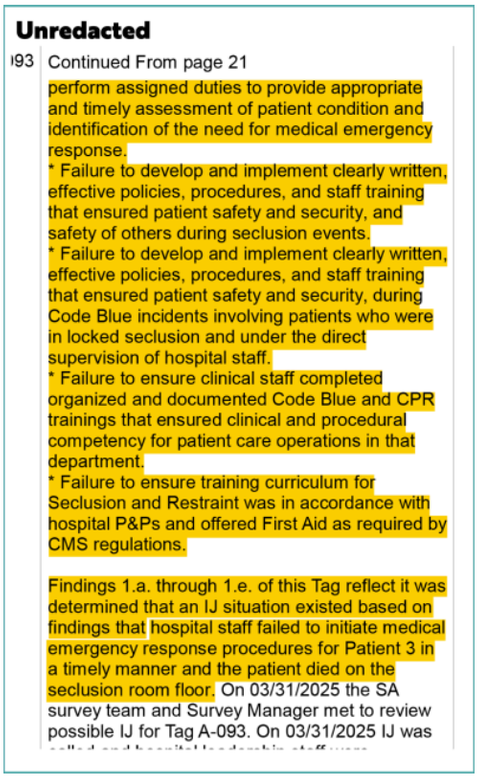
[redacted]

On 03/31/2025 the SA survey team and Survey Manager met to review possible IJ for Tag A-093. On 03/31/2025 IJ was



Unredacted

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perform assigned duties to provide appropriate and timely assessment of patient condition and identification of the need for medical emergency response.
* Failure to develop and implement clearly written, effective policies, procedures, and staff training that ensured patient safety and security, and safety of others during seclusion events.
* Failure to develop and implement clearly written, effective policies, procedures, and staff training that ensured patient safety and security, during Code Blue incidents involving patients who were in locked seclusion and under the direct supervision of hospital staff.
* Failure to ensure clinical staff completed organized and documented Code Blue and CPR trainings that ensured clinical and procedural competency for patient care operations in that department.
* Failure to ensure training curriculum for Seclusion and Restraint was in accordance with hospital P&Ps and offered First Aid as required by CMS regulations.

Findings 1.a. through 1.e. of this Tag reflect it was determined that an IJ situation existed based on findings that hospital staff failed to initiate medical emergency response procedures for Patient 3 in a timely manner and the patient died on the seclusion room floor. On 03/31/2025 the SA survey team and Survey Manager met to review possible IJ for Tag A-093. On 03/31/2025 IJ was

In all three falls, federal inspectors found problems with the hospital's response. They made their findings after staff interviews and reviews of records and security footage.

At 9:32 p.m., the footage showed Hass climbed atop the toilet to a standing position and fell. The video showed he appeared to hit his head on the wall or door, the report said.

The staffer assigned to watch him told investigators they did not notice him fall that first time but did see him get up off the floor.

The fall was not reported to the unit's registered nurse or recorded in notes that tracked his activity and movements hour by hour.

At 10:27 p.m., Hass fell a second time. Video footage showed he was standing on the bathroom floor, facing the window of the observation room, before he fell, the report said. He fell backward and got up and continued to walk around.

This time, a different staffer was assigned to watch him. That employee said they called the unit's registered nurse, who declined to respond to assess the patient, the report said.

Like the first fall, the hospital's log for that hour showed no fall — and no record that it was reported to a registered nurse.

"At no time were any staff observed on video to respond to Patient 3 after the first two falls in the seclusion room bathroom," the report said.

Seven minutes later, Hass fell a third and final time. He crawled up to stand on the toilet seat and, footage showed, hit his head on the floor. This time, he did not get up.

"The patient made no attempt to get up off of the floor and did not demonstrate any purposeful or voluntary movements," the report said.

A staffer reported the fall right away. More hospital staff arrived, but, the report said, the emergency response "was not timely or appropriate." Staff gathered in a hallway outside the room. The minutes ticked by as Hass was motionless.

It took more than four minutes before they checked his pulse. Five minutes and 40 seconds after the fall, they attempted CPR compressions. By then, he was gone.

Staffers later blamed the delayed emergency response on the patient's past behaviors of "playing possum" and being combative when they approached to help, the report said.

That account, including the delayed responses, is entirely redacted from the version the health authority released June 11 with a three-page cover letter from the agency in response to a public records request from Lookout Eugene-Springfield.

RELATED LINKS

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

About the unredacted report, Oregon State Hospital declined to make any officials available for an interview.

In a statement, Amber Shoebridge, a spokesperson for the agency, said the hospital has to follow federal and state privacy laws to protect personal health information of patients. That includes the federal Health Insurance Portability and Accountability Act.

"We try to share these reports to support transparency and accountability," Shoebridge said, noting the patient's name has been published in media accounts. "Unlike past reports, identifiable patient health information (PHI) is discussed in this report and would violate HIPAA and state law if disclosed."

Redacted

The cumulative effect of these systemic failures resulted in this Condition-level deficiency that represents a limited capacity on the part of the hospital to provide safe and adequate care. The failures included [redacted]. On 03/31/2025 the hospital was notified that an IJ situation had been determined to exist. Refer to Tag A-093 for the details of the IJ identification, IJ notification, IJ Removal Plan approval, and IJ Removal Plan Verification Visits. A third IJ

Unredacted

The cumulative effect of these systemic failures resulted in this Condition-level deficiency that represents a limited capacity on the part of the hospital to provide safe and adequate care. The failures included that hospital staff failed to initiate medical emergency response procedures for Patient 3 in a timely manner and the patient subsequently died on the seclusion room floor. Further, anteroom and RN staff failed to provide 1:1 constant observation, monitoring, response, and assessment for Patient 3 related to two falls that occurred within approximately an hour prior to the third fall and the medical emergency event. On 03/31/2025 the hospital was notified that an IJ situation had been determined to exist. Refer to Tag A-093 for the details of the IJ identification, IJ notification, IJ Removal Plan approval, and IJ Removal Plan Verification Visits. A third IJ

'Harm and death'

Inspectors repeatedly found the hospital failed.

“The hospital’s failures potentially contributed to harm and the death of Patient 3 and created the likelihood of harm to other patients,” the report said.

In the official version, the authority blacked out the phrase “harm and death of Patient 3.” In all, inspectors noted a failure in at least eight instances in Hass’ death.

Those include a failure to have a readily available oxygen supply for emergencies, a failure to develop clear policies and staff training, and a failure to keep staff training up-to-date for life-threatening code blue events.

Not everything was shielded from public view.

In some cases, the hospital’s failures were publicly released, but in a way that obscured the connection to the death. One unnamed employee, hired in 2013, had taken no annual code blue training since 2015, the report’s review of records found. The authority’s publicly released version mentioned that finding. But it blacked out the detail that this employee was among those who responded to Hass when he died.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	384008		C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON STATE HOSPITAL DISTINCT PART	2600 CENTER STREET NE SALEM, OR 97301

(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 115	Continued From page 69 and promoted. The hospital's failures potentially contributed to [redacted] and created the likelihood of harm to other patients.	A 115		

Unredacted

Continued From page 69

and promoted. The hospital's failures potentially contributed to harm and death of Patient 3 and created the likelihood of harm to other patients.

Tag A-095 for the details of the IJ identification, IJ notification, IJ Removal Plan approval, and IJ Removal Plan Verification Visits. A third IJ Removal Plan Verification Visit was conducted on 05/12/2025 and the IJ was determined to be removed.

Findings include:

1. Refer to the findings cited under this CoP, CFR 482.13(b) - Standard: Exercise of Rights. Those findings reflect the hospital failed to inform a patient of their health status in a timely manner and failed to have system to ensure that for all patients (Tag A-131).

2. Refer to the findings cited under this CoP, CFR 482.13(c) - Standard: Privacy and Safety. Those findings reflect the hospital failed to ensure the provision of care setting (Tag A-144).

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: TLWP11 Facility ID: 384008 If continuation sheet Page 70 of 242

A history of falls and an unlocked door

By the time Hass died, records show that employees struggled to find a solution to his mental health challenges — or to simply monitor him for safety. At the hospital, Hass suffered repeated harms, falls and constant instances when he was placed in restraints without a valid documented reason, the report said.

Inspectors found extensive problems in the last three months before Hass died.

In December 2024, staffers moved him to a cleaner room, placing him in restraints before the transfer. Inspectors noted it was not clear why they did so, as the documentation did not show any aggressive behaviors.

In January, he fell and appeared to hit his face, the report said. But his patient records showed no record that the unit’s registered nurse was notified about the fall.

In February, staff decided to move him to another cleaner seclusion room. The room he left was filthy, the report said, and covered in trash and feces.

The move was fraught with failures, the report said. Staff screamed for items and struggled to calm him as he was placed in restraints, the report said.

“The documentation reflected the scene was chaotic, disorganized without a clear plan or leader, and resulted in patient self-harm,” the report said.

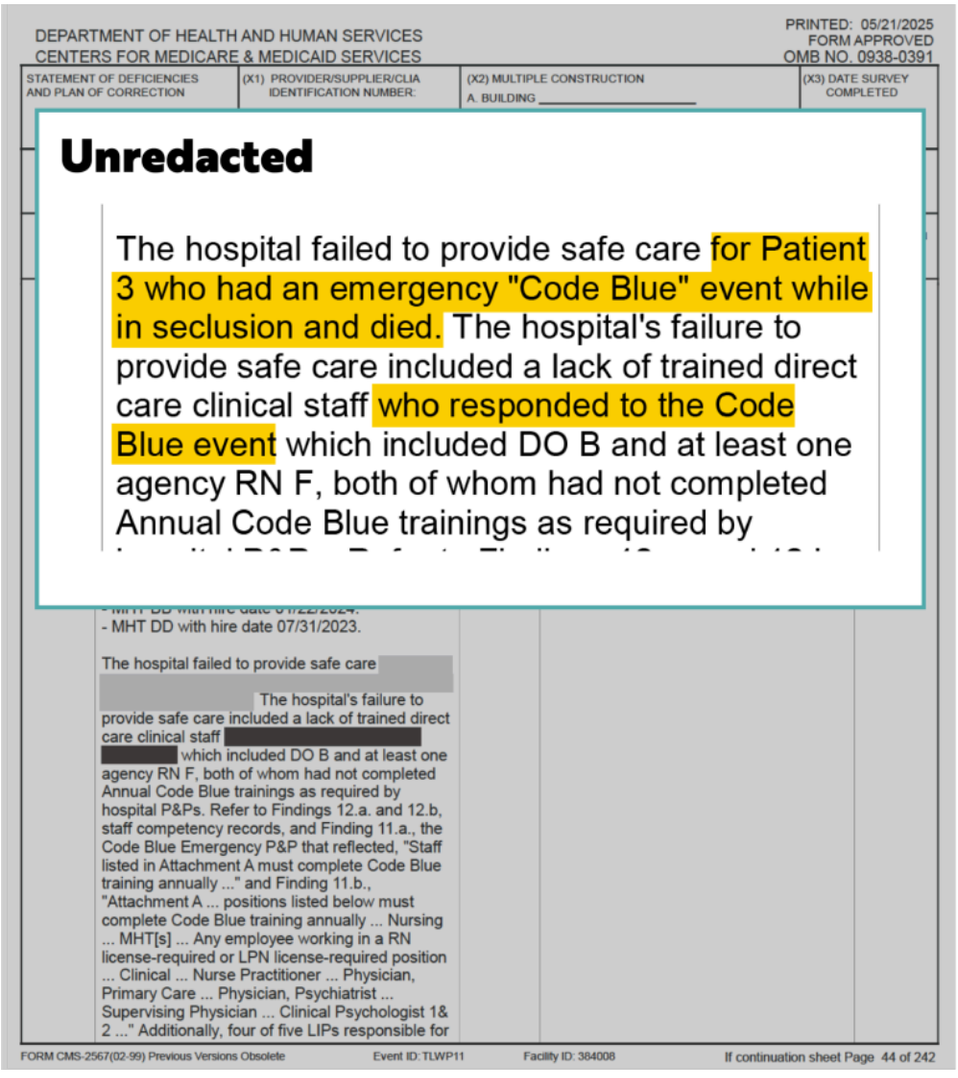
By the night he died, Hass had been in seclusion rooms for several months. At times, he jumped off the bathroom sink counter or toilet — self-harming behaviors hospital staff are charged with preventing as much as possible.

Despite that, the report shows that a doctor ordered the seclusion room’s door to the bathroom remain unlocked, allowing him access.

In the aftermath of the death, concerns remain.

Disability Rights Oregon, a watchdog and advocacy organization, has successfully litigated to compel the state hospital to admit patients sooner when they are waiting in county jails for treatment. In a statement, the group said the case demonstrates its concerns about the state hospital.

“This tragedy highlights our ongoing concerns about training and staff oversight at the Oregon State Hospital,” said Dave Boyer, managing attorney of Disability Rights Oregon’s Mental Health Rights Project. “We strongly encourage hospital leadership to focus on enhanced staff education, communication, and training — rather than dodging blame and further limiting the rights of those in their charge. Otherwise, another preventable death is inevitable.”



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2025
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED

Unredacted

The hospital failed to provide safe care for Patient 3 who had an emergency "Code Blue" event while in seclusion and died. The hospital's failure to provide safe care included a lack of trained direct care clinical staff who responded to the Code Blue event which included DO B and at least one agency RN F, both of whom had not completed Annual Code Blue trainings as required by

- MHT DD with hire date 07/31/2023.

The hospital failed to provide safe care [redacted] The hospital's failure to provide safe care included a lack of trained direct care clinical staff [redacted] which included DO B and at least one agency RN F, both of whom had not completed Annual Code Blue trainings as required by hospital P&Ps. Refer to Findings 12.a. and 12.b, staff competency records, and Finding 11.a., the Code Blue Emergency P&P that reflected, "Staff listed in Attachment A must complete Code Blue training annually ..." and Finding 11.b., "Attachment A ... positions listed below must complete Code Blue training annually ... Nursing ... MHT[s] ... Any employee working in a RN license-required or LPN license-required position ... Clinical ... Nurse Practitioner ... Physician, Primary Care ... Physician, Psychiatrist ... Supervising Physician ... Clinical Psychologist 1& 2 ..." Additionally, four of five LIPs responsible for

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: TLWP11 Facility ID: 384008 If continuation sheet Page 44 of 242

Shortcomings affect other patients

Other findings in the redacted report show the danger patients face — and the risks that remain.

In general, inspectors found the hospital overused seclusion and failed to keep patients besides Hass safe from harm.

For one patient who fell, a follow-up assessment failed to gauge the risk, as they were on at least four medications that increased their likelihood of a fall. Another patient managed to cover the cameras in a seclusion room's bathroom with wet toilet paper.

Yet another patient in seclusion used a broken plastic spoon to puncture a bed mattress. Another used an altered toothbrush to hurt their arm.

When they released the redacted report, health authority officials said the hospital's culture needs to change and included a three-page plan of immediate changes to reduce the risks for high-risk patients and operate as a 24/7 hospital should.

Later, Interim Superintendent James Diegel sent the federal agency a more detailed 45-page plan of correction with updates to seclusion and restraint policies. It includes staff training with first aid care for patients who are injured while in seclusion or restraints.

Graphics by Annie Aguiar

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