

Federal inspectors flag problems in 2 deaths at Oregon State Hospital

After investigating, federal inspectors found the state-run psychiatric hospital could have done more to prevent two patient deaths

BY **BEN BOTKIN** - AUGUST 26, 2024 5:53 PM



 The Oregon Health Authority oversees the Oregon State Hospital in Salem. (Oregon Health Authority)

Late last year, a patient at Oregon State Hospital walked up to a nurse’s station and said he was having trouble breathing.

After taking the man’s vitals, nursing staff helped him walk to a seclusion room in the state-run psychiatric hospital in Salem, which has more than 500 patients. He fell on his knees in the doorway and staff moved the patient out of the way and shut the door behind them. Alone in the room, the patient “rocked his head” and rolled on the floor.

The patient, a Black man, never left the room alive.

The account is part of a 96-page [federal report](#) released Monday on his death and another patient death in May. Investigators found that hospital staff committed numerous violations related to safety and security procedures and patient care and were faulty in investigating and correcting gaps in care.

The investigation by the federal Centers for Medicare and Medicaid Services included record reviews, interviews with staff and a look at security camera footage. The agency, which reimburses the hospital for treatment of Medicare patients, who are usually elderly, will require the state hospital to fix the problems to continue to receive that money.

The hospital’s interim superintendent and chief medical officer, Dr. Sara Walker, said the hospital will make the necessary changes.

“We have been entrusted with the care of some of Oregon’s most vulnerable residents,” Walker said in a statement. “Their safety and well-being are our top priority. We will continue to make the changes necessary to protect our patients.”

The findings are the latest violations to hit the state hospital after a year of problems. Those include the escape of a patient who drove off in a hospital vehicle, a lack of patient safety and a third patient who died shortly after his arrival from the Douglas County jail.

Patient care and safety are at the root of the hospital’s problems, investigators found. They include limited screenings of hospital visitors, staff checks of less than one second per patient to ensure they are breathing and poor medical care, records show.

At times, managers at the state hospital appeared at odds with the federal inspectors. The federal agency had to repeatedly prod the hospital for patient documentation and records necessary to complete its review, records show.

The hospital needs to come up with an approved plan of correction by Oct. 24 and will face an unannounced visit by then as well.

‘I can’t breathe’

The patient who died late last year had already been in and out of the state hospital three times. On Nov. 2 at the nurse’s station, he was desperate.

“I feel like I can’t breathe,” he said.

But hospital staff focused on his mental health – and his request to enter the seclusion room – after he fell on the floor and bumped his head, the report said. Inspectors honed in on how medical staff handled the situation, including gaps in his care when problems emerged.

Fifteen minutes after his complaint, he was walked into the seclusion room.

“I feel like I’m going to die,” he kept repeating as he entered the seclusion room.

Six minutes later, a staffer entered and left the room. After eight minutes, he stopped moving.

Two minutes later, staff tried to revive him. But the hospital did not call an ambulance until seven minutes after they called a “code blue,” which indicates a life or death emergency.

This was not the first time he’d been short of breath. On Oct. 13, he told a nurse he suffered from chest pains and shortness of breath, the report said.

And on Oct. 17 he said he had left leg pain. But hospital staff did not write up a treatment plan, the investigation found.

CMS inspectors said the hospital’s review of the incident was incomplete and failed to address the gaps in its response to the patient.

The hospital also failed to initially provide much of the documentation that inspectors requested for their review, including some medical records and other prior incident reports. Eventually, hospital staff provided more documentation and acknowledged they had not shared everything with inspectors, the report said.

Likely fentanyl overdose

On May 24, a patient died unexpectedly in bed, one day after a visit from an outsider. Oregon State Police found powder residue and seized it along with foil, records show.

The federal agency’s review of the case found that staff did not conduct thorough security screenings of visitors and conducted scant monitoring of sleeping patients to determine if they are alive.

The hospital staff also failed to follow up on warning signs of problems between the visit and his death, the report found. For example, when the visitor arrived, the security screening was “insufficient” to check for metallic objects, and the security wand did not pass over the feet. The visitor, a parent of the patient, later played with the patient’s feet under the table during the visit. Staff ignored that activity, the report said.

The hospital found him deceased the next morning. A review of security cameras and staff interviews found inadequate checks of patients at night.

In some instances, staff only stood outside and looked at the patients through the door into a darkened room. In one instance, a staff check of 12 patients happened within only 37 seconds, not enough time to check for respirations, the report said.

During three visual checks in less than an hour, the patient did not respond but staff did not approach him to determine if he was alive.

“Rather, they walked away with no sense of urgency to conduct other business,” the report said.

At 8:47 a.m., a staffer discovered the patient’s body was cold.