



Summary of Deficiencies

July 2018

- Patients identified at risk for suicide were not protected from self-harm and suicide attempts (patient committed suicide by hanging and died)
- The physical environment contained ligature risks that resulted in actual patient harm
- The physical environment contained blind spots that created the opportunity for patient self-harm or suicide without immediate detection
- Communication safety devices required for staff use were not available
- Elopement prevention, and staff awareness and alertness to potential hazards and risks were lacking
- Systems to ensure that equipment and supplies necessary for response to urgent/emergent medical conditions were available and in safe working condition were not fully implemented
- Medication errors occurred when RNs failed to administer the right medication to the right patient, in the right doses, by the right route at the right time
- Seclusion requirements were not met for those patients placed in seclusion
- Restraint and seclusion were not implemented by staff who met the restraint and seclusion training requirements
- Investigations of and response to patient incidents/events were not timely or complete to prevent recurrence