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Summary of findings from December 18, 2015 Immediate Jeopardy Revisit:

Patient #1

The facility failed to protect patient #1 from her self-harming behaviors and failed to protect other patients from her aggressive/assaultive behaviors. The facility failed to supervise the patient closely enough to prevent her from placing objects in her ears and vagina. The facility failed to supervise and evaluate the patient closely enough to protect other patients from her aggressive/assaultive acts including choking and pulling out hair. The facility failed to respond to the treatment teams warning that patient #1 and patient #2 were getting too close and they needed to be watched. The facility failed to respond to staff's concern about the bed placement of patient #1. The facility failed to supervise the patient closely enough to prevent her from having sexual relations with another patient. The facility failed to supervise the patient closely enough to prevent her from attempting suicide. The facility's decision to not place patient #1 on 1:1 status because it might reinforce her self-harming behaviors allowed the patient to continue to self-harm and put the health and safety of others at risk.

Record Review

Patient #1 was admitted on 5/21/14 with diagnoses of posttraumatic stress disorder (a mental health condition triggered by experiencing or seeing a terrifying event), Bipolar I disorder with psychotic features (a mood disorder characterized by unusually euphoric or agitated moods, along with depression which can severely impact a person's ability to function), and borderline personality disorder (mental disorder characterized by unstable moods, behavior, and relationships).

Record review revealed on almost a daily basis, the patient participated in some sort of self-harm by placing objects like coins, pens, spoons, knives, and safety pins in her eyes, ears, and vagina.

Record review revealed on almost a daily basis, the patient participated in some sort of assaultive/aggressive act against another patient or staff including choking, pulling handfuls of hair out, kicking, and throwing coffee.

Treatment team staff noted Patient #1 and Patient #2 sitting together and told nursing staff "to watch them". Treatment team indicated that patient #1 is targeting her roommate (patient #5) who is in a wheelchair and vulnerable.

By interview, treatment team staff indicated that even the MHTs told nursing staff that it was not appropriate for patient #2 with his history of sexual aggression to be next to patient #1 and that it was not appropriate for Patient #5 (who is in a wheelchair and unable to defend herself against attacks) to be roommates with patient #1. Nursing staff indicated that even if they move patient #1 out of this room, she will still target patient #5.

Staff caught Patient #1 and Patient #2 kissing in the TV room. Patient #1 and #2 report that they had sex earlier in the day. Patient #1 then transferred to a different unit by APRN staff B "for safety of other peers". No changes made to

treatment plan or orders to keep patients in the new unit safe from patient #1 or to keep her safe from herself until about 24 hours later when an order is written by APRN staff B to search the patient's room now and as needed for objects the patient might use to self-harm.

Patient #1 continued her self-harming behavior by inserting objects into her ear and vagina. Patient #1 continued her aggressive assaultive behaviors by choking and pulling patient's hair.

Patient #1 attempted suicide by tying her pants around her neck. Patient #1 remained on 15 minute observation status (RED) checks even after she attempted suicide.

Patient #2

The facility failed to change patient #2's observation status when he displayed inappropriate sexual behaviors and an aggressive/assaultive act. The facility failed to protect female patients when they placed patient #2 (a known sex offender who had been displaying inappropriate sexual behaviors) on the B ("Female") hallway giving him easier access to females and provided him more opportunity for consensual or non-consensual sexual contact. The facility failed to respond to the treatment teams warning that patient #1 and #2 were getting too close and needed to be watched. The facility failed to supervise and evaluate patient #2 closely enough to prevent him from having sexual relations with another patient. The facility failed to provide adequate supervision for patient #2 when staff did not place him on 15 minute observation checks after they discovered patient #1 and #2 kissing and after the patients reported that they had sex earlier in the day. The facility's failure to provide appropriate supervision for patient #2 when he transferred to the B1 unit and admitted to the B ("female") hallway placed female patients at a higher risk for sexual assault.

Record Review

Patient #2 admitted from Hospital BB due to recent history of 3 weeks with no aggression or sexual activity. Patient admitted to this hospital for less restrictive environment and for discharge planning. Patient with diagnosis of antisocial personality disorder (a mental health disorder characterized by disregard for other people) major depressive disorder with psychotic features (a mental disorder in which a person has depression along with loss of touch with reality). Patient identified at risk for sexual aggression with history of criminal sodomy. Patient with history of sexual abuse from mother and brother. Patient is a registered sex offender. Patient placed on 60 minute therapeutic observation status checks (ORANGE).

Patient #2 displayed inappropriate sexual behaviors including kissing other patients, attempting to kiss other patients, hugging and inappropriately touching other patients, and having another female patient place her hands down his pants.

After Patient #2 made a shank from a plastic knife and tried to stab someone in the neck for sitting too close to him, he was transferred to B1 Unit due to his aggression and sexually inappropriate comments and gestures. Patient #2 remained on 60 minute observation status checks (ORANGE) even after the transfer from the other unit when the patient had attempted to stab another patient and had sexually inappropriate behaviors. Nursing staff placed patient #2 on the B ("Female") hallway.

By Interview, treatment team staff felt like this was a poor room assignment due to patient's history of inappropriate sexual behaviors and recent aggression and indicate that nursing makes the decision about bed placement. Patient #2 remained in this room until after he reported that he had sex with patient #2 a few days later.

Patient #2 continued flirting with female patients in the B1 unit and making inappropriate sexual gestures like placing a blanket over himself and a female patient's lap sitting next to him. Treatment team staff noted Patient #1 and Patient #2 sitting together and told nursing staff "to watch them".

Staff caught patient #1 and patient #2 kissing in the TV room. Patient #1 and #2 reported that they had sex earlier in the day. The next day, the treatment team placed patient #2 on 15 minute checks related to the inappropriate sexual behavior the day before and had him moved to the A ("Male") hallway.

By interview, the treatment team indicated the patient should have been placed on 15 minute checks the day before after discovery of the reported sex with patient #1.