STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150035	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHWEST HEALTH- PORTER	85 EAST US HWY 6 VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for investigation of a Federal hospital complaint. Complaint Number: IN00451750 - Deficiencies related to the allegations are cited. (A0395 & A0800) Survey Dates: 02/27/2025 & 02/28/2025 Facility Number: 005033 QA: 3/5/2025	A 0000	Submission of the plan of correction is not an admission that the citations are accurate or that the hospital violated the regulations. Immediately upon receipt of the Survey Deficiency Statement, The hospital's Chief Executive Officer (CEO), Director of Quality, Chief Nursing Officer (CNO), Chief Operation Officer (COO), Chief Medical Officer (CMO) to review the survey findings Date completed: 3/12/25 Responsible Person: CEO The CEO notified and shared findings from the survey with the Governing Board Chairperson. Date Completed: 3/12/25	
A 0395 Bldg. 00	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. Based on document review and interview, the registered nurse failed to evaluate a patient per policy in one (1) instance. (Patient # 10) Findings include: 1. The facility policy titled, Suicide Risk Assessment and Interventions Columbia Protocol in Non-Behavioral Health Setting, version eight (8), no policy number, indicated on page two (2) - section Procedure - Required Action Steps -	A 0395	**Action Taken:** The Suicide Risk Assessment and Interventions Columbia Protocol in Non-Behavioral Health Setting was reviewed and no changes were required. **Training and Education:** Education includes: Columbia Suicide- Just In Time Tool (JIT), Patient Sitter Education, Suicide Risk Assessment and	04/09/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Darnella Young	Director of Quality	03/19/2025

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	Guidance - Determining suicide risk level can include additional information and sources other than the patient, such as Emergency Medical Services, significant others and/or other observers who report suicide ideation, intent and/or behavior. This policy was last revised on 06/08/2022. 2. Patient # 10's MR (medical record) indicated the patient was a 24 y/o (year/old) brought into H # 2's (Acute Care Hospital) Emergency Department (ED) by police on several dates including, but not limited to, the following: a. The Law Enforcement Statement In Support of Emergency Detention and Transport dated 01/15/2025 at 6:16 pm, indicated the patient was believed to be mentally ill due to - intellectual disability and other psychiatric disorders that substantially disturbed the individual's thinking, feeling, or behavior and impaired the individual's ability to function, and the person named above (patient # 10) was - dangerous to self and was in immediate need of hospitalization and treatment for the following reasons: Patient # 10 stated he/she would go in his/her room and self-harm. b. The Nurses note dated 01/15/2025 at 6:63 pm by N # 2 (Registered Nurse-RN), indicated the patient refused to answer the questions for the Columbia Suicide Risk Assessment. The patient was calculated (per the computer system) at low risk for suicide with no action interventions required. c. The Provider note dated 01/15/2025 at 7:34 pm by M # 2 (Doctor of Osteopathy-DO/Family Medicine), indicated Medical Decision Making - Patient had medical screening examination. The patient refused to cooperate with evaluation. There appears to be no acute change in his/her condition. He/she was considered safe to return to his/her group home. Patient was discharged back to H # 3 (Group Home).		Interventions Columbia Protocol in Non- Behavioral Health Setting Policy. Education will also be provided during annual education /competencies. All new hires will be educated as part of the nursing orientation. **Auditing/ Monitoring:** Nurse administration/ designee will complete audits on all patients that screen high risk according to the Suicide Risk Assessment and Interventions Columbia Protocol and require a sitter, until 4 consecutive months with a 100% compliance rate (Patient sitter, continuous observation with Q15 documentation according to policy, Columbia- Suicide Severity Rating Scale (C-SSRS) completed per shift, safe room checks and Risk level appropriateness) implemented 1/13/25. Effective 3/18/25, patient's refusal to answer questions will be added to the above auditing process (*Per Policy nurse decretion will be used to determine suicide risk level based on additional information and sources other than the patient, such as Emergency Medical Services, significant others and/or other observers who report suicide ideation, intent and/or behavio*r). Ongoing internal audits will be conducted monthly by the nursing administration Leader/designee. Results will be reported to leadership safety huddle daily.	

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	d. The Provider note dated 01/16/2025 at 6:45 pm by M # 2, indicated the diagnosis to be - intentional self-harm by strangulation. History of present illness - patient was found at his/her facility (H # 3) with a cord wrapped around his/her neck. The patient appeared to be hypoxic. 3. In interview on 02/27/2025 at approximately 2:50 pm with staff member A # 1 (Chief Nursing Officer-CNO), confirmed when the patient doesn't answer and/or refuses to answer the Columbia Suicide Risk Questions the system will automatically default to low risk. 4. In interview on 02/28/2025 at approximately 3:48 pm with medical staff member M # 4 (Chief Medical Officer-CMO), confirmed he/she believed it was a communication gap with the consult from H # 4. The nurse should use her discretion to change the suicide risk assessment if and/or when necessary.		Monthly report to the Quality Improvement Council, Medical Executive Committee and Governing Board. **Responsible:** Chief Nursing Officer Actions Taken #4- Communication was sent out on 2/28/25 to all emergency department physicians and also to the Behavioral Health Partners with acknowledgement of receipt that they are to communicate their organization's recommendations for treatment directly to the ED attending. The ED attending must document in the EMR, the identity of the behavioral health worker communicating those recommendations, the time of the discussion and the actual recommendation for care in their clinical progress note at the time of the encounter.	
A 0800 Bldg. 00	482.43(a) DISCHARGE PLANNING - EARLY IDENTIFICATION The hospital's discharge planning process must identify at an early stage of hospitalization those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning and must provide a discharge planning evaluation for those patients so identified as well as for other patients upon the request of the patient, patient's representative, or patient's			

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	physician. Based on document review and interview, the facility failed to provide appropriate discharge planning evaluation for a patient who had been previously identified as suicidal in one instance. (Patient # 10) Findings include: 1. The facility policy titled, Discharge Planning and Follow Up Care, version two (2), no policy number, indicated on page one (1) - section Procedure - number two (2) - to discharge a patient, obtain the completed chart and verify that all orders and reassessments have been completed and signed. This policy was last revised on 11/25/2024. 2. The facility policy titled, Suicide Risk Assessment and Interventions Columbia Protocol in Non-Behavioral Health Setting, version eight (8), no policy number, indicated on page two (2) - section Procedure - Required Action Steps - Guidance - Determining suicide risk level can include additional information and sources other than the patient, such as Emergency Medical Services, significant others and/or other observers who report suicide ideation, intent and/or behavior. This policy was last revised on 06/08/2022. 3. Patient # 10's MR indicated the following: The patient was a 24 y/o (year/old) brought into H # 2's (Acute Care Hospital) Emergency Department (ED) by police on several dates including, but not limited to, the following: a. The patient arrived to the ED on 01/14/2025 with the diagnosis of foreign body in hand, pica, and suicidal ideation. b. The Psychiatric Consult was ordered by M # 3	A 0800	Actions Taken The Discharge Planning and Follow Up Care Policy was reviewed and no changes were required. **Auditing and Monitoring:** Effective 3/18/25, the ED Assessment and Reassessment audits will include the review of appropriate discharge planning. A minimum of 50 ED patients per month will be audited from ESI 2 and 3 acuity ratings until there is 100% compliance for 4 consecutive months. Thereafter, ongoing internal audits will be conducted by the ED Department Leader/designee. All results will be reported to the leader safety huddle daily. The results will be reported to the Quality Improvement Council, Medical Executive Committee and Governing Board monthly. **Responsible:** Chief Nursing Officer	04/09/2025

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	(Doctor of Osteopathy-DO/Emergency Medicine). c. The Case Management (CM) note dated 01/15/2025 at 7:53 am, indicated the medical record chart was further reviewed by T # 1 (Transition Care Coordinator-TCC) with the current complaint being that the patient wants to overdose. d. The CM note dated 01/15/2025 at 12:07 pm, indicated H # 3, H # 2's charge nurse, Case Manager Director and Nurse Administration were all updated/aware, and were in agreement related to patient # 10 being discharged. e. The Provider note dated 01/15/2025 at 12:12 pm by M # 3, indicated - Calls-Consults - recommended H # 4 come and see the patient. It was felt that patient # 10 was not truly suicidal, but he/she had behavioral issues. The patient was discharged to H # 3 at 1:46 pm. f. The Law Enforcement Statement In Support of Emergency Detention and Transport dated 01/15/2025 at 6:16 pm, indicated the patient was back in the ED and was believed to be mentally ill due to - intellectual disability and other psychiatric disorders that substantially disturbed the individual's thinking, feeling, or behavior and impaired the individual's ability to function, and the person named above (patient # 10) was - dangerous to self and was in immediate need of hospitalization and treatment for the following reasons: Patient # 10 stated he/she would go in his/her room and self-harm. g. The Nurses note dated 01/15/2025 at 6:63 pm by N # 2 (Registered Nurse-RN), indicated the patient refused to answer the questions for the Columbia Suicide Risk Assessment. The patient was calculated (per the computer system) at low risk for suicide with no action interventions required. h. The Provider note dated 01/15/2025 at 7:34 pm by M # 2, Medical Decision Making - Patient had medical screening examination. The patient refused to cooperate with evaluation. He/she had			

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	numerous recent formal evaluations from H # 4 and was previously cleared to return to his/her group home. There appears to be no acute change in his/her condition. He/she was considered safe to return to his/her group home. Patient was discharged. i. The Triage Assessment dated 01/15/2025, signed by M # 1 on 01/16/2025 at 8:35 am on page 7, section Crisis Type - indicated suicidal, section Psychiatric Recommendations/Outcomes - M # 1 recommended that the client (patient # 10) needed to stay in the ED for the time being, and section Admission Criteria Met - indicated recent suicide attempt or gesture within seventy-two (72) hours prior to admit. j. The patient arrived to the ED on 01/16/2025 with the diagnosis of intentional self-harm by strangulation. k. The Provider note dated 01/16/2025 at 6:45 pm by M # 2, indicated the diagnosis to be - intentional self-harm by strangulation. History of present illness - patient was found at his/her facility (H # 3) with a cord wrapped around his/her neck. The patient appeared to be hypoxic. Patient was alone for approximately ten (10) to fifteen (15) minutes. Patient # 10 appeared stable on arrival to ED. He/she did not wish to answer questions at this time. 4. In interview on 02/27/2025 at approximately 2:50 pm with staff member A # 1 (Chief Nursing Officer-CNO), confirmed when the patient doesn't answer and/or refuses to answer the Columbia Suicide Risk Questions the system will automatically default to low risk. 5. In interview on 02/28/2025 at approximately 1:45 pm with medical staff member M # 2, confirmed when patient # 10 arrived to the ED in the evening of 01/15/2025, nothing had changed from earlier in			

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	the afternoon when he/she was discharged by medical staff member M # 3. When H # 4 comes in for a psychiatric consultation first they go talk to the patient, then go into a room where they phone the psychiatrist to discuss the assessment, then they are supposed to come find us to let us know their findings. Honestly, we all thought it was just attention seeking and maybe that clouded our judgement. 6. In interview on 02/28/2025 at approximately 2:10 pm with medical staff member M # 3, confirmed he/she never spoke to anyone from H # 4 related to the psychiatric evaluation recommendations. He/she confirmed receiving a call from CM (doesn't remember the name of person), indicating a meeting was held by CM, H # 3, patient # 10's guardian, hospital administration who all agreed to discharge patient # 10. Everyone thought it was behavioral issues. M # 3 further confirmed that he/she thought it was the "wrong play" to discharge the patient, but "I did". 7. In interview on 02/28/2025 at approximately 3:48 pm with medical staff member M # 4 (Chief Medical Officer-CMO), confirmed he/she believed it was a communication gap with the consults at H # 4. The nurse should use her discretion to change the suicide risk assessment if and/or when necessary.			
S 0000 Bldg. 00	This visit was for a State complaint hospital investigation. Complaint Number: IN00451750 - Deficiencies related to the allegation are cited. (S0930 & S1312)	S 0000	Submission of the plan of correction is not an admission that the citations are accurate or that the hospital violated the regulations.	

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	Survey Dates: 02/27/2025 & 02/28/2025 Facility Number: 005033 QA: 3/5/2025		Immediately upon receipt of the Survey Deficiency Statement, The hospital's Chief Executive Officer (CEO), Director of Quality, Chief Nursing Officer (CNO), Chief Operation Officer (COO), Chief Medical Officer (CMO) to review the survey findings Date completed: 3/12/25 Responsible Person: CEO The CEO notified and shared findings from the survey with the Governing Board Chairperson. Date Completed: 3/12/25	
S 0930 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. Based on document review and interview, the registered nurse failed to evaluate a patient appropriately per policy in one (1) instance. (Patient # 10) Findings include: 1. The facility policy titled, Suicide Risk Assessment and Interventions Columbia Protocol in Non-Behavioral Health Setting, version eight (8), no policy number, indicated on page two (2) - section Procedure - Required Action Steps - Guidance - Determining suicide risk level can include additional information and sources other	S 0930	In response to the Rule citation the Leadership team developed and implemented this plan of Correction including policy reviews, revisions to process training and education for staff, and incorporation of an on-going audit and monitoring of plan - S 930 **Action Taken:** The Suicide Risk Assessment and Interventions Columbia Protocol in Non-Behavioral Health Setting was	03/30/2025

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	than the patient, such as Emergency Medical Services, significant others and/or other observers who report suicide ideation, intent and/or behavior. This policy was last revised on 06/08/2022. 2. The facility policy titled, Scope of Service-Emergency Department, version three (3), no policy number, indicated on page one (1) - section - Standards of Guidelines for Practice - The Emergency Department follows the Emergency Nurses Association Standards of Practice when applicable, but they also dictate the care they provide to individual patient needs and the needs of the patient population. This policy was last revised on 11/25/2024. 3. Patient # 10's MR (medical record) indicated the following: the patient was a 24 y/o (year/old) brought into H # 2's (Acute Care Hospital) Emergency Department (ED) by police on several dates including, but not limited to, the following: a. The Law Enforcement Statement In Support of Emergency Detention and Transport dated 01/15/2025 at 6:16 pm, indicated the patient was believed to be mentally ill due to - intellectual disability and other psychiatric disorders that substantially disturbed the individual's thinking, feeling, or behavior and impaired the individual's ability to function, and the person named above (patient # 10) was - dangerous to self and was in immediate need of hospitalization and treatment for the following reasons: Patient # 10 stated he/she would go in his/her room and self-harm. b. The Nurses note dated 01/15/2025 at 6:63 pm by N # 2 (Registered Nurse-RN), indicated the patient refused to answer the questions for the Columbia Suicide Risk Assessment. The patient was calculated (per the computer system) at low risk for suicide with no action interventions required.		reviewed and no changes were required. **Training and Education:** Education includes: Columbia Suicide- Just In Time Tool (JIT), Patient Sitter Education, Suicide Risk Assessment and Interventions Columbia Protocol in Non- Behavioral Health Setting Policy. Education will also be provided during annual education /competencies. All new hires will be educated as part of the nursing orientation. **Auditing Monitoring:** Nurse administration/ designee will complete audits on all patients that screen high risk according to the Suicide Risk Assessment and Interventions Columbia Protocol and require a sitter, until 4 consecutive months with a 100% compliance rate (Patient sitter, continuous observation with Q15 documentation according to policy, Columbia- Suicide Severity Rating Scale (C-SSRS) completed per shift, safe room checks and Risk level appropriateness) implemented 1/13/25. Effective 3/18/25, patient's refusal to answer questions will be added to the above auditing process (*Per Policy nurse decretion will be used to determine suicide risk level based on additional information and sources other than the patient, such as Emergency Medical Services, significant others and/or other*	

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	c. The Provider note dated 01/15/2025 at 7:34 pm by M # 2 (Doctor of Osteopathy-DO/Family Medicine), indicated Medical Decision Making - Patient had medical screening examination. The patient refused to cooperate with evaluation. There appears to be no acute change in his/her condition. He/she was considered safe to return to his/her group home. Patient was discharged back to H # 3 (Group Home). d. The Provider note dated 01/16/2025 at 6:45 pm by M # 2, indicated the diagnosis to be - intentional self-harm by strangulation. History of present illness - patient was found at his/her facility (H # 3) with a cord wrapped around his/her neck. The patient appeared to be hypoxic. 4. In interview on 02/27/2025 at approximately 2:50 pm with staff member A # 1 (Chief Nursing Officer-CNO), confirmed when the patient doesn't answer and/or refuses to answer the Columbia Suicide Risk Questions the system will automatically default to low risk. 5. In interview on 02/28/2025 at approximately 3:48 pm with medical staff member M # 4 (Chief Medical Officer-CMO), confirmed he/she believed it was a communication gap with the consult from H # 4. The nurse should use her discretion to change the suicide risk assessment if and/or when necessary.		*observers who report suicide ideation, intent and/or behavio*r). Ongoing internal audits will be conducted monthly by the nursing administration Leader/designee. Results will be reported to leadership safety huddle daily. Monthly report to the Quality Improvement Council, Medical Executive Committee and Governing Board. **Responsible:** Chief Nursing Officer Actions Taken #5- Communication was sent out on 2/28/25 to all emergency department physicians and also to the Behavioral Health Partners with acknowledgement of receipt that they are to communicate their organization's recommendations for treatment directly to the ED attending. The ED attending must document in the EMR, the identity of the behavioral health worker communicating those recommendations, the time of the discussion and the actual recommendation for care in their clinical progress note at the time of the encounter.	
S 1312 Bldg. 00	410 IAC 15-1.5-10 UTILIZATION REVIEW & DISCHARGE PLANNING 410 IAC 15-1.5-10(e)(1) (e) To facilitate discharge as soon as			

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	an acute level of care is no longer required, the hospital shall have effective, ongoing discharge planning that: (1) facilitates the provisions of follow-up care; Based on document review and interview, the facility failed to provide appropriate discharge planning evaluation for a patient who had been previously identified as suicidal in one instance. (Patient # 10) Findings include: 1. The facility policy titled, Discharge Planning and Follow Up Care, version two (2), no policy number, indicated on page one (1) - section Procedure - number two (2) - to discharge a patient, obtain the completed chart and verify that all orders and reassessments have been completed and signed. This policy was last revised on 11/25/2024. 2. The facility policy titled, Suicide Risk Assessment and Interventions Columbia Protocol in Non-Behavioral Health Setting, version eight (8), no policy number, indicated on page two (2) - section Procedure - Required Action Steps - Guidance - Determining suicide risk level can include additional information and sources other than the patient, such as Emergency Medical Services, significant others and/or other observers who report suicide ideation, intent and/or behavior. This policy was last revised on 06/08/2022. 3. Patient # 10's MR indicated the following: The patient was a 24 y/o (year/old) brought into H # 2's (Acute Care Hospital) Emergency	S 1312	In response to the Rule citation the Leadership team developed and implemented this plan of Correction including policy reviews, revisions to process training and education for staff, and incorporation of an on-going audit and monitoring of plan - S 1312 #1- Actions Taken The Discharge Planning and Follow Up Care Policy was reviewed and no changes were required. **Auditing and Monitoring:** Effective 3/18/25, the ED Assessment and Reassessment audits will include the review of appropriate discharge planning. A minimum of 50 ED patients per month will be audited from ESI 2 and 3 acuity ratings until there is 100% compliance for 4 consecutive months. Thereafter, ongoing internal audits will be conducted by the ED Department Leader/designee. All results will be reported to the leader safety huddle daily. The results will be reported to the Quality Improvement Council, Medical Executive Committee and Governing Board monthly.	03/30/2025

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	Department (ED) by police on several dates including, but not limited to, the following: a. The patient arrived to the ED on 01/14/2025 with the diagnosis of foreign body in hand, pica, and suicidal ideation. b. The Psychiatric Consult was ordered by M # 3 (Doctor of Osteopathy-DO/Emergency Medicine). c. The Case Management (CM) note dated 01/15/2025 at 7:53 am, indicated the medical record chart was further reviewed by T # 1 (Transition Care Coordinator-TCC) with the current complaint being that the patient wants to overdose. d. The CM note dated 01/15/2025 at 12:07 pm, indicated H # 3, H # 2's charge nurse, Case Manager Director and Nurse Administration were all updated/aware, and were in agreement related to patient # 10 being discharged. e. The Provider note dated 01/15/2025 at 12:12 pm by M # 3, indicated - Calls-Consults - recommended H # 4 come and see the patient. It was felt that patient # 10 was not truly suicidal, but he/she had behavioral issues. The patient was discharged to H # 3 at 1:46 pm and arrived back to the ED on 01/15/2025 with the diagnosis of behavioral problems. f. The Law Enforcement Statement In Support of Emergency Detention and Transport dated 01/15/2025 at 6:16 pm, indicated the patient was believed to be mentally ill due to - intellectual disability and other psychiatric disorders that substantially disturbed the individual's thinking, feeling, or behavior and impaired the individual's ability to function, and the person named above (patient # 10) was - dangerous to self and was in immediate need of hospitalization and treatment for the following reasons: Patient # 10 stated he/she would go in his/her room and self-harm. g. The Nurses note dated 01/15/2025 at 6:63 pm by N # 2 (Registered Nurse-RN), indicated the patient refused to answer the questions for the Columbia		**Responsible:** Chief Nursing Officer **#2- Action Taken:** The Suicide Risk Assessment and Interventions Columbia Protocol in Non-Behavioral Health Setting was reviewed and no changes were required. **Training and Education:** Education includes: Columbia Suicide- Just In Time Tool (JIT), Patient Sitter Education, Suicide Risk Assessment and Interventions Columbia Protocol in Non- Behavioral Health Setting Policy. Education will also be provided during annual education /competencies. All new hires will be educated as part of the nursing orientation. **Auditing and Monitoring:** Nurse administration/ designee will complete audits on all patients that screen high risk according to the Suicide Risk Assessment and Interventions Columbia Protocol and require a sitter, until 4 consecutive months with a 100% compliance rate (Patient sitter, continuous observation with Q15 documentation according to policy, Columbia- Suicide Severity Rating Scale (C-SSRS) completed per shift, safe room checks and Risk level appropriateness) implemented 1/13/25. Effective 3/18/25, patient's refusal to answer questions will be added to the above auditing process (*Per*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150035	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHWEST HEALTH- PORTER	85 EAST US HWY 6 VALPARAISO, IN 46383

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	Suicide Risk Assessment. The patient was calculated (per the computer system) at low risk for suicide with no action interventions required. h. The Provider note dated 01/15/2025 at 7:34 pm by M # 2, Medical Decision Making - Patient had medical screening examination. The patient refused to cooperate with evaluation. He/she had numerous recent formal evaluations from H # 4 and was previously cleared to return to his/her group home. There appears to be no acute change in his/her condition. He/she was considered safe to return to his/her group home. Patient was discharged. i. The Triage Assessment dated 01/15/2025, signed by M # 1 on 01/16/2025 at 8:35 am on page 7, section Crisis Type - indicated suicidal, section Psychiatric Recommendations/Outcomes - M # 1 recommended that the client (patient # 10) needed to stay in the ED for the time being, and section Admission Criteria Met - indicated recent suicide attempt or gesture within seventy-two (72) hours prior to admit. j. The patient arrived to the ED on 01/16/2025 with the diagnosis of intentional self-harm by strangulation. k. The Provider note dated 01/16/2025 at 6:45 pm by M # 2, indicated the diagnosis to be - intentional self-harm by strangulation. History of present illness - patient was found at his/her facility (H # 3) with a cord wrapped around his/her neck. The patient appeared to be hypoxic. Patient was alone for approximately ten (10) to fifteen (15) minutes. Patient # 10 appeared stable on arrival to ED. He/she did not wish to answer questions at this time. 4. In interview on 02/27/2025 at approximately 2:50 pm with staff member A # 1 (Chief Nursing Officer-CNO), confirmed when the patient doesn't answer and/or refuses to answer the Columbia		*Policy nurse decretion will be used to determine suicide risk level based on additional information and sources other than the patient, such as Emergency Medical Services, significant others and/or other observers who report suicide ideation, intent and/or behavio*r). Ongoing internal audits will be conducted monthly by the nursing administration Leader/designee. Results will be reported to leadership safety huddle daily. Monthly report to the Quality Improvement Council, Medical Executive Committee and Governing Board. **Responsible:** Chief Nursing Officer	

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	Suicide Risk Questions the system will automatically default to low risk. 5. In interview on 02/28/2025 at approximately 1:45 pm with medical staff member M # 2, confirmed when patient # 10 arrived to the ED in the evening of 01/15/2025, nothing had changed from earlier in the afternoon when he/she was discharged by medical staff member M # 3. When H # 4 comes in for a psychiatric consultation first they go talk to the patient, then go into a room where they phone the psychiatrist to discuss the assessment, then they are supposed to come find us to let us know their findings. Honestly, we all thought it was just attention seeking and maybe that clouded our judgement. 6. In interview on 02/28/2025 at approximately 2:10 pm with medical staff member M # 3, confirmed he/she never spoke to anyone from H # 4 related to the psychiatric evaluation recommendations. He/she confirmed receiving a call from CM (doesn't remember the name of person), indicating a meeting was held by CM, H # 3, patient # 10's guardian, hospital administration who all agreed to discharge patient # 10. Everyone thought it was behavioral issues. M # 3 further confirmed that he/she thought it was the "wrong play" to discharge the patient, but "I did". 7. In interview on 02/28/2025 at approximately 3:48 pm with medical staff member M # 4 (Chief Medical Officer-CMO), confirmed he/she believed it was a communication gap with the consults at H # 4. The nurse should use her discretion to change the suicide risk assessment if and/or when necessary.			