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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Inpatient Mental Health Unit Processes at the West Palm Beach VA Healthcare System in Florida

Healthcare Inspection | **25-02766-130** | **June 4, 2026**

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Executive Summary

The VA Office of Inspector General (OIG) initiated a healthcare inspection on June 10, 2025, following inquiries from several members of Congress about the death of a patient (patient 1) in March 2024, perpetrated by another patient (patient 2) (event) on the inpatient mental health unit (3C) at the West Palm Beach VA Healthcare System (facility) in Florida.[1] One of the inquiries was related to whether facility leaders sustained measures implemented to address patient safety observation, policy, and oversight findings following a 2019 OIG inspection, prompted by a patient's suicide on 3C.[2] The inspection team conducted a site visit June 24–26, 2025, virtual follow-up interviews through December 8, 2025, and continued communications with facility leaders through December 19, 2025.

The OIG found that 3C staff did not comply with Veterans Health Administration (VHA) requirements outlined in the Mental Health Environment of Care (EOC) Checklist.[3] Specifically, staff assigned patient 1 to share a room with patient 2 despite patient 1 using a wheelchair and both patients being admitted for suicidal ideation and having high risk for suicide flags.[4] The mental health EOC checklist requires patients who use a wheelchair on an inpatient mental health unit to be assigned a single room or a shared room if both patients are considered low risk for suicide. Also, staff did not implement the required direct line of sight observation patient 1 needed due to use of a wheelchair and instead placed the patient on 15-minute observation (routine observation) and 30-minute observation.

The OIG followed up with the facility in December 2025 and learned that facility leaders had revised their room assignment screening tool to align with the mental health EOC checklist.

The OIG identified findings similar to those reported in the 2019 OIG inspection, including inconsistent patient safety observation practices and inaccurate documentation on the night of the event, inappropriate assignment of additional duties for staff, and facility policy that did not align

[1] On March 16, 2024, the OIG Office of Investigations initiated a criminal investigation into patient 1's death. Patient 2 was later committed to the custody of the Bureau of Prisons. Following confirmation that the OIG's Office of Investigations had concluded their work, the OIG's Office of Healthcare Inspections reviewed the congressional inquiry and initiated this inspection.

[2] VA OIG, *Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center Florida*, Report No. 19-07429-195, August 22, 2019.

[3] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist for Mental Health and Emergency Rooms," updated on April 30, 2024, March 19, 2025, May 19, 2025, and November 18, 2025. The versions of the checklist include similar language regarding patient room assignments, medical equipment, and suicide risk.

[4] A high risk for suicide patient record flag is an alert in a patient's electronic health record to "communicate to VA staff that a veteran is at high risk for suicide." VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

with VHA requirements.[5] Although facility leaders became aware that staff were not performing routine observations correctly and identified strategies for improvement, changes were not implemented.

As a result of the current OIG inspection, facility leaders implemented corrective actions including updating facility policy 118-01, *Enhanced Observation Levels,* to require provider orders when discontinuing a patient safety observation level and adding a direct line of sight observation level.[6] Further, the updated policy prohibits staff from performing patient safety observation while completing other duties.

The OIG made six recommendations to the Facility Director to ensure awareness and application of the mental health EOC checklist requirements, review and strengthen patient safety observation practices, ensure staff training on patient safety observation, develop and implement oversight processes for ongoing monitoring of patient safety observation practices and documentation and a plan to reassess the effectiveness of the oversight process, and ensure discrepancies between observation practice and documentation on 3C are reviewed and addressed.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

[5] VA OIG, *Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center Florida*; Facility Medical Center Policy 118-01, *Enhanced Observation Levels,* March 10, 2022; VHA Standard Operating Procedure (SOP) 1160.06.1, "Standard Operating Procedures for Maintaining Safety and Security on Inpatient Mental Health Units under VHA Directive 1160.06," September 29, 2023, updated October 11, 2024. The 2023 SOP was in place during the time of the events discussed in this report. For the purpose of this report, the 2024 SOP contains the same or similar language regarding patient safety observation unless otherwise noted.

[6] Facility Medical Center Policy 118-01, *Enhanced Observation Level*, December 19, 2025.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes B and C). The Facility Director informed the OIG that leaders will provide education to staff on the mental health EOC checklist and patient safety observation requirements, develop a standardized audit tool, and conduct regular audits of room assignment and patient safety observation practices on 3C. The Facility Director will monitor compliance through the Quality Patient Safety Council. The OIG will follow up on the planned actions until they are completed.

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Contents

Abbreviations

ADL	activities of daily living
AI	artificial intelligence
EHR	electronic health record
EOC	environment of care
OIG	Office of Inspector General
SOP	standard operating procedure
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) initiated a healthcare inspection on June 10, 2025, following inquiries from several members of Congress about the death of a patient (patient 1) in March 2024, perpetrated by another patient (patient 2) (event) on the inpatient mental health unit (3C) at the West Palm Beach VA Healthcare System (facility).[1] One of the inquiries was related to whether facility leaders sustained measures implemented to address patient safety observation, policy, and oversight findings from a 2019 OIG inspection, prompted by a patient's suicide on 3C.[2] The OIG conducted a site visit June 24–26, 2025, virtual follow-up interviews July 8–December 8, 2025, and continued to communicate with and receive updates from facility leaders through December 19, 2025.

Background

The facility, part of Veterans Integrated Service Network (VISN) 8, includes a medical center, seven outpatient clinics, a domiciliary, and a community living center.[3] The facility offers a range of services including inpatient mental health, surgical services, primary care, emergency care, long-term care, and hospice. From October 2023 through September 2024, the facility's medical center had 333 operating beds, which included 25 inpatient mental health operating beds; during that period, 525 unique patients received inpatient mental health treatment.

Inpatient Mental Health

Veterans Health Administration (VHA) Directive 1160.06(1), *Inpatient Mental Health Services*, sets a goal for inpatient mental health services to provide a safe, secure therapeutic environment for patients experiencing "acute and severe emotional or behavioral symptoms" who may be at risk of harm to self or others.[4] Mental health staff provide acute, high-intensity, clinical care to patients in a "locked inpatient setting to ensure safety and provide the type and intensity of clinical observation and intervention necessary."[5]

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[1] On March 16, 2024, the OIG Office of Investigations initiated a criminal investigation into patient 1's death. Patient 2 was later committed to the custody of the Bureau of Prisons. Following confirmation that the OIG's Office of Investigations had concluded their work, the OIG' Office of Healthcare Inspections reviewed the congressional inquiry and initiated this inspection.

[2] VA OIG, *Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center Florida*, Report No. 19-07429-195, August 22, 2019.

[3] "Locations," VA, accessed February 11, 2026, https://www.va.gov/west-palm-beach-health-care/locations.

[4] VHA Directive 1160.06(1), *Inpatient Mental Health Services*, September 27, 2023, amended December 27, 2024. The September directive was in place at the time of the subject patients' care. For the purpose of this report, the policies contain similar language regarding inpatient treatment.

[5] VHA Directive 1160.06(1).

Patient Safety Observation

Inpatient mental health staff conduct patient safety observations to ensure staff are aware of each patient's "location, activities, movement, and general status … at all times."[6] Patient safety observation levels describe the frequency that staff are to visually observe a patient as well as the required staff-to-patient ratio. The treatment team, which must include a psychiatric health care provider, a registered nurse, and one other team member from a designated discipline, determines the level of patient safety observation needed based on a patient's safety and care needs.[7] VHA Standard Operating Procedure (SOP) 1160.06.1, establishes four inpatient mental health patient safety observation levels, including every 30 minutes, every 15 minutes (routine observation), direct line of sight, and one-to-one. (See appendix A.)[8] Direct line of sight requires staff to "continuous[ly] observe" a patient, including those using medical devices, while one-to-one observation requires a staff member to be within arm's length of a patient.[9]

Mental Health Environment of Care

VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*, recognizes that the environment can pose safety risks for patients on inpatient mental health units, including those at risk for suicide. Facilities are expected to proactively identify and abate environmental hazards.[10] To support this effort, VHA developed the Mental Health Environment of Care (EOC) Checklist to help facilities identify and address environmental risks for suicide. The mental health EOC checklist consists of safety criteria for all unit areas including patient bedrooms and bathrooms.[11] The checklist also notes that medical equipment, such as wheelchairs, could be used for self-harm and outlines additional safeguards such as keeping a patient in direct line of sight to ensure safety for patients.[12] Inpatient mental health

[6] VHA SOP 1160.06.1, "Standard Operating Procedures for Maintaining Safety and Security on Inpatient Mental Health Units under VHA Directive 1160.06," September 29, 2023, was updated October 11, 2024. The 2023 SOP was in place during the time of the events discussed in this report. The SOPs contain the same or similar language regarding patient safety observation unless otherwise noted.

[7] VHA Directive 1160.06(1); VHA SOP 1160.06.1.

[8] Underlined terms are hyperlinks to another section of the report. To return to point of origin, press and hold the "alt" and "left arrow" keys together.

[9] VHA SOP 1160.06.1.

[10] VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*, May 12, 2017, rescinded and replaced on November 4, 2024. The 2017 directive was in place at the time of the patients' care. For the purpose of this report, the policies contain the same or similar language unless otherwise noted.

[11] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024.

[12] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist for Mental Health and Emergency Rooms," April 30, 2024, updated on March 19, 2025, May 19, 2025, and November 18, 2025. The versions of the checklist include similar language regarding patient room assignments, medical equipment, and suicide risk.

staff conduct daily EOC rounds to identify and abate environmental risks; these are conducted separately from patient safety observations.

Concerns

In May 2025, the OIG received an inquiry regarding patient 1's death and whether factors that contributed to the event were similar to issues identified in the OIG inspection conducted in 2019 following a patient's suicide on the same unit.

Following closure of an OIG criminal investigation, the OIG initiated a healthcare inspection to evaluate patient safety observation policies and practices on 3C and determine whether oversight measures implemented to address relevant recommendations from a 2019 OIG inspection were sustained.[13] Further, the OIG identified a concern regarding 3C staff's application of the mental health EOC checklist criteria for patients 1 and 2.

Related OIG Report

A 2019 OIG inspection at the facility evaluated the circumstances related to a patient's suicide on 3C. The OIG's *Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center Florida* included findings related to patient safety observation policy and practices, oversight, safety requirement awareness, and unclear expectations from leaders.

Relevant OIG recommendations included the former Facility Director

- "ensures that a policy on 15-minute safety rounding [routine observation] expectations be developed, and that all permanent and temporarily-assigned staff performing 15-minute safety rounding on unit 3C receive appropriate training regarding their duties," and
- "develops a mechanism to confirm staff compliance with 15-minute rounding [routine observation] requirements."[14]

In response, the former Facility Director proposed plans to develop a new policy for routine observation, train staff on the new policy, and create a tool to use in routine observation audits. In follow-up with the OIG, facility staff provided evidence that actions were implemented and monitored for compliance. The OIG closed the recommendations in April 2020.

[13] VA OIG, *Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center Florida*.
[14] VA OIG, *Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center Florida*.

Scope and Methodology

The OIG initiated the inspection on June 10, 2025, conducted a site visit June 24–26, 2025, and virtual follow-up interviews July 8, 2025–December 8, 2025.

The OIG interviewed VHA, VISN, and facility leaders and staff familiar with the subject patients' care and related processes.

The OIG reviewed patient 1's and patient 2's electronic health records (EHRs); police reports; closed-circuit video of 3C on the night of the event; relevant VHA directives, SOPs, and memoranda; and facility policies, SOPs, organizational charts, and quality reviews. The OIG also reviewed prior OIG reports, including the 2019 OIG inspection report related to a patient suicide on 3C, and the facility response to recommendations about patient safety observation.[15]

The OIG inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of the Inspectors General on Integrity and Efficiency's standards.[16] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and take full responsibility for the content of the publication. All references are for original source material, not artificial intelligence (AI)-generated content. The Office of Healthcare inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget Memorandum M-25-21, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust."[17]

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations

[15] VA OIG, *Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center Florida*.

[16] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

[17] Director for the Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," memorandum to Heads of Executive Departments and Agencies, April 3, 2025.

to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Patient Case Summaries

At the time of the event, patient 1 and patient 2 were assigned to the same shared room on unit 3C.

Patient 1

Patient 1 was in their late sixties and had a history of major depressive disorder, post-traumatic stress disorder, substance use disorders, a high risk for suicide flag designation, and multiple comorbid illnesses.[18] In early 2024, patient 1 presented to the facility emergency department in a wheelchair, with an exacerbation of chronic obstructive pulmonary disease and suicidal ideation. The patient told an emergency department physician about having attempted suicide by overdose with acetaminophen and melatonin. The emergency department physician admitted the patient to a medical unit for stabilization.

Sixteen days later, an inpatient medicine physician documented patient 1 as medically stable. Given the patient's report of continued suicidal ideation, a psychiatrist transferred the patient to 3C and placed orders for routine observation. After arriving at 3C, nursing staff documented the patient was also on close observation for activities of daily living (ADL) due to needing a wheelchair. Nursing staff documented completing safety observations as ordered. At 2:18 a.m., a 3C staff member activated a facility emergency response after the patient was found unresponsive in the bathroom. Following unsuccessful resuscitation attempts, a critical care clinician pronounced patient 1 deceased at 2:43 a.m.

Patient 2

In early 2024, patient 2, who was in their mid-thirties, presented to the facility's mental health same-day access clinic and requested to be seen by a provider. The patient reported anxiety, depression, psychotic symptoms, and suicidal ideation with intent and plan to use a firearm for self-harm. A psychiatrist evaluated and diagnosed patient 2 with a mood disorder and psychosis and escorted patient 2 to the emergency department for evaluation and admission to 3C. Patient 2 was admitted from the emergency department to 3C. The next day, which was the same day

[18] The OIG uses the singular form of they, "their" in this instance, for privacy purposes. A high risk for suicide patient record flag is an alert in a patient's EHR to "communicate to VA staff that a veteran is at high risk for suicide." VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

patient 1 was transferred to 3C, a nurse completed an admission screen for patient 2 that noted a positive suicide screen, the placement of one-to-one observation, and a negative violence risk screen.[19] A suicide prevention coordinator documented placement of a high risk for suicide flag in the patient's EHR. On the same day, 3C staff documented the absence of suicidal and homicidal ideations. Later that day, a physician assistant completed an evaluation, noted that the patient continued to deny suicidal ideation and homicidal ideation, discontinued the one-to-one, and ordered close observation for ADL.

The next day at 1:27 a.m., a nurse documented that staff monitored patient 2 via routine observation and that patient 2 denied suicidal and homicidal ideations. Approximately seven hours later, another nurse documented that patient 2 was sitting in bed with head down, reported suicidal ideation, and admitted to killing patient 1. Law enforcement was notified and patient 2 was later taken into custody.[20]

Inspection Results

1. Review of Mental Health Environment of Care Checklist

The OIG found that staff did not adhere to mental health EOC checklist patient safety requirements, which increased the risk of harm. Specifically, the OIG found that based on patient 1's wheelchair use, room assignments for patients 1 and 2 and the designated patient safety observation level for patient 1 were not appropriate. The OIG determined although (1) the mental health EOC checklist room assignment and direct line of sight observation requirements related to wheelchair use are intended to mitigate the risk of self-harm and suicide and (2) the wheelchair was not a contributing factor to the event, compliance with checklist safety requirements may have provided the precautions necessary to protect both patients.

Patient Room Assignment

The mental health EOC checklist requires staff to assign patients who use a wheelchair on an inpatient mental health unit to a single room or a shared room if both patients are considered low risk for suicide.[21]

The OIG found that staff assigned patient 1 to share a room with patient 2 despite patient 1 using a wheelchair and both patients being admitted for suicidal ideation and having high risk for suicide flags. Patient 1 was transferred back to 3C, due to major depressive disorder and suicidal

[19] The violence risk screen included three questions asking the patient about current thoughts of violence or suicide, and whether the patient had a history of violence on an inpatient mental health unit.

[20] The facility notified the OIG on the day of the event; the OIG Office of Investigations initiated a criminal investigation into patient 1's death. Patient 2 was later committed to the custody of the Bureau of Prisons.

[21] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist for Mental Health and Emergency Rooms," March 19, 2025.

ideation. On the same day patient 1 returned to 3C, a suicide prevention coordinator documented that patient 2 was considered high risk for suicide and placed a high risk for suicide flag in patient 2's EHR.

The chief nurse, mental health was unaware of the mental health EOC checklist requirement associated with room assignments for patients using wheelchairs and reported that at the time of the event, 3C staff did not have written guidance for determining room assignments. The OIG found that although staff developed and implemented a room assignment screening tool after the event, the tool did not incorporate required mental health EOC checklist safety considerations for patients using wheelchairs, such as patients' suicide risk levels.[22] However, in December 2025, the OIG learned that facility leaders had revised the room assignment screening tool to align with the EOC checklist requirements.

The OIG concluded that 3C staff compliance with VHA requirements would have resulted in different room assignments for patients 1 and 2.

Direct Line of Sight

The mental health EOC checklist requires that staff monitor patients who use wheelchairs on inpatient mental health units through the direct line of sight observation level, which involves constant observation by staff.[23]

The OIG found a 3C leader and former leaders as well as staff were unfamiliar with the wheelchair-related direct line of sight mental health EOC checklist requirement and cited observation practices that were inconsistent with the requirement. During interviews, 3C leaders and staff reported placing patients who use wheelchairs on concurrent routine observation, which occurs every 15 minutes, and close observation for ADL, which occurs every 30 minutes. EHR and 3C nursing report documentation revealed that when patient 1 transferred to 3C, staff noted the patient's use of a wheelchair and initiated both routine observation and "close observation for ADL," not direct line of sight. Staff continued documenting routine and 30-minute patient safety observation until the event.

The OIG concluded that 3C leaders' lack of awareness of VHA requirements contributed to staff not implementing direct line of sight observation for patient 1. This enhanced observation level would have provided additional safety measures that may have protected both patients.

[22] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist for Mental Health and Emergency Rooms," March 19, 2025.

[23] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist for Mental Health and Emergency Rooms," March 19, 2025. "Staff can observe multiple patients, but must remain in the area with patients, such that if a patient needs immediate intervention, the staff member can intervene and call other staff to help as needed." "Cameras cannot substitute for direct line-of-sight observation."

2. Review of Patient Observation and Previous OIG Findings

The OIG identified multiple findings that were similar to those in the 2019 OIG report, including issues with patient safety observation practices and documentation, assignment of additional duties during patient safety observation, unclear or no policy guidance, and insufficient oversight.[24]

Patient Safety Observation Practices

According to VHA SOP 1160.06.1, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06," and facility policy 118-01, *Enhanced Observation Levels*, routine observation requires staff to have "direct visual face-to-face interaction/observation" with the patient every 15 minutes.[25] VHA SOP 1160.06.1 also requires that staff document patient "activity and location at the time of the observation."[26]

The OIG observed that because of the unit design, staff needed to enter patient rooms while conducting routine observation to ensure the safety of a patient when sleeping. However, while reviewing video footage, the OIG found that nursing staff performed patient safety observations from a patient's doorway. Similarly, in the 2019 prior report, a nursing staff member did not enter the patient's room when conducting routine observation.[27] Of note, due to limitations with video footage, the team was unable to determine whether staff conducted patient safety observations for patients 1 and 2.[28]

In June and July 2025, staff reported to the OIG differing understandings of how patient safety observations should be performed on 3C. Some staff believed entering patients' rooms when conducting patient safety observation was not required.

The OIG also identified discrepancies between nursing observation practices and observation documentation on the night of the event. A nursing assistant initialed the routine observation log for patient 1 to signify completion during a 15-minute period, but video footage showed the observation was completed by a different nursing assistant. In an OIG interview, another nursing assistant reported documenting a patient safety observation of patient 2 during the night of the event without observing the patient.

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[24] VA OIG, *Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center Florida*.

[25] VHA SOP 1160.06.1, September 29, 2023; Facility Medical Center Policy 118-01, *Enhanced Observation Levels,* March 10, 2022.

[26] VHA SOP 1160.06.1, September 29, 2023.

[27] VA OIG, *Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center Florida*.

[28] The video footage used on 3C was motion activated, which resulted in lapses in footage at times due to poor lighting and the camera angle. Due to the limitations of the video footage, the view of patients 1 and 2's room is not clear or consistent. At the time of the OIG site visit, the facility no longer relied on motion activated video and had transitioned to continuous recording.

The OIG concluded that inadequate routine observation practices and documentation occurred on the night of the event. Similar to 2019, staff did not have a clear understanding of routine observation requirements, which contributed to gaps in safe monitoring of 3C patients and increased the risk of harm.

Adherence to Staff Assignment Requirements

The OIG found that on the night of the event, staff assigned to complete 30-minute patient safety observation for patients 1 and 2 were also assigned environmental rounding, which is similar to OIG findings in 2019 when nursing assistants were assigned other duties while conducting patient safety observation.[29]

VHA SOP 1160.06.1 requires that staff conducting 30-minute patient safety observation do not have other assigned duties.[30] The nurse manager acknowledged staff cannot effectively fulfill 30-minute patient safety observation duties while also completing environmental rounding and relayed that after the event, staff were instructed to no longer conduct these duties simultaneously. Following the OIG site visit, facility leaders updated policy 118-01, which included instruction that staff performing any patient safety observation are not to be assigned additional duties.[31]

Facility Observation Status Policy

In response to a 2019 finding that the facility lacked a policy regarding routine observation, leaders updated facility policy 118-01 in 2020 and added requirements related to routine observation.[32] Following this update, the OIG closed the recommendation.

During this inspection, the OIG found facility policy 118-01 was updated again in 2022. The 2022 version did not align with VHA SOP 1160.06.1 requirements regarding direct line of sight and discontinuation of a patient safety observation status order.[33]

The chief nurse, mental health reported becoming aware that the facility policy was not aligned with VHA requirements regarding direct line of sight observation when assuming the position in 2022, and communicated concerns to the former Associate Director, Patient Care Services and 3C medical director. The chief nurse explained that although revisions were made in March 2025 to align the policy with direct line of sight requirements, as of September 2025, changes had not

[29] Facility policy requires that staff conducting environmental rounding "continuously observe" the unit to identify safety hazards and do not have additional duties that may interrupt focus. Facility Medical Center SOP 118-MH-02, "Environmental Rounding on the Inpatient Mental Health Unit," July 8, 2021.

[30] VHA SOP 1160.06.1, September 29, 2023.

[31] Facility Medical Center Policy 118-01, *Enhanced Observation Level*, December 19, 2025.

[32] Facility Medical Center Policy 118-01, *Enhanced Observation Levels*, February 7, 2020.

[33] Facility Medical Center Policy 118-01, *Enhanced Observation Levels*, March 10, 2022; VHA SOP 1160.06.1, September 29, 2023.

been implemented due to a delay in updating an order option in the EHR and providing staff training.

On December 4, 2025, at the request of the OIG, the chief nurse, mental health provided documentation confirming the direct line of sight observation level had been implemented, including the EHR update and nursing staff training.[34]

The OIG also identified a discrepancy between facility policy 118-01 (2022) and VHA SOP 1160.06 related to order discontinuation of patient safety observation.[35] For patients on an inpatient mental health unit, a provider orders a patient safety observation level in the EHR.[36] While VHA SOP 1160.06.1 allows nursing staff to increase observation levels, it requires a provider order to decrease the level.[37] Facility policy 118-01 allowed discontinuation of observation without a provider order.[38]

On December 17, 2025, the OIG notified the Facility Director of this patient safety risk. In response, the facility submitted evidence that policy 118-01 was updated on December 19, 2025, to mitigate the risk.[39] Due to facility leaders' responsiveness to the discrepancy identified by the OIG and the corrective action taken to implement direct line of sight and align policy, the OIG did not issue a recommendation.

Leadership Oversight of Staff Compliance with Required Observation Practices

Although facility leaders sustained an auditing process developed to address the 2019 OIG findings, the facility lacked an oversight process to ensure routine observation was completed. The OIG found audits were focused on documentation compliance rather than staff's patient safety observation practices. Further, facility leaders were aware of ongoing problems with routine observation practices and had identified strategies to address deficiencies in staff compliance but had not implemented changes.

In OIG interviews, the 3C nurse manager and the former nurse manager reported reviewing routine observation logs to ensure all components were documented as expected.[40] The nurse

[34] Documentation provided by the chief nurse, mental health confirmed 3C provider and staff training for direct line of sight occurred in October, November, and early December 2025.

[35] Facility Medical Center Policy 118-01, *Enhanced Observation Levels*, March 10, 2022; VHA SOP 1160.06.1, September 29, 2023.

[36] VHA SOP 1160.06.1, September 29, 2023.

[37] VHA SOP 1160.06.1, September 29, 2023.

[38] Facility Medical Center Policy 118-01, *Enhanced Observation Levels*, March 10, 2022.

[39] Facility Medical Center Policy 118-01, *Enhanced Observation Level*, December 19, 2025.

[40] The former nurse manager was in the position at the time of the subject patients' care. The nurse manager was detailed and covering the position from July 2024 until December 2024 and transitioned permanently into the role in December 2024.

manager reported there were no audit processes in place to verify routine observation practice occurred as expected.

The OIG learned that an administrative investigation, completed in September 2021, found that four 3C staff did not conduct routine observation and falsified documentation. The investigative team recommended the nurse manager randomly review video to ensure staff were conducting routine observation as expected and to consider the use of electronic solutions for patient safety observation. Facility leaders identified a mobile monitoring technology system (mobile monitoring), which allows staff to perform proximity-based patient checks using wrist bands.[41] However, due to technology barriers and challenges with union regulations, neither recommendation was implemented.

In March 2024, VISN quality assurance site visit findings noted 3C staff voiced concerns that routine observation documentation did not accurately reflect current practice and, as a result, recommended the facility revisit the use of mobile monitoring.

The OIG also learned that in April and July 2025, the nurse manager reviewed video for two unrelated incidents and observed staff not completing routine observation. The nurse manager reported taking "corrective action," including staff reeducation and disciplinary actions.

The Facility Director reported routine observation documentation was a vulnerability across facilities and expressed support for the implementation of mobile monitoring. The associate chief of staff, mental health and nurse manager described a plan to implement mobile monitoring to increase accountability and provide additional assurance that patient safety observations are completed.

The chief nurse, mental health, reported that as of January 2026, the facility obtained the software and equipment, but did not have a planned implementation date for mobile monitoring.

The OIG concluded that despite audits of patient safety observation logs, facility leaders did not ensure compliance with patient safety observation practices.

Conclusion

The OIG found staff assigned patients 1 and 2 to share a room despite patient 1's use of a wheelchair and neither patient being classified as low risk for suicide. Additionally, staff did not implement the required direct line of sight observation for patient 1, needed due to wheelchair use.

The OIG identified deficiencies similar to those reported in a 2019 OIG inspection, including unclear or missing policy guidance, inconsistent patient safety observation practices, assignment

[41] "VA Technical Reference Model v25.12," VA Office of Information Technology, accessed January 15, 2026, https://www.oit.va.gov/Services/TRM/ToolPage.aspx?tid=15288.

of additional duties during patient safety observation, and insufficient oversight. Staff did not consistently perform routine observation as required, and some documented observations without direct visualization of patients. On the night of the event, staff assigned to complete 30-minute patient safety observation were also tasked with environmental rounding, contrary to VHA policy. Facility policy updates made in 2022 did not fully align with VHA requirements, particularly regarding direct line of sight observation and provider orders for discontinuing a patient safety observation status order. Further, although facility leaders sustained auditing processes to address 2019 findings, the audits focused on documentation rather than practice. The OIG also found that facility leaders learned staff were not conducting routine observation but did not implement identified alternative solutions.

During and following the inspection, facility leaders updated policy to include a direct line of sight observation level and require provider orders for discontinuing patient safety observation. Further, the updated policy prevented staff from performing patient safety observation while completing other duties. Leaders also developed a screening tool to guide room assignments, later revising it to align with mental health EOC checklist requirements.

The OIG made six recommendations to the Facility Director to strengthen awareness, training, oversight, and corrective action related to patient safety observation and mental health EOC checklist compliance.

The Facility Director informed the OIG that leaders will provide education to staff on the mental health EOC checklist and patient safety observation requirements, develop a standardized audit tool, and conduct regular audits of room assignment and patient safety observation practices on 3C. The Facility Director will monitor compliance through the Quality Patient Safety Council. The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Recommendations 1–6

1.The West Palm Beach VA Healthcare System Director ensures 3C leaders are aware of and comply with Mental Health Environment of Care Checklist requirements on the inpatient mental health unit.

2. The West Palm Beach VA Healthcare System Director reviews the inpatient mental health patient safety observation practices to ensure compliance with VHA SOP 1160.06.1, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06," and Facility Medical Center Policy 118-01, *Enhanced Observation Level* requirements.

3. The West Palm Beach VA Healthcare System Director ensures staff performing patient safety observation on 3C receive recurring training on conducting observation practices, including face-

to-face visualization, in alignment with VHA SOP 1160.06.1, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06," requirements.

4. The West Palm Beach VA Healthcare System Director develops and implements an oversight process for ongoing monitoring of inpatient mental health patient safety observation practices and documentation to ensure compliance with VHA SOP 1160.06.1, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06" requirements.

5. The West Palm Beach VA Healthcare System Director develops a plan to reassess the effectiveness of the oversight process for inpatient mental health patient safety observation practices and documentation.

6. The West Palm Beach VA Healthcare System Director ensures that when 3C leaders identify incongruencies between patient safety observation practice and documentation, 3C leaders conduct a review of the incident and take corrective action, as warranted.

Appendix A: Required Patient Safety Observation Levels

VHA Required Patient Safety Observation Levels on Inpatient Mental Health Units.

VHA Observation Level	Frequency	Contact Expectation of Patient and Staff	Additional Duties of Staff Observing Patient
30-Minute Patient Observation Rounds	Every 30 minutes	Face-to-face	No additional duties permitted.
Routine Observation	Every 15 minutes	Face-to-face	No additional duties permitted.
Direct Line of Sight	Continuous	Face-to-face	Expectation that facility policy dictates number of patients that staff can safely observe for direct line of sight.
One-to-One	Continuous	Face-to face, "arm's length" away from patient	No additional duties permitted.

Source: OIG analysis of VHA policy and information provided by VA central office.[42]

[42] VHA SOP 1160.06.1, September 29, 2023.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 9, 2026

From: Acting Director, Department of Veterans Affairs (VA) Sunshine Healthcare Network (10N08)

Subj: VA Office of Inspector General (OIG) Report, Draft Report: Review of Inpatient Mental Health Unit Processes at the West Palm Beach VA Healthcare System in Florida

To: Director, Office of Healthcare Inspections (54HL03)
Chief Integrity and Compliance Officer (10OIC)

1. I have reviewed the OIG's report including their findings and recommendations, and I concur with the report. Additionally, I have reviewed the Executive Director's response with actions and I concur.

2. I and my executive leadership team are committed to assisting the Healthcare System's Executive Director to close all recommendations expeditiously.

(*Original signed by:*)

David Dunning, MPA
Acting VISN 8 Network Director

[OIG comment: The OIG received the above memorandum from VHA on April 30, 2026.]

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 8, 2026

From: Director, Department of Veterans Affairs (VA) West Palm Beach VA Healthcare System (548)

Subj: VA Office of Inspector General (OIG) Report, Draft Report: Review of Inpatient Mental Health Unit Processes at the West Palm Beach VA Healthcare System in Florida

To: Director, VA Sunshine Healthcare Network (10N08)

1. We appreciate the opportunity to review and comment on the OIG report Review of Inpatient Mental Health Unit Processes at the West Palm Beach VA Healthcare System in Florida. West Palm Beach VA Healthcare System concurs with the recommendations and will take corrective action.

2. I have reviewed the documentation and concur with the response as submitted.

3. Should you need further information, please contact the Chief of Office of High Reliability (OHR).

(*Original signed by*:)

Cory P. Price, FACHE
Executive Director
WPB VA Healthcare System

[OIG comment: The OIG received the above memorandum from VHA on April 30, 2026.]

Facility Director Response

Recommendation 1

The West Palm Beach VA Healthcare System Director ensures 3C leaders are aware of and comply with Mental Health Environment of Care Checklist requirements on the inpatient mental health unit.

_X _Concur

____Nonconcur

Target date for completion: October 2026

Director Comments

Mental Health Leadership will re-educate all 3C Mental Health leaders, providers, nursing staff, Nursing Officers on Duty (NOD), Patient Safety Managers, and Interdisciplinary Safety Inspection Team (ISIT) members on Mental Health Environment of Care Checklist (MHEOCC) requirements and proper cohorting procedures. Nursing leadership will audit up to five admission cohorting checklists per week for six consecutive months, documenting any deficiencies and corrective actions. Psychiatry leadership will conduct weekly reviews of up to five new 3C admissions for six consecutive months to verify proper cohorting thorough documentation, and physician order compliance with MHEOCC guidelines. Monitoring, tracking, and reporting will continue monthly at the Quality Patient Safety Council (QPSC) until a compliance level of 95% or greater is achieved and maintained for six consecutive months.

Recommendation 2

The West Palm Beach VA Healthcare System Director reviews the inpatient mental health patient safety observation practices to ensure compliance with VHA SOP 1160.06.1, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06," and Facility Medical Center Policy 118-01, *Enhanced Observation Level* requirements.

_X _Concur

____Nonconcur

Target date for completion: July 2026

Director Comments

Mental Health leadership will develop a standardized audit tool aligned with VHA Directive 1160.06.1, Inpatient Mental Health Services and facility standard operating procedure 118-01, Enhanced Observation Levels, with completion by July 2026. Mental Health leadership will

conduct weekly face-to-face observations of 5 encounters per shift to verify that patient safety rounds are conducted in accordance with all regulations and that documentation accurately reflects required elements. Monitoring, tracking, and reporting will continue monthly at the QPSC until a compliance level of 95% or greater is achieved and maintained for six consecutive months.

Recommendation 3

The West Palm Beach VA Healthcare System Director ensures staff performing patient safety observation on 3C receive recurring training on conducting observation practices, including face-to-face visualization, in alignment with VHA SOP 1160.06.1, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06," requirements.

_X _Concur

____Nonconcur

Target date for completion: July 2026

Director Comments

All 3C nursing staff will complete training on all levels of patient safety observation, including return demonstration and a written assessment requiring a passing score. Refresher training requirement has been increased from annually to biannually. Monitoring, tracking, and reporting will continue monthly at the QPSC until a compliance level of 95% or greater is achieved and maintained for six consecutive months.

Recommendation 4

The West Palm Beach VA Healthcare System Director develops and implements an oversight process for ongoing monitoring of inpatient mental health patient safety observation practices and documentation to ensure compliance with VHA SOP 1160.06.1, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06" requirements.

_X _Concur

____Nonconcur

Target date for completion: November 2026

Director Comments

Mental Health leadership will develop a standardized audit tool aligned with VHA Directive 1160.06.1, Inpatient Mental Health Services and facility standard operating procedure 118-01,

Enhanced Observation Levels, with completion by July 2026. Mental Health leadership will conduct weekly documentation reviews of 5 charts across all shifts to verify that patient safety observations are conducted in accordance with all regulations and that documentation accurately reflects required elements. Monitoring, tracking, and reporting will continue monthly at the QPSC until a compliance level of 95% or greater is achieved and maintained for six consecutive months.

OIG Comments

The Facility Director's proposed oversight process to conduct weekly documentation reviews partially meets the intent of Recommendation 4. While the planned documentation audits are an important component of monitoring compliance with VHA SOP 1160.06.1, the action plan does not fully address the requirement to ensure that patient safety observation practices are being performed in accordance with policy. To meet the intent of the recommendation, the OIG suggests the Facility Director expand the oversight process to include direct assessment of patient safety observation practices, in addition to documentation reviews, and a plan to monitor ongoing compliance.

Recommendation 5

The West Palm Beach VA Healthcare System Director develops a plan to reassess the effectiveness of the oversight process.

_X _Concur

____Nonconcur

Target date for completion: December 2026

Director Comments

The Office of High Reliability (OHR) will provide inter-rater reliability checks of mental health leadership's actions. OHR will conduct 5 face-to-face observations across all shifts of inpatient mental health patient safety checks and the accompanying documentation to verify that observed practices are in accordance with regulations and are accurately documented. Deficiencies will be reported and corrective actions are required. Monitoring, tracking, and reporting will continue monthly at the QPSC until a compliance level of 95% or greater is achieved and maintained for six consecutive months.

Recommendation 6

The West Palm Beach VA Healthcare System Director ensures that when 3C leaders identify incongruencies between patient safety observation practice and documentation, 3C leaders conduct a review of the incident and take corrective action, as warranted.

_X _Concur

____Nonconcur

Target date for completion: November 2026

Director Comments

OHR will apply the developed audit tools to identify incidents of non-compliance. Identified incidents will be reported to mental health leadership within 1 business day. Mental health leadership will review findings with the involved staff member(s) to determine the facts of the incident. Mental health leadership will implement an action plan to include remedial training, enhanced observation of the staff member(s), or administrative action as appropriate. OHR will track and report all findings and action plans monthly at the QPSC. One hundred percent of all verified incidents of non-compliance will demonstrate an action plan and method to determine sustainment.

OIG Contact and Staff Acknowledgments

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