Recurring Patient Safety Failures at South Florida State Hospital



Disability Rights FLORIDA

October 16, 2026

Introduction

Disability Rights Florida (DRF) is the state's federally designated protection and advocacy system for people with disabilities. This year, DRF conducted multiple investigations into patient deaths and injuries at South Florida State Hospital (SFSH). As a result of these investigations, DRF has significant concerns about recurring patient safety failures at this facility. These concerns are not new: DRF identified similar concerns in past investigations, including those outlined in DRF's report "Preventable Harm: Patient Safety Failures in Florida's State Mental Health Treatment Facilities," released in February 2026.

To highlight the ongoing patient safety failures at SFSH, DRF has compiled three separate DRF investigations, all conducted over the last year. In each case, staff at SFSH were negligent in providing patient care, and that negligence contributed to patient injury and death. This report highlights failures by staff and administrators at SFSH, including:

1) adequately supervising vulnerable patients,
2) preventing medical emergencies,
3) recognizing medical emergencies as they are taking place,
4) responding to medical emergencies with adequate emergency care, and
5) implementing adequate corrective actions.

DRF finds these failures especially concerning because the residents involved had documented vulnerabilities and required specialized monitoring, supervision, or precautionary measures. Additionally, in some cases, DRF had already brought concerns to the attention of SFSH administrators during prior investigations. The recurrence of similar deficiencies despite prior notice and corrective action raises serious concerns about the effectiveness of SFSH's remedial measures, adequacy of staff training, and leadership's verification of staff competency in emergency response.

SFSH must do more to ensure that people receiving treatment at this facility do not experience preventable injuries and avoidable deaths while in state custody.

Three Investigations

In the last year alone, DRF has investigated two patient deaths and one patient injury at SFSH. Taken together, the three cases reveal concerning patterns in staff responses to medical emergencies at SFSH.

1) Mr. A[1]

In 2025, DRF investigated the death of Mr. A, a patient at SFSH who died in July of 2024. Mr. A was found by housekeeping staff "lying across a chair with his neck distended," unresponsive and without a pulse. While the suspected cause of death communicated to DRF was "cardiac arrest," DRF's review of Mr. A's records and video evidence revealed that neglect contributed to his death.

Mr. A's nursing and medical records documented that at the time of his death, Mr. A was on a mechanical soft diet and choking precautions due to his behaviors while eating. Records also reflect that behavioral staff were working with Mr. A to adhere to his prescribed soft diet and to decrease solid food-seeking behavior. Additionally, Mr. A was on supervised grounds and 30-minute supervisory checks.

However, video records from the date of his death revealed numerous instances where staff failed to adequately supervise Mr. A. Shortly before his death, Mr. A. was able to take solid food off a food cart and ingest it in front of staff, with no staff intervention. Video footage then shows Mr. A walking away to sit at a table in the dining room with four other residents. Over the course of seven minutes, Mr. A can be seen choking to death while seated at a table, again, with no staff intervention.

When staff finally discovered Mr. A's body and attempted life-saving interventions, they appeared confused and untrained in CPR procedure. After Mr. A's body was moved to the ground, one staff member can be seen performing CPR bent forward at the waist, instead of in a kneeling position. This incorrect positioning would have limited the leverage and precision needed for effective compressions. Despite the presence of over twenty medical professionals, including two doctors, CPR was not performed correctly until Fire Rescue arrived fifteen minutes after Mr. A's body was first found.

Following its investigation, DRF communicated its findings to SFSH administrators and proposed corrective actions, policy and procedure changes, and staff training. In response, SFSH reported that it had revised its Choking Precautions Policy to require the addition of a "blue smiley face sticker" to the ID badges of patients who were on choking precautions. SFSH also reported that it had reeducated staff on therapeutic diets and choking response, would continue to spot check CPR competency during monthly medical emergency drills, and would ensure staff were present during mealtimes moving forward. Despite these representations, a few months later another patient on choking precautions

[1] All patient names have been changed to protect their identity.

died after accessing solid food, staff failed to intervene effectively, and CPR was improperly administered.

2) Mr. B

In 2026, DRF investigated the death of Mr. B, a patient at SFSH who died in December of 2025. As in Mr. A's case, Mr. B choked to death in a common area after accessing solid food in front of staff despite being on choking precautions and died, despite the presence of over a dozen medical staff.

Video footage from a few minutes before the choking incident showed other residents and staff throwing solid food into paper trash bags placed on the floor in the dayroom in front of Mr. B. Mr. B, who had a prescribed diet of pureed meals and was known to frequently look for food in the garbage, can be seen immediately walking over to the trash bags, rifling through one of them, and bringing something from the bag up to his mouth. A staff person seated a few feet behind Mr. B alternately watched him, looked at her phone, and put on hand sanitizer. At no time did the staff person intervene to stop Mr. B from accessing the trash bags. Once the staff member noticed Mr. B eating, she left the area and returned with another staff member. The staff members spoke to Mr. B while he appeared to continue chewing, rubbed his back, and removed the trash bags from the day room before once again leaving Mr. B alone. Shortly afterwards, footage from another angle shows Mr. B walking into a hallway before falling to his knees and lying on the ground. It is concerning that once Mr. B accessed and began to consume solid food, staff took no action to intervene, beyond removing the trash bags from the room, and leaving him unsupervised immediately afterwards.

Once Mr. B was on the ground, staff attempted to intervene with lifesaving care. However, as with Mr. A, video of the events leading up to Mr. B's death by choking reflects a prolonged and disorganized response by staff to a resident in respiratory distress. The staff who responded to Mr. B's fall offered him water before lifting him into a standing position to attempt the Heimlich maneuver. They then moved Mr. B to the floor and rubbed his stomach in both a lying and seated position, before moving him to a chair, where they attempted to administer oxygen and continued to rub his stomach. Staff finally returned Mr. B to the ground to administer CPR, but as with Mr. A, did so without correct body positioning. Staff then interrupted CPR for another attempt at the Heimlich maneuver, even though Mr. B was no longer responsive. Although over a dozen staff members responded to this incident, it did not appear from video footage that there was a clear scene leader. Instead, staff appeared disorganized and unfamiliar with standard protocol for responding to a choking incident, until Fire Rescue arrived and took over the emergency response.

Following its investigation, DRF communicated its findings to SFSH administrators and proposed corrective actions, policy and procedure changes, and staff training. In response, SFSH reported that while it had not disciplined any staff involved in the emergency response, moving forward it would:

- Use portable, secure trash receptacles in all dining areas and remove them after each meal;
- Require nurses to conduct a post-meal sweep for food-related trash and institute a review of post-meal sweep documentation by a supervisor;
- Separate residents on choking precautions from the general population during meals and provide additional staff supervision;
- Deploy an updated CPR and Heimlich curriculum during new hire orientation, annual training, and recertification training;
- Post updated choking-response posters in dining areas; and
- Modify relevant policies to reflect these changes and review them with staff.

Additionally, SFSH reported that it would institute monthly choking-victim scenario drills that emphasized scene management and would create a Resuscitation Review Taskforce to analyze drill results and monitor corrective action for any identified deficiencies. However, the monthly choking drill results for May 2026 reflected ongoing issues with disorganized response, lack of scene leadership, and incorrect administration of CPR. When DRF requested drill results for June, no relevant results could be provided, because the following month's drill did not involve choking.

3) Ms. C

Although it did not involve a choking death, Ms. C's case also involved a lack of patient supervision and inadequate staff response to a medical emergency.

Ms. C, who was 81 years old at the time, experienced an unobserved fall in her room at SFSH in October of 2025. She died nine days later.

Video review revealed that immediately before falling, Ms. C had crawled on her hands and knees from a mattress on the floor to the open door to her room, where she waited for several minutes. When no one appeared, she attempted to stand and fell soon after. She was on the floor for approximately six minutes before staff appeared. Staff then left Ms. C on the floor for an additional five minutes before taking any action. When staff finally initiated physical contact, they did not appear to examine Ms. C for injuries before pulling her from a lying position into a wheelchair. Staff then left Ms. C in the wheelchair for approximately twenty minutes before they transferred her from the wheelchair to the bed,

again without any apparent assessment for physical injury. Additionally, staff did not use the appropriate amount of care during the transfers from the floor to the wheelchair and the wheelchair to the bed for such a frail patient, which may have exacerbated or caused additional injury. Ms. C was then left unattended in bed. Two days after the fall, Ms. C was finally admitted to Memorial Regional Hospital for a suspected hip fracture.

The lack of immediate assessment was particularly concerning because Ms. C was elderly, dependent on staff for activities of daily living, and subject to safety precautions and close monitoring requirements. Staff's conduct demonstrated a lack of urgency, suggesting that they did not appreciate that an unobserved fall involving an extremely frail resident could represent a serious medical event requiring immediate evaluation. The failure to conduct a prompt and thorough post-fall assessment resulted in Ms. C going untreated for a serious injury for two days and may have contributed to her death only eight days later.

Following its investigation, DRF communicated its findings to SFSH administrators and proposed corrective actions, policy and procedure changes, and staff training. SFSH reported taking the following corrective actions:

- Shifting their staffing schedule by one hour to increase coverage during the morning shift-change;
- Requiring Nurse Managers and Supervisors to submit a daily report of nursing rounds to their supervisor for review and follow-up on any identified issues;
- Conducting a hospital-wide re-education on policies related to two-way radio communication, safety observation rooms, patient supervision, and vital signs;
- Incorporating review of the above policies into new-hire and annual competency training;
- Reviewing the patient safety observation process at town hall meetings in November 2025 and April 2026;
- Implementing a video review and completion of a fall incident investigation form after all falls;
- Increase the number of medical stat drills related to falls and creation of the same Resuscitation Review Taskforce referenced in Mr. B's case; and
- Physically upgrading the SOR monitoring area with a larger monitor.

However, in response to DRF's specific inquiry, SFSH confirmed that while a staff member had been assigned to monitor the camera feed of Ms. C's room at the time of her fall, they did not witness it. SFSH did not provide information on why this lapse occurred. Additionally, the staffing change only shifts the hours staff are present on the unit but does

not increase the total number of staff. As a result, additional staffing during the morning shift change comes at the expense of staff presence later in the afternoon.

Recurring Failures in Patient Safety

Read together, the three cases described above reveal four recurring, interrelated failures spanning supervision, emergency recognition, emergency response, and corrective-action follow-through. Each is addressed below, with reference to the specific facts from Mr. A's, Mr. B's, and Ms. C's cases that illustrate the pattern.

1) Failure to Adequately Supervise Vulnerable Patients

In each of the three cases, SFSH staff failed to provide the level of supervision the resident's documented care plan required. Mr. A and Mr. B were both subject to choking precautions because of known risk factors, yet each was able to access and begin eating solid food in the direct presence of staff, and each was then left unsupervised in a common area long enough to choke to death before anyone intervened. Ms. C, an 81-year-old resident dependent on staff for mobility, crawled to her door and waited for several minutes for assistance that did not come; when she attempted to stand unassisted, she fell and was left on the floor for approximately six minutes before staff responded. In each instance, the resident's documented vulnerability called for heightened supervision; supervision that the facility's own precautions and monitoring requirements already required, but that staff did not carry out in practice.

2) Failure to Recognize Medical Emergencies

Staff's failure to recognize a developing or ongoing medical emergency compounded the supervision failures described above. Mr. A and Mr. B were each permitted to walk away from staff while actively eating food they were medically prohibited from having. In both cases Mr. A and Mr. B appeared to show difficulty while chewing. This was a warning sign that should have prompted intervention before either resident began to choke. Once Mr. B's condition became a true emergency, the responding staff members did not recognize the signs of an obstructed airway and offered him water rather than initiating a choking response. Similarly, when staff found Ms. C on the floor after her fall, they did not assess her for injury before repositioning and transferring her, treating what was in fact a medical emergency as a routine assistance request.

Across all three cases, staff's response was delayed, disorganized, or inconsistent with the seriousness of the resident's medical needs, reflecting a systemic gap in staff's ability to recognize when a resident requires urgent medical intervention.

3) Failure to Respond to Medical Emergencies with Adequate Care

Critically, SFSH's staff failed to provide adequate emergency care in all three cases.

In Mr. A's case, staff administered CPR incorrectly, using improper body positioning that limited its effectiveness. In Mr. B's case, staff response to an obstructed airway fell below expected emergency care standards. Staff offered water to a patient with suspected airway obstruction, delayed and interrupted CPR with ineffective interventions such as stomach rubbing, attempted the Heimlich maneuver even after Mr. B became unresponsive, and again administered CPR with improper positioning. Despite the presence of more than a dozen responding staff members in both cases, staff appeared disorganized and scene leadership was unclear. It is worth highlighting that in both cases, it took the arrival of EMTs before the patient received correctly administered CPR, even though both incidents occurred inside a hospital, with the patient surrounded by clinical staff. Residents in a hospital should not have to wait for outside EMS to receive properly administered life-saving care.

Additionally, during Mr. B's emergency, another resident was allowed to remain nearby and participate in the response, while other residents were not promptly cleared from the area. This presented risks of interference with care, unnecessary exposure of vulnerable residents to a traumatic event, and further evidence that staff lacked an organized emergency response structure.

In Ms. C's case, staff failed to provide adequate post-fall emergency care. Specifically, staff failed to assess her for injury immediately before moving her, failed to demonstrate appropriate urgency during the response, and failed to use safe transfer techniques, exposing her to additional risk of injury and delayed treatment.

4) Failure to Implement Adequate Corrective Actions

The incidents reviewed reflect substantial deficiencies in staff training related to prevention, emergency recognition, and emergency response.

Staff failed to adequately implement choking precautions for or supervise Mr. A. Even more concerningly, only a few months after the facility made assurances that it would revise polices, reeducate staff, spot check CPR competency through monthly drills, and increase staff presence during mealtimes, Mr. B died under strikingly similar circumstances. And yet, SFSH's response to Mr. B's death relied on largely the same corrective measures the facility had already represented to DRF as effective after Mr. A's death. The ID-badge sticker system, staff retraining on choking response and CPR, and increased staff

presence during meals were already in place, or had just been implemented, at the time Mr. B choked to death in front of a staff member who was present but did not intervene.

DRF's document review following Mr. B's death confirmed that the choking drill results for May 2026 reflected ongoing issues with disorganized response, lack of scene leadership, and incorrect administration of CPR. When DRF requested drill results for June, no relevant results could be provided, because the following month's drill did not involve choking. This suggests that the current frequency and administration of medical emergency drills are insufficient to ensure staff can deploy their training under pressure in emergency scenarios.

Additionally, SFSH's response to Mr. B's case offered no analysis of why the corrective actions taken after Mr. A's death failed to prevent Mr. B's death. This pattern suggests that SFSH's corrective-action process is designed to close out individual incident reviews rather than to identify and remedy the underlying systemic failure.

SFSH's response to Ms. C's fall reflects the same pattern: broad reliance on the facility's existing toolkit (increased drill frequency, the Resuscitation Review Taskforce, and policy re-education with signed attestations) applied without any case-specific analysis of what caused this particular failure. SFSH's stated corrective action of installing a larger monitoring screen fails to identify or address the underlying reason the assigned staff was not watching the monitoring screen during the fall. Similarly, shifting staffing schedules to provide increased staffing during the morning shift at the expense of the afternoon shift is unlikely to make patients safer overall. SFSH's response ultimately never addressed the extended period after the fall in which Ms. C was moved and transferred without an apparent injury assessment, or the two-day delay before she was taken to an outside hospital for a hip fracture.

As in the choking cases, SFSH's remediation is verified almost entirely through internal, self-documented review by the same nursing leadership structure whose supervision is at issue, rather than through any independent or externally verifiable audit, underscoring the need for external verification and root-cause analysis, rather than self-reported completion of repeated measures, before any future corrective action plan can be considered adequate.

Corrective Action Recommendations

DRF's investigations establish a pattern of patient safety failures at SFSH involving inadequate supervision, delayed recognition of medical emergencies, inadequate emergency care, insufficient staff training, and a failure to ensure staff competency. These deficiencies contributed to preventable risk for residents with known vulnerabilities. To address this pattern and prevent further avoidable deaths and injuries, DRF recommends that SFSH take the following corrective actions:

Make medical emergency drills more frequent, realistic, rigorous, and meaningful.

SFSH should increase the frequency of its medical drills. Each drill should assess and document the performance of individual participating staff members on a pass/fail or competency-based basis, rather than recording only that a drill occurred. Staff who do not demonstrate competency should be subject to a documented remediation plan and a defined timeline for reassessment before resuming unsupervised patient care duties. SFSH should further maintain longitudinal records of individual staff performance across drills so that recurring deficiencies, whether in a single staff member or a particular shift or unit, are identified and addressed.

Institute independent, external oversight of corrective action effectiveness.

SFSH's current practice of verifying its own corrective actions through internal review bodies, including the Resuscitation Review Taskforce, is insufficient given the recurrence of substantially similar failures despite repeated representations that corrective measures were working. SFSH should provide an independent monitor, which may include DRF, with standing access to drill results, incident investigation files, and relevant video footage, and should support periodic independent reporting on whether corrective actions taken in response to a specific incident have in fact prevented recurrence of the underlying failure. Verification of corrective action effectiveness should not rest solely with the same internal nursing leadership structure.

Increase resources dedicated to staffing, training, and accountability.

SFSH should provide dedicated, adequate staffing ratios for residents on choking precautions, fall precautions, or other heightened supervision requirements, rather than

redistributing existing staff across shifts in a manner that merely shifts coverage gaps from one part of the day to another, as occurred in Ms. C's case. SFSH should likewise ensure that staff training is provided during protected, dedicated training time rather than absorbed into existing clinical shifts and should allocate sufficient resources to support the frequency and rigor of drilling recommended above.

Require root-cause analysis as part of every corrective action plan.

Following any patient death or serious injury, SFSH's corrective action plan should include a documented analysis of why the underlying failure occurred and, where applicable, why any prior corrective actions adopted in response to a similar incident failed to prevent its recurrence. SFSH's response to Mr. B's death relied on largely the same measures previously represented as effective after Mr. A's death, without any analysis of why those measures did not prevent a substantially similar death only months later. Corrective action plans that do not include this analysis should not be considered complete.

Implement real-time monitoring to verify that required supervision levels are actually being carried out.

SFSH should adopt a mechanism, whether through supervisory spot audits, documented sign-off requirements, or technology-based verification, to confirm that supervision requirements such as 30-minute checks and mealtime monitoring for residents on choking precautions are being executed in practice and not merely documented as completed. In each of the three cases discussed in this report, the resident's care plan already called for the level of supervision that would have prevented the resulting harm; the failure was one of execution, not documentation.

Adopt a staff accountability mechanism for witnessed precaution violations and improperly performed emergency response.

SFSH should implement a defined process for reviewing individual staff conduct when a resident is observed violating a documented precaution without staff intervention, or when emergency care is administered incorrectly despite prior training and should impose appropriate consequences up to and including disciplinary action where warranted. SFSH's own response to Mr. B's death confirmed that no staff involved in the response were disciplined, notwithstanding the presence of a staff member who observed Mr. B accessing prohibited food and did not intervene.