

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 010001	(X3) Date Survey Completed 06/10/2016
Name of Provider or Supplier Southeast Health Medical Center	Street Address, City, State 1108 Ross Clark Circle, Dothan, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

(X4) ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency should be preceded by full regulatory or LSC identifying information)
A0000	An abbreviated survey was conducted to investigate complaint number AL 00034461. The complaint was unsubstantiated and standard level deficiencies were cited.
A0168	<p>PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(5)</p> <p>The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under 482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records (MR), facility policy and interviews with the staff it was determined the facility failed to ensure physician orders were written every 24 hours for the renewal of soft restraints for 1 of 4 MR's reviewed and affected MR # 4 and had the potential to negatively affect all patients served by the hospital. Findings include: Policy: Restraints and seclusion Utilization. Effective Date: 2/1/1980 Purpose: 1. To provide for the safety of patients, staff and others. Restraint Category: 1. Non-violent or non-self destructive behavior. Types of patients include: 1. Patients whose medical/surgical related conditions may impair the resolution of there physical problems by involuntarily disrupting life-support or other essential medical interventions (e.g., endotracheal tubes...) General Guidelines for Restraint and Seclusion: 4. ...A physician's written or verbal order should be obtained for restraint or seclusion. The order should be renewed daily according to the reason for restraint, non-violent or violent/aggressive behavior... Non-violent/Non-self-destructive Patient to Support Medical Healing: 2... Restraints for non-violent patients must be renewed/reordered daily. Continued use of restraints is authorized by the physician based upon his/her examination of the patient each calendar day. MR # 4 was admitted to the Critical Care Unit (CCU) from the Medical Surgical floor on 4/17</p>

/16 at 9:45 PM with an admitting diagnosis of Atrial Fibrillation with RVR (rapid ventricular response) and Septic Shock. Review of all the nurses notes from 4/26/16 at 4:05 PM to the time of death on 5/15/16 at 9:12 AM the patient was on a ventilator and wrist restraints were applied on 4/26/16 at 4:05 PM. Review of all the physician orders in the MR revealed there was no physician renewal orders for restraints for the following dates: 4/26/16 which was the initial dated wrist restraints were applied, 4/29/16, 4/30/16, 5/1/16, 5/2/16, 5/3/16, 5/6/16, 5/10/16 and 5/13/16. Review of the nurse note dated 4/28/16 at 10:05 AM the patient had wrist restraints on both wrists. Further review of this note revealed at 12:05 PM the nurse documented the patient had 2 wrist restraints and 2 ankle restraints on. Continues review of the nurse revealed no documentation as to why the ankle restraints were applied and review of the physician orders revealed no documentation of an order for the ankle restraints. An interview conducted on 6/10/16 at 8:30 AM with EI # 2, Quality Outcome Teamleader, confirmed physician orders were not written on a daily basis for the wrist restraints and there was no documentation of an order for the ankle restraints.

A0395

RN SUPERVISION OF NURSING CARE
CFR(s): 482.23(b)(3)

A registered nurse must supervise and evaluate the nursing care for each patient.

This STANDARD is not met as evidenced by:

Based on review of medical records (MR), facility policy and interviews with the staff it was determined the facility failed to ensure: 1. Wound documentation was consistent and accurate and documented in the MR. 2. Physician orders were written for all care and treatment provided. 3. The nurse documented turning the patient every 2 hours per hospital policy. This affected 2 of 4 MR's reviewed and did affect MR # 3 and MR # 4 and had the potential to negatively affect all patients served by the facility. Findings include: Policy: Assessment of a Patient Effective date: 10/1/1979 Purpose: To establish rapport with the patient and the family, provide support, and ease the transition into the hospital setting... Clinical Skills: Assessment: Wound Quick Sheet: 4. Check the practitioner's orders regarding wound care. 5. Review the patient's last documented wound assessment to use as comparison for the current wound assessment. 20. Cleanse the wound and change the wound dressing per the practitioner's order. 24. Document the procedure in the patient's record. 1. MR # 3 was admitted to the Critical Care Unit (CCU) on 5/3/16 with an admitting diagnosis of Status Post (S/P) Sigmoid Colostomy. Review of the Registered Nurse (RN) note dated 5/3/16 at 4:40 PM the RN documented the patient had 6 wounds (wd). Wd # 1, left upper arm (laceration/skin tear), Wd # 2, upper and lower abdomen (incisions), Wd # 3, Sacral/buttock area (right buttock), Wd # 4, abscess (left buttock) and a drain was in place, Wd # 5, Sacral/buttock area (Pressure) and Wd # 6, abrasions to second and third toe at top of bony prominence on bilateral feet. Review of the RN note dated 5/4/16 at 8:05 AM revealed the RN only completed documentation on wounds # 1, # 2, and wound # 3. There was no documentation on wound # 4, # 5, or wound # 6. Further review of the wound documentation for 5/4/16 at 8:05 AM revealed Wound # 1's location was the lower back and wound # 2 also was documented at the lower back. Wound # 3's location was the lower abdomen. Review of the RN note dated 5/4/16 at 3:05 PM revealed the RN documented wound # 1 as sacral/buttock area, wound # 2 the upper and lower abdomen. Further review revealed no further documentation of wounds # 3,4,5,and # 6. Review of the RN note dated 5/4/16 at 3:05 PM revealed the nurse documented multiple small gauze dressings present. Covered with Tegaderm. Dry and

intact. Further review revealed no documentation of which wounds had the gauze dressings. Review of all the physician orders revealed no orders for dry gauze dressings and Tegaderm. Review of the RN note dated 5/5/16 at 7:05 AM revealed the nurse documented Wound # 1 lower back, Wound # 2 lower back, wound # 3 right lower back. There was no mention of wound # 4, 5 and # 6. Review of the RN note dated 5/5/16 at 1:45 PM the nurse documented wound # 1 left lower back, wound # 2 right lower back. Further review revealed no documentation of wound # 3, 4, 5 or # 6. The nurse documented under wound care recommendations: Pack right lower back wound with 1/2 inch idofom gauze daily. Review of all the physician orders revealed no documentation an order was written for the idofom gauze packing daily. Review of the RN note dated 5/5/16 at 7:05 PM the nurse documented the following: wound # 1 intervention: app (applied) dsg (dressing), medium Wound care: cleaned, wound # 2 interventions: app dsg medium, wound care: cleaned packing changed. Further review of the note revealed the nurse documented wound # 1 as skin tear to left upper arm and wound # 2 a pressure wound to right buttock and there was no further mention of wound # 3, 4, 5 or # 6. Review of the RN note dated 5/6/16 at 7:05 AM the nurse documented wound # 1 to upper abdomen, wound # 2 right buttocks, wound # 3 as drain site with no documentation of the location. Further review revealed no documentation of wound # 4, 5, or wound # 6. Review of the physician order dated 5/3/16 at 5:58 PM the order was to clean wounds with H2O2 (Peroxide) or Hibiclens q (every) day, Pack back wound with wet to dry dressing of NS (Normal Saline). Review of all the nurse notes from each shift from 5/3/16 to 5/6/16 revealed no documentation of dressing changes per the physician orders. Review of the RN note dated 5/5/16 at 5:05 AM the patient was turned to the right side and at 7:05 AM and 2 hours later the nurse failed to document if the patient was turned. Further review revealed the nurse documented at 11:05 AM the patient was turned to the supine position and there is no further documentation of the patient being turned every two hours until 7:05 PM. Review of the MR revealed the nurses failed to document according to the initial assessment of the wounds by the location of the body and the number which corresponds with the correct body location. The documentation of the wounds is inconsistent and unclear. An interview was conducted on 6/9/16 at 3:00 PM with EI (Employee Identifier) # 3, Director Patient Care Services, who confirmed the policy for turning patients was every 2 hours and is to be documented in the MR. An interview was conducted on 6/10/16 at 9:00 AM with EI # 1, Clinical Nurse Specialist, who confirmed the documentation was inconsistent and incomplete. 2. MR # 4 was admitted to the Critical Care Unit (CCU) from the Medical Surgical floor on 4/17/16 at 9:45 PM with an admitting diagnosis of Atrial Fibrillation with RVR (rapid ventricular response) and Septic Shock. Review of the MR revealed on 4/30/16 at 12:13 PM the RN, documented the patient had a pressure area to the sacrum and labeled wound # 1 and was open to air. Review of the nurse note dated 5/1/16 at 11:00 PM the RN, documented the patient had two wounds. Wound # 1 to the sacral area and wound # 2 to the right lower leg which was a blister on the calf area. Review of the nurses note dated 5/2/16 at 8:05 AM the documentation revealed the two wounds and were open to air. Review of the nurse note dated 5/4/16 at 6:57 AM revealed EI # 4, RN wound care nurse, who documented 4 wounds. Wound # 1 sacral area the type was pressure wound and was not staged. Assessment consisted of purple and red in color and suspected deep tissue injury. Wound # 2 was the upper right leg lesion and open to air, Wound # 3 perineal area reddened and open to air and wound # 4 entire right arm weeping and bleeding and dressing was saturated and changed. Review of the nurse noted dated 5/4/16 at 7:00 PM the nurse documented wound # 1 to sacral area as a skin tear and open to air. The documentation revealed the nurse only documented on wound # 1 and wound # 2 for the entire shift. Further review revealed no documentation of wounds # 3 and # 4. Review of the nurse note dated 5/5/16 at 7:35

AM the nurse documented on wound # 1 the sacral area as a pressure area and wound # 2 to the right inner thigh which was an open blister. There was no further documentation on wound # 3 and wound # 4. Review of the nurse note dated 5/5/16 at 7:00 PM the nurse documented on wound # 1 to sacral area as a skin tear and wound # 2 to the right upper leg as a lesion. Further review revealed no documentation on wounds # 3 and # 4. Review of the nurse note dated 5/6/16 at 7:05 the nurse documented wound # 1 to sacral area and as a pressure wound and excoriated. Further review revealed the nurse documented wound # 2 as the right and left upper legs as blister sites that have ruptured on inner right and left thigh. Further review revealed no documentation of wounds # 3 or 4. Review of the nurse note dated 5/7/16 at 7:05 PM the nurse documented wound # 1 was now the right and upper leg and open to air and were fluid filled blisters that had ruptured. Wound # 2 is now the sacral area and documented the type as pressure wound and red and open to air. There was no further documentation on wounds # 3 and # 4. Review of the nurse note dated 5/8/16 at 7:05 AM the nurse documented wound # 1 was now the right and left upper legs and wound # 2 was the sacral area. Further review of the 5/8/16 nurse note at 7:05 PM revealed wound # 1 was the sacral area and wound # 2 as the right and left thighs. There was no further documentation for this shift for wounds # 3 and #4. Review of the wound care nurse documentation on 5/9/16 at 10:49 AM revealed documentation of wound # 1 to the sacral area and wound # 2 as a lesion to the right upper leg. Further review revealed no documentation of wound # 3 or # 4. Review of the nurse note dated 5/9/16 at 7:50 PM the nurse documented wound # 1 was located at the sacral area, perineal, right upper leg and left upper leg and documented as excoriated area. Review of the nurse note dated 5/9/16 at 11:05 PM the nurse documented wound # 1 as the sacral and perineal areas and was documented as excoriation and wound # 2 as the right upper leg and a lesion. There was no further documentation of wound # 3 or 4. Review of the nurse note dated 5/10/16 at 10:00 AM the nurse documented on wound # 2 to the right upper leg only. At 11:00 AM the nurse then documented on wound # 1 to the sacral area. Further review revealed there was no documentation of wounds # 3 or 4. Review of the nurse note dated 5/11/16 at 5:00 AM the nurse documented wound # 3 was cleaned and dressing applied. The nurse did not document where wound # 3 was located or what the wound was cleaned with and what type of dressing was applied. Further review revealed no documentation of wounds # 1, 2 or 4. Review of the nurse note dated 5/11/16 at 8:05 AM the nurse documented wound # 1 as the right upper leg and wound # 2 as the sacral/buttock area. Further review revealed the nurse documented "pt (patient) has a denuded area on both buttocks from excessive weeping edema, changing pads as needed...". Further review of the MR revealed no documentation of wounds # 3 or 4. Review of the nurse note dated 5/11/16 at 3:05 PM the nurse documented wound # 1 as right and left buttocks and perineal area and wound # 2 as the right interior thigh. Further review revealed the nurse documented in a separate entry wound # 1 to the coccyx. Further review revealed no documentation of wounds # 3 or 4. Review of the nurse note dated 5/11/16 at 11:05 PM the nurse documented wound # 1 as the sacral/buttock area and perineal and wound # 2 as the sacral/buttock area and the type was "pressure reddened" and open to air. There was no mention of wounds # 3 or 4. Review of the nurse note dated 5/12/16 at 3:05 AM the nurse documented wound # 1 as the sacral /buttock area and perineal area, wound # 2 as the sacral/buttock area type was pressure, and wound # 3 as the right upper leg stating right medial upper thigh. Review of the nurse note dated 5/12/16 at 8:05 AM the nurse documented wound # 1 as sacral/buttock and perineal area the type of wound was a diaper rash and pressure, wound # 2 was right upper leg with large area of ruptured blisters. There was no further documentation of wounds # 3 or 4. Review of the nurse note dated 5/12/16 at 3:15 PM the nurse documented wound # 1 as coccyx area, wound # 2 as the right and

left buttock and back side of upper thighs and wound # 3 as the right inner thigh. Review of the nurse note dated 5/13/16 at 2:00 AM the nurse documented the dressing was changed to wound # 1 the right inner thigh. No further documentation of the other wounds. Review of the nurse note dated 5/13/16 at 7:15 AM the nurse documented wound # 1 was located at the sacral/buttock area, perineal area, right upper leg and left upper leg. Further review revealed no documentation of wounds # 2, 3, and 4. Review of the MR revealed the nurses failed to document according to the initial assessment of the wounds by the location of the body and the number which corresponds with the correct body location. The documentation of the wounds is inconsistent and unclear. An interview was conducted on 6/9/16 at 8:30 AM with EI # 4, RN Wound Care nurse, who stated the staff does not document by the number of each wound but by the location of the wound. When asked if each wound was to be documented on separately EI # 4 stated yes. An interview was conducted on 6/10/16 at 9:00 AM with EI # 3 who confirmed the documentation of the nurses for the wounds was not consistent and clear.