

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 010001	(X3) Date Survey Completed 09/29/2017
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	A full survey following a complaint with conditions of participation cited was completed at the request of The Centers for Medicare and Medicaid Services (CMS) on 9/29/17. Based on the full survey the Alabama State Survey Agency recommends Southeast Alabama Medical Center be found out of compliance with the condition 482.41: Physical Environment, based on the Life Safety Code survey findings. The cited conditions from the 8/24/17 complaint survey were in substantial compliance based on the acceptable plan of correction and on-site full survey: 482.12, Governing Body; 482.13, Patient Rights; 482.21, Quality Assurance Performance Improvement and 482.23, Nursing Services.
A0116	<p>PATIENT RIGHTS: NOTICE OF RIGHTS CFR(s): 482.13(a)</p> <p>Patients's Rights: Notice of Rights</p> <p>This STANDARD is not met as evidenced by: Based on observation, medical record (MR) review, and interviews, it was determined the facility failed to provide a copy of the Patient's Rights on admission to the Heart and Vascular Unit. This affected 11 of 11 patients in the unit on 9/27/17, and has the potential to affect all patients served by the facility. Findings include: During a tour and review of medical records on 9/27/17 at 2:45 PM, on the Heart and Vascular Unit, revealed there was no documentation in the medical record of Patient's Rights notification. The surveyors requested a copy of the Patient's Rights provided to patients on admission. No one on the unit was able to provide a copy. An interview on 9/27/17 at 3:00 PM with Employee Identifier (EI) # 27, Registered Nurse, Clinical Director, confirmed there was no documentation in the MRs. An interview was then conducted with EI # 28, Registration Representative, who stated, "I know they are working on something to give patients," but confirmed they currently do not.</p>

PATIENT RIGHTS: CARE IN SAFE SETTING

CFR(s): 482.13(c)(2)

The patient has the right to receive care in a safe setting.

This STANDARD is not met as evidenced by:

Based on review of medical records (MR), and interviews with the staff, it was determined the facility failed to ensure the staff followed the education training for hourly rounds by the nursing staff in the Behavioral Medical Unit (BMU). This affected Patient Identifier (PI) # 43, 1 of 1 record reviewed of a patient who was admitted to the BMU and had the potential to negatively affect all patients admitted to the BMU. Findings include: 1. PI # 43 was admitted to the BMU on 9/15/17 with an admitting diagnosis of Paranoia Agitation. Review of the MR revealed Q (every) HR (hour) Safety Precautions for the nurses to be completed. Review of the Q 1 HR rounds documentation began on 9/15/17 at 2025 (8:25 PM) and ended on 9/26/17 at 1343 (1:43 PM) when the patient was discharged. Review of the Q 1 HR forms revealed on 9/15/17 at 6:01 AM, a round was completed by the nurse and not again until 7:33 AM, which was 1 hour and 32 minutes. At 2:10 PM, a round was complete and the next round was completed at 3:43 PM, which was 1 hour and 33 minutes and the next round completed was at 4:59 PM, which was 1 hour and 16 minutes. On 9/17/17 the nurse completed a round at 1:15 AM and the next round completed was at 2:46 AM, which was 1 hour and 31 minutes. At 6:05 AM, a round was complete and not again until 7:20 AM, which was 1 hour and 15 minutes later. Further review revealed the nurse completed a round at 2:02 PM and not again until 3:37 PM, which was 1 hour and 35 minutes later. At 7:10 PM, the nurse completed a round and did not complete the next round until 8:45 PM, which was 1 hour and 35 minutes later. Review of the 9/18/17 hourly rounding form revealed at 12:06 PM, a round was completed and not again until 1:40 PM which was 1 hour and 34 minutes. At 5:08 PM a round was completed by the nurse and the next round occurred at 6:25 PM, which was 1 hour and 17 minutes later. At 10:09 PM a round was completed and not again until 11:25 PM, which was 1 hour and 16 minutes later. On 9/19/17 at 1:23 AM a round was complete and the next round was completed at 2:41 AM, which was 1 hour and 18 minutes later. Further review revealed a round was complete at 6:00 AM and not again until 7:39 AM, which was 1 hour and 39 minutes. At 8:36 AM the nurse completed a round and then not again until 9:50 AM, which was 1 hour and 14 minutes later. At 7:34 PM a round was complete and the nurse did not make the next round until 8:54 PM, which was 1 hour and 20 minutes later. On 9/20/17 at 2:00 AM the nurse made a round and not again until 3:26 AM, which was 1 hour and 22 minutes later. At 6:01 a round was complete and the next round completed was at 7:15 AM, which was 1 hour and 14 minutes later. Further review revealed at 1:09 PM, the nurse completed a round and the next round was not completed until 2:29 PM, which was 1 hour and 20 minutes later. At 4:31 PM, a round was completed and the nurse did not make the next round until 5:43 PM, which was 1 hour and 12 minutes later. On 9/21/17 at 2:03 AM a round was completed and not again until 3:23 AM, which was 1 hour and 20 minutes later. At 10:10 AM, a round was completed and the next round occurred at 11:28 AM, which was 1 hour and 18 minutes later. Further review revealed the nurse completed a round at 2:15 PM and not again until 3:46 PM, which was 1 hour and 31 minutes later. At 4:43 PM a round had been completed and the next round was not conducted until 5:58 PM, which was 1 hour and 15 minutes later. On 9/22/17 the nurse completed a round at 6:05 AM a round was completed and then the next round completed was at 7:25 AM, which was 1 hour and 20 minutes later. At 1:05 PM the nurse had completed a round and then not again until 2:19 PM,

which was 1 hour and 14 minutes later. On 9/23/17 the nurse conducted an hourly round at 1:03 AM and not again until 2:33 AM, which was 1 hour and 30 minutes later. At 6:05 hourly rounds were conducted and then not again until 7:26 AM, which was 1 hour and 21 minutes. Further review revealed the nurse conducted an hourly round at 10:08 AM and then again at 11:25 AM, which was 1 hour and 17 minutes later. At 1:03 PM, the nurse conducted an hourly round and then again at 2: 23 PM, which was 1 hour and 20 minutes later. On 9/24/17 at 4:13 AM rounds were completed and then at 5:49 the nurse completed the next hourly round, which was 1 hour and 36 minutes later. At 12:03 PM the nurse completed hourly rounds and again at 1:21 PM, which was 1 hour and 18 minutes later. Further review revealed the nurse completed an hourly round at 6:15 PM and not again until 7:32 PM, which was 1 hour and 17 minutes later. On 9/26/17 hourly rounds were conducted at 2:18 AM and not again until 3: 39 AM, which was 1 hour and 21 minutes. On 9/28/17 at 10:30 AM Employee Identifier (EI) # 29, Chief Nursing Officer (CNO), was asked what the nursing staff were taught about the every hour rounds in the BMU as far as documentation. EI # 29 stated she would find out and let the surveyor know. On 9/28/17 at 11:30 AM, EI # 29 stated the staff are to document every 60 minutes. EI # 29 also verified the above mentioned findings and stated "the hourly rounds are to be every 60 minutes.

A0159

PATIENT RIGHTS: RESTRAINT OR SECLUSION
 CFR(s): 482.13(e)(1)(i)(A)

Definitions. (i) A restraint is- (A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or

This STANDARD is not met as evidenced by:
 Based on the review of medical records (MR), policy and interview it was determined the facility failed to observe patients in restraints and document on the Restraint Flowsheet at a minimum of every 2 hours. This affected Patient Identifier (PI) # 38 , 1 of 1 patient restrained in the Neuro Critical Care unit. Findings include: Facility Policy: Restraints and Seclusion Utilization Effective Date: 2/1/1980 Policy: Southeast Alabama Medical Center (SEAMC) in accordance with its mission and core values, respect the rights of our patients and thereby strives to provide them with the safest possible environment. ... When restraint/ seclusion is necessary, the rights and dignity of the patient are respected, and when appropriate, family involvement in the treatment is attempted and documented. Purpose 2. To establish guidelines that protect patient rights and dignity with regards to the use of restraints and seclusion in the therapeutic environment. General Guidelines for Restraint and Seclusion 1. Generally, restraint(s) or seclusion is used if less restrictive measures have proven unsuccessful. ... 3. A registered nurse, physician's assistant, or physician with appropriate training and education should determine if there is a danger that the patient might interfere with essential medical treatment interventions OR injure himself/herself, another patient, visitor, or staff member. ...1. When restraints are implemented, patients should be monitored/assessed/assisted frequently and the following documented every 2 hours: mental status check, level of distress, agitation... bathroom offered/elimination needs met, fluids and/or nutrition offered, hygiene needs met, comfort measures...skin and circulatory checks. 9. Restraint/seclusion should be discontinued as soon as possible after the patient meets the criteria for discontinuation... 1. PI # 38 was admitted to the Neuro Critical Care unit on 9/23/17 with diagnosis of Altered Mental Status with Sub Acute Chronic Hygroma requiring

burr hole intervention. Tubes in place included: Indwelling Urinary Catheter, Peripheral Intravenous (IV) in right hand, burr hole in head with Jackson-Pratt (JP) drain. Review of the medical record revealed on 9/26/17 the patient became anxious, agitated and uncooperative, attempting to exit the bed, pulling at catheter, pulling at drain and IV tubing, requiring the application of soft limb restraints to the left and right wrists. On 9/27/17 at 11:15 AM, the surveyor with the assistance of Employee Identifier (EI) # 19, Education Coordinator, reviewed the electronic medical record documentation and noted the last documentation by the Registered Nurse (RN) was at 7:00 AM on 9/27/17. EI# 19 stated that sometimes the RN has an open note and it is not possible to view it in the current documentation until she closes it. EI # 19 checked for the nurse that was assigned to PI # 38 and verified there was no open note. On 9/27/17 at 11:30 AM, the surveyor and EI # 19 went to the Neuro Critical Care Unit and observed the patient lying quietly in the bed with soft restraints to left and right wrist. The surveyor and EI # 17, Unit Director of Neuro Intensive Care Unit reviewed the restraint documentation on the unit. The last documentation by the nurse was at 7:00 AM on 9/27/17. EI # 17 stated the facility policy was for RN documentation on patients in restraint every 2 hours. An interview was conducted on 9/28/17 at 11:38 AM with EI # 17, who confirmed the above findings.

A0283

QUALITY IMPROVEMENT ACTIVITIES

CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3)

(b) Program Data (2) [The hospital must use the data collected to -] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.

This STANDARD is not met as evidenced by:
Based on review of the Quality Improvement Plan - Policy and interviews, it was determined the hospital failed to implement corrective actions focusing on performance improvement, ensure actions taken have a positive affect on patient outcomes, safety and quality of care. This had the potential to negatively affect all patients served by the hospital. Findings include: Quality Improvement Plan- Policy Fiscal Year 2016 I. Purpose ... the fiscal year 2017 Quality Improvement Plan is designed to establish, organize, implement, monitor and document evidence of an ongoing and systematic quality improvement process... V. Goals and Objectives The fundamental goal of Southeast Alabama Medical Center is to continuously improve the quality of all patient care and other services, as needed by the customer. This will be achieved by: A. Implementing a systemic, organization-wide process that identifies area with opportunities, including planning for performance improvement, and determining the number of individuals and types of skills needed to accomplish these improvements... D. Utilize a dashboard reporting tool to improve communication and transparency throughout the organization of quality indicators, metrics, and benchmarks. E. Evaluating the processes by which care and services are delivered and implementing changes to improve these processes... H. Overseeing and evaluating the effectiveness of quality improvement activities through internal and external benchmarking and modifying processes as necessary to improve the care and services

provided to customers. Fiscal year 2017 Quality Improvement Goals ... The organization will focus on improving performance processes so that the customers will receive safe, timely, efficient, effective, equitable and patient centered care. Organization Performance Scorecard "Quality Metrics" a) Decrease Hospital Acquired Conditions (HAC) and improve outcomes related to the following: ... 3. Surgical Site Infections (SSI) Regulatory Required Tracking and Trending Quality Metrics (Hospital)... K) Anesthesia/ moderate sedation/ deep sedation adverse events

1. The Department of Quality Management monitors Rapid Response and Code 4 calls for any potential over sedation concerns.
2. The Department of Quality Management and Anesthesia monitors deep cases performed in the Emergency Department for compliance with policy.
3. The Department of Quality Management and Anesthesia monitors cases where a reversal agent (that was medically necessary) was administered following procedure.

VIII. Scope of (Quality Improvement) QI Activities... The Quality Management Director has the responsibility for the overall support of all performance improvement activities in Southeast Alabama Medical Center (SAMC)... This includes assisting with the mechanism for data collection, data display, report preparation, data trending, data integration, team and department support.

X. Methodology For Improving Organizational Performance... All appropriate individuals, departments, and committees shall work collaboratively, using the following process as a model of continuous improvement, when starting a new improvement project, when developing a new or improved design of a process, product or services, when defining a repetitive work process, when planning data collection and analysis in order to verify, prioritize problems or root causes and when implementing any change to improve outcomes and other hospital processes... During an interview conducted on 9/26/17 at 10:15 AM with Employee Identifier (EI) # 12, Registered Nurse (RN) Operations Leader Pre/Post Anesthesia and same day Surgery, the surveyor asked EI # 12 the types of data she is collecting for post-anesthesia care unit (PACU). EI # 12 informed the surveyor she collects information related to hold times such as waiting for a bed on the nursing floors and the information gathered is submitted monthly to Surgical Services Committee only. In an interview conducted on 9/26/17 at 2:55 PM with EI # 14, Certified Registered Nurse Anesthetist (CRNA) and EI # 15, Surgical Services Medical Director, the surveyor was informed the CRNA and the Medical Director of Anesthesia collects and reviews the same indicators monthly, but submits the collected audits to 2 different outside vendors. EI # 26, Medical Director, Anesthesia Department submits his/ her audits to E-preop reporting system. EI # 26 informed the surveyor that his/ her department had not receive any results/findings from E-preop since the first of the year. EI # 14 provided the surveyor with his/her reports. The surveyor further asked EI # 14 and EI # 15 if the results of audits are submitted to the hospital-wide Quality, both informed the surveyor that their reports of audits are sent to the Surgical Committee and both are unsure if it goes to any other committee. An interview was conducted on 9/27/17 at 11:00 AM with EI # 1 Director of Quality, who verified Surgical Services, including Operating Room, Anesthesia and PACU do not send their audit reports and results to her.

A0392

STAFFING AND DELIVERY OF CARE
CFR(s): 482.23(b)

The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient.

This STANDARD is not met as evidenced by:

Based on medical record (MR) review, hospital policies, Alabama Board of Nursing (ABN) Administrative Code and interviews, it was determined the hospital failed to:

- 1). Follow doctor's orders for Strict Intake and Output (I & O).
- 2). Document accurate daily weights, as ordered.
- 3). Ensure patient's wound care was provided per physician orders and ABN Standards of Nursing Practice, and documentation was completed.
- 4). Ensure the RN documented IV insertions per facility policy.
- 5). Ensure all physician orders were written for wound care.

This affected Patient Identifier (PI) # 21, PI # 24, PI # 25 and PI # 1, 4 of 26 in-patient records reviewed and had the potential to affect all patient's served by this facility. Findings include: ***** Policy: Intake and Output Reviewed and Revised: 1/17

Accurate intake and output records shall be kept as indicated below:

1. When ordered by a physician.... Purpose: To maintain an accurate record of the patient's fluid balance. Procedure: 1. Instruct and educate patient/family on intake and output procedure. ... 3. Total the amount of fluid consumed at each meal. Check all drinking containers. 4. To be sure all fluid intake has been measured, check with the patient and/or family member to include fluids served between meals. 5. Other intake includes IV fluids... 6. Record each voiding on the information board in the patient's room. Instruct the patient to void into the collecting device (bedpan, urinal, commode or commode collector pan)... Documentation: 1. Record total intake and output at each shift in electronic medical record (EMR). ***** Policy Title: Intravenous Lock-Intermittent Infusion Policy: A registered Nurse or qualified LPN (Licensed Practical Nurse) may insert a peripheral Intravenous (IV) catheter for an IV lock, or convert an existing peripheral IV to an IV lock upon order of physician... Documentation: ... 3. IV flushed and patency... ***** Policy Title: Wound Measurements Effective Date: 8/1/2015 Purpose: To provide guidelines for obtaining wound or ulcer measurements. Policy: Measurements taken will be: Length... Width... Depth... It is important that measuring procedures are consistent throughout the organization in order to determine improvement of the wound... Wound measurements are obtained at an initial visit, weekly visit, if there is a significant change in wound size and post debridement... ***** Alabama Board of Nursing Administrative Code Chapter 610-X-6 Standards of Nursing Practice 610-X-6-.06 Documentation Standards. Nursing Chapter 610-X-6 Supp. 9/30/16 6-11 (1) The standards for documentation of nursing care provided to patients by licensed nurses are based on principles of documentation, regardless of the documentation format. (2) Documentation of nursing care shall be: ... (c) Complete. Complete documentation includes reporting and documenting on appropriate records a patient's status, including signs and symptoms, responses, treatments, medications, other nursing care rendered, communication of pertinent information to other health team members, and unusual occurrences involving the patient. A signature of the writer, whether electronic or written, is required in order for the documentation to be considered complete. ***** 1. PI # 21 was admitted to the facility on 9/22/17, with the diagnoses of Generalized Weakness, Productive Cough with Yellow Sputum, Chronic Obstructive Pulmonary Disease and History of Alcohol Abuse. A review of the MR revealed doctor's orders dated 9/22/17 at 3:18 PM, "Strict Intake and Output." A copy of the Intake/Output Inquiry was requested by the surveyor and received from Employee Identifier (EI) # 7, RN on 9/28/17 at 11:15 AM. A review of the Intake/Output Inquiry report revealed the following: No documentation of I & O for 9/22/17 9/23/17, I & O was documented at 2:43 PM only. No documentation of I & O for all shifts for 9/24/17. Intake recorded on 9/25/17 at 2:58 PM and output recorded on 9/25/17 at 12:30 AM, 2:05 AM, 6:12 AM, and 3:02 PM. There was no documentation of I & O recorded for 9/26/17, 9/27/17, or until time report was printed

on 9/28/17. Further review of the MR revealed an Assessment Report dated 9/23/17 at 2:01 PM, by a Registered Dietitian, consulted for "Malnutrition." The report states, "No intake recorded in I/Os." There was no documentation in the MR of education to the patient regarding I & O. In an interview on 9/27/17 at 10:00 AM, EI # 6, RN stated it was the nurses' ultimate responsibility to record any intake information, written on the dry erase board in the patient's room, in the EMR. Further review of the MR revealed doctor's orders dated 9/22/17 at 3:18 PM to "Weigh patient daily." The surveyor requested and received a report of daily weights from EI # 7, RN. Review of the report revealed the following information: 9/23/17 at 12:14 AM- 108.00 lbs. 9/23/17 at 11:00 PM- 126.00 lbs. 9/25/17 at 3:26 PM- 125.10 lbs. 9/26/17 at 1:20 PM- 116.30 lbs. No weight was recorded for 9/27/17, and none recorded for 9/28/17 at 10:15 AM when report was printed. There was no documentation the discrepancies in weight were investigated or reported to the physician. During an interview on 9/29/17 at 10:05 AM, with EI # 9, RN, the above findings were confirmed. He also stated the bed scales should have been re-calculated to obtain accurate weights. 37268 2. PI # 24 was admitted to the facility on 9/25/17 with diagnoses including SIRS (Systemic Inflammatory Response Syndrome, Possible UTI (Urinary Tract Infection), and Altered Mental Status. Review of the Daily Focus Assessment Reports dated 9/25/17 through 9/27/17 printed at 6:07 AM revealed the following documentation: "IV (Intravenous) Assessments... 9/25/17 20:30(8:30 PM)... Note: currently has an IV site in L (Left) hand; previous nurse advised she had to insert new IV as pt pulled out IV she came to floor..." The RN (Registered Nurse) failed to document the insertion of the IV on 9/25/17. Review of the Physician (MD) Orders dated 9/26/17 at 3:26 PM revealed: "Clean and let dry buttocks and sacral area apply moisture barrier advance skin protectant wand. Do not let skin touch anything for 30 sec (seconds)..." Review of Nurse's Notes dated 9/26/17 revealed the following documentation: "Left buttocks Interventions: Wound care cleaned, open to air, used aseptic technique..." There was no documented orders for what to use when cleaning the buttocks area; the RN failed to clarify the wound care order and document what was used to clean the patient's buttocks area. Further review of Nurse's Notes dated 9/26/17 revealed the following documentation: "Groin intervention: Wound care cleaned, used aseptic technique." There were no documented physician orders to clean groin wound. The nurse failed to obtain wound care order for cleaning the patient's groin area. The RN failed to document what was used to clean the patient's groin area. Review of Nurse's Notes dated 9/26/17 through 9/27/17 revealed no documentation of wound measurements according to facility policy. An interview was conducted on 9/29/17 at 10:30 AM with EI # 9, RN Director, 6 - East who confirmed the above finding. EI # 9 stated, "staff failed to document the Length, Width, and Depth measurements of the patient's wound." 3. PI # 25 was admitted to the facility on 9/26/17 with diagnosis including Necrotic Left 3rd Toe. Review of the MD Orders dated 9/27/17 at 9:33 AM revealed: "Wound care to see- until perform dressing change with NS (Normal Saline) cleaner and apply nonstick type dressing, gauze and wrap with kling or kerlex." Review of Nurse's Notes dated 9/27/17 revealed documentation of the wound length, and width only. The nurse failed to document the wound depth measurement. An interview was conducted on 9/29/17 at 10:49 AM with EI # 9, RN Director, 6-East who confirmed the staff failed to measure the patient's wound per ABN Standards of Nursing Practice. 32470 4. PI # 1 was admitted to the facility on 9/24/17 with an admitting diagnosis of Infected Decubitus and End Stage Renal Disease. Review of the 9/24/17 nursing assessment documentation at 19:10 PM (7:10 PM) revealed the nurse documented wound cleaned and dressed to the right heel. Further review revealed no documentation as to what the wound was cleaned with or what type of dressing was applied. Review of the 9/25/17 assessment at 17:45 (5:45

PM) revealed the nurse documented under right heel interventions: wound care, open to air. Further review revealed no documentation as to what type of wound care was performed. Review of the physician orders revealed no documentation of an order written to leave the wound open to air. An interview was conducted on 9/29/17 at 9:30 AM with EI # 31, Clinical Specialist, who confirmed the above mentioned findings.

A0396

NURSING CARE PLAN
CFR(s): 482.23(b)(4)

The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan

This STANDARD is not met as evidenced by:
Based on review of facility policies, medical records (MR) and interviews, it was determined the facility failed to ensure: 1. Patient discharge plans were started for all patients upon admission. 2. All nursing care plans were individualized for the patient's nursing care needs. This affected 2 of 26 in-patient records reviewed, including Patient Identifier (PI) # 24, # 25 and has the potential to affect all patients served. Findings include: Policy Title: Patient Care Plans Documentation Effective date: 2/20/2012 Policy: All patients admitted to patient Care Services nursing units shall have an individualized plan of care documented electronic in the medical record preferably within 8 hours but no later than within 24 hours of admission. A RN (Registered Nurse) or a LPN (Licensed Practical Nurse) will evaluate each patient's care plan daily. The RN must review and revise/update the care plan as needed each day. Purpose: To initiate nursing measures appropriate to current nursing practice. Procedure: ... 2. Only the RN may develop and initiate the patient's care plan and will individualize the care plan as appropriate to the patient's clinical history and physical assessment... 5. The RN will choose the top three to five problems/nursing diagnosis for his or her patient... Review And Revise/Update 1. The RN will review the appropriateness of each patient's care plan and revise/update as needed each day... 3. In any additional problem/nursing diagnosis is identified, it can be added to the patient's care plan and individualized for the patient... ***** Policy Title: Discharge Planning Effective date: 7/1/1994 Policy: All patients admitted to Southeast Alabama Medical Center should be screened upon admission for discharged planning needs. Purpose: To provide appropriate screening, assessment, planning, implementation and evaluation for the patient in preparation for discharge. Procedure: On Admission and Continued Stay: 1. Upon admission the staff nurse completes admission assessment to include, but not limited to, discharge needs... 12. Documentation is completed by the case manager/social worker and placed in the patient's medical record... ***** 1. PI # 24 was admitted to the facility on 9/25/17 with diagnoses including SIRS (Systemic Inflammatory Response Syndrome, Possible UTI (Urinary Tract Infection), and Altered Mental Status. Review of the Patient Care Plan Report dated 9/25/17 revealed the following Nursing diagnosis: Anxiety, Pain, Knowledge Deficit, and Fear /Anxiety Related to Unfamiliar Surroundings. The patient's care plan was not individualized to meet his/her needs according to the admitting diagnosis of SIRS, UTI, and Altered Mental Status. Review of the MR dated 9/25/17 through 9/27/17 at 11:23 AM revealed no documentation of the patient's discharge plan. The surveyor asked EI # 2, Quality Outcomes Team Leader, "When should the patient's discharge planning be performed and documented?" EI # 2 stated, "Upon admission." The staff failed to document the patient's discharge plans

per facility policy. An interview was conducted on 9/29/17 at 10:30 AM with Employee Identifier (EI) # 9, Registered Nurse (RN) Director, 6-East who confirmed the patient's care plan was not individualized for his/her admitting diagnosis. 2. PI # 25 was admitted to the facility on 9/26/17 with diagnoses including Necrotic Left 3rd Toe. Review of the Patient Care Plan Report dated 9/26/17 at 5:07 PM revealed the following Nursing diagnosis: Anxiety, Pain, Knowledge Deficit, and Fear/Anxiety Related to Unfamiliar Surroundings. The patient's care plan was not individualized to meet his/her needs according to the admitting diagnosis of Necrotic Left 3rd Toe. An interview was conducted on 9/29/17 at 10:30 AM with EI # 9, who confirmed the patient's care plan was not individualized to meet his/her needs according to the admitting diagnosis.

A0620

DIRECTOR OF DIETARY SERVICES
CFR(s): 482.28(a)(1)

The hospital must have a full-time employee who- (i) Serves as director of the food and dietetic services; (ii) Is responsible for daily management of the dietary services; and (iii) Is qualified by experience or training.

This STANDARD is not met as evidenced by:
Based on a tour of the Dietary Department, interviews, review of facility's policies, National Restaurant Association Educational Foundation poster and Safety Data Sheet, it was determined the Dietary Department failed to: 1. Label opened foods appropriately. 2. Maintain temperature logs for all refrigerators and freezers. 3. Ensure proper attire for employees. 4. Ensure cleaning of the dish washing machine was performed properly. 5. Check the temperature for the sanitizing solution sink. 6. Use a test kit to check the concentration of the sanitizing solution. 7. Store sanitizing solution properly. This had the potential to affect all people served by the facility. Findings include: ***** Policy Number L-23: Storage of Food and Supplies Revised: 1/17 Food and supplies should be stored in a manner to accommodate known practices for storing food in a safe and sanitary manner. ...6. Leftovers should be covered, labeled as to content, dated and refrigerated within one hour after use. They should be used within 3 days. ...15. Storage area temperatures should be monitored and recorded daily. ***** Policy Number C-1: Professional Appearance Revised: 1 /17 ...Hair: Hair confinement should be used in areas where appropriate for job duties. Hair must be confined by a hairnet, cap, or other means. ***** Policy Number K-32: Policy Title: Dish Machine Policy: To ensure cleaning of dish machine is performed properly. Procedures: A. De-Liming: Overview ... 2. Put in Lime-a-way... 4. Run Lime-a-way out... ***** National Restaurant Association Educational Foundation poster located in the three compartment sink work area: Title: How To Clean And Sanitize In A Three-Compartment Sink ... There are 5 steps for cleaning and sanitizing in a three-compartment sink... 4. Immerse items in sanitizer in the third sink, Check the time and temperature requirements for the sanitizer you are using and use a test kit to check concentration... ***** Safety Data Sheet (ECOLAB) Title: Oasis 146 Multi-Quat Sanitizer ... Section 7. Handling and storage... Storage: Keep out of reach of children. Keep container tightly closed... ***** 37268 1. During a tour of the Dietary Departments conducted on 9/26/17 at 9:16 AM with EI # 8, the following observations were made: A rusty can opener located in the Main kitchen food preparation area. The dishwashing machine had lime and calcium build-up throughout the inside. The staff failed to de-lime the machine properly per policy and procedure. The staff in the Main kitchen did not check the temperature and chemical concentration during manual dishwashing of pots and pans per posted procedure

instructions. Further observation revealed the chemical concentration test strips available for use were expired on 4/15/14. EI # 8 stated, "All of the test strips are expired; We will contact our vendor and have them to over night us some more test strips" There were no test strips available to verify the chemical concentration for the sanitizing sink per posted procedure instructions. There were open containers of sanitizing solution buckets throughout the Main kitchen, Oak Garden kitchen, and the Physician's Lounge kitchen. The staff failed to follow the manufacturer's instructions for storing sanitizing solution. The staff in the Oak Garden kitchen did not check the temperature and chemical concentration during manual dishwashing of pots and pans per posted procedure instructions. The surveyor asked EI # 30, Dietary Assistant, "Who verifies that chemicals are being dispensed into the sanitizing sink appropriately?" EI # 30 replied, "Maintenance ensures that the chemicals are being delivered through the dispenser." The surveyor asked EI # 30, "Do you ever check the chemical concentration in your sanitizing sink?" EI # 30 stated, "No." 2. During a tour on 9/26/17 at 9:45 AM of the Oak Garden dining facility, the surveyors observed the following: a. The temperature log for the large refrigerator was missing data for 9/26/17, and the dining facility was open and serving food. There was no temperature log for the under the counter small refrigerator. b. The cleaning log for the kitchen was missing data for 9/25/17. c. Upon entering the kitchen, the surveyor observed the cook was not wearing a hair net. d. The following items were observed in the large refrigerator: (1) One opened container of Kraft Mayonnaise labeled "Use by 9/20/17." (1) One opened container of orange juice with no expiration date. (1) One opened container of apple juice with no expiration date. (1) One opened container of Reser's Quality Deli Salad with no expiration date. e. All prepared food items in the display case were missing expiration dates. During an interview on 9/26/17 at 10:15 AM, with Employee Identifier (EI) # 8, Dietary Manager, the above findings were confirmed. 3. During a tour of the Dietary Department on 9/26/17 at 10:20 AM, the surveyors observed the following: a. In cooler # 8: A large pan of "pasta casserole" as identified by EI # 8, with no label as to content and expiration date. A tray of sliced ham with no label or expiration date. A rack of rolls, opened, with no expiration date. (2) large containers of fruit mixture with no label or expiration date. (1) container of clear yellow liquid with no label or expiration date. b. In the storage room, the following items were found opened, with no expiration date: 1 bottle Marsala Cooking Wine 1 bottle Worcestershire 1 bottle of Molasses with a manufacturer's expiration date of 2016 1 bottle of Regina Cooking Wine 1 bottle of Fine Sherry 1 bottle of Hot Sauce 2 bottles of La Choy soy sauce 1 bottle of Red Wine vinegar 1 bag Mini Marshmallows 1 bottle of Hershey's Syrup 1 bag of soft tortillas, laying open 1 half used bag of Rotini pasta 1 bag elbow macaroni 1 bag wide noodles 1 bag bowtie pasta At 10:30 AM the surveyors observed plating of food items for patient consumption. (1) One of (2) two servers failed to wear an apron. During an interview on 9/26/17 at 11:55, with EI # 8, the above findings were confirmed. 4. During a tour of the Physician's Lounge on 9/26/17 at 2:53 PM, the following items were observed: One large freezer, One large refrigerator, and 3 small refrigerators with no temperature control logs. One can opener with rusted blades. 10 prepared sandwiches with no dates of expiration. One large refrigerator which contained the following: 4 large salad dressings, opened, with no expiration date. 1 container of egg whites, with no label or expiration date. 1 container of fruit, 8 containers of vegetables, no label or expiration date. One large Freezer which contained the following: 2 cake halves, with no label or expiration date. 1 opened bag of meat patties, not sealed. 1 opened bag of frozen biscuits. An interview was conducted on 9/26/17 at 3:20 PM with EI # 8 who confirmed the above findings.

A0700

PHYSICAL ENVIRONMENT

CFR(s): 482.41

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

This CONDITION is not met as evidenced by:

Based on observations during facility tour with hospital staff by the Fire Safety Compliance Officer and staff interviews, it was determined that the facility was not constructed, arranged and maintained to ensure patient safety. This had the potential to negatively affect all patients served by the facility. Findings include: Refer to Life Safety Code violations

A0749

INFECTION CONTROL PROGRAM

CFR(s): 482.42(a)(1)

The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.

This STANDARD is not met as evidenced by:

Based on review of facility policy and procedure, Centers for Disease Control (CDC) frequently asked questions (FAQs), observations and interviews it was determined the facility failed to ensure: 1. Patient care staff, including Certified Registered Nurse Anesthetist and Anesthesiologist performed hand hygiene before and after glove removal. 2. Single-dose syringes were not carried from patient room to other areas of the treatment floor. This affected Patient Identifier (PI) # 45, PI # 46, PI # 47 and had the potential to negatively affect all patients care for by this facility. Findings include: Facility Policy: Infection Prevention and Control Manual Standard Isolation Precautions Effective date: 10/1/1978 Reviewed: 07/11, 05/17, 02/15, 02/16, 01/17 Policy: Southeast Alabama Medical Center promotes the basic isolation precaution guideline published by the Healthcare Infection Control Practices Advisory Committee /Centers for Disease Control and Prevention (HICPAC/CDC). Purpose: To follow research based guidelines/recommendations that are applicable across the continuum of care. Procedure: Standard Precautions should be used in the care of all patients. 1. Perform Hand Hygiene: a. Before having direct contact and after direct contact with patients. b. After contact with blood, body fluids, or excretions, mucous membranes, nonintact skin or wound dressings. c. After contact with a patient's intact skin (e.g. when taking a pulse or blood pressure or lifting a patient). d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. f. After removing gloves. ... 3. Soiled Patient Care Equipment: handle in a manner that prevents transfer of microorganisms to others and to the environment... ... 5. Medications packages as single-use vials should not be used for more than one patient... Facility Procedure: Anesthesia - Department Protocol Procedure for Subarachnoid Block (SAB) Effective date: 7/1/1990 Date Reviewed /Revised: 01/00, 01/09, 2/10, 3/11, 2/17, 9/17 Purpose: Placement Epidural, and SAB with aseptic technique for procedures requiring Neuraxial anesthesia. Procedure: ... Spinal and Epidural injection procedures are performed in a manner consistent with hospital infection control policies and procedures to maximize the prevention and communicable diseases. This includes: 1) Hand hygiene performed before and after

the procedure. 2) The spinal injection procedure is performed using aseptic technique... CDC - FAQs regarding Safe Practices for Medical Injections ... Questions about Single-dose/Single-use Vials What is a single-dose or single-use vial? A single-dose or single-use vial is a vial of liquid medication intended for parenteral administration (injection or infusion) that is meant for use in a single patient for a single case/procedure/injection. Single-dose or single-use vials are labeled as such by the manufacturer and typically lack an antimicrobial preservative. ... What are examples of the "immediate patient treatment area"? Examples of immediate patient treatment areas include operating and procedure rooms, anesthesia and procedure carts, and patient rooms or bays.

1. An observation was conducted on 9/26/17 at 10:00 AM in the Cat Scan (CT) area. During the observation, Employee Identifier (EI) # 5, CT Technician, was observed preparing an Intravenous (IV) dye machine for injection. Once machine was completed EI # 5 returned to the viewing area with the gloves on and waited until the CT scan was complete. Once complete EI # 5 returned in to the room with the patient disconnected the IV and flushed the site with 10 ml (milliliters) of Normal Saline (NS). EI # 5 then assisted the patient onto the hospital bed and transported out of the CT area with the same gloves on. EI # 5 returned to the CT area removed gloves and donned a clean pair of gloves without sanitizing or washing hands and cleaned the CT machine. An interview was conducted on 9/26/17 at 10:35 AM with EI # 16, Director of Radiology who confirmed the above mentioned findings.

2. An observation was conducted on 9/27/17 at 8:25 AM on 6-East Neurosurgery/Neurology Unit with EI # 25, Registered Nurse (RN) to observe medication administration. During the observation, EI # 25 checked the patient's pedal pulse with gloved hands and used the same gloves to: Document the patient's information on the computer system. Listen to the patient's anterior breath sounds and Apical heart rate. Flush the patient's right arm IV (Intravenous) line. EI # 25 failed to remove gloves and sanitize his/her hands per policy. An interview was conducted on 9/27/17 at 12:00 AM with EI # 2, Quality Outcomes Team Leader who confirmed the above mentioned findings.

3. An observation was conducted on 9/27/17 at 8:25 AM on 6-East Neurosurgery/Neurology Unit with EI # 32, LPN (Licensed Practical Nurse) to observe medication administration. During the observation, EI # 32 administered oral, and topical medications and used the same gloves to: Document the patient's information on the computer system. Assessed the patient's feet. Listen to the patient's anterior breath sounds and Apical heart rate. Reached into his/her pockets where he /she stored multiple 10 ml NS syringes to remove his/her pen to write information on a piece of paper. EI # 32 failed to remove gloves and sanitize his/her hands per policy. An interview was conducted on 9/27/17 at 12:00 AM with EI # 2 who confirmed the above mentioned findings.

4. An observation was conducted on 9/27/17 at 8:35 AM to observe EI # 3, RN administer medications in the Critical Care Unit (CCU). During the observation, EI # 3 administered medications per an OG (Oral Gastric) tube. Once complete, EI # 3 removed gloves and donned a clean pair of gloves without sanitizing or washing his/her hands. EI # 3 then gave IV medication and administered a NS flush per IV. EI # 3 then removed gloves cleaned the area of used supplies and donned a clean pair of gloves without sanitizing or washing hands. An interview was conducted on 9/27/17 at 10:00 AM with EI # 10, Director of CCU, who confirmed the above mentioned findings.

5. An observation of medication administration was conducted on 9/27/17 at 8:40 AM with EI # 20, RN for an unsampled patient (PI # 45). During this observation, EI # 20 failed to perform hand hygiene prior to obtaining clean gloves. After oral medication was administered, EI # 20 exited the patient's room. It was observed located in EI # 20's pants pocket were three (3) syringes. The surveyor asked what were in the syringes and EI # 20 stated NS flush. She stated she carries them around, "just in case she needs to flush

a patient's IV line" 6. On 9/27/17 at 8:50 AM, the surveyor observed EI # 21, RN had prepared medications for an unsampled patient (PI # 46). Just prior to administration of medications, EI # 21 had assisted the Patient Care Technician (PCT) with cleaning the patient. EI # 21 removed her gloves and donned clean gloves. EI # 21 failed to perform hand hygiene prior to obtaining and donning clean gloves. The surveyor asked EI # 21 to step outside the room, at which time, EI # 21 removed her gloves and performed hand hygiene. EI # 21 verified she had not performed hand hygiene prior to obtaining and donning clean gloves and that she should have done so.

7. An observation was conducted on 9/27/17 at 9:00 AM in the CCU with EI # 4, RN to observe a medication administration. During the observation, EI # 4 administered subcutaneous (SQ) medication and using the same gloves, EI # 4 crushed oral medications and dissolved them in a medication cup. EI # 4 then donned a second pair of gloves over the dirty gloves and applied a topical lotion to the patient's abdominal folds and thigh folds. EI # 4 removed the second pair of gloves and administered the dissolved medication per the OG tube and cleared the tube by flushing. EI # 4 then removed gloves and donned a clean pair of gloves without sanitizing or washing hands and applied a duoderm to the patient's left knee. EI # 4 then flushed the IV line with 10 ml (milliliters) of NS without cleaning the IV port prior to flushing. An interview was conducted on 9/27/17 at 10:00 AM with EI # 10 who confirmed the above mentioned findings. 39098

9. An observation was conducted on 9/27/17 at 9:45 AM on the 7-East nursing unit to observe EI # 24, RN, change the dressing on an Infusaport of an unsampled patient. EI # 24 prepared the patient, opened the kit, donned sterile gloves, then reached in kit and picked up sterile mask and place around ears. EI # 24 removed his personal eye glasses with sterile gloves. Realizing this, he removed the sterile gloves, left room to retrieve another kit and failed to perform hand washing or sanitize hands before leaving room. On the second attempt, EI # 24 donned sterile gloves before reaching into the sterile kit and putting on the mask looping it around the ears. EI # 24 failed to maintain sterile technique for the infusaport dressing change. After leaving the room, EI # 7, RN, Infection Control, confirmed the above findings. 10. On 9/27/17 at 10:40 AM, the surveyor observed surgical staff setting up the operating room (OR) in preparation for Caesarian section (C-section) for an unsampled patient (PI # 47). During this observation time, the surveyor observed EI # 22, RN perform hand hygiene using hand sanitizer. EI # 22 applied hand sanitizer and rubbed hands together for approximately 5 seconds. Once the patient was brought to the OR, EI # 23, Anesthesiologist picked up a rolling stool to move it and the stool fell apart with pieces landing on the floor. EI # 23 picked up the parts, put the stool back together and donned gloves for the Epidural anesthesia. EI # 23 failed to perform hand hygiene after picking up the stool parts from the floor prior to donning gloves. After the patient's lower back was prepared for Epidural anesthesia, EI # 23 removed gloves and donned sterile gloves. EI # 23 failed to perform hand hygiene after glove removal and prior to donning sterile gloves. 37268

8. An observation was conducted on 9/27/17 at 9:41 AM on 6-East Nursing Unit with EI # 33, RN to observe medication administration. During the observation, EI # 33 removed the end connector from Ganciclovir Sodium (Cytovene) 400 mg (milligrams) in 100 ml NS and connected the medline pump to the IV port. EI # 33 used the same gloves to turn on the blood pressure monitor machine. EI # 33 did not remove gloves and sanitize his/her hands per policy. An interview was conducted on 9/27/17 at 12:00 AM with EI # 2 who confirmed the above mentioned findings.