

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 010001	(X3) Date Survey Completed 08/11/2011
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)
A0395	<p>RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3)</p> <p>A registered nurse must supervise and evaluate the nursing care for each patient.</p> <p>This STANDARD is not met as evidenced by: Based on the review of the facility's policies and procedures and medical records and interviews with the staff, it was determined the facility failed to ensure the nursing staff followed the physician's orders for incentive spirometers, vital signs, and follow the policies for intake and output (I&O) for each patient. This affect medical record (MR) #s 150488, 149169 and 429328. Findings include: Facility Policy Titled: Care and Removal of Jackson Pratt and Hemovac, Drains Number 229 Revised 12/09 Procedure for Care of Drains Equipment ...Container for measuring drainage 6. Empty the collector at the end of each shift (unless contraindicated). Make sure that the drain remains compressed at all times (unless contraindicated). Documentation 2. Record amount of drainage on intake and output (I&O) sheet 3. Record color and consistency of collected drainage Facility Policy Post-Operative Care Number 198 Revised 12/09 Guidelines 3. Routine post-op vital signs for patients receiving a general anesthetic and spinal anesthesia should begin on return to the unit: a. Blood pressure, pulse and respirations: every 15 minutes for one hour; every 30 minutes for one hour; every hour for 4 hours; then, every 4 hours for 24 hours. b. Temperature every 4 hours for 24 hours. If the temperature is above 100 degrees orally, continue checking every 4 hours until afebrile for 24 hours. 1. MR # 150488 was admitted to the facility on 7/19/10 with diagnoses including Degenerative Joint Disease and underwent a Total Hip Replacement of the Right Hip on 7/19/10. Review of the Total Post-Op Orders dated 7/19/10 revealed orders Routine Post-Op vital signs and I&O every 8 hours. Review of the I&Os dated 7/19/10 at 15:00 to 7/21/10 01:05 revealed 1 entry for the Hemovac drainage on 7/20/10 at 14:58 which included 90 cc (cubic centimeters). An interview was conducted on 8/10/11 at 1:40 PM with</p>

Employee Identifier (EI) # 4, Registered Nurse (RN), Director of Neurology, confirmed the Hemovac should have been emptied at the end of each shift and the amount and color of drainage should have been documented. Review of the Procedure Comments dated 7/19/10 revealed documentation the patient received General Endotracheal Anesthesia for the Total Hip Replacement. Review of the nurses' documentation for vital signs revealed no documentation of a blood pressure, heart rate, respiration or temperature after 7/20/10 at 14:10. The vital signs should have been checked every 4 hours until 21:10 on 7/20/10. Review of the nurses' documentation dated 7/20/10 at 21:00 revealed the patient was found unresponsive and a code was called. The patient was moved to the Critical Care Unit on a ventilator and expired on 7/21/10 at 5:35 AM. An interview was conducted on 8/10/11 at 1:35 PM with EI # 1, Quality Outcomes Coordinator who confirmed there was no documentation of a blood pressure, heart rate, respiration or temperature after 7/20/10 at 14:10 and the vital signs should have been checked every 4 hours until 21:10 on 7/20/10.

2. MR # 149169 was admitted to the facility on 8/8/11 with diagnoses including Osteoarthritis Right Shoulder and underwent surgery on the right shoulder on 8/8/11. Review of the Post-Op Orders dated 8/8/11 revealed orders for an Incentive Spirometry every 4 hours times 48 hours. An observation of the patient was conducted on 8/9/11 at 2:35 PM by the surveyor with EI # 2, the Director of Quality. Upon entering the room the surveyor asked the patient and family if they had an incentive spirometer and the response was, "no". EI # 1 then looked in the computer system to identify documentation the incentive spirometer had been given and taught to the patient/family by the nursing staff and none could be found. An interview was conducted on 8/10/11 at 1:35 PM with EI # 3, Registered Nurse (RN), Clinical Nurse Specialist, who verified the Incentive Spirometers had been the responsibility of Respiratory Services until April 2011 when it became the responsibility of Nursing Services.

3. MR # 429328 was admitted to the facility on 8/8/11 with diagnoses including Degenerative Joint Disease/Right Hip and underwent a right hip replacement on 8/8/11. Review of the Post-Op Orders dated 8/8/11 revealed orders for an Incentive Spirometry every 4 hours times 48 hours. An observation of the patient was conducted on 8/9/11 at 12:35 PM. Upon entering the room the surveyor asked the patient and family if they had an incentive spirometer and the response was, "no". EI # 1 then looked in the computer system to identify documentation the incentive spirometer had been given and taught to the patient/family by the nursing staff and none could be found.