Department of Health & Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0391

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 010001	(X3) Date Survey Completed 08/24/2017
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)
A0057	CHIEF EXECUTIVE OFFICER CFR(s): 482.12(b) The governing body must appoint a chief executive officer who is responsible for managing the hospital. This STANDARD is not met as evidenced by: Based on observations, review of facility policies, Facility Scope of Care Behavioral Health Services (BHS) / Behavioral Medicine Unit (BMU), facility work order maintenance requests, security video footage, Root Cause Analysis (RCA), medical records, Risk Management Worksheets, Unit Profile reports, Safety Checklist documentation, Minutes Houston County Health Care Authority Quality Committee, interviews and Facility's Corrective Action Plan submitted to the surveyors on 8 /24/17, it was determined the governing body failed to ensure: 1. Psychiatric patients were provided care in a safe environment. 2. Mental Health Technicians (MHTs) performed patient safety rounds every 15 minutes. 3. The Registered Nurse (RN) conducted hourly rounds on patients and supervised the care provided by the MHTs to ensure patient observations were conducted every 15 minutes according to physician orders. 4. The BMU staff recognized the complexity of Patient Identifier (PI) #1's previous suicide attempts, including the attempt to self violence in the facility's Emergency Department (ED) and place the patient on 1:1 observation. 5. A treatment plan was implemented and updated for a suicidal patient to provide safe care and environment for PI # 1. 6. The BMU staff recognized PI # 2's self-destructive behaviors while in the BMU and was placed on 1:1 observation. 7. PI # 2's right to be free of restraint was not violated by placing the patient in a geri-chair (cardiac chair) for greater than 15 hours after being found trying to harm him/herself. 8. The BMU staff conducted environmental safety rounding each shift and ensure physical surroundings were safely maintained to protect patients to prevent potential harm. 9. Patient occurrences were reported,

	investigated, analyzed and preventative measures were implemented to prevent further occurrences. 10. The sentinel event involving PI # 1, a patient who successfully committed suicide while a patient in the BMU was reviewed in monthly quality meetings of the governing body. 11. Governing Body Quality Committee meetings were conducted for the months of July 2017 and as of the date of this survey (8/24/17) August 2017. 12. The BMU (2 North and 3 North) was staffed according to their budgeted target hours, which increased the patient work load for licensed, unlicensed and clerical staff caring for those patients. This affected 3 of 3 medical records (PI # 1, PI # 2, PI # 3) and 3 of 6 patients with adverse occurrences (PI # 4, PI # 6 and PI # 7). This also has the potential to negatively affect all patients admitted to this facility. Findings include: Refer to A115, A263, A309 and A385 for findings.