

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)
A0154	<p>USE OF RESTRAINT OR SECLUSION CFR(s): 482.13(e)</p> <p>Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records, facility policy and interview it was determined in 1 of 3 patient medical records reviewed, the patient's right to be free of restraint was violated by placing a patient in a geri-chair (cardiac chair) for greater than 15 hours after being found trying to harm him/herself. This affected Patient Identifier (PI) # 2 and has the potential to affect all patients receiving care in the facility. 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) and seclusion is used if less restrictive measures have proven unsuccessful. ... 4. ... The order should be reviewed daily according to the reason for restraints or seclusion, non violent, violent/ aggressive behavior. 7. Implementation of restraints and or seclusion should be accompanied by a modification to the patient's plan of care within 8 hours of</p>

restraint application. Thereafter, the plan of care would be updated daily with the care plan evaluation. 9. Restraint/seclusion should be discontinued as soon as possible after the patient meets the criteria for discontinuation. Violent and/or Self-destructive Patient (Behavior that jeopardized the immediate physician safety of the patient, staff or others). 4. Orders for restraint and/or seclusion for patients exhibiting violent and/or self-destructive behaviors should be limited to: 1. Four (4) hours for adults age 18 and older. ... 5. When patient is placed on restraint/seclusion: 1. Pockets, socks, etc., should be checked for dangerous items and such items should be removed. 2. The patient should be made aware that he/she is involved in determining his/her length of stay and be made aware that he/she must do to get out of seclusion. The procedure and expectation of care should be explained to the patient and documented in the medical record. 10. The patient exhibiting violent and/or self-destructive behavior and in restraints or seclusion should be observed at least every fifteen (15) minutes. Such observation should include efforts to interact verbally with the patient. Observation should be documented on the FREQUENT OBSERVATION FLOWSHEET: BEHAVIORAL MEDICINE. 12. Range of Motion should be performed every two (2) hours or more frequently unless contraindicated by patient's condition or behavior. If range of motion is not performed, reason should be documented in the patient record. Quality Monitoring 1. The use of restraint and seclusion is monitored and evaluated on an ongoing basis and is reported to the patient Safety Committee and Quality Safety Committee. 2. Any occurrences of prolonged restraints are identified and actions taken to reduce or eliminate the use of restraints are evaluated/analyzed by the treatment team. Prolonged restraints for violent and/or self-destructive patients is defined as 24 hours 1. PI # 2 was admitted to the facility on 6/8/17 with the diagnoses of Suicidal Ideations, Paranoid Schizophrenia, Hallucination and Panic Attack. Review of the Psychosocial Assessment performed on 6/8/17 revealed the patient was found "hanging in a tree and was cut down by the law enforcement and was taken to the hospital." Patient stated "lots of stressors in life that is why (he/she) decided to hang self." The patient was subsequently admitted to the hospital's Behavioral Medicine Unit (BMU). During staff rounds on 6/9/17 at 10:28 PM, the staff who was making rounds checked on the patient who was "staying in the bathroom." The staff found strips of torn gown made into a noose in the garbage can. Patient stated he/she was feeling suicidal and hearing voices. The psychiatrist was notified. At 2:30 AM on 6/10/17, the patient was placed in a cardiac chair (geri-chair) at the nursing station in full view of the staff at all times "related to his/her suicide attempt." There was no written order from the psychiatrist to place the patient in a cardiac chair (geri-chair) at the nursing station. At 7:26 AM on 6/10/17, the Mental Health Technician (MHT) noted the patient was covering his/her head with a blanket while in the cardiac chair (geri-chair) in full view of the nursing station. The MHT redirected the patient a few times and asked what he/she was doing, the patient did not respond to the redirection, so the MHT pulled the blanket off and the patient was noted attempting to "chew on the water pitcher cover." The MHT then removed the water pitcher from the patient. Review of the daily Focus Assessment Report revealed documentation "this information was..." The staff failed to complete his/her documentation. Group Note on 6/10/17 at 9:07 AM, Psychiatrist ordered "patient not to be in (his/her) room alone and to sleep in Geri-chair near the nurses desk." The Group Note further described the patient as "does not maintain consistent eye contact but will answer questions and thanked the writer when (his/her) medicine was given. Patient remains very flat." During the group session on 6/10/17 at 11:00 AM, patient was observed resting in the Geri-chair and dozing at intervals. On 6/11/17 at 1:16 AM Group Note: patient asleep in cardiac chair (geri-chair) at the nursing station with 1:1 sitter in attendance. On 6/12/17 at 3:46 AM Group Note: It was documented the patient was "laying in cardiac chair (geri-chair) in hallway with 1:1 sitter." Review of

Group Note on 6/12/17 at 2:00 PM, staff spoke with patient who was in a cardiac chair (geri-chair) with 1:1 precautions in the hall. Patient stated that he/she has just had "enough and tried to hang himself but the officer cut (him/her) down." The staff further documented the patient "seems hopeless about (his/her) future." Patient reports hallucinations. Patient is also homeless. Further review of the Daily Focus assessment Report dated 6/9/17 to 6/12/17 the time the patient was restrained in the cardiac/geri-chair revealed no documentation that range of motion was performed according to the facility policy. Review of the nurse notes from 6/10/17 to 6/14/17 revealed no documentation range of motion was performed every two (2) hours or more frequently. There was no documentation form labeled Frequent Observation Flowsheet: Behavioral Medicine given to the surveyor regarding patient observation. An interview conducted on 8/24/17 at 2:45 PM with Employee Identifier (EI) # 2, Interim Director Behavioral Health, who confirmed the staff failed to follow the facility's policy for restraints (cardiac/geri-chair), physician orders for restraints, observations of the patient in restraints and documentation related to those observations.