

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)
A0286	<p>PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3)</p> <p>(a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established.</p> <p>This STANDARD is not met as evidenced by: Based on review of the facility policy, medical records, Risk Management Worksheets, interviews and the Facility's Corrective Action Plan, it was determined the facility failed to ensure patient occurrences were reported, investigated, analyzed and preventative measures were implemented to prevent further occurrences. This affected 1 of 3 medical records (Patient Identifier (PI) # 2) 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: Facility Policy: Quality Plan Effective Date: 1/1/2002 Policy: ... The hospital's governing body will provide oversight that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. Purpose: 1. To establish organizational guidelines for</p>

developing, implementing and maintaining an ongoing system for managing quality and patient safety... 5. To demonstrate a consistent endeavor to deliver safe, effective, optimal patient care and services in an environment of minimal risks The Governing Board has defined the scope of organizational performance improvement as an overall assessment of the efficacy of performance improvement activities with a focus on continually improving care provided, and promoting patient safety practices throughout the Hospital and its entities... .. Every member of the organization has a role in providing quality, safe care. Leaders play a role in fostering improvement. 1. ... leaders including the governing board, the chief executive officer, and other senior management, the elected officers of the medical staff, department directors, and directors of nursing units... 3. Department managers and their staff ... under the direction of their administrative contact are responsible for quality activities ... 5. The department manager or his/her designee should review and report the status and results of quality activities to the Quality Management Department Clinical Practice Guidelines, based on evidenced based medicine, are considered when designing or improving processes. The hospital leaders identify criteria for the selection and implementation of clinical practice guidelines ... Collections and analysis of certain data is required. These are: ... 7. Adverse events/ near misses a. Quality Management monitors level of harm and near misses as it relates to reported medication variances... .. Certain analyses have specific defined timeframes such as Root Cause Analysis, 30 days from event... .. The hospital has the following committees that provide oversight of the quality requirements by reviewing and acting on reports and recommendations from: 1. Quality Safety Council is to incorporate the organization's Mission... Responsibilities is to assist with determining targets and ensure corrective and preventive actions are taken by the organization are implemented, measured and monitored... 2. Adverse Outcomes is to provide a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety. This is accomplished through mechanisms that support effective response to potential or actual Patient Safety concerns or near misses or hazardous conditions, ongoing proactive reduction in medical/health care errors, and integration of patient safety priorities into new design and redesign of relevant organization processes, functions, and services. 3. Patient Safety Committee is to improve patient safety and reduce risks to patients through an environment that encourages: recognition and acknowledgement of risks to patient safety... and initiation of actions to reduce these risks. The internal reporting of possible risks and any action taken. A focus on processes and systems ... 4. Physical Environment Committee is to adopt, implement and monitor a comprehensive hospital wide safety program, designed to produce safe characteristics and practices for the elimination and /or reduction, to the greatest extent possible, hazards to patients, visitors and staff... A root cause analysis (RCA) shall be conducted on all incidents that impact or threaten patient safety and close calls involving a recipient of care... A patient safety concern is an unexpected occurrence involving death, permanent harm or severe temporary harm of a patient or the risk thereof... The phrase "risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. To identify, analyze for root cause, and improve to the extent possible, the following events will always have a root cause analysis: 1. Suicide of a patient in a setting where the patient receives around the clock care, treatment or services or within 72 hours of discharge... 12. Any elopement (that is, unauthorized departure) of a patient from a staffed around-the clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient... Upon notification of a patient safety concern or near miss, an administrative leader or his/her designee will initiate an immediate investigation involving appropriate department head and appropriate personnel. The basics of the RCA are: 1. Assign a team, including

personnel closest to the occurrence along with supervisory staff to investigate the event immediately. 2. Set the goal of thirty (30) days for completion of the RCA. 3. Clearly define the event or near miss and brainstorm all possible causes. Focus on processes, not people... 5. Redesign the process that will eliminate the risk of the root cause occurrence. 6. Complete the RCA form and submit to Quality Management within 30 days of the event. Include the number, skill mix and competency of all staff on duty in the area of the occurrence. 7. Quality Management staff will assign a date and time for the team to meet and discuss the RCA with Adverse Outcomes Committee. 8. Follow up to the RCA will be required by the Adverse Outcomes Committee. Follow up should address the interventions put into place to avoid another occurrence. The Quality Management staff will assign dates for follow up ... The organization recognizes the impact of effective communication in the promotion of safety and quality. Effective communication is measured by timeliness, accuracy and use by the audience. Leadership roles in providing effective communication are: ... 2. Assessment of internal and external needs ... 4. Assess environmental changes as they relate to communication needs of the patients, community, physicians, staff and management... ... The organization will adhere to all requirements for mandatory reporting of adverse events and will meet requirements for voluntary program for patient safety concern reporting ... The Governing Board, Senior Leadership and the organized Medical Staff will collaborate and manage conflicts that may hinder the delivery of quality safe patient care The Adverse Outcomes Committee reviews the organization's initial management of Patient Safety concerns... Occurrence reporting is a key part of the management information system, provides support and assistance in the overall institutional objective of improved patient care ... Any hospital employee who becomes aware of an incident must report that incident by completing an Occurrence Report. The Occurrence Report consists of two components, an Incident Report and a Quality Assurance narrative, which provided in-depth detail. The Occurrence Report is to be completed online... To complete an on-line Occurrence Report you must access Inside SAMC and do the following: ... 7. Complete the Incident Report by filling in all required fields ... 8. The next section is the Quality Assurance Narrative; this section provides in-depth details about the incident ... 10. Quality Management will receive immediate notification that an incident report has been submitted. 11. After being reviewed by Quality Management the occurrence Report will be forwarded to the appropriate Department Head for follow up/investigation by placing it on the Department Head's Midas work list. The Department Head will receive notification by e-mail that an incident report had been placed on their work list. The Department Health should complete the follow up/investigation within 72 hours ... 14. Department Investigations - The extent of investigation will depend on the seriousness of the event. The department head or designee shall investigate all incidents. Based on severity or trend direction, formal investigation will be performed by the department head or designee and/or Risk Management. 15. Analysis - The Quality Management Department is responsible for producing a monthly analysis of incidents by type, location and time to appropriate committees and administration for review. 22965 1. See A144 related to the self-destructive behaviors and occurrences for PI # 2. The surveyor requested information related to those occurrences and none was provided. At 3:00 PM on 8/24/17 an Occurrence report was requested by the surveyor, EI # 4, Quality Outcomes Team Leader and was informed there was no report submitted to Quality Outcomes. 32470 On 8/23/17 the Occurrence Report summary was requested, received and reviewed by the surveyor. The surveyor chose 6 occurrences between the months of March 2017 and August 2017 and requested the documentation which was submitted for each occurrence. 2. Review of the Risk Management Worksheet presented to the surveyor on PI (Patient Identifier) # 4 revealed the nurse documented on the worksheet

(occurrence) report he/she was making hourly rounds and knocked on the patient's door and entered room. Upon entering the room the patient jumped down off the toilet in the bathroom where he/she had partially removed the vent over the toilet. Further review of the documentation revealed maintenance was notified and remounted the grill with zipit mounts. Review of the Risk Management Worksheet documentation provided revealed no documentation as to what actions were taken and what preventive measures were taken to prevent the occurrence from happening again. Further review of the worksheet revealed on 7/24/2017: Ref. (refer) to Emp. (employee) EI # 10, Director of Behavioral Medicine (no longer employed), Ref. to Dept (department): Behavioral Medicine Unit, Reason: need follow up and preventive measure, Comment: area is blank, Action: area is blank, Disposition: area is blank and Date Closed: no date was documented. Review of the documentation revealed no documentation the incident was taken to the Root Cause Analysis (RCA) Committee for review. The surveyor asked several times for any other information including the RCA information for the incident and was provided no other documentation. An interview was conducted on 8/23/17 at 3:10 PM with Employee Identifier (EI) # 1, Director of Quality Management, and EI # 4, Quality Outcomes Teamleader, who confirmed the incident was not presented to the RCA committee for evaluation. 3. Review of the documentation dated 7/18/17 presented to the surveyor on PI # 6 revealed the patient was taken down to 1 North for court and was sitting in the waiting area. Patient stood up and ran out the glass doors leading to the outside and eloped. The police department was notified and the patient was found by the local police. According to interviews conducted on 8/23/17 with the staff several staff reported the patient was brought back to the hospital approximately 30 minutes to 1 hour later. Review of the RCA documentation dated 7/18/17 revealed security did not assist with escorting patients from the unit to court unless called by the staff. Security was not called to assist with escorting this patient. Further review of the RCA report revealed as of 7/19/17 security was notified by the Director of the Behavioral Medicine Unit (BMU) who informed the Director, security they should arrive prior to (the) patient being taken to the court room. A meeting was held on 8/14/17 with the head of security and the Director of the BMU to discuss and review the process. Review of the RCA dated 8/14/17 revealed the occurrence was discussed and it was decided to attempt to move the court room to 3 north or to lock the doors leading to the outside during court. Further review of the RCA revealed on 8/16/17, EI # 2, Interim Director Behavioral Health, met with the judge after the court session and court was relocated to 1 North beginning 8/22/17 and the door to the outside would be locked during court sessions. Review of the 8/21/17 RCA documentation revealed the Director of security notified the day shift security staff of the new process. Further review of the RCA documentation revealed during court hearings, the glass doors leading to the hospital's exterior will be locked by security officer. Entrance from the outside is attained, however inadvertent exiting prevented and the security director informed all day shift security personnel of the new process. An interview with EI # 3, Nurse Manager, was conducted on 8/24/17 at 10:30 AM who reported the court hearing was moved to 3 north on a trial basis for one court session on 8/15/17. On 8/24/17 at 8:30 AM the surveyors observed the area on 1 North where the court hearing was in session. EI # 2 was present along with the fire Marshall, security and EI # 7, Director of Safety. EI # 2 was asked if the glass doors were locked since court was in session. EI # 2 replied "yes they are". The surveyor opened the first glass door leading to the outside of the hospital. EI # 2 stated "yes you can open the first door, but the second door will not open as long as the first door is still open". The surveyor held open the first door and opened the second door and was able to exit to the outside of the hospital. EI # 7 and the fire Marshall were discussing the actual locking of the glass doors on 8/24/17 at 8:30 AM while the surveyors were present. The incident occurred

on 7/18/17 when PI # 6 exited the hospital waiting for court and no actions or preventive measures were taken until 8/24/17 when the surveyors were present. An interview was conducted on 8/24/17 at 9:00 AM with EI # 1 and EI # 2, who confirmed no actions had taken place until 8/24/17. 4. Review of the occurrence report dated 7/26/17 revealed PI # 7 eloped (ran out) from 3 North Behavioral Unit by kicking the door, which released the magnet on the door and the patient ran through the doors and headed to the 3 East area. BMU staff ran out of the unit and caught PI # 7 and escorted PI # 7 back to the unit and placed him/her in seclusion and restraints. Review of the occurrence report revealed the following documentation: Ref to Emp: EI # 10, Former Director of Behavioral Health (no longer employed), Reason: need follow up and preventive measure, Comments: area is blank, Action: area is blank. Further review of the documentation revealed no other documentation as to what the follow up or the preventive measure was or that the incident was referred to the RCA for review. When the surveyor asked for the RCA report, the surveyor was told by EI # 4, the team has 30 days to complete and as of the survey date the report was not complete. Review of the Risk Management Worksheet dated 7/27/17 revealed PI # 7 was given a court order and PI # 7 became upset broke the unit door and eloped. The staff called a Brubaker (an announcement over head to call for assistance with a person out of control). Further review of the occurrence report revealed no other documentation as to whether PI # 7 left the unit once the door was opened or the end result. The only other documentation was the staff documenting on whether the police should deliver the court order instead of the staff in the Risk Management Worksheet. Review of the documentation on the Risk Management Worksheet revealed the following: Ref. to Dept: Security Services, Reason: need follow up and preventive measure, Comment: area is blank, Action: area is blank and Disposition: area is blank. Further review revealed the following documentation: Ref. to Dept: Case Management, Reason: need follow up and preventive measure, Comments: area is blank, Action: area is blank and Disposition: area is blank. The surveyor asked EI # 4 if there was an RCA report for each of these occurrences and EI # 4, Quality Outcomes Team Leader, replied " no, not yet they have 30 days to complete the report". After review of the Risk Management Worksheet documentation it was documented PI # 7 eloped 2 days in a row by kicking the locked door of the unit and running out. Further review of the Risk Management Worksheet revealed no documentation by each department as to what the follow up or preventive measure was, any actions that were taken and no documentation the occurrences were taken to the RCA committee with a Organizational Response or Findings or the Action required. An interview was conducted on 8/24/17 at 11:00 AM with EI # 4 who confirmed the above mentioned findings. On 8/23/17 at 5:26 PM, the surveyors met with administrative staff of the facility to outline the identified concerns noted above. The survey team requested a corrective action plan to address the identified concerns. Review of the Corrective Action Plan documentation submitted to the surveyors on 8/24/17 at 7:00 PM revealed the following corrective actions: Finding 4: Risk for elopement of patients attending court inside the facility. Cause of nonconformity was egress area not secured on 1st floor where patients are taken for court hearings. The Organization Corrective Plan documentation outlined the following actions: August 24, 2017, City Fire Marshall review of egress area, recommendations for keyed mag (magnetic) lock to the egress door in the BMU 1st floor, locked 24-7. All employees in this unit will have a mag lock key. Remove exit sign. August 25, 2017, transport procedure updated. Court proceedings currently held in the North building, 1st floor. The court room/conference room is accessed by an interior door with dual wing access doors. Prior to the first patient transport, the exterior door will be locked and remain locked throughout the proceedings. Each patient transported from their assigned unit is accompanied by security personnel to the court room, one officer per

patient transport. August 25, 2017, educate all security officers and BMU clinical staff on the new transport procedure. All employees in the BMU 1st floor have key to mag lock and educated regarding door lock. August 25, 2017, recommendations of City Fire Marshall implemented. Transport procedure change implemented. BMU 1st floor egress removed. August 25, 2017, Director of Security and Interim Director of Behavioral Medicine implement fire marshall recommendations. Monitor twice weekly the escort of patients by a Security Office (from the BMU unit to court). Weekly results reported at IPO and monthly CSR. Target 90 %, monitor 3 consecutive months, re-evaluate status at CSR. Finding 6: Numerous documented patient hanging attempts during hospitalization. Cause of nonconformity was failure of BMU staff to report documented suicide attempts by hanging (Patient Identifier # 2) during hospitalization. Administration with no knowledge of the safety concern prior to August 23, 2017. The Organization Corrective Plan documentation outlined the following actions: Staff audited facility email communication (during the onsite survey visit), determined previous Director of Behavioral Medicine was aware of the safety concerns on June 10, 2017. Noncompliance with occurrence reporting identified. Quality Management completed an occurrence report (Patient Identifier # 2), requested root cause analysis (RCA), due September 22, 2017. RCA will be presented to the Adverse Outcomes Committee, interventions implemented. In May and June 2017, the organization had one successful hanging and several attempts... Organization follow-up: RCA interventions implemented which may result in ongoing monitoring, process to be determined.