

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  010001	<b>(X3) Date Survey Completed</b>  08/24/2017
<b>Name of Provider or Supplier</b>  Southeast Health Medical Center	<b>Street Address, City, State</b>  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.		

<b>(X4) ID Prefix Tag</b>	<b>Summary Statement of Deficiencies</b>  (Each deficiency should be preceded by full regulatory or LSC identifying information)
<b>A0395</b>	<p><b>RN SUPERVISION OF NURSING CARE</b> 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 review of facility policies, medical records, security video footage, Root Cause Analysis (RCA), interviews, Facility's Corrective Action Plan received from the facility on 8/24/17 prior to the surveyor's departure, it was determined the Registered Nurse (RN) failed to supervise the care provided by the Mental Health Technicians (MHT) to ensure patient observations were conducted every 15 minutes according to physician orders. This affected 3 of 3 medical records reviewed, including Patient Identifier (PI) # 1, PI # 2, PI # 3 and has the potential to negatively affect all patients admitted to the facility's Behavioral Medicine Unit (BMU). Findings include: Facility Policy: Observation with Documentation - Behavioral Medicine Effective Date: 9/1/2009 Policy: The Behavioral Health Services will provide a safe environment for patients admitted to the unit with suicidal/homicidal ideation (or who become suicidal after admission) impaired reality testing, potential withdrawal and patients in seclusion and/or restraints by appropriate observation and documentation on observation sheet. Purpose: To ensure patient and staff safety. Procedure: 1. Patient is placed on appropriate observation (as outlined below) with documentation in electronic record either by direct physician order or nursing order... 3. Notify physician of any significant change in patient's condition. Observation: 4. Close observation: A patient on close observation must be where staff can visualize see him/her at all times. Patient must have approximately one minute in bathroom with the door closed. 5. Q15 (Every 15) Minute Observation: All patient are on Q15 minute observation for the duration of their stay. 6. 1:1 Observation: A patient on 1:1 observation is to be no more than arm's length away from staff member at all times. Staff member may not leave the patient at any time unless relieved by</p>

another staff member. Documentation will reflect Q15 minute observation. \*\*\*\*\* Facility Policy: Rounds-Behavioral Medicine Effective Date: 9/1/2009 Policy: Rounds on patients admitted to BHS (Behavioral Health Services) will be made by personnel to ensure appropriate patient records and care. Purpose: To evaluate the status of all patients, determine the overall status of the unit, and identify administrative needs. Procedure: ... B. Objectives of Rounds for Clinical Coordinator or Charge Nurse 1. To observe the condition of patients... 4. To observe nursing staff performance... 7. To observe safety measures C. Objectives for Rounds for Q15 minute observations 1. To evaluate the safety of the patient... \*\*\*\*\* Facility Policy: Intensity of Care 1:1 Observation Criteria-Behavioral Medicine Effective Date: 1/1/1989 Policy: At times patients on the BHS unit may verbalize or exhibit behaviors that require a more intense level of observation. The safety of all patients and staff is a major concern on the BHS unit. Purpose: Identify guidelines for 1:1 observation to ensure patient/staff safety. Procedure: 1. 1:1 observation will be initiated for one of the following: a. Patient is in immediate danger of harming self. b. Patient is in immediate danger of harming others. c. Active psychosis requiring constant redirection. 2. The charge nurse may initiate 1:1 observation but physician should be notified within one hour to obtain order. 3. One staff member will be assigned to be with the patient at all times... 5. Explain reason for 1:1 observation to patient in a calm and reassuring manner. Provide safety and support to the patient. 6. Document in patient's medical record the reason for the increase in observation and the interventions initiated. \*\*\*\*\* Facility Policy: Rounding Policy Effective Date: 10/09 Policy: All nursing staff is required to complete hourly rounding on all patients and assess for pain, position, potty and possessions. Purpose: To improve patient satisfaction, patient trust, patient care, patient safety, and reduce the amount of call light interruptions. Procedure: ... All nursing staff is required to evaluate for pain, potty, position, and possessions on an hourly basis to ensure patient's needs are met. Nursing staff should initial hourly roundings checklist sheet in room to confirm rounding has been completed... 1. Patient Identifier (PI) # 1 was admitted to the facility on 5/14/17 with Auditory Hallucinations, Psychosis and Suicidal Ideations. PI # 1 presented to the Emergency Department (ED) on 5/14/17 with complaints of, "... can't remember anything... back hurts so bad and I don't know if it is my body or just life in general..." The patient stated he/she had suicidal ideation, security was notified and suicide precautions were in place. On 5/14/17 at 5:57 AM, while the patient was in the ED, the ED Technician was present in the room while security was called away when the patient grabbed (his/her) purse and began to put on makeup. The patient was digging through the purse and became upset when the Technician saw something silver that was concealed by the bag. The staff member called for help and the patient proceeded to try to put a pocket knife to his/her left wrist and cause harm to self. With security's help, all of the patient's belongings including the knife were removed and the patient was placed in a hospital gown. The patient was subsequently admitted to the facility in the BMU. Review of the Psychiatric Evaluation History and Physical dated 5/14/17 revealed the patient's chief complaint was, "I hear him." The psychiatrist documented, "... Per ER (Emergency Room), patient complaining of hearing 2 or 3 different people inside of (him/her), the voices... are (his/her) own and is just different people that live in (him/her)... the voices tell (him/her) to kill (self). Patient has suicidal ideation. Patient reports multiple suicide attempts in the past and stated... had tried to overdose and has tried to hang (self) on 2 occasions. Patient denied any visual hallucinations... denied homicidal ideation... As of today... patient very irritable, we need to encourage (him/her) several times to finish the evaluation. Patient reported hearing all kinds of things, like... own voice telling (him/her) different things including telling (him/her) to kill (self)... Patient reported paranoia, said, "they are talking about me."... reported

depression... no energy, poor appetite, and said, "he tells me don't eat."... said the person inside of (him/her) is with (him/her)... reported suicidal thought, said, "you don't need a plan, you just do it..." Further review of the Psychiatric History and Physical dated 5/14/17 revealed, "... Mental Status Examination: ... poorly groomed, not well cooperative, with poor eye contact... psychomotor agitation... Mood: Depressed. Affect: Very irritable, constricted, labile. Thought process and association: Illogical and loose. Thought content: ... reports auditory hallucinations, paranoia,, suicidal thought. Insight: Poor. Judgement: Poor... Concentration and attention span: Poor... Differential Diagnoses: ... Substance-induced psychotic disorder... Methamphetamine abuse... Rule out gender identity disorder... Rule out schizophrenia... Rule out mood disorder... Treatment Plan: 1. Safety: Admit the patient to psych inpatient unit, start q15 minute observation, and monitor patient's vital signs closely..." Review of the medical record revealed physician orders dated 5/14/17 for Q 15 minute checks. The surveyor reviewed the patient's medical record on 8/21/17 and there was no documentation Q 15 minute checks were completed. On 8/22/17 at 8:30 AM, the surveyor requested a copy of the patient's entire medical record and pointed out there was no documentation of Q 15 minute safety checks. On 8/22/17 at 10:00 AM, the patient's medical record was given to the surveyor and copies of documents entitled "Q 15 Minute Safety Rounding Sheet" for the entire time the patient was admitted to this facility. A review of the Q 15 Minute Safety Rounding Sheet dated 5/30/17 revealed multiple patients were listed, including PI # 1. On 8/22/17 at 10:00 AM, when questioned about the Q 15 Minute Rounding Sheet, Employee Identifier (EI) # 3, Nurse Manager stated the documents are not part of the patient's permanent medical record and are kept on the unit in a notebook. A review of the security video footage for 5/30/17 was conducted on 8/22/17 at 10:15 AM. A review of this video footage revealed at 9:29 AM, the patient was seen talking with a male and female at the end of the hallway, (identified as the Psychiatrist and Case Manager). The patient turned away from the Psychiatrist and Case Manager and walked toward his/her room. At 9:30 and 11 seconds (AM), the patient was visibly upset, placed his/her hands on the top of his/her head, walked into his/her room at 9:30 and 15 seconds (AM) and shut the door. None of the nursing staff entered the room or checked on the patient after he/she entered the room and closed the door. At 11:18 and 44 seconds (AM), a male staff member (identified as the MHT) was seen running down the hall from the nurse's station to the patient's room. The patient's door remained closed until 11:18 AM and 49 seconds (AM), when the MHT opened the door and found the patient hanging from the bathroom door by a bed sheet. A review of the Q 15 Minute Safety Rounding Sheet dated 5/30/17 revealed the Mental Health Technicians (MHTs) documented the patient was in his/her room from 9:30 AM to 2:15 PM. There was no documentation the Registered Nurse (RN) completed hourly rounding on the patient. Cardiopulmonary Resuscitation was performed and the patient was pronounced dead on 5/30/17 at 11:39 AM. Review of the Root Cause Analysis (RCA) dated 5/30/17 related to PI # 1's successful suicide revealed, "... Items Analyzed... What human factors were relevant to the outcome? Policy and procedure was not followed. Q15 minute rounds were not completed by staff... Action Required: Two employees terminated on 5/31/17. Education given again for standards for q 15 minute rounds. Met with each shift change and emphasized importance of rounding by nurses and MHT on 5/30/17 and 5/31/17. Email to all staff for expectations for rounding... Questions regarding future planning... If able to put the q 15 minute checks into electronic format would be better so the exact time the patient is seen would be captured... Need to explore being able to document q 15 minute observations in electronic format..." An interview was conducted on 8/22/17 at 9:52 AM with Employee Identifier (EI) # 1, Director Quality

Management who verified the above findings. 22965 2. 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 Psychiatric Evaluation History and Physical Treatment Plan/ Safety: Admit patient to psych inpatient unit, start every 15 minute observation and monitor patient's vital signs closely. Review of the Q 15 Minute Safety Rounding Sheet (Q 15 Min SRS) 6/8/17 revealed the following codes: Location : Dayroom (D), Patient Room (P), Group Room (G), Hallway (H) and Unassigned Patient Room (UPR). Review of the 6/9/17, 6/10/17, 6/12/17 Q 15 Min SRS at 2 North (N) from 11:15 AM to 3:00 PM revealed the MHT documented the location code and the letter "A." There was no documentation on the Q 15 Min SRS of a legend for "A". When EI # 3, Nurse Manager was asked by the surveyor of what "A" meant, EI # 3 stated that it "probably meant alert/awake", but was not sure. Review of the 6/8/17, 6/9/17, 6/10/17 Q 15 Min SRS at 2N from 7:15 PM to 11:00 PM revealed the MHT documented the location code and the letter "S." There was no documentation on the Q 15 Min SRS of a legend for "S". When EI # 3, Nurse Manager was asked by the surveyor of what "S" meant, EI # 3 stated that it "probably meant sleeping", but was not sure. Review of the 6/11/17 Q 15 Min SRS from 3N revealed from 3:15 PM to 7:00 PM, there was no documented patient observation and /or where the patient was located. Review of the 6/12/17 Q 15 Min SRS from 3N revealed from 11:15 AM to 3:00 PM, the patient was located in the hallway, but no patient behaviors were documented. Review of the Daily Focus Assessment Report revealed no documented of the reason the patient was in the hallway. There was no documentation of the patient behavior. Review of the 6/13/17 and 6/14/17 Q 15 Min SRS revealed from 7:15 AM to 11:00 AM revealed the patient in an Unassigned Patient Room (UPR). There was no documentation of the patient's behavior. Review of the 6/15/17 Q 15 Min SRS from 7:15 AM to 11:00 AM, revealed no documentation of where the patient was located or the patient's behavior. In an interview conducted on 8/24/17 at 2:45 PM, EI # 2, Interim Director of Behavioral Health confirmed the aforementioned findings. 30952 2. PI # 3 was presented to the ED on 3/8/17 with reports of increased depression and thoughts of suicide which included a plan.. PI # 3 was admitted to the 2N BMU on 3/8/17 with diagnoses including Suicidal Ideations, Depressive Disorder, Chronic Pain and Polysubstance Abuse. Review of the physician history and physical documentation included every 15 minute safety checks. There was no Q 15 Minute Safety Rounding Sheet documentation received in the certified medical record documentation requested by the surveyor. In an interview on 8/22/17 at 10:09 AM, EI # 3, Clinical Nurse Manager, verified safety rounds completed were documented in a multi-patient format which included all patients on the unit and was not part of the patient medical record. The surveyors requested PI # 3's safety round documentation. Review of the facility document titled, Q (every) 15 Minute Safety Rounding Sheet dated 3/8/17 and 3/9/17 revealed the MHT documented the patient location using a location code (abbreviation) every 15 minutes. There was no code for patient behavior. Review of PI # 3's Q 15 Minute Safety Rounding Sheet for 3/8/17 from 11:15 PM through 3/9/17 at 7:00 AM failed to include documentation of PI # 3's behaviors or activity. There was no documentation the nurse completed safety rounds verification every hour on PI # 3 per facility policy from admission on 3/8/17 to discharge on 3/9/17. In an interview on 8/24/17 at 10:30 AM, EI # 2 reported MHTs complete the rounding sheets every 15 minutes and the documentation should include the patient location and activity. EI # 2 confirmed on 3/8/17 from 11:15 PM to 3/9/17 at 7:00 AM, the 15 minute safety rounding sheet documentation did not reveal PI # 3's activity as requested by physicians. Staff should document for patient awake, "A" and patient sleeping, "S". EI # 2 confirmed the nurse should document safety rounds hourly using his/her tool. No hourly safety nurse rounding

documentation or nurse tool was provided. The above findings were confirmed. 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 Organization Corrective Action Plan submitted to the surveyors on 8/24/17 at 7:00 PM revealed the facility identified the following: Finding 1: Observations every 15 minutes not completed (by Mental Health Technician's [MHT]) Nonconformity with the organization policy, Observation with Documentation-Behavioral Medicine. Every 15 minute observations were not completed by the MHT which impacted PI # 1's suicide by hanging on 5/30/17 on 3 N BMU. The Organization Corrective Plan documentation outlined the following actions: May 30, 2017, team member discussion of the 5/30/17 events. May 31, 2017, dismissal of 2 MHT for falsification of medical records. May 31, 2017, 2 N and 3 N BMU staff education on Observation with Documentation-Behavioral Medicine policy, use of the multi-patient, pre-filled time slot for patient observations documentation, compliance would be monitored. July 7, 2017, documentation tool, (Q 15 Minute Safety Rounding Sheet) updated to require the MHT to document the correct (actual) time the patient was observed. August 23, 2017, tool reviewed and updated, begin use of updated documentation, patient specific, with actual time observed to include patient behavior and location. August 23, 2017 to August 28, 2017, staff training is 1:1 (one to one), MHT education on updated Q 15 Minute Safety Rounding Tool, patient specific, completed every 15 minutes for the actual time staff observed the patient behavior and location during a 24 hour period. Review of the MHT documentation on the Q 15 Minute Safety Rounding Sheet is to be completed by the Clinical Nurse Manager or Charge Nurse every 24 hours. The documentation is then placed in the patient medical record. The Interim Director of Behavioral Medicine and Vice President of Patient Care Services is responsible for implementation and adherence to the corrective action plan and organization policy. August 24, 2017, Organization followup begins, Charge Nurse or Charge Nurse on 2 N and 3 N BMU monitor each MHT's documentation by direct observation 2 times each shift, total of 6 observations per day. Validation of the observation is documented on the tool. Non-compliance action is immediate education and/or progressive discipline. Weekly results communicated at Improving Patient Outcomes (IPO) and monthly to Continuous Survey Readiness (CSR), target 90 % with 3 consecutive month monitoring and re-evaluate monitoring status at CSR. Finding 2: Observations every one hour not completed (by licensed staff). Nonconformity with licensed nurses documenting observations every one hour as indicated on Observation with Documentation-Behavioral Medicine. (The surveyors observed noncompliance with completing the hourly safety rounds as evidenced in facility video monitoring of the 5/30/17 event). The Organization Corrective Plan documentation outlined the following actions: May 30, 2017, team member discussion of the 5/30/17 events, PI # 1's suicide by hanging on 5/30/17 on 3 N BMU. The Registered Nurse (RN) admitted to not observing PI # 1 every hour. June 5, 2017, 2 N and 3 N BMU staff education on the expectation of hourly nurse round completion. August 23, 2017, an Every One Hour Safety Precaution form was developed, patient specific, requires actual observation time, patient behavior and location over a 24 hour period, documented by licensed staff. August 23, 2017, use of new observation tool, the Every One Hour Safety Precaution form began. August 23 to August 28, 2017, licensed staff training is 1:1, for use of the Every One Hour Safety Precaution form. Review of the Every One Hour Safety Precaution form is to be completed by the Clinical Nurse Manager or Charge Nurse every 24 hours. The documentation is then placed in the patient medical record. August 24, 2017-The Observation with Documentation-Behavioral Medicine policy was updated to reflect licensed staff monitoring of the patient behavior and location hourly. The Interim Director of

Behavioral Medicine and Vice President of Patient Care Services is responsible for implementation and adherence to the corrective action plan and organization policy. August 24, 2017, Organization followup begins, Charge Nurse or Charge Nurse on 2 N and 3 N BMU monitor each licensed staff's documentation by direct observation 2 times each shift, a total of 6 observations per day. Validation of the observation is documented on the tool. Non-compliance action is immediate education and/or progressive discipline. Weekly results communicated at IPO and monthly to CSR, target 90 % with 3 consecutive month monitoring and re-evaluate monitoring status at CSR.