

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 010001	(X3) Date Survey Completed 09/29/2017
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)
A0144	<p>PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2)</p> <p>The patient has the right to receive care in a safe setting.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records (MR), and interviews with the staff, it was determined the facility failed to ensure the staff followed the education training for hourly rounds by the nursing staff in the Behavioral Medical Unit (BMU). This affected Patient Identifier (PI) # 43, 1 of 1 record reviewed of a patient who was admitted to the BMU and had the potential to negatively affect all patients admitted to the BMU. Findings include: 1. PI # 43 was admitted to the BMU on 9/15/17 with an admitting diagnosis of Paranoia Agitation. Review of the MR revealed Q (every) HR (hour) Safety Precautions for the nurses to be completed. Review of the Q 1 HR rounds documentation began on 9/15/17 at 2025 (8:25 PM) and ended on 9/26/17 at 1343 (1:43 PM) when the patient was discharged. Review of the Q 1 HR forms revealed on 9/15/17 at 6:01 AM, a round was completed by the nurse and not again until 7:33 AM, which was 1 hour and 32 minutes. At 2:10 PM, a round was complete and the next round was completed at 3:43 PM, which was 1 hour and 33 minutes and the next round completed was at 4:59 PM, which was 1 hour and 16 minutes. On 9/17/17 the nurse completed a round at 1:15 AM and the next round completed was at 2:46 AM, which was 1 hour and 31 minutes. At 6:05 AM, a round was complete and not again until 7:20 AM, which was 1 hour and 15 minutes later. Further review revealed the nurse completed a round at 2:02 PM and not again until 3:37 PM, which was 1 hour and 35 minutes later. At 7:10 PM, the nurse completed a round and did not complete the next round until 8:45 PM, which was 1 hour and 35 minutes later. Review of the 9/18/17 hourly rounding form revealed at 12:06 PM, a round was completed and not again until 1:40 PM which was 1 hour and 34 minutes. At 5:08 PM a round was completed by the nurse and the next round occurred at 6:25 PM, which</p>

was 1 hour and 17 minutes later. At 10:09 PM a round was completed and not again until 11:25 PM, which was 1 hour and 16 minutes later. On 9/19/17 at 1:23 AM a round was complete and the next round was completed at 2:41 AM, which was 1 hour and 18 minutes later. Further review revealed a round was complete at 6:00 AM and not again until 7:39 AM, which was 1 hour and 39 minutes. At 8:36 AM the nurse completed a round and then not again until 9:50 AM, which was 1 hour and 14 minutes later. At 7:34 PM a round was complete and the nurse did not make the next round until 8:54 PM, which was 1 hour and 20 minutes later. On 9/20/17 at 2:00 AM the nurse made a round and not again until 3:26 AM, which was 1 hour and 22 minutes later. At 6:01 a round was complete and the next round completed was at 7:15 AM, which was 1 hour and 14 minutes later. Further review revealed at 1:09 PM, the nurse completed a round and the next round was not completed until 2:29 PM, which was 1 hour and 20 minutes later. At 4:31 PM, a round was completed and the nurse did not make the next round until 5:43 PM, which was 1 hour and 12 minutes later. On 9/21/17 at 2:03 AM a round was completed and not again until 3:23 AM, which was 1 hour and 20 minutes later. At 10:10 AM, a round was completed and the next round occurred at 11:28 AM, which was 1 hour and 18 minutes later. Further review revealed the nurse completed a round at 2:15 PM and not again until 3:46 PM, which was 1 hour and 31 minutes later. At 4:43 PM a round had been completed and the next round was not conducted until 5:58 PM, which was 1 hour and 15 minutes later. On 9/22/17 the nurse completed a round at 6:05 AM a round was completed and then the next round completed was at 7:25 AM, which was 1 hour and 20 minutes later. At 1:05 PM the nurse had completed a round and then not again until 2:19 PM, which was 1 hour and 14 minutes later. On 9/23/17 the nurse conducted an hourly round at 1:03 AM and not again until 2:33 AM, which was 1 hour and 30 minutes later. At 6:05 hourly rounds were conducted and then not again until 7:26 AM, which was 1 hour and 21 minutes. Further review revealed the nurse conducted an hourly round at 10:08 AM and then again at 11:25 AM, which was 1 hour and 17 minutes later. At 1:03 PM, the nurse conducted an hourly round and then again at 2:23 PM, which was 1 hour and 20 minutes later. On 9/24/17 at 4:13 AM rounds were completed and then at 5:49 the nurse completed the next hourly round, which was 1 hour and 36 minutes later. At 12:03 PM the nurse completed hourly rounds and again at 1:21 PM, which was 1 hour and 18 minutes later. Further review revealed the nurse completed an hourly round at 6:15 PM and not again until 7:32 PM, which was 1 hour and 17 minutes later. On 9/26/17 hourly rounds were conducted at 2:18 AM and not again until 3:39 AM, which was 1 hour and 21 minutes. On 9/28/17 at 10:30 AM Employee Identifier (EI) # 29, Chief Nursing Officer (CNO), was asked what the nursing staff were taught about the every hour rounds in the BMU as far as documentation. EI # 29 stated she would find out and let the surveyor know. On 9/28/17 at 11:30 AM, EI # 29 stated the staff are to document every 60 minutes. EI # 29 also verified the above mentioned findings and stated "the hourly rounds are to be every 60 minutes.