

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  010001	<b>(X3) Date Survey Completed</b>  09/29/2017
<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>A0159</b>	<p><b>PATIENT RIGHTS: RESTRAINT OR SECLUSION</b> CFR(s): 482.13(e)(1)(i)(A)</p> <p>Definitions. (i) A restraint is- (A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or</p> <p>This STANDARD is not met as evidenced by: Based on the review of medical records (MR), policy and interview it was determined the facility failed to observe patients in restraints and document on the Restraint Flowsheet at a minimum of every 2 hours. This affected Patient Identifier (PI) # 38 , 1 of 1 patient restrained in the Neuro Critical Care unit. 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) or seclusion is used if less restrictive measures have proven unsuccessful. ... 3. A registered nurse, physician&amp;#x27;s assistant, or physician with appropriate training and education should determine if there is a danger that the patient might interfere with essential medical treatment interventions OR injure himself/herself, another patient, visitor, or staff member. ...1. When restraints are implemented, patients should be monitored/assessed/assisted frequently and the following documented every 2 hours: mental status check, level of distress, agitation... bathroom offered/elimination needs met, fluids and/or nutrition offered, hygiene needs met, comfort measures...skin and circulatory checks. 9. Restraint/seclusion</p>

should be discontinued as soon as possible after the patient meets the criteria for discontinuation... 1. PI # 38 was admitted to the Neuro Critical Care unit on 9/23/17 with diagnosis of Altered Mental Status with Sub Acute Chronic Hygroma requiring burr hole intervention. Tubes in place included: Indwelling Urinary Catheter, Peripheral Intravenous (IV) in right hand, burr hole in head with Jackson-Pratt (JP) drain. Review of the medical record revealed on 9/26/17 the patient became anxious, agitated and uncooperative, attempting to exit the bed, pulling at catheter, pulling at drain and IV tubing, requiring the application of soft limb restraints to the left and right wrists. On 9/27/17 at 11:15 AM, the surveyor with the assistance of Employee Identifier (EI) # 19, Education Coordinator, reviewed the electronic medical record documentation and noted the last documentation by the Registered Nurse (RN) was at 7:00 AM on 9/27/17. EI# 19 stated that sometimes the RN has an open note and it is not possible to view it in the current documentation until she closes it. EI # 19 checked for the nurse that was assigned to PI # 38 and verified there was no open note. On 9/27/17 at 11:30 AM, the surveyor and EI # 19 went to the Neuro Critical Care Unit and observed the patient lying quietly in the bed with soft restraints to left and right wrist. The surveyor and EI # 17, Unit Director of Neuro Intensive Care Unit reviewed the restraint documentation on the unit. The last documentation by the nurse was at 7:00 AM on 9/27/17. EI # 17 stated the facility policy was for RN documentation on patients in restraint every 2 hours. An interview was conducted on 9/28/17 at 11:38 AM with EI # 17, who confirmed the above findings.