

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)
A0392	<p>STAFFING AND DELIVERY OF CARE CFR(s): 482.23(b)</p> <p>The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient.</p> <p>This STANDARD is not met as evidenced by: Based on medical record (MR) review, hospital policies, Alabama Board of Nursing (ABN) Administrative Code and interviews, it was determined the hospital failed to:</p> <ol style="list-style-type: none"> 1). Follow doctor's orders for Strict Intake and Output (I & O). 2). Document accurate daily weights, as ordered. 3). Ensure patient's wound care was provided per physician orders and ABN Standards of Nursing Practice, and documentation was completed. 4). Ensure the RN documented IV insertions per facility policy. 5). Ensure all physician orders were written for wound care. This affected Patient Identifier (PI) # 21, PI # 24, PI # 25 and PI # 1, 4 of 26 in-patient records reviewed and had the potential to affect all patient's served by this facility. Findings include: ***** Policy: Intake and Output Reviewed and Revised: 1/17 Accurate intake and output records shall be kept as indicated below: 1. When ordered by a physician.... Purpose: To maintain an accurate record of the patient's fluid balance. Procedure: 1. Instruct and educate patient/family on intake and output procedure. ... 3. Total the amount of fluid consumed at each meal. Check all drinking containers. 4. To be sure all fluid intake has been measured, check with the patient and/or family member to include fluids served between meals. 5. Other intake includes IV fluids... 6. Record each voiding on the information board in the patient's room. Instruct the patient to void into the collecting device (bedpan, urinal, commode or commode collector pan)... Documentation: 1. Record

total intake and output at each shift in electronic medical record (EMR). ***** Policy Title: Intravenous Lock-Intermittent Infusion Policy: A registered Nurse or qualified LPN (Licensed Practical Nurse) may insert a peripheral Intravenous (IV) catheter for an IV lock, or convert an existing peripheral IV to an IV lock upon order of physician... Documentation: ... 3. IV flushed and patency... ***** Policy Title: Wound Measurements Effective Date: 8/1/2015 Purpose: To provide guidelines for obtaining wound or ulcer measurements. Policy: Measurements taken will be: Length... Width... Depth... It is important that measuring procedures are consistent throughout the organization in order to determine improvement of the wound... Wound measurements are obtained at an initial visit, weekly visit, if there is a significant change in wound size and post debridement... ***** Alabama Board of Nursing Administrative Code Chapter 610-X-6 Standards of Nursing Practice 610-X-6-.06 Documentation Standards. Nursing Chapter 610-X-6 Supp. 9/30/16 6-11 (1) The standards for documentation of nursing care provided to patients by licensed nurses are based on principles of documentation, regardless of the documentation format. (2) Documentation of nursing care shall be: ... (c) Complete. Complete documentation includes reporting and documenting on appropriate records a patient's status, including signs and symptoms, responses, treatments, medications, other nursing care rendered, communication of pertinent information to other health team members, and unusual occurrences involving the patient. A signature of the writer, whether electronic or written, is required in order for the documentation to be considered complete. ***** 1. PI # 21 was admitted to the facility on 9/22/17, with the diagnoses of Generalized Weakness, Productive Cough with Yellow Sputum, Chronic Obstructive Pulmonary Disease and History of Alcohol Abuse. A review of the MR revealed doctor's orders dated 9/22/17 at 3:18 PM, "Strict Intake and Output." A copy of the Intake/Output Inquiry was requested by the surveyor and received from Employee Identifier (EI) # 7, RN on 9/28/17 at 11:15 AM. A review of the Intake/Output Inquiry report revealed the following: No documentation of I & O for 9/22/17 9/23/17, I & O was documented at 2:43 PM only. No documentation of I & O for all shifts for 9/24/17. Intake recorded on 9/25/17 at 2:58 PM and output recorded on 9/25/17 at 12:30 AM, 2:05 AM, 6:12 AM, and 3:02 PM. There was no documentation of I & O recorded for 9/26/17, 9/27/17, or until time report was printed on 9/28/17. Further review of the MR revealed an Assessment Report dated 9/23/17 at 2:01 PM, by a Registered Dietitian, consulted for "Malnutrition." The report states, "No intake recorded in I/Os." There was no documentation in the MR of education to the patient regarding I & O. In an interview on 9/27/17 at 10:00 AM, EI # 6, RN stated it was the nurses' ultimate responsibility to record any intake information, written on the dry erase board in the patient's room, in the EMR. Further review of the MR revealed doctor's orders dated 9/22/17 at 3:18 PM to "Weigh patient daily." The surveyor requested and received a report of daily weights from EI # 7, RN. Review of the report revealed the following information: 9/23/17 at 12:14 AM- 108.00 lbs. 9/23/17 at 11:00 PM- 126.00 lbs. 9/25/17 at 3:26 PM- 125.10 lbs. 9/26/17 at 1:20 PM- 116.30 lbs. No weight was recorded for 9/27/17, and none recorded for 9/28/17 at 10:15 AM when report was printed. There was no documentation the discrepancies in weight were investigated or reported to the physician. During an interview on 9/29/17 at 10:05 AM, with EI # 9, RN, the above findings were confirmed. He also stated the bed scales should have been re-calculated to obtain accurate weights. 37268 2. PI # 24 was admitted to the facility on 9/25/17 with diagnoses including SIRS (Systemic Inflammatory Response Syndrome, Possible UTI (Urinary Tract Infection), and Altered Mental Status. Review of the Daily Focus Assessment Reports dated 9/25/17 through 9/27/17 printed at 6:07 AM revealed the following documentation: "IV (Intravenous) Assessments... 9/25/17 20:30(8:30 PM)... Note: currently has an IV site in L (Left) hand; previous nurse advised she had to

insert new IV as pt pulled out IV she came to floor..." The RN (Registered Nurse) failed to document the insertion of the IV on 9/25/17. Review of the Physician (MD) Orders dated 9/26/17 at 3:26 PM revealed: "Clean and let dry buttocks and sacral area apply moisture barrier advance skin protectant wand. Do not let skin touch anything for 30 sec (seconds)..." Review of Nurse's Notes dated 9/26/17 revealed the following documentation: "Left buttocks Interventions: Wound care cleaned, open to air, used aseptic technique..." There was no documented orders for what to use when cleaning the buttocks area; the RN failed to clarify the wound care order and document what was used to clean the patient's buttocks area. Further review of Nurse's Notes dated 9/26/17 revealed the following documentation: "Groin intervention: Wound care cleaned, used aseptic technique." There were no documented physician orders to clean groin wound. The nurse failed to obtain wound care order for cleaning the patient's groin area. The RN failed to document what was used to clean the patient's groin area. Review of Nurse's Notes dated 9/26/17 through 9/27/17 revealed no documentation of wound measurements according to facility policy. An interview was conducted on 9/29/17 at 10:30 AM with EI # 9, RN Director, 6 - East who confirmed the above finding. EI # 9 stated, "staff failed to document the Length, Width, and Depth measurements of the patient's wound." 3. PI # 25 was admitted to the facility on 9/26/17 with diagnosis including Necrotic Left 3rd Toe. Review of the MD Orders dated 9/27/17 at 9:33 AM revealed: "Wound care to see- until perform dressing change with NS (Normal Saline) cleaner and apply nonstick type dressing, gauze and wrap with kling or kerlex." Review of Nurse's Notes dated 9/27/17 revealed documentation of the wound length, and width only. The nurse failed to document the wound depth measurement. An interview was conducted on 9/29/17 at 10:49 AM with EI # 9, RN Director, 6-East who confirmed the staff failed to measure the patient's wound per ABN Standards of Nursing Practice. 32470 4. PI # 1 was admitted to the facility on 9/24/17 with an admitting diagnosis of Infected Decubitus and End Stage Renal Disease. Review of the 9/24/17 nursing assessment documentation at 19:10 PM (7:10 PM) revealed the nurse documented wound cleaned and dressed to the right heel. Further review revealed no documentation as to what the wound was cleaned with or what type of dressing was applied. Review of the 9/25/17 assessment at 17:45 (5:45 PM) revealed the nurse documented under right heel interventions: wound care, open to air. Further review revealed no documentation as to what type of wound care was performed. Review of the physician orders revealed no documentation of an order written to leave the wound open to air. An interview was conducted on 9/29/17 at 9:30 AM with EI # 31, Clinical Specialist, who confirmed the above mentioned findings.