

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)
A0396	<p>NURSING CARE PLAN CFR(s): 482.23(b)(4)</p> <p>The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan</p> <p>This STANDARD is not met as evidenced by: Based on review of facility policies, medical records (MR) and interviews, it was determined the facility failed to ensure: 1. Patient discharge plans were started for all patients upon admission. 2. All nursing care plans were individualized for the patient's nursing care needs. This affected 2 of 26 in-patient records reviewed, including Patient Identifier (PI) # 24, # 25 and has the potential to affect all patients served. Findings include: Policy Title: Patient Care Plans Documentation Effective date: 2/20/2012 Policy: All patients admitted to patient Care Services nursing units shall have an individualized plan of care documented electronic in the medical record preferably within 8 hours but no later than within 24 hours of admission. A RN (Registered Nurse) or a LPN (Licensed Practical Nurse) will evaluate each patient's care plan daily. The RN must review and revise/update the care plan as needed each day. Purpose: To initiate nursing measures appropriate to current nursing practice. Procedure: ... 2. Only the RN may develop and initiate the patient's care plan and will individualize the care plan as appropriate to the patient's clinical history and physical assessment... 5. The RN will choose the top three to five problems/nursing diagnosis for his or her patient... Review And Revise/Update 1. The RN will review the appropriateness of each patient's care plan and revise/update as needed each day... 3. In any additional problem/nursing diagnosis is identified, it can be added to the patient's care plan and individualized for the patient... ***** Policy Title: Discharge Planning Effective date: 7/1/1994 Policy: All patients admitted to Southeast Alabama Medical Center</p>

should be screened upon admission for discharged planning needs. Purpose: To provide appropriate screening, assessment, planning, implementation and evaluation for the patient in preparation for discharge. Procedure: On Admission and Continued Stay: 1. Upon admission the staff nurse completes admission assessment to include, but not limited to, discharge needs... 12. Documentation is completed by the case manager/social worker and placed in the patient's medical record... ***** 1. 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 Patient Care Plan Report dated 9/25/17 revealed the following Nursing diagnosis: Anxiety, Pain, Knowledge Deficit, and Fear /Anxiety Related to Unfamiliar Surroundings. The patient's care plan was not individualized to meet his/her needs according to the admitting diagnosis of SIRS, UTI, and Altered Mental Status. Review of the MR dated 9/25/17 through 9/27/17 at 11:23 AM revealed no documentation of the patient's discharge plan. The surveyor asked EI # 2, Quality Outcomes Team Leader, "When should the patient's discharge planning be performed and documented?" EI # 2 stated, "Upon admission." The staff failed to document the patient's discharge plans per facility policy. An interview was conducted on 9/29/17 at 10:30 AM with Employee Identifier (EI) # 9, Registered Nurse (RN) Director, 6-East who confirmed the patient's care plan was not individualized for his/her admitting diagnosis. 2. PI # 25 was admitted to the facility on 9/26/17 with diagnoses including Necrotic Left 3rd Toe. Review of the Patient Care Plan Report dated 9/26/17 at 5:07 PM revealed the following Nursing diagnosis: Anxiety, Pain, Knowledge Deficit, and Fear/Anxiety Related to Unfamiliar Surroundings. The patient's care plan was not individualized to meet his/her needs according to the admitting diagnosis of Necrotic Left 3rd Toe. An interview was conducted on 9/29/17 at 10:30 AM with EI # 9, who confirmed the patient's care plan was not individualized to meet his/her needs according to the admitting diagnosis.