

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 010001	(X3) Date Survey Completed 08/02/2021
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)
A2407	<p>STABILIZING TREATMENT CFR(s): 489.24(d)(1-3)</p> <p>(1) General. Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either- (i) within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition. (ii) For for transfer of the individual to another medical facility in accordance with paragraph (e) of this section. (2) Exception: Application to inpatients. (i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual (ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment. (iii) A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation. (3) Refusal to consent to treatment. A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's behalf) does not consent to the examination or treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both.</p>

This STANDARD is not met as evidenced by:

Based on review of facility policies and procedures, medical records (MR), and interview with staff, it was determined the facility failed to ensure: 1. The staff implemented steps to prevent a patient(s) with Suicidal Ideation (SI) from leaving prior to receiving stabilizing treatment, including placement of the patient(s) in a safe environment area, initiation of 1:1 observation and/or constant observation, and documenting every 15 minute observations of the patient(s) behavior per the facility policy, including Patient Identifier (PI) # 11 and PI # 15 2. A patient having hallucinations was re-evaluated for the dangerousness of the hallucinations and the family was apprised of the risks and benefits of leaving given the patient's hallucinations, including PI # 18. This deficient practice affected 3 of 23 MR's reviewed and had the potential to affect all patients treated at this facility. Findings include: Facility Policy: Suicide Precaution Policy Number: None Department: Patient Care Services Effective Date: 10/1/96 Purpose: To provide a safe environment for patients who are a potential for suicide or have a past history of attempted suicide and re-present with SI or who have expressed SI. Policy Statement: To provide a safe, secure and structured environment for psychiatric patients who demonstrate suicidal intent, either verbal or non-verbal. These patients will be placed on suicidal precautions. Procedures: Emergency Department (ED): Initiate suicide precautions if the patient has suicidal thoughts. Nursing may initiate 1:1 observation on an emergent basis, but must follow-up with the attending physician, or their delegate, for a physician's order. 1) Patient will be on constant observation. ...c) If the patient leaves the room, a staff member must accompany him or her, including observation when toileting. 2) A qualified staff member will document the 15 min (minute) observation checks noting patient's behavior. Facility Policy: Emergency Medical Treatment and Labor Act (EMTALA) Administrative Policy Effective Date: 4/1/19 Purpose: To comply with the EMTALA.... Policy Statement: It is the policy of Southeast Health that individuals coming to the emergency department and who require emergency medical services receive an appropriate medical screening examination (MSE) and stabilization of any emergency medical condition (EMC) ... Procedure: Patients coming to the Emergency Department (ED): ...2. Provide necessary stabilizing treatment to an individual with an EMC or an individual in active labor. 1. PI # 11 presented to the ED 4 times within a 24 hours timeframe. PI # 11 first presented to the ED on 5/18/21 at 3:36 PM with a chief complaint of, "I am suicidal, I want to jump off a bridge. I'm also having right foot pain." Review of the triage assessment dated 5/18/21 at 3:37 PM revealed documentation of "Neurological ...Within Defined Limits...Psychiatric evaluation...I am suicidal, I want to jump off a bridge. I'm also having right foot pain." Review of the Physician Assistant (PA) assessment dated 5/18/21 at 3:43 PM revealed documentation, " ...Psychiatric/Behavioral...positive for dysphoric mood, hallucinations and suicidal ideas, negative for confusion...Neurological...Mental Status...alert and oriented to person, place and time...Psychiatric...Attention normal... Does not perceive auditory or visual hallucinations...Mood and Affect... normal,... Speech...normal, Behavior...cooperative,...Thought Content...Is not paranoid. Does not include homicidal or suicidal ideation." Review of the Q (every) 15 (minute) Safety Precautions Form revealed the following documentation: At 3:45 PM, PI # 11's behavior was calm At 4:00 PM, PI # 11's behavior was calm At 4:15 PM, PI # 11's behavior was bizarre. At 4:30 PM, PI # 11's behavior was bizarre and demanding. At 4:34 PM. documentation revealed "patient walked out." There was no documentation of the type of bizarre behavior PI # 11 displayed and the ED provider was notified of PI # 11's bizarre and demanding behavior.

Review of the Columbia Suicide Severity Risk Assessment dated 5/18/21 at 4:19 PM revealed documentation of a risk score of low risk. Review of the PA documentation dated 5/18/21 at 5:25 PM revealed, "Patient left the ED without completing the entire evaluation." PI # 11 presented a second time to the ED on 5/18/21 at 5:47 PM, with a chief complaint of, "I can't stop singing and I am suicidal." Review of the triage assessment dated 5/18/21 at 5:58 PM revealed documentation of "Neurological ... "Within Defined Limits"... Psychiatric evaluation..."I can't stop singing and I am suicidal." Review of the PA assessment on 5/18/21 at 5:59 PM documented, "States (he/she) took some ecstasy (ecstasy) today...Review of Systems... Psychiatric/Behavioral...Positive for confusion, the patient is nervous/anxious...Neurological...Mental status alert...Psychiatric...Mood and Affect..."Mood is elated, Affect is inappropriate...Thought Content...Delusional...Cognition and Memory...Cognition is impaired." Review of the nursing notes dated 5/18/21 at 7:42 PM revealed documentation of "Called Pt (Patient) and received no answer." The documented disposition was AMA (against medical advice) at 8:02 PM. There was no documentation the patient was placed on suicide precautions including a safe environment area, 1:1 observation and/or constant observation initiated and the patients behavior documented every 15 minutes per the facility policy. There was no documentation of a Columbia Suicide Severity Risk Assessment being performed. PI # 11 presented a third time to the ED on 5/19/21 at 3:13 AM with a chief complaint of suicide attempt. The triage assessment on 5/19/21 at 3:17 AM documented the patient stated, "I caught my boyfriend having f***** my mom. I'm suicidal and want to kill myself. I walked out in front of a car about 20 minutes ago." Review of the nursing notes dated 5/19/21 at 3:52 AM revealed documentation of..."Pt has left ER (emergency room) 3 times now. (He/She) states, "Nevermind I'm fine. I don't want to be seen." Review of the nursing notes dated 5/19/21 at 5:32 AM revealed documentation of ..."Disposition was set to LWBS (left without being seen) after triage. There was no documentation the patient was placed on suicide precautions including a safe environment area, 1:1 observation and/or constant observation initiated and the patients behavior documented every 15 minutes per the facility policy. There was no documentation of a Columbia Suicide Severity Risk Assessment being performed. PI # 11 presented to the ED a fourth time on 5/19/21 at 11:29 AM with a chief complaint of Suicidal and Foot Pain. Suicide safety measures were implemented, a psychiatric hold was initiated, and the patient was admitted to the inpatient psychiatric unit under the care of a psychiatrist with diagnosis Psychotic Disorder, R/O (rule out) Schizophrenia, Cannabis Use Disorder. An interview was conducted on 7/30/21 at 1:07 PM with Employee Identifier (EI) # 4, Director of Emergency Services, regarding PI # 11's third ED visit on 5/19/21 at 3:13 AM. EI # 4 was asked if the physician, PA, or NP (Nurse Practitioner) on duty was notified of the patient's three attempts to leave as documented by the nurse at 3:52 AM after voicing SI/attempted suicide? EI # 4 answered there was nothing documented the nurse got the physician or midlevel to do the medical screening exam. EI # 4 was also asked if the patient was placed on 1:1 observation and a suicide risk assessment performed? EI # 4 stated, "Not on this visit. On suicide attempts we try to get them in a room as soon as possible, then 1:1 is put into place. We do have a policy for 1:1 observation once placed in a room." EI # 4 was asked if any ED staff witnessed the patient leaving? EI # 4 stated, "It's not clear based on charting. Don't know if witnessed or not. We had the AMA form ready to sign." In a second email interview conducted 8/6/21 at 1:07 PM for the patient visits on 5/18/21, EI # 5, ED Performance Improvement Coordinator, was asked if the attending ED provider was notified that the patient's behavior had changed from calm, to bizarre and demanding by ED staff on visit 5/18/21 at 3:36 PM? EI # 5 answered no. EI # 5 also confirmed there was a Psychiatrist on call 5/18/21, but the patient left before

completing treatment on both visits to determine if one needed to be consulted. EI # 5 was also asked if the patient was placed in a safe environment on visit 5/18/21? EI # 5 stated the patient was never placed in a room. 40119 2. PI # 15 presented to the facility ED on 5/13/21 at 8:38 PM with an arrival complaint of SI and attempt. Review of the MR revealed documentation the patient was called for triage at 8:48 PM and again at 8:57 PM. The patient did not respond to either call and was documented as LWBS at 8:57 PM. There was no documentation the patient was placed in a safe environment area, 1:1 observation and/or constant observation was initiated and the patients behavior was documented every 15 minutes per the facility policy. An interview was conducted on 8/2/21 at 8:32 AM with EI # 5, Performance Improvement Coordinator, Emergency Department, who verbalized the facility staff member who took the arrival complaint was a registration clerk and the patient eloped prior to being seen by a clinical person. EI # 5 also verbalized the facility protocol for a patient presenting with a SI and attempt complaint would have been for the registration clerk to place the patient information in the system and notify a nurse. EI # 5 confirmed there was no documentation of the above suicide precautions per the facility policy. 3. PI # 18 presented to the facility ED on 7/8/21 at 9:07 PM with an arrival complaint of "Psych (Psychiatric) Problem - Seeing People." Review of the Triage note dated 7/8/21 at 9:16 PM revealed documentation of the chief complaint as "Psychiatric Evaluation (Auditory and visual hallucinations). Review of the Physician Assistant (PA) note dated 7/9/21 at 12:11 AM revealed documentation PI # 18 "... presents...with (his/her) parents with a chief complaint of '(he/she) is seeing stuff and talking to (himself/herself).'...Over the past few weeks patient has had worsening hallucinations. Patient is seeing people and talking to people that are not present according to the (parent identified). The patient agrees that (he/she) has been seeing and hearing people that are not present. Patient reports that the people are trying to get (him/her) and kill (him/her). Patient...does feel paranoid towards the hallucinations...would like the patient transferred to a pediatric facility to assist with psychiatric care as (he/she) reports that the hallucinations are getting worse... Psychiatric: Attention and Perception...inattentive. Mood and Affect: Mood is anxious. Affect is flat... Thought Content:...paranoid..." Review of the nursing note dated 7/9/21 at 5:37 PM revealed documentation the patient was hearing voices that wanted to kill an cut him/her. Review of the PA note dated 7/9/21 at 6:00 PM revealed documentation of "patient remains in the ED with auditory hallucination telling (him/her) they are going to kill (him/her)....no acute distress and currently boarded in the ED awaiting transfer/placement...Patient reports voices telling (him/her) they are going to kill (him/her). Family does not feel comfortable taking patient home. (He/She) will remain in the ED until placement can be facilitated...no acute distress with family at bedside..." Review of the PA note dated 7/10/21 at 1:21 PM revealed documentation of "patient remains in the ED with auditory hallucination telling (him/her) they are going to kill (him/her)....no acute distress and currently boarded in the ED awaiting transfer/placement...Patient reports voices telling (him/her) they are going to kill (him/her). Family does not feel comfortable taking patient home. (He/She) will remain in the ED until placement can be facilitated...no acute distress with family at bedside..." Review of the nursing note dated 7/10/21 at 7:15 PM revealed documentation the patient had no change in condition and the family verbalized the patient was still hearing voices that are threatening to cut and kill him/her. Review of the nursing note dated 7/10/21 at 8:10 revealed documentation the PA was at the bedside with the patient's parent who had decided to have the patient discharged and would seek help for the patient on an outpatient basis. Review of the PA note dated 7/10/21 at 8:25 PM revealed documentation of "patient remains in the ED with auditory hallucination telling (him/her) they are going to kill (him/her)....no acute distress and currently boarded in the ED awaiting transfer/placement...Patient

reports voices telling (him/her) they are going to kill (him/her). Family does not feel comfortable taking patient home. (He/She) will remain in the ED until placement can be facilitated... No bed placement was facilitated. (Parent Identified) desires to take patient home and follow up outpatient. Return precautions given. (Parent Identified) ok (okay) with plan. There was no documentation the patient was re-evaluated for dangerousness of the hallucinations and the patient's family was apprised of the risks and benefits of leaving given the patient's auditory and visual hallucinations. Review of the Discharge Information revealed the patient was discharge home on 7/10/21 at 8:54 PM. There was no documentation PI # 18 was stabilized prior to being discharged home, PI # 18 was re-evaluated for dangerousness of the auditory and visual hallucinations and the family was apprised of the risks and benefits of leaving given the patient's auditory and visual hallucinations. An interview was conducted on 8/2/21 at 8:36 PM with EI # 5, who confirmed there was no documentation the patient was re-evaluated prior to discharging home for the dangerousness of the auditory and visual hallucinations and the family was apprised of the risks and benefits of leaving given the patient's auditory and visual hallucinations.