Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number** 010006	**(X3) Date Survey Completed** 04/11/2019
Name of Provider or Supplier North Alabama Medical Center	**Street Address, City, State** 1701 Veterans Drive, Florence, 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	STAFFING AND DELIVERY OF CARE CFR(s): 482.23(b) 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. This STANDARD is not met as evidenced by: Based on review of medical records (MR), facility policies and procedures, and interviews, it was determined the facility failed to ensure the staff: a) Obtained and followed the physician's orders for wound care. b) Performed wound assessments and measured wounds per policy. c) Documented specific wound care performed. d) Documented care provided for removal of Central Venous Line (CVL). e) Followed the hospital policy for Tracheostomy (trach) care. f) Followed the hospital policy, performed and documented pain assessments/reassessments in the ED (emergency department). This affected 5 of 22 records reviewed including MR # 20, MR # 19, MR # 9, MR # 18 and MR # 10, and Unsampled Patient # 1, and 4 of 16 ED MR's reviewed which included ED MR's # 16, # 2, # 4, and # 5. This had the potential to negatively affect all patients served by this facility. Findings Include: Policy: Physician Orders, Protocols, Pre-Printed and Standing Orders Policy Number: H110.PCS.105 Date Reviewed: 10/2019 Policy ...Protocols are a specific set of orders developed by physicians or other clinical staff and approved by the medical staff... Procedure ...II. Verbal or Telephone Orders: A. Verbal or telephone orders shall be kept to a minimum and only used in emergent/urgent situations... I. Each verbal or telephone order shall be dated, timed and identified by the names of the individuals who gave and received the order... VIII. Protocols A. Protocols must be initiated by a written, electronic order, or telephone order... B. The protocol order can

be initiated before the physician authenticates the order, much like a telephone order. C. After printing off the protocol, document the date, time, and sign off the order... D. The protocol will be placed on the medical record like any physician order... E. The physician will authenticate (sign, date, and time) the use of the protocol, at the next patient visit or electronically, as soon as possible, or by 30 days... Policy: Wound and Skin Care Policy and Procedure Policy Number: H110.PCS.182 Date Reviewed: 11 /2018 Policy ...Upon identification of skin breakdown, skin/wound care will be initiated according to the Wound Care Treatment (WCT) Protocol unless otherwise ordered by the physician.. Wound Care Treatment Protocol: Assessment: 1. Assess areas of skin breakdown initially for location, stage, size... Notify the physician and the wound care nurse of any areas of skin breakdown, including rashes. 2. Reassess the areas of skin breakdown at every dressing change and document size and appearance of wound on Wednesdays weekly. If the condition of the patient or wound deteriorates, re-evaluate... Notify the physician and the wound care nurse... Central Venous Catheter (CVC) Dressing Change/Site Care/ Catheter Care/Removal Policy #: H110.PCS.151 Revised Date: 9/2018 Purpose To minimize the risk of the patient acquiring a central line-associated blood stream infection while providing intermediate to long-term venous access... Procedure: V. Removal of Central Line... B. Document in the electronic medical record 1) Patient's response including presence or absence of dyspnea 2) Condition of the site. 3) Confirmed placement of occlusive dressing. Policy/Procedure Title: Suctioning Endotracheal- Tracheostomy Policy # H110.771.046 Revised Date: 12/2015 Procedure: Equipment: e) Sterile Saline- pour bottle... 8... pour normal saline (30-50 cc (cubic centimeters) into the solution container... Policy/Procedure Title: Pain Management Policy # H 110.PCS. 090 Revised Date: 10/2018 Purpose It is the organization's goal to provide patients with pain management in a safe and effective method... Reduce the severity of pain Educate...of the need to report unrelieved pain Enhance the patient's comfort and satisfaction Policy It is the patient's right to have their pain managed as adequately as can be safety provided...This information is analyzed to make care, treatment, and care decisions. ...Pain Assessment: ...The pain assessment should include...location of pain...Intensity of pain utilizing the appropriate patient pain scale...Description of the pain... Pain scales: 1. Adult Numerical intensity scale 0-10 (with 0 being no pain and 10 being the most severe pain possible)... Pain Intensity... is evaluated as...Severe pain is rated as a pain score of greater than 7. Pain Management Plan 1. A pain management plan is developed based on assessment data...implemented and evaluated for appropriations and effectiveness. Effectiveness of the pain management plan is determined by the patient's self reported intensity of pain and should be documented... Pain Reassessment: 1. Pain will be reassessed...after each pain intervention 2. Pain will be reassessed after administration of any pain medication within appropriate times based on method of administration and nursing judgement... 1. MR # 20 was admitted to the hospital on 3/21/19 with diagnoses including Left Hip Fracture and Schizoaffective Disorder. Review of the MR revealed an Adult Admission Patient Assessment dated 3/21/19 at 5:48 AM. For the question, "Does pt (patient) have wound" the RN (Registered Nurse) documented, "No." Review of MR revealed the following order dated 3/23/19 at 6:00 AM, "Change dressing L (left) hip (paint with betadine)." There was no documentation the care was performed. Review of the Wound Photography and Staging Documentation Form dated 3/24/19 at 5:30 AM, contained the following information, "Location of Wound: Coccyx; Wound Stage: Type II; Measurements of Wound: 1.75 x 0.75 cm (centimeters)..." There was no depth of wound documented. Review of the RN Adult Shift Assessments dated 3/24/19 at 2:32 PM, 3/24/19 at 7:09 PM, and 3/25/19 at 9:27 AM revealed no documentation of the coccyx wound. There was no documentation the physician was notified of the new wound and there were no orders for wound care

in the MR. Review of the Wound Photography and Staging Documentation Form dated 3/27/19 at 4:55 PM revealed the coccyx wound had increased in length to 3 cm and width to 2 cm. There was no depth documented. There was no documentation the physician was notified of the increased size of the wound, according to policy. Review of the RN Adult Shift Assessment dated 3/29/19 at 9:00 PM revealed the RN failed to document the presence of the coccyx wound, or an assessment of the dressing. Review of the Wound Photography and Staging Documentation Form dated 4/4/19 at 5:50 PM revealed the coccyx wound had increased in length to 4 cm and width was 2 cm. There was no depth documented. There was no documentation the physician was notified of the increased size of the wound, according to policy. The surveyor was unable to determine what wound care was provided to the coccyx wound, or the frequency of care provided. An interview was conducted on 4/10/19 at 8:00 AM with Employee Identifier (EI) # 18, RN (Registered Nurse), WCC, (Wound Care Certified), who stated the care for wounds was nurse driven, and there were no protocols or orders for wound care. During an interview conducted on 4/11/19 at 9:51 AM with EI # 34, Director, Risk Management and Compliance, the above findings were confirmed. 34107 2. MR # 19 was admitted to the facility on 4/5/19 for Coronary Heart Disease and possible Coronary Artery Bypass Grafting (CABG). Review of the MR revealed a Central Venous Line (CVL) was placed in surgery. Review of the 4/9/19 flow sheet revealed documentation of, "CVL d/c (discontinued)". Review of the 4/9/19 Skilled Nurse (SN) notes revealed no documentation when /or who removed the CVL, the care provided after the CVL removal, or how the patient tolerated the CVL removal. The surveyor asked, "Who removed the CVL and when?" EI # 23, RN, stated, "The RN taking care of the patient yesterday failed to document." The staff failed to document care provided to the patient per policy. In an interview conducted on 4/10/19, at 9:40 AM, EI # 22, Critical Care Director, confirmed the above findings. 3. MR # 9 was admitted to the facility on 3/29/19 with Acute Respiratory Failure. During an observation of endotracheal suctioning and care of tracheostomy (trach) conducted on 4/9/19 at 2:00 PM, the surveyor observed the EI # 41, RN, open a 1000 milliliter (ml) bottle of Sterile Water. EI # 41 poured the Sterile Water into the trach kit container and then cleaned the trach with the Sterile Water. The RN failed to use Sterile Normal Saline as stated in policy. In an interview conducted on 4/9/19 at 3:25 PM, EI # 22 confirmed the above findings. 30952 4. ED MR # 16 presented to the ED on 4/9/19 at 12:28 PM with a chief complaint back pain and nausea. During an observation of care on 4/9/19 at 1:30 PM, EI # 1, ED RN, administered a narcotic analgesic, Dilaudid 1 mg (milligram) IM (intramuscularly) and anti-emetic (nausea) Phenergan 25 mg IM for complaints of lower back pain, described by the patient as severe pain 9 (1-10 pain scale). The acceptable pain level documented was 3. ED MR # 16 exited the ED on 4/9/19 at 3:51 PM. There was no documentation EI # 1 re-assessed the patient's pain level following the narcotic pain administration. In an interview on 4/11/19 at 10:35 AM, EI # 38, Chief Nursing Officer confirmed the above findings. 5. ED MR # 2 presented to the ED on 4/7/19 at 1:32 PM with a chief complaint shortness of breath 1 week post (after) hysterectomy. On 4/7/19 at 2:45 PM, the ED RN documented Morphine Sulfate (narcotic analgesic) 2 mg IV and Metoclopramide 10 mg IV administered for pain level 10. There was no documentation the ED RN re-assessed the pain level following the narcotic administration. In an interview on 4/11/19 at 10:15 AM, EI # 38 reported the pain re-assessment should have been completed 30 minutes after medication administration. 6. ED MR # 4 presented to the ED on 4/6/19 at 8:26 AM with the chief compliant, wound complications. Review of the ED RN documentation at 8:36 AM revealed the pain evaluation consisted of the following documentation "Are you in pain now?" The documented response was Yes. There was no pain assessment documentation of the present pain level, intensity and pain description.

The staff documentation failed to include a complete pain assessment per the facility pain management policy. In an interview on 4/11/19 at 9:48 AM, EI # 38 confirmed the above findings. 7. ED MR # 5 presented to the ED on 3/5/19 at 4:13 PM with the chief complaint documented "cpr" (cardiopulmonary resuscitation). The ED physician documented the patient arrived at the facility intubated and stable. Review of the ED RN documentation at 4:59 PM revealed the pain evaluation consisted of the following documentation "Are you in pain now? " The documented response was Yes. There was no pain assessment documentation of the present pain level, intensity and pain description. The staff documentation failed to include a complete pain assessment per the facility pain management policy. In an interview on 4/11/19 at 10:00 AM, EI # 38 confirmed the above findings. 40119 8. An observation was conducted on 4/9/19 at 12:58 PM to observe EI # 32, Registered Nurse, perform wound care for Unsampled Patient # 1. During the observation, EI # 32 removed the dressing to the Left Lateral Thigh surgical wound, wiped with plain gauze, placed clean gauze over wound, and secured gauze with tape. On 4/11/19 at 10:00 AM the surveyor requested the wound assessment, wound care documentation, and wound care order for the Left Lateral Thigh Surgical wound from EI # 33, Nurse Educator. An interview was conducted on 4/11/19 at 10:44 AM, EI # 33 verbalized there was no documentation of the Left Lateral Thigh assessment or wound care documentation in EI # 32's note and there was no physician's order for wound care to the Left Lateral Thigh. 32470 9. MR # 18 was admitted to the facility on 2/19/19 with an admitting diagnosis of Acute Toxic Metabolic Encephalopathy. Review nurses Adult Admission Patient Assessment documentation dated 2/19/19 revealed patient had a Stage II pressure wound to the right coccyx and a Mepilex dressing was applied. Review of all the physician orders within the MR revealed no order was written for the Mepilex dressing or how often the dressing was to be changed. An interview was conducted on 4/11/19 at 10:00 AM with EI # 35, Registered Nurse, who confirmed no orders were written for wound care. 10. MR # 10 was admitted to the facility on 4/2/19 with an admitting diagnosis of Necrotic Foot Ulcer. On 4/9/19 at 10:00 AM the surveyor entered the Medical Surgical area with EI # 12, Assistant Administrator, for a chart review of wound patients. Review of the Adult Admission Patient Assessment dated 4/2/19 revealed the patient had a pressure ulcer to the right great toe with no drainage and contained eschar to the wound bed. There was no stage documented to this wound. Review of the medical record in the Electronic Medical Record (EMR) system revealed no documentation pictures were taken of the wound. The surveyor asked EI # 18, RN, wound nurse, about pictures. EI # 18 stated "it is not a pressure wound so no pictures are to be taken. Only pressure ulcers get pictures." The surveyor asked EI # 18 why on admission was it documented as a pressure ulcer and EI # 18 replied "I'm not sure." Further review of the EMR revealed no documentation of wound measurements on admission or during MR #10's stay at the hospital. EI # 18 stated " it was not a pressure ulcer so measurements were not taken" An interview was conducted on 4/9/19 at 11:00 AM with EI # 12. The surveyor explained measurements were not taken on admission. EI # 12 stated " measurements are to be taken on admission.