

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)
A0454	<p>CONTENT OF RECORD: ORDERS DATED & SIGNED CFR(s): 482.24(c)(2)</p> <p>All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records (MR), facility policy and procedure and interview with administrative staff, it was determined the facility failed to ensure all verbal orders were documented in dated, timed, and authenticated for all inpatient records reviewed. This affected MR # 19, MR # 16, 2 of 22 medical records reviewed and 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: 10/2018 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... 1. 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 documentation the patient had a Central Venous Line (CVL) placed in surgery. Review of the 4/9/19 flow sheet revealed documentation "CVL d/c (discontinued)" Review of the MR revealed no physician's order or verbal order to remove the CVL. During the record review on 4/10/19, the surveyor asked Employee Identifier (EI) # 23, RN, "When was the CVL removed? EI # 23 stated, "The RN taking care of the patient yesterday failed to document the order." The staff failed to follow facility policy for documenting receipt of physician verbal orders. In an interview conducted</p>

on 4/10/19 at 9:40 AM, EI # 22, Critical Care Director, confirmed the above findings.

2. MR # 16 was admitted to the facility on 12/8/18 with Inferior STEMI (ST Elevation Myocardial Infarction), (Per Taber's Medical Dictionary, "Electrical activity of the heart consisting of waves called P,Q, R, S, T and sometimes U). Review of the 12/9/18 Skilled Nurse (SN) notes revealed documentation the patient was placed in Non-Violent Restraints at 6:50 PM. The staff failed to document physician's verbal order to start restraints on 12/9/18 at 6:50 PM. In an interview conducted on 4/11/19 at 9:55 AM, EI # 36, Health Information Management, confirmed the above findings.