DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

				ING	I COM	(X3) DATE SURVEY COMPLETED		
		040071	A. BUILDING		R-C			
NAME OF PROVIDER OR SUPPLIER			10	STREET ADDRESS, CITY, STATE, ZIP CODE			02/02/2018	
,					0 WEST 40TH AVENUE			
JEFFERSON REGIONAL MEDICAL CENTER			PINE BLUFF, AR 71603					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETION DATE		
{A 000} IN	NITIAL COMMENT	rs .	{A 0	00}				
Fe cit co Th	ebruary 2, 2018 fo ited on 01/04/18. / orrected and no ne	sit survey was conducted on r all previous deficiencies All deficiencies have been ow noncompliance was found. inpliance with 42 CFR Part or a hospital.						
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							,	
					•			
			,		·			
		ER/SUPPLIER REPRESENTATIVE'S SI			TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TITLE

(X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		040071	B. WING		C 01/04/2018		
NAME OF PROVIDER OR SUPPLIER JEFFERSON REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1600 WEST 40TH AVENUE PINE BLUFF, AR 71603				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		D BE COMPLÉTION		
A 395	An entrance confer Facility Representa 5, 2017. The Representa 5, 2017. The Representa 5, 2017. The Representatives of the visit Survey. An exit conference Representatives at findings of the surve Representatives we present additional ir presented. RN SUPERVISION CFR(s): 482.23(b)(3 A registered nurse of the nursing care for This STANDARD is Based on clinical rewas determined a Resupervise and evaluation of two (Patient #3 and staff failed to obtain and ensure the Physicial make decisions registed potential to protect the potential to prot	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INTIAL COMMENTS In entrance conference was conducted with acility Representatives at 9:45 AM on December 2017. The Representatives were informed the acrpose of the visit was to conduct a Complaint curvey. In exit conference was conducted with Facility epresentatives at 3:30 PM on 12/07/17. The adings of the survey were discussed. The expresentatives were given an opportunity to esent additional information and none was esented. N SUPERVISION OF NURSING CARE		A395 RN Supervision of Nursing CFR: 482.23(b)(3) A. Members of the quality departm will audit the daily weights weekly beginning January 5, 2018. Results these audits will be sent to unit managers/coordinators and directo Auditing will continue while a repebeing built to assist the directors we daily audit. B. Director of Quality or designeer review and revise the general and a order sets for clinical appropriatent daily weight orders. C. Director of Quality or designeer change the frequency of the output the order view on the orders tab to clarify the task frequency and decressaff confusion. D. Regulatory specialist will review policies and procedures regarding day weights and make any revisions necessary to address the above mentioned changes.	nent / s of rs. Ort is ith a will dmit ess of 1/26/2018 vill of ase 2/15/2018		
ABORATORY	DIRECTORIS OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE TO THE TOTAL OF THE PARTY	(X6) DATE		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 01/09/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 040071 B. WING 01/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1600 WEST 40TH AVENUE JEFFERSON REGIONAL MEDICAL CENTER PINE BLUFF, AR 71603 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) A 395 Continued From page 1 A 395 E. Director of Quality or designee will the clinical record showed no weights documented from 12/24/17 through 01/04/18. create a report to assist the nursing During an interview with the Regulatory managers/directors with auditing of Compliance Officer at 10:20 AM on 01/04/17, she daily weigh order compliance. 1/26/2018 verified the above findings. F. Managers/Coordinators or his/her B. Review of Patient #5's clinical record showed designee will audit 100% of the daily orders authored by Physician #2 at 2:44 PM on weigh orders each day the week of Jan 12/26/17 for daily weights at 6:00 AM. Review of 29th. Daily weigh audits will be the clinical record showed a weight of 175 lbs on conducted 3x week the week of Feb. 5 12/16/17. Review of the clinical record showed no and will be done one day a week the weights documented from 12/26/17 through 01/04/18. During an interview with the Regulatory week of Feb. 12. Random checks of the Compliance Officer at 12:20 PM on 01/04/18, she daily weigh order compliance will verified the above findings. continue by the managers/coordiantors and the quality department to ensure continued compliance. 2/16/18 G. Staff education will be done by the managers/coordinators of each unit to update the staff on changes made to the EMR concerning daily weigh orders, documentation, and policy changes. 2/16/18

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		040071	B. WING		С	
NAME OF PROVIDER OR SUPPLIER		D. 111110		1 01	/04/2018	
JEFFERSON REGIONAL MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1600 WEST 40TH AVENUE PINE BLUFF, AR 71603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROPRIES (PROSS-REFERENCE)	ILD BE	(X6) COMPLETION DATE
A 000	INITIAL COMMENT	S	Α0	000		
	Facility Representat 5, 2017. The Repre	ence was conducted with ives at 9:45 AM on December sentatives were informed the was to conduct a Complaint				
A 205	Representatives at 4 findings of the surve Representatives we present additional in presented.	vas conducted with Facility 4:00 PM on 12/07/17. The y were discussed. The re given an opportunity to formation and none was				
	CFR(s): 482.23(b)(3	nust supervise and evaluate	A 39	95		2/16/18
	This STANDARD is Based on clinical rewas determined a Resupervise and evaluation of two (Patient #3 and staff failed to obtain a Failure to obtain and ensure the Physiciar make decisions regathe potential to prolohospitalization. The Patient #3 and #5 on A. Review of Patient	not met as evidenced by: cord review and interview, it egistered Nurse failed to ate the nursing care for two id #5) Patients in that nursing and record daily weights. record daily weights did not in had information needed to irding patient care and had ing the patient's failed practice affected in 01/04/18. Findings follow: #3's clinical record showed				
	12/23/17 for daily we the clinical record sh	Physician #1 at 5:51 PM on ights at 6:00 AM. Review of owed a weight of 100 ented on 12/23/17. Review of				
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE		(X6) DATE

01/26/2018

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NAME OF PROVIDER OR SUPPLIER JEFFERSON REGIONAL MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP O 1600 WEST 40TH AVENUE PINE BLUFF, AR 71603		70472010	
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A 395	the clinical record documented from During an interview Compliance Office verified the above B. Review of Patie orders authored by 12/26/17 for daily the clinical record 12/16/17. Review of weights document 01/04/18. During a	showed no weights 12/24/17 through 01/04/18. w with the Regulatory r at 10:20 AM on 01/04/17, she findings. nt #5's clinical record showed w Physician #2 at 2:44 PM on weights at 6:00 AM. Review of showed a weight of 175 lbs on of the clinical record showed no ed from 12/26/17 through an interview with the Regulatory r at 12:20 PM on 01/04/18, she	Α3	95			