STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	040071	A. BUILDING _____ B. WING _____	C 02/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON REGIONAL MEDICAL CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS An entrance conference was conducted with Facility Representatives at 0825 on 02/07/17. The Representatives were informed the purpose of the visit was to conduct a Complaint Survey. An exit conference was conducted with Facility Representatives at 1545 on 02/08/17. The findings of the survey were discussed. The Facility Representatives were given an opportunity to present additional information and none was presented.	A 000	A395 482.23(b)(3) RN Supervision of Nursing Care A. 1. The 2CE staff was informed of survey findings following the state health visit.	2/10/2017
			2. The 2CE Manager/Patient Care Coordinator will educate the 2CE staff on the Electronic Nursing Documentation Policy (Nursing Policy 500.2—Attachment A) and the Assessment and Re-assessment of Patients Policy (Administrative Policy 4.23—Attachment B) and obtain a signed roster.	2/24/2017
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on clinical record review, policy and procedure review and interview it was determined a RN (Registered Nurse) failed to supervise the care of one (#7) of one (#7) wound care patient in that there were not wound assessments for five (night shift on 02/03/17, night shift on 02/05/17, day and night shift on 02/06/17 and day shift on 02/07/17) of 15 (01/30/17 through 02/07/17) shifts. Failure to document the wound appearance did not give other providers the physical information necessary to make decisions regarding care and treatment. The failed practice affected Patient #7 on 02/08/17. Findings follow: A. Review of Patient #7's clinical record revealed a nursing note authored by the Wound Care Nurse at 1115 on 01/31/17 that revealed the following wounds: Ulcer 1 right heel - unstageable, moist with black	A 395	3. The 2CE Manager/Patient Care Coordinator will educate the 2CE staff on head-to-toe assessment parameters and RN discipline requirements. A copy of the head-to-toe assessment parameters and a laminated RN discipline card will be provided to each RN staff member. (Attachments C and D)	2/24/2017
			4. All 2CE unit-based RNs will be observed performing a head-to-toe assessment at the bedside by the Manager/Coordinator or designee to validate competency. A review of the corresponding documentation will also be completed by the observer. (Attachment E)	3/24/2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

President + CEO | 02-22-17

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.

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A 395	Continued From page 1 eschar, unable to visualize wound base, ulcer base is yellow with slough present, peri-wound are is intact. Light or minimal amount of yellow drainage noted, no odor... Ulcer 3 sacrum - unstageable, moist, unable to visualize wound base, ulcer base is yellow with slough present, peri-wound area is intact... Ulcer 4 Left Ischium - Stage III, ulcer base is yellow, ulcer base is pink with slough present, peri-wound area intact, no odor, no drainage... Ulcer 5 left heel - unstageable, black eschar present, unable to visualize wound base, peri-wound area is intact, light or minimal amount of drainage, seroganguineous, no odor... Wound 2 left fifth toe - missing toenail, wound base is moist, wound base pink, peri-wound are intact, peri-wound area dry. Wound 3 left anterior foot - ruptured blister, wound base is moist, wound base pink, peri-wound area is intact, peri-wound area is dry, peri-wound area is erythemic... Wound 4 left lower anterior leg - ruptured blister, wound base moist, wound base pink, peri-wound area is intact, peri-wound area is dry, peri-wound area is erythemic... Wound 5 perineum - perineum/yeast like rash, no open areas, peri-wound area is intact, peri-wound area is moist, peri-wound area is erythemic... B. Review of the nursing notes revealed the following: 02/03/17 7 PM (Ante Meridian) shift, no wound assessment. 02/05/17 7 PM shift, no wound assessment. 02/06/17 7 AM (Ante Meridian) shift, no wound assessment. 02/06/17 7 PM shift, no assessment of Ulcers 1,3, 4 or 5, or Wounds 3 and 5. 02/07/17 AM shift, no assessment of Ulcers 3, 4	A 395	5. The 2CE Manager/Patient Care Coordinator will audit current patients on 2CE for complete RN head-to-toe assessments including modification of row labels when applicable. Monitoring will begin 2/9/2017 with the following sequence: daily x 3 weeks; three times weekly x1 week, twice weekly x1 week, and then randomly. (Attachment F)	3/24/2017

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A 395	Continued From page 2 and 5 or Wounds 3, 4 and 5. C. Review of the policy and procedure titled "Electronic Nursing Documentation" received from the Regulatory Specialist at 1040 on 02/07/17 revealed the following under DOCUMENTATION GUIDELINES: under Type of Documentation - Physical Assessment of System, Who - RN, Where - Daily Flowsheet, What - Systems Assessment, Time Frame - Each shift within 4 hours, Head to Toe Assessment Start of all shifts and:... D. During an interview with the Assistant Vice President of Patient Care Services and the Clinical Educator at 1405 on 02/08/17 both stated the head to toe nursing assessment includes all wounds. E. The findings of A, B and C were verified during an interview with the Regulatory Specialist at 1230 on 02/08/17.	A 395		

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