DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES MB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C 040071 B. WING 02/08/2017 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 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 000 INITIAL COMMENTS A 000 482.23(b)(3) RN Supervision of Nursing Care An entrance conference was conducted with Facility Representatives at 0825 on 02/07/17. 1. The 2CE staff was informed of survey findings The Representatives were informed the purpose 2/10/2017 following the state health visit. of the visit was to conduct a Complaint Survey. 2. The 2CE Manager/Patient Care Coordinator An exit conference was conducted with Facility will educate the 2CE staff on the Electronic Representatives at 1545 on 02/08/17. The Nursing Documentation Policy (Nursing Policy findings of the survey were discussed. The 500.2—Attachment A) and the Assessment and Facility Representatives were given an Re-assessment of Patients Policy (Administrative 2/24/2017 opportunity to present additional information and Policy 4.23—Attachment B) and obtain a signed none was presented. roster. 482.23(b)(3) RN SUPERVISION OF NURSING A 395 A 395 3. The 2CE Manager/Patient Care Coordinator CARE will educate the 2CE staff on head-to-toe assessment parameters and RN discipline A registered nurse must supervise and evaluate requirements. A copy of the head-to-toe the nursing care for each patient. assessment parameters and a laminated RN discipline card will be provided to each RN staff 2/24/2017 This STANDARD is not met as evidenced by: member. (Attachments C and D) Based on clinical record review, policy and procedure review and interview it was determined 4. All 2CE unit-based RNs will be observed a RN (Registered Nurse) failed to supervise the performing a head-to-toe assessment at the care of one (#7) of one (#7) wound care patient in bedside by the Manager/Coordinator or designee that there were not wound assessments for five to validate competency. A review of the (night shift on 02/03/17, night shift on 02/05/17, corresponding documentation will also be day and night shift on 02/06/17 and day shift on 3/24/2017 completed by the observer. (Attachment E) 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 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4WT211

Facility ID: ARHO00046

If continuation sheet Page 1 of 3

PRINTED: 02/10/2017

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

PRINTED: 02/10/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER		!		TREET ADDRESS, CITY, STATE, ZIP CODE	02/08/2017		
NAME OF PROVIDER OR SUPPLIER JEFFERSON REGIONAL MEDICAL CENTER			1600 WEST 40TH AVENUE PINE BLUFF, AR 71603					
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A 395	eschar, unable to verificate is intact. Light of drainage noted, no Ulcer 3 sacrum - uvisualize wound be slough present, pe Ulcer 4 Left Ischiur yellow, ulcer base peri-wound area in Ulcer 5 left heel - upresent, unable to peri-wound area is of drainage, seroga Wound 2 left fifth to base is moist, wou intact, peri-wound area is yound 3 left anteri wound base is moi peri-wound area is peri-wound area is peri-wound area is yound 4 left lower wound base moist, area is intact, peri-area is erythemic Wound 5 perineum open areas, peri-wound 5 perineum open areas, peri-warea is moist, peri-area is moist, peri-wound 5 perineum open areas, peri-warea is moist, peri-area is moist, per	visualize wound base, ulcer slough present, peri-wound or minimal amount of yellow odor Instageable, moist, unable to use, ulcer base is yellow with ri-wound area is intact In - Stage III, ulcer base is is pink with slough present, tact, no odor, no drainage unstageable, black eschar visualize wound base, intact, light or minimal amount anguineous, no odor In the end of the minimal amount anguineous, no odor In the end of the minimal amount anguineous, no odor In the end of the minimal amount area dry. In the end of the minimal amount area dry. In the end of	A3	395	5. The 2CE Manager/Patient Care Coording will audit current patients on 2CE for come 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 weekly x1 week, twice weekly x1 week, a randomly. (Attachment F)	plete e. e times	3/24/2017	

PRINTED: 02/10/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING ___ C 040071 B. WING 02/08/2017 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 DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 395 | Continued From page 2 A 395 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.

PRINTED: 02/10/2017 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 C 040071 02/08/2017 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 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID m (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 000 **INITIAL COMMENTS** A 000 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. 482.23(b)(3) RN SUPERVISION OF NURSING A 395 A 395 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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Ulcer 1 right heel - unstageable, moist with black

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

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