LABORATORY	A 900	(X4) ID PREFIX TAG	JEFFER		STATEMENT AND PLAN C	DEPAR CENTE
DIRECTOR'S OR PROVIDE	INITIAL COMMENTS On 05/20/20 at \$:15 AM, an entrance of was conducted with Facility Representatives were informed the of the visit was to conduct a complaint; On 05/26/20 at 2:30 PM, a telephone exconference was conducted with Facility Representatives. The Representatives informed no deficiencies were cited.	SUMMARY STA: (EACH DEFICIENCY REGULATORY OR LS	NAME OF PROVIDER OR SUPPLIER JEFFERSON REGIONAL MEDICAL CENTER		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	TMENT OF HEALTH RS FOR MEDICARE
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	INITIAL COMMENTS On 05/20/20 at 8:15 AM, an entrance conference was conducted with Facility Representatives. The Representatives were informed the purpose of the visit was to conduct a complaint survey. On 05/26/20 at 2:30 PM, a telephone exit conference was conducted with Facility Representatives. The Representatives were informed no deficiencies were cited.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFYCIELY, MUST BE PRECEIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	CAL CENTER	040071	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES
ATURE	A 000	PREFIX TAG		B. WING	(X2) MULTIPI	
3100		PROVIDERS PLAN OF CORRECTION [EACH CORRECTIVE ACTION SHOULD RE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY]	STREET ADMESS, CITY, STATE, ZIP CODE 1600 WEST 40TH AVENUE PINE BLUFF, AR 71603		E CONSTRUCTION	PR OM
(X8) DATE		BE COMPLETION DATE		05/26/2020	(X3) DATE SURVEY	PRINTED: 06/15/2020 FORM APPROVED OMB NO. 0938-0391

Any deficiency statement ending with an asterisk (*) denoise a deficiency which the institution may be excussed from correcting providing it is determined that other sateguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are discissable 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 disclossable 14 days following the date these documents are made available to the facility. If deficiencies are clied, an approved plan of correction is requisite to continued program participation.

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

Event ID: 7SY011

Fadily ID: ARHO00046

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