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 _____	R 08/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON REGIONAL MEDICAL CENTER	1600 WEST 40TH AVENUE PINE BLUFF, AR 71603

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{A 000}	INITIAL COMMENTS A desk review revisit survey was conducted on 08/20/18 for all previous deficiencies cited on 07/20/18. All deficiencies have been corrected and no new non-compliance was found. The Facility is in compliance with 42 CFR Part 482, Requirements for a hospital.	{A 000}		

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.

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A 000	INITIAL COMMENTS An entrance conference was conducted with Facility Representatives at 9:20 AM on 07/16/18. The Representatives were informed the purpose of the visit was to conduct a Medicare recertification survey. An exit conference was conducted with Facility Representatives at 3:25 PM on 07/20/18. The findings of the survey were discussed. The Representatives were given an opportunity to present additional information and none was presented.	A 000	A 491: Pharmacy Administration CFR 482.25(a) A--A review of the policy was performed by the OR Educator. No changes were found to be needed based on manufacturer's recommendations. C—1(a) All fluids were checked following the finding by the state surveyor and any solutions that were not dated per policy were removed from the warmer. C—1 (b) Surgical staff failed to follow manufacturer's recommendations and follow policy for storage of fluids in the warmer. An in-service was conducted by the OR Educator concerning the warmer cabinet policy and the proper storage and labeling of fluids. C—1 (c) A sign addressing the proper labeling and storage of fluids will be placed on the OR fluid warmer by the OR Manager or designee. C—1 (d) The OR Manager or designee will conduct a weekly audit on each warmer for 12 weeks, starting 8/13/18, then twice a month for 3 months, followed by once a month for six months with 100% compliance expected.	A 7/27/18 C (1)(a) 7/23/18 C (1)(b) 8/9/18 C (1)(c) 8/13/18 C (1) (d) Auditing to begin 8/13/18
A 491	PHARMACY ADMINISTRATION CFR(s): 482.25(a) [§482.25 Condition of Participation: Pharmaceutical Services .....The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.] §482.25(a) Standard: Pharmacy Management and Administration The pharmacy or drug storage area must be administered in accordance with accepted professional principles. This STANDARD is not met as evidenced by: Based on review of policy, review of manufacturer's recommendations, observation and interview, it was determined the facility failed to adhere to accepted professional standards in that they did not follow their policy for storage of fluids in warmers and did not follow manufacturer's recommendations for storage temperature of Mannitol for injection in one	A 491		

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

President + CEO | 08/15/18

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 491	Continued From page 1 (Surgical Services) of two (Surgical Services and Labor and Delivery) areas. By not following policies and manufacturer's recommendations for storage, the facility could not assure the safety and efficacy of the solutions/medication available for patient use. The failed practice had the likelihood to affect all patients having procedures in the facility that required warm fluids and the improperly stored medications. Findings follow: A. Review of the facility's policy titled, "Warmers: Blankets and Fluid," revised on 01/11/18, showed the fluids should be labeled with the removal/expiration date, to identify when they should be removed from the warming cabinet. B. Review of Manufacturer's storage recommendations for Mannitol for injection showed the medication should be stored at room temperature, between 68 and 77 degrees Fahrenheit. C. During a tour of the facility on 07/16/18 from 1:04 PM to 2:50 PM, observation showed the following being stored in a warmer reading 102 degrees Fahrenheit in Surgical Services: 1) Six - 3000 ml (milliliter) bags of Sodium Chloride for irrigation, not labeled with the removal/expiration date on them 2) One - Mannitol 12.5 grams/ 50 ml. C. During an interview on 07/16/18 at 2:45 PM, the Director of Surgical Services verified the fluids were stored without being labeled and the Mannitol was stored in the warmer instead of at room temperature.	A 491	C—2 (a) The Mannitol was removed from the warmer on the day it was discovered by the surveyor and returned to the pharmacy. C—2 (b) Surgical staff failed to follow manufacturer's recommendations and follow policy for storage temperature of Mannitol for injection. An in-service was conducted by the OR Educator concerning the proper storage of Mannitol for injection. C—2 (b) The anesthesia staff were also educated concerning the policy and recommended storage temperature for Mannitol by the Medical Director of Anesthesia. C—2 (c) A sign showing that no medications are allowed in the warmers will be placed by the OR Manager on each of the warmers. C—2 (d) The OR Manager or designee will conduct a weekly audit on each warmer for 12 weeks, starting 8/13/18, then twice a month for 3 months, followed by once a month for six months with 100% compliance expected.	C (2) (a) 7/27/18 C (2) (b) 8/9/18 C(2) (c) 8/17/18 C(2) (c) 8/13/18 C(2) (d) Auditing to begin 8/13/18
A 749	INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(1) The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and	A 749		

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A 749	Continued From page 2 communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, policy and procedure review, and interview, it was determined the Infection Control Nurse failed to identify risks which had the potential to lead to infections in that equipment was not cleaned after patient contact, a refrigerator and a freezer designated to store breast milk was not clean and ready to use, one (portable) of eight bronchoscopes was not stored to prevent cross contamination, and staff were observed not washing their hands after patient contact. Failure to ensure equipment was cleaned after patient use, the nursery refrigerator and freezer were clean, the bronchoscope was hung, and not touching other scopes, and staff washed their hands after patient contact had the potential to allow cross contamination between patients, and staff. The failed practice affected Patient #31, and had the likelihood to affect any patient whose care required the use of the portable bronchoscope, glucometer and any infant whose mother's breast milk was stored in the nursery refrigerator or freezer. Findings follow: A. Review of the policy and procedure titled "Infection Control Guidelines," received from the Infection Control Nurse on 07/18/18, showed employees should perform hand hygiene before and after each patient contact. B. Observation of a finger stick for blood glucose results at 11:00 AM on 07/16/18 showed Patient Care Technician II #1 (PCT #1) lay the bottle of blood glucose strips and the glucometer on the	A 749	A749 Infection Control Program CFR 482.24 (a)(1) A—A review of the policy by the infection control officer revealed no changes that needed to be made. B—(1) The Nursing Policy "Blood Glucose Monitoring" was reviewed. Additional information will be added to the policy concerning proper cleaning of surfaces and the glucometer. B— (2) Additional education will be provided to the staff concerning the proper cleaning of the glucometer and the policy changes. C—(1) The refrigerator and freezer in the nursery designated to store breast milk was immediately cleaned following the findings by the surveyor by the nursery staff. C—(2) Education was provided to the staff by the Clinical Nurse Manager of Maternal Child Services concerning the importance of keeping the refrigerator and freezer clean. C—(3) The Clinical Nurse Manager of Maternal Child Services checked the refrigerator/freezer every day for one week following the initial finding.	A 7/20/18 B(1) 8/31/18 B (2) 8/31/18 C (1) 7/16/18 C (2) 7/16/18 C (3) 7/23/18

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A 749	Continued From page 3 patient's over bed table without cleansing the over bed table first. After the finger stick was obtained, PCT #1 picked the glucometer up and placed it in the basket which contained the thermometer, then picked up the bottle containing the strips and placed them in her uniform pocket. During an interview with PCT #1 at 11:10 AM on 07/16/18 she stated she should have cleaned the glucometer prior to placing it back in the basket and should not have placed the bottle of strips in her pocket because it contaminated her uniform. C. Observation on 07/16/18 at 1:25 PM of the nursery refrigerator designated to store breast milk showed multiple brown stains on three of three door shelves, and one large stain on the bottom shelf of the unit. Observation of the nursery freezer designated to store breast milk showed multiple brown stains on three of three door shelves. The above findings were verified with the Nurse Manager at the time of the observation. D. Observation on 07/16/18 at 2:55 PM of the stored bronchoscopes showed one (small portable battery operated) of eight bronchoscopes was laying on the rack instead of hung in a slot, and was touching the last two bronchoscopes on the right side of the rack. The above findings were verified with Registered Respiratory Therapist #1 at the time of the observation. E. Observation of the pre-operative care of Patient #31 showed the following: Physician #1 completed the pre-operative assessment of Patient #31 which included placing a stethoscope on the patient's chest and back areas, then palpating the areas where an old port was to be	A 749	C—(4) The breast milk refrigerator/freezer will be cleaned weekly by the nursing staff. C—(5) The Clinical Nurse Manager of designee will check the refrigerator/freezer weekly for cleanliness. D—(1) The Director of Respiratory Services examined the storage cabinet and determined that there was appropriate room in the cabinet for the scope to be hung properly. D—(2) Staff in the Bronch Lab were educated by the Director of Respiratory Services concerning proper storage of the scope. D—(3) The Director of Respiratory Services or designee will check weekly to ensure that the scopes are being stored properly. E—(1) Education on hand hygiene was added to the communication on the screens in the physicians lounge. E—(2) Signs will be placed in the Same Day Surgery area to remind all staff of performing proper hand hygiene	C (4) Beginning 7/3/18 C (5) Beginning 7/24/18 D (1) 8/7/18 D (2) 8/7/18 D (3) Beginning 8/14/18 E (1) 7/27/18 E (2) 8/24/18

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A 749	Continued From page 4 removed and a new port inserted. Physician #1 then drew with a skin marker onto the right shoulder of Patient #31. Physician #1 then left the room without performing hand hygiene with hand sanitizer and passed a sink without performing hand hygiene before leaving the area. During an interview with Registered Nurse #2 at 12:15 PM on 07/18/18 the above findings were verified. F. Observation of the pre-operative care of Patient #21 showed the following: Certified Registered Nurse Anesthetist #1 (CRNA) completed the pre-operative assessment of Patient #31 and left the room without performing hand hygiene and passed a sink without performing hand hygiene. CRNA #1 was stopped and asked if hand hygiene was supposed to be performed after patient contact. During an interview with CRNA #1 at 12:40 PM on 07/18/18 he stated he planned to wash his hands once he got to the OR (Operating Room). Based on observation and interview, it was determined the facility failed to ensure only currently dated supplies were available for patient use in two of two crash carts in the ambulatory surgery unit and one of two scrub sink areas toured. Failure to ensure only currently dated supplies were available for patient use had the potential to allow unsterile items to be utilized in patient care. The failed practice had the potential to affect any patient whose care required the use of the expired supplies. Findings follow: A. Observation of the crash cart in the Holding and PACU (Post Anesthesia Care Unit) at 10:15 AM on 07/18/18 showed two of two Multi-Lumen CVC (Cardiovascular) kits with expiration dates of	A 749	F—Education was provided to the Anesthesia staff by the Medical Director of Anesthesia concerning proper hand hygiene. A—(1) The crash cart in the Holding and PACU area of the ambulatory surgery center was immediately serviced and all expired supplies removed following the surveyors findings. A—(2) All crash carts within the JRMC facility will be checked for expired supplies and restocked. A—(3) A new process was developed in which the outside of the crash cart will now be marked with the next expiration date of any item in the cart. Nurses will check this date as well as the medication expiration date when the crash cart checks are completed and return the cart to pharmacy as needed for restocking of expiring items. A—(4) Education on the new process will be provided to the nursing staff.	F 7/24/18 A (1) 7/18/18 A (2) 8/30/18 A (3) 8/30/18 A (4) 8/31/18

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A 749	Continued From page 5 03/31/18 and 06/30/18; and three of three ABG (Arterial Blood Gas) Kits expired 05/18. During an interview with the Director of Surgical Services at 10:20 AM on 07/18/18 the above findings were verified. B. Observation of the two scrub sinks between Operating Room #2 and #4 showed four of four Povidone Scrub brushes lying on the sink which expired 04/18. During an interview with the Ambulatory Surgery Unit Coordinator at 10:35 AM on 07/18/18 the above findings were verified. C. Observation of the Operating Room crash cart showed one of two Multi Lumen CVC kits expired 06/30/18, one of three Intubation Stylet 7.5 mm (millimeter) expired 02/18 and 4 of 8 ABG Line Draw Kits with expiration dates of 01/18, 04/18 and two dated 05/18. During an interview with the Director of Surgical Services at 10:45 AM on 07/18/18 the above findings were verified. Based on review of policy and procedure, annual Infection Control staff training, and physician and allied health credential files, it was determined two (Physician's #10 and #11) of eleven (two Certified Registered Nurse Anesthetists, one Physician's Assistant, and eight physicians) credentialed staff members did not have a current Tuberculosis (TB) test. Failure to ensure all staff had a current TB screening had the potential to allow TB exposure to other staff members, patients and visitors. The failed practice had the likelihood to affect patients, staff and visitors who were in contact with Physicians #10 and #11. Findings follow: A. Review of the policy and procedure titled	A 749	B— (1) All remaining scrub brushes in the ambulatory surgery center were checked following this finding to ensure that no other scrub brushes were expired. Any scrub brushes that were expired were disposed of according to policy. B—(2) Education will be provided to the orderlies responsible for stocking the brushes to reinforce checking for expiration dates as part of the stocking process. C—(1) The crash cart in the Holding and PACU area of the ambulatory surgery center was immediately serviced and all expired supplies removed following the surveyors findings. C—(2) All crash carts within the JRMC facility will be checked for expired supplies and restocked. C—(3) A new process was developed in which the outside of the crash cart will now be marked with the next expiration date of any item in the cart. Nurses will check this date as well as the medication	B (1) 7/18/18 B(2) 8/17/18 C (1) 7/18/18 C (2) 8/30/18

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A 749	Continued From page 6 "Facility Health Program," received from the Regulatory Specialist at 11:50 AM on 07/16/18 showed employment screenings included TB skin test and review of the annual Infection Control training received from the Regulatory Specialist on 07/16/18 showed an annual TB test was required of all employees. B. Review of Physician #10's credential file showed no evidence a TB screening had been performed. During an interview with the Director of Quality and Regulatory at 3:35 PM on 07/17/18 the above findings were verified. C. Review of Physician #11's credential file showed a TB screening performed on 04/11/17 which expired on 04/13/18. During an interview with the Director of Quality and Regulatory at 4:10 PM on 07/17/18 the above findings were verified. Based on review of policy, observation and interview, it was determined the Infection Control Officer failed to identify the unsanitary condition of a patient ice machine in that one of one Outpatient Rehabilitation ice machines had stains and residue on the face of the machine where the cup is placed to receive the ice, and the chute that dispenses the ice had a white residue buildup. The failed practice had the likelihood for ice to become contaminated and could affect any patient receiving ice that had been dispensed from the ice machine. Findings follow. A. Review of the facility's policy titled, "Cleaning and Disinfection of Equipment," revised on 03/18/17, showed ice machines were to be wiped down daily and terminally cleaned by maintenance on an as needed basis. B. During a tour of Outpatient Rehabilitation on 07/18/18 from 10:25 AM to 10:42 AM, the ice	A 749	expiration date when the crash cart checks are completed and return the cart to pharmacy as needed for restocking of expiring items. C—(4) Education on the new process will be provided to the nursing staff. B & C— (1) The Medical Staff Office Coordinator will complete a review of all credentialed staff members to identify any staff members who are out of compliance with the TB testing policy and take steps to ensure that any staff member not in compliance is brought in to compliance. B & C— (2) The Medical Staff Office Coordinator will update the personnel file and the Cactus system accordingly once the staff member is brought in to compliance. B & C— (3) An electronic query of the TB expiration date in Cactus will be created. That query will be used to create an alerting system to the medical staff office staff which will prompt a proactive approach to contacting the credentialed staff member and ensure that the TB policy and procedure for personnel is maintained. The medical staff office will report their compliance	C (3) 8/30/18 C (4) 8/31/18 B&C (1) 9/13/18 B&C (2) 9/13/18

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A 749	Continued From page 7 machine showed stains and residue on the face of the machine where the cup is placed to receive the ice, and the chute that dispenses the ice had a white residue buildup. C. During an interview on 07/18/18 at 10:37 AM, Occupational Therapist #1 verified the stains, residue and white buildup and verified the ice is used for patient's drinks in Outpatient Rehabilitation.	A 749	to the Director of Quality weekly x4 weeks, monthly x2 months and quarterly thereafter. B—(1)The ice machine in the outpatient therapy department was cleaned following the finding by the surveyors on 7/18/18.	B&C (3) 9/13/18 B (1) 7/18/18
A 951	OPERATING ROOM POLICIES CFR(s): 482.51(b) Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care. This STANDARD is not met as evidenced by: Based on policy and procedure review, observation and interview, it was determined the facility failed to follow its policy and procedure and selected national practice guidelines in that it failed to ensure one of one (#1) Surgeon changed his scrubs prior to performing a surgical procedure, one (Pre-operative Area) of two (Pre-operative Area and Operating Room) areas toured failed to follow policy and procedure in that scrub uniforms were being worn outside and back into the Pre-operative Area and one of one employee wore scrub uniform outside and back into the Operating Room (OR) suite. The failed practice had the potential to affect Patient #31 and had the potential to allow contamination into the operative area and the operative suite. Findings follow: A. Review of the policy and procedure titled	A 951	B—(2) The EVS department will be responsible for ensuring that the ice machine is cleaned daily Monday-Friday. A cleaning log has been developed and is located near the ice machine for employees to document when the machine has been cleaned. B—(3) A Outpatient Therapy Tech has been assigned to review the cleaning log daily Monday-Friday for compliance. A 951 Operating Room Policies CFR 482.51(b) A—The "Surgical Attire for Operating and Recovery Rooms" will be amended to remove the Recovery Room and Patient Receiving Area staff from the scrub attire requirements.	B (2) Beginning 7/24/18 B (3) 7/24/18 A 8/31/18

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A 951	Continued From page 8 "Surgical Attire for Operating and Recovery Rooms," received from the Regulatory Specialist at 11:50 AM on 07/16/18 showed the policy pertained to all Operating Room, Recovery Room and Patient Receiving Area staff. Review of the policy showed staff were to wear short sleeved scrub uniforms provided by the laundry and medical and nursing personnel were not to wear attire home or outside the hospital. B. Observation on 07/18/18 at 10:05 AM showed the Director of Surgical Services wore ceil blue scrubs out of the operating suite, outside, across the street to the ambulatory surgery unit, and into the surgical suite. During an interview with Director of Surgical Services at 10:55 AM on 07/18/18 the above findings were verified. C. Observation at 12:05 PM on 07/18/18 showed Physician #1 performing the pre-operative assessment on Patient #31 while wearing navy scrub uniforms. D. Observation from 8:45 AM to 12:45 PM on 07/18/18 showed multiple Pre-Operative Area employees wearing scrub uniforms of various colors. During an interview with Registered Nurse #2 (RN) at 12:20 PM on 07/18/18, RN #2 stated Pre-Operative Area staff scrub uniforms were not furnished and Pre-Operative employees were allowed to wear their own uniforms from home. RN #2 stated OR and Recovery Room employees were furnished scrubs by the facility. E. During an interview with the Director of Surgical Services and RN #1 at 2:45 PM on 07/18/18 both stated OR staff were allowed to launder their scrub uniforms at home and bring them to the facility to change into. The Director of	A 951	B & C—Education will be done with the surgical services staff to reinforce the requirement that scrubs are not to be worn outside of the hospital. D—The "Surgical Attire for Operating and Recovery Rooms" will be amended to remove the Recovery Room and Patient Receiving Area staff from the scrub attire requirements. E— (1) The "Surgical Attire for Operating and Recovery Room" will be amended to show that home laundered scrubs will be allowed in the OR if personnel bring the scrubs from home and change in their respective dressing rooms. E— (2) Education will be provided to the OR staff concerning the policy changes and the new scrub requirements. F— (1) The "Surgical Attire for Operating and Recovery Room" will be amended to show that home laundered scrubs will be allowed in the OR if personnel bring the scrubs from home and change in their respective dressing rooms. F— (2) Education will be provided to the JRMC surgeons concerning the policy changes and the new scrub requirements.	B&C 8/31/18 D 8/31/18 E (1) 8/31/18 E (2) 8/31/18 F (1) 8/31/18 F (2) 8/31/18

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	040071	A. BUILDING _____ B. WING _____	07/20/2018

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A 951	Continued From page 9 Surgical Services stated the national guidelines the facility chose to adhere to was AORN (Association of Perioperative Nurses). Review of the 2018 AORN guidelines received from RN #1 at 2:50 PM on 07/18/18 showed clean surgical attire laundered in a health-care accredited laundry facility should be worn, personal clothing that cannot be contained within the scrub attire should be laundered in a health-care accredited laundry facility, and surgical staff should change into street clothes whenever going outside. F. Observation of Patient #31's surgical procedure on 07/18/18 showed Physician #1 wearing navy scrubs. During an interview with Physician #1 at 3:07 PM on 07/18/18 he was asked where his scrub uniforms were laundered. Physician #1 stated his wife laundered them at home, he put them on and wore them to the facility, which included performing Patient #31's surgical procedure while wearing the scrubs which were laundered at home and worn outside of the facility. G. Review of the 07/18/18 surgical schedule received from the Regulatory Specialist on 07/17/18, showed Physician #1 had seven patients scheduled for surgical procedures and Patient #31 was the third patient, scheduled at 10:45 AM.	A 951	E & F— (3) Random visual inspection of surgical scrubs will be performed by the OR Manager or designee. Any employee/vendor/other personnel required to enter the OR area who appears to not be in compliance with the new policy will be asked to change his/her scrubs or will be provided an outer covering (bunny suit) to wear while in the OR area.	E&F (3) 9/4/18

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A 000	INITIAL COMMENTS An entrance conference was conducted with Facility Representatives at 9:20 AM on 07/16/18. The Representatives were informed the purpose of the visit was to conduct a Medicare recertification survey. An exit conference was conducted with Facility Representatives at 3:25 PM on 07/20/18. The findings of the survey were discussed. The Representatives were given an opportunity to present additional information and none was presented.	A 000		
A 491	PHARMACY ADMINISTRATION CFR(s): 482.25(a) [§482.25 Condition of Participation: Pharmaceutical Services .....The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.] §482.25(a) Standard: Pharmacy Management and Administration The pharmacy or drug storage area must be administered in accordance with accepted professional principles. This STANDARD is not met as evidenced by: Based on review of policy, review of manufacturer's recommendations, observation and interview, it was determined the facility failed to adhere to accepted professional standards in that they did not follow their policy for storage of fluids in warmers and did not follow manufacturer's recommendations for storage temperature of Mannitol for injection in one	A 491		

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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 491	Continued From page 1 (Surgical Services) of two (Surgical Services and Labor and Delivery) areas. By not following policies and manufacturer's recommendations for storage, the facility could not assure the safety and efficacy of the solutions/medication available for patient use. The failed practice had the likelihood to affect all patients having procedures in the facility that required warm fluids and the improperly stored medications. Findings follow: A. Review of the facility's policy titled, "Warmers: Blankets and Fluid," revised on 01/11/18, showed the fluids should be labeled with the removal/expiration date, to identify when they should be removed from the warming cabinet. B. Review of Manufacturer's storage recommendations for Mannitol for injection showed the medication should be stored at room temperature, between 68 and 77 degrees Fahrenheit. C. During a tour of the facility on 07/16/18 from 1:04 PM to 2:50 PM, observation showed the following being stored in a warmer reading 102 degrees Fahrenheit in Surgical Services: 1) Six - 3000 ml (milliliter) bags of Sodium Chloride for irrigation, not labeled with the removal/expiration date on them 2) One - Mannitol 12.5 grams/ 50 ml. C. During an interview on 07/16/18 at 2:45 PM, the Director of Surgical Services verified the fluids were stored without being labeled and the Mannitol was stored in the warmer instead of at room temperature.	A 491		
A 749	INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(1) The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and	A 749		

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A 749	Continued From page 2 communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, policy and procedure review, and interview, it was determined the Infection Control Nurse failed to identify risks which had the potential to lead to infections in that equipment was not cleaned after patient contact, a refrigerator and a freezer designated to store breast milk was not clean and ready to use, one (portable) of eight bronchoscopes was not stored to prevent cross contamination, and staff were observed not washing their hands after patient contact. Failure to ensure equipment was cleaned after patient use, the nursery refrigerator and freezer were clean, the bronchoscope was hung, and not touching other scopes, and staff washed their hands after patient contact had the potential to allow cross contamination between patients, and staff. The failed practice affected Patient #31, and had the likelihood to affect any patient whose care required the use of the portable bronchoscope, glucometer and any infant whose mother's breast milk was stored in the nursery refrigerator or freezer. Findings follow: A. Review of the policy and procedure titled "Infection Control Guidelines," received from the Infection Control Nurse on 07/18/18, showed employees should perform hand hygiene before and after each patient contact. B. Observation of a finger stick for blood glucose results at 11:00 AM on 07/16/18 showed Patient Care Technician II #1 (PCT #1) lay the bottle of blood glucose strips and the glucometer on the	A 749		

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A 749	Continued From page 3 patient's over bed table without cleansing the over bed table first. After the finger stick was obtained, PCT #1 picked the glucometer up and placed it in the basket which contained the thermometer, then picked up the bottle containing the strips and placed them in her uniform pocket. During an interview with PCT #1 at 11:10 AM on 07/16/18 she stated she should have cleaned the glucometer prior to placing it back in the basket and should not have placed the bottle of strips in her pocket because it contaminated her uniform. C. Observation on 07/16/18 at 1:25 PM of the nursery refrigerator designated to store breast milk showed multiple brown stains on three of three door shelves, and one large stain on the bottom shelf of the unit. Observation of the nursery freezer designated to store breast milk showed multiple brown stains on three of three door shelves. The above findings were verified with the Nurse Manager at the time of the observation. D. Observation on 07/16/18 at 2:55 PM of the stored bronchoscopes showed one (small portable battery operated) of eight bronchoscopes was laying on the rack instead of hung in a slot, and was touching the last two bronchoscopes on the right side of the rack. The above findings were verified with Registered Respiratory Therapist #1 at the time of the observation. E. Observation of the pre-operative care of Patient #31 showed the following: Physician #1 completed the pre-operative assessment of Patient #31 which included placing a stethoscope on the patient's chest and back areas, then palpating the areas where an old port was to be	A 749		

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A 749	Continued From page 4 removed and a new port inserted. Physician #1 then drew with a skin marker onto the right shoulder of Patient #31. Physician #1 then left the room without performing hand hygiene with hand sanitizer and passed a sink without performing hand hygiene before leaving the area. During an interview with Registered Nurse #2 at 12:15 PM on 07/18/18 the above findings were verified. F. Observation of the pre-operative care of Patient #21 showed the following: Certified Registered Nurse Anesthetist #1 (CRNA) completed the pre-operative assessment of Patient #31 and left the room without performing hand hygiene and passed a sink without performing hand hygiene. CRNA #1 was stopped and asked if hand hygiene was supposed to be performed after patient contact. During an interview with CRNA #1 at 12:40 PM on 07/18/18 he stated he planned to wash his hands once he got to the OR (Operating Room). Based on observation and interview, it was determined the facility failed to ensure only currently dated supplies were available for patient use in two of two crash carts in the ambulatory surgery unit and one of two scrub sink areas toured. Failure to ensure only currently dated supplies were available for patient use had the potential to allow unsterile items to be utilized in patient care. The failed practice had the potential to affect any patient whose care required the use of the expired supplies. Findings follow: A. Observation of the crash cart in the Holding and PACU (Post Anesthesia Care Unit) at 10:15 AM on 07/18/18 showed two of two Multi-Lumen CVC (Cardiovascular) kits with expiration dates of	A 749		

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A 749	Continued From page 5 03/31/18 and 06/30/18; and three of three ABG (Arterial Blood Gas) Kits expired 05/18. During an interview with the Director of Surgical Services at 10:20 AM on 07/18/18 the above findings were verified. B. Observation of the two scrub sinks between Operating Room #2 and #4 showed four of four Povidone Scrub brushes lying on the sink which expired 04/18. During an interview with the Ambulatory Surgery Unit Coordinator at 10:35 AM on 07/18/18 the above findings were verified. C. Observation of the Operating Room crash cart showed one of two Multi Lumen CVC kits expired 06/30/18, one of three Intubation Stylet 7.5 mm (millimeter) expired 02/18 and 4 of 8 ABG Line Draw Kits with expiration dates of 01/18, 04/18 and two dated 05/18. During an interview with the Director of Surgical Services at 10:45 AM on 07/18/18 the above findings were verified. Based on review of policy and procedure, annual Infection Control staff training, and physician and allied health credential files, it was determined two (Physician's #10 and #11) of eleven (two Certified Registered Nurse Anesthetists, one Physician's Assistant, and eight physicians) credentialed staff members did not have a current Tuberculosis (TB) test. Failure to ensure all staff had a current TB screening had the potential to allow TB exposure to other staff members, patients and visitors. The failed practice had the likelihood to affect patients, staff and visitors who were in contact with Physicians #10 and #11. Findings follow: A. Review of the policy and procedure titled	A 749		

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A 749	Continued From page 6 "Facility Health Program," received from the Regulatory Specialist at 11:50 AM on 07/16/18 showed employment screenings included TB skin test and review of the annual Infection Control training received from the Regulatory Specialist on 07/16/18 showed an annual TB test was required of all employees. B. Review of Physician #10's credential file showed no evidence a TB screening had been performed. During an interview with the Director of Quality and Regulatory at 3:35 PM on 07/17/18 the above findings were verified. C. Review of Physician #11's credential file showed a TB screening performed on 04/11/17 which expired on 04/13/18. During an interview with the Director of Quality and Regulatory at 4:10 PM on 07/17/18 the above findings were verified. Based on review of policy, observation and interview, it was determined the Infection Control Officer failed to identify the unsanitary condition of a patient ice machine in that one of one Outpatient Rehabilitation ice machines had stains and residue on the face of the machine where the cup is placed to receive the ice, and the chute that dispenses the ice had a white residue buildup. The failed practice had the likelihood for ice to become contaminated and could affect any patient receiving ice that had been dispensed from the ice machine. Findings follow. A. Review of the facility's policy titled, "Cleaning and Disinfection of Equipment," revised on 03/18/17, showed ice machines were to be wiped down daily and terminally cleaned by maintenance on an as needed basis. B. During a tour of Outpatient Rehabilitation on 07/18/18 from 10:25 AM to 10:42 AM, the ice	A 749		

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A 749	Continued From page 7 machine showed stains and residue on the face of the machine where the cup is placed to receive the ice, and the chute that dispenses the ice had a white residue buildup. C. During an interview on 07/18/18 at 10:37 AM, Occupational Therapist #1 verified the stains, residue and white buildup and verified the ice is used for patient's drinks in Outpatient Rehabilitation.	A 749		
A 951	OPERATING ROOM POLICIES CFR(s): 482.51(b) Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care. This STANDARD is not met as evidenced by: Based on policy and procedure review, observation and interview, it was determined the facility failed to follow its policy and procedure and selected national practice guidelines in that it failed to ensure one of one (#1) Surgeon changed his scrubs prior to performing a surgical procedure, one (Pre-operative Area) of two (Pre-operative Area and Operating Room) areas toured failed to follow policy and procedure in that scrub uniforms were being worn outside and back into the Pre-operative Area and one of one employee wore scrub uniform outside and back into the Operating Room (OR) suite. The failed practice had the potential to affect Patient #31 and had the potential to allow contamination into the operative area and the operative suite. Findings follow: A. Review of the policy and procedure titled	A 951		

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A 951	Continued From page 8 "Surgical Attire for Operating and Recovery Rooms," received from the Regulatory Specialist at 11:50 AM on 07/16/18 showed the policy pertained to all Operating Room, Recovery Room and Patient Receiving Area staff. Review of the policy showed staff were to wear short sleeved scrub uniforms provided by the laundry and medical and nursing personnel were not to wear attire home or outside the hospital. B. Observation on 07/18/18 at 10:05 AM showed the Director of Surgical Services wore ceil blue scrubs out of the operating suite, outside, across the street to the ambulatory surgery unit, and into the surgical suite. During an interview with Director of Surgical Services at 10:55 AM on 07/18/18 the above findings were verified. C. Observation at 12:05 PM on 07/18/18 showed Physician #1 performing the pre-operative assessment on Patient #31 while wearing navy scrub uniforms. D. Observation from 8:45 AM to 12:45 PM on 07/18/18 showed multiple Pre-Operative Area employees wearing scrub uniforms of various colors. During an interview with Registered Nurse #2 (RN) at 12:20 PM on 07/18/18, RN #2 stated Pre-Operative Area staff scrub uniforms were not furnished and Pre-Operative employees were allowed to wear their own uniforms from home. RN #2 stated OR and Recovery Room employees were furnished scrubs by the facility. E. During an interview with the Director of Surgical Services and RN #1 at 2:45 PM on 07/18/18 both stated OR staff were allowed to launder their scrub uniforms at home and bring them to the facility to change into. The Director of	A 951		

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A 951	Continued From page 9 Surgical Services stated the national guidelines the facility chose to adhere to was AORN (Association of Perioperative Nurses). Review of the 2018 AORN guidelines received from RN #1 at 2:50 PM on 07/18/18 showed clean surgical attire laundered in a health-care accredited laundry facility should be worn, personal clothing that cannot be contained within the scrub attire should be laundered in a health-care accredited laundry facility, and surgical staff should change into street clothes whenever going outside. F. Observation of Patient #31's surgical procedure on 07/18/18 showed Physician #1 wearing navy scrubs. During an interview with Physician #1 at 3:07 PM on 07/18/18 he was asked where his scrub uniforms were laundered. Physician #1 stated his wife laundered them at home, he put them on and wore them to the facility, which included performing Patient #31's surgical procedure while wearing the scrubs which were laundered at home and worn outside of the facility. G. Review of the 07/18/18 surgical schedule received from the Regulatory Specialist on 07/17/18, showed Physician #1 had seven patients scheduled for surgical procedures and Patient #31 was the third patient, scheduled at 10:45 AM.	A 951		

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K 000	INITIAL COMMENTS On 07/16/18 at 9:20 AM, an entrance conference was conducted with Facility Representatives. The Representatives were informed the purpose of the visit was to conduct a Medicare recertification survey. On 07/17/18 at 3:00 PM, an exit conference was conducted with Facility Representatives. The facility was notified no Life Safety Code deficiencies were cited. The facility was in compliance with the provisions of the Life Safety Code (NFPA 101, 2012 Edition).	K 000		

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	040071	A. BUILDING _____ B. WING _____	07/17/2018

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
E 000	Initial Comments On 07/16/18 at 9:20 AM, an entrance conference was conducted with Facility Representatives. The facility was informed the purpose of the visit was to conduct a Medicare recertification survey. On 07/17/18 at 3:00 PM, an exit conference was conducted with Facility Representatives. The findings of the survey were discussed. The Facility Representatives were informed no Emergency Preparedness deficiencies were cited. The facility was in compliance with 42 CFR 482.15 Condition of Participation: Emergency preparedness.	E 000		

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.