PRINTED: 08/20/2018 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES OF CORRECTION			(X3) DATE SURVEY COMPLETED			
		040071	B. WING			R 08/20/2018	
NAME OF PROVIDER OR SUPPLIER  JEFFERSON REGIONAL MEDICAL CENTER				1	BTREET 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 PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOUL		) 13년	(X5) COMPLETION DATE
{A 000}	A desk review revis 08/20/18 for all prev 07/20/18. All deficie and no new non-col	sit survey was conducted on vious deficiencies cited on encies have been corrected mpliance was found. The lance with 42 CFR Part 482,	{A 0	00}			
		, toophean					
-							
-							
ABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		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.

PRINTED: 08/02/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		040071	B. WING_		07/20/2018
	PROVIDER OR SUPPLIER SON REGIONAL MED	ICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 WEST 40TH AVENUE PINE BLUFF, AR 71603	,
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	MUST BEPRECEDET BY FULL VI US SCIDENTIFM CHIFORMATION)	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION
A 491	An entrance conference Facility Representative of the visit was to correcertification survers. An exit conference Representatives at findings of the surversentatives we present additional inpresented. PHARMACY ADMIL CFR(s): 482.25(a)  [§482.25 Condition Pharmaceutical Semman and proced minimize drug error delegated to the hopharmaceutical semman and Administration The pharmacy or dradministered in accepted profession This STANDARD is Based on review of manufacturer's recond interview, it was to adhere to accept	rence was conducted with tives at 9:20 AM on 07/16/18. It is swere informed the purpose onduct a Medicare by.  was conducted with Facility 3:25 PM on 07/20/18. The ey were discussed. The ey were discussed. The ere given an opportunity to information and none was NISTRATION  of Participation: rices ff is responsible for developing ures that is. This function may be spital's organized vice.]  d: Pharmacy Management rug storage area must be ordance with nal principles. Is not met as evidenced by: If policy, review of ommendations, observation is determined the facility failed ed professional standards in	A 49	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 be on manufacturer's recommendation C—1(a) All fluids were checked following the finding by the state surveyor and any solutions that we dated per policy were removed from warmer.  C—1 (b) Surgical staff failed to fol manufacturer's recommendations a follow policy for storage of fluids i warmer. An in-service was conduct the OR Educator concerning the was cabinet policy and the proper storage labeling of fluids.  C—1 (c) A sign addressing the propagate in the OR fluid warmer by to OR Manager or designee.  C—1 (d) The OR Manager or designed warmer for 12 weeks, starting 8/13/then twice a month for 3 months, followed by once a month for six metals.	ased ased A 7/27/18 as.  The not as a C (1)(a) 7/23/18  Low and an the ased by armer as and C (1)(b) 8/9/18  The company of the ase as a C (1)(c) 8/13/18  The company of the ase as a C (1) (d) Auditing to begin
	fluids in warmers ar manufacturer's reco temperature of Man	ommendations for storage unitol for injection in one	·	with 100% compliance expected.	
LABORATOR'	Y DIRECTOR'S OR PROVID	ERISUPALIER REPRESENTATIVE'S SIGI	NATURE	TITLE	(X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		040071	B. WING		07/20/2018	
	PROVIDER OR SUPPLIER  SON REGIONAL MED	ICAL CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 WEST 40TH AVENUE PINE BLUFF, AR 71603		
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A 491	Labor and Delivery) policies and manufa storage, the facility and efficacy of the s for patient use. The	ge 1 of two (Surgical Services and areas. By not following acturer's recommendations for could not assure the safety solutions/medication available failed practice had the all patients having procedures	A 491	from the warmer on the day it was discovered by the surveyor and ret to the pharmacy.  C-2 (b) Surgical staff failed to fo manufacturer's recommendations.	C (2) (a) 7/27/18 billow and	
	in the facility that re improperly stored m A. Review of the fa Blankets and Fluid, the fluids should be removal/expiration of	quired warm fluids and the nedications. Findings follow: cility's policy titled, "Warmers: ' revised on 01/11/18, showed labeled with the date, to identify when they		follow policy for storage temperate Mannitol for injection. An in-service conducted by the OR Educator concerning the proper storage of Mannitol for injection.	ure of ice was C (2) (b) 8/9/18	
,	B. Review of Manu recommendations for showed the medical temperature, betwee Fahrenheit. C. During a tour of	or Mannitol for injection tion should be stored at room en 68 and 77 degrees the facility on 07/16/18 from		C—2 (b) The anesthesia staff were educated concerning the policy and recommended storage temperature Mannitol by the Medical Director Anesthesia.	d for	
	following being stord degrees Fahrenheit 1) Six - 3000 ml (m Chloride for irrigatio	, observation showed the ed in a warmer reading 102 in Surgical Services: illiliter) bags of Sodium not labeled with the		C—2 (c) A sign showing that no medications are allowed in the war will be placed by the OR Manager each of the warmers.	rmers on C(2) (c) 8/13/18	
A 749	the Director of Surg were stored without	2.5 grams/ 50 ml. iew on 07/16/18 at 2:45 PM, ical Services verified the fluids being labeled and the I in the warmer instead of at ROL PROGRAM	A 749	C—2 (d) The OR Manager or design will conduct a weekly audit on each warmer for 12 weeks, starting 8/13 then twice a month for 3 months, followed by once a month for six month 100% compliance expected.	C(2) (d) Auditing to	
	develop a system for	l officer or officers must or identifying, reporting, ontrolling infections and				

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A 749	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		A 7	'49	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.		A 7/20/18
	review, and intervient infection Control N which had the pote equipment was not a refrigerator and a breast milk was not (portable) of eight	ew, it was determined the urse failed to identify risks ential to lead to infections in that t cleaned after patient contact, a freezer designated to store at clean and ready to use, one bronchoscopes was not stored			B—(1) The Nursing Policy "Blood Glucose Monitoring" was reviewed Additional information will be adde the policy concerning proper clean surfaces and the glucometer.	ed to	B(1) 8/31/18
	observed not wash contact. Failure to cleaned after patie and freezer were c hung, and not touc	ontamination, and staff were ning their hands after patient ensure equipment was nt use, the nursery refrigerator lean, the bronchoscope was hing other scopes, and staff	·		B— (2) Additional education will be provided to the staff concerning the proper cleaning of the glucometer the policy changes.	e	B (2) 8/31/18
	potential to allow c patients, and staff. Patient #31, and ha patient whose care portable bronchose	s after patient contact had the ross contamination between The failed practice affected ad the likelihood to affect any required the use of the cope, glucometer and any er's breast milk was stored in			C—(1) The refrigerator and freezer the nursery designated to store bre milk was immediately cleaned follo the findings by the surveyor by the nursery staff.	east wing	C (1) 7/16/18
	follow:  A. Review of the polynomial Control Control Ninfection Control N	pater or freezer. Findings  policy and procedure titled  Suidelines," received from the urse on 07/18/18, showed		,	C—(2) Education was provided to t staff by the Clinical Nurse Manager Maternal Child Services concerning importance of keeping the refrigera and freezer clean.	of the	C (2) 7/16/18
	and after each pati B. Observation of a results at 11:00 AM Care Technician II	perform hand hygiene before ent contact.  a finger stick for blood glucose on 07/16/18 showed Patient #1 (PCT #1) lay the bottle of s and the glucometer on the			C—(3) The Clinical Nurse Manager of Maternal Child Services checked the refrigerator/freezer every day for oweek following the initial finding.	e	C (3) 7/23/18

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,	PROVIDER OR SUPPLIER SON REGIONAL MED	· ·	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 WEST 40TH AVENUE PINE BLUFF, AR 71603	1 2//22/22
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION
A 749	patient's over bed to over bed table first. obtained, PCT #1 placed it in the bas thermometer, then the strips and placed During an interview 07/16/18 she stated glucometer prior to	table without cleansing the After the finger stick was picked the glucometer up and sket which contained the picked up the bottle containing ed them in her uniform pocket. It with PCT #1 at 11:10 AM on d she should have cleaned the placing it back in the basket	. A 749	C—(4) The breast milk refrigerator/freezer will be cleaned weekly by the nursing staff.  C—(5) The Clinical Nurse Manager designee will check the refrigerator/freezer weekly for cleanliness.	7/3/18
	C. Observation on unursery refrigerator milk showed multip three door shelves, bottom shelf of the nursery freezer des showed multiple brodoor shelves. The a	ve placed the bottle of strips in e it contaminated her uniform.  07/16/18 at 1:25 PM of the r designated to store breast ble brown stains on three of , and one large stain on the unit. Observation of the signated to store breast milk rown stains on three of three above findings were verified mager at the time of the		D—(1) The Director of Respiratory Services examined the storage cab and determined that there was appropriate room in the cabinet fo scope to be hung properly.  D—(2) Staff in the Bronch Lab were educated by the Director of Respira Services concerning proper storage the scope.	inet
	D. Observation on a stored bronchoscopes was hung in a slot, and bronchoscopes on above findings were	07/16/18 at 2:55 PM of the pes showed one (small erated) of eight is laying on the rack instead of was touching the last two the right side of the rack. The re verified with Registered pist #1 at the time of the		D—(3) The Director of Respiratory Services or designee will check wee to ensure that the scopes are being stored properly.  E—(1) Education on hand hygiene added to the communication on the screens in the physicians lounge.	8/14/18 was E (1)
	Patient #31 showed completed the pre- Patient #31 which it on the patient's che	he pre-operative care of d the following: Physician #1 operative assessment of included placing a stethoscope est and back areas, then s where an old port was to be		E—(2) Signs will be placed in the Sa Day Surgery area to remind all staf performing proper hand hygiene	l .

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DAT CON	(X3) DATE SURVEY COMPLETED	
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A 749	removed and a new then drew with a sk shoulder of Patient room without perfor sanitizer and passe hand hygiene befor interview with Regis on 07/18/18 the about F. Observation of the Patient #21 showed Registered Nurse A completed the pre-Cepatient #31 and left hand hygiene and performing hand hy and asked if hand hygiene and performed after pat interview with CRN/he stated he planned got to the OR (Open Based on observation determined the facilic currently dated suppuse in two of two crasurgery unit and one toured. Failure to esupplies were available potential to allow unpatient care. The fato affect any patient of the expired supple A. Observation of the and PACU (Post And AM on 07/18/18 shows and patient should be supple to the expired supple A. Observation of the and PACU (Post And AM on 07/18/18 shows and patient should be supple to the expired supple to the expir	in marker onto the right #31. Physician #1 then left the ming hand hygiene with hand d a sink without performing e leaving the area. During an stered Nurse #2 at 12:15 PM ove findings were verified.  The pre-operative care of I the following: Certified anesthetist #1 (CRNA) operative assessment of the room without performing rassed a sink without giene. CRNA #1 was stopped hygiene was supposed to be lient contact. During an A #1 at 12:40 PM on 07/18/18 and to wash his hands once he	A 74	F—Education was provided to the Anesthesia staff by the Medical of Anesthesia concerning proper hygiene.  A—(1) The crash cart in the Hold PACU area of the ambulatory surcenter was immediately serviced expired supplies removed follow surveyors findings.  A—(2) All crash carts within the facility will be checked for expired supplies and restocked.  A—(3) A new process was develow which the outside of the crash cannow be marked with the next extended and return check this date as well as the meexpiration date when the crash of checks are completed and return cart to pharmacy as needed for restocking of expiring items.  A—(4) Education on the new prowill be provided to the nursing states.	ing and ing and all ing the in	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	03/31/18 and 06/30 (Arterial Blood Gas an interview with that 10:20 AM on 07/verified.  B. Observation of the Operating Room #2 Povidone Scrub bruexpired 04/18. Durit Ambulatory Surgery on 07/18/18 the above 06/30/18, one of the C. Observation of the showed one of two 06/30/18, one of the (millimeter) expired Draw Kits with expirand two dated 05/13 the Director of Surg 07/18/18 the above Based on review of Infection Control standing health credent two (Physician's #10 Certified Registered Physician's Assistance Central ed staff of Tuberculosis (TB) thad a current TB scallow TB exposure patients and visitors likelihood to affect pwere in contact with Findings follow:	ge 5 /18; and three of three ABG ) Kits expired 05/18. During e Director of Surgical Services 18/18 the above findings were he two scrub sinks between 2 and #4 showed four of four ishes lying on the sink which hig an interview with the y Unit Coordinator at 10:35 AM ove findings were verified. he Operating Room crash cart Multi Lumen CVC kits expired ree Intubation Stylet 7.5 mm 02/18 and 4 of 8 ABG Line ration dates of 01/18, 04/18 B. During an interview with hical Services at 10:45 AM on findings were verified.  policy and procedure, annual aff training, and physician and tial files, it was determined 0 and #11) of eleven (two d Nurse Anesthetists, one ht, and eight physicians) hembers did not have a current est. Failure to ensure all staff breening had the potential to to other staff members, s. The failed practice had the postients, staff and visitors who of Physicians #10 and #11.  licy and procedure titled	Α7	<b>'49</b>	B— (1) All remaining scrub brushes the ambulatory surgery center wer checked following this finding to er that no other scrub brushes were expired. Any scrub brushes that we expired were disposed of according policy.  B—(2) Education will be provided torderlies responsible for stocking the brushes to reinforce checking for expiration dates as part of the stock process.  C—(1) The crash cart in the Holding PACU area of the ambulatory surge center was immediately serviced at expired supplies removed following surveyors findings.  C—(2) All crash carts within the JRM facility will be checked for expired supplies and restocked.  C—(3) A new process was developed which the outside of the crash cart now be marked with the next expired ate of any item in the cart. Nurses check this date as well as the medical expectation of the crash cart.	ensure ere g to o the he king g and ery nd all g the will ation will	B (1) 7/18/18  B(2) 8/17/18  C (1) 7/18/18  C (2) 8/30/18

	EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION.  A. BUILDING			(X3) DATE SURVEY COMPLETED			
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A 749	Continued From pa "Facility Health Pro Regulatory Specials showed employme test and review of t training received fro on 07/16/18 showe required of all employme B. Review of Physic showed no evidence performed. During of Quality and Regulate above findings C. Review of Physic showed a TB scree which expired on 0- with the Director of PM on 07/17/18 the Based on review of interview, it was de Officer failed to ide a patient ice machil Outpatient Rehabili and residue on the cup is placed to rec that dispenses the	age 6 gram," received from the ist at 11:50 AM on 07/16/18 int screenings included TB skin the annual Infection Control om the Regulatory Specialist d an annual TB test was loyees.  cian #10's credential file the a TB screening had been an interview with the Director ulatory at 3:35 PM on 07/17/18	A 74	DEFICIENCY)	cart in the ocess taff. fice ew of all lentify of colicy y staff ought in fice connel dingly at in to	C (3) 8/30/18 C (4) 8/31/18 B&C (1) 9/13/18 B&C (2) 9/13/18	
	ice to become cont	aminated and could affect any ethat had been dispensed		That query will be used to create alerting system to the medical st office staff which will prompt a	an an		
	and Disinfection of 03/18/17, showed in down daily and term maintenance on an B. During a tour of			proactive approach to contacting credentialed staff member and e that the TB policy and procedure personnel is maintained. The me staff office will report their comp	ensure for dical		

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A 749	machine showed stoof the machine whethe ice, and the chua white residue buil C. During an intervi Occupational There residue and white bused for patient's direction.  OPERATING ROO CFR(s): 482.51(b)  Surgical services mand resources. Poi must be designed to maintenance of high practice and patients.	ains and residue on the face are the cup is placed to receive ate that dispenses the ice had dup.  ew on 07/18/18 at 10:37 AM, apist #1 verified the stains, audidup and verified the ice is rinks in Outpatient  M POLICIES  The consistent with needs icies governing surgical care to assure the achievement and the standards of medical	A 749	to the Director of Quality weekly xweeks, monthly x2 months and quarterly thereafter.  B—(1)The ice machine in the output therapy department was cleaned following the finding by the survey on 7/18/18.  B—(2) The EVS department will be responsible for ensuring that the ice machine is cleaned daily Monday-FA cleaning log has been developed is located near the ice machine for employees to document when the machine has been cleaned.	etient ors e riday. and	B&C (3) 9/13/18 B (1) 7/18/18 B (2) Beginning 7/24/18
	Based on policy an observation and interfacility failed to follo and selected nation failed to ensure one his scrubs prior to procedure, one (Pre-operative Area toured failed to follo scrub uniforms were into the Pre-operative employee wore scrub into the Operating Foractice had the potention the operative area a Findings follow:	s not met as evidenced by: ad procedure review, erview, it was determined the w its policy and procedure al practice guidelines in that it of one (#1) Surgeon changed beforming a surgical e-operative Area) of two and Operating Room) areas w policy and procedure in that e being worn outside and back ve Area and one of one ub uniform outside and back Room (OR) suite. The failed tential to affect Patient #31 al to allow contamination into and the operative suite.		B—(3) A Outpatient Therapy Tech I been assigned to review the cleaning 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 amend to remove the Recovery Room and Patient Receiving Area staff from the scrub attire requirements.	ng log e. ng nded	B (3) 7/24/18 A 8/31/18

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
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A 951	Continued From paragrams and Patient Received for at 11:50 AM on 07/pertained to all Operand Patient Received policy showed staff scrub uniforms promedical and nursing attire home or outsing attire home or outsing scrubs out of the operation of the Director of Surgical scrubs out of the amount of the surgical suite. Director of Surgical 07/18/18 the above C. Observation at 1 Physician #1 perform assessment on Pat scrub uniforms.  D. Observation from 07/18/18 showed memployees wearing colors. During an in #2 (RN) at 12:20 Pt Pre-Operative Area	ge 8 Deprating and Recovery rom the Regulatory Specialist 16/18 showed the policy erating Room, Recovery Room ing Area staff. Review of the were to wear short sleeved vided by the laundry and g personnel were not to wear	A 9			th the the to be ting ended to swill bring	B&C 8/31/18 D 8/31/18 E (1) 8/31/18 E (2) 8/31/18
·	RN #2 stated OR a employees were full E. During an intervi Surgical Services a 07/18/18 both state launder their scrub	ir own uniforms from home.  Ind Recovery Room  Inished scrubs by the facility.  In with the Director of  Ind RN #1 at 2:45 PM on  Ind OR staff were allowed to  Indiforms at home and bring  In co change into. The Director of		J	their respective dressing rooms.  F— (2) Education will be provided JRMC surgeons concerning the pochanges and the new scrub requirements.		F (2) 8/31/18

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	PROVIDER OR SUPPLIER BON REGIONAL MED		[ ,	STREET ADDRESS, CITY, STATE, ZIP COD 1600 WEST 40TH AVENUE PINE BLUFF, AR 71603			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOCK CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETION DATE	
A 951	Surgical Services s the facility chose to (Association of Per the 2018 AORN gu at 2:50 PM on 07/1 attire laundered in laundry facility sho that cannot be con- should be laundered laundry facility, and into street clothes of	age 9 stated the national guidelines of adhere to was AORN rioperative Nurses). Review of suidelines received from RN #1 8/18 showed clean surgical a health-care accredited suid be worn, personal clothing tained within the scrub attire and in a health-care accredited is surgical staff should change whenever going outside.	A 951	E & F— (3) Random visual inspesurgical scrubs will be performed. OR Manager or designee. Any employee/vendor/other person required to enter the OR area appears to not be in compliant the new policy will be asked to his/her scrubs or will be provide outer covering (bunny suit) to while in the OR area.	ed by the nnel who e with change ed an	E&F (3) 9/4/18	
	procedure on 07/18 wearing navy scruk Physician #1 at 3:0 asked where his so Physician #1 stated home, he put them facility, which inclusingical procedure	8/18 showed Physician #1 bs. During an interview with by PM on 07/18/18 he was crub uniforms were laundered. d his wife laundered them at on and wore them to the ded performing Patient #31's while wearing the scrubs red at home and worn outside					
	received from the F 07/17/18, showed I patients scheduled	07/18/18 surgical schedule Regulatory Specialist on Physician #1 had seven for surgical procedures and e third patient, scheduled at					

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				3) DATE SURVEY COMPLETED			
	. <b>040071</b> B. V		B. WING_		07	07/20/2018	
	PROVIDER OR SUPPLIER SON REGIONAL MED	DICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP O 1600 WEST 40TH AVENUE PINE BLUFF, AR 71603			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
A 000	INITIAL COMMEN	тѕ	A 00	00			
	Facility Representa						
A 491	Representatives at findings of the survinger Representatives we	was conducted with Facility 3:25 PM on 07/20/18. The ey were discussed. The ere given an opportunity to nformation and none was	A 49	91			
	policies and proced	rvices  ff is responsible for developing lures that s. This function may be spital's organized					
	and Administration The pharmacy or di administered in acc accepted profession This STANDARD is Based on review of manufacturer's reco and interview, it was to adhere to accept that they did not foll fluids in warmers ar	nal principles. s not met as evidenced by: f policy, review of ommendations, observation s determined the facility failed ed professional standards in ow their policy for storage of					
LABORATORY	temperature of Man	ommendations for storage initol for injection in one DER/SUPPLIER REPRESENTATIVE'S SIG	MATURE	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ID		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		040071	B. WING		07.	/20/2018	
	PROVIDER OR SUPPLIER SON REGIONAL MED	ICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 1600 WEST 40TH AVENUE PINE BLUFF, AR 71603			
(X4) ID PREFIX TAG	(EACH DEFICIÈNCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X6) COMPLETION DATE	
A 749	Labor and Delivery, policies and manufastorage, the facility and efficacy of the storage, the facility and efficacy of the stored to affect a in the facility that reimproperly stored m. Review of the fa Blankets and Fluid, the fluids should be removal/expiration should be removal be removed B. Review of Manurecommendations f showed the medica temperature, betwee Fahrenheit.  C. During a tour of 1:04 PM to 2:50 PM following being stored egrees Fahrenheit.  C. During an intervithe Director of Surgivere stored without Mannitol was stored room temperature.	of two (Surgical Services and areas. By not following acturer's recommendations for could not assure the safety solutions/medication available failed practice had the all patients having procedures quired warm fluids and the nedications. Findings follow wellity's policy titled, "Warmers: " revised on 01/11/18, showed labeled with the date, to identify when they from the warming cabinet. facturer's storage or Mannitol for injection tion should be stored at room en 68 and 77 degrees  the facility on 07/16/18 from 1, observation showed the ed in a warmer reading 102 in Surgical Services: illililiter) bags of Sodium on, not labeled with the date on them 2.5 grams/ 50 ml. iew on 07/16/18 at 2:45 PM, ical Services verified the fluids being labeled and the lin the warmer instead of at ROL PROGRAM	A 49				
	The infection contro develop a system for	ol officer or officers must or identifying, reporting, ontrolling infections and					

	INCOLUCIO INITERIO INTERIO INT	O MILLYIOPTIA OLITAIOLO			ON CHAIN	. 0930-0391	
	TATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
		040071	B. WING	·	07/	07/20/2018	
	PROVIDER OR SUPPLIER SON REGIONAL MED	ICAL CENTER	16	FREET ADDRESS, CITY, STATE, ZIP CO 500 WEST 40TH AVENUE INE BLUFF, AR 71603			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID , PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
A 749	Continued From pa communicable dise personnel.	ge 2 ases of patients and	A 749				
	Based on observat review, and intervie Infection Control Nu which had the poter equipment was not a refrigerator and a breast milk was not (portable) of eight b to prevent cross corobserved not washi contact. Failure to cleaned after patien and freezer were ck hung, and not touch washed their hands potential to allow cropatients, and staff. Patient #31, and hapatient whose care portable bronchose infant whose mother	ion, policy and procedure w, it was determined the arse failed to identify risks intial to lead to infections in that cleaned after patient contact, freezer designated to store clean and ready to use, one ronchoscopes was not stored intamination, and staff were interest equipment was it use, the nursery refrigerator ean, the bronchoscope was ining other scopes, and staff after patient contact had the coss contamination between the failed practice affected in the likelihood to affect any required the use of the ope, glucometer and any its breast milk was stored in after or freezer. Findings					
	"Infection Control G Infection Control Nu employees should p and after each patie						
	results at 11:00 AM Care Technician II #	finger stick for blood glucose on 07/16/18 showed Patient 1 (PCT #1) lay the bottle of			·	·	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		040071	B. WING_		07	/20/2018	
	PROVIDER OR SUPPLIER SON REGIONAL IMED	ICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1600 WEST 40TH AVENUE PINE BLUFF, AR 71603			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
A 749	over bed table first. obtained, PCT #1 p placed it in the basl thermometer, then the strips and place During an interview 07/16/18 she stated glucometer prior to and should not have her pocket because C. Observation on (nursery refrigerator milk showed multiple three door shelves, bottom shelf of the nursery freezer des showed multiple brodoor shelves. The a	ge 3 able without cleansing the After the finger stick was icked the glucometer up and ket which contained the picked up the bottle containing d them in her uniform pocket. with PCT#1 at 11:10 AM on I she should have cleaned the placing it back in the basket e placed the bottle of strips in a it contaminated her uniform.  17/16/18 at 1:25 PM of the designated to store breast the brown stains on three of and one large stain on the unit. Observation of the ignated to store breast milk own stains on three of three ager at the time of the	A 74	19			
	stored bronchoscop portable battery ope bronchoscopes was hung in a slot, and v bronchoscopes on t above findings were	or/16/18 at 2:55 PM of the es showed one (small prated) of eight laying on the rack instead of was touching the last two he right side of the rack. The everified with Registered st #1 at the time of the					
	Patient #31 showed completed the pre-ceptient #31 which in on the patient's chee	e pre-operative care of the following: Physician #1 perative assessment of cluded placing a stethoscope st and back areas, then where an old port was to be					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		040071	B. WING	د المراجع و المر	07	07/20/2018	
NAME OF PROVIDER OR SUPPLIER  JEFFERSON REGIONAL MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP O 1600 WEST 40TH AVENUE PINE BLUFF, AR 71603			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COI ( EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
A 749	then drew with a sk shoulder of Patient room without perform sanitizer and passe hand hygiene beform interview with Registion 07/18/18 the about F. Observation of the Patient #21 showed Registered Nurse Accompleted the pre- Patient #31 and left hand hygiene and performing hand hy and asked if hand hy and asked if hand hy interview with CRN	v port inserted. Physician #1 in marker onto the right #31. Physician #1 then left the ming hand hygiene with hand id a sink without performing the leaving the area. During an stered Nurse #2 at 12:15 PM tove findings were verified.  The pre-operative care of the following: Certified the following: Certified the following: Certified the room without performing the pre-operative care of the following: Certified the fo	Α7	49			
	determined the faci currently dated sup use in two of two cr surgery unit and on toured. Failure to a supplies were avail potential to allow ur patient care. The fact to affect any patient of the expired supplied. A. Observation of the and PACU (Post Ar AM on 07/18/18 she	on and interview, it was lity failed to ensure only plies were available for patient ash carts in the ambulatory e of two scrub sink areas ensure only currently dated able for patient use had the esterile items to be utilized in alled practice had the potential t whose care required the use lies. Findings follow:  ne crash cart in the Holding esthesia Care Unit) at 10:15 bowed two of two Multi-Lumen ary kits with expiration dates of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DAT COM	(X3) DATE SURVEY COMPLETED		
		040071	B. WING	·		07/	20/2018	
	PROVIDER OR SUPPLIER SON REGIONAL MED	ICAL 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 SCIDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORE	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULI RENCED TO THE APPROF DEFICIENCY)	SHOULD BE COM		
A 749	(Arterial Blood Gas an interview with the	ge 5 /18; and three of three ABG ) Kits expired 05/18. During e Director of Surgical Services 18/18 the above findings were	Α7	49				
	Operating Room #2 Povidone Scrub bru expired 04/18. Durid Ambulatory Surgery	ne two scrub sinks between 2 and #4 showed four of four ishes lying on the sink which ng an interview with the 7 Unit Coordinator at 10:35 AM ove findings were verified.						
	showed one of two 06/30/18, one of thr (millimeter) expired Draw Kits with expired and two dated 05/18 the Director of Surg	ne Operating Room crash cart Multi Lumen CVC kits expired ree Intubation Stylet 7.5 mm 02/18 and 4 of 8 ABG Line ration dates of 01/18, 04/18 B. During an interview with ical Services at 10:45 AM on findings were verified.			·			
	Infection Control sta allied health creden two (Physician's #10 Certified Registered Physician's Assistan credentialed staff m Tuberculosis (TB) to had a current TB so allow TB exposure to patients and visitors likelihood to affect p	policy and procedure, annual aff training, and physician and tial files, it was determined 0 and #11) of eleven (two I Nurse Anesthetists, one and and eight physicians) tembers did not have a current est. Failure to ensure all staff treening had the potential to to other staff members, and the patients, staff and visitors who Physicians #10 and #11.						
	A. Review of the po-	licv and procedure titled						

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLIETED	
•		040071	B. WING		07	12012040	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C		/20/2018	
a see halled been be		MOAL OF NEW POR		1600 WEST 40TH AVENUE			
JEFFER	SON REGIONAL MEI	DICAL CENTER	İ	PINE BLUFF, AR 71603			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
A 749	Continued From p	age 6	A 74	19			
	"Facility Health Pro Regulatory Special showed employmentest and review of training received from	ogram," received from the list at 11:50 AM on 07/16/18 ent screenings included TB skin the annual Infection Control rom the Regulatory Specialist ed an annual TB test was					
	showed no evidence performed. During	ician #10's credential file ce a TB screening had been an interview with the Director julatory at 3:35 PM on 07/17/18 were verified					
	showed a TB scree which expired on 0 with the Director of PM on 07/17/18 th Based on review o interview, it was de Officer failed to ide	ician #11's credential file ening performed on 04/11/17 04/13/18. During an interview of Quality and Regulatory at 4:10 e above findings were verified. of policy, observation and extermined the Infection Control entify the unsanitary condition of					
	Outpatient Rehabil and residue on the cup is placed to re- that dispenses the buildup. The failed ice to become con- patient receiving ic	ine in that one of one litation ice machines had stains a face of the machine where the ceive the ice, and the chute ice had a white residue practice had the likelihood for taminated and could affect any the that had been dispensed ne. Findings follow.					
	and Disinfection of 03/18/17, showed in down daily and term maintenance on ar B. During a tour of			-			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		040071	B. WING		07	/20/2018	
	PROVIDER OR SUPPLIER	ICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1600 WEST 40TH AVENUE PINE BLUFF, AR 71603			
(X4) IĐ PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
A 749	of the machine whe the ice, and the chu a white residue built. C. During an intervit Occupational There residue and white bused for patient's dischabilitation.  OPERATING ROO CFR(s): 482.51(b)  Surgical services mand resources. Polymust be designed to maintenance of high practice and patient. This STANDARD is Based on policy an observation and interaction and selected nation failed to ensure one his scrubs prior to procedure, one (Precoperative Area toured failed to follo scrub uniforms were into the Pre-operative mployee wore scruinto the Operating Fractice had the potential and had the potential occupants.	tains and residue on the face are the cup is placed to receive ate that dispenses the ice had dup.  The company of the stains, apist #1 verified the stains, buildup and verified the ice is rinks in Outpatient  M POLICIES  Thust be consistent with needs licies governing surgical care to assure the achievement and histandards of medical	A 74				
	A. Review of the po	licy and procedure titled '		·			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		040071	B. WING	(All All As a last and a department of the company and company and company as a com	07	/20/2018	
	PROVIDER OR SUPPLIER SON REGIONAL MED	DICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1600 WEST 40TH AVENUE PINE BLUFF, AR 71603			
(X4) ID PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
A 951	Rooms," received to at 11:50 AM on 07/ pertained to all Operained Patient Received policy showed staff scrub uniforms pro	Operating and Recovery from the Regulatory Specialist 16/18 showed the policy erating Room, Recovery Rooming Area staff. Review of the were to wear short steeved vided by the laundry and g personnel were not to wear	Α9	51			
	the Director of Surgiscrubs out of the or the street to the and the surgical suite. It Director of Surgical 07/18/18 the above C. Observation at 1 Physician #1 perfor	07/18/18 at 10:05 AM showed gical Services wore ceil blue perating suite, outside, across abulatory surgery unit, and into During an interview with Services at 10:55 AM on findings were verified.  12:05 PM on 07/18/18 showed rming the pre-operative tient #31 while wearing navy					
	07/18/18 showed memployees wearing colors. During an ir #2 (RN) at 12:20 Pi Pre-Operative Area furnished and Pre-dallowed to wear the RN #2 stated OR a	m 8:45 AM to 12:45 PM on nultiple Pre-Operative Area scrub uniforms of various aterview with Registered Nurse M on 07/18/18, RN #2 stated a staff scrub uniforms were not Operative employees were air own uniforms from home. In decovery Room rnished scrubs by the facility.	,				
	Surgical Services a 07/18/18 both state launder their scrub	ew with the Director of ind RN #1 at 2:45 PM on d OR staff were allowed to uniforms at home and bring to change into. The Director of			• •		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		040071	B. WING		07	//20/2018	
	PROVIDER OR SUPPLIER  SON REGIONAL MED	ICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1600 WEST 40TH AVENUE PINE BLUFF, AR 71603			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FUEL  SCIDENTIFYING INFORMATION)	ID PREFD TAG	PROVIDER'S PLAN OF CORE ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
A 951	the facility chose to (Association of Perithe 2018 AORN guilat 2:50 PM on 07/1: attire laundered in a laundry facility shouthat cannot be continued that cannot be continued and the facility, and into street clothes with the continued facility, and into street clothes with the facility of Pericedure on 07/18 wearing navy scrub Physician #1 at 3:00 asked where his so Physician #1 stated home, he put them facility, which include surgical procedure which were launder of the facility.  G. Review of the Oreceived from the R 07/17/18, showed Ppatients scheduled	ge 9 tated the national guidelines adhere to was AORN operative Nurses). Review of Idelines received from RN #1 8/18 showed clean surgical a health-care accredited Id be worn, personal clothing ained within the scrub attire of in a health-care accredited surgical staff should change whenever going outside.  attient #31's surgical /18 showed Physician #1 s. During an interview with 7 PM on 07/18/18 he was rub uniforms were laundered. his wife laundered them at on and wore them to the ed performing Patient #31's while wearing the scrubs ed at home and worn outside  7/18/18 surgical schedule egulatory Specialist on thysician #1 had seven for surgical procedures and third patient, scheduled	A 9	51			

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	l' of deficiencies de correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - JEFFERSON REGIONAL MEDICA CENTER			(X3) DATE SURVEY COMPLETED	
		040071	B. WING			07/17/2018	
	PROVIDER OR SUPPLIER	ICAL CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 600 WEST 40TH AVENUE INE BLUFF, AR 71603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	-s	Κ¢	000			
	was conducted with			-			
		ompliance with the provisions ode (NFPA 101, 2012 Edition).				٠	
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						•	
ABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE ·

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	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONS		TE SURVEY MPLETED		
		040071	B. WING	<b></b>	a	.07	//17/2018	
	PROVIDER OR SUPPLIER  SON REGIONAL MED	ICAL CENTER		1600 WE	TREET ADDRESS, CITY, STATE, ZIP CODE 600 WEST 40TH AVENUE INE 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 CORREC (EACH CORRECTIVE ACTION SHO ROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
E 000	was conducted with The facility was info was to conduct a M On 07/17/18 at 3:00 conducted with Fac findings of the surve Facility Represental Emergency Prepare cited.  The facility was in conducted with Facility Representations of the surve Facility Representations of the survey Facility Representations of the survey Facility Representations of the survey Prepared Cited.	O AM, an entrance conference Facility Representatives. In the purpose of the visit edicare recertification survey.  O PM, an exit conference was litty Representatives. The early were discussed. The lives were informed no edness deficiencies were compliance with 42 CFR Participation; Emergency	EC	00				
ABOBATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATIDE		TITI F		(X6) DATE	

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