PRINTED: 09/07/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	040071		B. WING				R-C 09/07/2017	
NAME OF PROVIDER OR SUPPLIER  JEFFERSON REGIONAL MEDICAL CENTER				16	REET ADDRESS, CITY, STATE, ZIP CODE 00 WEST 40TH AVENUE NE BLUFF, AR 71603	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	WIIM II	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACTIVE ACTIV		CTION SHOULD BE THE APPROPRIATE		
{A 000}	09/07/17 for all defi deficiencies have b non-compliance ide	rey was conducted on ciencies sited on 08/16/17. All een corrected, and no new entified. The facility is in CFR Part 482, requirement	{A 0					
LABORATOR	/ DIRECTOR'S OR PROVID	DER/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.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
'		A. BOILDING			l c		
040071			B. WING			08/16/2017	
NAME OF PROVIDER OR SUPPLIER				ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
JEEEED	SON REGIONAL MED	ICAL CENTER		16	600 WEST 40TH AVENUE		
JEFFER	ON REGIONAL MED	IOAL OLIVIER		Pl	NE BLUFF, AR 71603		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE	
A 000	An entrance conference Facility Representa 2017. The Facility informed the purpor Complaint Survey.  An exit conference Representatives at findings of the surve Representatives we present additional in presented.  482.55(a) ORGANI  Organization and Diservices are provided.  This STANDARD is Based on Crash Coprocedure review, a determined the Factor (30A, 30B, 29A) examined were che Emergency Departic check the crash can the defibrillators were the event they were failed practice had a patient whose care defibrillator. Finding A. Review of the Crishowed the following 1) 30A Crash Cart of five (08/09/17, 08/1	rence was conducted with tives at 8:30AM on August 16, Representatives were se of the visit was to conduct a was conducted with Facility 3:10PM on 08/16/17. The ey were discussed. The ere given an opportunity to information and none was ZATION AND DIRECTION irection. If emergency ed at the hospital is not met as evidenced by: art check sheets, policy and and interview, it was eility failed to ensure four of a and 27B) crash carts ecked every shift by ment personnel. Failure to interview the potential to affect any required the use of the great cart check sheets and cart check sheets and cart check sheets and cart check sheets sheets and cart check sheets and cart check sheets sheets and cart check sheet missing checks of 17, 08/12/17, 08/14/17 and	A C	000		ion necked owing neld on crash ch Cart g arge at the shift the cre eted. r oday imes a nly to	8/16/17 8/17/17 8/17/17 8/31/17
	08/15/17) of fifteen night shifts.	(08/01/17 through 08/15/17)			BY: Law John Comments and Com	him Arra pura gons d	
LABORATOR		DEB/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.

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TPLE CONSTRUCTION  NG		COMPLETED		
		040071	B. WING		08	/16/2017		
NAME OF PROVIDER OR SUPPLIER  JEFFERSON REGIONAL MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
A1101	2) 30B Crash Cart five (08/09/17, 08/08/15/17) of fifteen night shifts. 3) 29A Crash Cart (08/15/17) of fifteen night shifts. 4) 27B Crash Cart nine (08/07/17 through Code Blue Proces Maintenance" received following under "Ill and Defibrillator Micrash carts with en and medications a locations.  1. Crash cart at to be performed by during which patien Cart and Defibrillate 2. Signature of maintenance and to be recorded on Maintenance Recommitted in the Emergency 108/16/17 he stated responsibility to performed in the Emergency 108/16/17 he stated responsibility to performed in 19:15AM on 08/16/17	check sheet missing checks 10/17, 08/12/17, 08/14/17 and (08/01/17 through 08/15/17) check sheet missing one n (08/01/17 through 08/15/17) check sheet missing checks ough 08/15/17) of fifteen 08/15/17) night shifts.		01.				

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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			C 08/16/2017		
NAME OF PROVIDER OR SUPPLIER  JEFFERSON REGIONAL MEDICAL CENTER				1	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 WEST 40TH AVENUE PINE BLUFF, AR 71603	1 001	10/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		) BE	(X5) COMPLETION DATE
A 000	INITIAL COMMEN	rs	Α (	000			
	Facility Representa 2017. The Facility informed the purpor Complaint Survey. An exit conference Representatives at findings of the surve Representatives we	rence was conducted with tives at 8:30AM on August 16, Representatives were se of the visit was to conduct a was conducted with Facility 3:10PM on 08/16/17. The ey were discussed. The ere given an opportunity to offormation and none was					
A1101		ZATION AND DIRECTION irection. If emergency	A11	101			9/15/17
	This STANDARD is Based on Crash Coprocedure review, a determined the Factour (30A, 30B, 29A examined were che Emergency Departr check the crash can the defibrillators we the event they were failed practice had to	s not met as evidenced by: art check sheets, policy and and interview, it was ility failed to ensure four of and 27B) crash carts cked every shift by ment personnel. Failure to its every shift did not ensure re functional and working in a needed for patient care. The the potential to affect any required the use of the					
	showed the followin 1) 30A Crash Cart of five (08/09/17, 08/1	ash Cart check sheets g: check sheet missing checks 0/17, 08/12/17, 08/14/17 and (08/01/17 through 08/15/17)					

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

TITLE

(X6) DATE 08/29/2017

00/29/2017

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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NAME OF PROVIDER OR SUPPLIER  JEFFERSON REGIONAL MEDICAL CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 1600 WEST 40TH AVENUE PINE BLUFF, AR 71603  CROSS-REFERENCE OR DEPICIENCES (EACH OBERICANY OR LISC IDENTIFYING INFORMATION)  REGULATORY OR LISC IDENTIFYING INFORMATION)  A1101  Continued From page 1 2) 30B Crash Cart check sheet missing checks five (08/09/17, 08/14/17 and 08/15/17) of fifteen (08/01/17 through 08/15/17) night shifts. 3) 29A Crash Cart check sheet missing one (08/15/17) for fire (08/01/17 through 08/15/17) night shifts. 4) 27B Crash Cart check sheet missing one (08/16/17) through 08/15/17) of fifteen (08/01/17 through	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED C		
STREET ADDRESS, CITY, STATE, ZIP CODE			040071	B. WING			1			
PREFIX TAG  REGULATORY OR ISC IDENTIFYING INFORMATION)  A1101  Continued From page 1 2) 30B Crash Cart check sheet missing checks five (08/09/17), 08/10/17, 08/12/17, 08/14/17 and 08/15/17) of fifteen (08/01/17 through 08/15/17) night shifts. 3) 29A Crash Cart check sheet missing one (08/15/17) of fifteen (08/01/17 through 08/15/17) night shifts. 4) 27B Crash Cart check sheet missing checks nine (08/07/17 through 08/15/17) of fifteen (08/07/17 through 08/15/17 through 0					1600 WEST 40TH AVENUE					
2) 30B Crash Cart check sheet missing checks five (08/09/17, 08/10/17, 08/12/17, 08/14/17 and 08/15/17) of fifteen (08/01/17 through 08/15/17) night shifts. 3) 29A Crash Cart check sheet missing one (08/15/17) of fifteen (08/01/17 through 08/15/17) night shifts. 4) 27B Crash Cart check sheet missing checks nine (08/07/17 through 08/15/17) of fifteen (08/01/17 through 08/15/17) night shifts.  B. Review of the policy and procedure titled "Code Blue Process and Crash Cart Maintenance" received on 08/16/17 showed the following under "III PROCDURE C. Crash Cart and Defibrillator Maintenance, Standardized crash carts with emergency equipment, supplies and medications are maintained in designated locations.  1. Crash cart and defibrillator maintenance is to be performed by licensed personnel every shift during which patient care is rendered. See Crash Cart and Defibrillator Maintenance procedure. 2. Signature of person performing maintenance and the crash cart lock number are to be recorded on the Crash Cart and Defibrillator Maintenance Record located on the crash Cart and Defibrillator Maintenance Record located on the crash Cart and Defibrillator Maintenance Record located on the crash cart checks every shift.  D. The findings in A, B and C were confirmed at 9:15AM on 08/16/17 during an interview with the	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI.		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION		
The state of the mineral state of the state	A1101	2) 30B Crash Cart of five (08/09/17, 08/1 08/15/17) of fifteen night shifts. 3) 29A Crash Cart of (08/15/17) of fifteen night shifts. 4) 27B Crash Cart of (08/07/17 through 008/01/17 through 008/01/18/18/18/19/19/19/19/19/19/19/19/19/19/19/19/19/	check sheet missing checks 0/17, 08/12/17, 08/14/17 and (08/01/17 through 08/15/17) check sheet missing one (08/01/17 through 08/15/17) check sheet missing checks ugh 08/15/17) of fifteen 08/15/17) night shifts.  Slicy and procedure titled and Crash Cart ved on 08/16/17 showed the PROCDUREC. Crash Cart intenance, Standardized ergency equipment, supplies e maintained in designated and defibrillator maintenance is licensed personnel every shift to care is rendered. See Crash or Maintenance procedure, person performing he crash cart lock number are the Crash Cart and Defibrillator decated on the crash cart with the Nursing Director Department at 9:10AM on it was the charge nurse's form the crash cart checks	A11	01					