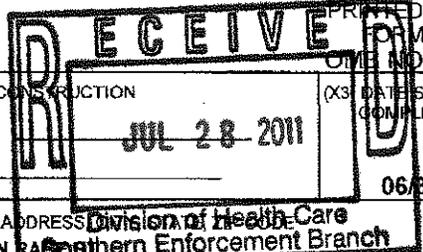


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 07/15/2011  
FORM APPROVED  
CML NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185387	(X2) MULTIPLE CORRECTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/30/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  T J SAMSON COMMUNITY HOSPITAL	STREET ADDRESS Division of Health Care 1301 N 2nd Southern Enforcement Branch GLASGOW, KY 42141
---	---

(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
F 000	INITIAL COMMENTS	F 000		
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a sanitary, orderly, and comfortable interior. The entry doors to two resident rooms were scarred exposing splintered wood, an overbed light covering was loose, and several overbed lights did not have a pull cord for residents to activate the overbed lights.</p> <p>The findings include: The facility had no environment policy.</p> <p>During the environmental tour of the facility on 06/28-30/11, the following items were observed to be in need of repair:</p> <ul style="list-style-type: none"> <li>-The overbed light panel/covering in resident room 291 was loose and had strips of tape connecting the side panels.</li> <li>-The entry door to resident rooms 287 and 293 were scarred, exposing splintered wood.</li> </ul>	F 253	<p><del>F 253</del> The following corrections were implemented for the environmental compliance issues:</p> <ol style="list-style-type: none"> <li>1. All patient rooms were surveyed to assess for need of repairs and/or hazardous risk assessment. Work orders were submitted for any repairs identified. 7-1-11</li> <li>2. Room 291 overbed light work order submitted and completed 7-21-11.</li> <li>3. Pull cords on all overbed lights replaced with new cords for all rooms with overbed lights (rooms 281-292) completed 7-20-11.</li> <li>4. Replacement doors to resident rooms have been ordered to replace existing doors. Carpentry Dept. has a work order in place to complete when doors arrive. 7-7-11</li> </ol> <p>To prevent further reoccurrences of non-compliance the following actions have been put in place:</p> <ol style="list-style-type: none"> <li>1. Updated housekeeping terminal cleaning policy checklist now includes overbed light pull cord in place, if missing maintenance work order will be submitted.</li> </ol>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Shendy Moore, RN, MSN, LNHA* TITLE: *Administrator* (X6) DATE: *7-28-11*

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.

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

PRINTED: 07/15/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185387	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/30/2011
NAME OF PROVIDER OR SUPPLIER  T J SAMSON COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1301 N RACE ST GLASGOW, KY 42141	
(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
F 253	Continued From page 1 -The overbed lights in resident rooms 286, 287, 289, 290, and 291 did not have an accessible pull cord for residents to activate the overbed lights.  Interview on 06/29/11, at 10:30 AM, with an unsampled resident in room 290 revealed the resident expressed the desire to have a pull cord on the overbed light which would permit the resident to activate his/her light when needed.  Interview on 06/30/11, at 10:25 AM, with the Maintenance Supervisor (MS) revealed rounds were conducted one to two times each day to look for items in need of repair but maintenance staff did not enter resident rooms. The MS stated the Maintenance Department depended on the nursing staff and housekeeping staff to identify any items in need of repair in resident rooms. The MS stated staff communicated any needed repairs by e-mail or by calling the Maintenance Department. The MS was not aware of the identified areas in need of repair.	F 253	F 253 continued: 2. Director of Nursing or designee will do weekly rounds to each room to inspect for needed repairs. When identified, work orders will be submitted to maintenance department. 7-21-11	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by:	F 371	F 371 The following actions have been implemented to correct the identified to correct the identified non-compliance: 1. Dietary supervisor reviewed safe food handling policy with entire dietary staff. 7-1-11 2. Daily surveillance rounds were initiated in dietary department by Infection Control Nurse. 7-1-11 Non-compliance will result in immediate one-on-one reinforcement of policy. Repeated non-compliance will result in disciplinary action.	

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

PRINTED: 07/15/2011  
FORM APPROVED  
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185387	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/30/2011
NAME OF PROVIDER OR SUPPLIER  T J SAMSON COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1301 N RACE ST GLASGOW, KY 42141	
(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
F 371	<p>Continued From page 2</p> <p>Based on observation, interview, and review of facility policy, it was determined the facility failed to prepare, store, and distribute food under sanitary conditions. The facility failed to ensure food service staff properly sanitized hands and utilized proper glove changing during preparation of resident meal trays during the evening meal on 06/28/11.</p> <p>The findings include:</p> <p>Review of the facility's Food Service policy (revised 9/2000) revealed hospital approved gloves were to be worn by food service employees to prevent cross-contamination during food preparation and serving. The policy guided food service staff to wash hands before beginning a task and before the application of gloves. Gloves were to be changed when soiled or damaged, if a task was interrupted, before beginning a new task, and at least every four hours of continual use, after handling raw meat and before handling cooked or ready-to-eat foods. The policy further directed staff to wash hands after removing gloves and before putting on clean gloves.</p> <p>Observation of tray line service during the evening meal on 06/28/11, revealed the cook opened the microwave oven with his gloved hand, removed a bowl of soup, and then continued to prepare resident trays. The cook was observed to handle hamburger buns, hoagie buns, and sliced cheese with the soiled gloves.</p> <p>Further observation revealed the cook opened the lid to the enclosed plate warmer and removed several plates. The cook continued to prepare</p>	F 371	<p><u>F 371</u> continued:</p> <p>3. Mandatory inservice is scheduled for dietary department 7-28-11 and 7-29-11 to reinforce current safe food handling policy by Infection Control Nurse.</p>	7-29-11

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

PRINTED: 07/15/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185387	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  06/30/2011
NAME OF PROVIDER OR SUPPLIER  T J SAMSON COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 N RACE ST GLASGOW, KY 42141		
(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
F 371	<p>Continued From page 3</p> <p>resident trays with the same soiled gloves and handled hamburger buns, hoagie buns, and sliced cheese with the soiled gloves.</p> <p>Interview on 06/28/11, at 5:45 PM, with the cook revealed he was knowledgeable of the requirement to change gloves any time contact was made with a dirty object. The cook stated hands should be washed any time gloves were removed. The cook stated he just failed to change his gloves and wash his hands as required.</p>	F 371		

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

PRINTED: 12/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185387</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/30/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>T J SAMSON COMMUNITY HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1301 N RACE ST GLASGOW, KY 42141</b>		
(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	
K 000	INITIAL COMMENTS  A life safety code survey was initiated and concluded on 06/30/11, for compliance with Title 42, Code of Federal Regulations, §483.70(a). The facility was found to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.	K 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.