

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

PRINTED: 08/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/24/2013
NAME OF PROVIDER OR SUPPLIER  MUHLENBERG COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345	
(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  A recertification/abbreviated survey (KY #20446) was conducted on 07/21/13 through 07/24/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of a "E". KY #20446 was unsubstantiated with no deficiencies cited.	F 000		
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: Based on observation and interview it was determined the facility failed to ensure food was stored, prepared and served under sanitary conditions. Observations in the kitchen revealed the walk in freezer with a build up of frozen condensation and a build up of grey grime on the door, refrigerator drawers in an unclean condition, and left over items in the refrigerator that were not discarded after the third day. In addition, observation of the unit refrigerators revealed resident and staff food items, some of them partially consumed and some unpackaged, unlabeled and undated.	F 371	F371 Unit Refrigerator (Shared) Please see attached Page 1 for response to this deficient policy.	08/16/13



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

TITLE

(X6) DATE

*Becky Jagers, NHA*

*Administrator*

*8-15-13*

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 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>186008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/24/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>MUHLENBERG COMMUNITY HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 HOPKINSVILLE ST. GREENVILLE, KY 42346</b>		
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F 371	<p>Continued From page 1</p> <p>Findings include:</p> <p>Review of the facility policy, titled, "HACCP/FOOD SAFETY PROGRAM", last revised 08/09, revealed food that is opened or removed from original packaging should be stored properly covered, in food grade containers and clearly labeled. Additionally, clearly labeled sanitizer of the proper concentration must be available and used to sanitize all food-contact surfaces of stationary equipment, i.e., work counters/tables. Spray bottles with sanitizing solution may be used for stationary equipment surfaces must be kept wet for minimum of one minute.</p> <p>Observation of the facility kitchen, on 07/21/13 at 1:00 PM, revealed:</p> <ol style="list-style-type: none"> <li>1. the walk in freezer had a large amount of frozen condensation droplets on the freezer ceiling and frozen puddles of condensation on the freezer floor. The door to the freezer was in disrepair and did not seal properly when closed. Additionally, there was a build up of grey grime on the freezer door.</li> </ol> <p>Review of the latest Health Department inspection, dated 04/08/13, revealed the freezer door gasket had been identified as in disrepair.</p> <ol style="list-style-type: none"> <li>2. the reach in refrigerated drawers located at the preparation area had food debris and discolored smears on the edges and inside.</li> <li>3. the reach in cooler contained a large tray that was half full of yellow colored jello with a date of 06/30/13 on it. Another tray of partly used jello had a date of 07/16/13.</li> </ol>	F 371	<p>F371 Food Procure, Store/ Prepare/Serve - Sanitary. Please see attached Page 2 through Page 4 for response to this 4-Part Deficiency.</p>	08/13/13	

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F 371	Continued From page 2  4. the reach in refrigerator had opened packages of chicken tenders with no label or date on them and debris was observed on the refrigerator floor.  Interview with the weekend Dietary Supervisor during the observations on 07/21/13 revealed the walk in freezer had problems with the condensation due to the door not properly closing and had been in that condition for a while. The dietary supervisor also stated the refrigerator drawers were to be cleaned daily and had not been cleaned. Left over food was to be discarded after three days and opened food items were to have a label with a date.  An interview with the Food Service Director, on 07/23/13 at 4:15 PM, revealed he had inquired about repairing the walk in freezer door but the bids had not been approved. The Food Service Director stated the dish washer was responsible to wipe walls shelves but did not know if they knew to wipe down the exteriors of the appliance doors. He additionally stated who ever was working a station in the kitchen was responsible for cleaning that area daily.  An interview with the Director of Nursing (DON), on 07/24/13 at 1:00 PM, revealed the freezer door should be repaired and cleaning should be done as needed. The DON stated the Food Services Director was responsible to ensure cleaning was completed.	F 371			

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NAME OF PROVIDER OR SUPPLIER  MUHLENBERG COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345	
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1967</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two (2) stories, Type II (222)</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system installed in 1967 and upgraded in 1984 with 14 heat and 191 smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 07/23/13. Muhlenberg Community Hospital was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for forty-five (45) beds with a census of thirty-seven (37) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000		

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

TITLE

(X6) DATE

*Becky Jiggins, NHA*

*Administrator*

*8-15-13*

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K 000	Continued From page 1 Fire)	K 000		
K 025 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for forty-five (45) beds with a census of thirty-seven (37) on the day of the survey. The facility failed to ensure five (5) smoke barriers were sealed around pipes and wires to resist the passage of smoke as they extended on each side of the corridor.</p> <p>The findings include:</p>	K 025	K025 Life Safety Code Standard Please see attached Page 1 for response to this deficiency.	08/12/13

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K 025	<p>Continued From page 2</p> <p>Observations, on 07/23/13 between 1:00 PM and 2:30 PM with the Director of Plant Operations, revealed the smoke partitions, extending above the ceiling located on each side of the corridors were penetrated by pipes and wires.</p> <p>Interview, on 07/23/13 between 1:00 PM and 2:30 PM with the Director of Plant Operations, revealed he was aware there were smoke barriers but he had not completed an audit on the barriers once they were outside of the corridors.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> <li>1. Be made on either side of the smoke barrier, or</li> <li>2. Be made by an approved device designed for the specific purpose.</li> </ol>	K 025		

K025 Life Safety Code Standard
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1. Corrective Action – The Director of Engineering implemented corrective action for this deficiency which had the potential to affect 6 of 6 smoke compartments, all residents, staff and visitors. This included:
  - a. On July 29, 2013 a fire wall service provider was contacted to repair the pipe penetrations above the ceiling located on each side of the corridors. (See Attachment #1 for Life Safety)
2. Identification of other potential harm from this deficiency – The Director of Plant Operations verified that the 6 of 6 smoke compartments identified during the inspection process does include the entire LTC Facility.
3. Systemic changes to assure this deficient practice will not recur – The Engineering Department will ensure the proper separation extends above the ceiling located on each side of the corridors by annual inspection for penetrations through issuance of preventative maintenance work requests for March of each year.
4. Monitoring to ensure that the deficient practice will not recur – The Director of Plant Operations will monitor all corrective actions by annual review of the maintenance logs housed in the Engineering Department and file a report with the Safety Committee annually.
5. Date of Completion – 8/12/13