

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

PRINTED: 04/22/2014  
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  R 04/10/2014
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 000}	INITIAL COMMENTS  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 04/10/14 as alleged.	{F 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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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 000	INITIAL COMMENTS  A Standard Recertification Survey was conducted on 03/18/14 through 03/20/14 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 an "E".	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility On-Line Work Order Request Entry Form, it was determined the facility failed to provide maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  The findings include:  Review of the facility Work Order Request Entry Form, (undated) and an interview with the Administrator, on 03/20/14 at 11:34 AM, revealed the process for reporting environmental concerns was to fill out the work order and e-mail this information to the Maintenance Department. A review of the form revealed the staff were to report the location, the area requiring attention, and a description of the problem. Further instructions on the form were to submit the request and "please be patient and submit only once."	F 253	 <u>F 253</u> <u>3-20-14 Corrective action taken:</u> A. Hallway on SNU wing- the two identified tiles with black discoloration were replaced after surveyor's exit conference. The Maintenance Department completed a cost analysis to replace the ceiling frame and tiles in hallway, family room, kitchen dining area as well as nursing station. The request for supplies has been submitted to administration and work order confirmed on 4-10-14. A time line to complete the replacement of the ceiling areas listed project is 6-10-14. B. Kitchen Area-3-20-14 Maintenance Department removed the damaged plaster, treated area with bleach water, and patched identified area. A second coat of plaster was applied on 3-24-14 and surface was painted 3-10-14.  <i>Other residents that could be affected by finding:</i> Removed black ceiling tile from SNU hallway and cracked plaster in Kitchen area. Immediate intervention decreased the risk for all residents and staff within the facility.	

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

TITLE

(X6) DATE

*Mandy Moore MSN LNHA*

*Admin*

*4-10-14*

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NAME OF PROVIDER OR SUPPLIER  T J SAMSON COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1301 N RACE ST GLASGOW, KY 42141		
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F 253	Continued From page 1  Observations, during tour of the Long Term Care (LTC) Wing of the hospital, on 03/18/14 at 8:00 PM, and a tour of the kitchen, on 03/19/14 at 12:00 PM, and throughout the duration of the survey, revealed the following:  A. Ceiling tiles, throughout the wing, were noted to have discolorations with yellow/orange colored rings and two of the ceiling tiles were noted to have blackened spots.  B. An area, approximately two (2) foot by two (2) foot space, of cracked, raised, and bubbled plaster to the soffit and wall over the handwashing sink and near the tray line, that was yellow/orange colored and crumbled with touch.  Interview with the Dietary Manager, on 03/19/14 at 2:25 PM, revealed the discolored soffit and wall area was first noted on 03/01/14, and the Maintenance Department was notified on 03/01/14. Maintenance was notified again, on 03/11/14, as the situation had not been addressed, and as of 03/19/14, she stated nothing had been done about the situation.  Interview with the Maintenance Director, on 03/20/14 at 10:25 AM, revealed the Maintenance Department was first made aware of the crumbling plaster on 03/01/14, due to water dripping from that area. He stated they were having some concerns with water leaks at that time and wanted to be sure the problem was fixed before beginning repairs. However, he had not visualized the area himself and had no record of anyone else looking at the area, and stated he was "unaware it was that bad. The area would have to be barricaded, sprayed with a mixture of	F 253	<i>Measures to prevent reoccurrence and sustaining improvement:</i> Current process include twice annually, a multidisciplinary team walking through each clinical area of the facility to assess for Hazardous Environmental Risks. Once a risk is identified, a work order is placed to correct findings and a time line is identified to correct risk based on nature of findings. The current checklist has been updated to incorporate inspection of all ceiling areas. In addition, employees were reminded 4-8-14 at regularly scheduled staff meeting to report findings of concern 'such as wet ceiling tiles' to immediate supervisor or submit an on line work order request.	4-10-14	

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NAME OF PROVIDER OR SUPPLIER  T J SAMSON COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1301 N RACE ST GLASGOW, KY 42141		
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F 253	<p>Continued From page 2</p> <p>bleach and water, and patched." In response to the ceiling tiles on the LTC Wing, he stated they periodically conducted a tour of the facility to check on environmental issues. In the past, when the tiles become discolored, they were taken down, spray painted, and put back up in the ceiling. He stated he was unaware some of the tiles had black spots and rings, and those tiles should be replaced.</p> <p>An interview with the Administrator, on 03/20/14 at 11:34 AM, revealed compliance rounds were made to check environmental conditions on the wing. Although she was unaware of the ringed, discolorations, and blackened areas to the tile, she stated she was aware the tiles were spray painted and did not match. She stated they would have to do a more thorough evaluation of the wing and include the ceiling tiles.</p>	F 253			

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NAME OF PROVIDER OR SUPPLIER  T J SAMSON COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1301 N RACE ST GLASGOW, KY 42141	
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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: 1971</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Type I (443)</p> <p>SMOKE COMPARTMENTS: One (1) smoke compartment</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type I generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 03/20/14. TJ Sampson Community Hospital was found to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixteen (16) beds with a census of eleven (11) on the day of the survey.</p>	K 000		

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

*Sherry Moore MSN LNHA*

TITLE

*Admin*

(X6) DATE

*4-10-14*

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