DEPARTMENT OF HEALTH AND HUMAN SERVICES							FORM APPROVED		
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OM	B 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		
		185387	B. WING _				06/09/2020		
NAME OF PF	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE				
TJSAMS	ON COMMUNITY HOSPI	TAL			1 N RACE STREET				
				GL	ASGOW, KY 42141				
(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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 000			F	000					
	was initiated on 06/08 06/09/2020. The facili compliance with 42 C regulations and has in Medicare & Medicaid Centers for Disease C	FR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention practices to prepare for							
LABORATORY	DIRECTOR'S OR PROVIDER!	SUPPLIER REPRESENTATIVE'S SIGNATU	RE		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: 06/12/2020

DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NC	). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY
		185387	B. WING			06/	09/2020
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
T J SAMS		<b>FAL</b>			301 N RACE STREET		
				GLASGOW, KY 42141			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
	Survey was initiated of concluded on 06/09/2	d Emergency Preparedness on 06/08/2020 and 020. The facility was found ith 42 CFR 483.73 related					
		SUPPLIER REPRESENTATIVE'S SIGNATUR	25		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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## PRINTED: 06/12/2020 FORM APPROVED

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
100761		B. WING		06/09/2020		
ROVIDER OR SUPPLIER						
ON COMMUNITY HOSP	ριται					
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	TION SHOULD BE COMPLETE APPROPRIATE DATE		
was initiated on 06/0 06/09/2020. The fac	08/2020 and concluded on cility was found to be in	N 000				
	DF CORRECTION ROVIDER OR SUPPLIER ON COMMUNITY HOSP SUMMARY S (EACH DEFICIEN REGULATORY OF Initial Comments A COVID-19 Focuse was initiated on 06/0 06/09/2020. The fac	DF CORRECTION IDENTIFICATION NUMBER: 100761 ROVIDER OR SUPPLIER STREET A 1301 N I GLASGO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	DF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         100761       B. WING         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE,         ON COMMUNITY HOSPITAL       1301 N RACE STREET         GLASGOW, KY 42141       GLASGOW, KY 42141         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Initial Comments       N 000         A COVID-19 Focused Infection Control Survey was initiated on 06/08/2020 and concluded on 06/09/2020. The facility was found to be in       N 000	DF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:	

TNX611