

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42206	
(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 246	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the call system in the residents' bathrooms were accessible related to no emergency pull cord/chains available for resident use.</p> <p>Findings Include: Interview with the Administrator, on 07/12/13 at 1:30 PM, revealed the facility had no policy to address the emergency call lights in the residents' bathroom.</p> <p>1. Observations during the initial tour, on</p>	F 246	<p>483.15 (e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>1. On 8/5/2013 the Maintenance Director along with Double Dome Systems finished replacing the call light push buttons with Pull Strings in the bathrooms of rooms #101, #103, #105, #106, #107, #110 and the five (5) shared bathrooms between rooms #114 and #116, #117 and #119, #118 and #120, #121 and #123, and #122 and #124.</p> <p>2. On 7/29/13 the Maintenance Director along with Rick Williams from Double Dome Systems checked all the call lights on 100 Hall to determine if any other call lights needed to be rewired to remove the push button call lights and replace with pull strings. Rewiring pull strings were ordered at that time.</p>	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephanie Semriva, Administrator TITLE: _____ (X6) DATE: 8/6/2013

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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FORM APPROVED
OMB NO: 0938-0391

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

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NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42206		
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F 246	Continued From page 1 07/10/13 at 11:03 AM, revealed there were no call light strings, in the bathrooms for Rooms #101, #103, #105, #106, #107, #110, and five (5) shared bathrooms between rooms #114 and #116, #117 and #119, #116 and #120, #121 and #123, and #122 and #124. Interview with Certified Nurse Aide (CNA) #1, on 07/11/13 at 2:00 PM, revealed residents would not have access to the emergency call button on the wall if the resident fell in floor or was not seated on the commode. Interview with CNA #2, on 07/12/13 at 11:05 AM, revealed staff remained with residents during toileting that were not aware an emergency call button was located on the wall. Interview with Licensed Practical Nurse (LPN) #1, on 07/12/13 at 11:20 AM, revealed if a resident was unable to reach the emergency call light on the wall, the resident would have to yell out for assistance of staff and/or be steady enough to reach the emergency call button on the wall.	F 246	3. On 8/5/2013 the DON in-serviced the staff on the new pull strings call lights in the bathrooms on the 100 hall. Staff will continue to follow "Placement of Call Light & Answering the Call Light" policy/procedure. On 8/1/2013 the Administrator revised CQI Form N-21, "Nurse Safety Inspection" to include "Are all bathrooms accessible to residents equipped with an adequate call system?" 4. The DON will complete revised CQI Form N-21, "Nurse Safety Inspection" once a month for three months, then quarterly thereafter. Completion Date 8/6/2013	8/6/13	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 1. A leg strap for the urinary catheter was secured for Resident #1 on 7/11/2013 by charge nurse.		

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NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42206		
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F 282	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policy, it was determined the facility failed to ensure the interventions of the care plan were carried out for one resident (#1,) in the select sample of thirteen (13) residents, related to the failure to utilize a required leg strap to secure a urinary catheter.</p> <p>Findings include:</p> <p>A review of the undated facility policy "Using the Care Plan," revealed the care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have the responsibility for providing care or services. Changes in the resident's condition must be reported to the MDS Coordinator so the revisions can be made.</p> <p>A record review revealed Resident #1 was admitted to the facility on 06/03/13 with diagnoses to include Vascular Dementia with Behavioral Disturbance; Urinary Retention, Chronic Kidney Disease. Further review revealed Hospice Services were obtained for the resident on 05/23/13, due to declining health and anticipation the resident would not live six months due to declining medical conditions.</p> <p>A review of Resident #1's significant change Minimum Data Set (MDS) assessment, dated 06/07/13, revealed the facility assessed the</p>	F 282	<p>2. The House Supervisor conducted an audit on 7/11/2013 on all residents with catheters to ensure all those residents had leg straps secured for those catheters.</p> <p>3. The CNA responsible for that resident was counseled by the DON on following the Nurse Aide Care Plan and Comprehensive Care Plan on 7/30/2013. The nursing staff was in-serviced on 8/2/2013 by the DON on following the Nurse Aide and Comprehensive Care Plans for their residents. N-8 was updated 8/2/13 to include the question "Is catheter leg strap secured to leg."</p> <p>4. The DON will complete CQI Form N-8, "Catheter Use Review", weekly for four weeks, then quarterly thereafter.</p> <p>Completion Date 8/3/2013</p>	8/3/13

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NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42206	
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F 282	Continued From page 3 resident's cognition as moderately impaired and required extensive assist of two staff members with Activities of Daily Living (ADLs). A review of the Comprehensive Care Plan for the urinary catheter, dated 05/24/13, revealed an intervention to attach the catheter tubing to the leg with a leg strap to hold in place and prevent injury. Observations of Resident #1, during a skin assessment, on 07/11/13 at 1:30 PM, revealed the resident was lying on the urinary catheter, that was not secured with a leg strap. An interview with Licensed Practical Nurse (LPN) #1, on 07/11/13 at 1:00 PM and on 07/12/13 at 1:10 PM, revealed the resident was not wearing the leg strap, as required by the care plan, as the strap possibly became soiled and the staff member forgot to replace the strap with a new one, as there were several extras available. An interview with Registered Nurse (RN) #1, on 07/11/13 at 1:30 PM, revealed there was no reason for not applying the leg strap to the urinary catheter and stated the resident should not have been lying on the tubing.	F 282		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review	F 367	F367 483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN 1. a. The tray card and Therapeutic Diet Order of Resident #16 was reviewed by the Dietary Manager on 7/11/2013 for accuracy.	

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NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42206	
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F 367	<p>Continued From page 4</p> <p>and facility policy review it was determined the facility failed to ensure a therapeutic diet was followed for one (1) resident (#1), in the selected sample of thirteen (13) residents, and one resident (#16), not in the selected sample. Resident #1 and #16 were served quartered/whole meats during two separate lunch meals when they were supposed to receive diced/chopped meat.</p> <p>Findings include:</p> <p>A review of the facility's policy and procedure titled "Therapeutic Diets" (n.d.), undated, revealed "The Dietary Manager will establish and use a tray identification system to ensure that each resident receives his or her diet as ordered. Mechanically altered diets, as well as diets modified for medical and nutritional needs, will be considered "therapeutic diets."</p> <p>1. A record review revealed Resident #16 was admitted to the facility on 07/09/13 with diagnoses to include Alzheimer's Dementia, Cerebral Vascular Accident, and Hyperlipidemia.</p> <p>An observation on 07/10/13 at 11:30 AM of Resident #16 eating lunch in the main dining room revealed the resident was served whole meatballs. A review of the dietary tray card revealed the resident was supposed to have diced meats. An observation, on 07/11/13 at 11:47 AM, of Resident #16 eating lunch in the main dining room, revealed the resident was served a hamburger patty cut into quarters and not diced as the tray card indicated it should be.</p> <p>2. A review of Resident #1's tray card revealed</p>	F 367	<p>b. On 7/29/2013 the CNA responsible for feeding Resident #1 was in-serviced by the DON on what to do if a resident's meal does not match the tray card.</p> <p>2. The Dietary Manger completed an audit using CQI Form D-7, "Tray Accuracy", on 7/26/2013 to ensure all residents with orders for mechanically or therapeutic diets were served the proper diet and the diet cards matched the orders.</p> <p>3. The Dietary Manger in-serviced her staff on 7/12/2013 on the importance of tray accuracy and following the tray card. The DON in-serviced Nursing and Dietary Staff on 8/2/2013 on "Therapeutic Diets" policy/procedure and what to do if a tray came to a resident that did not match his/her tray card. CQI form D-7 was updated 8/2/13 to increase threshold from 95% to 100% accuracy.</p>	

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F 367	<p>Continued From page 5</p> <p>the resident was a "feeder," required a Consistent Carbohydrates, with No Added Salt, Mechanical Soft and Chopped Meat Diet.</p> <p>An observation of the noon meal, on 07/11/13 at 11:55 AM, revealed a hamburger on Resident #1's tray that had been cut twice, through the middle, to create four quartered sections. The CNA was feeding the resident and was observed to chop the hamburger into small pieces with a spoon. CNA #1 stated she was fearful of any resident choking and always chopped their food up more, prior to feeding the residents.</p> <p>An interview with Certified Nursing Assistant (CNA) #3, on 07/10/13 at 12:00 PM, revealed if she saw something wrong with a resident's tray card she would go to the kitchen and let them know something was on the resident's tray that was not supposed to be there.</p> <p>An interview with Certified Medication Technician (CMT) #1, on 07/10/13 at 12:05 PM, revealed if she saw something on a resident's tray that was not supposed to be on there according to the tray card, she would let dietary staff know and ask for something else.</p> <p>An interview with the Dietary Manager, on 07/12/13 at 1:10 PM, revealed she considered diced meats as smaller chunked up pieces of meat and not whole or quartered. She further stated the cook is responsible for dicing the meat once the dietary aide has called the tray card information out to her.</p> <p>An interview with the Director of Nursing (DON), on 07/12/13 at 1:00 PM, revealed she believed</p>	F 367	<p>4. The Dietary Manager will complete CQI Form D-7, "Tray Accuracy", weekly for four weeks then monthly thereafter.</p> <p>Completion Date 8/3/2013.</p>	8/3/13	

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NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42206		
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F 367	Continued From page 6 the CNA's were supposed to be looking at the tray cards to make sure the meal is resident appropriate. She further stated during their orientation time on the floor with other aides as well as through inservices, they should have been shown how to check the tray cards.	F 367			
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, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure food was stored under sanitary conditions. A review of the facility's census and condition, dated 07/10/13, revealed there were 50 residents in the building and all residents but two received their meals from the kitchen. Findings include: Review of the Food Storage policy, undated, revealed cold foods would be maintained at temperatures of forty (40) degrees Fahrenheit (F) or below.	F 371	F 371 483.35(i) FOOD PROCEDURE, STORE/PREPARE/SERVE-SANITARY 1. On 7/11/2013, at 4:20pm, the potato salad was put on ice and the temperature was brought down to 40°F and finished being served to the residents. 2. On 7/12/2013 the Dietary Manager was in-serviced to place cold food items going to be served in smaller containers, bring out one container from the refrigerator at time and place it in a tub of ice to keep cool. This would ensure the temperature to be kept below 40°F.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2013
NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42206		
(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	Continued From page 7 Review of the product detail for Southern Style Mustard Potato Salad, undated, revealed the ingredients included mayonnaise. Observation, on 07/11/13 at 10:50 AM, revealed the following temperatures prior to food service: 1. pureed potato salad- 46 degrees 2. small container of regular potato salad- 44 degrees 3. large container of regular potato salad- 42 degrees Observation, on 07/11/13 at 11:00 AM, revealed the potato salad was placed on resident trays at this time. Interview with the Cook, on 07/11/13 at 11:00 AM, revealed cold food temperatures were supposed to be below 41 degrees; however, it was okay to be above temperature if the food was sitting out of the refrigerator. Interview with the Dietary Manager, on 07/11/13 at 11:05 AM, revealed she expected staff to serve cold food at the appropriate temperature of 40 degrees or below; however, they were going to serve the potato salad to the residents. Interview, on 07/11/13 at 4:20 PM, revealed the staff later re-arranged the potato salad on ice until it was 40 degrees; however, the surveyor was not present to verify.	F 371	3. The policy titled, "Food Storage" was revised by the Corporate Compliance Director on 7/25/2013 to state that "Cold food above 40°F will not be served." The Dietary Manager was in-serviced on the revised Policy on 7/25/2013. The Dietary Manager in-serviced her staff on 7/26/2013 on the new policy, how to serve cold food, and food temperatures. 4. The Dietary Manager will complete CQI Form D-6, "Dining Service" weekly for four weeks, then monthly thereafter. Completion Date 7/27/2013	7/27/13	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system	F 463	F463 483.70(f) RESIDENT CALL SYSTEM-ROOMS/TOILET/BATH		

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NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42206	
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F 463	<p>Continued From page 8</p> <p>from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure each bathroom, accessible to residents, was equipped to receive resident calls through a communication system.</p> <p>Findings include:</p> <p>A review of the "Placement of Call Light & Answering Call Light" policy/procedure, undated, revealed the purpose was to respond to the resident's request and needs. General guidelines included explaining to residents a call system was located in the bathroom.</p> <p>Observation with Maintenance, on 07/12/13 at 9:10 AM, revealed two bathrooms located beside the 100 hall nurse's station without a call system. Maintenance verified at this time both bathrooms were unlocked and accessible to residents.</p> <p>Interview with Maintenance, on 07/12/13 at 9:20 AM, revealed there was no hardware to lock the doors from the outside at this time. He indicated the plan was to add doorknobs to both bathroom doors; however, he did not have the equipment at the time to fix them. He verified there was no documentation of a plan in place.</p> <p>Interview with the Administrator, on 07/12/13 at 9:30 AM, revealed there was a plan to put automatic locking knobs on both bathrooms;</p>	F 463	<ol style="list-style-type: none"> 1. Glover's lock Service was called and on 7/12/2013. He installed automatic lock door knobs on the bathrooms used for employees and visitors to ensure that residents would not have access to those bathrooms because they do not contain a call system. 2. A tour of the building was done on 7/12/2013 by the Maintenance Director to ensure all bathrooms that were accessible to residents had a call system in place. 3. On 7/30/2013 The Administrator revised CQI Form N-21, "Nurse Safety Inspection" to include "Are all bathrooms accessible to residents equipped with an adequate call system?" 4. The DON will complete CQI Form N-21, "Nurse Safety Inspection" once a month for three months, then quarterly thereafter. <p>Completion Date: 7/31/2013</p>	7/31/13

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NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42206		
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F 463	Continued From page 9 however, they were waiting on the equipment to arrive. She was unsure how long the plan had been discussed.	F 463			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2013
NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42208	
(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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1966.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1967 and upgraded in 1998, with 84 smoke detectors and 4 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1967.</p> <p>GENERATOR: Type II generator installed in 1966. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 07-10-13 and 07-11-13. Auburn Healthcare was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Sixty-Six (66) beds with a census of Fifty (50) 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: Stephanie Sennow, Administrator TITLE: _____ (X6) DATE: 8/5/2013

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2013
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NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42206
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(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	Continued From page 1 Fire).	K 000		
K 018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms would latch properly in accordance with NFPA standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments, fifty (50) residents, staff and visitors. The facility is certified for Sixty-Six</p>	K 018	<p>K 018 NFPA 101 LIFE SAFETY CODE STANDARDS</p> <ol style="list-style-type: none"> On 7/30/2013 The Maintenance Director corrected the corridor doors to rooms #207,209, 101,103,108, and 118 so they would latch properly. On 7/11/2013 The Maintenance Director checked all corridor doors to make sure they latched properly. On 7/30/2013 the Administrator revised CQI Form ES-3, Life Safety to include: "Corridor doors latch easily when closed." The Maintenance Director will complete revised CQI Form ES-3, "Life Safety", weekly for four weeks, then monthly thereafter. <p>Completion Date 7/31/2013</p>	7/31/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2013	
NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42206		
(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 018	<p>Continued From page 2</p> <p>(66) beds with a census of Fifty (50) on the day of the survey. The facility failed to ensure six (6) corridor doors to the resident rooms were latching properly.</p> <p>The findings include:</p> <p>Observations, on 07/11/13 between 9:40 AM and 11:30 AM with the Maintenance Supervisor, revealed the corridor doors to rooms #207, 209, 101, 103, 108, and 118 would not latch properly.</p> <p>Interview, on 07/11/13 between 9:40 AM and 11:30 AM with the Maintenance Supervisor, revealed the facility had added a sealant strip from the previous survey to fix the gaps and the strip is affecting the doors latching properly.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1 3/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p>	K 018	<p>K072 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>1. One medicine cart was removed from the facility on 7/22/2013; the trashcans were removed from the corridor on 7/11/2013. The dirty linen carts and two medicine carts were placed in empty rooms.</p> <p>2. The DON In-serviced Staff on 8/2/2013 on keeping the corridor clear and if medicine or linen carts are being used they must be moved every 30 minutes at min. The couch, two tables, and chairs permanently stored in the 200 lobby were bolted down by the Maintenance Director on 7/16/2013 so that they were fixed furniture and meet the requirements for a walver.</p>	

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NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42206	
(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 018	Continued From page 3 Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018	3. A request for a waiver was sent to OIG on 7/31/2013 by the Administrator to allow the furniture to remain in the 200 Lobby. Auburn Health Care completed their annual survey for life safety on 7/11/2013. The facility was cited on K 072, Means of Egress not being clear. As permitted in CMS S & C 12-21-LSC(3) permitting seating groupings of furniture in corridors, Auburn Health Care is requesting a waiver for the 200 lobby area that also happens to be a means of egress. The area meets the 2012 Life Safety Code Section 19.2.3.4 Item 5, letters a-h as stated below: “(5) Where the corridor width is at least 8ft (2440mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a.) The fixed furniture is securely attached to the floor or to the wall. (b.) The fixed furniture does not reduce the clear unobstructed corridor with to less than 6ft (1850mm) except as permitted by 19.2.3.4 (2) (c.) The fixed furniture is located only on one side of the corridor. (d.) The fixed furniture is grouped such that each grouping does not exceed an area of 50ft ² (4.6m ²)”	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect four (4) of six (6) smoke compartments, fifty (50) residents, staff and visitors. The facility is certified for Sixty-Six (66) beds with a census of Fifty (50) on	K 072		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2013
NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42206	
(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 072	Continued From page 4 the day of the survey. The facility failed to ensure medicine carts, trash cans, and dirty linen carts were properly stored out of the corridor when not in use. This deficiency was cited on the previous survey in 2011. The findings include: Observation, on 07/11/13 between 9:15 AM and 10:00 AM with the Maintenance Supervisor, revealed dirty linen carts stored in the corridors of 200 hall, front 200 hall and 100 hall. Further observation revealed medicine carts stored in the front 200 hall and a trash can stored in the corridor. The final observation was the lobby area at the front of the 200 hall had a couch, two (2) tables, and a chair stored permanently in the corridor. Interview, on 07/11/13 between 9:15 AM and 10:00 AM with the Maintenance Supervisor, revealed he was unaware the staff was storing the carts improperly. This is a repeat deficiency. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	(e.) The fixed furniture groupings addressed in 19.2.3.4 (5)(d) are separated from each other by distance of at least 10ft (3050mm) (f.) The fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g.) Corridors throughout the smoke compartment are protected by an electronically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (h.) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8."	
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4	K 073	Since Auburn Health Care meets the above criteria and having this waiver will not adversely impact the safety and health of the residents, staff and visitors, the facility would greatly appreciate an approval of a waiver. The area serves as the main lobby for the facility.	

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NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42206	
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K 073	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no highly flammable furniture was used in the facility, in accordance with NFPA standards. The deficiency had the potential to affect five (5) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty-Six (66) beds with a census of Fifty (50) on the day of the survey. The facility failed to ensure resident upholstered chairs from home were being properly protected by a smoke detector. The findings include: Observation, on 07/11/13 between 9:15 AM and 10:00 AM with the Maintenance Supervisor, revealed resident chairs that were brought from home with no smoke detector installed in rooms located throughout the resident rooms in the facility. Interview, on 07/11/13 between 9:15 AM and 10:00 AM with the Maintenance Supervisor, revealed he was unaware if an upholstered chair was brought from home it must be protected by a smoke alarm. Reference: NFPA 101 (2000 Edition) 19.7.5.2 Newly introduced upholstered furniture within health care occupancies shall meet the criteria specified when tested in accordance with the methods cited in 10.3.2(2) and	K 073	There is plenty of room to use that exit in case of an emergency with the fixed furniture in place. The residents very much enjoy sitting in that area and like to interact with the visitors that come and go through that exit. If you have any questions regarding this request, please contact Stephanie Semrick, Administrator at 270-542-4111. Thank you for your consideration. On 7/30/2013 the Administrator revised CQI Form ES-3, Life Safety. 4. The Maintenance Director will complete revised CQI Form ES-3, "Life Safety", weekly for four weeks; then monthly thereafter. Completion Date 8/5/2013 K073 NFPA 101 LIFE SAFETY CODE STANDARD 1. On 7/16/2013 battery powered smoke detectors were purchased and placed in the	8/5/13

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NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42208		
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K 073	Continued From page 8 10,3,3. Exception: Upholstered furniture belonging to the patient in sleeping rooms of nursing homes, provided that a smoke detector is installed in such rooms. Battery-powered single-station smoke detectors shall be permitted.	K 073	rooms by the Maintenance Director where residents had upholstered chairs or furniture from home. 2. On 7/11/2013 the Maintenance Director checked all resident rooms for personal upholstered chairs or other upholstered furniture. Battery powered smoke detectors were placed in additional rooms found on 7/16/2013 by the Maintenance Director. 3. On 7/30/2013 the Administrator revised CQI Form ES-3, Life Safety to include: "If a resident has brought upholstered furniture from home, a smoke detector is in the room". 4. The Maintenance Director will complete revised CQI Form ES-3, "Life Safety", weekly for four weeks, then monthly thereafter. Completion Date 7/31/2013	7/31/13	