

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

PRINTED: 09/17/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2015
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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
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F 000	<p>INITIAL COMMENTS</p> <p>A Recertification Survey was conducted on 09/09/15 through 09/11/15 with deficiencies cited at the highest Scope and Severity of an "E".</p> <p>F 371 SS=E 483.35(I) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observations of the kitchen, revealed out of date food items stored in the refrigerator, refrigerators with temperatures ranging from 48 to 50 degrees Fahrenheit (F) and food served below the acceptable range for hot food temperatures.</p> <p>Review of the facility's Census and Condition, dated 09/09/15, revealed there were fifty-one (51) residents in the facility and one (1) of those residents received tube feedings and did not eat food from the kitchen area and there were ten residents who received ground meats with their</p>	F 000 F 371	<p>F 371 483.35(I) FOOD PROCURE, STORE, PREPARE, SERVE-SANITARY</p> <p>The corrective actions accomplished for those residents found to be affected by the deficient practice is:</p> <ul style="list-style-type: none"> The Dietary Manager discarded the individualized packets of sour cream & the health shakes on 9/9/15. The Dietary Manager adjusted the thermostats, 9/11/15, on the four refrigerators observed with the temperatures of 48-50 degrees F. On 9/9/15, the Dietary Manager immediately re-in-serviced her staff on the proper procedure for heating and reheating meat prior to plating and serving. <p>The facility identified other residents having the potential to be affected the same deficient practice by:</p> <ul style="list-style-type: none"> The Dietary Manager audited all food products in the dietary department and discarded any out of date items on 9/9/15. 	9/27/15
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>(Cynthia Newton)</i>	TITLE <i>Assistant Administrator</i>	(X6) DATE <i>9/25/15</i>
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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: 185049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/11/2015
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	<p>Continued From page 1 meals.</p> <p>The findings include:</p> <p>Review of the facility "Food Storage" Policy, undated, revealed food shall be rotated, as delivered and used in a first in, first out method and items will be dated to facilitate this procedure. Cold food will be maintained at temperatures of 40 degrees F, or below. Hot foods or potentially hazardous food will leave the steam table at 140 degrees F, or above.</p> <p>1. Observation of the refrigerators, on 09/09/15 at 10:50 AM, revealed approximately thirty (30) individualized packets of sour cream, dated 08/30/15 and twelve (12) fortified, pre-packaged health shakes, dated 09/07/15.</p> <p>2. Observations of the kitchen, on 09/09/15 at 10:50 AM and 09/11/15 at 3:00 PM, revealed four (4) refrigerators with temperatures of 48 to 50 degrees F.</p> <p>3. Observation of the tray line, on 09/09/15 at 11:12 AM, revealed the temperature of ground beef was 110 degrees F. The meat was not reheated and was plated, covered and placed in the meal cart, to be served.</p> <p>Interview with the Cook, on 09/09/15 at 12:03 PM, revealed the ground beef should have been re-heated to a temperature of 140 to 180 degrees F.</p> <p>Interview with the Dietary Manager, on 09/09/15 at 12:10 PM and 09/11/15 at 3:30 PM, revealed the ground beef should have been re-heated and she was not aware the food items, in the</p>	F 371	<ul style="list-style-type: none"> • After adjusting the thermostats in the four refrigerators on 9/11/15, the Dietary Manager monitored and recorded the temps for all the refrigerators on the Equipment Temperature Log throughout the day to ensure that the temperature inside all the refrigerators held at 40 degrees F or below. • The Dietary Manager tested the supper meal 9/11/15 to ensure that all cold and hot foods were served at the proper temperatures. <p><u>The measures put into place to ensure that the deficient practice will not recur was:</u></p> <ul style="list-style-type: none"> • On 9/15/15, the Administrator in-serviced the Dietary Manager on: <ul style="list-style-type: none"> ○ monitoring and discarding out dated food items ○ checking, maintaining and recording refrigerator temperatures twice daily on the Equipment Temperature log, and ○ testing and recording food temperatures at each meal. • On 9/17/15, the Dietary Manager completed in-servicing all the dietary staff on: 		

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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	
F 371	Continued From page 2 refrigerator, were out of date. The refrigerators should have been holding foods at temperatures of 40 degrees F. or below and stated the refrigerator doors may have been left open too long during the storage of food items.	F 371	<ul style="list-style-type: none"> o monitoring and discarding out dated food items o checking, maintaining and recording refrigerator temperatures twice daily on the Equipment Temperature Log o testing, heating, reheating, plating, serving and recording food temperatures at each meal on the Food Temperature Record. 		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility policy, it was determined the facility failed to provide a safe, functional and comfortable environment for residents, staff and the public, as evidenced by the front entry doors leading to the 200 Wing from the outside sidewalk, that failed to properly close and lock. The findings include: Review of the facility policy "Exits or Means of Egress, undated, revealed the exit doors will be inspected, at least weekly, by the Maintenance Director, to ensure proper functioning and documented on the QWAPI Form and on the Weekly Preventable Maintenance Schedule. Observations on 09/09/15 at 11:25 PM and 09/11/15 at 12:45 PM and 3:55 PM, revealed the 200 Wing entry doors would not completely latch when visitors and staff would enter and exit the doors and lacked about a two (2) to four (4) inch	F 465	<ul style="list-style-type: none"> • The Dietary Manager will attach a copy of the Equipment Temperature Log and the Food Temperature Record with her Dietary Report that is turned in to the Administrator monthly. • On 9/22/15, the Administrator implemented the Sanitation Safety Review, Sanitation Rounds form and Dietary Review Audit form. The new (QAPI) forms contain entire sections pertaining to rotating stock and discarding out of date food, refrigerator/freezer temps and checking/serving food at the appropriate temperatures. 		

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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	
F 465	<p>Continued From page 3</p> <p>gap of closing. One visitor was noted to push the door closed to ensure they were locked.</p> <p>Observation on 09/09/15 at 11:52 AM, revealed the Maintenance Director and a contractor were working on the doors and stated the right door would not close properly and the left door has a "two-inch-play" and the director was noted to have been able to lift the door and move the entire door, one to two (1-2) inches in the door frame. The doors were observed with a code box entry and exit device and the wandergard alarm system.</p> <p>Interview with the Maintenance Director, on 09/11/15 at 12:45 PM, revealed he was aware of the doors not completely latching and had a contractor come and evaluate the situation and stated the facility probably needed to replace the doors to completely rectify the situation, as the doors were original to the building and were "worn out." The Maintenance Director revealed there was no door closure policy, that he was aware of, yet he had only been at the facility approximately one (1) month.</p> <p>Interview, on 09/11/15 at 3:15 PM, with the Administrator revealed she was not aware they were not functioning properly until recently and stated the facility was looking at having the doors replaced.</p>	F 465	<ul style="list-style-type: none"> On 9/24/15, the Assistant Administrator in-serviced the Dietary Manager on the new (QAPI) Sanitation Safety Review, Sanitation Rounds form, Dietary Review Audit form. <p><u>The facility plans to monitor its performance to ensure that solutions are sustained by:</u></p> <ul style="list-style-type: none"> The Dietary Manager will complete the (QAPI) Sanitation Safety Review, Sanitation Rounds form, Dietary Review Audit form monthly. The Administrator will review QAPI forms to ensure any issues identified are addressed through action plans. <p>F 465 483.70(h) SAFE/FUNCTIONAL/SANITARY/ COMFORTABLE ENVIRONMENT</p> <p><u>The corrective actions accomplished for those residents found to be affected by the deficient practice is:</u></p> <ul style="list-style-type: none"> The Maintenance Director installed a new door closure mechanism and completed the repairs on the 200 Wing doors 9/14/15. 	9/27/15	



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The facility identified other residents having the potential to be affected the same deficient practice by:

- The Maintenance Director audited all the exit doors to ensure they opened and closed properly 9/14/15.

The measures put into place to ensure that the deficient practice will not recur was:

- The Administrator reviewed the Exits or Means of Egress Policy 9/14/15 and found it to be sufficient.
- The Assistant Administrator in-serviced the Maintenance Director 9/14/15 on the contents of the Exits or Means of Egress Policy and initiating the current daily & weekly maintenance check forms.
- Administrator revised the Maintenance Director's Monthly Report 9/15/15 that will be completed and turned in to the Administrator each month. The form includes a section about making the Administrator aware of any safety issues found in the building immediately.
- On 9/15/15, the Administrator revised QAPI form ES-12 titled "Preventative Maintenance Review" to include a section on proper door closure and functioning.



continue F 465

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- On 9/21/15, the Administrator implemented new Daily & Weekly Maintenance Check forms that include a specific section pertaining to door closures & functioning.
- Administrator revised QAPI form ES-13 titled "Preventative Maintenance Calendar" that includes a review of the tasks specified on the Maintenance Daily/ Weekly checks and the Maintenance Monthly Report 9/21/15.
- Administrator in-services the Maintenance Director 9/22/15 on the new Daily & Weekly Maintenance Checks, revised Monthly Report and QAPI forms ES-12 "Preventative Maintenance Review" and ES-13 "Preventative Maintenance Calendar".

The facility plans to monitor its performance to ensure that solutions are sustained by:

- The Maintenance Director will complete QAPI forms ES-12 titled "Preventative Maintenance Review" and ES-13 "Preventative Maintenance Calendar" monthly for three months beginning in September, then quarterly per regular QAPI schedule. The Administrator will review QAPI forms to ensure any issues identified are addressed through action plans.

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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 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 Life Safety Code Survey was initiated and concluded on 09/09/15, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000		

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

TITLE

(X8) DATE

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