

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

PRINTED: 07/15/2014  
FORM APPROVED  
OMB NO. 0938-0391

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  07/03/2014
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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 000	INITIAL COMMENTS  A Recertification Survey was conducted on 06/30/14 through 07/03/14 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "F."	F 000		
F 253 SS=D	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 and interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior related to improper storage of equipment in front of the eyewash station.  The findings include:  Interview with the Maintenance Supervisor, on 07/03/14 at 2:15 PM, revealed there was no policy regarding blocking access to the eye wash station.  1. Observation of the storage room on 07/03/14 at 1:00 PM, revealed a housekeeping cart blocking access to an eye wash station.  Interview with Housekeeper #1, on 07/03/14 at 1:15 PM, revealed the housekeeping cart was always kept in front of the eyewash station and she stated there was no other place to store the	F 253	F 253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  <u>The corrective actions accomplished for those residents found to be affected by the deficient practice is:</u> <ul style="list-style-type: none"> <li>The housekeeping cart was removed from in front of the eye wash station 7/3/14 by Housekeeping Supervisor.</li> </ul> <u>How the facility identified other residents having the potential to be affected the same deficient practice is:</u> <ul style="list-style-type: none"> <li>On 7/3/14, the Maintenance Director checked to ensure the remaining eye stations in the building were not blocked by anything.</li> </ul> <u>The measures put into place to ensure that the deficient practice will not recur was:</u> <ul style="list-style-type: none"> <li>The Corporate Officer revised and implemented the "Eye Wash Station" policy 7/15/14 to include, "Eye wash stations must be accessible at all times &amp; Never block or store items in front of an Eye wash station.</li> <li>The Daily Maintenance Check List was revised 7/15/14 by the Administrator to include an additional check of "Ensuring easy access to eyewash stations."</li> <li>Staff were in-serviced by Administrator 7/15/14 on ensuring that <del>nothing</del> is stored in front of the eyewash stations.</li> </ul>	7/26/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deane Miller TITLE: Int Administrator (X6) DATE: 7/25/14

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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F 253	Continued From page 1 cart.  Interview with the Maintenance Director, on 07/03/14 at 1:00 PM, revealed storage space was at a minimum, at the facility and he was aware the eye wash station should not have been blocked yet was unable to find an alternate location.  Interview with the Administrator, on 07/03/14 at 2:15 PM, revealed she was unaware of the housekeeping cart, stored in front of the eye wash station and stated this would be resolved.	F 253	<ul style="list-style-type: none"> <li>A Corporate Officer revised Quality Assurance form ES-7 titled, "Safety Inspection-Housekeeping" 7/22/14 to include "the question "Were the eyewash stations easily accessible to everyone."</li> <li>The Housekeeping Supervisor completed Quality Assurance Form ES-7 titled, "Safety Inspection-Housekeeping " 7/25/14.</li> </ul> <p><u>The facility plans to monitor its performance to ensure that solutions are sustained by:</u></p> <ul style="list-style-type: none"> <li>Quality Assurance form ES-7 "Safety Inspection-Housekeeping" will be completed monthly for 2 months, then quarterly thereafter by Housekeeping Supervisor.</li> </ul>		
F 371 SS=F	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 facility policy review, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observations of the kitchen revealed: There was no access to cold water, at the hand wash sink; there was no trash can near the hand wash sink; and, the ice maker had a build up of substances on the metal plate over the ice cubes; And the freezer temperatures ranged	F 371	<p>F 371 483.35(i) FOOD PROCURE, STORE, PREPARE, SERVE-SANITARY</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"> <li>The water temperatures were stabilized to the kitchen sink after the Maintenance Director replaced the faucet, turned the cold water value back on and removed the bucket 7/24/14.</li> </ul>	7/26/14	

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F 371	<p>Continued From page 2</p> <p>from ten degrees Fahrenheit (F) to 38 degrees F.</p> <p>Review of the facility's Census and Condition, dated 06/30/14, revealed there were (fifty-six) 56 residents in the facility and three (3) of those residents were tube feeders and did not eat food from the kitchen area.</p> <p>The findings include:</p> <p>Review of the facility Management and Personnel Guide 2005 Food Code" and "Handwashing Procedure", not dated, revealed the staff were to only use the hand washing sink and not use the prep sink or mop sink. Hands and exposed arms were to have been lathered, vigorously rubbed for 20 seconds and rinsed with clean water. A review of the "Kentucky Food Code" for 2005 revealed frozen foods shall be kept frozen and should be stored at a temperature of zero degrees F or below.</p> <p>1. Observation and use of the hand sink on 07/01/14 at 10:20 AM and 07/03/14 at 9:40 AM, revealed there was no available cold water at the sink and the hot water temperature tested 122 degrees F, with the kitchen's calibrated thermometer. In addition, there was no available waste container, near the sink, for used paper towels.</p> <p>Interview with the Dietary Manager, on 07/03/14 at 9:40 AM, revealed the cold water had been turned off for approximately one (1) year. She also stated there was no place to store a waste can as the red bucket, stored under the sink, was needed to catch any water-leaks and stated the staff had to open the door to the dry storage area and use the trash can there.</p>	F 371	<ul style="list-style-type: none"> <li>The Dietary Manager ordered a step-on waste container and put in near the kitchen sink 7/18/14.</li> <li>The Maintenance Director repaired the latch on the freezer door, but the freezer failed to maintain the appropriate temperature. New freezers were purchased, delivered and put into place 7/25/14.</li> <li>The Dietary Manager cleaned the built up substance on the metal plate over the ice cubes on the ice maker 7/1/14.</li> </ul> <p><u>How the facility identified other residents having the potential to be affected the same deficient practice is:</u></p> <p>All residents have the potential to be affected by the deficient practice.</p> <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"> <li>The Dietary Cleaning Schedule is now being completed twice weekly instead of once weekly by the Dietary Staff.</li> <li>The Dietary Manager in-serviced the dietary staff 7/12/14 on completing the cleaning schedule twice weekly.</li> </ul>		

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F 371	<p>Continued From page 3</p> <p>2. Observation of freezer and refrigerators, on 07/01/13 at 10:30 AM, revealed the outside walk-in freezer temperature at ten (10) degrees F and on 07/03/14 at 10:00 AM, the temperature was thirty-eight (38) degrees F. In addition, the latch on the freezer door was broken and the kitchen staff had to obtain a step-ladder, kept beside the freezer, and stand on the ladder to physically close the latch, in order for the freezer door to stay closed.</p> <p>Review of the "Equipment Temperature Logs" for June and July 2014, revealed the outside walk-in freezer temperatures were documented from ten to thirty degrees F.</p> <p>Interview with the Dietary Manager, on 07/03/13 at 10:25 AM, revealed she had reported concerns with the freezers and stated the temperatures should be kept at zero (0) degrees.</p> <p>3. Observation of the ice machine, on 07/01/14 at 10:40 AM, revealed a cream colored build-up of substances, on the metal plate, over the ice cubes.</p> <p>Interview with the Dietary Manager, on 07/01/14 at 10:50 AM, revealed she was not aware of the build-up and stated the ice maker was scheduled to be cleaned every Friday. However, a review of the "Dietary Cleaning Schedule" for June 2014 and July 2014 revealed the cleaning had not been documented as having been completed.</p> <p>Interview with the Administrator, on 07/03/14 at 10:45 AM, revealed she was aware of the concerns in the kitchen and stated these would be corrected.</p>	F 371	<ul style="list-style-type: none"> <li>The Administrator in-serviced the Dietary Manager on ensuring the dietary staff follow the Cleaning Schedule 7/12/14.</li> <li>Quality Assurance Form D-8 "Dietary Department Audit" was revised 7/21/14 by a Corporate Officer to include checking for : <ul style="list-style-type: none"> <li>Is waste can near sink</li> <li>Is freezer door latching properly</li> <li>Are there any water leaks</li> </ul> </li> </ul> <p><u>The facility plans to monitor its performance to ensure that solutions are sustained by:</u></p> <ul style="list-style-type: none"> <li>The Dietary Manager will complete Quality Assurance form D-8 "Dietary Department Audit" monthly for 2 months, then quarterly per regular QA schedule.</li> </ul>		

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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: 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 07/01/14. The facility 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-seven (57) 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

*Diane Miller*

TITLE

*Int Administrator*

(X6) DATE

*7/25/14*

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K 000	Continued From page 1 Fire).	K 000			
K 025 SS=E	Deficiencies were cited with the highest deficiency identified at "F" level. <b>NFPA 101 LIFE SAFETY CODE STANDARD</b> 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  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 National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect three (3) of six (6) smoke compartments, thirty six (36) residents, staff and visitors. The facility has the capacity for sixty-six (66) beds and at the time of the survey, the census was fifty-seven (57).  The findings include:  Observation, on 07/01/14 at 9:30 AM with the Maintenance Director, revealed the smoke	K 025	<b>K025</b> <b>NFPA 101 LIFE SAFETY</b> <b>CODE STANDARD</b> <b>Smoke Barriers</b>  The corrective actions taken for those residents found to have been affected by the deficient practice were: <ul style="list-style-type: none"><li>The one (1) one (1") hole and open pipe penetrating the smoke partition, extended above the ceiling located in the 200 hall, and the two (2) two inch (2") holes penetrating the smoke partition in the Breezeway were sealed with Fire Stop on 7/16/14--7/24/14 by the Maintenance Director.</li></ul> The facility will identify other residents having the potential to be affected by the same defiant practice by: <ul style="list-style-type: none"><li>An audit was conducted 7/16/14 by the Maintenance Director for the entire facility to identify any penetrations within the fire wall that had not been sealed. Any penetration identified will be sealed with Fire Stop.</li></ul>	7/26/14	

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K 025	<p>Continued From page 2</p> <p>partition, extending above the ceiling located in the Breezeway Hall had two (2) two inch (2") holes penetrating the smoke partition that were not sealed to resist the passage of smoke.</p> <p>Interview, on 07/01/14 at 9:31 AM with the Maintenance Director, revealed the facility had just recently installed some new wiring, however, he was not aware of the unsealed penetrations in the smoke partition.</p> <p>Observation, on 07/01/14 at 9:44 AM with the Maintenance Director, revealed the smoke partition, extending above the ceiling located in the 200 Hall had one (1) one inch (1") hole penetrating the smoke partition that was not sealed to resist the passage of smoke. Further observation revealed an open pipe penetrating the smoke partition that was not sealed to the wall or sealed on the inside of the pipe.</p> <p>Interview, on 07/01/14 at 9:45 AM with the Maintenance Director, revealed the facility had just recently installed some new wiring, however, he was not aware of the unsealed penetrations in the smoke partition.</p> <p>The census of fifty-seven (57) was verified by the Administrator on 07/01/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 07/01/14.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101 (2000 Edition). 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</p>	K 025	<p>The measures put into place to ensure the deficient practice will not recur was:</p> <ul style="list-style-type: none"> <li>On 7/23/14, the Corporate Officer Implemented a new policy titled "Life Safety" to include: "The Maintenance Director will maintain facility building/grounds in accordance with NFPA 101 Life Safety Code Standards".</li> <li>The Corporate Officer reviewed the CQI form "ES-3 Life Safety" 7/23/14 to ensure the following information was included: "There are no penetrations identified in fire walls or smoke partitions."</li> <li>The Maintenance Director was in-serviced on 7/23/14 by the Administrator on K025; maintaining smoke barriers that would resist the passage of smoke between smoke compartments, the new policy titled "Life Safety" and CQI tool "ES-3 Life Safety"</li> </ul>	

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K 025	Continued From page 3 barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (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 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.  8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025	The facility plans to monitor its performance to ensure that solutions are sustained are: <ul style="list-style-type: none"> <li>CQI form "ES-3 Life Safety" was initially completed 7/24/14 and will be completed monthly for two months and per CQI schedule thereafter by the Maintenance Director.</li> </ul>	
K'027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least	K 027	K027 NFPA 101 LIFE SAFETY CODE STANDARDS Cross-corridor coordinating device	7/26/14

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K 027	<p>Continued From page 4</p> <p>1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect two (2) of six (6) smoke compartments, thirty-six (36) residents, staff and visitors. The facility has the capacity for sixty-six (66) beds and at the time of the survey, the census was fifty-seven (57).</p> <p>The findings include:</p> <p>Observation, on 07/01/14 at 11:15 PM with the Maintenance Director, revealed the cross-corridor doors located in the 200 Hall would not close completely when tested. The doors were equipped with a coordinating device that would not function properly after the initial closure.</p> <p>Interview, on 07/01/14 at 11:16 PM with the Maintenance Director, revealed he was not aware the coordinating device was out of adjustment.</p> <p>The census of fifty-seven (57) was verified by the</p>	K 027	<p>The corrective actions taken for those residents found to have been affected by the deficient practice were:</p> <ul style="list-style-type: none"> <li>The cross-corridor coordinating device on the 200 hall was adjusted 7/3/14 to function properly by coordinating the doors when closing to resist the passage of smoke through the smoke barrier.</li> </ul> <p>The facility will identify other residents having the potential to be affected by the same defiant practice by:</p> <ul style="list-style-type: none"> <li>An audit was conducted 7/3/14 by the Maintenance Director to ensure all cross-corridor coordinating devices functioned properly. Any coordinating devices found not functioning properly was adjusted to resist the passage of smoke through the smoke barrier.</li> </ul> <p>The measures put into place to ensure the deficient practice will not recur was:</p> <ul style="list-style-type: none"> <li>On 7/23/14, the Corporate Officer Implemented a new policy titled "Life Safety" to include: "The Maintenance Director will maintain facility building/grounds in accordance with NFPA 101 Life Safety Code Standards".</li> </ul>	



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K 029	<p>Continued From page 6</p> <p>Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with the National Fire Protection Agency (NFPA) standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, eighteen (18) residents, staff and visitors. The facility has the capacity for sixty-six (66) beds and at the time of the survey, the census was fifty-seven (57).</p> <p>The findings include:</p> <p>Observation, on 07/01/14 at 10:38 AM, with the Maintenance Director revealed the door to a hazardous storage room located across the hall from room #110 had an unapproved hold open device (flip down type) installed on the door. The device prevented the door from being self-closing as required.</p> <p>Interview, on 07/01/14 at 10:39 AM, with the Maintenance Director revealed he was aware of the hazardous storage room, however; he was not aware the hold open device had to be of an approved type.</p> <p>Observation, on 07/01/14 at 11:00 AM, with the Maintenance Director revealed resident room #104 was being used as a hazardous storage room for three (3) trash and dirty linen carts. The door was not equipped with a self-closing device</p> <p>Interview, on 07/01/14 at 11:01 AM, with the Maintenance Director revealed he was not aware the room would have to meet the requirements of a hazardous storage room by storing the carts in the room.</p>	K 029	<p>The corrective actions taken for those residents found to have been affected by the deficient practice were:</p> <ul style="list-style-type: none"> <li>The unapproved hold open device (flip down type) across the hall from room #110 was removed by the Maintenance Director on 7/3/2014. The (3) trash and dirty linen carts in room #104 were removed 7/3/14 by the Housekeeping Supervisor.</li> </ul> <p>The facility will identify other residents having the potential to be affected by the same defiant practice by:</p> <ul style="list-style-type: none"> <li>An audit was conducted by the Maintenance Director on 7/7/14 to ensure no other door had an unapproved hold open device and any room used to store hazardous items had a self-closing mechanism installed on the door.</li> </ul> <p>The measures put into place to ensure the deficient practice will not recur was:</p> <ul style="list-style-type: none"> <li>On 7/23/14, the Corporate Officer Implemented a new policy titled "Life Safety" to include: "The Maintenance Director will maintain facility building/grounds in accordance with NFPA 101 Life Safety Code Standards".</li> </ul>		

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K 029	Continued From page 7  The census of fifty-seven (57) was verified by the Administrator on 07/01/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 07/01/14.  Actual NFPA Standard:  Reference: NFPA 101 (2000 Edition) 19.3.2 Protection from Hazards.  Reference: NFPA 101 (2000 Edition) 9.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or	K 029	<ul style="list-style-type: none"> <li>On 7/23/14, the Corporate Officer revised the CQI form "ES-3 Life Safety" to ensure the following information was included: "Rooms and Offices considered hazardous areas: door has a self closing device and no unapproved hold open devices (flip down type) are used."</li> <li>The Maintenance Director was in-serviced 7/23/14 by the Administrator on K029; the protection from hazards, the new policy titled "Life Safety" and on the revised CQI form titled "ES-3 Life Safety".</li> </ul> <p>The facility plans to monitor its performance to ensure that solutions are sustained are:</p> <ul style="list-style-type: none"> <li>The CQI form "ES-3 Life Safety" was initially completed 7/24/14 and will be completed monthly for two months and per CQI schedule thereafter by the Maintenance Director.</li> </ul>	

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K 029	<p>Continued From page 8</p> <p>combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8 Self-Closing Devices.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®.</p>	K 029			

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K 029	Continued From page 9 (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 029		
K 032 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors in the path of egress were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect one (1) of two (2) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty-six (66) beds and at the time of the survey, the census was fifty-seven (57).  The findings include:  Observation, on 07/01/14 at 10:34 AM with the Maintenance Director, revealed the exit door located in the dining room that leads to the public way did not swing in the path of egress.  Interview, on 07/01/14 at 10:35 AM with the Maintenance Director, revealed he was not aware	K 032	K032 NFPA 101 LIFE SAFETY CODE STANDARDS Exit door in 100 Dining Room  The corrective actions taken for those residents found to have been affected by the deficient practice were: <ul style="list-style-type: none"><li>The Fire Marshall was contacted 7/14/14 by the Maintenance Director. After visually inspecting the dining room on 7/15/14, the Fire Marshall gave permission to remove the "Exit" sign above the dining room door. The evacuation route signage in that area was updated and the "Exit" sign was officially removed 7/18/14.</li></ul> The facility will identify other residents having the potential to be affected by the same defiant practice by: <ul style="list-style-type: none"><li>On 7/15/14 the Maintenance Director audited all other facility "Exit" doors to ensure proper swing in the direction of egress.</li></ul>	7/26/14

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K 032	Continued From page 10 the door had to swing in the direction of egress.  The census of fifty-seven (57) was verified by the Administrator on 07/01/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 07/01/14.  Actual NFPA Standard:  Reference: NFPA 101 (2000 Edition) 7.2.1.4.2 Doors required to be of the side-hinged or pivoted-swinging type shall swing in the direction of egress travel where serving a room or area with an occupant load of 50 or more. Exception No. 1: Doors in horizontal exits shall not be required to swing in the direction of egress travel where exempted in 7.2.4.3.6. Exception No. 2: Smoke barrier doors shall not be required to swing in the direction of egress travel as provided in Chapter 19. Reference: NFPA 101 (2000 Edition) 7.2.1.4.3 A door shall swing in the direction of egress travel where used in an exit enclosure or where serving a high hazard contents area, unless it is a door from an individual living unit that opens directly into an exit enclosure.	K 032	The measures put into place to ensure the deficient practice will not recur was: <ul style="list-style-type: none"><li>On 7/23/14, the Corporate Officer Implemented a new policy titled "Life Safety" to include: "The Maintenance Director will maintain facility building/grounds in accordance with NFPA 101 Life Safety Code Standards".</li><li>On 7/23/14 the Corporate Office revised the CQI form ES-3 titled "Life Safety" to include the following information: "All exit doors open in the direction of egress and close properly"</li><li>The Maintenance Director was in-serviced 7/23/14 by the Administrator on K032; ensuring paths of egress were maintained, the new policy titled "Life Safety" and on the revised CQI form titled "ES-3 Life Safety".</li></ul>		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain emergency lighting in accordance with the	K 046	The facility plans to monitor its performance to ensure that solutions are sustained are: <ul style="list-style-type: none"><li>The CQI form "ES-3 Life Safety" was initially completed 7/24/14 and will be completed monthly for two months and per CQI schedule thereafter by the Maintenance Director.</li></ul>	7/26/14	

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K 046	<p>Continued From page 11</p> <p>National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, four (4) residents, staff and visitors. The facility has the capacity for sixty-six (66) beds and at the time of the survey, the census was fifty-seven (57).</p> <p>The findings include:</p> <p>Observation, on 07/01/14 at 10:31 AM, with the Maintenance Director revealed the battery powered emergency light located in the Kitchen failed to illuminate when tested.</p> <p>Interview, on 07/01/14 at 10:32 AM, with the Maintenance Director revealed he was not aware the battery powered emergency light located in the kitchen had stopped working.</p> <p>The census of fifty-seven (57) was verified by the Administrator on 07/01/14. The survey findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 07/01/14.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency illumination shall be provided for not less than 11/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6</p>	K 046	<p>K046 NFPA 101 LIFE SAFETY CODE STANDARDS Emergency Lighting</p> <p>The corrective actions taken for those residents found to have been affected by the deficient practice were:</p> <ul style="list-style-type: none"> <li>On 7/23/14 the Maintenance Director removed the battery powered emergency light located in the kitchen.</li> </ul> <p>The facility will identify other residents having the potential to be affected by the same defiant practice by:</p> <ul style="list-style-type: none"> <li>On 7/23/14 the Maintenance Director inspected all other battery powered emergency lighting for proper functioning and any identified as deficient were be replaced/repared at that time.</li> </ul> <p>The measures put into place to ensure the deficient practice will not recur was:</p> <ul style="list-style-type: none"> <li>On 7/23/14, the Corporate Officer reviewed the facility policy titled "Emergency Lighting" and CQI form titled "ES-3 Life Safety" to ensure the following information was included: "Battery powered emergency lights and exit lights are tested for 30 seconds monthly and 90 minutes annually."</li> </ul>	7/26/14

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K 046	Continued From page 12 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.  7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046	<ul style="list-style-type: none"> <li>The Maintenance Director was in-serviced 7/23/14 by the Administrator on K046; maintaining emergency lighting in accordance with NFPA standards, revised "Emergency Lighting" policy and CQI form titled "ES-3 Life Safety".</li> </ul> <p>The facility plans to monitor its performance to ensure that solutions are sustained are</p> <ul style="list-style-type: none"> <li>The CQI form "ES-3 Life Safety" was initially completed 7/24/14 and will be completed monthly for two months and per CQI schedule thereafter by the Maintenance Director.</li> </ul> <p style="text-align: center;">K052 NFPA 101 LIFE SAFETY CODE STANDARDS Fire alarm system inspection &amp; testing</p> <p>The corrective actions taken for those residents found to have been affected by the deficient practice were:</p> <ul style="list-style-type: none"> <li>On 7/16/14 Vanguard-Fire System fixed the fire alarm system to ensure once the fire alarm was placed in silent mode, the magnetic hold open devices for the smoke doors did not re-energize and the audible alarm would reactivate once a secondary initialing device (manual pull station) was activated in a separate zone.</li> </ul>		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		7/26/14	

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K 052	Continued From page 13  This STANDARD is not met as evidenced by: Based on observation during the testing of the fire alarm and interview, it was determined the facility failed to ensure the fire alarm system was inspected and tested in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice has the potential to affect six (6) of six (6) smoke compartments, all residents, staff and visitors. The facility has the capacity for sixty-six (66) beds and at the time of the survey, the census was fifty-seven (57).  The findings include:  Observation during the testing of the fire alarm, on 07/01/14 at 11:43 AM with the Maintenance Director, revealed once the fire alarm was placed in silent mode the magnetic hold open devices for the smoke doors re-energized.  Interview, on 07/01/14 at 11:45 AM with the Maintenance Director, revealed he was unaware the magnetic hold open devices were not to re-energize when the fire alarm control panel was placed in silent mode.  Observation during the testing of the fire alarm, on 07/01/14 at 11:44 AM with the Maintenance Director, revealed once the fire alarm control panel was placed in silent mode the audible alarm would not re-alarm when a second initiating device (manual pull station) was activated.	K 052	The facility will identify other residents having the potential to be affected by the same defiant practice by: <ul style="list-style-type: none"><li>On 7/16/14 the Maintenance Director audited the facility to ensure no magnetic hold open device was re-energized when fire alarm system was placed in silent mode and ensured that each pull station in a separate zone would reactivate the audible alarm system during silent mode.</li></ul> The measures put into place to ensure the deficient practice will not recur was: <ul style="list-style-type: none"><li>On 7/23/14, the Corporate Officer Implemented a new policy titled "Life Safety" to include: "The Maintenance Director will maintain facility building/grounds in accordance with NFPA 101 Life Safety Code Standards".</li><li>On 7/23/14 the Corporate Officer revised the CQI form titled "ES-3 Life Safety" to include the following information: "All alarm boxes are tested annually to ensure: proper functioning, secondary pull station in separate zone reactivates the audible alarm in silent mode" and "Magnetic hold open device does not re-energize during audible or silent alarm mode."</li></ul>	

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K 052	Continued From page 14 Interview, on 07/01/14 at 11:45 AM with the Maintenance Director, revealed he was unaware the fire alarm was to re-alarm if another initiating device (manual pull station) was activated.  The census of fifty-seven (57) was verified by the Administrator on 07/01/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 07/01/14.  Actual NFPA Standard:  NFPA 101, 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.  NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on sprinkler testing record review and interview, it was determined the facility failed to maintain the sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, all residents, staff and visitors. The facility has the capacity for sixty-six (66) beds and at the time of the survey, the census was fifty-seven (57).	K 052	<ul style="list-style-type: none"> <li>On 7/23/14 the Maintenance Director was in-serviced by the Administrator on K052; ensuring fire alarm system was inspected and tested in accordance with NFPA Standards, the new policy titled "Life Safety and the revised CQI form ES-3 titled "Life Safety".</li> </ul> <p>The facility plans to monitor its performance to ensure that solutions are sustained are:</p> <ul style="list-style-type: none"> <li>The CQI form "ES-3 Life Safety" was initially completed 7/24/14 and will be completed monthly for two months and per CQI schedule thereafter by the Maintenance Director.</li> </ul> <p style="text-align: center;">K062 NFPA 101 LIFE SAFETY CODE STANDARDS Failed to conduct sprinkler inspection in 4<sup>th</sup> quarter</p> <p>The corrective actions taken for those residents found to have been affected by the deficient practice were:</p> <ul style="list-style-type: none"> <li>Armor Fire Protection completed: <ul style="list-style-type: none"> <li><del>a.</del> 1<sup>st</sup> quarter 2014 sprinkler test 1/8/14</li> <li>b. 2nd quarter 2014 sprinkler test 4/23/14</li> <li>c. 3<sup>rd</sup> quarter sprinkler test 7/2/14.</li> </ul> </li> </ul>	
K 062 SS=F		K 062		7/26/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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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  07/01/2014
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 062	<p>Continued From page 15</p> <p>The findings include:</p> <p>Sprinkler testing record review, on 07/01/14 at 12:09 PM with the Maintenance Director, revealed the facility failed to conduct the quarterly sprinkler inspection in the fourth (4th) quarter of 2013.</p> <p>Interview, on 07/01/14 at 12:10 PM with the Maintenance Director, revealed he relied on his Sprinkler Company to ensure the system was inspected properly and quarterly as required.</p> <p>The census of fifty-seven (57) was verified by the Administrator on 07/01/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 07/01/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 25 (1998 Edition), 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance.</p> <p>Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference</p>	K 062	<p>The facility will identify other residents having the potential to be affected by the same defiant practice by:</p> <ul style="list-style-type: none"> <li>As of 7/22/14, no current resident is affected by the deficient practice. The facility has been in compliance with quarterly sprinkler inspections since 1/8/14.</li> </ul> <p>The measures put into place to ensure the deficient practice will not recur was:</p> <ul style="list-style-type: none"> <li>On 7/23/14, the Corporate Officer Implemented a Policy titled "Life Safety" to include the following information: "The Maintenance Director will maintain facility building/grounds in accordance with NFPA 101 Life Safety Code Standards".</li> <li>On 7/23/14 the Corporate Officer revised the CQI form ES-3 titled "Life Safety" to include the following question: "The sprinkler system is tested quarterly by a qualified agency and is documented within that quarter."</li> </ul>		

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K 062	Continued From page 16 Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction-Investigation Maintenance 5 years or as needed Chapter 10  Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Component Activity Frequency Reference	K 062	<ul style="list-style-type: none"> <li>The Maintenance Director was in-serviced by the Administrator 7/23/14 on K062; ensuring maintenance of the sprinkler system in accordance with NFPA Standards and the new Life Safety Policy.</li> </ul> <p>The facility plans to monitor its performance to ensure that solutions are sustained are:</p> <ul style="list-style-type: none"> <li>The CQI ES-3 form titled "Life Safety" was initially completed 7/24/14 and will be completed monthly for two months, then per CQI calendar thereafter by the Maintenance Director.</li> </ul>	

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K 062	Continued From page 17 Control Valves Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No. 1 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1 Alarm Valves Exterior Inspection Monthly 9-4.1.1 Interior Inspection 5 years 9-4.1.2 Strainers, filters, orifices Inspection 5 years 9-4.1.2 Check Valves Interior Inspection 5 years 9-4.2.1 Preaction/Deluge Valves Enclosure (during cold weather) Inspection Daily/weekly 9-4.3.1 Exterior Inspection Monthly 9-4.3.1.2 Interior Inspection Annually/5 years 9-4.3.1.3 Strainers, filters, orifices Inspection 5 years 9-4.3.1.4 Dry Pipe Valves/Quick-Opening Devices Enclosure (during cold weather) Inspection Daily/weekly 9-4.4.1.1 Exterior Inspection Monthly 9-4.4.1.3 Interior Inspection Annually 9-4.4.1.4 Strainers, filters, orifices Inspection 5 years 9-4.4.1.5 Pressure Reducing and Relief Valves Sprinkler systems Inspection Quarterly 9-5.1.1 Hose connections Inspection Quarterly 9-5.2.1 Hose racks Inspection Quarterly 9-5.3.1 Fire pumps Casing relief valves Inspection Weekly 9-5.5.1, 9-5.5.1.1 Pressure relief valves Inspection Weekly 9-5.5.2, 9-5.5.2.1 Backflow Prevention Assemblies Reduced pressure Inspection Weekly/monthly	K 062		

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K 062	Continued From page 18 9-6.1 Reduced pressure detectors Inspection Weekly/monthly 9-6.1 Fire Department Connections Inspection Quarterly 9-7.1 Main Drains Test Annually 9-2.6, 9-3.4.2 Waterflow Alarms Test Quarterly 9-2.7 Control Valves Position Test Annually 9-3.4.1 Operation Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3 Preaction/Deluge Valves Priming water Test Quarterly 9-4.3.2.1 Low air pressure alarms Test Quarterly 9-4.3.2.10 Full flow Test Annually 9-4.3.2.2 Dry Pipe Valves/Quick-Opening Devices Priming water Test Quarterly 9-4.4.2.1 Low air pressure alarm Test Quarterly 9-4.4.2.6 Quick-opening devices Test Quarterly 9-4.4.2.4 Trip test Test Annually 9-4.4.2.2 Full flow trip test Test 3 years 9-4.4.2.2.1 Pressure Reducing and Relief Valves Sprinkler systems Test 5 years 9-5.1.2 Circulation relief Test Annually 9-5.5.1.2 Pressure relief valves Test Annually 9-5.5.2.2 Hose connections Test 5 years 9-5.2.2 Hose racks Test 5 years 9-5.3.2 Backflow Prevention Assemblies Test Annually 9-6.2 Control Valves Maintenance Annually 9-3.5 Preaction/Deluge Valves Maintenance Annually 9-4.3.3.2 Dry Pipe Valves/Quick-Opening Devices Maintenance Annually 9-4.4.3.2	K 062			
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 066		7/26/14	

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K 066	<p>Continued From page 19</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the designated outdoor smoking area for the residents was properly equipped for safe smoking, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect residents using the smoking areas and staff. The facility has the capacity for sixty-six (66) beds and at the time of the survey, the census was fifty-seven (57).</p>	K 066	<p>K066 NFPA 101 LIFE SAFETY CODE STANDARDS Smoking container</p> <p>The corrective actions taken for those residents found to have been affected by the deficient practice were:</p> <ul style="list-style-type: none"> <li>An approved red metal container with a self closing lid to empty ashtrays into for disposal was placed on the Breezeway 7/23/14 by the Administrator.</li> </ul> <p>The facility will identify other residents having the potential to be affected by the same defiant practice by:</p> <ul style="list-style-type: none"> <li>There is only one designated smoking area at the facility. The red metal container has a sign on top of it with the words, "Ash Tray Disposal Only. No Trash." was placed on the Breezeway 7/23/14 by Administrator.</li> </ul>	

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K 066	<p>Continued From page 20</p> <p>The findings include:</p> <p>Observation, on 07/01/14 at 11:30 AM, with the Maintenance Director revealed the designated outdoor smoking area for residents and staff did not have an approved metal container with a self-closing lid to empty ashtrays into for disposal.</p> <p>Interview, on 07/01/14 at 11:31 AM, with the Maintenance Director revealed he was not aware of the requirement that the designated, outdoor smoking area for residents was to be equipped with an approved metal container with a self-closing lid to empty ash trays into for disposal.</p> <p>The census of fifty-seven (57) was verified by the Administrator on 07/01/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 07/01/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition) 19.7.4* Smoking. Smoking regulations shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international</p>	K 066	<p>The measures put into place to ensure the deficient practice will not recur was:</p> <ul style="list-style-type: none"> <li>On 7/23/14, the Corporate Officer Implemented a new policy titled "Life Safety" to include: "The Maintenance Director will maintain facility building/grounds in accordance with NFPA 101 Life Safety Code Standards".</li> <li>On 7/23/13, the Corporate Officer revised the CQI form ES-3 titled "Life Safety" to include the following information: "Approved metal container with self closing lid is available to empty ashtrays into."</li> <li>On 7/23/14 the Maintenance Director was in-serviced by the Administrator on K066; ensuring designated outdoor smoking area for the residents are properly equipped for safe smoking in accordance with NFPA Standards.</li> <li>The Administrator initiated in-service training with staff in charge of taking the residents out to smoke on the purpose and use of the red metal container 7/23/14.</li> </ul>		

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K 066	Continued From page 21 symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.  Reference: S & C Letter: 12-04-NH; Date: November 10, 2011 Smoking Safety in Long Term Care Facilities	K 066	The facility plans to monitor its performance to ensure that solutions are sustained are: • The CQI form "ES-3 Life Safety" was initially completed 7/24/14 and will be completed monthly for two months and per CQI schedule thereafter by the Maintenance Director.	
K 072 SS=D	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	K 072	K072 NFPA 101 LIFE SAFETY CODE STANDARDS Hoyer lift in path of egress  The corrective actions taken for those residents found to have been affected by the deficient practice were:	7/26/14

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K 072	Continued From page 22 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 National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect one (1) of six (6) smoke compartments, sixteen (16) residents, staff and visitors. The facility has the capacity for sixty-six (66) beds and at the time of the survey, the census was fifty-seven (57).  The findings include:  Observation, on 07/01/14 at 9:38 AM with the Maintenance Director, revealed a patient lift stored in the egress path of the Breezeway Hall. The patient lift was observed unattended from 9:38 AM to 11:00 AM.  Interview, on 07/01/14 at 11:01 AM with the Maintenance Director, revealed the patient lift is routinely left in the Breezeway Hall.  The census of fifty-seven (57) was verified by the Administrator on 07/01/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 07/01/14.  Actual NFPA Standard:  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.  NFPA 101 LIFE SAFETY CODE STANDARD	K 072	<ul style="list-style-type: none"> <li>The vending machine company was contacted 7/23/14 by the Office Manager to come remove the drink machine located in the Breezeway Hall alcove. The vending machine was removed 7/24/14. The patient lift is being stored in the alcove on the Breezeway Hall out of the path of egress.</li> </ul> <p>The facility will identify other residents having the potential to be affected by the same defiant practice by:</p> <ul style="list-style-type: none"> <li>The Maintenance Director reviewed all paths of egress to ensure exit access is maintained in accordance to NFPA Standards 7/23/14.</li> </ul> <p>The measures put into place to ensure the deficient practice will not recur was:</p> <ul style="list-style-type: none"> <li>On 7/23/14, the Corporate Officer Implemented a new policy titled "Life Safety" to include: "The Maintenance Director will maintain facility building/grounds in accordance with NFPA 101 Life Safety Code Standards".</li> <li>The CQI form ES-3 titled "Life Safety" was revised 7/23/14 by the Corporate Officer to include the following question: "All exit doors and exit ways are unobstructed".</li> <li>The Maintenance Director was in-serviced 7/23/14 by the Administrator on K072; maintaining exit access and</li> </ul>	7/26/14
K 144 SS=F		K 144		

K 072 cont. on page 24

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K 144	<p>Continued From page 23</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation, generator testing record review and interview, the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, sixty-six (66) residents, staff and visitors. The facility has the capacity for sixty-six (66) beds and at the time of the survey, the census was fifty-seven (57).</p> <p>The findings include:</p> <p>Generator testing record review, on 07/01/14 at 10:15 AM with the Maintenance Director, revealed the facility did not document the transfer times monthly when the power was transferred during the monthly testing of the generator transfer switch.</p> <p>Interview, on 07/01/14 at 10:16 AM with the Maintenance Director, revealed he was new to his position and was not aware the transfer times were to be documented monthly.</p> <p>Observation, on 07/01/14 at 10:27 AM with the</p>	K 144	<p><i>done.</i></p> <p>revised CQI form ES-3 titled "Life Safety".</p> <p>The facility plans to monitor its performance to ensure that solutions are sustained are:</p> <ul style="list-style-type: none"> <li>The CQI form "ES-3 Life Safety" was initially completed 7/24/14 and will be completed monthly for two months and per CQI schedule thereafter by the Maintenance Director.</li> </ul> <p>K144 NFPA 101 LIFE SAFETY CODE STANDARD Generator transfer switch testing, battery charger hooked to battery instead of prime mover</p> <p>The corrective actions taken for those residents found to have been affected by the deficient practice were:</p> <ul style="list-style-type: none"> <li>The generator was run under load by the Maintenance Director on 7/24/14. The time it took to transfer power to generator was recorded on the generator log.</li> </ul>	7/26/14

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

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FORM APPROVED  
OMB NO. 0938-0391

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  07/01/2014
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 144	<p>Continued From page 24</p> <p>Maintenance Director, revealed the battery charger located inside the generator enclosure to keep the battery charged for the emergency generator was connected directly to the battery terminals instead of through the prime mover starter.</p> <p>Interview, on 07/01/14 at 10:28 AM with the Maintenance Director, revealed he was not aware the battery charger could not be connected directly to the battery terminals.</p> <p>The census of fifty-seven (57) was verified by the Administrator on 07/01/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 07/01/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 99 (1999 Edition) 3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.)</p> <p>The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>a. Individual visual signals shall indicate the following:</p> <ol style="list-style-type: none"> <li>1. When the emergency or auxiliary power source is operating to supply power to load</li> <li>2. When the battery charger is malfunctioning</li> </ol> <p>b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following:</p> <ol style="list-style-type: none"> <li>1. Low lubricating oil pressure</li> </ol>	K 144	<ul style="list-style-type: none"> <li>• On 7/24/14 the battery charger located inside the generator enclosure was repaired to ensure the generator was not directly hooked to the battery terminals but was instead wired through the prime mover starter.</li> </ul> <p>The facility will identify other residents having the potential to be affected by the same defiant practice by:</p> <ul style="list-style-type: none"> <li>• All residents had the potential to be affected by this deficient practice.</li> </ul> <p>The measures put into place to ensure the deficient practice will not recur was:</p> <ul style="list-style-type: none"> <li>• On 7/23/14, the Corporate Officer Implemented a new policy titled "Life Safety" to include: "The Maintenance Director will maintain facility building/grounds in accordance with NFPA 101 Life Safety Code Standards".</li> <li>• The CQI form ES-3 titled "Life Safety" was revised 7/23/14 by the Corporate Officer to include the following question: "The generator is hooked to emergency battery through prime mover starter-(not directly to battery terminals)".</li> </ul>		

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K 144	<p>Continued From page 25</p> <p>2. Low water temperature (below those required in 3-4.1.1.9)</p> <p>3. Excessive water temperature</p> <p>4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply</p> <p>5. Overcrank (failed to start)</p> <p>6. Overspeed</p> <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]</p> <p>Reference: NFPA 110 (1999 Edition) 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.</p> <p>Reference: NFPA 99 (1999 Edition) 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-</p>	K 144	<ul style="list-style-type: none"> <li>The Maintenance Director was in-serviced 7/23/14 by the Administrator on K144; maintaining generator set by NFPA Standards, new policy titled "Life Safety" and revised CQI form ES-3 titled "Life Safety".</li> </ul> <p>The facility plans to monitor its performance to ensure that solutions are sustained are:</p> <ul style="list-style-type: none"> <li>The CQI form "ES-3 Life Safety" was initially completed 7/24/14 and will be completed monthly for two months and per CQI schedule thereafter by the Maintenance Director.</li> </ul>		

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K 144	<p>Continued From page 26</p> <p>5.3.1. (b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b). Actual Standard: NFPA 110, 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position. Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. (b) Inspection and Testing. 1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. 2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p>	K 144		

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K 144	<p>Continued From page 27</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p> <p>Actual Standard: NFPA 99, 3- 3-4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.</p> <p>Reference: NFPA 99 (1999 Edition) 6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p> <p>Reference: NFPA 99 (1999 Edition) 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established</p> <p>Reference: NFPA 99 (1999 Edition) 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p> <p>Reference: NFPA 99 (1999 Edition) 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p> <p>Reference: NFPA 101 ( 2000 edition) 7.9.1.2</p>	K 144			

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K 144	<p>Continued From page 28</p> <p>Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted. Reference: NFPA 110 (1999 ed.) 5-7 Heating, Cooling, and Ventilating. 5-7.1* Consideration shall be given to properly sizing the ventilation or air-conditioning systems to remove all the heat rejected to the EPS equipment room by the energy converter, uninsulated or insulated exhaust pipes, and other heat-producing equipment. 5-7.2 Adequate ventilation shall be provided to prevent temperatures or temperature rises in the EPS and related accessory equipment that exceed the recommendations of the manufacturer. 5-7.3 For the EPS equipment room, the ventilation or cooling equipment, or both, shall be sized so that the ambient temperature shall not exceed the EPS equipment manufacturer ' s criteria or allowable maximum temperatures.</p> <p>Reference: NFPA 110 (1999 Edition) 5-2.1 The EPS shall be installed in a separate room for Level 1 installations. EPSS equipment shall be permitted to be installed in this room. The room shall have a minimum 2-hour fire rating or shall be located in an adequate</p>	K 144			

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K 144	Continued From page 29 enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building codes. No other equipment, including architectural appurtenances, except those that serve this space, shall be permitted in this room.	K 144			
K 147 SS=D	Reference: NFPA 110 (1999 Edition) 6-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers' recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals. NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, eight (8) residents, staff and visitors. The facility	K 147	K147 NFPA 101 LIFE SAFETY CODE STANDARD Power strip, open electrical junction box  The corrective actions taken for those residents found to have been affected by the deficient practice were: <ul style="list-style-type: none"> <li>The power strip in room #220 was removed 7/2/14 by Maintenance Director.</li> <li>The open electrical junction box located in the laundry area on the back of the clothes dryer was covered on 7/24/14 by Maintenance Director.</li> </ul>	7/26/14	

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K 147	<p>Continued From page 30</p> <p>has the capacity for sixty-six (66) beds and at the time of the survey, the census was fifty-seven (57).</p> <p>The findings include:</p> <p>Observation, on 07/01/14 at 11:19 AM with the Maintenance Director, revealed a refrigerator plugged into a power strip located in room #220.</p> <p>Interview, on 07/01/14 at 11:20 AM with the Maintenance Director, revealed he was not aware the power strip had been misused.</p> <p>Observation, on 07/01/14 at 11:28 AM with the Maintenance Director, revealed an open electrical junction box located in the laundry area on the back of the clothes dryer.</p> <p>Interview, on 07/01/14 at 11:29 AM with the Maintenance Director, revealed he was not aware the electrical junction box had been left open after recent repairs by the former Maintenance Director.</p> <p>The census of fifty-seven (57) was verified by the Administrator on 07/01/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 07/01/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. _____ Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be</p>	K 147	<p>The facility will identify other residents having the potential to be affected by the same defiant practice by:</p> <ul style="list-style-type: none"> <li>• The Maintenance Director audited all resident rooms on 7/8/14 to see if any other power strips were in use.</li> <li>• The Maintenance Director also audited all electrical junction boxes to ensure they were covered appropriately on 7/8/14.</li> <li>• All resident items that were powered by a power strips were relocated or removed by Housekeeping and Maintenance staff 7/24/14.</li> </ul> <p>The measures put into place to ensure the deficient practice will not recur was:</p> <ul style="list-style-type: none"> <li>• The Corporate Officer Implemented a new policy 7/23/14 titled "Life Safety" to include: "The Maintenance Director will maintain facility building/grounds in accordance with NFPA 101 Life Safety Code Standards".</li> <li>• The CQI form ES-3 titled "Life Safety" was revised 7/23/14 by the Corporate Officer to include the following question: "All electrical junction boxes are covered."</li> </ul>	

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K 147	<p>Continued From page 31</p> <p>permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 (1999 Edition) 400-8 ( Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <p>(1) As a substitute for the fixed wiring of a structure</p> <p>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</p> <p>(3) Where run through doorways, windows, or similar openings</p> <p>(4) Where attached to building surfaces</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 (D) Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference NFPA 70 (1999) edition 370-28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.</p>	K 147	<ul style="list-style-type: none"> <li>The Maintenance Director was in-serviced 7/23/14 by the Administrator on K147; ensuring electrical wiring was maintained by NFPA Standards, new policy titled "Life Safety" and revised CQI form ES-3 titled "Life Safety".</li> </ul> <p>The facility plans to monitor its performance to ensure that solutions are sustained are:</p> <ul style="list-style-type: none"> <li>The CQI form ES-3 titled "Life Safety" was initially completed 7/24/14 then monthly for two months, then per CQI calendar thereafter by the Maintenance Director</li> </ul>		