DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		185049	B. WING_			11/	13/2020
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
AUBURN	HEALTH CARE				9 PEARL ST. JBURN, KY 42206		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	was initiated on 11/12 11/13/2020. The facili compliance with 42 C regulations and has in	FR 483.80 infection control mplemented the Centers for id (CMS) and Centers for Prevention (CDC) ces to prepare for					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	KE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 11/18/2020

DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0.0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185049	B. WING			11/	13/2020
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUBURN	HEALTH CARE				39 PEARL ST. UBURN, KY 42206		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
	Survey was initiated of concluded on 11/13/2	d Emergency Preparedness on 11/12/2020 and 020. The facility was found ith 42 CFR 483.73 related					
		SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
	100295	B. WING		11/13/2020		
HEALTH CARE						
(EACH DEFICIENC	TATEMENT OF DEFICIENCIES	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE COMPL THE APPROPRIATE DATE		
was initiated on 11/12 11/13/2020. The facil	2/2020 and concluded on lity was found to be in	N 000				
	F CORRECTION ROVIDER OR SUPPLIER HEALTH CARE SUMMARY ST (EACH DEFICIENC REGULATORY OR Initial Comments A COVID-19 Focuse was initiated on 11/1 11/13/2020. The faci	F CORRECTION IDENTIFICATION NUMBER: 100295 ROVIDER OR SUPPLIER STREET HEALTH CARE 139 PEA AUBUR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 100295 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE IEALTH CARE 139 PEARL ST. AUBURN, KY 42206 ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated on 11/12/2020 and concluded on 11/13/2020. The facility was found to be in N 000	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 100295 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE IEALTH CARE 139 PEARL ST. AUBURN, KY 42206 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC Initial Comments N 000 N 000 Initiated on 11/12/2020 and concluded on 11/13/2020. The facility was found to be in	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	

SQHZ11