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

PRINTED: 07/29/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185049	B. WING			07/29/2020	
NAME OF PROVIDER OR SUPPLIER  AUBURN HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP COI 139 PEARL ST. AUBURN, KY 42206	DE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	was initiated on 07/28 07/29/2020. The facil compliance with 42 C regulations and has it Medicare & Medicaid Centers for Disease C (CDC) recommended COVID-19. Total cens	d Infection Control Survey 8/2020 and concluded on ity was found to be in FR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention		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.

Facility ID: 100295

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

PRINTED: 07/29/2020 FORM APPROVED OMB NO. 0938-0391

AND DIAN OF CORRECTION IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
<b>185049</b>	B. WING		07/29/2020	
NAME OF PROVIDER OR SUPPLIER  AUBURN HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE  139 PEARL ST.  AUBURN, KY 42206		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			
E 000 Initial Comments  A COVID-19 Focused Emergency Preparedness Survey was initiated on 07/28/2020 and concluded on 07/29/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).	EC			

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

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: 07/29/2020 FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED				
NAME OF D	POVIDED OD SLIDDI IED	100295	B. WING 07/29/2020						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  139 PEARL ST.									
AUBURN HEALTH CARE  AUBURN, KY 42206									
(X4) ID PREFIX TAG	(EACH DEFICIENC				(X5) COMPLETE DATE				
N 000	Initial Comments		N 000						
N 000	A COVID-19 Focused was initiated 07/28/20	Infection Control Survey 020 and concluded on lity was found to be in to 42 CFR 483.80.	N 000						
1									

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

TITLE (X6) DATE