

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

PRINTED: 03/24/2010
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 03/11/2010
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NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST., PO BOX 9 AUBURN, KY 42206
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F 000	INITIAL COMMENTS	F 000		
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to promote care that maintained or enhanced dignity for one resident (#9), in the selected sample of 13. Resident #9 was observed in multiple areas of the facility on three consecutive survey days dressed in clothing soiled with urine. There was an overwhelming odor of urine noted. Additionally, observation revealed the resident's room had a strong urine odor, that was detected from the hall. Findings include:</p> <p>Record review revealed Resident #9 had diagnoses to include Dementia with Behavior Disturbance, Benign Prostrate Hypertrophy, Depression and Insomnia.</p> <p>A review of the Minimum Data Set (MDS), dated 02/08/10, revealed the facility assessed the resident as requiring limited assistance to</p>	F 241	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>1. On 3/12/2010, Resident #9's entire wardrobe was laundered, resident's room was deep cleaned, mattress replaced and wheel chair was deep cleaned to eliminate odors off the resident and ensure dignity is preserved.</p> <p>The following interventions were put in place for Resident #9.</p> <ul style="list-style-type: none"> a. Resident's room will be deep cleaned on a weekly basis. b. Housekeeping rounds increased to twice a day and as needed to eliminate odors. c. All clothing will be washed weekly and laundry aide will ensure that resident has clean clothing available at all times. d. Behavior Mapping Record was updated with interventions <ul style="list-style-type: none"> i. Encourage resident to wear an appropriate incontinence product (i.e. brief) ii. Encourage resident to change clothing when soiled e. Resident was provided with additional handkerchiefs to offer if resident refuses to wear incontinence product or change clothing when soiled. 	4/15/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Katherine C. Evans</i>	TITLE NHA	(X6) DATE 4/2/10
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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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F 241	<p>Continued From page 1</p> <p>maintain personal hygiene, dressing and requiring extensive assistance for bathing. The resident was frequently incontinent of urine.</p> <p>Observations conducted on 03/09/10 at 9:30 AM, 2:00 PM and 4:00 PM and on 03/10/10 at 9:10 AM and 1:15 PM and 3:30 PM, and on 03/11/10 at 2:00 PM revealed Resident #9 propelled up and down the hall in a wheelchair, using the handrails on the wall, sat with peers during activities and in the dining room and spent time in his/her room. During each observation of the resident, a very strong odor of urine was detected and the resident was observed covering his/her wet clothing (in the groin area) with a turquoise colored handkerchief. An observation on 03/10/10 at 1:15 PM, revealed Resident #9 was sitting in the doorway of the resident's room with his/her eyes closed and resting his/her head on the turquoise colored handkerchief, which was in the resident's right hand. All observations revealed an overwhelming odor of urine coming from the resident's body.</p> <p>An interview on 03/10/10 at approximately 3:30 PM with the resident revealed he/she denied any concerns with provision of care and became hostile when asked about incontinent care needs.</p> <p>Interviews conducted on 03/09/10 at 2:00 PM with housekeeping staff, on 03/10/10 at 3:45 PM with Certified Nurse Aide #1, on 03/11/10 at 2:00 PM with Registered Nurse #1, and on 03/11/10 at 2:20 PM with Licensed Practical Nurse #1 revealed Resident #9 refused care most of the time. The resident was incontinent and attempted to conceal evidence of incontinence with a wash rag or something else placed over his/her lap. The resident also refused to change</p>	F 241	<p>f. Resident has been changed to offer showers daily.</p> <p>g. Resident's wheelchair will be cleaned by third shift daily.</p> <p>h. Resident's screened bedroom window will be opened to ventilate room as weather permits.</p> <p>2. On 3/18/2010, the interdisciplinary Team audited the facility and residents to determine that care is provided to residents in a manner and environment that ensures each resident's dignity and respect is honored.</p> <p>The following interventions were put in place by the Housekeeping Supervisor for any other resident identified through the audits completed by the interdisciplinary Team.</p> <p>a. Resident's room will be deep cleaned on a weekly basis.</p> <p>b. Housekeeping rounds increased to twice a day and as needed to eliminate odors.</p> <p>c. Resident may be offered showers daily.</p> <p>d. Resident's wheelchair may be cleaned by third shift daily if applicable.</p> <p>e. Resident's screened bedroom window will be opened to ventilate room as weather permits.</p>		

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F 241	<p>Continued From page 2</p> <p>clothes and/or bathe at times. The resident exhibited behaviors of hiding urine soaked clothing items in dresser drawers or the closet and refused to allow staff to remove them for laundering. Certain staff was able to encourage appropriate hygiene; however, many times the resident became threatening and struck out at staff. The staff interviews revealed the resident had a strong odor of urine most of the time and other residents and visitors had complained.</p> <p>An interview with the Director of Nursing, on 03/09/10 at 12:05 PM, revealed she was aware of the overwhelming odor in the hall which originated from Resident #9's room. The resident refused care, became belligerent, hid soiled clothing, wet the bed, urinated in the trash can and refused to let staff clean the room. At times, certain staff were able to convince the resident to allow them to assist with a shower and clean the room. The DON stated, "We have tried everything we can think of".</p> <p>An interview on 03/11/10 at 1:00 PM with a resident, who resided in a room near Resident #9's room, revealed the smell from Resident #9's room was offensive. The resident had asked the housekeeper and CNAs to do something about the odor on multiple occasions. The housekeeper and CNAs "sprayed" something in Resident #9's room and it helped for awhile. The resident stated when Resident #9 was close by, the smell "would knock you down". The resident stated he/she felt embarrassed when visitors came to the facility and felt embarrassed for Resident #9, as well.</p> <p>An interview with the Administrator on 03/11/10 at approximately 2:00 PM, revealed Resident #9</p>	F 241	<p>3. Facility staff was In-serviced on specific interventions, reporting odors, and location of afterhours cleaning supply location on 3/19/2010 (Attachment #1).</p> <p>An In-service on dignity was initiated 4/1/2010 and will be completed 4/8/2010 with the next scheduled In-service (attachment #2).</p> <p>Housekeeping Director will complete audits weekly to identify any other areas/residents affected by displeasing odors (Attachment #3).</p> <p>4. CQI form ES-1, General Environment, was completed 4/1/2010. CQI form ES-1, General Environment, will be completed 5 times a week for two weeks, weekly for two months and then monthly thereafter (Attachment #4)</p> <p>CQI form SS-5, Quality of Life/Resident Observation, was completed 4/1/2010. CQI form SS-5, Quality of Life/Resident Observation, will be completed weekly for 4 weeks then monthly thereafter (Attachment #5).</p>	

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F 241	<p>Continued From page 3</p> <p>exhibited behaviors which included refusal of incontinent care and became physically aggressive with staff. At times, certain staff was able to coax the resident to allow assistance with showering and clean clothes, but there were times when nothing could be done to convince the resident to accept the care needed.</p> <p>A review of a care plan related to behaviors, dated 02/08/10 to 05/08/10, revealed the resident was described as "Non-Compliance/Resists care (Grooming, smoking, toileting, bathing, changing clothes and linens), Physically Abusive and trying to hide or cover up incontinent episodes". Care plan interventions included: " Request alternate staff member to assist with calming resident, be sure not to over crowd or over-stimulate resident, allow resident to wander freely within facility but remove from area as needed if abusive or socially inappropriate behaviors occur and if behavior is annoying peers, take to a separate area temporarily."</p>	F 241		
F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide medically related social services to attain , maintain or improve the ability to manage everyday physical, mental and psychosocial</p>	F 250	<p>483.15(G)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICES</p> <ol style="list-style-type: none"> 1. A referral was placed by the Nursing Home Administrator to Two Rivers Central Intake on 3/10/2010. <p>On 3/12/2010, Logan County Protection and Permanency LSW Amanda Lowdy came to the facility to interview Resident #9 to initiate investigation of self neglect and determine if guardianship referral is appropriate.</p>	4/15/2010

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F 250	<p>Continued From page 4</p> <p>needs for one resident (#9), in the selected sample of 13. Resident #9 refused care, was physically aggressive toward staff and other residents and refused Psychological evaluation on multiple occasions. Although a need for guardianship application was identified and a referral initiated, the facility failed to ensure the action was followed through completion. Findings include:</p> <p>Record review revealed Resident #9 had diagnoses to include Dementia with Behavior Disturbance, Benign Prostrate Hypertrophy, Depression and Insomnia.</p> <p>A review of the Minimum Data Set (MDS) and Resident Assessment Protocol (RAP), dated 02/08/10, revealed the resident was assessed as moderately cognitively impaired, decisions were poor and the resident required supervision. The resident was identified as requiring assistance to maintain personal hygiene, dressing and extensive assistance for bathing and tended to be incontinent daily with some control present. The resident's impelments were chronic in nature and were not expected to improve.</p> <p>Observations on 03/09/10 at 9:30 AM, on 03/10/10 at 9:10 AM, and on 03/11/10 at 1:15 PM, revealed Resident #9 was in his/her room, the facility hall, the dining room and the lobby/activity area. The resident was observed dressed in the same clothes all three survey days and an overwhelming odor of urine was noted. The resident's room was neat, but had an overwhelming odor of urine.</p> <p>Interviews on 03/09/10 at 12:05 PM with the Director of Nursing, on 03/09/10 at 2:00 PM with</p>	F 250	<p>On 3/26/2010, Social Service Director spoke with DCBS Protection and Permanency Supervisor and LSW via speaker phone. DCBS established that guardianship placement was not appropriate because the resident is alert and oriented x 3, but did express that the referral would be sent to the supervisor of Two Rivers Guardianship Services.</p> <p>On 3/29/2010, Nursing Home Administrator spoke with the Ombudsman and the Ombudsman Associate via conference call regarding additional interventions to be utilized by the facility to ensure the residents dignity and individuality be maintained.</p> <p>On 3/31/2010 the Nursing Home Administrator met with Tom Noe, Logan County Attorney to proceed with court appointed State Guardianship.</p> <p>2. On 3/18/2010, the interdisciplinary team conducted an audit to identify if any other residents were in need of guardianship referrals to establish a responsible party and ensure services attain or maintain the highest practicable physical, mental, and psychosocial well-being is met. Any other resident identified for need of guardianship will be referred to Two Rivers DCBS Central Intake.</p>		

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F 250	<p>Continued From page 5</p> <p>housekeeping staff, on 03/10/10 at 3:45 PM with Certified Nurse Aide #1, on 03/11/10 at 1:50 PM with the Social Services Director, on 3/11/10 at 2:00 PM with the Administrator and Registered Nurse #1 and on 03/11/10 at 2:20 PM with Licensed Practical Nurse #1, revealed Resident #9 had exhibited aggressive behaviors toward staff and other residents at times. The resident had daily episodes of incontinence and refused to allow staff to assist him/her to bath or change clothes at times. The resident exhibited behaviors of hiding urine soaked clothing items in dresser drawers or in a closet and refused to allow staff to remove the items for laundering. Certain staff were able to encourage appropriate hygiene at times, but many times the resident became threatening and struck out at staff. The staff stated the resident almost always had a strong odor of urine and other residents and visitors complained.</p> <p>An interview with the Administrator on 03/11/10 at approximately 2:00 PM, revealed the resident had an altercation with another resident and attempted to strike the other resident with his/her cane. On 03/23/09, the resident was sent for a psychiatric evaluation but refused to get out of the police car. The Psychiatric facility evaluated the resident in the car, while in the parking lot, and returned the resident to the facility with a conclusion that stated the resident's clinical needs outweighed the behavioral needs. The Administrator also revealed a referral for guardianship was made on 06/30/09, but the facility failed to follow through to ensure the referral was addressed. The Administrator provided no explanation for the lack of further action on behalf of Resident #9. The Administrator stated she felt the facility should not</p>	F 250	<p>3. Any other resident identified for need of guardianship and referred to Two Rivers Central Intake will be monitored weekly until a responsible party has been identified or guardianship referral has been denied. Documentation of follow up monitoring will be recorded in the resident record.</p> <p>On 3/24/2010, Social Service Director was in-serviced by Nursing Home Administrator on how to identify when a resident may need a guardianship referral, the referral process of guardianship, necessary follow-up and weekly documentation (Attachment #6).</p> <p>4. CQI form SS-8, Guardianship, was completed 4/2/2010. CQI form SS-8, Guardianship, will be completed monthly for three consecutive months and then quarterly thereafter (Attachment #7).</p>		

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F 250	Continued From page 6	F 250	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	4/15/2010
F 252 SB=E	<p>quit trying to acquire guardianship. She stated, "My role is to make the referral".</p> <p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, it was determined the facility failed to provide a clean, comfortable and homelike environment related to objectionable odors, improperly stored items and scratched and worn night stands in the resident rooms, for one of two wings at the facility. Findings include:</p> <p>Observations, on 03/09/10 at 9:10 AM, 9:30 AM and 10:45 AM on the 100 Wing of the facility, revealed the strong odor of urine in the hallway of Rooms #123 through #117. Night stands in rooms on the 100 Wing were scratched and marred and in need of refinishing. Room #120 had the tables covered with table cloths.</p> <p>An observation, on 03/09/10 at 10:00 AM, of the storage room on the 100 wing revealed 16 cardboard boxes of briefs and gloves, which were stacked directly on the floor of the eight foot by ten foot storage room on the 100 wing.</p> <p>An interview, on 03/09/10 at 10:05 AM, with the Medical Records Clerk, who was responsible for the stock in the area, revealed the storage room</p>	F 252	<p>1. On 3/12/2010, room belonging to Resident #9 on 100 hall was deep cleaned and all of resident #9 laundry was washed to decrease odors.</p> <p>On 3/24/2010, the table in room #120 was inspected and determined to be resident's personal possession and in good working order. The tablecloth was sprayed with fire retardant spray 4/1/2010 allowing resident to maintain a homelike environment.</p> <p>The bedside tables on the 100 hall will be repaired or replaced.</p> <p>On 3/9/2010, the cardboard boxes of briefs and gloves in the storage room were elevated off the floor. Additional storage shelving units were added to the supply room on 3/15/2010 to ensure a safer environment.</p> <p>2. On 3/24/10, the Maintenance Director inspected bedside tables throughout the facility to determine the need for replacing or refinishing. On 4/1/10, ten bedside tables were ordered for those bedside tables identified to be beyond repair (attachment #17). Additional bedside tables will be ordered as needed.</p> <p>On 3/18/2010, the Interdisciplinary Team conducted an audit of the facility to identify any area of the building with persistent odors.</p> <p>On 3/15/2010, the Maintenance Director conducted an audit of the facility to identify any area that may be overstocked with supplies creating any unsafe conditions and ensure supplies are elevated off the floor.</p>	

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F 252	Continued From page 7 was the only place available for storage of the items. The clerk stated she had requested shelves "for more than a year," without response to the need. An observation, on 03/09/10 at 2:50 PM, of the Storage room on the 100 wing revealed the boxes, which contained the briefs, had been disassembled. The briefs were in stacks over five feet in height on the floor. The briefs were observed leaning against the wall. An interview, on 03/10/10 at 3:00 PM, with the Maintenance Director revealed the night stands on the 100 wing were "just old and needed refinishing." He was aware of the need for shelves in the storage room, but could not get the shelves made, due to being behind on other projects and he had no assistant. An interview, on 03/10/10 at 3:10 PM, with the Administrator revealed she was aware of the facility's storage problems and of the maintenance work that was needed. The Administrator stated the facility had difficulty keeping an assistant in this position.	F 252	3. On 3/19/2010, facility staff was in-serviced on reporting any persistent odors to the Housekeeping Supervisor and staff for immediate intervention and location of after housekeeping duty hours cleaning supplies to use as needed (attachment #8). On 4/8/2010, facility staff will be in-serviced on reporting any identified furniture or equipment needing repair in the maintenance log promptly (attachment #9). Maintenance/Housekeeping will complete rounds daily on an ongoing basis to ensure a safe, clean, comfortable and homelike environment (attachment #10).		
F 454 SS=E	483.70 LIFE SAFETY FROM FIRE The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe environment related to areas of trash and debris around the perimeter of the building and a	F 454	4. CQI form ES-1, General Environment, was completed 4/1/2010. CQI form ES-1, General Environment will be conducted 5 times a week for two weeks, weekly for two weeks then monthly thereafter (Attachment # 4). CQI form SS-5, Quality of Life/Resident Observation, was completed 4/1/2010. CQI form SS-5, Quality of Life/Resident Observation, will be completed weekly for 4 weeks then monthly thereafter (Attachment #5). CQI form ES-14, Housekeeping Review, was completed 4/1/2010. CQI form ES-14, Housekeeping Review, will be completed weekly for 4 weeks then monthly thereafter (Attachment #11).		

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NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST., PO BOX 9 AUBURN, KY 42206	
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F 454	<p>Continuad From page 8</p> <p>retaining wall that was observed crumbling and in a state of disrepair. Findings include:</p> <p>An observation of the area around the dumpster, on 03/09/10 at 3:40 PM, revealed two hydraulic lift beds, without mattresses, at the side of the storage shed, along with a broken lounge chair turned upside down, 13-five gallon buckets, a wooden pallet and an aluminum door.</p> <p>An observation of the outside perimeter of the facility, on 03/10/10 at 2:30 PM, revealed a broken antennae, laying on the roof, near the edge of the building. There was an area of exposed cable wires, along the side of the building in the courtyard, that were not contained in the opened storage box mounted on the brick wall. Just outside the 200 wing, 32 inches from the building, was a crumbling, cement block retaining wall, stacked three blocks high, which was not secured by mortar and leaning toward air conditioning units and windows. In addition, there were two stacks of four tires, an old cooler and wooden planks on the ground located behind the storage shed and near the Administration Building.</p> <p>An interview, on 03/09/10 at 3:45 PM, with the Dietary Manager revealed the beds located beside the dumpster had been there "a week or so" because there was no room in the storage shed for the items and no way to dispose of the beds. The other discarded items had been there "for some time."</p> <p>An interview, on 03/10/10 at 2:30 PM, with the Maintenance Supervisor revealed the supervisor was supposed to haul the discarded items to the junk yard, but his truck had been "in the shop"</p>	F 454	<p>483.70 LIFE SAFETY FROM FIRE</p> <ol style="list-style-type: none"> On 3/10/2010, all trash and debris identified (two hydraulic lift beds, broken lounge chair, 13-5 gallon buckets, a wooden pallet, aluminum door, broken antennae, two stacks of 4 tires, an old cooler and wooden planks) was collected and removed from the perimeter of the facility. On 3/10/2010, the Cable Company was called to replace/repair the storage box mounted to the brick wall outside the 200 hall to accommodate all cable wires. There work was completed on 3/12/2010. The crumbling retaining wall on the south side of the facility will be removed by 4/15/2010. The Nursing Home Administrator and Maintenance Director toured the grounds on 3/10 /2010, 3/17/2010, 3/24/2010 and on 3/31/2010 to ensure the facility is designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. No new areas were identified. On 4/8/2010, facility staff will be in-serviced to report any debris or refuse on facility grounds immediately to Maintenance Director and document in the maintenance log (attachment #12). 	4/15/2010

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

PRINTED: 03/24/2010
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 03/11/2010
NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST., PO BOX 9 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 454	Continued From page 9 and the staff member who should have been maintaining the outside grounds had recently quit his position. An interview, on 03/10/10 at 3:00 PM, with the Administrator revealed she was unsure if the retaining wall was on facility property. She stated the problem with the trash would be addressed and resolved.	F 454	Maintenance Director will complete outdoor rounds weekly to ensure the facility is designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public (Attachment #3). Any deficient area identified will be cleaned and/or repaired at that time. 4. CQI form ES-2, Review of Facility Exterior, was completed 4/1/2010. CQI form ES-2, Review of Facility Exterior, will be completed on a monthly basis (Attachment # 13).		

Complete In-Service Training Report

Facility: Auburn Health Care Department: All Departments

Date: 3/19/2010 Time: 2:00 PM

Meeting Area: 100 Dining Room

Employee Group(s) Present: Facility Staff

Subjects Covered:

Odor Control

- 1) Interventions to use for resident(s) or areas w/ odors
- 2) Report persistent odors to Charge Nurse or Housekeeping
- 3) Housekeeping Cart/chemicals available for any staff to use when HSK not in facility - After house cleaning supplies

Signature: Katherine C. Evans, NHA

attachment # 1a

Complete In-Service Training Report

Facility: Auburn Health Care Department: All Departments

Date: 4/1/2010 Time: 3:00 PM

Meeting Area: Nurse's Station

Employee Group(s) Present: Facility Staff

Subjects Covered:

Dignity

It is our responsibility to ensure that the facility promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

See Attachment for definition of dignity from the Interpretive Guidelines of the "Long Term Care Survey" Manual.

Signature: Kathleen C. Evans, NHA

attachment # 2a

Dignity In-service

4.1.2010

What: Dignity In-Service
From: Stephanie Semrick, SSD
Who: All Staff
When: 4/1/2010

In caring for residents in a long term care facility the staff member must not forget that even though this is their place of employment, this is the residents' home.

This in-service is phrased as how a resident might think. Maybe it's your grandmother, past neighbor or a previous member of your church. In respect of this in-service her name is Ms. Smith.

Ms Smith: I wish they would come and answer my call light, I can't hold it like I used to. After my five kids, if I sneeze before the aide gets here, she's gonna have a bigger mess to clean up. The previous shift forgot to place a pad in my pants.

Ms. Smith: I hope today is my shower day. I think I stink. I'm all sticky and my hair desperately needs washing. My head itches. My son is supposed to come see me today and bring the grandkids. The little ones were too scared to sit in my lap last time. I guess it was because I smelled bad and my hair was messy.

Ms. Smith: I sure am thirsty. At least I did get my shower. But they forgot to clean under my nails though. I do hate having dirty nails. We're supposed to have fried chicken for lunch and I hate to eat it with my dirty hands. Boy, I sure would like a drink of ice cold water. When my aide was in here though, she was in a hurry and didn't move my over bed table within reach. Let's see where's my call light....oh, I see it. It's hanging on the curtain.

Ms. Smith: Oh, here come my grandkids. Aren't they cute? I just wanna give them a great big squeeze. What's that? Why do I have a beard? What's that in my teeth? My breath stinks? Oh, dear. Maybe next time you come I can hold you and you won't cry. And maybe next time my son won't have to kiss my forehead.

attachment # 2b

~~F225
cont.~~

~~reports are to be made. As such, states may not eliminate the obligation for any of the alleged violations (i.e., mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property) to be reported, nor can the state establish longer time frames for reporting than mandated in the regulations at §§483.10(c)(2) and (4). No state can override the obligation of the nursing home to fulfill the requirements under §483.13(c), so long as the Medicare/Medicaid certification is in place.~~

F240

§483.15 Quality of Life

A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

Interpretive Guidelines §483.15

The intention of the quality of life requirements is to specify the facility's responsibilities toward creating and sustaining an environment that humanizes and individualizes each resident. Compliance decisions here are driven by the quality of life each resident experiences.

F241

§483.15(a) Dignity

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

(Rev. 48; Issued: 06-12-09; Effective/Implementation Date: 06-12-09)

Interpretive Guidelines §483.15(a)

"Dignity" means that in their interactions with residents, staff carries out activities that assist the resident to maintain and enhance his/her self-esteem and self-worth. Some examples include (but are not limited to):

- Grooming residents as they wish to be groomed (e.g., hair combed and styled, beards shaved/trimmed, nails clean and clipped);
- Encouraging and assisting residents to dress in their own clothes appropriate to the time of day and individual preferences rather than hospital-type gowns;
- Assisting residents to attend activities of their own choosing;
- Labeling each resident's clothing in a way that respects his or her dignity;

Attachment #20

F241 cont.

- Promoting resident independence and dignity in dining (such as avoidance of:
 - o Day-to-day use of plastic cutlery and paper/plastic dishware;
 - o Bibs (also known as clothing protectors) instead of napkins (except by resident choice);
 - o Staff standing over residents while assisting them to eat;
 - o Staff interacting/conversing only with each other rather than with residents, while assisting residents;
- Respecting resident's private space and property (e.g., not changing radio or television station without resident's permission, knocking on doors and requesting permission to enter, closing doors as requested by the resident, not moving or inspecting resident's personal possessions without permission);
- Respecting resident's by speaking respectfully, addressing the resident with a name of the resident's choice, avoiding use of labels for residents such as "feeders," not excluding residents from conversations or discussing residents in community settings in which others can overhear private information;
- Focusing on residents as individuals when they talk to them and addressing residents as individuals when providing care and services.
- Maintaining an environment in which there are no signs posted in residents' rooms or in staff work areas able to be seen by other residents and/or visitors that include confidential clinical or personal information (such as information about incontinence, cognitive status). It is allowable to post signs with this type of information in more private locations such as the inside of a closet or in staff locations that are not viewable by the public. An exception can be made in an individual case if a resident or responsible family member insists on the posting of care information at the bedside (e.g., do not take blood pressure in right arm). This does not prohibit the display of resident names on their doors nor does it prohibit display of resident memorabilia and/or biographical information in or outside their rooms

Attachment # 2d

**F241
cont.**

v

with their consent or the consent of the responsible party if the resident is unable to give consent. (This restriction does not include the CDC isolation-precaution-transmission-based signage for reasons of public health protection, as long as the sign does not reveal the type of infection);

- Grooming residents as they wish to be groomed (e.g., removal of facial hair for women, maintaining the resident's personal preferences regarding hair length/style, facial hair for men, and clothing style). NOTE: For issues of failure to keep dependent residents' faces, hands, fingernails, hair, and clothing clean, refer to Activities of Daily Living (ADLs), Tag F312;
- Maintaining resident privacy of body including keeping residents sufficiently covered, such as with a robe, while being taken to areas outside their room, such as the bathing area (one method of ensuring resident privacy and dignity is to transport residents while they are dressed and assist them to dress and undress in the bathing room). NOTE: For issues of lack of visual privacy for a resident while that resident is receiving ADL care from staff in the bedroom, bathroom, or bathing room, refer to §483.10(e), Privacy and Confidentiality; Tag F164. Use Dignity F241 for issues of visual privacy while residents are being transported through common areas or are uncovered in their rooms and in view of others when not receiving care; and
- Refraining from practices demeaning to residents such as keeping urinary catheter bags uncovered, refusing to comply with a resident's request for toileting assistance during meal times, and restricting residents from use of common areas open to the general public such as lobbies and restrooms, unless they are on transmission-based isolation precautions or are restricted according to their care planned needs. An exception can be made for certain restrooms that are not equipped with call cords for safety.

Procedures §483.15(a)

For sampled residents, use resident and family interviews as well as information from the Resident Assessment Instrument (RAI) and comprehensive care plan to consider the resident's former life style and personal choices made while in the facility to obtain a picture of the resident's individual needs and preferences.

Attachment # 2c

**F241
cont.**

Throughout the survey, observe: Do staff show respect for residents? When staff interact with a resident, do staff pay attention to the resident as an individual? Do staff respond in a timely manner to the resident's requests for assistance? Do they explain to the resident what care they are doing or where they are taking the resident? Do staff groom residents as they wish to be groomed?

In group activities, do staff members focus attention on the group of residents? Or, do staff members appear distracted when they interact with residents? For example, do they continue to talk with each other while doing a "task" for a resident(s) as if the resident were not present?

Are residents restricted from using common areas open to the public such as the lobby or common area restrooms? If so, determine if the particular area is restricted to the resident for the resident's safety. For example, does the restroom lack a call cord for safety? If so, that restroom may be restricted from resident use. Are there signs regarding care information posted in view in residents' rooms? If these are observed, determine if such signs are there by resident or family direction. If so, these signs are allowable. If a particular resident has been restricted from common areas by the care team, confer with staff to determine the reason for the restriction.

Do staff members communicate personal information about residents in a way that protects the confidentiality of the information and the dignity of residents? This includes both verbal and written communications such as signage in resident rooms and lists of residents with certain conditions such as incontinence and pressure ulcers (or verbal staff reports of these confidential matters) at nursing stations in view or in hearing of residents and visitors. This does not include clinical information written in a resident's record.

Determine if staff members respond in a dignified manner to residents with cognitive impairments, such as not contradicting what residents are saying, and addressing what residents are trying to express (the agenda) behind their behavior. For example, a resident with dementia may be attempting to exit the building in the afternoon, but the actual intent is a desire to meet her children at the school bus, as she did when a young mother. Allowing the behavior under supervision such as walking with the resident without challenging or disputing the resident's intent and conversing with the resident about the desire (tell me about your children) may assist the behavior to dissipate, and the staff member can then invite the resident to come along to have a drink or snack or participate in a task or activity. For more

attachment # 2f

Quality Indicator: General Environment
Threshold: 90%

ES-1

Directions: Members of the quality action team will tour the facility in areas listed (look at 10% of the rooms on each unit). Members should talk to residents and get their perspective in order to do an accurate assessment. A 'no' response may indicate a potential problem.

		X = Yes		O = No		N/A - Not Applicable	
		Residents Rooms	Dining Area	Lounge Area	Hallways	Therapy Room	Lobby
1	Chairs are comfortable and facilitate the resident getting up and down.						
2	Tables are at a comfortable height for residents, w/c's fit properly under them.						
3	Furnishings are structurally sound and functioning.						
4	Curtains are clean and correctly hung. Privacy curtains provide adequate						
5	Wheelchairs are clean, in good repair, and stored properly.						
6	Mattresses are clean, comfortable and in good condition. Bed frames are without rust or dirt.						
7	There is sufficient space for residents and activities. Resident rooms have enough space to promote easy mobility and provide adequate closet space.						
8	The area/room is free of unpleasant odors.						
9	The area/room has a personal feel to it.						
10	An easily accessible bathroom is nearby.						
11	Nurse call system is functioning properly						
12	The noise level is acceptable to residents. Overhead paging system is used for emergencies only.						
13	Lighting is adequate for tasks.						
14	Emergency outlets are clearly labeled.						
15	Water is available in all essential areas.						
16	Water temp is 110 F and is documented and monitored routinely.						
17	Entrances and exits are lighted.						
18	Room temperature is 71 - 81 F.						
19	Ventilation is adequate (especially in smoking areas).						

		Residents Rooms	Dining Area	Lounge Area	Hallways	Therapy Room	Lobby
20	Oxygen storage area is labeled, resident rooms with oxygen have signs posted.						
21	Smoking and non-smoking areas are identified.						
22	Pest control program in place and area is pest free.						
23	Handrails and bathroom grab bars are present and secure.						
24	The area is free of hazards.						
25	Ceilings and floor tiles are in good repair.						
26	No holes found in walls or doors.						
27	Paint/wall paper is in good condition.						
28	Glare from any light source, including sun, is eliminated. There is non-glare wax on the floor.						
29	Hazardous chemicals or any hazardous substance that a resident could be exposed to are locked up properly.						

Item #	Comments

Percentage of compliance = $\frac{\# \text{ Yes responses}}{\text{total \# of responses}} \times 100$ % Compliance: _____

Threshold met: Yes No Plan of correction implemented: Yes No

Date completed: _____ By: _____

attachment # 4b

**Continuous Quality Improvement
Social Services**

SS-5

Indicator: Quality of Life/Resident Observation

Threshold: 100%

Directions Members of the quality action team will observe residents and document on appearance, hygiene and dignity issues.

Criteria/Question Mark 'X' for YES, 'O' for NO, or 'N/A'	Resident				
	1	2	3	4	5
1. Is the resident wearing his/her own clothing?					
2. Is the resident wearing appropriate clothing? (Seasonal, matching, correct order)					
3. Is the resident wearing his/her glasses (if applicable)?					
4. Is the resident wearing hearing aide (if applicable)?					
5. Is the resident's hair cleaned/appropriately combed?					
6. Has the resident been shaved/facial hair remove?					
7. Are the resident's teeth/dentures in appropriate condition?					
8. Are the resident's fingernails clean and trimmed?					
9. Is the resident free from body odor, urine/feces odor?					
10. Is privacy provided during all aspects of care?					
11. Does the resident regularly attend at least one group activity per week?					
12. Did staff interact appropriately with the resident upon this observation?					
13. NACP reviewed for documentation.					
14. Does the staff provide privacy during personal care and treatment times?					

Percentage of Compliance= $\frac{\# \text{ Yes responses}}{\text{total \# of responses}} \times 10$ % Compliance _____

Threshold met: **YES** **NO** Plan of correction implemented: **YES** **NO**

Date completed: _____ By: _____

attachment #5

Complete In-Service Training Report

Facility: Auburn Health Care Department: Social Services

Date: 3/24/2010 Time: 2:00 PM

Meeting Area: 100 Dining Room

Employee Group(s) Present: Social Service Director

Subjects Covered:
Guardianship Process
1) How to identify if a resident needs a guardian appointed
2) Proper referral reporting process
3) Agencies involved for guardainship placement
4) Follow up required
5) Documentation of follow up weekly

Signature: Katherine C. Evans, NHA

attachment # 1a

Stephanie Senrick

attachment # 6b

Quality Indicator: Guardianship
 Threshold: 100%

SS - 8

Directions: A member of the CQI team will review resident medical records for every resident who is their own responsible party or has a responsible party that is not attentive to their needs. Review is required to determine if a guardianship referral is needed. Utilize the entire record to include cognitive assessments, progress notes, nurses notes, etc. Use additional forms as needed.

X = Yes O = No NA = Not Applicable		Resident				
		1	2	3	4	5
1	Is the resident responsible party "self" or not attentive to resident's needs (medical, psychosocial well-being, business and legal needs)?					
To include, but not limited to: (Answer what has supportive documentation only)						
	Resident Interview					
	Chart Review					
	Phone Calls					
	Verifying Contact information with Doctor or Referring Hospital					
	Certified Mail					
*** Documentation should include all detailed information of attempt to identify next of kin and/or willing responsible party, to include dates with follow up completed in a timely manner***						
4	Does resident have a cognitive impairment?					
5	Can resident make appropriate decisions regarding safety, healthcare, financial, and business needs?					
6	Is resident compliant with services, care, and policies/procedures of the facility?					
7	Does resident present danger to self or others?					
8	Has the resident exhibited a status change?					
To include, but not limited to (Answer those that apply only)						
	Has residents health improved or declined significantly					
	Does resident require urgent medical needs requiring consent					
	Does resident endanger the health of the other residents in the facility					
	Is resident no long competent to make legal decisions					

Attachment # 7a

SS-8

X = Yes O = No NA = Not Applicable	Resident				
	1	2	3	4	5
7) Do any other DCBS Licensed Social Workers have guardianship over a resident and document?					
9 Is referral agency identified?					
10 If referral declined or resident did not meet criteria for guardianship, then:					
Was expertae appointed or advised on an as needed basis by DCBS Licensed Social Worker:					
Is follow up complete with new referral with any significant change in health, mental status or financial need.					
Is follow up completed with every quarterly, annual, or significant change RAI Assessment.					
Are all attempts appropriately documented					

Percentage of Compliance = $\frac{\text{\# of Yes responses}}{\text{total \# of respons}}$ x 100 % Compliance: _____

Threshold met: Yes No Plan of correction implemented: Yes No

Date Completed: _____ By: _____

attachment # 76

Complete In-Service Training Report

Facility: Auburn Health Care Department: All Departments

Date: 3/19/2010 Time: 2:00 PM

Meeting Area: 100 Dining Room

Employee Group(s) Present: Facility Staff

Subjects Covered:
Odor Control
1) Interventions to use for resident(s) or areas w odors
2) Report persistent odors to Charge Nurse or Housekeeping
3) Housekeeping Cart/chemicals available for any staff to use when HKB not in facility - After hours cleaning supplies

Signature: Kathleen C. Evans, NHA

Complete In-Service Training Report

Facility: Auburn Health Care Department: All Departments

Date: 4/1/2010 Time: 3:00 PM

Meeting Area: Nurse's Station

Employee Group(s) Present: Facility Staff

Subjects Covered:
REPORTING TO MAINTENANCE AND HOUSEKEEPING
A) Maintenance Log Book
B) Report all furniture, equipment, facility areas in Maintenance Log
C) Report any debris or refuse on facility grounds immediately
to Maintenance/Housekeeping and document in Maintenance
Log Book

Signature: Barbara Davenport

attachment # 9a

Daily Housekeeping/Maintenance Rounds

Month/Year _____	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Grounds:																																
Verify walkways free of debris/hazards																																
Ensure ice/snow have been removed from walkways (seasonal)																																
Ensure landscape free weeds, limbs, refuse																																
Facility:																																
Ensure is building free of persistent odors																																
Identify areas needing additional cleaning and/or deep cleaning																																
Verify furniture/décor free of dust																																
Verify furniture/décor in working order and in good condition																																
Ensure all flammable/combustible chemicals stored properly (check all areas)																																
Laundry Room:																																
Ensure front of dryers free of lint buildup																																
Ensure back of dryers free of lint buildup																																
Ensure are dryer vents free of lint buildup																																
Verify laundry room free of clutter																																
Verify lint removal log been completed properly																																
General:																																
Complete water temperature log																																

Implemented 4/3/2010

Attachment #10

attachment #10

Quality Indicator: Housekeeping Review

ES-14

Threshold: 95%

Directions: Members of the quality action team will tour the facility in areas listed (look at 10% of the rooms on each unit). A "No" response may indicate a potential problem.

		X = Yes O = No N/A = Not Applicable					
		Residents Rooms	Dining Area	Lounge Area	Hallways	Therapy Room	Lobby
1	The floor is clean.						
2	Windows are free from dust and dirt.						
3	Curtains are clean and hung properly.						
4	Furniture is safe and sturdy.						
5	Furniture is clean and dust free including chairs, tables, and dressers.						
6	Furniture scratched and/or marred is refinished or replaced.						
7	Residents personal items that are not flame retardant are sprayed with flame retardant spray.						
8	Waste baskets are clean under plastic lining.						
9	If floors are being mopped, "wet floor" signs clearly mark the wet areas.						
10	Soap dispenser is full and without dried soap.						
11	Paper towel holders have towels.						
12	Sinks are clean and free of debris.						
13	Walls are clean and free of dirt.						
14	Floor baseboards in all areas are clean.						
15	Light fixtures are dust free.						
16	Pictures and objects on the wall are dust free.						
17	Mirrors are clean and free of spots.						
18	Floor polish is non-slip and non-glare.						
19	Cleaning supplies are either being used or stored.						
20	There are no hazards in the areas that could cause residents to fall or otherwise injure themselves.						
21							
22							
23							

Complete In-Service Training Report

Facility: Auburn Health Care Department: All Departments

Date: 4/1/2010 Time: 3:00 PM

Meeting Area: Nurse's Station

Employee Group(s) Present: Facility Staff

Subjects Covered:
REPORTING TO MAINTENANCE AND HOUSEKEEPING
A) Maintenance Log Book
B) Report all furniture, equipment, facility areas in Maintenance Log
C) Report any debris or refuse on facility grounds immediately
to Maintenance/Housekeeping and document in Maintenance
Log Book

Signature: Barbara Davenport

attachment # 12 a

Quality Indicator: Review of Facility Exterior
Threshold: 90%

ES-2

Directions: Members of the quality action team will inspect the outside areas of the facility, looking for problems related to appearance, safety, cleanliness, and general maintenance. A 'no' answer may indicate a potential problem.

X = Yes O = No N/A = Not Applicable		
The following are in good repair:	yes/no	Comments
1. Loading docks		
2. Back and side yards (general)		
3. Porches and/or patios		
4. Furnishings and equipment in outdoor recreation areas		
5. Exterior walls		
6. Roof		
7. Entrance		
8. Driveway		
9. Stairs, ramps, sidewalks		
10. Employee parking area(s)		
11. Front yard (general)		
12. Lawn		
13. Shrubs and plantings		
14. Trash area		
15. Lighting (esp. parking and entrances)		
16. Windows and doors (caulking around windows)		
17. Unattached buildings		
18. Visitors parking lot		
19. Staff designated smoking area is free of trash/debris.		
20.		

ES-2

	yes/no	Comments
21.		
22.		
23.		
24.		

Percentage of compliance = $\frac{\# \text{ Yes responses}}{\text{total \# of responses}} \times 100$ %Compliance: _____

Threshold met: Yes No Plan of correction implemented: Yes No

Date completed: _____ By: _____



YOUR ELDERCARE EQUIPMENT EXPERTS

For billing inquiries, please contact:

Renee Schubert

1-800-889-2504 FAX 1-800-250-1961

INVOICE #: 17798025
ACCOUNT #: 20149
 INVOICE DATE: 4/1/2010
 TERMS: NET 30
 CUSTOMER PO #: VERBAL KATHERINE
 ORDER #: 16100414
 ACCOUNT MANAGER: Frank Pokorny
 1-888-367-3503
 ORDER PLACED BY: Ms. Katherine Evans

BILL TO: Attn: Accounts Payable
 Auburn Health Care-HPSI
 139 Pearl St
 PO Box 9
 Auburn, KY 42206-0009

SHIP TO: Auburn Health Care-HPSI
 139 Pearl St
 Auburn, KY 42206-0009

ITEM#	DESCRIPTION	U/M	ORD	INVD	PRICE	EXT. PRICE
78028-2	Heartland Bedside Cabinet, 3-Drawer Finish = Wild Cherry QS	EACH	10	10	\$122.00	\$1,220.00
					SUBTOTAL	\$1,220.00
					FREIGHT	\$269.80
					TAX	\$89.39
					TOTAL	\$1,579.19
					AMOUNT PAID	\$0.00
					BALANCE DUE	\$1,579.19

Your affiliation with HPSI pays every time you buy from Direct Supply. We have already deducted your savings of \$150.00 from this invoice.

You can view your invoices and account status online, anytime at www.directsupply.net

Notice of Discount Reporting & Use Tax Payment Obligations

Discounts: The net price of products on this invoice reflects discounts you received. The anti-kickback regulations of the Social Security Act require you and your facilities to fully and accurately report these discounts and the actual product price you paid in any applicable cost report, claim or charge to any federal state health care program, and certain third parties. Upon request by the Office of Inspector General, Secretary of HHS or any state agency, you must provide a copy of any agreement between you and us as well as relevant information regarding these discounts and the actual product prices you paid.

Use Tax: In addition, if we are required to be registered to collect sales tax in your state and you have not provided us with a tax exemption certificate acceptable to the taxing authorities, we have added sales tax to the invoice. If we are not so registered, then we are not required to collect such sales tax and you are responsible for calculating and paying applicable sales taxes for all products you purchase from us.



FINANCIAL SERVICES
1-800-634-7338

SALES OFFICES
1-800-634-7328

FEDERAL ID# 39-1519806

Please enclose remittance slip to ensure proper credit
 Auburn Health Care-HPSI

Remit To: Direct Supply, Inc.
 Box 88201
 Milwaukee, WI 53288-0201

INVOICE #: 17798025
ACCOUNT #: 20149

INVOICE DATE: 4/1/2010
 ORDER #: 16100414

AMOUNT DUE: \$1,579.19

201490000017798025000040110000001579195

attachment # 17

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

PRINTED: 03/24/2010
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 03/09/2010
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NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST, PO BOX 9 AUBURN, KY 42208
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	INITIAL COMMENTS	K 000		
K 062 SS=F	<p>A Life Safety Code Survey was conducted on 03/09/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 482.41(b) (Life Safety from Fire) relating to NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited at K 062 F, K135 E and K 147 F.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 03/09/10, it was determined the facility failed to ensure sprinkler heads were free of lint and dust as required by NFPA 25 1999 Edition.</p> <p>The findings to include:</p> <p>A tour of the facility conducted 03/09/10 at 9:30 AM, revealed sprinkler heads throughout the facility had a build-up of lint and dust.</p> <p>Interview with the Maintenance Director on 03/09/10 at 9:35 AM, revealed he was unaware of the build-up of lint and dust on the sprinkler heads.</p> <p>Reference to: NFPA 25 1999 Edition 2-2 Inspection, 2-2.1 Sprinklers.</p>	K 062	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <ol style="list-style-type: none"> On 3/9/2010 all sprinkler heads we inspected by Maintenance Director. During the inspection, any sprinkler heads identified with dust and/or lint were cleaned immediately. Maintenance Director will include visualizing sprinkler heads with weekly rounds and identify any that need cleaning. Any sprinkler head identified during audits that are corroded or rusty will be replaced. Housekeeping/Maintenance will complete weekly rounds to ensure sprinkler heads are free of dust and lint (attachment #3). CQI form ES-3 Life Safety was initially completed 4/1/2010 and will be completed weekly x4 weeks then monthly thereafter (attachment #15). 	4/15/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kathleen C. Evans</i>	TITLE NHA	(X6) DATE 4/2/10
---	--------------	---------------------

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

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

PRINTED: 03/24/2010
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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 03/09/2010
NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST., PO BOX 8 AUBURN, KY 42200		
(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	Continued From page 1 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062			
K 135 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Flammable and combustible liquids are used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for flammable and combustible liquids are constructed in accordance with NFPA 30, Flammable and Combustible Liquids Code, NFPA 99. 4.3, 10.7.2.1. This STANDARD is not met as evidenced by: Based on observation and staff interviews conducted on 03/09/10, it was determined the facility failed to properly store flammable and combustible liquids. The findings include: Observation during the Life Safety Code inspection on 03/09/10 at 10:45 AM, revealed one can of 10 ounce White Lithium Grease, five cans of Touch N Foam and six cans of Orange Burst were stored in the Laundry on a shelf. The label on the above items stated combustible, danger,	K 135	NFPA 101 LIFE SAFETY CODE STANDARD 1. A flammable proof cabinet was purchased 4/1/2010 for the Laundry/Housekeeping Storage room to store all flammable and combustible liquids (attachment #18). 2. On 3/9/2010, the Maintenance Director inspected storage areas and facility to ensure all combustible liquids are properly stored. Any combustible liquids will be placed in the flammable proof cabinet when available. 3. Facility staff will be in-serviced, 4/8/2010, on proper storage of flammable and combustible liquids (attachment #16). 4. CQI form ES-3 Life Safety was initially completed 4/1/2010 and will be completed weekly x4 weeks then monthly thereafter (attachment #15).	4/15/10	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST., PO BOX 9 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 135	Continued From page 2 extremely flammable. All flammable materials shall be stored in a flammable proof cabinet.	K 135			
K 147 SS=F	An interview conducted with the Maintenance Director on 03/09/10 at 11:00 AM, revealed the facility did not have a flammable proof cabinet. 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 conducted on 03/09/10, it was determined the facility failed to ensure that electrical wiring and standards met NFPA requirements. The findings include: Observation during the Life Safety Code tour conducted on 03/09/10 at 10:00 AM with the Maintenance Director, revealed the facility did not have an annunciator alarm for the emergency generator. An interview with the Maintenance Director on 03/09/10 at 10:05 AM revealed the facility was not aware of the regulatory requirement of an annunciator alarm for the generator. Reference to: NFPA 99, 1999 Edition	K 147 NFPA 101 LIFE SAFETY CODE STANDARD 1. A visual and auditory alarm will be placed at the Nurses' Station on the 100 Hall. 2. An In-service will begin immediately upon completion of installation of the annunciator alarm, to ensure facility staff is aware of its purpose. Orientation to the annunciator alarm will be added to the facility orientation checklist (attachment #19). 3. CQI form ES-3 Life Safety was initially completed 4/1/2010 and will be completed weekly x 4 weeks then monthly thereafter (attachment #15).	4/15/10		

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NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST., PO BOX 0 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 147	<p>Continued From page 3</p> <p>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). The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follow:</p> <p>(a) Individual visual signals shall indicate the following:</p> <ol style="list-style-type: none"> 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning <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"> 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel- when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed <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</p> <p>5-3.1 The Level 1 or Level 2 EPS equipment</p>	K 147			

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NAME OF PROVIDER OR SUPPLIER AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST., PO BOX 9 AUBURN, KY 42208		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 147	<p>Continued From page 4</p> <p>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 101 2000 edition</p> <p>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 1 1/2 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.</p> <p>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.</p>	K 147			

Weekly Housekeeping/Maintenance Rounds

Month/Year _____	Date: _____ Week 1	Date: _____ Week 2	Date: _____ Week 3	Date: _____ Week 4	Date: _____ Week 5 (as applies)
Grounds:					
Verify walkways free of debris/hazards					
Ensure ice/snow have been removed from walkways (seasonal)					
Verify grounds have been mowed (seasonal)					
Ensure landscape free weeds, limbs, refuse					
Facility:					
Ensure building free of persistent odors					
Identify areas needing additional cleaning and/or deep cleaning					
Verify sprinkler heads free for dust and lint					
Ensure scratches/blemishes been addressed on furniture and décor					
Verify furniture/décor free of dust					
Verify furniture/décor in working order and in good condition					
Ensure all flammable/combustible chemicals stored properly (check all areas)					
Laundry Room:					
Ensure front of dryers free of lint buildup					
Ensure back of dryers free of lint buildup					
Ensure dryer vents free of lint buildup					
Verify laundry room free of clutter					
Verify lint removal log been completed properly					
General:					
Ensure all emergency supplies in place in the employee break room					
Complete emergency lights testing					
Ensure exit signs properly luminated					
Complete water temperature log					
Ensure all heat/air units and filters are monitored per protocol					

Implemented 4/1/2010

attachment # 3

Quality Indicator: Life Safety

ES-3

Threshold: 90%

Directions: Members of the quality action team should walk through the facility and check records as needed to answer the questions below. A "no" response may indicated a potential problem.

	Yes	No	Comment
Smoking Hazards:			
1			Smoking regulations are enforced.
2			"No Smoking" signs are posted where necessary.
3			Safe type ashtrays are used by residents in designated smoking areas.
Combustible Storage and Waste Materials:			
4			Combustible materials are stored neatly in proper containers
5			Combustibles are stored away from heat.
6			No combustibles are stored in boiler room.
7			Waste materials are stored in proper containers.
8			Waste containers are emptied on each shift or more frequently when needed.
9			Flammable and combustible liquids are stored in a flammable proof cabinet.
Flammable Liquids and Compressed Gases:			
10			Safety cans re provided for flammable liquids when in use (one gallon or more).
11			Smoking is prohibited adjacent to flammable liquid storage.
12			Compressed gas cylinders are properly handled when used.
Electrical Wiring and Equipment:			
13			There are no excessive multiple wiring connections to wall receptacle.
14			Light bulbs are not in contact with combustibles.
15			Power strips are used appropriately.
16			There are no extension cords in resident rooms.
17			Exhaust fans re operating properly.
Sprinkler, Fire Detection, and Alarm System:			
18			Sprinkler heads are unobstructed 18" below sprinkler head deflector.

ES-3

	Yes	No	Comment
19 Fire alarm boxes are accessible to residents and staff.			
20 All alarm boxes are tested annually.			
21 Sprinkler heads are free from dust, dirt, rust, etc.			
Fire & Smoke Partition Door & Fire Areas Separations			
22 Doors are unobstructed.			
23 Necessary doors are kept closed			
Exit, Exit way and Exit signs			
24 All illuminated exit signs are lit.			
25 All exit doors and exit ways are unobstructed			
26 All exit door open and close properly			
27 Furniture is placed so occupants can quickly and safely evacuate their rooms.			
28 Grounds are kept clear of objects that might impede evacuation.			
Extinguishers and Hose Stations			
29 All extinguishers are mounted in designated locations			
30 Extinguishers are unobstructed and accessible			
31 Extinguisher seals are intact and inspection tags initiated and dated every 30 days by the Maintenance Director.			
32 No leaks, corrosion or other defects are noted			
33 Extinguishers are serviced by qualified agency annually			
34 Extinguisher are hydrostatically tested as required			
35 An appropriate extinguisher is located adjacent to hazard.			
36 Cabinet doors on hose stations operate properly.			
37 Retract of hose is done annually.			
38 The nozzle is in place.			

ES-3

	Yes	No	Comment
Emergency Equipment and Procedures			
39			Battery powered emergency lights are tested & recorded.
40			Emergency generator is tested under load for at least 30 seconds weekly.
41			Emergency generator is tested under load for at least one and one half hours annually.
42			Emergency generator is adequate to power exit lights, fire alarm and life support systems.
43			Emergency generator alarm annunciator is properly working.
44			Fire drills are conducted monthly (rotating each shift monthly).
45			New staff orientation includes fire and evacuation procedures.
46			Evacuation procedures are practiced.
47			The fire department participates in drill annually.
Woods (atmos)			
48			Heating and ventilation systems are working and regularly inspected.
49			Air conditioning and furnace filters are inspected and changed according to an established timetable.
50			The heating plant is checked and serviced by a qualified individual annually.
51			The combustion air intake is unobstructed
52			Residents smoke only when supervised by staff.

Percentage of Compliance = $\frac{\# \text{ of Yes responses}}{\text{total \# of responses}} \times 100$

% Compliance: _____

Threshold Met: YES NO

Plan of Correction Implemented: YES NO

Date Completed: _____

By: _____

Revised 4/1/10

Thank you for shopping with Interstate Products, Inc. - Interstate Products, Inc.

- CATEGORIES**
- Absorbents
- Berms
- Bladder Tanks
- Cleaners / Coatings
- Emergency Response
- Facility Maintenance
- Grounds Maintenance
- Ice Control
- Material Handling
- Parking Lot / Traffic Safety
- Safety Cabinets / Cans
- Spill Kits
- Spill Containment
- Storage / Handling
- Storage Buildings
- Stormwater
- Sort by Manufacturer

Item
**JAMCO 45 Gal. Flammable Cabinet
 (Manual Close)**

Item Confirmation Required

Thank you for your order!

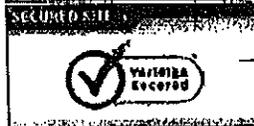
Your Confirmation Number is 989-33548

Quantity	Description
1	45 Gallon Flammable Safety Cabinet, Manual Close Doors, Yellow

Rate	Amount
\$597.00	\$597.00
Tax	0.00
Total	\$597.00

CONTACT US

CONTACT US VIA EMAIL



HOW TO ORDER

attachment # 18

Complete In-Service Training Report

Facility: Auburn Health Care Department: All Departments

Date: _____ Time: _____

Meeting Area: _____

Employee Group(s) Present: Facility Staff

Subjects Covered:
<u>Flammable and Combustible Liquid Storage</u>
1) Flammable Proof Cabinet
2) NFPA and Life Safety Regulation
3) Location of Cabinet
4) All flammable and combustible liquids and chemicals must be stored in the flammable proof cabinet
5) Cabinet is located in the storage room beside Laundry Room

Signature: _____

attachment # 16

FACILITY ORIENTATION CHECKLIST

Auburn Health Care

NAME: _____ DATE OF HIRE: _____

Administrative Nurse/Medical Records

Attendance Policy
 Counseling and Disciplinary action/ discharge
 Job Description
 Salary/Raises/Evaluations
 Incentive programs
 Gait belt/Back belt/Keys
 Introduce to staff and residents
 Time clock / Break times / Lunch times
 Time edit sheets
 Holidays
 Schedule / Request for days off
 Parking Area and Lockers
 Universal Precautions/Hand washing
 Marketing and Abuse Video
 Cleaning Blood Spills/Blood Spill Kits
 Needle Stick Policy/Sharps/PPE
 Tour of facility
 Disaster plan
 Fire Drills / Other Safety Drills
 Elopement Drills
 Employee Handbook/File
 Incident Reports Resident/Employee
 Theft and security
 Chain of command
 MSDS manual / Job Hazards
 Central supply / Charges
 Sexual harassment
 Entering facility on off hours
 Accident Prevention
 Emergency Phone Numbers
 Review of personnel policies

W-2 Forms
 Staff meeting / In-service attendance
 Resident Privacy
 Professional conduct
 Communication with residents and visitors
 Pay period / Check distribution
 Insurance
 Vacation
 Review of Job Description
 Appropriate uniform/Personal Appearance
 HIV/AIDS
 TB/PPD's
 Influenza and Pneumonia Vaccines
 Exposure Control Program/Book
 Infection Control Program
 Accident Prevention/Safety
 Care Trek System
 Broken / unsafe equipment
 Maintenance Hours/Repair Book
 Emergency generator
 Promoting dining with dignity
 Location/Review of Policies & Procedures
 Cordless Phone Use
 Unusual Occurrences (ex. Choking, wandering,
 missing resident, fall, altercation, etc.)
 Walk to Dine Program
 Use of call light system
 Resident population
 MD Notification of changes in resident condition
 Pain Management

Department Head Signature: _____ Date: _____

DIETARY MANAGER

Introduction to dietary staff
 Explain thickened liquids
 Procedure for passing ice water
 Cleaning water pitchers
 Dining process / feeding groups
 Return items to kitchen
 Dietary cards
 Therapeutic diets
 Personnel allowed in kitchen
 Diet orders / Changes
 Posting menus
 Substitutions
 Heights and weights
 Settling up trays
 Infection Control
 Wearing hair nets

Before and after meal grooming
 Hall trays
 Second helpings
 Kitchen hours
 Water with meals
 Snacks
 Noise level in dining room
 Bussing tables
 Seating arrangement
 Meal times
 Promoting dining with dignity
 Nurse in Dining
 Overview of Dept.
 Serve table/room all same time
 All Hands on Deck

Department Head Signature: _____ Date: _____

SOCIAL SERVICES

- Patient confidentiality
- Abuse and neglect policy
- Missing resident policy
- Assisting activities
- Employee stress and burnout
- Reporting missing items
- Resident rights
- Complaint and grievance procedure
- Smoking areas and policy
- Privacy

- Role of social worker
- No code / DNR/ Chart labels, name plates
- Visiting hours
- Resident counsel
- Quality of Life
- Noise level in building
- Resident behaviors
- Admission process
- Advance Directives
- Care of resident's personal items

Department Head Signature: _____ Date: _____

OFFICE MANAGER

- Bereavement
- Name tag / time clock badge
- Office supplies
- Copy machines
- Personal phone calls / (in and out)
- Anniversary date
- Office hours
- Phone and intercom use

ADMINISTRATOR

- Welcome/Evaluations
- Mission
- Philosophy
- Witness will/legal document
- Abuse Registry Checks
- Criminal Record Checks
- History of the Facility
- Quality Assurance & Forms/Committees
- Corporate Compliance Program
- HIPAA/Confidentiality

Office Manager Signature: _____ Date _____

Administrators Signature: _____ Date: _____

MDS/CARE PLAN COORD./HOUSE SUPERVISOR

- MDS process
- Care plans
- Nurse aide care plan
- Care conferences
- Reporting hours awake
- ADL charting
- Mood and behavior charting
- Restraints
- Side rails and positioning devices
- Purpose of therapy
- Spilling
- Gait Belt Use
- Blood Spill Kits

- Hydration pass and charting
- Nurse aide paperwork
- Fall Prevention and Transferring
- Bed and chair alarms
- Meal consumption
- Labs
- Restorative--to include assignments, grids, documentation, and orientation on how to perform all Restorative duties (Be sure to notify all C.N.A.'s that in the event that the Restorative aide is absent it is th their responsibility to perform those duties.)
- Location of Protective Equipment masks, gowns, goggles.

Department Head Signature: _____ Date: _____

C.N.A./Medical Records

- Introduce to staff
- Introduce to residents
- Explain shift routine
- Answer questions
- Give positive feedback
- Make sure nurse gives PPD on date of hire
- Bed Cranks to be turned in.

- Scavenger Hunt
- Skills test
- Other tests
- Body mechanics
- Resident transfers
- How to use Hydraulic Lift
- Charging Supplies

Medical Records Signature: _____ Date: _____

DON

Policy and Procedure books
 Facility audits
 Compliance rounds
 Leadership
 Infection control
 Supervision and Time Management
 Availability
 Overview of Dept.
 Reporting Resident Changes
 Overview Residents Routine
 Philosophy of care

EDK Emergency Drug Kit
 90 Day probationary period
 Communication book
 Organization
 24hr. Report and follow up
 Survey Process/Regulations
 Review Nursing Information Book
 Review Master Copy Book
 Review Sample Admission Packet
 Call light to be answered timely
 Review of in-service training

Department Head Signature: _____ Date: _____

ACTIVITIES

Purpose of Activities
 Employees responsibility
 Activity Calendars
 Volunteer Program
 Overview of Dept.
 Getting residents to activities

ENVIRONMENTAL

Keeping Rooms Tidy
 No Incontinent Pads/Tubing in Trash
 Bagging/Washing Linens
 Linen Service
 Disinfecting Shower Chairs/Tubs
 Wet Floor Signs
 Chemical Storage/Lock up/Environmental Hazards
 Janitors Closets
 Cleaning Spills/Supplies
 Overview of Dept
 Generator Annunciator Alarm

Dept. Head Signature: _____ Dept Head Signature _____
 Date: _____ Date: _____

I HAVE RECEIVED THE APPROPRIATE ORIENTATION LISTED ON THE PRECEDING PAGES AND I UNDERSTAND THE POLICIES AND PROCEDURES EXPLAINED TO ME. I WILL ABIDE BY THE RULES AND REGULATIONS OF AUBURN HEALTH CARE.

EMPLOYEES SIGNATURE: _____ DATE: _____

SUPERVISORS SIGNATURE: _____ DATE: _____

(Supervisor Is responsible for seeing that Facility Orientation Checklist Is completed and placed in employee file within 7 days of hire.)