

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

PRINTED: 04/14/2011
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 03/31/2011
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
F 000	INITIAL COMMENTS An annual survey and an abbreviated survey (KY #16129) were conducted 03/29/11 through 03/31/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal requirements with deficiencies cited at the highest S/S of an "E". KY #16129 was substantiated with deficiencies cited.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents for one resident (#9), in the selected sample of twelve. It was alleged that Certified Nurse Aide (CNA) #3 was "rude and rough" with Resident #9 during the provision of care on the evening of 02/07/11. LPN #3, who worked the night shift that same night, was made aware of the allegation by the resident. LPN #1, who worked the next day, was made aware of the allegation by LPN #3 through a report at shift change; however, neither of them reported the alleged incident to their supervisor(s). The alleged incident was not reported to the Administrator, Director of Nursing (DON) or Assistant Director of Nursing (ADON) until 02/09/11, at which time CNA #3 was suspended from work and an investigation was	F 226	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 1. The incident was reported to proper authorities on 2/9/2011. Investigation started at that time. <ul style="list-style-type: none"> CNA #3 was suspended on 2/9/2011 and was terminated on 2/15/2011. LPN #1 and LPN #3 received disciplinary action for failure to report an abuse allegation. 2. On 4/19/2011 and 4/20/2011 the SSD interviewed alert and oriented residents to check for any signs of unreported events or abuse. The results of the interviews revealed that all concerns/ grievances had been promptly addressed. <ul style="list-style-type: none"> Following the Resident Council meeting on 2/10/2011, the residents were informed on reporting abuse and grievances to charge nurse or any department head. An Abuse Monitoring Tool was implemented to be done monthly on all three shifts. 3. Implemented Abuse Binders for each nurses' desk. Charge nurses were in-serviced on the contents of the binders on 4/19/2011-4/20/2011.	4/21/11



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Stephanie Vernier* TITLE: *Administrator* (X6) DATE: *4/22/11*

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 226	Continued From page 1 initiated. Findings include: A review of the facility's policy/procedure, entitled "Abuse Policy," revised 08/10/10, revealed "Staff suspecting or witnessing an incident involving a resident will immediately report any alleged incidents of abuse, including injuries of unknown origin, to the charge nurse or supervisor." A record review revealed Resident #9 was admitted to the facility on 01/20/05 with diagnoses to include Chronic Airway Obstruction, Congestive Heart Failure, Gastroesophageal Reflux Disease, Hypertension and History of Stroke. A review of the quarterly Minimum Data Set (MDS) assessment, dated 02/21/11, revealed the resident to be alerted and oriented with an impaired gait. He/she was incontinent of bladder and required assistance with transfers. An interview with Resident #9, on 03/29/11 at 10:25 AM, revealed on the 3 PM -11 PM shift on 02/07/11, CNA# 3 spoke to him/her roughly and handled him/her roughly while his/her brief was being changed. He/she stated the CNA pulled the brief out from the front, instead of rolling him/her to the side. The resident stated, "This hurt my back and it felt awful." When Resident #9 voiced the complaint to CNA #3 about his/her back, the CNA responded that the resident was just very touchy. Resident #9 stated he/she reported the incident to the 11 PM -7 AM charge nurse that same night when the nurse was administering his/her medication. Additionally, the resident stated that CNA #3 came to his/her room the next morning around 8:00 AM and apologized for the	F 226	<ul style="list-style-type: none"> Revised Abuse Policy and Abuse Quiz on 4/19/2011. Abuse In-Service using the revised policy was conducted during a mandatory meeting held on 4/19/2011. Revised abuse test given. 4. The CQI Form A-8, "Abuse Investigation and Reporting" will be completed by the Administrator monthly for 3 months, then quarterly and PRN. CQI Form A-9, "Corporate Review of Abuse Investigation and Reporting," is a follow up review of the Administrator's CQI report to ensure compliance is maintained. 5. Completion date 4/21/2011 		

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F 226	<p>Continued From page 2</p> <p>incident and said "let's just forget about it."</p> <p>An interview with CNA #1, on 03/30/11 at 3:05 PM, revealed she worked the 3 PM -11 PM shift with CNA #3 on 02/07/11. She stated CNAs usually worked as a team but on that night during last rounds, CNA #3 went into Resident #9's room alone instead of waiting for her. CNA #1 had no further contact with the resident that shift and was not aware of an allegation of abuse until the investigation.</p> <p>An interview with Licensed Practical Nurse (LPN) #3, on 03/31/11 at 8:55 AM, revealed Resident #9 reported the allegation of abuse to her on 02/08/11 between 12:00 AM - 12:30 AM as she passed medication. She stated the resident was awake and anxious at that time and this was unusual because he/she was usually asleep at that time. She stated the resident told her that CNA #3 was rude and rough with him/her while his/her brief was being changed by the CNA. LPN #3 stated that she reported the incident to the oncoming day shift charge nurse (LPN #1); however, she did not report the incident to administration because "I did not expect it to be abuse." She stated the facility had trained her about abuse/neglect and she realized she should have called her supervisor immediately.</p> <p>An interview with LPN #1, on 03/30/11 at 2:35 PM, revealed LPN #3 reported the incident to her on 02/08/11 at shift change. It was reported that Resident #9 was upset because CNA#3 was rude and rough with him/her while his/her brief was being changed the previous evening. CNA#3 was currently in the building, so LPN#1 went to CNA#3 and advised her to go talk with Resident #9 because the resident was upset. LPN #1</p>	F 226			

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F 226	<p>Continued From page 3</p> <p>stated the CNA was allowed to go to the resident's room. When CNA #3 returned from the resident's room, she reported that the resident was all right. LPN #1 stated she was trained on abuse/neglect and when to report, but she did not think the situation "was that serious" at the time. She realized she should have made sure the incident was reported to the supervisor immediately.</p> <p>An interview with CNA #3 (alleged perpetrator), on 03/30/11 at 2:30 PM, revealed, on 02/07/11 at 10:15 PM -10:30 PM, she went into Resident #9's room during last rounds and pulled his/her brief out from under him/her from the front. She stated, "It was just easier that way." When the resident yelled out, the CNA told him/her that the brief was too tight and offered to get him/her a larger size. The resident refused and said the size was fine. CNA #3 did not report the resident's complaint of pain to anyone. She was not aware the resident was upset until the next morning when LPN #1 told her about it. She went to the resident's room on 02/08/11 around 8:00 AM to ask the resident why he/she was upset. The resident told CNA #3 that she was rude and rough while his/her brief was being changed and this hurt his/her back. CNA#3 stated she apologized to the resident and explained it was not her intent to hurt him/her, and promised she would not change his/her brief that way again. The CNA left the building shortly after the conversation with the resident and returned to work on another unit that day as previously scheduled.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 03/31/11 at 9:10 AM, revealed the allegation of abuse was reported to her by the resident on 02/09/11. She and the Director of</p>	F 226			

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F 226	Continued From page 4 Nursing (DON) reported the incident to the Administrator immediately and the investigation was initiated at that time. CNA #3 was suspended on 02/09/11 and was terminated on 02/16/11. Interviews with the DON and the Administrator, on 03/31/11 at 4:05 PM and at 5:10 PM, revealed they would have expected LPN #3 and/or LPN #1 to notify a supervisor immediately and CNA#3 should have been removed from resident care immediately, pending an investigation. They revealed they expected the staff to be knowledgeable of the Abuse/Neglect policy and procedures due to training and in-services provided.	F 226			
F 253 SS=C	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 observations, interviews and record reviews, it was determined the facility failed to ensure the necessary housekeeping and laundry services were maintained for a sanitary, orderly and comfortable environment related to the residents' nightstands in disrepair, over-the-bed tables were rusty, window blinds were bent or torn and heater housing units in the residents' rooms were noted to have dents and rusted areas underneath with debris. This was observed on entrance to the facility and existed on both wings of the facility all three days of the annual survey,	F 253	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES 1. Following issues were corrected on 4/15/2011-4/21/2011. <ul style="list-style-type: none">• 1. The base of the over bed tables in rooms #105, #114A, #114B and #116 were painted.• 2. Nightstands in rooms #104 A, #104B, #106, #110, #114, #207 B, #217, #220 A, #220B were cleaned and scratch cover applied. The drawer pulls were replaced in room #219.• 3. The blinds in rooms #104, #120 and #124 were replaced.• 4. The heater housing units in rooms #105, #107, #110, #114, #118, #120, #122, #124, #213 were cleaned and painted. The back board cover was replaced in Room #201.• 5. The black marks and scuffs in Room #218 A & B were removed.• 6. The Coax cable in Rooms #203 and #218 were removed from the floor and stored properly.• 7. The footboard in Room #118 was replaced. The wall behind the bed in Room #203 B was repaired.	4/22/11	

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F 253 Continued From page 5
03/29/11 through 03/31/11.
Findings include:

Observations, on 03/29/11 at 9:40 AM and on 3/31/11 at 4:30 PM revealed:

1. Rusty over-the-bed tables were noted in Room #105, #114 A, #114 B and #116.
2. Nightstands were scuffed and scratched and drawers were displaced in Rooms #104 A, #104 B, #106, #110, #114, #207 B, #217, #220 A, #220 B and #219 had a drawer pull missing.
3. Window blinds were torn or bent in Rooms #104, #120 and #124.
4. The heater housing units in Rooms #106, #107, #110, #114, #118, #120, #122, #124 and #213 were open and exposed at the bottom in an area that was approximately nine inches high by 40 inches wide and were noted to have debris and rust that extended out into the tile flooring. The backing board cover for the housing needed replaced in Room #201.
5. The floor in Rooms #218 A and #218 B had large areas of black marks and scuffs.
6. Coax cable in Rooms #203 and #218 was wound in rolls and laying on the floor.
7. There were knicks and scratches on the footboard in Room #118 B. In Room #203 B, the paint and sheet rock behind the bed headboard was noted to have large scratches.
8. The wardrobe doors in Room #120 were out of line and would not close completely.

F 253

- 8. New hinges were put on the wardrobe doors in Room #120.
- 9. In Room #121 the bathroom floor was cleaned with a rust remover product. The bathtub in Room #203 was cleaned with a rust remover product.
- 10. The curtain rod was replaced and wallpaper in the bathroom in Room #204 was removed and new border applied.
- 11. The hand held shower sprayer was removed in Room #201 and replaced with a standard shower head.

2. Revised Compliance Round Form implemented on 4/20/2011. A compliance round completed on all rooms and lobbies was done on 4/20/2011.
3. On 4/20/2011, The Environmental Director was In-serviced on his job description/ responsibilities along with the revised End of the Month Report. The Daily checklist and Weekly Preventative Maintenance forms were updated to include issues sighted during survey. A new Painting Schedule was developed and implemented. Environmental Services Staff were In-serviced on the revised cleaning schedule on 4/18/2011. All departments were informed on the location and purpose of the Maintenance Log during a mandatory In-service conducted 4/19/2011.
4. The Administrator will review the completed Daily Checklist and Weekly Preventative Maintenance forms for continued compliance with POC. CQI Form ES-1, "General Environment" will be completed weekly for 4 weeks, then monthly by the Environmental Director.
5. Completion Date 4/22/2011

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F 253	Continued From page 6 9. In Room #121, there was a rusty corner in the bathroom floor and a bathtub in Room #203 had a rust colored stain from a leaking faucet. 10. In Room #204, the curtain rod was bowed and the wallpaper border, in the bathroom, had been placed over an already existing border, which showed through the holes in the border. The border was curled at the top and bottom and all the way around the bathroom. 11. The hand held shower in Room #201 was disconnected from the shower head and was wrapped in circles around the shower valves, with a sign that read "do not turn on the valve." An interview with the Maintenance Director, on 03/31/11 at 5:00 PM, revealed he had treated the nightstands with a refinishing oil, but stated "This treatment does not last long." He also stated staff members have a "Maintenance Log" on each of the two wings, as well as being able to tell him verbally. He stated he was not made aware of the needed repairs or environmental maintenance, despite his routine room checks and review of the logs. An interview with Housekeeper #1, on 03/31/11 at 10:50 AM, revealed if there were concerns with the maintenance of the rooms, he "just told the maintenance man."	F 253		
F 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assesment must accurately reflect the resident's status. A registered nurse must conduct or coordinate	F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED 1. Resident #1, Resident #2, Resident #5 and Resident #7 MDS Assessments were appropriately signed by RN #2, MDS Coordinator on 4/18/2011.	4/21/11

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F 278	<p>Continued From page 7</p> <p>each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview, it was determined the facility failed to ensure Minimum Data Set (MDS) assessments were appropriately completed and signed by the Registered Nurse (RN) MDS Coordinator for four residents (#1, #2, #5 and #7), in the selected sample of 12.</p> <p>Findings included:</p> <p>1. A record review revealed Resident #1 was</p>	F 278	<p>2. An Audit was completed on 4/18/2011 of all MDS assessments since 10/1/2010 to assure all MDS assessments have been signed appropriately.</p> <p>3. The CQI form N-19 was revised on 4/20/2011 to include reviewing sections V, X, Z and CAAs for signatures. New system implemented for medical records to review MDS assessments before filing.</p> <p>4. The revised CQI Form N-19, "RAI Process" will be completed weekly for 4 weeks then quarterly thereafter.</p> <p>5. Completion date 4/21/2011.</p>	

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F 278	<p>Continued From page 8</p> <p>admitted to the facility on 01/19/09 with diagnoses to include Acute Renal Failure, Hypertension, Failure to Thrive-Adult, History of Colon Cancer and Atrial Fibrillation.</p> <p>A review of the quarterly MDS, with a completion date of 10/16/10, revealed Section Z0500A, which is for the "Assessment Administration," was not signed by the RN MDS Coordinator.</p> <p>2. A record review revealed Resident #2 was admitted to the facility on 09/24/08 and readmitted on 12/02/10 with diagnoses to include Congestive Heart Failure, Diabetes Mellitus, Hypertension, Cerebral Vascular Accident with Aphasia, Hemiplegia and Cirrhosis.</p> <p>A review of the admission MDS, with a completion date of 12/02/10, revealed Sections V0200B1 and V0200C1, which is for the "Care Area Assessment Summary," was not signed by the RN MDS Coordinator.</p> <p>3. A record review revealed Resident #5 was admitted to the facility on 11/05/10 with diagnoses to include Convulsions, Dysphagia, Atresia Large Intestine, Spina Bifida and Hydrocephalus.</p> <p>A review of the admission MDS, with a completion date of 11/18/10, revealed Sections V0200B1 and V0200C1, which is for the "Care Area Assessment Summary," was not signed by the RN MDS Coordinator.</p> <p>4. A record review revealed Resident #7 was admitted to the facility on 09/12/07 with diagnoses to include Mild Mental Retardation, Cerebral Vascular Accident with left-sided hemiparesis, Hypertension and Blindness.</p>	F 278		
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F 278	Continued From page 9 A review of the significant change MDS, with a completion date of 03/24/11, revealed Sections V0200B1 and V0200C1, which is for the "Care Area Assessment Summary," was not signed by the RN MDS Coordinator. An interview with RN #2 (MDS Coordinator), on 03/31/11 at 2:00 PM, revealed she knew she was supposed to sign Section V and Section Z on the MDS 3.0. She stated, "I just did not do it."	F 278			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure one resident (#7), in the selected sample of 12, was free of significant medication errors. Resident #7 received two doses of potassium which were ordered to be withheld. Findings include: A review of the facility's policy and procedure "Administering Medications," revised 07/06/09, revealed "The individual administering the medication must ensure that the right medication, right dosage, right time and right method of administration are verified (e.g., review of drug label, physician's order, etc.) before the medication is administered. Should a drug be withheld, refused, or given other than at the scheduled time, the individual administering the medication must initial and circle the MAR space	F 333	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 1. MAR for Resident #7 was corrected on 3/31/2011. The Attending physician and family were notified of the med error on 3/31/2011. LPN #1 received disciplinary action on 4/1/11. An In-Service on "Administering Medications" was conducted on 4/1/2011 for CMA#1 and LPN#1. 2. An audit on physicians' orders and MARs and TARs was conducted on 4/20/11 and 4/21/2011 to assure all the residents' MARs and TARs matched with the physician's orders. 3. An In-Service on "Administering Medications" was conducted on 4/1/2011 for CMI's and charge nurses. On 4/20/2011, CQI Form N-22, "Chart Audit Review" was revised to include comparing the Physicians orders with the MARs and TARs, the Administering Medication Policy was updated, and the	4/22/11	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/31/2011
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 333	<p>Continued From page 10 provided for that particular drug."</p> <p>A record review revealed Resident #7 was admitted to the facility on 09/12/07 with diagnoses to include Mild Mental Retardation, Cerebral Vascular Accident with left-sided hemiparesis, Hypertension and Blindness.</p> <p>A review of a physician's order, dated 03/14/11, revealed "hold potassium for two weeks and repeat laboratory test in two weeks." The laboratory test was completed on 03/28/11 and indicated potassium 5.5 high (H) with a notation at the bottom, dated 03/29/11, "Continue to hold potassium, recheck in two weeks."</p> <p>A review of a physician's order, dated 03/29/11 at 8:00 AM, revealed "Continue to hold potassium until further orders. Recheck potassium in two weeks."</p> <p>A review of a Medication Administration Record (MAR), dated 03/11, revealed the potassium was withheld on 03/14/11 through 03/28/11. However, on 03/29/11 and 03/30/11, the 8:00 PM dose was administered.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 03/31/11 at 2:30 PM, revealed she was aware that the potassium was to be withheld until the end of the month. She stated, "I guess nobody told Certified Medication Aide (CMA #1) that it should not be administered."</p> <p>An interview with CMA #1, on 03/31/11 at 3:50 PM, revealed she saw the line marked through at the end of 03/28/11 and thought that it was supposed to be administered on 03/29/11. She stated, "I thought day shift just forgot to initial it."</p>	F 333	<p>Physician Orders Policy was revised to include making modifications on MARs and TARs to reflect the order change.</p> <p>4. The CQI Form N-16, "Review of Medication Pass" will be completed weekly for 4 weeks, then monthly for 3 months, then quarterly.</p> <p>5. Completion date 4/22/2011.</p>	

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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	
F 333	Continued From page 11 She did not look at the physician's orders prior to medication administration. The nurse was responsible to make changes on the MAR. She also stated she should not have administered the potassium. An interview with the Director of Nursing (DON), on 03/31/11 at 4:05 PM, revealed the nurse was the person who was responsible to change the MAR, not the CMA. She stated she was aware if the potassium level was too high, it could affect the heart.	F 333			
F 371 SS=E	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 observations, interviews and review of the facility's policy/procedure, it was determined the facility failed to ensure food was prepared, stored and distributed under sanitary conditions related to a large build-up of dust on multiple kitchen surfaces. Findings include: A review of the facility's policy and procedure, "Sanitation," undated, revealed "The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen	F 371	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 1. The dust on the stove hood filter, cool air return vent, air conditioner vent, on power plugs and the plumbing pipe above the hand washing sink was removed and the area was thoroughly cleaned on 3/29/2011. 2. The Dietary Manager conducted a kitchen audit in the kitchen to assure sanitary conditions were met on 3/29/2011. Any dusty surfaces found were cleaned at that time. The Registered Dietician conducted a kitchen audit again on 3/30/2011. 3. The "Dietary Cleaning Schedule" form was revised on 4/18/11. An In-service on "Sanitation" was completed on 4/20/11 and again the revised cleaning schedules reviewed for the dietary staff. The CQI Form D-8, "Dietary Department Audit", was revised on 4/20/2011.	4/21/11	

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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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 12 and dining areas. Food Service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment." Observations of the kitchen, on 03/29/11 at 8:50 AM and at 11:00 AM revealed: 1. The stove hood filter directly above the stove burners had a dust build-up. 2. The cool air return vent located in dry storage area and above dried goods had a build-up of dust. 3. The air conditioner vent located above the produce refrigerator had a build-up of dust. 4. A power plug to located directly above the steam table had a build-up of dust. 5. The plumbing pipe located above the handwashing sink had long, multiple layers of dust. Interviews with the Dietary Manager, on 03/29/11 at 8:50 AM and at 11:00 AM, revealed the dietary staff was responsible to ensure the stove hood filter, air conditioner vent and plumbing pipes were cleaned. She was unsure of the date the last time the stove hood filter or plumbing pipes were cleaned. She stated maintenance was responsible to ensure the cool air return vent and plumbing pipes were cleaned. Additionally, she stated, there was not a cleaning schedule in place to identify designated days to clean the stove hood filter, air conditioner vent, power plug and plumbing pipes.	F 371	4. The CQI Form D-8, "Dietary department Audit", will be completed weekly for 4 weeks then monthly thereafter. 5. Completion date 4/21/2011.		
F 441 SS=0	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 1. RN#3 received a written reprimand and in-serviced for failure to wash her hands or change gloves while providing wound care and dressing changes on 4/1/2011.	4/22/11	

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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 441

Continued From page 13 of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record reviews, it was determined the facility failed to ensure staff washed their hands and/or changed

F 441

2. RN #3 attended a Wound Care Seminar sponsored by Advanced Tissue on 4/21/2011. In-services on Skin Care Management, The Wound Care Policy, and Infection Control were given to all Charge nurses on 4/19/2011. A Hand Washing In-Service was given to staff on 4/20/2011.
3. The CQI Form IC-2, "Infection Control General" was revised to include an observation of a dressing change to ensure proper infection control procedures are being followed.
4. Hand Washing and Infection Control In-services will be conducted monthly for the next three months during the mandatory staff meetings. The CQI Form IC-2, "Infection Control General", will be completed weekly for 4 weeks then quarterly thereafter.
5. Completion Date 4/22/2011

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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 441	<p>Continued From page 14</p> <p>gloves, after each direct resident contact for which hand washing and/or glove changing was indicated by accepted professional practice, for two residents (#1 and #4), in the selected sample of 12.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure "Skin Care Management," dated 06/18/09, revealed dressing changes were to be completed using clean technique.</p> <p>A review of the "Wound Care Policy," dated 01/02, revealed the nurse was to dispose of the soiled dressing after removal, in an appropriate receptacle, wash and dry hands and put on a new pair of gloves prior to placing the new dressing. The rationale was to reduce the transmission of microorganisms.</p> <p>1. A record review revealed Resident #1 was admitted to the facility on 01/19/09 with diagnoses to include Coronary Artery Disease and History of Sepsis.</p> <p>A review of an annual Minimum Data Set (MDS), dated 01/13/11, revealed the facility identified Resident #1 to be severely cognitively impaired with a history of a Stage III pressure sore.</p> <p>An observation of a dressing change, on 03/30/11 at 9:45 AM, revealed Registered Nurse (RN) #3 did not change her gloves after removing the old dressing that was noted to have a moderate amount of sanguineous drainage. The nurse did not wash her hands and she continued to wear the same gloves to apply normal saline to a two inch by two inch (2x2) gauze pad, and then wipe the center of the wound. Additionally, she</p>	F 441		
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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
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F 441	<p>Continued From page 15</p> <p>moistened a 2x2 gauze pad and placed this in the center of the wound bed. A dry 2x2 gauze pad was then placed over the site and secured the dressing with a wide gauze bandage and paper tape.</p> <p>2. A record review revealed Resident #4 was admitted on 01/22/11 with diagnoses to include Arterial Sclerosis and Alzheimer's Dementia.</p> <p>A review of a significant change MDS, dated 02/04/11, revealed the facility identified Resident #4 to be severely cognitively impaired with a history of a Stage III pressure sore.</p> <p>An observation of a dressing change, on 03/30/11 at 10:30 AM, revealed RN #3 did not change her gloves or wash her hands between dressing changes to the resident's left ankle and right forearm.</p> <p>An interview with RN #3, on 03/30/11 at 9:50 AM, revealed "I usually use the same set of gloves throughout the procedure."</p> <p>An interview with the Director of Nursing (DON), on 03/31/11 at 2:00 PM, revealed she expected RN #3 "to know better."</p>	F 441		
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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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K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and conducted on 03/29/11 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.</p>	K 000		
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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.