

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

PRINTED: 07/08/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  188049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/22/2012
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 recertification survey was conducted on 06/20/12 through 06/22/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with deficiencies cited at the highest scope and severity of an "E."	F 000		
F 164 SS-E	<del>483.10(a), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</del>  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records:  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.  The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.  The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	  F 164 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  1. The two staff members providing incontinent care to resident #5 received disciplinary action by the DON for not providing privacy during care.  On 6/22/2012, Privacy curtains that were in storage were immediately hung by the Maintenance Director in rooms #104, #118, #120, #122, #203, #204, #205, #218, and #222 to provide adequate privacy.  On 6/22/2012, Privacy curtains were ordered by the Administrator through Direct Supply for rooms #201, #202, #206, #207, #209, #215, #217, #219, #220, #221, #223, and #224.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Stephanie Nemich TITLE Administrator (X6) DATE 7/31/12

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 164	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure personal privacy during provision of incontinent care for one resident (#10). In the selected sample of thirteen residents, Additionally, observations on the 100 Hall and the 200 Hall revealed adequate and functioning privacy curtains were not available for each resident residing in the facility.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Privacy and Dignity," undated, revealed "Each resident will be provided privacy during bathing, grooming, peri-care, wound care and any other personal care. Privacy curtain and drapes/blinds will be closed in bedrooms and shower rooms when providing wound or personal care and close the door that opens to the hallway."</p> <p>1. A record review revealed the facility admitted Resident #5 on 12/28/07 with diagnoses to include Dementia and Psychotic Disorder. A review of the quarterly Minimum Data Set (MDS), dated 04/02/12, revealed the resident was incontinent of bowel and bladder and totally dependent on two (2) staff for bed mobility, transfer, and toilet use.</p> <p>An observation during a skin assessment and incontinent care, on 06/21/12 at 1:40 PM, revealed the resident was laying in the bed on his/her back. Two staff were present preparing to provide incontinent care. The door to the</p>	F 164	<p>Extra privacy curtains were also ordered by the Administrator on 7/13/2012.</p> <p>Hooks, hangers to secure privacy curtains were ordered by the Administrator on 7/11/2012.</p> <p>The Maintenance Director placed new pull chains in rooms n#106, #114, #116, and #122. New pull chain systems were ordered by the Administrator on 7/13/2012 for rooms #102, #104, #108, #110, #118, #120, #124.</p> <p>2. On 7/12/2012 the Administrator completed compliance rounds to ensure that staff was providing privacy during routine care.</p> <p>On 7/12/2012, (who) completed an audit on all resident rooms to ensure that privacy could be obtained until the required equipment ordered had arrived. Every bed could be ensured privacy either by pulling the existing privacy curtain and/ or shutting the door, and closing the blinds.</p>		

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F 164	<p>Continued From page 2</p> <p>resident's room was open to the hallway with no privacy curtains in use, and the resident was exposed from the waist down. The resident's roommate was also present in the room. Resident #5 was in full view of others, and provision of the resident's care could be observed by other staff, residents, or visitors, who passed by the resident's door.</p> <p>An interview with Registered Nurse (RN) #1, on 06/21/12 at 1:55 PM, revealed the staff should have closed the privacy curtain and the door to the hallway prior to provision of incontinent care. She stated, "they should know what to do."</p> <p>An interview with the Director of Nursing (DON), on 06/21/12 at 3:05 PM, revealed she expected the staff to close the door, the window blinds, and pull the privacy curtain around the resident prior to the provision of care.</p> <p>2. An observation of residents' rooms was conducted on 06/22/12 beginning at 2:00 PM. Observations revealed privacy curtain tracks in some of the rooms were equipped with a switch box and pull chains which enabled the curtains to be routed to one side of the room or the other. Rooms #102, #104, #106, #108, #110, #114, #116, #118, #120, #122, and #124 were equipped with the switch boxes; however, each room had one or both chains missing which prevented a privacy curtain to be directed to Bed A or Bed B, leaving one side of the room without privacy. Additionally, Rooms #104, #118, #120, and #122 required two curtains to provide adequate privacy and there was only one curtain in place.</p> <p>Further observation, on 06/22/12, revealed</p>	F 164	<p>3. On 6/22/2012, (who) completed an In-service for all departments on Resident Rights and Privacy and Dignity.</p> <p>On 7/13/12, the Administrator revised the "Daily Housekeeping/ Maintenance Rounds Checklist" to include a daily check for proper function and hanging of privacy curtains and to ensure two privacy curtains were placed in every semi private room.</p> <p>4. CQI Form SS-5 "Resident Observation" will be completed by the Maintenance Director weekly for 4 weeks, monthly for 3 months then quarterly thereafter. CQI Form ES-1 "General Environment" will be completed by the Maintenance Director weekly for 4 weeks, monthly for 3 months then quarterly thereafter.</p> <p>5. Completion date 7/14/2012.</p>		

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F 164	Continued From page 3 Rooms #201, #202, #203, #204, #205, #206, #207, #209, #215, #217, #218, #219, #220, #221, #222, #223, and #224 required two curtains to provide adequate privacy; however, each room had only one curtain.  An interview with RN #1, on 06/22/12 at 2:25 PM, revealed she was aware that some of the privacy curtain tracks had the pull chains missing. She stated the curtains could not be switched from one side of the room to the other which caused certain residents to be in view during private procedures, such as Incontinent care, wound care, or skin assessments.  An interview and observation with the laundry staff, on 06/22/12 at 3:00 PM, revealed there were nine curtains available in the laundry. The laundry staff stated there were not enough curtains to provide privacy for everyone and there had not been enough privacy curtains in awhile. A timeframe was not provided.  An interview with the DON, on 06/22/12 at 2:20 PM, revealed there was not enough privacy curtains for all of the residents' rooms. The DON stated many of the switch boxes in the facility were missing pull chains to route the privacy curtains in the appropriate direction. The DON further revealed the bed by the door was exposed to anyone that was in the hall, because the curtains did not entirely cover the bed by the door.	F 164			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's	F 279	F 279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  1. On 7/9/2012, the MDS Coordinator developed a comprehensive care plan for Resident #2 Indwelling suprapubic catheter.		

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F 279	<p>Continued From page 4 comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.26; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to develop a comprehensive care plan related to an indwelling catheter for one resident (#2), in the selected sample of thirteen residents.</p> <p>Findings include: The facility was unable to provide a policy/procedure related to care plans.</p> <p>A record review revealed the facility admitted Resident #2 on 07/07/11 with diagnoses to include Quadriplegia, Neurogenic Bladder, and Suprapubic catheter.</p>	F 279	<p>2. On 7/6/2012, the DON completed an audit to ensure that residents with catheters and residents with any other identified special need were care planned to ensure the resident's highest practicable physical, mental, and psychosocial well-being. A comprehensive care plan will be implemented by the DON for any resident identified during the audit</p> <p>3. On 7/13/12, the DON completed an in-service for Licensed Nurses and MDS Coordinator to ensure</p> <ul style="list-style-type: none"> <li>The development and implementation of comprehensive care plans based on specific needs identified during the comprehensive assessment</li> </ul> <p>The CQI tool N-8 "Catheter Use Review" was revised by the Corporate Compliance Officer on 7/12/12 adding question # 7 which states "Is the care plan specific to the type of catheter that was ordered by the physician?"</p>		

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F 279	Continued From page 5  A review of the admission Minimum Data Set (MDS), dated 07/22/11, revealed Resident #2 was admitted to the facility with an indwelling suprapubic catheter. The resident was ambulatory and required total assistance of two staff for bed mobility, transfers, and toileting. A review of the quarterly MDS, dated 03/22/12, revealed Resident #2 had an indwelling suprapubic catheter. The resident was non-ambulatory and required total assistance of two staff for bed mobility, transfers, and toileting.  A review of the physician's orders, dated 06/07/12, revealed "suprapubic catheter to bedside drainage, change monthly and as needed."  An observation during a skin assessment, on 06/22/12 at 10:45 AM and 11:00 AM, revealed the resident had a suprapubic catheter and was status-post bilateral above the knee amputation with staples intact; however, a review of Resident #2's record revealed no evidence of a care plan related to an indwelling suprapubic catheter.  An interview with the Director of Nursing (DON), on 06/22/12 at 3:05 PM, revealed she expected the admitting nurse to initiate a care plan upon admission. After completion of the MDS assessment, the MDS Coordinator should replace the initial care plan and implement a new care plan. She stated there should be a care plan in place related to Resident #2's suprapubic catheter.	F 279	The Corporate Compliance Officer in-serviced the DON on the revised CQI tool N-8 "Catheter Use Review" on 7/12/12.  4. CQI Tool N-8 "Catheter Use Review" is a QA form that will document the review of physician order, assessment, care plan and observation of residents with catheters. The form will be completed by the DON weekly for 4 weeks, monthly for 3 months then quarterly thereafter.  Any problems identified during the completion of the QA process will be action planned by the DON.  5. Completion Date 7/14/2012.	
F 315 <del>88-E</del>	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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F 315	<p>Continued From page 6</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure appropriate care and services related to indwelling urinary catheters for four residents (#2, #5, #8, and #9), in the selected sample of thirteen residents. Resident #9 was observed with an indwelling urinary catheter bag and tubing laying on the floor, and there was no evidence of a physician's order for the indwelling urinary catheter. Residents #2, #5 and #8 had indwelling urinary catheters and were observed without the catheter tubing secured by a leg strap as per the facility's policy.</p> <p>Findings include: A review of the facility's policy/procedure, dated 08/02, revealed "Be sure the catheter tubing and drainage bag are kept off the floor, and ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh)."</p>	F 315	<p>F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <ol style="list-style-type: none"> <li>On 6/22/12, the ADON secured Resident's #2, #5 and #6 catheter with a leg strap and obtained a physician's order for resident #9 indwelling catheter.</li> <li>An audit was completed on 7/13/2012 by the DON and ADON to ensure all residents with a catheter: <ul style="list-style-type: none"> <li>had a physician order detailing appropriate clinical diagnosis</li> <li>had a care plan implemented to ensure appropriate treatment and services.</li> </ul> </li> <li>On 6/22/12, the ADON completed an In-service for Licensed Nurse, CMT and CNA on: <ul style="list-style-type: none"> <li>Physician orders are to include appropriate clinical conditions that justify a catheter,</li> <li>catheter care, and</li> <li>securing catheters.</li> </ul> </li> </ol>	

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F 315	<p>Continued From page 7</p> <p>1. A record review revealed the facility admitted Resident #9 on 11/11/11 with diagnoses to include Diabetes Mellitus, Anemia, Kidney Disease, Organic Brain Syndrome, Convulsions, and Cerebral Vascular Accident. Further review revealed the resident required assistance with bed mobility, transfers, toileting, personal hygiene, and was mobile per wheelchair.</p> <p>Further review revealed Resident #9 was found unresponsive on 06/07/12 and was admitted to the local hospital. He/she was re-admitted to the facility on 06/15/12 with an indwelling urinary catheter in place. There was no evidence of a physician's order for the indwelling urinary catheter.</p> <p>Observation, on 06/21/12 at 8:25 AM, revealed Resident #9 propelled himself/herself down the hallway in a wheelchair with the urinary catheter bag and the catheter tubing dragging on the floor. An observation at 4:00 PM revealed the resident was in the common area near the nurses' station. He/she was sitting in a wheelchair with the urinary catheter drainage bag laying directly on the floor underneath the resident's wheelchair.</p> <p>Observation, on 06/22/12 at 8:25 AM and at 2:15 PM, revealed the resident's indwelling urinary catheter was not secured, in order to prevent trauma from pulling on the catheter or to prevent friction to the resident's bladder.</p> <p>2. A record review revealed the facility admitted Resident #2 on 07/07/11 with diagnoses to include Quadriplegia, Neurogenic Bladder, Diabetes Mellitus, and Suprapubic Catheter.</p>	F 315	<p>The CQI Tool N-8, "Catheter Use Review" was revised on 7/12/2012 by the Corporate Compliance Officer to include question #8 that states "Is the catheter secured with a leg strap?" The Corporate Compliance Officer in-serviced the DON on the revised CQI tool N-8 "Catheter Use Review" on 7/12/12.</p> <p>4. The CQI Tool N-8 "Catheter-Use Review" is a QA form that will document the review of physician order, assessment, care plan and observation of residents with catheters. The form will be completed by the DON weekly for 4 weeks, monthly for 3 months then quarterly thereafter. Any problems identified during the completion of the QA process will be action planned by the DON.</p> <p>5. Completion Date 7/14/2012.</p>		

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F 316	<p>Continued From page 8</p> <p>An observation during a skin assessment, on 06/22/12 at 11:00 AM, revealed Resident #2's catheter tubing was unsecured to his/her leg to prevent injury.</p> <p>3. A record review revealed the facility admitted Resident #5 on 12/28/07 with diagnoses to include Congestive Heart Failure, Renal Failure, and Dementia.</p> <p>An observation during catheter care, on 06/21/12 at 1:40 PM, and an observation on 06/22/12 at 3:45 PM, revealed Resident #5's catheter tubing was unsecured to his/her leg to prevent injury.</p> <p>4. A record review revealed the facility admitted Resident #8 on 06/15/12 with diagnoses to include Cerebral Vascular Accident, Gastrointestinal Hemorrhage, Drug abuse, Tobacco Use Disorder, and Urinary Retention.</p> <p>A review of the physician's admission orders, dated 06/15/12, revealed an indwelling catheter to bedside drainage.</p> <p>An observation of the resident's catheter, on 06/21/12 at 9:48 AM, revealed his/her catheter tubing was unsecured to his/her leg.</p> <p>An interview with CNA #1, on 06/22/12 at 4:40 PM, revealed "we do not use leg straps, and do not secure catheter tubing normally."</p> <p>An interview with CNA #3, on 06/22/12 at 4:50 PM, revealed she was assigned to Resident # 6 and he/she did not have a leg strap to secure catheter tubing and does not use anything to secure catheter tubing. She stated, "we just be</p>	F 315			

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F 315	Continued From page 9 careful and watch it and make sure the tubing stays in place."  An interview with Licensed Practical Nurse (LPN) #2, on 06/22/12 at 2:15 PM, revealed urinary catheters should be secured to prevent trauma to a resident's bladder.  An interview with the Director of Nursing (DON) on 06/22/12 at 2:45 PM, revealed the facility's policy was for indwelling catheters to be secured and the nurse was responsible to ensure that it was secured.	F 315			

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NAME OF PROVIDER OR SUPPLIER  AUBURN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42206
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(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
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{K 000}	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1987</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200)</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke and heat detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 08/20/12. Auburn Healthcare was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for sixty-six (66) beds with a census of fifty-one (51) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	{K 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephanie Semriva TITLE: Administrator (X4) DATE: 9/12/2012

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  R 08/22/2012
NAME OF PROVIDER OR SUPPLIER  AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42206		
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(K 000)	Continued From page 1  Deficiencies were cited with the highest deficiency identified at "F" level.  A standard Life Safety Code follow-up survey was conducted on 08/22/12. Auburn Health Care was found not to be in compliance with the requirements for participation in Medicare and Medicaid.	(K 000)			
(K 027) SS=F	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  This STANDARD is not met as evidenced by: Based on observation and interview, during the follow-up survey conducted on 08/22/12, it was determined the facility failed to ensure the deficiency cited on 08/20/12 during the standard survey, was corrected as outlined in the facility's plan of correction. The facility's alleged compliance date was 08/14/12.  Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would	(K 027)	<b>K 027 NFPA 101 LIFE SAFETY CODE STANDARD</b>  1. Western Kentucky Door was contacted after the Initial Life Safety Inspection and appointment was made however, WKD failed to make that appt. WKD was called again on 7/2/2012 and an appointment was made for 7/6/2012. WKD came to the facility on 7/6/2012 to figure a bid on installing the coordinators. WKD was supposed to fax the bid to the facility upon their return to the office but did not do so. Only after a complaint was made by the Administrator to the company was the bid emailed from WKD to the facility.  On 8/23/2012 Western Kentucky Doors installed six coordinating devices on six cross corridor doors. WKD door was called again on 8/29/2012 and at that time additional parts were ordered. On 9/6/2012 Western Kentucky Door returned to the facility again and installed 6 AL Closures to the doors and 6 carry bars. On 9/11/2012 WKD returned to the facility and installed L brackets to 6 doors. The work completed on this day ensures that the deficiency cited on 6/20/2012 is now corrected.		

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NAME OF PROVIDER OR SUPPLIER  AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42208		
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(K 027)	<p>Continued From page 2</p> <p>resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for sixty-six (66) beds with a census of fifty-one (51) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 08/22/12 between 10:30 AM and 11:00 AM with the Environmental Director, revealed the cross-corridor doors located throughout the facility would not close completely when tested. This was due to the doors not having a coordinating device to ensure the door without the t-astagal would close first after the initial close.</p> <p>Interview, on 08/22/12 between 10:30 AM and 11:00 AM with the Environmental Director, revealed he had contacted Western KY Door and they came to the facility to give them a bid to repair the doors. Once the contractor left the Environmental Director had contacted them several times to get the bid or some sort of paperwork to say they were going to complete the work but has not been able to get anything from the company.</p> <p>Interview, on 08/22/12 between 10:30 AM and 11:00 AM with the Administrator, revealed she was aware the company had been at the facility to give them a bid to complete the work but there was nothing to show this work was going to be completed. She was unaware the Plan of Correction said an appointment was made with Western Kentucky Doors to install a coordinating device on the doors. She was also unaware once</p>	2. (K 027)	<p>Each cross corridor door was checked by the Administrator and the Environmental Services Director on 9/11/2012 and each corridor door was found to have a coordinating device to ensure the door without the t-astagal would close first after the initial close.</p> <p>3. The Administrator was In-serviced by the Corporate Compliance Officer on 8/22/2012 on Plan of Corrections and Completion Dates.</p> <p>The Environmental Services Director was given a calendar and In-serviced on 9/10/2012 on tracking and documenting on his calendar the following: when he originally spoke to the vendor, who he spoke with, and noting the upcoming appointment date so that he may follow up with them to ensure the work is completed. He was also educated on following up immediately with vendors that missed their appointment.</p> <p>The facility purchased "Fire, Building, and Life Safety Code Documentation" manual on 8/7/2012. On 9/11/2012, the facility obtained online membership with NFPA and will receive updates and training opportunities via email. The Administrator and Environmental Services Director have online access to the current edition of NFPA 101 and NFPA 99.</p>		

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NAME OF PROVIDER OR SUPPLIER  AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST. AUBURN, KY 42208	
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{K 027}	Continued From page 3 a completion date was put on the Plan of Correction, that at this date the facility is alleging compliance with CMS.  NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.  Reference: NFPA 80 (1999 Edition)  2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.  Reference: NFPA 101 (2000 edition)  8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	4. {K 027}	The ESD will complete CQI Form ES-3 monthly for 3 months then quarterly thereafter.  Any "No" or non-compliance issues found following the completion of ES-3 will be addressed on an in-house Action Plan that states the non-compliance issue, the plan(s) to achieve compliance and the completion date.  Together, the Administrator and ESD develop the action plan and then monitor the interventions until compliance is achieved.  The Administrator assigns certain CQI monitor tools to all department managers on a monthly basis. The name of the tool dictates its contents and focus areas. After completing the tool, a copy of the completed forms are returned to the Administrator for review and monitoring so continuous quality services can be maintained.	
{K 050} SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is	5. {K 050} K 050 NFPA 101 LIFE SAFETY CODE STANDARD	Completion Date 9/11/2012.  1. A fire drill was conducted on 8/22/2012 at 2:50pm so that August's fire drill will have a significantly larger variation of time than the one held previously that month.	9/11/12

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(K 050)	<p>Continued From page 4</p> <p>assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, during the follow-up survey conducted on 08/22/12, it was determined the facility failed to ensure the deficiency cited on 06/20/12 during the standard survey, was corrected as outlined in the facility's plan of correction. The facility's alleged compliance date was 08/14/12.</p> <p>Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for sixty-six (66) beds with a census of fifty-one (51) on the day of the survey.</p> <p>The findings include:</p> <p>Fire Drill review, on 06/20/12 between 10:00 AM and 11:00 AM with the Environmental Director, revealed the fire drills were not being conducted at unexpected times under varied conditions. First shift fire drills were being conducted predictably between 8:30 AM and 9:30 AM and second shift between 6:39 PM and 8:05 PM. Further observation showed the drills were being</p>	(K 050)	<p>September's monthly fire drill was held on 9/8/2012 at 9:50pm for the second shift.</p> <p>2. On 9/10/2012 the Administrator made a Fire Drill Calendar that listed the days, times, and varying conditions of each month's fire drill till the end of 2013 for the Environmental Services Director to follow to ensure the deficiency cited on 6/20/2012 is corrected.</p> <p>The ESD is to turn in to the Administrator the fire drill form the next business day after the drill was conducted. The Environmental Services Director will receive disciplinary action if the Fire Drill Calendar is not followed and an additional fire drill will be performed for that month.</p> <p>3. On 8/22/2012, the Administrator was in-serviced by the Corporate Compliance Officer on Plans of Corrections and Completion Dates.</p> <p>On 9/10/2012, The Environmental Services Director was in-serviced on the newly implemented Fire Drill Calendar. He was instructed to strictly follow the calendar to ensure that the fire drills are in compliance with the Life Safety Code. He was also informed that the Fire Drill Calendar was confidential information and not to be shared with other staff members.</p>		

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{K 050}	<p>Continued From page 5</p> <p>conducted at the end of each month. Current review of the fire drills revealed the facility has performed one fire drill on 1st shift since the standard survey at 8:30 AM on 8-13-12, and at 6:00 PM on 08-29-12.</p> <p>Interview, on 08/22/12 between 10:00 AM and 11:00 AM, with the Environmental Director, revealed he was concentrating on not doing the fire drills on the same day of each month and he did not pay attention to the times that he did the fire drills.</p> <p>Interview, on 08/22/12 between 10:00 AM and 11:00 AM, with the Administrator, revealed she was unaware the fire drills were still not being conducted at random times.</p> <p>Reference: NFPA Standard NFPA 101 10.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p>	{K 050}	<p>On 8/23/2012 Corporate Compliance Officer revised CQI Form ES-6, "Fire and Evacuation Drill" to include item # 20 "Was time and day of drill significantly different from previous months' drills?" and item #21 "Was drill conducted under different conditions than previous months' drills?"</p> <p>4. ESD will complete CQI Form ES-6 monthly for 3 months then quarterly thereafter. Any "No" or non-compliance issues found following the completion of ES-6 will be addressed on an in-house Action Plan that states the non-compliance issue, the plan(s) to achieve compliance and the completion date.</p> <p>Together, the Administrator and ESD develop the action plan and then monitor the interventions until compliance is achieved.</p> <p>The Administrator assigns certain CQI monitor tools to all department managers on a monthly basis. The name of the tool dictates its contents and focus areas. After completing the tool, a copy of the completed forms are returned to the Administrator for review and monitoring so continuous quality services can be maintained.</p> <p>5. Completion Date 9/10/2012.</p>	9/10/12