Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185049	A. Building B. Wing	03/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Nursing and Rehabilitation Center	139 Pearl Street Auburn, KY 42206

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to implement the care plan related to advance directives for one (Resident (R) 1) of 19 sampled residents reviewed for care plans. R1's care plan identified the resident as a Full Code (indicating that Cardiopulmonary Resuscitation (CPR) should be performed if the resident was found without vital signs.); however, staff failed to implement the care plan, and no lifesaving measures were attempted.On [DATE], at 3:10 PM the Administrator was provided a copy of the CMS Immediate Jeopardy (IJ) Template and was notified that the failure to implement the resident's care plan by performing CPR in accordance was likely to cause serious injury, impairment, or death. This failure constituted IJ at 42 CFR 483.21 (b) F656. The IJ was determined to exist on [DATE], when staff failed to implement R1's care plan and initiate CPR when the resident was found without pulse or respiration.The facility provided an acceptable IJ Removal Plan on [DATE]. The plan alleged the IJ was removed on [DATE]. A Partial Extended Survey and IJ Removal Validation was conducted on [DATE]. The State Survey Agency (SSA) validated the IJ was removed on [DATE], as alleged. The deficient practice remained at a scope and severity of D following the removal of the immediate jeopardy. The findings include:Review of the facility's policy titled Comprehensive Care Plans Standard of Practice, reviewed 04/2025, revealed the facility would provide individualized comprehensive care plans that included measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs. The facility's Care Planning/Interdisciplinary Team, in coordination with the resident, family and/or representative, would develop and maintain a comprehensive care plan for each resident that identified the highest level of functioning the resident may be expected to attain.Review of R1's Face Sheet revealed the facility admitted the resident on [DATE]. R1's diagnoses included chronic obstructive pulmonary disease (COPD), unspecified dementia, chronic kidney disease, and acquired absence of the left and right legs below the knee.Review of a Physician's Order, dated [DATE], revealed an order for R1to be a Full Code status.Review of the Advanced Directives Comprehensive Care Plan established on [DATE], with an onset date of [DATE], revealed R1 was a be Full Code status. The goals were to have R1's health care wishes/advance directives honored. Interventions in place for R1 were to communicate the resident's choice and provide CPR.Review of a Progress Note dated [DATE] at 4:30 PM, (late entry) revealed that at approximately 10:25 AM, Kentucky Medication Technician (KMA) 3 found R1 not breathing and cold to touch. Registered Nurse (RN) 1 was called to the room and found R1 with no heart rate, no breath sounds, and cold to touch. The Progress Note failed to indicate whether CPR was administered in accordance with R1's care plan. Review of a certified Death Certificate revealed R1 expired in the facility on [DATE] at 10:29 AM. (Refer to F678.)Interviews with State Registered Nurse Aide (SRNA)1 on [DATE] at 2:55 PM, R1's daughter on [DATE] at 3:50 PM, KMA3 on [DATE] at 8:45 AM, RN1 on [DATE] at 11:45 AM, and Licensed Practical Nurse (LPN) 2 on [DATE] at 9:00 AM confirmed that staff failed to implement R1's care plan and provide CPR in accordance with the resident's care plan.During interview with RN1 on [DATE] at 11:45 AM, she stated that she did not know the resident's code status (however, it was listed on R1's (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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NAME OF PROVIDER OR SUPPLIER Auburn Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 139 Pearl Street Auburn, KY 42206	

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	care plan.) Further interview with RN1 revealed that staff failed to follow the care plan and perform CPR, based on directions from KMA3, who also worked (while not at the facility) as a deputy coroner.During interview on [DATE] at 8:45AM, KMA3 stated she failed to follow R1's care plan regarding her Full Code status. In reviewing the incident, KMA3 stated she should have gone into the medical record system to get the resident's code status, gotten help, called an ambulance, gotten a crash cart, and then begun CPR. Interview on [DATE] at 2:20 PM with Minimum Data Set (MDS) Coordinator 1 revealed that it was important for staff to follow care plans, including the Advance Direction portion which listed a resident's code status.During an interview on [DATE] at 9:00 AM, LPN2 confirmed that KMA3 and RN1 had a discussion and made the decision to withhold CPR as R1 was gone. LPN2 stated that staff should have followed the care plan, stating When someone is a Full Code, CPR should be performed.During a telephone interview on [DATE] at 1:50 PM, the Medical Director stated that staff should have followed the care plan. The Medical Director stated that the facility should have initiated CPR if the resident was a Full Code. During an interview on [DATE] at 9:25 AM, the County Coroner stated that while working as a KMA in the facility, KMA3 had no authority to prevent life saving measures from being given to R1. Per the Coroner, nothing that KMA 3 could have said should have stopped the nurses from doing CPR (in accordance with the resident's care plan.)During an interview on [DATE] at 1:25 PM, Regional Nurse 1 stated staff listened to KMA3, rather than following the code status as directed on the Advance Directive care plan, adding, That was what lead to the facility's failure. Additional interview with Regional Nurse 1 on [DATE] at 10:57 AM revealed that for residents who were care planned as a Full Code, CPR shall be initiated by the nurse while waiting for emergency procedures to arrive.During an interview on [DATE] at 3:10 PM, the Interim Director of Nursing (DON) 14 stated the expectation would have been for staff to follow the Advance Directive care plan and perform CPR for a resident who is a Full Code until the ambulance arrives. Interview on [DATE] at 1:35 PM with the Administrator revealed the failure was that staff decided not to do CPR on a Full Code resident in accordance with her care plan. The Administrator stated RN1 decided not to perform CPR and may have leaned on KMA3's advice, saying, CPR should have been given.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. Based on interview, record review and review of the facility's policy, the facility failed to ensure Cardiopulmonary Resuscitation (CPR) was initiated for one (Resident (R) 1) of 19 sampled residents reviewed for Advance Directives. Staff found R1 unresponsive on 11/09/2025 without pulse or respiration. R1 was a Full Code status (indicating that CPR should be performed if the resident was found without vital signs); however, no lifesaving measures were attempted. On 03/04/2026 at 3:10 PM, the Administrator was provided a copy of the CMS Immediate Jeopardy (IJ) Template and was notified the failure to ensure residents were provided CPR was likely to cause serious injury, impairment, or death. This failure constituted IJ at 42 CFR 483.24 F678, as well as Substandard Quality of Care (SQC) at 42 CFR 483.24, Quality of Care. The IJ was determined to exist on 11/09/2025, when R1 was found without pulse or respiration and CPR was not initiated.The facility provided an acceptable IJ Removal Plan on 03/05/2026. The plan alleged the IJ was removed on 03/05/2026. A Partial Extended Survey and IJ Removal Validation was conducted on 03/06/2026. The State Survey Agency (SSA) validated the IJ was removed on 03/05/2026, as alleged. The deficient practice remained at a scope and severity of D following the removal of the immediate jeopardy. The findings include:Review of the facility's policy titled Cardiopulmonary Resuscitation, (CPR) revised 03/2019, revealed the facility would provide emergency basic life support immediately when needed, including CPR, to any resident requiring such care prior to the arrival of emergency medical personnel in accordance with related physician's orders, such as a Full Code, and the resident's advance directives.Review of R1's Face Sheet revealed the facility admitted the resident on 09/25/2025. R1's diagnoses included chronic obstructive pulmonary disease (COPD), unspecified dementia, chronic kidney disease, and acquired absence of the left and right legs below the knee.Review of a Physician's Order dated 09/26/2025, revealed an order for R1 to be a Full Code status.Review of the Advance Directives Comprehensive Care Plan, established on 10/02/2025, with an onset date of 10/03/2025, revealed R1 was a Full Code. Goals in place were to have health care wishes/advance directives honored. The care plan interventions in place for R1 included to communicate the resident's choice and provide CPR.Review of a Progress Note, dated 11/09/2025 at 4:30 PM (late entry), revealed that R1 ate a few bites of food around 8:00 AM. State Registered Nurse Aide (SRNA) 1 called Licensed Practical Nurse (LPN) 2 to R1's room at approximately 9:00 AM to check the resident. R1's arms were cold, but R1's legs, chest, and face were warm to touch; the resident had a good carotid pulse and good breath sounds, and when moved, R1 moaned and shuffled legs. At approximately 10:25 AM, Kentucky Medication Technician (KMA) 3 found R1 not breathing and cold to the touch, Registered Nurse (RN) 1 was called to the room and found the resident with no heart rate, no breath sounds, and cold to touch. The facility called the daughter at 10:30 AM to inform her that her mother was deceased . Per the note, the daughter stayed around the facility and asked several questions. The Progress Note failed to indicate whether CPR was administered in accordance with R1's care plan and/or physician's orders. Review of a certified Death Certificate revealed R1 expired on 11/09/2025 at 10:29 AM in the facility. During an interview on 02/25/2026 at 3:50 PM, R1's daughter stated that at approximately 10:00 AM, a staff member called and reported R1's eyes were glazed. KMA3 then called ten minutes later and reported R1 was deceased . The daughter stated that no CPR was given and upon arrival to the facility, she overheard staff talking about not knowing R1's code status and the reason no CPR was given. The daughter stated, I will never know how much time I may have had with my mother cause no CPR was given. During an interview on 02/25/2026 at 2:55 PM, SRNA1 stated she received a report from night shift that R1 was doing great and had been eating well. At approximately 8:00 AM, SRNA1 reported to LPN2 that R1 was not doing good, as evidenced by her mouth staying open and not responding verbally. SRNA1 stated she went to KMA3, who assessed R1 and reported R1 was dead. SRNA1 asked KMA3 if she needed to start CPR and KMA3 reported (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	nothing could be done. SRNA1 stated she then asked LPN2 about R1's code status. RN1 and LPN2 reviewed files at the nurse's station and identified R1 was a Full Code. RN1 and LPN2 then went to R1's room. RN1 used the stethoscope and reported nothing could be done. RN1 asked KMA3 if she had performed CPR, and KMA3 replied that she did not know R1s code status.During interview on 02/26/2026 at 8:45AM, KMA3 reported she was approached by SRNA1, who stated R1 was not well. KMA3 stated she went to R1's room and assessed R1 to be cold and stiff to touch. KMA3 went and told staff and then returned to R1's room with LPN2 and RN1. LPN2 then returned to the nurse's station to look at the resident's code status. KMA3 reported that R1was cold, her eyes suctioned shut, and nothing could be done. KMA3 stated that, in addition to her role as a KMA in the facility, she also worked separately as a deputy coroner. KMA3 confirmed that on the day that R1 expired, she was not working as a deputy coroner, and instead, was responsible for providing care to residents of the facility. In reviewing the incident, KMA3 stated she should have gone into the medical record system to look for the resident's code status, gotten help, called an ambulance, gotten a crash cart, and then begun CPR. During an interview on 02/26/2026 at 11:45 AM, RN1 reported KMA3 came down the hallway, yelling R1 was dead. RN1 checked all pulse areas to verify R1 was dead and reported R1's elbows were stiff and limp. RN1 reported she did not know R1's code status and no one in the room performed CPR. RN1 confirmed CPR was not performed, stating, I just listened to [KMA3]. RN1 noted that KMA3, who was a deputy coroner, pronounced R1 dead. RN1 added that in the future, if a resident was a Full Code, she would perform CPR.During a telephone interview on 03/01/2026 at 1:50 PM, the Medical Director stated the facility staff did not follow the CPR protocol. The Medical Director stated the staff should have initiated CPR if R1 was a Full Code. During an interview on 03/02/2026 at 9:00 AM, LPN2 stated she was at the nurse's station charting when SRNA1 came to her on 11/09/2025 at approximately 8:00 AM and told her that R1 did not look good. LPN2 stated she entered the room to check R1's vital signs and, at that time, they were in normal limits. LPN2 stated she went back to the nurse's station and continued to chart. Ten minutes later, LPN2 again checked on R1, who seemed the same. After this, LPN2 was then summoned by KMA3 and, upon heading to R1's room, encountered RN1 who asked her to help her with R1. LPN2 stated KMA3 and RN1 (who assessed the resident) had a discussion and made the decision to withhold CPR as R1 was gone. LPN2 stated that, at the time, she relied on the decision RN1 made with KMA3. LPN2 confirmed that facility staff should have performed CPR, stating, When someone is a Full Code, CPR should be performed.During an interview on 02/27/2026 at 9:25 AM, the County Coroner stated that when working in the facility as an aide, KMA3 had no authority to prevent life saving measures from being given to a resident. The County Coroner stated that nothing that KMA3 could have said should have stopped nurses from performing CPR.During an interview on 03/02/2026 at 1:25 PM, Regional Nurse 1 stated the failure to provide CPR was because staff listened to KMA3 rather than following the code status adding, That was what lead to the facility's failure. Additional interview with Regional Nurse 1 on 03/07/2026 at 10:57 AM revealed that for residents who were a Full Code, CPR shall be initiated by the nurse while waiting for emergency procedures to arrive.During an interview on 03/02/2026 at 3:10 PM, the Interim Director of Nursing (DON) 14 stated the expectation would have been to perform CPR when a resident was a Full Code until the ambulance arrived. The Interim DON stated, As a licensed nurse, we do not make the decision to not do CPR when a resident is a Full Code.During an interview on 03/02/2026 at 1:35 PM, the Administrator stated the failure was that staff decided to not perform CPR on a Full Code resident. The Administrator stated RN1 decided to not perform CPR and may have leaned on KMA3, adding, CPR should have been given.