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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Health Care	139 Pearl St. 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37031 Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of seven sampled residents (R 7). During an observation on 04/09/2025 at 10:20 AM, Licensed Practical Nurse (LPN) 1 failed to sanitize her hands between glove changes. Further, LPN 1, failed to wear gown, mask, and eye protection while providing care to a resident on contact precautions. The findings include: Review of the facility policy titled, Infection Control, dated 08/2001 revealed the facility would provide a safe sanitary and comfortable environment. Review of the facility policy titled, Handwashing, dated 08/2001 revealed handwashing was regarded as the single most important means of preventing the spread of infections. All personnel should follow the established handwashing procedures to prevent the spread of infection and disease to other personnel, patients, and visitors. Further review of the policy revealed employees would perform appropriate ten to fifteen second handwashing procedures under the following conditions: whenever hands were obviously soiled, before handling clean or soiled dressings, gauze pads, etc, after contact with blood, body fluids, excretions, secretions, mucous membranes, or non intact skin, and after removing gloves. The use of gloves would not replace handwashing. Review of R 7s' Admission Record revealed the facility admitted the resident on 01/24/2012 with diagnoses which included: osteomyelitis, type 2 diabetes mellitus with foot ulcer, pressure ulcer of right buttock, and obesity. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/09/2025 at 10:40 AM, LPN 1 failed to wash her hands after removing a soiled packing strip to right buttock. She double gloved the soiled dressing and placed in trash and put on non-sterile gloves without sanitizing her hands. LPN 1 cleaned the wound with wound cleanser and dried the right buttock area with a dry gauze. She removed her gloves after cleaning and donned a third pair of gloves without sanitizing her hands. LPN 1 packed the wound with packing strips and Dakin's solution and placed a border gauze over the wound. She removed her gloves, and began to clean up the bedside table. Further LPN 1 failed to adhere to the contact isolation protocol and use the appropriate personal protective equipment such as a gown, mask, and eye protection while providing wound care. During an interview with LPN 1 on 04/10/2025 at 10:16 AM, she stated she wasn't aware the resident was on contact isolation. She stated she should have worn a gown, eye protection and mask. LPN 1 further stated she should have washed her hands between glove changes. During an interview with the Director of Nursing (DON) on 04/10/2025 at 11:13 AM, she stated she expected staff to follow the contact isolation protocol when performing close contact care with residents. She further stated she expected staff to follow the facility policies concerning handwashing with donning and doffing gloves during care. During an interview on 04/10/2025 at 11:22 AM, the Administrator stated she expected all staff to follow contact isolation guidelines and facility policies concerning handwashing.