

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225661	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center of Auburn		STREET ADDRESS, CITY, STATE, ZIP CODE 14 Masonic Circle Auburn, MA 01501	

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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>15203</p> <p>Based on interviews and records reviewed, for two of five sampled residents (Residents #2 and #3), the Facility failed to ensure staff implemented and followed the Facility Abuse Prohibition Policy, when Resident #2 and the family member of Resident #3 (Family Member #1) reported allegations of abuse by Housekeeper #1 to multiple staff members and staff did not immediately report the allegations to their immediate Supervisor, Administrator or designee.</p> <p>Findings include:</p> <p>The Facility Policy titled Abuse-Reporting and Response-No Crime Suspected, last reviewed 6/17/24, indicated that all associates are mandated to immediately report suspected resident abuse/neglect to their immediate supervisor and/or Facility representative.</p> <p>1) Resident #2's medical record indicated he/she was admitted to the Facility during December of 2022. Resident #2's most recent Minimum Data Set (MDS) Assessment, dated 12/06/24, indicated his/her cognitive patterns were intact.</p> <p>During an interview on 1/03/25 at 12:20 P.M., Housekeeper #2 said that at some point after 11/15/24 (exact date unknown), Resident #2 told her about an incident in which he/she was awakened by Housekeeper #1 giving him/her a kiss on the cheek. Housekeeper #2 said that she did not immediately report Resident #2's allegation to her immediate supervisor or the Administrator.</p> <p>During an interview on 1/03/25 at 1:45 P.M., the Administrator said that Housekeeper #2 came to her after speaking with the Surveyor 1/03/25 and reported that Resident #2 had previously told her that Housekeeper #1 had kissed him/her on the cheek.</p> <p>2) Resident #3's medical record indicated he/she was admitted to the Facility during May of 2024.</p> <p>Resident #3's most recent Minimum Data Set (MDS) Assessment, dated 5/18/24, indicated his/her cognitive patterns were moderately impaired.</p> <p>During a telephone interview on 1/08/25 at 1:02 P.M, Family Member #1 said that, at some point during Resident #3's stay at the Facility (between May and July 2024, exact date unknown), Resident #3 told her that Housekeeper #1 came into his/her room and put his hands under his/her shirt. Family Member #1 said that she reported Resident #3's allegation about Housekeeper #1 to Nurse #2.</p> <p>(continued on next page)</p>

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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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 1/08/25 at 3:30 P.M., Nurse #2 said that Family Member #1 told her about an incident in which Resident #3 alleged Housekeeper #1 put his hands under his/her shirt. Nurse #2 said that she reported Family Member #1's allegation however, said she could not be certain to whom and said she thought she reported the allegation to Unit Manager #2, Unit Manager #3 or the Assistant Director of Nursing.</p> <p>During telephone interviews with Unit Manager #1 on 1/09/25 at 3:50 P.M., Unit Manager #2 on 1/10/25 at 11:30 P.M. and the Assistant Director of Nursing on 1/14/25 at 10:10 A.M., they said Nurse #2 did not report Family Member #1's allegation that Housekeeper #1 put his hands under Resident #3's shirt to them.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>15203</p> <p>Based on interviews and records reviewed, for two of five sampled residents (Residents #1 and #4), the Facility failed to ensure they reported allegations of abuse by Housekeeper #1 to the Department of Public Health (DPH) as required, when after being notified by staff that Housekeeper #1 potentially sexually abused Residents #1 and #4, the Director of Nursing and the Administrator did not report the allegations to the DPH, as required.</p> <p>Findings include:</p> <p>The Facility Policy titled Abuse-Reporting and Response-No Crime Suspected, last reviewed 6/17/24, indicated that all alleged violations, must be reported to the administrator of the Facility and to other officials in accordance with State law through established procedures, including the State Survey and Certification Agency.</p> <p>1) Resident #1's medical record indicated he/she was admitted to the Facility during August of 2020.</p> <p>Resident #1's most recent Minimum Data Set (MDS) Assessment, dated 10/30/24, indicated his/her cognitive patterns were severely impaired.</p> <p>During an interview on 1/03/25 at 1:20 P.M., Certified Nurse Aide (CNA) #1 said that on 11/15/24 around lunch time (exact time unknown), she went to Resident #1's room, the bathroom door was closed and Resident #1 was not in the room. CNA #1 said that when she tried to open the bathroom door to see if Resident #1 was inside, the door would not open. CNA #1 said that she knocked and tried the door again after a few seconds and said she was able to open the door. CNA #1 said that Housekeeper #1 and Resident #1 were alone in the bathroom.</p> <p>CNA #1 said that she reported finding Resident #1 alone in the bathroom with Housekeeper #1 to Nurse #1, the Director of Nurses and the Assistant Director of Nurses.</p> <p>During an interview on 1/03/25 at 4:00 P.M. with the Administrator and the Director of Nursing, they said that Nurse #1 had reported to the Director of Nursing on 11/15/24 that Housekeeper #1 was found alone in the bathroom with Resident #1.</p> <p>The Director of Nursing and Administrator said that they initiated an investigation into CNA #1's observation and determined that nothing untoward happened to Resident #1. The Director of Nursing and Administrator said that they did not report the allegation to the Department of Public Health. The Administrator said that she did not think CNA #1's report was an allegation of abuse or having to do with harm to Resident #1, but thought it was an instance in which staff of the nursing department was telling on another department.</p> <p>2) Resident #4's medical record indicated he/she was admitted to the Facility during August of 2024 and discharged during December 2024.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #4's most recent MDS Assessment, dated 11/14/24, indicated his/her cognitive patterns were intact.</p> <p>During a telephone interview on 1/08/25 at 3:30 P.M., CNA #4 said that, sometime during Resident #4's stay in the facility (exact date unknown), Resident #4 told her that he/she felt like Housekeeper #1 was stalking him/her and always staring at him/her, CNA #4 said that she reported Resident #4's complaint to one of the nurses (exact name unknown).</p> <p>During a telephone interview on 1/08/25 at 2:15 P.M., the Occupational Therapy Assistant said that Resident #4 expressed concerns to her about Housekeeper #1. The Occupational Therapy Assistant said Resident #4 told her that Housekeeper #1 was always around him/her, always in the hallway outside of his/her room and he/she could always hear his voice. The Occupational Therapy Assistant said that Resident #4's perception was that he/she got too much attention from Housekeeper #1.</p> <p>The Occupational Therapy Assistant said that she reported Resident #4's concerns to the Director of Nursing. The Occupational Therapy Assistant said a day or two later (exact date unknown), Resident #4 complained a second time about Housekeeper #1, saying that he/she felt uncomfortable with the degree that Housekeeper #1 was around him/her. The Occupational Therapy Assistant said she reported Resident #4's concerns a second time, reporting them to Unit Manager #2 or #3. The Occupational Therapy Assistant said that Resident #4 was fearful, anxious and upset when talking to him/her about Housekeeper #1.</p> <p>The Director of Nursing said that the Occupational Therapy Assistant told her about concerns that Resident #4 had reported regarding Housekeeper #1.</p> <p>The Director of Nursing provided a Written Statement, dated 9/04/24, (written and signed by herself) which indicated that Resident #4 told Occupational Therapy Assistant that he/she thought Housekeeper #1 was weird, that he spent a lot of time in his/her room and he must think that he/she was his/her boyfriend. The Written Statement indicated the Director of Nursing investigated Resident #4's concern by speaking to Resident #4 and he/she said he/she was not afraid of Housekeeper #1, worried or concerned and stated he/she felt safe and comfortable.</p> <p>The Director of Nursing said that based on her conversation with Resident #4, she did not report the allegation to the Department of Public Health.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>15203</p> <p>Based on interviews and records reviewed, for two of five sampled residents (Resident #1 and #4), the Facility failed to ensure that after being made aware of allegations of potential sexual abuse by a staff member that they obtained and maintained evidence that a thorough investigation was completed, including conducting and documenting assessments of both residents and obtaining and documenting staff member interviews.</p> <p>Findings include:</p> <p>The Facility Policy titled Abuse-Conducting an Investigation, last reviewed 6/17/24, indicated that all allegations of abuse are promptly and thoroughly investigated. The Policy indicated alleged victims will be examined for signs of injury, including a physical examination or psychosocial assessment. The Policy indicated the investigation was expected to include, although not be limited to, interviews with the alleged victim and their representative, the alleged perpetrator and witnesses.</p> <p>The Facility Policy titled Abuse-Reporting and Response-No Crime Suspected, last reviewed 6/17/24, indicated that at the time that an incident is reported, the nurse will immediately assess the resident.</p> <p>1) Resident #1's medical record indicated he/she was admitted to the Facility during August of 2020.</p> <p>Resident #1's most recent Minimum Data Set (MDS) Assessment, dated 10/30/24, indicated his/her cognitive patterns were severely impaired.</p> <p>During an interview on 1/03/25 at 1:20 P.M., Certified Nurse Aide (CNA) #1 said that on 11/15/24 around lunch time (exact time unknown), she went to Resident #1's room, the bathroom door was closed and Resident #1 was not in the room. CNA #1 said that when she tried to open the bathroom door, it would not open. CNA #1 said that she knocked and tried the door again after a few seconds and said she was able to open the door. CNA #1 said that Housekeeper #1 and Resident #1 were alone in the bathroom.</p> <p>CNA #1 said that she reported finding Resident #1 alone in the bathroom with Housekeeper #1 to Nurse #1, the Director of Nurses and the Assistant Director of Nurses.</p> <p>During an interview on 1/03/25 at 4:00 P.M. with the Administrator and the Director of Nursing, they said that on 11/15/24, Nurse #1 reported that Housekeeper #1 was alone in the bathroom with Resident #1. The Director of Nursing and Administrator said that they initiated an investigation of CNA #1's observation and determined that nothing untoward happened to Resident #1.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Director of Nursing said that during the investigation, she and the Assistant Director of Nursing saw Resident #1 seated in his/her bedroom. The Director of Nursing said that Resident #1 looked OK, his/her clothes were not disheveled and his/her behavior was at baseline. The Director of Nursing said that she did not conduct a physical assessment of Resident #1, or ask another nurse to conduct a physical assessment, and instead relied on CNA #1's statement that she had provided incontinence care to Resident #1 after finding him/her alone in the bathroom with Housekeeper #1 and his/her incontinence brief and clothing appeared undisturbed.</p> <p>Review of the Facility's Internal Investigation, dated 11/21/24, indicated there was no documentation to support the Facility having had Resident #1 examined by a nurse or documented interviews with Housekeeper #1, other staff working on Resident #1's unit at the time of the alleged incident, or Resident #1's representative.</p> <p>2) Resident #4's medical record indicated he/she was admitted to the Facility during August of 2024 and discharged during December 2024.</p> <p>Resident #4's MDS Assessment, dated 11/14/24, indicated his/her cognitive patterns were intact.</p> <p>During a telephone on 1/08/25 at 3:30 P.M., CNA #4 said that during Resident #4's admission in the facility, (exact date unknown), Resident #4 told her that he/she felt like Housekeeper #1 was stalking him/her and always staring at him/her. CNA #4 said that she reported CNA #4's complaint to one of the nurses.</p> <p>During a telephone interview on 1/08/25 at 2:15 P.M., the Occupational Therapy Assistant said that sometime in September 2024 (exact date unknown), Resident #4 expressed concerns to her about Housekeeper #1. The Occupational Therapy Assistant said Resident #4 told her that Housekeeper #1 was always around him/her, always in the hallway outside of his/her room and he/she could always hear his voice. The Occupational Therapy Assistant said that Resident #4's perception was that he/she got too much attention from Housekeeper #1. The Occupational Therapy Assistant said that she reported Resident #4's comments to the Director of Nursing.</p> <p>The Occupational Therapy Assistant said that, a day or two later (exact date unknown), Resident #4 complained a second time to her about Housekeeper #1, saying that he/she felt uncomfortable with the degree that he was around him/her and she reported Resident #4's second complaint to Unit Manager #2 or #3. The Occupational Therapy Assistant said that Resident #4 was fearful, anxious and upset when talking about Housekeeper #1.</p> <p>The Director of Nursing said that the Occupational Therapy Assistant had told her about concerns that Resident #4 reported. The Director of Nursing provided a Written Statement, dated 9/04/24 and signed by herself, which indicated that Resident #4 had told an Occupational Therapy Assistant that he/she thought Housekeeper #1 was weird, that he spent a lot of time in his/her room and he must think that he/she was his/her boyfriend. The Written Statement indicated the Director of Nursing investigated Resident #4's concern by speaking to him/her and that he/she said he/she was not afraid of Housekeeper #1, worried or concerned and stated he/she felt safe and comfortable.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Facility's Internal Investigation, dated 9/04/24, indicated there was no documentation to support the Facility having had Resident #4 examined by a nurse or documented interviews with Housekeeper #1, other staff working on Resident #4's unit at the time of the alleged incident, or Resident #4's representative during the investigation of the allegation.</p>