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 04/23/2026
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)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on records reviewed and interviews for one of three residents (Resident #1), whose Physician's Orders indicated he/she was NPO (nothing by mouth) with medications to be administered via his/her percutaneous endoscopic gastrostomy tube (PEG tube, a flexible tube inserted through the abdominal wall into the stomach to deliver nutrition, fluids and medications directly), the Facility failed to ensure he/she was free from a significant medication error when Nurse #1 administered a medication to him/her orally instead of through his/her PEG tube placing him/her at risk for aspiration (when food, liquid, or saliva enters the airway and lungs).Findings include:Review of the Facility Policy titled Administration of Medications, dated as revised on 09/09/25, indicated the Facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms.Review of the Facility's Incident Report, dated 03/28/26, indicated that Resident #1 was found by his/her 7:00 A.M. - 3:00 P.M. nurse having a blue crushed substance in his/her mouth and that there was a cup of water on his/her bedside table.Resident #1 was admitted to the Facility in March 2026, diagnoses included Dysphagia (difficulty swallowing), Pneumonitis (inflammation of lung tissue) due to inhalation of food and vomit, Hypothyroidism (a condition where the thyroid gland does not produce enough hormones to meet the body's needs), with a history of Aspiration Pneumonia (a lung infection caused by inhaling foreign material such as food, drink, vomit, or saliva), was non-verbal and developmentally delayed.Review of Resident #1's Physician's Orders for March 2026 indicated he/she had the following orders:NPO (nil per os, meaning nothing by mouth), use PEG tube for feeding and medication, initiated 03/24/26.Levothyroxine (a medication used to treat hypothyroidism) 137 micrograms (mcg) tablet via PEG tube one time a day for low thyroid hormone, initiated on 03/26/26.Review of Resident #1's March 2026 Medication Administration Record (MAR) indicated Nurse #1 administered 137 mcg of Levothyroxine on 03/28/26 to Resident #1.During a telephone interview on 04/26/26 at 10:40 A.M., Nurse #2 said he was working the 7:00 A.M. - 3:00 P.M. shift on 03/28/26, and when he entered Resident #1's room to administer his/her 8:00 A.M. medications and PEG tube feeding. Nurse #2 said while he was assessing Resident #1, he noticed there was a blue substance in and around his/her mouth and a cup of water on his/her bedside table. Nurse #2 said he was concerned by this observation because he knew Resident #1 could not have anything by mouth and he said it looked as though he/she had eaten and/or drank something. Nurse #2 said Resident #1's medical record and nursing assignment sheet clearly indicated he/she was NPO and said if he/she ate or drank anything it would put him/her at risk for aspiration.During a telephone interview on 04/25/26 at 1:55 P.M., Nurse #1 said she worked the 11:00 P.M. - 7:00 A.M. shift on 03/27/26 into 03/28/26 and said Resident #1 was on her assignment.Nurse #1 said she entered Resident #1's room that morning, said she told him/her that she had his/her thyroid medication and elevated the head of his/her bed. Nurse #1 said she placed the pill in Resident #1's open mouth, followed by a sip of water and said he/she began to cough. Nurse #1 said she elevated the head of Resident #1's bed further, he/she stopped coughing and when she left his/her room, he/she appeared comfortable. Nurse #1 said she did not realize she made a medication error until Unit Manager #1 contacted her to ask if she gave Resident #1 medication orally. Nurse #1 said looking back, she remembered that Nurse #2 told (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
	225661	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Auburn	14 Masonic Circle Auburn, MA 01501

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her that Resident #1 was NPO at the start of her shift and said giving Resident #1 medication orally was an oversight and a mistake on her part.During an interview on 04/23/26 at 3:30 P.M., Unit Manager #1 said one of the nurses called her on the morning of 03/28/26 to tell her they were concerned that a nurse had given Resident #1 his/her medication orally, that there was a blue substance on his/her mouth and a cup of water on his/her table. Unit Manager #1 instructed the nurse to call the Director of Nursing to report this incident.Unit Manager #1 said Resident #1's Physician's orders clearly indicated he/she was NPO and all his/her medications were to be administered through his/her PEG tube.During an interview on 04/23/26 at 4:15 P.M., the Director of Nursing (DON) said Nursing staff called her on 03/28/26 to tell her they suspected Nurse #1 had given Resident #1 a medication orally because he/she was found by Nurse #2 to have a blue substance in and around his/her mouth and that there was a cup of water left on his/her bedside table.The DON said she spoke with Nurse #1 on the phone and asked her if she had given Resident #1 his Levothyroxine orally that morning. The DON said Nurse #1 told her she did not remember doing so.The DON said she told Nurse #1 that Resident #1 was found with a blue substance in his/her mouth and that there was a cup of water at his/her bedside. The DON said after describing how Resident #1 was found, Nurse #1 told her she must have given him/her his medication orally in error. The DON said she verified that Resident #1's Levothyroxine pill was blue in color and said Nurse #1 signed off on administering Levothyroxine to Resident #1 on 03/28/26.The DON said Resident #1's Physician's Orders clearly indicated in his/her medical record that he was NPO, that all of his/her medication administration instructions indicated they were to be administered via his/her PEG tube, and said Nurse #1 did not follow Physician Orders which put Resident #1 at risk for aspiration. On 04/24/26, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of 03/31/26, which addressed the area of concern as evidenced by:A) On 03/28/26, Resident #1 was transferred to the hospital for evaluation but chose not to return to the Facility. B) On 03/28/26, the Unit Manager provided verbal education to Nurse #1 regarding implementing Physician's Orders.C) Nurse #1 was also required to and completed eight hours of nursing education modules, which included medication administration, was required to demonstrate competency through written evaluation, and required to undergo observations by the SDC during medication administration passes. D) The Staff Development Coordinator (SDC) and/or her designee will continue to provide additional education to all clinical staff regarding the rights of medication administration, as needed.E) On 03/29/26, Nursing staff completed education modules assigned by the SDC that included: Enteral tube drug installation, oral drug administration, and oral medication adherence. After completion of the education modules, the SDC required Nursing staff to demonstrate competency via in person demonstration and written evaluations. F) On 03/30/26, the Director of Clinical Services conducted a house-wide audit to determine whether there were any other residents who were NPO and receiving medication per the enteral route - none were found. Additional audits were scheduled to be completed weekly, going forward to ensure continued compliance.G) On 03/30/26, Facility Administration conducted an ad-hoc Quality Assessment and Performance Improvement (QAPI) meeting and approved an action plan as follows: conduct a facility wide audit to determine whether there were any other residents in the facility who were NPO and received medications per the enteral route with audits to be conducted weekly x4 then monthly thereafter until compliance is achieved.H) Results of Audits will be brought to and discussed during QAPI meetings, to review for continued compliance.I) The Director of Nursing and/or Designee are responsible for overall compliance.