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	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Auburn	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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and interviews, the facility failed to complete Comprehensive Minimum Data Set (MDS) Assessments that accurately reflected the status of two Residents (#14 and #141) out of a total sample of 30 residents. Specifically, 1. For Resident #14, the facility failed to accurately code for Hospice services when Resident #14 was ordered for and had been receiving Hospice services during the assessment period. 2. For Resident #141, the facility failed to accurately code for discharge return anticipated when the Resident was transferred to the hospital for evaluation of an acute change in health status. Findings include: Review of the CMS Resident Assessment Instrument (RAI) Manual 3.0, located at CMS.gov included but was not limited to: -The RAI process has multiple regulatory requirements which require the assessment accurately reflects the resident's status. 1. Resident #14 was admitted to the facility in December 2016, with diagnoses including Multiple Sclerosis (MS) and Dementia. Review of Resident #14's Medical Record included but was not limited to: -The Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of zero out of a total possible score of 15. -The Resident had an invoked Health Care Proxy (HCP: person that can make decisions related to health care when someone is unable to do so themselves), effective 7/18/18. -The Resident had a Physician's order for Hospice services, effective 3/27/25. Review of Resident #14's Person-Centered Care Plan, revised on 4/4/25, included but was not limited to: (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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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	-The Resident was admitted to Hospice Services on 3/27/25. Review of Resident #14's MDS with assessment reference date of 4/11/25, failed to indicate that the Resident received Hospice Services. During an interview on 6/16/25 at 10:45 A.M., MDS Nurse #1 said that the facility followed the RAI manual guidelines for coding of MDS assessments. MDS Nurse #1 said Resident #14 had been receiving Hospice Services since 3/27/25. MDS Nurse #1 said that the Hospice Services should have been coded on the Resident's MDS dated [DATE], because Hospice Services were in place. MDS Nurse #1 said that Resident#14's MDS data was inaccurate and did not reflect the Resident's status. 2. Resident #141 was admitted to the facility in July 2023 with diagnoses including Hypertension (HTN) and Atrial Fibrillation (A-Fib). Review of Resident #141's Medical Record included but was not limited to: -A Nursing Progress Note dated 3/22/25, indicated the Resident was unresponsive with abnormal vital signs, had shortness of breath, discomfort and low oxygen levels of 79% when breathing room air. -A Physician's order to send the Resident to the hospital for evaluation, effective 3/22/25. Review of the Resident's MDS with reference date of 3/22/25, included but was not limited to: -Resident #141 was discharged with return not anticipated. During an interview on 6/18/25 at 11:55 A.M., MDS Nurse #1 said at the time of the hospital transfer the facility had expected the Resident to return. MDS Nurse #1 said that the Resident passed away while at the hospital. MDS Nurse #1 said that the MDS coding was inaccurate because the facility did not have reason to believe that the Resident was not going to return to the facility at the time of the Resident's transfer to the hospital for evaluation. MDS Nurse #1 said that the MDS assessment should have been coded as discharge return anticipated but was not coded as required.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interviews, and record reviews, the facility failed to notify the state mental health authority (Pre-admission Screening and Resident Review [PASRR] Office) promptly of the need for Resident Review for one Resident (#12) out of a total sample of 30 total residents, when the Resident experienced a significant change in his/her mental condition from his/her initial Level I PASRR. Specifically, the facility failed to notify the PASRR Office of the need for Resident Review when Resident #12, who was diagnosed with Depression, acquired new diagnoses of Delusional Disorders and Hallucinations during his/her stay at the facility and a new medication treatment of Seroquel (antipsychotic medication) was implemented. Findings include: Resident #12 was admitted to the facility in February 2024 with diagnoses including Depression. Review of Resident #12's Level I PASRR dated 2/2/24, indicated the following: -no documented diagnosis of a mental illness or disorder (MI/D: Schizophrenia, Somatoform Disorder, Delusional Disorder, Mood, PTSD, Severe Anxiety/Panic Disorder, Schizoaffective Disorder, Other Psychotic Disorder, Paranoia, Personality Disorder, other mental disorder that may lead to chronic disability). -screen for serious mental illness (SMI) was negative. -A Level II PASRR Evaluation was not indicated. Review of Resident #12's Physician Order dated 2/5/24, indicated: -Mirtazapine (antidepressant medication) Tablet 7.5 mg (milligrams), Give 1 tablet by mouth at bedtime for Depression. Review of Resident #12's Behavioral Health Visit Note dated 2/29/24, indicated: -was seen by Behavioral Health for initial evaluation and medication adjustment with chief complaint of recent delusional thoughts. -there was a concern during evening/night shifts that the Resident was becoming confused and having psychotic thoughts ranging from delusions to possible visual hallucinations (VHs). -family reported this was happening at home, though the frequency/intensity/examples were unknown. -will start with a recommendation for PRN(as needed) Trazodone and see how [he/she] responds. Review of Resident #12's Medical Diagnosis Listing indicated: (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A new diagnosis of Delusional Disorders (mental illness where individuals hold strong, persistent beliefs that are not based on reality) was added on 2/29/24. -A new diagnosis of Hallucinations (sensing things such as visions, sounds, or smells that seem real but are not) was added on 3/1/24. Review of Resident #12's Physician orders dated 3/1/24, indicated: -Seroquel (Quetiapine Fumarate: antipsychotic medication) Oral Tablet, Give 12.5 mg by mouth at bedtime related to Hallucinations. Review of Resident #12's March 2024 Medication Administration Record (MAR) indicated the ordered Seroquel began being administered to the Resident on 3/2/24. Review of Resident #12's Behavioral Health Visit Note dated 3/14/24, indicated the following: -was seen by Behavioral Health for medication management with a chief complaint for delusional thoughts. -Seroquel (antipsychotic medication) had been added to the Resident's medication regimen on 3/1/24. -Per facility staff, the Resident had not exhibited any further delusional thinking nor hallucinations. Review of Resident #12's Behavioral Health Visit Note dated 12/30/24, indicated a gradual dose reduction (GDR) of Seroquel was recommended. Review of Resident #12's clinical record indicated: -Physician order to discontinue Seroquel Oral Tablet (Quetiapine Fumarate). Give 12.5 mg by mouth at bedtime related to Hallucinations on 12/31/24. -Physician order dated 12/31/24, with a discontinue date of 1/24/25, for Seroquel Oral Tablet, Give 12.5 mg by mouth at bedtime every other day for antipsychotics related to hallucinations. -Physician order dated 1/24/25, with no discontinue date, for Seroquel Oral Tablet. Give 25 mg by mouth at bedtime for antipsychotics related to Hallucinations. -Physician Order, dated 1/24/25, for Seroquel Oral tablet. Give 12.5 mg by mouth at bedtime for antipsychotics related to hallucinations for three days. Review of Resident #12's MARs from March 2024 through 6/16/25, indicated Seroquel was administered to the Resident as ordered by the Physician. Review of Resident #12's clinical record failed to include any evidence that Resident #12 was referred to the PASRR Office for Resident Review when the Resident experienced a change in mental condition from his/her initial Level I PASRR, dated 2/2/24. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/25 at 12:10 P.M., the Social Worker (SW) said Resident #12 had not been referred to the PASRR Office for Resident Review when the Resident experienced a change in mental condition from his/her initial Level I PASRR and required changes to be implemented to his/her psychotropic medication regimen. The SW said Resident #12 should have been referred to the PASRR Office for Resident Review when he/she was newly diagnosed with Delusional Disorders, Hallucinations, and required treatment with antipsychotic medication.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to identify a change in condition relative to bilateral lower extremity edema (swelling) in a timely manner, for one Resident (#37) out of a total sample of 30 residents. Specifically, the facility failed to: -identify the onset of Resident #37's bilateral lower extremity edema in a timely manner when the Resident had previously been assessed to have no edema. -assess the Resident's bilateral lower extremity edema timely once the bilateral lower extremity (BLE) edema was identified, putting the Resident at risk for delayed assessment and treatment. Findings include: Review of the facility's Policy and Procedure titled Heart Failure, Long-Term Care, revised 1/13/25, indicated the following: -In Residents with Chronic Heart Failure, . drug therapy, diet changes, and activity restrictions usually help control symptoms. -Nursing interventions: >Inspect dependent areas, including the lower extremities for edema, note the amount and degree of pitting if present. -Monitoring: >Extremities, for peripheral edema and other signs and symptoms of fluid overload. Resident #37 was admitted to the facility in May 2025, with diagnoses including Malignant Neoplasm of Pancreas, Hypertension (HTN), Atrial Fibrillation (A-Fib), Stage Two Chronic Kidney Disease, and Chronic Heart Failure with Preserved Ejection Fraction. Review of Resident #37's Activities of Daily Living (ADL) Care Plan initiated 5/16/25, indicated: -Assist with mobility and ADLs as needed. Review of Resident #37's Nursing admission assessment dated [DATE], indicated: -Resident has a diagnosis of Heart Failure. -Resident had no edema. -Resident was admitted for palliative care (specialized care focused on improving one's quality of life for people with serious illness [es]). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nurse Practitioner (NP) Encounter Note dated 5/19/25, indicated Resident #37: -was newly admitted to the facility for long term, palliative care. -had a diagnosis of Chronic Heart Failure. -presented with no acute joint swelling. -presented with no edema. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #37: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15 total possible points. -did not exhibit any refusal of care. -required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for bathing and showering. Review of Resident #37's Physician orders indicated: -Furosemide (Lasix: diuretic medication used to remove excess fluid from the body) Oral Tablet 20 mg (milligrams), Give 1 tablet by mouth in the morning for CHF, dated 5/16/25. -Dabigatran Etexilate Mesylate (anticoagulant [blood thinning] medication) Oral Capsule. Give 150 mg by mouth every 12 hours for anticoagulants, dated 5/16/25. -Hydralazine (vasodilator medication that relaxes blood vessels and allow blood to flow more easily) HCl Oral Tablet 25 mg. Give 1 tablet by mouth two times a day for antihypertensives, dated 5/16/25. -No weights for comfort [sic], dated 5/22/25. -Diltiazem (medication used to treat high blood pressure, chest pain, and to control heart rate) HCl Oral Tablet 120 mg. Give 3 tablets by mouth one time a day for calcium channel blockers dated 5/16/25, with a discontinue date of 6/9/25. -Cardizem (Diltiazem HCl) Oral Tablet. Give 360 mg by mouth one time a day for prophylaxis dated 6/5/25, with a discontinue date of 6/10/25. -Cardizem LA Oral Tablet Extended Release 24 Hour 360 mg. Give 1 tablet by mouth in the morning for rate, bp (blood pressure), dated 6/10/25 with no discontinue date. On 6/12/25 at 8:16 A.M., the surveyor observed the following: -Resident #37 was sitting in a chair beside his/her bed, with both feet positioned on the floor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident wore a shoe with Velcro closures and open toe on his/her left foot and a slipper on his/her right foot. -The top of the Resident's right foot (portion not covered by the slipper) to just above the right ankle was puffy and shiny. During an interview at the time, Resident #37 said he/she had swelling in both lower extremities. Resident #37 said the swelling was new and began a couple of days prior. Resident #37 said he/she did not know what the swelling was from. The Resident then removed his/her slipper and open toe Velcro enclosure shoe and the surveyor observed an indentation in the skin across the top of the Resident's right foot where the top edge of the slipper made contact with the Resident's skin. The surveyor also observed that the top of the Resident's left foot was puffy and shiny. On 6/13/25 at 9:05 A.M., the surveyor observed the following: -Nurse #1 was passing medications for residents on the same side of the Unit where Resident #37 resided. -Resident #37 was sitting in a chair beside his/her bed, with both feet positioned on the floor. -The Resident wore slippers on both feet. -A portion of the tops of the Resident's feet not covered by the slippers and the Resident's ankles were visible to the surveyor. -The portion of the tops of the Resident's feet and ankles visible to the surveyor were puffy and shiny, and the right foot and ankle was larger than the left foot and ankle. During an interview at the time, Resident #37 said he/she still had swelling in his/her feet and he/she did not know why they were swollen. Resident #37 said he/she should really get after someone to look at his/her feet because he/she did not think anything was being done to address the swelling. During an interview on 6/13/25 at 9:05 A.M., Certified Nurses Aide (CNA) #1 said she frequently provided assistance with ADL care for Resident #37. CNA #1 said the Resident completed much of his/her own sponge bathing and dressing, with supervision and verbal reminders to be thorough, and that the Resident required assistance to bathe in the shower. CNA #1 said that Resident #37 had recently been requiring more supervision and cues while bathing as the Resident was starting to forget to bathe certain parts of his/her body. CNA #1 said she had provided Resident #37 with assistance to shower on 6/11/25, and that the Resident's feet looked swollen at that time. CNA #1 further said she did not think the Resident's feet looking swollen was new, so she did not alert the Nurse. CNA #1 said if she thought the swelling was new, she would have told the Nurse so that the Nurse could follow-up with the Resident. During an interview on 6/13/25 at 9:20 A.M., Nurse #1 said he worked regularly at the facility and provided care for Resident #37 often and that he was responsible for the Resident's care on 6/12/25. Nurse #1 said he was not aware of Resident #37 having any edema in his/her lower extremities. Nurse #1 then said he would see the Resident and alert the Physician if the Resident had lower extremity swelling. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/25 at 9:35 A.M., Nurse #1 said the Physician was in the facility and that he had alerted the Physician of Resident #37 having lower extremity edema. During a follow-up interview on 6/13/25 at 3:00 P.M., Nurse #1 said he thought the Physician had seen Resident #37 that day because he asked the Physician to see the Resident. Nurse #1 reviewed the Resident's clinical record and said he did not see a progress note from the Physician, so the Physician probably did not make any new orders for the Resident. Nurse #1 said that Physician was good about alerting the Nurses if he had new orders or changes in treatment for residents on the Unit. Review of Resident #37's clinical record on 6/17/25 at 7:23 A.M. failed to include any evidence that Resident #37's lower extremity edema had been assessed. During an interview on 6/17/25 at 7:35 A.M., Unit Manager (UM) #1 said she would have to look into whether Resident #37's lower extremity edema had been assessed. On 6/17/25 at 7:48 A.M., UM #1 requested the surveyor accompany her to observe Resident #37's lower extremities. The surveyor and UM #1 observed the following: -Resident #37 was lying in bed, covered with bed sheets and his/her lower extremities were not exposed. -UM #1 uncovered Resident #37's lower extremities, with the Resident's permission. -The top of the Resident's left foot to the front of the left lower ankle were puffy. -The top of the Resident's right foot to just above the right ankle was puffy and the skin had a firm, tight appearance. -UM #1 swept her hands, palm side down, over the Resident's front lower legs. During an interview at the time, UM #1 said this was the Resident's baseline and depending on who completed an assessment and how they completed the assessment, would determine whether or not a Resident had edema. UM #1 then said Resident #37 did not have any edema upon admission to the facility, and that the Resident did not currently have pitting edema. The surveyor then observed UM #1 complete the following: -UM #1 used a finger and thumb to apply pressure to Resident #37's right lower extremity, above the ankle, and the Resident's left ankle. -The surveyor observed impressions remaining in the areas of the Resident's lower extremities where UM #1 had applied pressure. During an interview at the time, UM #1 said Resident #37 did have pitting edema. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview immediately after exiting Resident #37's room, UM #1 said she was not sure if the Physician assessed the Resident on 6/13/25. UM #1 said the Physician may have seen the Resident and not provided new orders. UM #1 then said she would see whether the Physician was in the facility at this time and would update the surveyor on the results of the Physician's assessment of the Resident. During an interview on 6/17/25 at 9:37 A.M., the Director of Nursing (DON) said she spoke with the Physician and the Physician was unable to assess Resident #37 on 6/13/25 because the Resident was in an outdoor activity. The DON said Resident #37 would be assessed by a Provider on this date (6/17/25). Review of Resident #37's Physician orders dated 6/17/25, indicated: -Furosemide Oral Tablet 20 mg. Give 1 tablet by mouth in the morning for CHF. On hold from 6/17/25 to 6/20/25. -Furosemide Oral Tablet 40 mg. Give 40 mg by mouth one time a day for BLE edema for 3 Days. -BMP (basic metabolic panel: blood test used to measure several key substances in the blood, including kidney function markers) one time only for increase in diuretic for 1 Day, ordered 6/17/25 with a start date of 6/20/25. During an interview on 6/17/25 at 12:19 P.M., Physician Assistant (PA) #1 said nursing staff requested she assess Resident #37 on 6/17/25 for new onset of swelling in the Resident's lower extremities. PA #1 said the swelling was a new problem for the Resident. PA #1 said when she assessed the Resident on 6/17/25, the Resident had significant pitting edema, more in the right lower extremity than the left lower extremity. PA #1 said the Resident had 3 plus (+) pitting edema in the right lower extremity and 2+ pitting edema in the left lower extremity. PA #1 said she attributed Resident #37's lower extremity edema to the Resident's CHF. PA #1 said it was important for a new onset of edema to be identified and reported to the Provider right away so the Provider can assess the edema and provide instructions for care. PA #1 further said after assessing Resident #37 on 6/17/25, she provided an order to double the Resident's Furosemide and ordered a BMP to be drawn to ensure the increase in Furosemide did not impact the Resident's kidney function. During a follow-up interview on 6/17/25 at 1:30 P.M., UM #1 said if a Resident experienced a new onset of edema, the Nurse was responsible to write a Nursing Note or Health Status Note indicating the change of condition. UM #1 said the Nursing or Health Status Note would be where the Nurse would record the assessment of a Resident's edema. UM #1 said Nurse #1 should have completed a Nursing or Health Status Note relative to Resident #37's change in condition with an assessment related to the Resident's lower extremity edema on 6/13/25, but Nurse #1 did not. During an interview on 6/17/25 at 1:53 P.M., the Physician said he was not aware Resident #37 had any lower extremity edema until 6/13/25. The Physician said he was unable to assess the Resident while he was at the facility on 6/13/25, because the Resident was engaged in an outdoor activity. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/17/25 at 2:30 P.M., the DON said communication was left for PA #2 to assess Resident #37 on 6/14/25 for lower extremity edema after the Physician was unable to assess the Resident on 6/13/25. The DON said PA #2 worked at the facility on 6/14/25 and did not assess the Resident. The DON further said she did not know why PA #2 did not assess the Resident and that PA #2 was now on vacation. During an interview on 6/17/25 at 3:55 P.M., Nurse #2 said she was assigned to provide nursing care for Resident #37 that day (6/17/25) and that Nurse #1 did not work at the facility on 6/17/25. Nurse #2 said Residents with CHF required monitoring for changes including shortness of breath, decreased physical functioning, fatigue, and edema. Nurse #2 said some Residents with CHF may require daily weights to assist with monitoring their condition. Nurse #2 said if a Resident was not to be weighed daily, the Nurse was responsible to ask the Resident if they were experiencing any changes that were related to CHF and also observe the Resident for symptoms, including edema. Nurse #2 said orders or instructions for monitoring a Resident's symptoms of CHF and diuretic use would not be indicated in a Resident's record, but Nurses were responsible to monitor for any change in symptoms for Residents with CHF at a required frequency of every shift.

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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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to adhere to infection control standards of practice to prevent contamination and the spread of infections for two Residents (#101 and #4) out of a total sample of 30 residents. Specifically, 1) for Resident #101, the facility failed to ensure that appropriate Personal Protective Equipment (PPE: items such as gowns and gloves worn to prevent the spread of infection) was worn as required for the Resident on Enhanced Barrier Precautions (EBP), and that hand hygiene was performed before donning (putting on) PPE and during provision of urinary catheter care, placing the Resident at increased risk of contamination and the spread of infections. 2) for Resident #4, the facility failed to ensure that the appropriate PPE was worn as required when providing urinary catheter care, placing the Resident at increased risk of the spread of infections. Findings include: Review of CDC Guideline for Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, revised 6/28/24, retrieved from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html indicated: -Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. -Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). -Enhanced Barrier Precautions expand the use of gown and gloves beyond anticipated blood and body fluid exposures. They focus on use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. -Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). -Standard Precautions still apply while using Enhanced Barrier Precautions. For example, if splashes and sprays are anticipated during the high-contact care activity, face protection should be used in addition to the gown and gloves. Review of the facility policy titled Enhanced Barrier Precautions, revised 4/22/25, indicated the following: (continued on next page)

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	06/18/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-EBP are indicated for residents with any of the following: >wound and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO {Multi-Drug-Resistant Organism} >indwelling medical device examples include urinary catheters . -The facility should develop a process to communicate which residents require the use of EBP for all high-contact care activities. The facility may choose to post signage on the door or wall outside of the resident room indicating the resident is on Enhanced Barrier Precautions. -Examples of high-contact resident care activities requiring gown and glove use include: >device care or use: central line, urinary catheter Review of the facility policy titled Hand Hygiene, reviewed 6/3/24, indicated the following: -Associates perform hand hygiene (even if gloves are used) in the following situations: >before and after contact with the resident. 1) Resident #101 was admitted to the facility in March 2021 with diagnoses including Alzheimer's Disease and Neuromuscular Dysfunction of the Bladder. Review of Resident #101's Minimum Data Set (MDS) assessment dated [DATE] indicated that the Resident had an indwelling urinary catheter. Review of Resident #101's June 2025 Physician orders indicated: -an active order initiated on 6/6/25 for Enhanced Barrier Precautions (EBP), Diagnosis: Foley [type of indwelling urinary catheter] Catheter. On 6/13/25 at 2:40 P.M., during an Indwelling Urinary Catheter observation with Nurse #1, the surveyor observed: -Nurse #1 did not perform hand hygiene, donned gloves only and entered Resident #101's room. -Nurse #1 performed a hands-on assessment of the size of Resident #101's indwelling urinary catheter. -Nurse #1 doffed gloves and performed hand hygiene before exiting the Resident's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/25 at 3:01 P.M., the surveyor, Nurse #1, Unit Manager (UM #1), reviewed the EBP sign at Resident #101's door. Nurse #1 said he had performed a hands-on assessment of the Resident's catheter but did not believe he needed to wear a gown. UM #1 said that any hands-on care of the catheter required a gown according to the EBP sign. Nurse #1 said that he had recently washed his hands but had not done so between using the computer at the nurses station and donning the gloves to assess Resident #101. UM #1 said that Nurse #1 should have performed hand hygiene before donning PPE and entering the Resident's room. 2) Resident #4 was admitted to the facility in March 2025 with diagnoses including incomplete Paraplegia and Neuromuscular Dysfunction of the Bladder. Review of Resident #4's MDS assessment dated [DATE], indicated the Resident had an indwelling urinary catheter. Review of Resident #4's June 2025 Physician orders indicated: -an active order initiated 4/2/25 for EB, Diagnosis: catheter, drains, wounds, colostomy. On 6/13/25 at 2:45 P.M., during an Indwelling Urinary Catheter observation with UM #2, the surveyor observed the following: -UM #2 performed hand hygiene, donned gloves only and entered Resident #4's room. -UM #2 performed a hands-on assessment of the size of Resident #4's indwelling urinary catheter. -UM #2 doffed gloves and performed hand hygiene before exiting the Resident's room. During an interview on 6/13/25 at 2:47 P.M., the surveyor and UM #2 observed the EBP sign outside Resident #4's door. UM #2 said the sign indicated a gown and glove were required for care of the indwelling urinary catheter. UM #2 said she had not worn a gown when she completed the hands-on assessment of the indwelling urinary catheter but should have due to infection control and potential contamination concerns.