STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365072	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anna Maria of Aurora	889 North Aurora Road Aurora, OH 44202

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 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 record review, interview, policy review, the facility failed to ensure medications were administered as ordered for Resident #195. This affected one (Resident #195) of three residents reviewed for quality of care. The facility census was 88.Findings include: Review of the closed medical record revealed Resident #195 was admitted on [DATE] with diagnoses including atrial fibrillation, coronary artery disease, type II diabetes mellitus, urinary retention requiring an indwelling urinary catheter, and protein-calorie malnutrition.Record review of the resident's care plan revealed care plans initiated on 06/30/25 addressed Resident #195's activities of daily living, nutrition, urinary catheter, fall prevention, cardiovascular status, and chronic medical conditions. The care plan included interventions to monitor changes in condition, notify the physician of changes in condition, administer medications as ordered, obtain laboratory studies as ordered, and provide Physical Therapy, Occupational Therapy, and Speech Therapy as indicated. The care plan was reviewed and revised on 12/10/25 following the resident's hospitalization to address the resident's decline in functional status, increased dependence on staff with activities of daily living, hospice services, and changing care needs.Record review of the Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #195 was cognitively intact, exhibited no behavioral symptoms, was independent or required supervision with activities of daily living and mobility, had an indwelling urinary catheter, and was frequently incontinent of bowel.Record review revealed Resident #195 was hospitalized on [DATE] with sepsis, pneumonia, urinary tract infection, and abnormal laboratory findings and returned to the facility on [DATE]. Nursing documentation following readmission reflected a significant decline requiring a mechanical lift for transfers, increased assistance with feeding, decreased trunk control, inability to straighten the bilateral lower extremities because of stiffness, and therapy services were ordered.Record review of Social Services documentation dated 12/16/25 revealed the Resident #195's daughter requested hospice services because of the resident's continued decline and elected to discontinue therapy services. Hospice documentation revealed the resident was admitted to hospice effective 12/17/25.Record review of physician orders revealed an order dated 12/17/25 at 9:30 P.M. for Lorazepam (Ativan) 0.5 milligrams (mg) (antianxiety) by mouth every four hours as needed. Record review further revealed a physician order dated 12/18/25 at 8:00 P.M. for Ativan 0.5 mg by mouth every two hours. Physician orders further revealed Morphine Sulfate concentrate (opioid pain medication) was increased to every two hours for management of the resident's end-of-life symptoms.Record review of nursing documentation dated 12/17/25 at 5:56 P.M. revealed the resident was anxious, pulling at clothing, and reaching outward. Documentation reflected the family requested Ativan and the Certified Nurse Practitioner (CNP) was notified.Record review of nursing documentation dated 12/18/25 at 10:44 A.M. revealed Resident #195's respirations of 53 breaths per minute. Morphine was administered without effective relief. Hospice contacted the CNP, and the Morphine dosage was increased.Record review of nursing documentation dated 12/18/25 at 6:43 P.M. revealed Resident #195's respirations remained elevated at 56 breaths per minute. Hospice contacted the on-call provider, who issued new medication orders, including Morphine every two hours and Lorazepam (Ativan) every two hours. Documentation reflected the resident's family (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	remaining at the bedside.Review of the December 2025 Medication Administration Record (MAR) revealed Lorazepam (Ativan) was documented as administered at 6:00 A.M. on 12/18/25. The next documented administration occurred at 4:00 A.M. on 12/19/25 despite physician orders directing administration every two hours.During an interview on 06/16/26 at 4:00 P.M., the Director of Nursing (DON) revealed the facility exhausted its emergency starter supply of Ativan and the pharmacy advised the medication had already been packaged for routine delivery.During an interview on 06/17/26 at 9:48 A.M., Clinical Director of Gardens of the Western Reserve Hospice #644 revealed hospice ordered Ativan for management of the resident's end-of-life symptoms and confirmed the resident experienced increasing respiratory distress requiring continued symptom management.During an interview on 06/17/26 at 10:00 A.M., Pharmacy Operations Manager #645 revealed the medication had been dispensed on 12/17/25 for delivery on 12/18/25. The facility contacted the pharmacy at 7:10 P.M., hospice contacted the pharmacy at 8:08 P.M., and at 8:14 P.M. the agency nurse reported not having access to the medication storage unit. The medication remained available within the medication storage unit and could have been obtained if temporary access had been authorized.During an interview on 06/17/26 at 11:20 A.M., the DON and Licensed Practical Nurse (LPN) Nurse Manager #578 revealed agency nurses could be granted temporary access to the medication storage unit after normal pharmacy hours when needed.Review of the facility's Medication Administration Policy revealed medications were to be administered as ordered by the physician. The policy further directed nursing staff to review physician orders for accuracy, transfer medication orders to the MAR, assign medication administration times, administer medications as ordered, document medication administration, monitor residents for adverse drug reactions, and notify the physician of adverse reactions.Review of the Medication Storage Unit Access (STATSAFE) Policy revealed agency nurses were not routinely granted access to the medication storage unit. If an agency nurse required a controlled substance and two facility-employed licensed nurses were unavailable, the DON or designee could authorize temporary access. If temporary access could not be authorized and the medication could not be obtained through routine procedures, the pharmacy was to be contacted for a medication drop shipment.This deficient practice represents non-compliance investigated under Complaint Number 2716326.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and review of facility policies, the facility failed to administer physicianˆordered medications as prescribed for one resident (Resident #194) of three reviewed for medication administration. The facility did not ensure that admission medications ordered for the evening of 12/18/25 were administered as required, resulting in a delay in treatment for Resident #194. This affected one (Resident #194) of three residents reviewed for medication administration. The facility census was 88.Findings include: Review of Resident #194's closed medical record revealed the resident was admitted to the facility on [DATE] from an Acute Care Hospital Rehabilitation following spinal reconstruction surgery. Pertinent diagnoses included post-laminectomy syndrome, rheumatoid arthritis, urinary retention, urinary tract infection, hypothyroidism, hypertension, asthma, depression, and chronic pain requiring ongoing medication management.Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #194 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact and able to communicate healthcare needs. The MDS further documented the resident experienced frequent pain that did not interfere with sleep or participation in activities.Review of the comprehensive care plan initiated 12/19/25 revealed interventions directing staff to administer medications as ordered, routinely assess pain, monitor the effectiveness of pain interventions, notify the physician of changes in condition, and document the resident's response to interventions.Review of physician orders dated 12/18/25 revealed admission medication orders were received and verified by the attending physician at approximately 5:21 P.M. Orders included, but were not limited to, cephalexin (Keflex) (antibiotic), budesonide/formoterol (Symbicort) (inhaler for asthma and chronic obstructive pulmonary disease), sulfasalazine (anti-inflammatory), pregabalin (Lyrica) (anticonvulsant and neuropathic pain agent), methocarbamol (muscle relaxant), levothyroxine (hormone replacement), oxycodone (opioid pain medication) as needed (PRN), and additional prescribed medications. These medications were ordered for administration beginning the evening of the resident's admission.Review of the December 2025 Medication Administration Record (MAR) revealed physician-ordered medications, including Keflex, Symbicort, sulfasalazine, Lyrica, methocarbamol, levothyroxine, and PRN oxycodone, scheduled for administration on the evening of 12/18/25, were not documented as administered following physician verification of the admission orders. Documentation reflected these medications were first administered on 12/19/25. The MAR further documented the resident's pain assessment was zero on a pain scale of zero to ten, ten being the worst, upon admission and subsequently increased to six and later nine prior to the first documented administration of the ordered medications on 12/19/25.Review of nursing progress notes revealed no nursing documentation addressing the failure to administer the ordered medications, attempts to obtain the medications, physician notification, or resident follow-up during the overnight period following admission. Nursing documentation did not resume until approximately 11:00 A.M. on 12/19/25.During an interview on 06/17/26 at 1:45 P.M., the Director of Nursing (DON) stated the admission paperwork had not been completed until the following day, there were no nursing progress notes documented until approximately 11:00 A.M. on 12/19/25, and Resident #194 did not receive the nighttime medications ordered on 12/18/25. The DON further stated she was unable to explain how the agency nurse documented the resident's pain as zero on admission and nine the following morning and confirmed the resident's ordered nighttime medications had not been administered.Review of the facility's Medication Administration Policy revealed it is the facility's policy to administer medications as ordered by the physician. The policy further directed staff to review admission medications against discharge orders, review medications with the physician, transfer medications to the MAR as verified by the physician, assign a time for medication administration, monitor residents for adverse reactions (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following medication administration, and notify the physician when indicated.Review of the facility's Pain Evaluation and Management Policy and Procedure revealed pain evaluations are to be completed upon admission, an individualized pain management care plan is to be initiated for residents with identified pain, charge nurses are to monitor pain every shift and complete supporting documentation in the electronic health record, and nursing staff are responsible for notifying the physician if pain is not controlled.This deficiency represents non-compliance investigated under Complaint Number 2700370.