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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365844 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/23/2024 |
| NAME OF PROVIDER OR SUPPLIER Aurora Manor Special Care Cent | | STREET ADDRESS, CITY, STATE, ZIP CODE 101 S Bissell Rd 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) |
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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>Based on closed record review and interview, the facility failed to ensure Resident #65, who had a history of substance use disorder was assessed for these risks and had comprehensive and individualized care planned interventions initiated and implemented to ensure the resident's safety to prevent drug overdose.</p> <p>Actual harm occurred on [DATE] when Resident #65 was found unresponsive in the facility due to a drug overdose. The resident subsequently passed away. This affected one (#65) of one resident reviewed for death.</p> <p>Findings include:</p> <p>Review of Resident #65's Preadmission Screening and Resident Review Result (PASRR) Notice form dated [DATE] revealed the resident did not require level two services. The resident had a diagnosis of a substance use related disorder with the last substance abuse reported as [DATE].</p> <p>Review of Resident #65's admission hospital paperwork dated [DATE] revealed the resident had a history of substance abuse with last heroin usage reported as [DATE] and last marijuana usage reported as [DATE].</p> <p>Review of Resident #65's closed medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including anxiety disorder, other psychoactive substance abuse and multiple fractures. The resident was admitted for short term placement for skilled therapy services following a motor vehicle accident.</p> <p>Review of Resident #65's physician's orders revealed the following medication orders: An order dated [DATE] (discontinued [DATE]) for Gabapentin 400 mg (milligrams) give one capsule by mouth every eight hours for pain due at 06:00 A.M., 2:00 P.M. and 10:00 P.M.; an order dated [DATE] (discontinued [DATE]) for Methocarbamol oral tablet 1000 mg give one tablet every six hours for muscle spasms due at 12:00 A.M., 6:00 A.M., 12:00 P.M. and 6:00 P.M.; an order dated [DATE] (discontinued [DATE]) for Acetaminophen give 650 mg by mouth every six hours as needed for pain; an order dated [DATE] (discontinued [DATE]) for Oxycodone 5 mg give one tablet every four hours as needed for pain; and an order dated [DATE] (discontinued [DATE]) for Xanax 0.5 mg give one tablet by mouth every 12 hours as needed for anxiety.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689 Level of Harm - Actual harm Residents Affected - Few | <p>Review of Resident #65's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.</p> <p>Review of Resident #65's Medicine Progress Note form dated [DATE] revealed the resident required pain medications related to multiple fractures but had a history of heroin abuse. A discussion was held with tapering of medications as he heals and discussed the risk of relapse on heroin. The resident was agitated with the discussion and stated he had no interest in using heroin again and only wanted pain control.</p> <p>Review of Resident #65's anxiety care plan dated [DATE] indicated the resident had a history of anxiety and drug use. The plan of care indicated the resident would request pain medications prior to his next scheduled administration and would make accusations that he had never received the medications despite nursing documentation and two staff present during administration. He would attempt to order alcohol from restaurants to be delivered to the facility and became anxious and agitated with staff regarding the pain medications.</p> <p>Review of Resident #65's anxiety care plan interventions included to administer medications, consult pharmacist for gradual dose reductions (GDR), implement non-pharmacological interventions, and refer to psych services.</p> <p>Resident #65's medical record did not include evidence of the resident's substance use was assessed therefore care planned interventions did not address any increased monitoring or supervision to prevent potential behaviors including drug overdose.</p> <p>Review of Resident #65's medication administration record for [DATE] revealed the resident had medications due at 8:00 A.M. and 9:00 A.M. including an iron tablet, Lovenox (anti-coagulant injection) and Lexapro (antidepressant). Record review revealed these medications were not administered as ordered on this date.</p> <p>Review of Resident #65's progress note dated [DATE] at 1:00 P.M. authored by Licensed Practical Nurse (LPN) #813 indicated at approximately 12:10 P.M. the nurse went into the room to medicate the resident. The resident was unresponsive, and the nurse initiated cardiopulmonary resuscitation (CPR) immediately. The nurse called to State tested Nursing Assistant (STNA) to send in another nurse.</p> <p>Review of Resident #65's emergency medical technician squad (EMS) report dated [DATE] revealed the squad arrived for a [AGE] year-old male in full arrest. Upon arrival, the nursing staff provided manual chest compressions and breaths with a bag valve mask (BVM). Per nursing staff, the resident's last known wellness check was around 10:00 A.M. Staff found the resident at noon pulseless and apneic and began CPR. CPR was taken over by EMS. The resident's cardiac rhythm showed asystole. Three rounds of epinephrine as well and two rounds of Narcan were administered. The time of death was pronounced on [DATE] at 12:30 P.M. The report indicated the call was received on [DATE] at 12:13 P.M., the squad dispatched at 12:14 P.M., on scene and in contact with the resident at 12:17 P.M.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Review of Resident #65's Coroner Report Form dated [DATE] indicated the police were called to the resident's room following the death and officers advised the coroner that the death was a possible drug overdose. The police had found evidence of drugs found in the resident's room. A wallet was in the room and inside the wallet was a white piece of paper folded up with a white powdery substance in it. There was also a blue piece of paper rolled up with some other white powdery substance. The wallet also contained a very small spoon typically used for drug activity. The basis of examination and/or investigation, in the coroner's opinion, identified the cause of death as acute intoxication by Alprazolam, Fentanyl and Gabapentin.</p> <p>Interview on [DATE] at 8:45 A.M. with the Administrator, Regional Registered Nurse (RN) #812 and the Director of Nursing (DON) indicated Resident #65 had a prior history of drug abuse and he expired in the facility due to an overdose provided by a visitor.</p> <p>Interview on [DATE] at 10:21 A.M. with LPN #813 revealed she did not administer Resident #65's morning medications on [DATE] because she did not come in until 10:30 A.M. She stated she went in to administer the resident noon medications and found the resident unresponsive, still warm and in bed. She stated this was the first time she had attempted to assess the resident on [DATE] because she clocked in late to the facility.</p> <p>Interview on [DATE] at 8:59 A.M. with Coroner Department #831 indicated their department was notified of Resident #65's death on [DATE] at 12:37 P.M. He stated from what their department understood, the deceased died by acute Fentanyl overdose and Gabapentin which were provided by a friend.</p> <p>Interview on [DATE] at 1:32 P.M. with RN Regional #812 confirmed Resident #65 had a prior history of substance abuse. RN Regional #812 confirmed Resident #65's medical record and comprehensive care plans did not include interventions to address the resident's substance abuse history on admission or following the medicine progress note visit on [DATE] when there was discussion related to pain medication. There was no evidence the facility adequately and thoroughly assessed or implemented interventions including but not limited to increased monitoring or supervision of the resident as well as increased supervision of visitors to prevent possible behaviors including a relapse of his substance abuse disorder.</p> <p>Interview on [DATE] at 4:30 P.M. with Licensed Social Worker (LSW) #830 indicated Resident #65 had ordered door dash at some point (unknown date) and had ordered alcohol with the door dash. LSW #830 confirmed the facility talked to the resident and removed the alcohol but did not include increased supervision and monitoring for the resident as part of the resident's care planned interventions to ensure the resident's safety. She stated she was made aware of the incident after it occurred.</p> <p>Interview on [DATE] at 9:49 A.M. with Resident #65's stepmother revealed following admission, the resident had been getting better (with physical therapy). However, the resident's stepmother voiced concerns she felt the resident received inadequate monitoring for drug use related to the resident's history of prior substance abuse.</p> <p>Interview on [DATE] at 10:09 A.M. with Paramedic #830 indicated the staff completed adequate compressions during Resident #65's CPR. Paramedic #830 confirmed the resident was cyanotic and warm with no rigor mortis noticed at the time of the CPR. Paramedic #830 revealed the squad was informed Resident #65 had a visitor earlier in the day and administered the Narcan as a precaution.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Interview on [DATE] at 10:40 A.M. with RN Regional #812 revealed Resident #65 had received therapy services on [DATE] from 9:27 A.M. to 10:17 A.M. After therapy the resident went back to his room. RN Regional #812 indicated the resident did not request assistance and staff did not go into the room from the end of therapy until the resident was found unresponsive on [DATE] at 12:10 P.M.</p> <p>Review of the Behavior Management Program policy revised [DATE] revealed the goal of the facility was to improve management of behaviors and move closer to the goal of ending any inappropriate or unnecessary use of antipsychotic medications. The facility would assess and track behavior that negatively impacted each resident in regard to their quality of life.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00152414.</p> |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>Based on record review and interview, the facility failed to ensure Resident #65's medications were administered as ordered. This finding affected one (Resident #65) of five residents reviewed for medication administration.</p> <p>Findings include:</p> <p>Review of Resident #65's medical record revealed the resident was admitted on [DATE] with diagnoses including anxiety disorder, other psychoactive substance abuse and multiple fractures.</p> <p>Review of Resident #65's physician orders revealed an order dated 07/01/23 for Lexapro (antidepressant) give 10 mg (milligrams) by mouth one time a day for depression due at 9:00 A.M.; Ferrous Sulfate (iron) 325 mg by mouth two times a day for anemia due at 08:00 A.M. and 08:00 P.M.; and Lovenox injection (anticoagulant) 30 mg/0.3 ml (milliliters) give one vial subcutaneously two times a day for health maintenance due at 08:00 A.M. and 08:00 P.M.</p> <p>Review of Resident #65's medication administration records (MARS) from 08/01/23 to 08/21/23 revealed no evidence the resident's Lexapro, iron and Lovenox anticoagulant medications were administered as ordered.</p> <p>Interview on 04/17/24 at 10:21 A.M. with Licensed Practical Nurse (LPN) #813 confirmed she did not administer Resident #65's morning medications as ordered.</p> <p>Review of the General Dose Preparation and Medication Administration policy revised 01/01/13 indicated the facility staff should verify each time a medication was administered that it was the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time and for the correct resident.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00152414.</p> |