STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365844	A. Building B. Wing	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurora Manor Special Care Cent	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36650 Based on record review and staff interview, the facility failed to notify the physician of residents not receiving medications as physician ordered. This affected five (Residents #1, #3, #8, #24, and #55) of 13 residents receiving insulin in the facility. The facility census was 63. Findings include: 1. Review of the medical record for Resident #1 revealed an admitted d 04/25/24. Diagnoses included type II diabetes mellitus and end stage renal failure. Review of the medication administration record (MAR) for May 2024 revealed on 05/05/24 at 9:30 P.M., Resident #1 did not have his blood sugar check and did not receive any insulin as physician ordered. At the bottom of the MAR under reasons not administered on 05/05/24 at 9:30 P.M. stated drug/item unavailable. There was no documentation in the medical record that the physician was notified that Resident #1's insulin and blood sugar check were not administered as physician ordered on 05/05/24. Interview on 05/09/24 at 3:00 P.M. with Regional Nurse #310 verified Resident #1 did not receive insulin due to the resident's blood sugar was not taken and was unable to administer insulin per sliding scale. Regional Nurse #310 verified the physician was not notified. 2. Review of the medical record for Resident #3 revealed an admitted [DATE]. Diagnosis included type II diabetes mellitus. Review of Resident #3's physician orders for 03/28/24 revealed Humalog KwikPen Insulin (short acting insulin) 100 unit/milliliter (ml) give eight units subcutaneous (SQ) before meals and Lantus Soloster U-100 insulin (long-acting insulin) 100 unit/ml, give 18 units SQ at bedtime. Review of the MAR for May 2024 revealed on 05/05/24 at 9:00 P.M., Lantus 18 unit/ml was not administered, and blood glucose was not checked. On 05/06/24 at 7:30 A.M. glucose sugar was not checked, and insulin was not administered. At the bottom of MAR under reason not administered on 05/06/24 at 7:30 A.M. stated no testing strips available. There was no documentation in the medical record that the physician was notified that Resident #3's insulin and blood sugar check were not administered as physician ordered on 05/05/24 and 05/06/24. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/09/24 at 3:00 P.M. with Regional Nurse #310 verified Resident #3 did not receive insulin two times due to the resident's blood sugar was not taken and was unable to administer insulin per sliding scale. Regional Nurse #310 verified the physician was not notified. 3. Review of the medical record for Resident #8 revealed an admitted [DATE]. Diagnosis included type II diabetes mellitus. Review of Resident #8's physician orders dated 03/30/24 revealed an order for insulin lispro 100 unit/ml per sliding scale before meals and at bedtime. Review of the MAR for May 2024 revealed on 05/05/24 at bedtime (8:00 P.M. to 10:30 P.M.), Resident #8 did not have his blood glucose taken and no insulin was administered. There was no notation for the reason not administered. There was no documentation in the medical record that the physician was notified that Resident #8's insulin and blood sugar check were not administered as physician ordered on 05/05/24. Interview on 05/09/24 at 3:00 P.M. with Regional Nurse #310 verified Resident #8 did not receive insulin due to the resident's blood sugar was not taken and was unable to administer insulin per sliding scale. Regional Nurse #310 verified the physician was not notified. 4. Review of the medical record for Resident #24 revealed an admitted [DATE]. Diagnosis included type II diabetes mellitus. Review of Resident #24's physician order dated 03/30/24 revealed insulin lispro 100 unit/ml per sliding scale before meals and at bedtime. Review of the MAR for May 2024 revealed on 05/04/24 at bedtime (7:00 P.M.-11:00 P.M.,) on 05/05/24 at morning (6:00 A.M. to 7:00 A.M.) and the bedtime (7:00 P.M.-11:00 P.M.) and on 05/06/24 at morning (6:00 A.M. to 7:00 A.M.), Resident #24's blood sugar was not checked, and no insulin was administered. Insulin was given at other scheduled times and blood glucose was checked. At the bottom of the MAR under reason not administered on 05/06/24 at morning (6:00 A.M. - 7:00 A.M.) stated no testing strips available. There was no documentation in the medical record that the physician was notified that Resident #24's insulin and blood sugar check were not administered as physician ordered on 05/04/24, twice on 05/05/24 and on 05/06/24. Interview on 05/09/24 at 3:00 P.M. with Regional Nurse #310 verified Resident #24 did not receive insulin four times due to the resident's blood sugar was not taken and was unable to administer insulin per sliding scale. Regional Nurse #310 verified the physician was not notified. 5. Review of the medical record for Resident #55 revealed an admitted on 03/27/24. Diagnosis included type II diabetes mellitus. Review of Resident #55's physician orders dated 04/01/24 revealed an order for insulin lispro (short acting insulin) 100 unit/ml per sliding scale before meals and at bedtime. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MAR for May 2024 revealed on 05/05/24 at dinner (4:00 P.M.) and bedtime (9:00 P.M.), Resident #55 did not have their blood sugar checked and was not administered insulin. At the bottom of MAR under on 05/05/24 at 4:00 P.M. stated reason not administered was no testing strips available. There was no documentation in the medical record that the physician was notified that Resident #55's insulin and blood sugar check were not administered as physician ordered on 05/05/24. Interview on 05/09/24 at 3:00 P.M. with Regional Nurse #310 verified Resident #55 did not receive insulin due to the resident's blood sugar was not taken and was unable to administer insulin per sliding scale. Regional Nurse #310 verified the physician was not notified. Interview on 05/13/24 at 8:41 A.M. with Licensed Practical Nurse (LPN) #306 verified she did not notify the physician that the residents did not receive their insulin as physician ordered. This was an incidental finding during the course of the complaint investigation.

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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 - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36650 Based on record review, observation, and resident and staff interview, the facility failed to administer medications as physician ordered, resulting in significant medication errors. This affected five (Resident #1, #3, #8, #24 and #55) of thirteen residents reviewed for insulin. The facility census was 63. Findings include: 1. Review of the medical record for Resident #1 revealed an admitted d 04/25/24. Diagnoses included type II diabetes mellitus and end stage renal failure. Review of Resident #1's physician order for May 2024 revealed Humalog (insulin) U-100 100 unit per milliliter (ml) before meals and at bedtime. Review of the medication administration record (MAR) for May 2024 revealed on 05/05/24 at 9:30 P.M., Resident #1 did not have his blood sugar check and did not receive any insulin as physician ordered. At the bottom of the MAR under reasons not administered on 05/05/24 at 9:30 P.M. stated drug/item unavailable. Interview on 05/09/24 at 3:00 P.M. with Regional Nurse #310 verified Resident #1 did not receive insulin due to the resident's blood sugar was not taken and was unable to administer insulin per sliding scale. Regional Nurse #310 revealed the next shift blood sugars were taken as ordered the glucometer strips were found. 2. Review of the medical record for Resident #3 revealed an admitted [DATE]. Diagnosis included type II diabetes mellitus. Review of Resident #3's physician orders for 03/28/24 revealed Humalog KwikPen Insulin (short acting insulin) 100 unit/milliliter (ml) give eight units subcutaneous (SQ) before meals and Lantus Soloster U-100 insulin (long-acting insulin) 100 unit/ml, give 18 units SQ at bedtime. Review of the MAR for May 2024 revealed on 05/05/24 at 9:00 P.M., Lantus 18 unit/ml was not administered, and blood glucose was not checked. On 05/06/24 at 7:30 A.M. glucose sugar was not checked, and insulin was not administered. At the bottom of MAR under reason not administered on 05/06/24 at 7:30 A.M. stated no testing strips available. Interview on 05/09/24 at 3:00 P.M. with Regional Nurse #310 verified Resident #3 did not receive insulin two times due to the resident's blood sugar was not taken and was unable to administer insulin per sliding scale. Regional Nurse #310 revealed the next shift blood sugars were taken as ordered the glucometer strips were found. 3. Review of the medical record for Resident #8 revealed an admitted [DATE]. Diagnosis included type II diabetes mellitus. (continued on next page)

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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 - Some	Review of Resident #8's physician orders dated 03/30/24 revealed an order for insulin lispro 100 unit/ml per sliding scale before meals and at bedtime. Review of the MAR for May 2024 revealed on 05/05/24 at bedtime (8:00 P.M. to 10:30 P.M.), Resident #8 did not have his blood glucose taken and no insulin was administered. There was no notation for the reason not administered. Interview on 05/09/24 at 3:00 P.M. with Regional Nurse #310 verified Resident #8 did not receive insulin due to the resident's blood sugar was not taken and was unable to administer insulin per sliding scale. Regional Nurse #310 revealed the next shift blood sugars were taken as ordered the glucometer strips were found. 4. Review of the medical record for Resident #24 revealed an admitted [DATE]. Diagnosis included type II diabetes mellitus. Review of Resident #24's physician order dated 03/30/24 revealed insulin lispro 100 unit/ml per sliding scale before meals and at bedtime. Review of the MAR for May 2024 revealed on 05/04/24 at bedtime (7:00 P.M.-11:00 P.M.,) on 05/05/24 at morning (6:00 A.M. to 7:00 A.M.) and the bedtime (7:00 P.M.-11:00 P.M.) and on 05/06/24 at morning (6:00 A.M. to 7:00 A.M.), Resident #24's blood sugar was not checked, and no insulin was administered. Insulin was given at other scheduled times and blood glucose was checked. At the bottom of the MAR under reason not administered on 05/06/24 at morning (6:00 A.M.-7:00 A.M.) stated no testing strips available. Interview on 05/09/24 at 10:04 A.M. with Resident #24 stated one time the nurse was not able to administered their insulin due to her not having any glucometer strips to test their blood sugar. Later, they must have found the strips because the nurse checked my blood sugar and administered insulin per sliding schedule. Interview on 05/09/24 at 3:00 P.M. with Regional Nurse #310 verified Resident #24 did not receive insulin four times due to the resident's blood sugar was not taken and was unable to administer insulin per sliding scale. 5. Review of the medical record for Resident #55 revealed an admitted on 03/27/24. Diagnosis included type II diabetes mellitus. Review of Resident #55's physician orders dated 04/01/24 revealed an order for insulin lispro (short acting insulin) 100 unit/ml per sliding scale before meals and at bedtime. Review of the MAR for May 2024 revealed on 05/05/24 at dinner (4:00 P.M.) and bedtime (9:00 P.M.), Resident #55 did not have their blood sugar checked and was not administered insulin. At the bottom of MAR under on 05/05/24 at 4:00 P.M. stated reason not administered was no testing strips available. Observation on 05/09/24 at 9:30 A.M. of the medication storage room and the 100-Hall, 200-Hall and 400-Hall medication carts revealed plenty of insulin needles and glucometer strips. (continued on next page)

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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 - Some	Interview on 05/09/24 at 1:25 P.M. with Administrator stated on 05/05/24, Licensed Practical Nurse (LPN) #306 called to yell at her and stated she was going to the police station to turn her keys in. She stated there was no glucose strip in the building. The Administrator told LPN #306 to look in the medication room or storage room. The Administrator stated she told LPN #306 to go look in the supply room and call her back if she did not find any glucometer strips. The Administrator stated the nurse did not call her back. Interview on 05/09/24 at 3:00 P.M. with Regional Nurse #310 verified Resident #55 did not receive insulin due to the resident's blood sugar was not taken and was unable to administer insulin per sliding scale. Regional Nurse #310 revealed the next shift blood sugars were taken as ordered the glucometer strips were found. Interview on 05/13/24 at 8:41 A.M. with LPN #306 revealed she worked on 05/05/24 and she was told by the day shift nurse that there were no glucometer strips in the building so blood sugar could not be taken, and she was trying to reach management all day. LPN #306 stated she tried to call the Administrator and there was no answer. The Administrator called back after she called the police to report she did not have supplies to do her job safely and was going to bring the medication cart keys to them. LPN #306 stated the Administrator was upset and told her to check central supply and medication room for glucometer strips and she could not take the keys to the police station, or she would report her to the board of nursing for abandonment. LPN #306 stated she could not find the glucometer strips. This deficiency represents non-compliance investigated under Complaint Number OH00153676.