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	08/28/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review, resident interview, staff interview, and review of witness statements, the facility Administrator failed to treat Resident #21 in a dignified and respectful manner. This affected one resident (#21) of three reviewed. The facility census was 56. Findings include: Review of the medical record for Resident #21 revealed an admitted [DATE] with diagnoses including anxiety disorder, major depressive disorder, congestive heart failure, chronic obstructive pulmonary disease, hypertension, and type two diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) Assessment, dated 08/07/24, revealed Resident #21 had no cognitive impairment. On 08/28/24 at 9:06 A.M., an interview with Resident #21 stated the Administrator yelled at her and argued with her, which Resident #21 felt was inappropriate. On 08/28/24 at 9:55 A.M., an interview with Licensed Practical Nurse (LPN) #214 confirmed they witnessed the Administrator yelling at Resident #21, gesturing at her with her hands and pointing a finger at her. LPN #214 stated this incident occurred in the middle of the building by the nurses station. On 08/28/24 at 3:53 P.M., an interview with Regional Registered Nurse (RN) #242 stated the Administrator was verbally inappropriate with Resident #21, threatening to kick Resident #21 out of the building. Review of Resident #21's signed statement, dated 08/28/24, indicated the Administrator told Resident #21 that she was in charge and she would kick Resident #21 out. Review of LPN #214's signed statement, dated 08/28/24, confirmed the Administrator yelled at Resident #21 and the Administrator told Resident #21 that she could kick Resident #21 out of the facility. LPN #214 further stated it was a bad choice of words and uncalled for. This deficiency represents non-compliance investigated under Complaint Number OH00155871.

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
	365844	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurora Manor Special Care Cent	101 S Bissell Rd Aurora, OH 44202

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review, resident interview, staff interview, and review of witness statements, the facility failed to ensure allegations of abuse were reported by staff in a timely manner, which led to a delay in the investigation of the alleged incident. This affected one resident (#21) of three reviewed. The facility census was 56. Findings include: Review of the medical record for Resident #21 revealed an admitted [DATE] with diagnoses including anxiety disorder, major depressive disorder, congestive heart failure, chronic obstructive pulmonary disease, hypertension, and type two diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) Assessment, dated 08/07/24, revealed Resident #21 had no cognitive impairment. On 08/28/24 at 9:06 A.M., an interview with Resident #21 stated the Administrator yelled at her and argued with her, which Resident #21 felt was inappropriate. On 08/28/24 at 9:55 A.M., an interview with Licensed Practical Nurse (LPN) #214 confirmed they witnessed the Administrator yelling at Resident #21, gesturing at her with her hands and pointing a finger at her. LPN #214 stated this incident occurred in the middle of the building by the nurses station a few weeks ago and they reported it to the former Director of Nursing (DON). On 08/28/24 at 2:05 P.M., an interview with Regional Registered Nurse (RN) #242 denied knowledge of anyone accusing the Administrator of verbal abuse. On 08/28/24 at 3:53 P.M., an interview with Regional RN #242 stated it was never reported to the regional team that a resident or staff member had alleged verbal abuse incidents against the Administrator. Regional RN #242 confirmed that the Administrator was verbally inappropriate with Resident #21, threatening to kick Resident #21 out of the building. Review of Resident #21's signed statement, dated 08/28/24, indicated the Administrator told Resident #21 that she was in charge and she would kick Resident #21 out. Review of LPN #214's signed statement, dated 08/28/24, confirmed there was an incident a couple weeks ago when the Administrator yelled at Resident #21 and the Administrator told Resident #21 that she could kick Resident #21 out of the facility. Review of the facility's policy titled Ohio Resident Abuse Policy, dated 07/11/24, revealed facility staff must immediately report all allegations of abuse to the Administrator or Abuse Coordinator. The policy further indicated that all investigations must be completed within five working days of the alleged occurrence. This deficiency represents non-compliance investigated under Complaint Number OH00155871.