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	11/21/2024

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 - Few	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** 42730 Based on record review, observation, interview and review of facility policy, the facility failed to ensure Resident #11's family were notified of a change in condition. This affected one resident (Resident #11) of three residents reviewed for notification of change. The facility census was 65. Findings include: Review of the medical record for Resident #11 revealed she admitted to the facility on [DATE] with diagnoses including chronic diastolic congestive heart failure, chronic obstructive pulmonary disease, and dysthymic disorder. Resident #11 was not responsible for herself, and her sister was listed as her responsible party. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 15 indicating she was alert and oriented to person, place, and time. Review of the MDS assessment revealed she was dependent on staff for activities of daily living (ADLs). Review of the care plan dated 06/10/24 revealed Resident #11 was at risk for deterioration in ADLs related to assistance required from staff and altered mood and behaviors related to depression and anxiety with interventions that included provide assistance of two staff and monitor and report any changes. Review of a weekly observation assessment dated [DATE] at 3:35 P.M. revealed Resident #11 was observed to have old bruising above her left eye. Review of the Self-Reported Incident dated 11/14/24 based on the facility investigation revealed Resident #11 had a bruise that was discovered on the left side of her forehead with a small discoloration to forearm. Further review of the investigation revealed Resident #26 hit Resident #11 in the face resulting in a bruise above her left eyebrow. Both Certified Nursing Assistant (CNA) #856 and #900 witnessed the incident and revealed the incident occurred on 11/04/24. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Few	Interview and observation on 11/19/24 at 8:43 A.M. with Resident #11 revealed on 11/04/24 Resident #26 approached her near the central nurse's station and punched her in the head after a brief verbal altercation that left bruising to the left side of her head. Resident #11 revealed the nurse, who she did not recall, and Assistant Director of Nursing (ADON) #849 checked on her and she was provided an ice pack and medication to help with the pain. Resident #11 revealed Certified Nursing Assistant (CNA) #801 was present during the alleged incident. Observation of three timestamped photos dated 11/09/24 provided by Resident #11 revealed a bluish-purple discoloration, approximately the size of a half-dollar, located above her left eyebrow. Observation on 11/19/24 at 8:43 A.M. of Resident #11 face, revealed a yellow-brownish discoloration, approximately the size of a half-dollar, located above her left eyebrow. Interview on 11/19/24 at 1:58 P.M. with CNA #801 revealed Resident #11 and Resident #26 was observed calling each other out of their names near the central nursing station on 11/04/24, when Resident #11 hit Resident #26 on the head. CNA #801 revealed she did not recall what staff were present, but she documented the incident on an incident report. CNA #801 revealed that the initial incident report must have been lost, because ADON #849 requested she redo it and the ADON #849 now had a copy. Interview on 11/19/24 at 2:15 P.M. with ADON #849 confirmed and verified Resident #11 had bruising above her left eyebrow related to being hit by Resident #26 on 11/04/24 and the incident was not reported t0 Resident #11's family member. Interview on 11/20/24 at 10:17 A.M. with Resident #11 sister revealed staff did not inform her of the incident of physical abuse between Resident #11 and Resident #26 that occurred on 11/04/24. Resident #11 sister revealed she visited Resident #11 between 11/10/24 and 11/16/24 and another staff member who she could not recall informed her of the incident of physical abuse and explained the bruising to Resident #11's forehead. Interview on 11/21/24 at 11:33 A.M. with the Administrator revealed Resident #26 punched Resident #11 in the head that lead to bruising on 11/04/24. The Administrator revealed staff did not inform her until 11/14/24. The Administrator revealed no one reported the bruising or physical altercation from 11/04/24 to 11/13/24, no one documented the physical altercation, and the incident was not reported to Resident #11 sister. Review of the facility document titled Resident Change in Condition Policy revised 06/27/24, revealed the facility had a policy in place to recognize and intervene in the event of a change in condition and the physician and family and/or responsible party would be notified as soon as the nurse had identified the change in condition and the resident was stable. Review of the document revealed the facility did not implement the policy in regard to the allegation. This deficiency represents non-compliance investigated under Complaint Number OH00159817.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on observation, resident medical record review, resident interview, staff interviews, and facility policy review, the facility failed to ensure Resident #11 and #26 were free from abuse. This affected two residents (Resident #11 and #26) of three residents reviewed for abuse. The facility census was 65. Findings include: 1. Review of the medical record for Resident #11 revealed she admitted to the facility on [DATE] with diagnoses that included chronic diastolic congestive heart failure, chronic obstructive pulmonary disease, and dysthymic disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 15 that indicated she was alert and oriented to person, place, and time. Review of the MDS assessment revealed she was dependent on staff for activities of daily living (ADLs). Review of the care plan dated 06/10/24 revealed Resident #11 was at risk for deterioration in ADLs related to assistance required from staff and altered mood and behaviors related to depression and anxiety with interventions that included provide assistance of two staff and monitor and report any changes. Review of the weekly observation assessment dated [DATE] at 3:35 P.M. revealed Resident #11 was observed to have old bruising above her left eye and to the left scapula area. Review of the progress note in Resident #11's medical record dated 11/04/24 at 5:18 P.M. but recorded as a late entry on 11/15/24 at 12:20 P.M. approximately eleven days later, revealed Resident #11 and Resident #26 had a verbal altercation that resulted in Resident #11 stating she and Resident #26 did not get along. Review of the progress note revealed Resident #11 was reminded that she had a behavioral contract in place to stay away from Resident #26. Review of the incident log dated 08/19/24 to 11/19/24, revealed Resident #11 had an incident of alleged abuse dated 11/15/24 at 1:35 P.M. created by the Director of Nursing (DON) with no other incidents listed in regard to physical abuse. Review of the progress note dated 11/18/24 at 1:27 P.M. in Resident #11 medical record revealed the interdisciplinary team (IDT) met and reviewed the allegation of abuse and an investigation was initiated. Review of the progress note revealed Resident #11 received a head-to-toe observation with no negative findings. Review of the progress note revealed the documented head-to-toe assessment was incorrect as an observation of Resident #11 on 11/19/24 at 8:43 A.M., one day later, revealed a yellow-brownish discoloration, approximately the size of a half-dollar, located above her left eyebrow. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #26 revealed he admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, cirrhosis of liver, and bipolar disorder, current episode manic without psychotic features. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #26 had a BIMS score of 10 that indicated he was alert and oriented with cognition impairment. Review of the MDS assessment revealed he was dependent on staff for activities of daily living (ADLs). Review of the care plan dated 04/27/24 revealed Resident #26 was at risk for altered mood and behaviors related to bipolar and depression with interventions that included providing 15-to-30-minute checks or one-on-one as needed. Review of the physician orders dated 08/31/24 revealed Resident #26 had an order in place to protect other residents from harm. Review of the Self-Reported Incident dated 11/14/24 based on the facility investigation revealed Resident #11 had a bruise that was discovered on the left side of her forehead with a small discoloration to forearm. Further review of the investigation revealed after a verbal altercation, Resident #11 made hand gestures near Resident #26 and made contact. Resident #26 then proceeded to make physical contact with Resident #11's face resulting in a bruise above her left eyebrow. Review of the investigation revealed Certified Nursing Assistant (CNA) #856 and #900 witnessed the physical altercation between Resident #11 and Resident #26. CNA #900 revealed Resident #11 slapped Resident #26 and Resident #26 proceeded to punch Resident #11 in the head. CNA #856 revealed Resident #11 verbally threatened Resident #26 and Resident #26 responded by punching Resident #11 in the head. Both CNA #856 and #900 revealed the incident occurred on 11/04/24. Interview on 11/19/24 at 8:34 A.M. with Licensed Practical Nurse (LPN) #872 revealed she worked 7:00 A.M. to 2:00 P.M. on the day the alleged physical abuse occurred between Resident #11 and Resident #26. LPN #872 revealed the physical altercation occurred after she her shift ended, and she had left for the day. LPN #872 revealed she seen the bruise located on Resident #11 forehead above her left eye. LPN #872 revealed she did not document, report or complete an assessment due to being informed that another staff member had completed it on the day it occurred. Interview and observation on 11/19/24 at 8:43 A.M. with Resident #11 revealed on 11/04/24 Resident #26 approached her near the central nurse's station and punched her multiple times in the head after a brief verbal altercation that left bruising to the left side of her head. Resident #11 revealed the nurse, who she did not recall, and ADON #849 checked on her and she was provided an ice pack and medication to help with the pain. Resident #11 revealed CNA #801 was present during the alleged incident. Observation of the three timestamped photos dated 11/09/24 provided by Resident #11 revealed a bluish-purple discoloration, approximately the size of a half-dollar, located above her left eyebrow. Observation on 11/19/24 at 8:43 A.M. of Resident #11 face, revealed a yellow-brownish discoloration, approximately the size of a half-dollar, located above her left eyebrow. Interview on 11/19/24 at 1:50 P.M. with Resident #26 was attempted. However, Resident #26 declined. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/19/24 at 1:58 P.M. with CNA #801 revealed Resident #11 and Resident #26 was observed calling each other out of their names near the central nursing station on 11/04/24, when Resident #11 hit Resident #26 on the head. CNA #801 revealed she did not recall what staff were present, but she documented the incident on an incident report. CNA #801 revealed that the initial incident report must have been lost, because ADON #849 requested she redo it and the ADON #849 now had a copy. Interview on 11/19/24 at 2:15 P.M. with ADON #849 revealed she was in the building on the day, 11/04/24, the alleged abuse occurred but she was not aware of the physical altercation that took place. ADON #849 revealed Resident #11 and Resident #26 had a history of not getting along and had behavior contracts in place to stay away from each other. ADON #849 revealed she was not aware of any bruising to Resident #11 face and did not observe any bruising to her face on 11/04/24 and the days after. ADON #849 revealed [NAME] Regional Nurse (SRN) #879 informed her of Resident #11 bruising to her face. ADON #849 revealed she did not recall the day it was brought to her attention. ADON #849 confirmed and verified Resident #11 bruising related to being hit by Resident #26. ADON #849 verified a timely investigation did not occur immediately after the incident between Resident #11 and #26. Interview on 11/19/24 at 2:22 P.M. with the Administrator revealed Resident #11 and Resident #26 had a physical altercation on 11/04/24 and it was reported late to the Ohio Department of Health. Administrator also revealed there was no documentation of the incident and staff present did not follow the abuse procedures and protocols. Interview on 11/19/24 at 2:28 P.M. with SRN #879 revealed she observed an old bruising to Resident #11 face on 11/14/24 and reported it to the Administrator and DON. SRN #879 revealed Resident #11 had discoloration near her left eye and told her that Resident #26 hit her. Interview on 11/20/24 at 8:39 A.M. with LPN #803 revealed she was aware of Resident #11 bruising located above her left eyebrow. LPN #803 revealed when she saw the bruising, approximately 10 days ago, it appeared to not be fresh. LPN #803 revealed the bruise appeared in the shape of a C and was an old, faint, purple, yellow brown in color and was near the end and resolving. Interview on 11/21/24 at 11:33 A.M. with the Administrator revealed Resident #26 punched Resident #11 in the head that lead to bruising on 11/04/24. The Administrator revealed staff did not inform her until 11/14/24, therefore the SRI was initiated late. The Administrator revealed Resident #11 approached Resident #26 and a verbal altercation began, and as a result, Resident #26 punched her in the head. The Administrator revealed both residents had behavior contracts in place in which they were to remain away from each other and staff were to monitor for compliance with the contracts. The Administrator revealed CNA #900 and LPN #901, who were unavailable for interview, both were present at the time of the incident. The Administrator revealed no one reported the bruising or physical altercation from 11/04/24 to 11/13/24, no one documented the physical altercation, staff did not monitor both residents for compliance of behavior contracts, and the incident was reported to the Ohio Department of Health late. The Administrator confirmed and verified the above findings at the time of the interview. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility document titled Ohio Resident Abuse Policy revised 07/11/24, revealed the facility had a policy in place to investigate all allegations, suspicions, and incidents of abuse. Physical abuse involves hitting, slapping, pinching, kicking and controlling behavior through corporal punishment. Review of the policy revealed the facility staff, which included, but not limited to, employees, consultants, contractors, volunteers and other caregivers who provide care and services to the residents on behalf of the facility, were to immediately report all such allegations to the Administrator. Review of the policy revealed the facility would monitor residents with a history of aggressive behaviors or behaviors and needs that may lead to conflict. This deficiency represents non-compliance investigated under Complaint Number OH00159817.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on observation, resident medical record review, resident interview, staff interviews, and facility policy review, the facility failed to ensure the abuse policy was implemented for an incident of abuse involving Resident #11 and #26. This affected two (Resident #11 and #26) of three residents reviewed for abuse. The facility census was 65. Findings include: Review of the medical record for Resident #11 revealed she admitted to the facility on [DATE] with diagnoses that included chronic diastolic congestive heart failure, chronic obstructive pulmonary disease, and dysthymic disorder. Review of the medical record for Resident #26 revealed he admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, cirrhosis of liver, and bipolar disorder, current episode manic without psychotic features. Review of the incident log dated 08/19/24 to 11/19/24, revealed Resident #11 had an incident of alleged abuse dated 11/15/24 at 1:35 P.M. created by the Director of Nursing (DON) with no other incidents listed in regard to the physical abuse. Review of the progress note in Resident #11 medical record dated 11/04/24 at 5:18 P.M. but recorded as a late entry on 11/15/24 at 12:20 P.M. approximately eleven days later, revealed Resident #11 and Resident #26 had a verbal altercation that resulted in Resident #11 stating she and Resident #26 did not get along. Review of the progress note revealed Resident #11 was reminded that she had a behavioral contract in place to stay away from Resident #26. Review of the Self-Reported Incident dated 11/14/24 based on the facility investigation revealed Resident #11 had a bruise that was discovered on the left side of her forehead with a small discoloration to forearm. Further review of the investigation revealed after a verbal altercation, Resident #11 made hand gestures near Resident #26 and made contact. Resident #26 then proceeded to make physical contact with Resident #11's face resulting in a bruise above her left eyebrow. Review of the investigation revealed Certified Nursing Assistant (CNA) #856 and #900 witnessed the physical altercation between Resident #11 and Resident #26. CNA #900 revealed Resident #11 slapped Resident #26 and Resident #26 proceeded to punch Resident #11 in the head. CNA #856 revealed Resident #11 verbally threatened Resident #26 and Resident #26 responded by punching Resident #11 in the head. Both CNA #856 and #900 revealed the incident occurred on 11/04/24. Interview and observation on 11/19/24 at 8:43 A.M. with Resident #11 revealed on 11/04/24 Resident #26 approached her near the central nurse's station and punched her multiple times in the head after a brief verbal altercation that left bruising to the left side of her head. Resident #11 revealed the nurse, who she did not recall, and ADON #849 checked on her and she was provided an ice pack and medication to help with the pain. Resident #11 revealed CNA #801 was present during the alleged incident. Observation of the three timestamped photos dated 11/09/24 provided by Resident #11 revealed a bluish-purple discoloration, approximately the size of a half-dollar, located above her left eyebrow. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/19/24 at 8:43 A.M. of Resident #11 face, revealed a yellow-brownish discoloration, approximately the size of a half-dollar, located above her left eyebrow. Interview on 11/19/24 at 1:50 P.M. with Resident #26 was attempted. However, Resident #26 declined. Interview on 11/19/24 at 1:58 P.M. with CNA #801 revealed Resident #11 and Resident #26 was observed calling each other out of their names near the central nursing station on 11/04/24, when Resident #11 hit Resident #26 on the head. CNA #801 revealed she did not recall what staff were present, but she documented the incident on an incident report. CNA #801 revealed that the initial incident report must have been lost, because ADON #849 requested she redo it and the ADON #849 now had a copy. Interview on 11/21/24 at 11:33 A.M. with the Administrator revealed Resident #26 punched Resident #11 in the head that lead to bruising on 11/04/24. The Administrator revealed staff did not inform her until 11/14/24, therefore the SRI was initiated late. The Administrator revealed no one reported the bruising or physical altercation from 11/04/24 to 11/13/24, no one documented the physical altercation, staff did not monitor both residents for compliance of behavior contracts, staff did not follow the abuse policy and protocol, and the incident was reported to the Ohio Department of Health late. The Administrator confirmed and verified the above findings at the time of the interview. Review of the facility document titled Ohio Resident Abuse Policy revised 07/11/24, revealed the facility had a policy in place to investigate and immediately report all allegations, suspicions, and incidents of abuse. Physical abuse was defined as hitting, slapping, pinching, kicking and controlling behavior through corporal punishment. This deficiency represents non-compliance investigated under Complaint Number OH00159817.

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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** 42730 Based on resident medical record review, resident interview, staff interviews, and facility policy review, the facility failed to ensure an allegation of abuse was reported to the State Agency. This affected two (Resident #11 and #26) of three residents reviewed for abuse. The facility census was 65. Findings include: Review of the medical record for Resident #11 revealed she admitted to the facility on [DATE] with diagnoses that included chronic diastolic congestive heart failure, chronic obstructive pulmonary disease, and dysthymic disorder. Review of the medical record for Resident #26 revealed he admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, cirrhosis of liver, and bipolar disorder, current episode manic without psychotic features. Review of the incident log dated 08/19/24 to 11/19/24, revealed Resident #11 had an incident of alleged abuse dated 11/15/24 at 1:35 P.M. created by the Director of Nursing (DON) with no other incidents listed in regard to the physical abuse. Review of the progress note in Resident #11 medical record dated 11/04/24 at 5:18 P.M. but recorded as a late entry on 11/15/24 at 12:20 P.M. approximately eleven days later, revealed Resident #11 and Resident #26 had a verbal altercation that resulted in Resident #11 stating she and Resident #26 did not get along. Review of the progress note revealed Resident #11 was reminded that she had a behavioral contract in place to stay away from Resident #26. Review of the Self-Reported Incident dated 11/14/24 based on the facility investigation revealed Resident #11 had a bruise that was discovered on the left side of her forehead with a small discoloration to forearm. Further review of the investigation revealed after a verbal altercation, Resident #11 made hand gestures near Resident #26 and made contact. Resident #26 then proceeded to make physical contact with Resident #11's face resulting in a bruise above her left eyebrow. Review of the investigation revealed Certified Nursing Assistant (CNA) #856 and #900 witnessed the physical altercation between Resident #11 and Resident #26. CNA #900 revealed Resident #11 slapped Resident #26 and Resident #26 proceeded to punch Resident #11 in the head. CNA #856 revealed Resident #11 verbally threatened Resident #26 and Resident #26 responded by punching Resident #11 in the head. Both CNA #856 and #900 revealed the incident occurred on 11/04/24. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 11/19/24 at 8:43 A.M. with Resident #11 revealed on 11/04/24 Resident #26 approached her near the central nurse's station and punched her multiple times in the head after a brief verbal altercation that left bruising to the left side of her head. Resident #11 revealed the nurse, who she did not recall, and ADON #849 checked on her and she was provided an ice pack and medication to help with the pain. Resident #11 revealed CNA #801 was present during the alleged incident. Observation of the three timestamped photos dated 11/09/24 provided by Resident #11 revealed a bluish-purple discoloration, approximately the size of a half-dollar, located above her left eyebrow. Interview on 11/21/24 at 11:33 A.M. with the Administrator revealed Resident #26 punched Resident #11 in the head that lead to bruising on 11/04/24. The Administrator revealed staff did not inform her until 11/14/24, therefore the SRI was initiated late. The Administrator revealed no one reported the bruising or physical altercation from 11/04/24 to 11/13/24, no one documented the physical altercation, staff did not monitor both residents for compliance of behavior contracts, staff did not follow the abuse policy and protocol, and the incident was reported to the Ohio Department of Health late. The Administrator confirmed and verified the above findings at the time of the interview. Review of the facility document titled Ohio Resident Abuse Policy revised 07/11/24, revealed the facility had a policy in place to investigate and immediately report all allegations, suspicions, and incidents of abuse. Physical abuse was defined as hitting, slapping, pinching, kicking and controlling behavior through corporal punishment. This deficiency represents non-compliance investigated under Complaint Number OH00159817.

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	11/21/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on observation, resident medical record review, resident interview, staff interviews, and facility policy review, the facility failed to ensure an allegation of abuse was thoroughly and timely investigated for Resident #11 and Resident #26. This affected two (Resident #11 and #26) of three residents reviewed for abuse. The facility census was 65. Findings include: 1.Review of the medical record for Resident #11 revealed she admitted to the facility on [DATE] with diagnoses that included chronic diastolic congestive heart failure, chronic obstructive pulmonary disease, and dysthymic disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 15 that indicated she was alert and oriented to person, place, and time. Review of the MDS assessment revealed she was dependent on staff for activities of daily living (ADLs). Review of the care plan dated 06/10/24 revealed Resident #11 was at risk for deterioration in ADLs related to assistance required from staff and altered mood and behaviors related to depression and anxiety with interventions that included provide assistance of two staff and monitor and report any changes. Review of the weekly observation assessment dated [DATE] at 3:35 P.M. revealed Resident #11 was observed to have old bruising above her left eye and to the left scapula area. Review of the progress note in Resident #11 medical record dated 11/04/24 at 5:18 P.M. but recorded as a late entry on 11/15/24 at 12:20 P.M. approximately eleven days later, revealed Resident #11 and Resident #26 had a verbal altercation resulting in Resident #11 stating she and Resident #26 did not get along. Review of the progress note revealed Resident #11 was reminded that she had a behavioral contract in place to stay away from Resident #26. Review of the progress note dated 11/18/24 at 1:27 P.M. in Resident #11's medical record revealed the interdisciplinary team (IDT) met and reviewed the allegation of abuse and an investigation was initiated. Review of the progress note revealed Resident #11 received a head-to-to-toe observation with no negative findings. 2.Review of the medical record for Resident #26 revealed he admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, cirrhosis of liver, and bipolar disorder, current episode manic without psychotic features. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 10 that indicated he was alert and oriented with cognition impairment. Review of the MDS assessment revealed he was dependent on staff for activities of daily living (ADLs). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 04/27/24 revealed Resident #26 was at risk for altered mood and behaviors related to bipolar and depression with interventions that included providing 15-to-30-minute checks or one-on-one as needed. Review of the physician orders dated 08/31/24 revealed Resident #26 had an order in place to protect other residents from harm. Review of the incident log dated 08/19/24 to 11/19/24, revealed Resident #11 had an incident of alleged abuse incident dated 11/15/24 at 1:35 P.M. created by the Director of Nursing (DON) with no other incidents listed in regard to the physical abuse. Review of the Self-Reported Incident dated 11/14/24 based on the facility investigation revealed Resident #11 had a bruise that was discovered on the left side of her forehead with a small discoloration to forearm. Further review of the investigation revealed after a verbal altercation, Resident #11 made hand gestures near Resident #26 and made contact. Resident #26 then proceeded to make physical contact with Resident #11's face resulting in a bruise above her left eyebrow. Review of the investigation revealed CNA #856 and #900 witnessed the physical altercation between Resident #11 and Resident #26. CNA #900 revealed Resident #11 slapped Resident #26 and Resident #26 proceeded to punch Resident #11 in the head. CNA #856 revealed Resident #11 verbally threatened Resident #26 and Resident #26 responded by punching Resident #11 in the head. Both CNA #856 and #900 revealed the incident occurred on 11/04/24. Interview on 11/19/24 at 8:34 A.M. with Licensed Practical Nurse (LPN) #872 revealed she worked 7:00 A.M. to 2:00 P.M. on the day the alleged physical abuse occurred between Resident #11 and Resident #26. LPN #872 revealed the physical altercation occurred after she her shift ended, and she had left for the day. LPN #872 revealed she seen the bruise located on Resident #11 forehead above her left eye. LPN #872 revealed she did not document or complete an assessment due to being informed that another staff member had completed it on the day it occurred. Interview and observation on 11/19/24 at 8:43 A.M. with Resident #11 revealed on 11/04/24 Resident #26 approached her near the central nurse's station and punched her multiple times in the head after a brief verbal altercation that left bruising to the left side of her head. Resident #11 revealed the nurse, who she did not recall, and Assistant Director of Nursing (ADON) #849 checked on her and she was provided an ice pack and medication to help with the pain. Resident #11 revealed Certified Nursing Assistant (CNA) #801 was present during the alleged incident. Observation of the three timestamped photos dated 11/09/24 provided by Resident #11 revealed a bluish-purple discoloration, approximately the size of a half-dollar, located above her left eyebrow. Observation on 11/19/24 at 8:43 A.M. of Resident #11 face, revealed a yellow-brownish discoloration, approximately the size of a half-dollar, located above her left eyebrow. Interview on 11/19/24 at 1:50 P.M. with Resident #26 was attempted. However, Resident #26 declined. Interview on 11/21/24 at 11:33 A.M. with the Administrator revealed Resident #26 punched Resident #11 in the head that lead to bruising on 11/04/24. The Administrator revealed staff did not inform her until 11/14/24, therefore the SRI and investigation was initiated late. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility document titled Ohio Resident Abuse Policy revised 07/11/24, revealed the facility had a policy in place to immediately investigate all allegations, suspicions, and incidents of abuse. This deficiency represents non-compliance investigated under Complaint Number OH00159817.

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36650 Based on record review, interview and review of facility policy, the facility failed to ensure Resident #75's physician ordered laboratory services were completed and reported to the physician as required. This affected one resident (Resident #75) of one resident reviewed for laboratory services. The facility census was 65. Findings Include: Review of the medial record for Resident #75 revealed an admitted [DATE]. Diagnoses included cirrhosis of liver, obesity, chronic pain, heart failure and pulmonary edema. Review of a progress note on 10/17/24 at 6:21 P.M. revealed the Nurse Practitioner (NP) #883 was in to see Resident #75 regarding congestions and not feeling well. She ordered Stat (immediately) Basic Metabolic Panel (a blood test which provides information about body fluid balance and metabolism) and a chest x-ray. Review of the labs drawn on 10/17/24 at 1:20 P.M. for the basic metabolic panel (BMP) revealed the specimen hemolyzed (break down of red blood cells causing the specimen to be unusable) so the facility was to reschedule the BMP. Interview on 11/21/24 at 10:27 A.M. with NP #883 revealed she ordered a stat BMP on 10/17/24 for Resident #75. NP #883 verified that the facility should have checked on the Stat BMP and rescheduled the test if the sample was not adequate. Interview on 11/21/24 at 10:35 A.M. with the Director of Nursing (DON) verified Resident #75 had orders for a stat BMP and due to the specimen being hemolyzed the lab was not completed. The nursing staff should have followed up on the lab and reschedule for the lab to be redrawn. Review of the facility policy Resident Change in Condition policy, dated 06/27/24 revealed the nurse would address any emergency care required given the situation and gather information and the most recent labs to the provide/physician. This deficiency identified non-compliance during investigation of Complaint Number OH00159522.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 36650 Based on observations, interview and policy review the facility failed to ensure resident rooms were clean and sanitary for Resident #36, #1, #34, #59 and #50. This affected five residents (#36, #1, #34, #59 and #50) out of eight residents reviewed for physical environment. The facility census was 65. Finding Include: Observation on 11/20/24 at 11:41 A.M. of Resident #36's room revealed a black grimy buildup on the floor showing wheelchair tracks all over the floor, and tables and tops of furniture were dusty. Resident #36 stated they don't clean his room every day and he would like the room cleaned. Observation on 11/20/24 at 11:54 A.M. of Resident #1's room revealed the floor was not swept as there was a build up on dirt in the corners with pieces of paper on the floor and footprints on the floor. Resident #1 stated her room was not cleaned on a daily basis. Interview on 11/20/24 at 12:00 P.M. with Resident #34 revealed housekeeping did not clean her room since she had been there. Observation of her room revealed a build up of dust and dirt around the edge of wall and in corners. Observation on 11/20/24 at 12:03 P.M. of Resident #59's room revealed a plastic bag, paper towels, and an empty wipes container on the floor, and under the bed was food with various debris on the floor in front of bed. Observation on 11/20/24 at 1:06 P.M. of Resident 50's room revealed dried food and drink in front of his bed on the fall matt, food was around the wheels of his bed caked on the floor and in front of his recliner there was dried food stuck to the floor. Resident #50 stated housekeeping would come in but did not really clean and they never clean his bathroom. Observation of the bathroom revealed brown wet liquid around the base of toilet with a brown paper towel in front of toilet soaking up the wetness. The toilet seat was covered with hair and around the base of the toilet was dry brown substance and dust on top of it. Observation was conducted on 11/20/24 at 3:15 P.M. with the Administrator and Director of Nursing (DON) who verified the above findings and verified housekeeping was to clean rooms daily. Interview on 11/21/24 at 10:55 A.M. with Housekeeping Manager (HM) #834 revealed resident rooms were to be cleaned daily. Rooms should be swept and mopped, all high touch areas cleaned, and bathrooms cleaned daily. Deep cleaning was done with room moves and discharges. HM #834 stated there was only one housekeeper working yesterday and there was no second shift housekeeper but the nurse aides could clean any area needing cleaned when the housekeepers are not working. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy Environmental Services: Housekeeping, dated 08/30/22 revealed removal of soiled/used items, clean surfaces with saturated cleaning cloth any soiled surfaces around the room, clean bed rails, overbed table, bedside stand, resident chair, call light devices. Clean sink, bath, shower area and high touch surfaces with disinfectant. Clean toilet bowl with designated cleaner. Sweep and mop floor. This deficiency represents noncompliance identified during investigation of Complaint Number OH00159532.