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	01/26/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility investigation review, policy and procedure review and interview, the facility failed to develop and implement a comprehensive, effective and individualized fall management program to decrease Resident #26's risk of falls and/or accident/injury. This affected one resident (#26) of three residents reviewed for accidents. The facility census was 57. Review of the medical record for Resident #26 revealed an admission date of 06/30/25 with diagnoses including chronic venous insufficiency, osteoarthritis, dementia, muscle weakness, and fracture of pubis with routine healing. Review of the [NAME] Fall Risk assessment dated [DATE] revealed Resident #26 was high risk for falls. Review of the plan of care dated 07/01/25 revealed Resident #26 was at risk for falling related to impaired safety awareness with an intervention (dated 07.06/25) to encourage non-skid socks as tolerated. The care plan also reflected Resident #26's ability for activities of daily living (ADL) (e.g., transfer, walk in room, walk in corridor, dress, eat, toilet, maintain personal hygiene) had deteriorated related to chronic venous statis. Interventions (revised 07/11/25) included providing two staff assistance for transfers and manual wheelchair for mobility with one assist. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had severely impaired cognition, was dependent on staff for toileting and transfers, and required substantial/maximal assistance from staff for bed mobility. Review of a physical therapy Discharge summary dated [DATE] revealed Resident #26 had exhausted insurance benefits. Further progress was limited by cognitive deficits. The discharge summary revealed Resident #26 mostly required minimal assist for functional skills for initiation of task and safety cueing; however, the resident had been observed to self-transfer. The discharge summary included a recommendation for limited assistance for safety due to high fall risk related to age/condition and cognitive deficits. Exact discharge disposition to be determined. Staff were aware of resident's current functional level and needs. Record review revealed no changes were made to the resident's fall/safety plan of care following the resident's discharge from therapy. Review of a progress note dated 08/07/25 at 1:55 A.M. revealed Resident #26 was observed in her room on the floor on her buttocks. Resident #26 stated she did not know what happened. Resident #26 had left elbow skin tear that was cleansed with normal saline (NS) and wrapped. The note indicated Resident #26 was alert and oriented to person and place and vital signs were within normal limits. The resident's power of attorney (POA), physician, and Director of Nursing (DON) were notified. The bed was placed in the lowest position, and the call light was in reach. Review of the facility fall investigation revealed Resident #26 had an unwitnessed fall on 08/07/25 at 1:30 A.M. in the resident's room. Resident #26 was last visualized at 1:00 A.M. in bed. When found, the resident was noted to be barefoot, but the investigation also noted all fall interventions were in place. Review of a written statement by Licensed Practical Nurse (LPN) #336 revealed the resident was heard yelling from her room. The aide informed the nurse the resident was on the floor. Resident #26 was assessed for (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: 365844	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injuries and assisted into her wheelchair. The assigned nurse was notified and took over from that point. Further review of the written statements revealed no statement was obtained from the aide (CAN #400) who was assigned to Resident #26 during this time. The root cause analysis of the fall noted the resident was old (age included), confused, and unbalanced. The fall investigation did not include information as to why non-skid socks were not in place as care planned at the time the resident was found on the floor.Review of the nursing schedule for 08/06/25 into 08/07/25 revealed CNA #400 worked from 3:00 P.M. to 7:00 A.M. and was assigned to Resident #26. Review of a progress note dated 08/07/25 at 6:45 P.M. revealed Resident #26 transferred to hospital due to obtaining a severe skin tear during transfer. Exposed tissues with continuous bleeding present. Resident #26 currently on Warfarin (Coumadin) (blood thinner). All parties were notified. The progress note did not include any additional information as to how the skin tear occurred during the transfer or what caused the skin tear. Review of an incident investigation related to the resident's skin tear on 08/07/25 revealed a witness statement dated 08/07/25 from CNA #366. The statement revealed while transferring Resident #26 into the bed she bumped her leg against the wheelchair and it started bleeding. The CNA got the nurse, and the nurse evaluated it and notified the nurse practitioner (NP). The NP said to send Resident #26 to the ER. There was no root cause analysis included with the investigation. Review of the hospital record (dated 08/07/25) revealed reason for visit was a fall. Diagnoses included closed nondisplaced pelvic (fracture), multiple skin tears, and fall. Instructions noted two stitches needed to be taken out in seven to ten days, one horizontal mattress suture (stitching technique used to close high-tension wounds) and the other simple suture both were done through steri-strips for better hold. Review of a progress note dated 08/08/25 at 12:17 A.M. revealed report received from the nurse from the local emergency room (ER). Resident #26 had a skin tear to the left leg which required stitches and steri-strips. The progress note also reflected Resident #26 had a pubic [NAME] pelvic fracture. Received Tylenol (analgesic) at the ER. The resident returned to the facility via ambulance at 1:00 A.M. Review of a progress note dated 08/08/25 at 1:51 A.M. revealed Resident #26 returned at 1:30 A.M via ambulance. The resident was transferred into bed by two staff. The laceration to the left anterior shin was redressed. The physician was notified. Resident #26 was resting quietly in bed and denied pain at this time.Review of the quarterly MDS assessment dated [DATE] revealed Resident #26 had severely impaired cognition, required substantial/maximal (staff) assistance for bed mobility, and was dependent on staff for toileting hygiene and transfers. Review of an email dated 09/30/25 at 8:32 P.M. from Licensed Practical Nurse (LPN) #401 to the Director of Nursing (DON) revealed this nurse was notified by CNA #366 of Resident #26 obtaining a severe skin tear during a transfer (on 08/07/25) to bed from the wheelchair. Upon entering resident's room, she noticed the resident was crying and a significant amount of blood was coming from the resident's left lower extremity. CNA #366 assisted with grabbing towels to hold pressure on the area. LPN #401 could not get the bleeding to stop. She wrapped the resident's leg, obtained vital signs, and sent the resident to the ER. A telephone interview on 01/20/26 at 3:31 P.M. with CNA #366 revealed 08/07/25 was the first time she had been assigned to care for Resident #26; although she had previously helped other CNAs with the resident's care. CNA #366 revealed on this date between 5:00 P.M. and 6:00 P.M. she was assisting Resident #26 to bed, because her shift ended at 7:00 P.M. CNA #366 stated while transferring Resident #26 from her wheelchair to bed, the resident scraped her leg on the side of the wheelchair leg rest. CNA #366 stated she was alone when she transferred Resident #26, and she had to go get the nurse. CNA #366 stated Resident #26's leg immediately started bleeding, which was why she went to get the nurse. CNA #366 stated the resident skin was so thin and the nurse called the doctor and they sent the (continued on next page)

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	01/26/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident out (to the hospital). During the interview, CNA #366 stated the resident was not heavy and she felt due to the resident's weight she could transfer her alone. The CNA did not recall or provide any additional information as to what level of assistance the resident required per her plan of care . A telephone interview on 01/21/26 at 9:51 A.M. with CNA #400 revealed she did not recall Resident #26 having a fall in August 2025 and if there was a fall she stated she would have completed a witness statement. The CNA then revealed the DON had recently called and wanted her to complete a statement for a fall now after all these months later. CNA #400 stated Resident #26 was pretty much total care but could stand depending on her mind set and strength. CNA #400 stated Resident #26 was not able to take off her socks or bottoms and to her knowledge, there were no issues with her wearing (non-skid) socks. CNA #400 stated Resident #26 did not wear shoes due to having very thin skin and easily getting skin tears. Interview on 01/21/26 at 11:32 A.M. with the DON verified there was one aide transferring Resident #26 when the skin tear occurred on 08/07/25, and the care plan in place for the resident identified the resident required two staff assist for transfers. The DON stated the resident had dementia and thin skin. The DON also stated Resident #26 could take off socks and clothes but verified there was no documented evidence related to the resident taking off socks or not wanting socks on. The DON verified there was no statement from CNA (#400) who was assigned to Resident #26 on 08/07/25 following the resident's fall. The DON also verified the incident report indicated Resident #26 was barefoot and the care plan indicated encourage non-skid socks as tolerated. Interview on 01/22/26 at 8:47 A.M. with the DON and Physical Therapist (PT) #402 revealed Resident #26 had been discharged from PT on 07/27/25 with discharge recommendations for minimal assistance from staff, indicating one person assist, for transfers. However, the DON verified the care plan had not been updated to include this change from therapy. The DON stated MDS staff were responsible for updating care plans and when the care plan was updated it would also update the Kardex for the aides. Interview on 01/22/26 at 10:15 A.M. with the DON verified the MDS assessments dated 07/07/25 and 09/26/25 indicated Resident #26 was dependent on staff for transfers. Interviews on 01/22/26 at 10:24 A.M. and at 10:38 A.M. with MDS LPN #302 revealed the MDS assessment data was obtained from the charting by the CNA staff, nurses and therapy. MDS LPN #302 stated dependent on staff indicated two-person assist, and substantial/maximal assistance provided more than 50% of the effort done by staff.Review of the policy Fall Prevention and Management Policy, revised 08/26/24, revealed residents would be assessed for fall risk(s) on admission, quarterly, and as needed. If risks were identified, preventive measures would be in place and care planned. All falls would be reviewed and investigated. This deficiency represents non-compliance investigated under Complaint Number 1306236 (OH00167206).

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 01/26/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to ensure oxygen tubing was dated as changed weekly for equipment management and infection control. This affected one resident (Resident #56) of nine residents identified as utilizing oxygen (Residents #7, #13, #22, #35, #43, #49, #56, #61 and #73). The facility census was 57.Findings include:A review of the medical records for Resident #56 revealed the date of admission as 08/28/25. Significant diagnoses included multiple sclerosis, chronic respiratory failure with hypoxia (low oxygen level), tracheostomy (a tube inserted through the neck to maintain an airway) status, encephalitis (inflammation of the brain) and encephalomyelitis (inflammation of the brain and spinal cord). Significant orders included oxygen via tracheostomy collar at five liters per minute to maintain an oxygen level of greater than 90 percent, clean oxygen concentrator and filter, change tubing weekly (every seven days) and change out disposable respiratory supplies weekly.A review of the quarterly Minimum Data Set assessment (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00 (Resident rarely understood or severe cognitive deficit). Section O of the MDS revealed Resident #56 utilized oxygen therapy.A care plan reviewed/revised on 11/27/25 revealed Resident #56 required oxygen therapy related to a diagnosis of chronic respiratory failure, presence of tracheostomy and multiple sclerosis. Interventions included changing tubing weekly; cleaning equipment and filters weekly.On 01/20/26 at 1:55 P.M. an observation of Resident #56 revealed them in bed. Oxygen was being administered via a tracheostomy mask. The oxygen tubing was dated 12/25/25. Certified Nurse Aide (CNA) #361 verified the oxygen tubing was dated 12/25/25 at the time of the observation.A review of the facility policy titled; Oxygen Administration (all routes), revised on 06/23/25, revealed licensed clinicians with demonstrated competence will administer oxygen via the specified route as ordered by a provider. The policy further revealed to change tubing, mask, cannula weekly and document in the electronic health record (EHR).This deficiency represents non-compliance investigated under Master Complaint Number 2687582.