

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  04/09/2026
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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY</b> Based on observation of video footage, closed medical record review, Self-Reported Incident review, review of witness statements, policy review, and interview, the facility failed to protect Resident #70's right to be free from physical abuse by Certified Nursing Assistant (CNA) #80. This resulted in Immediate Jeopardy and Actual Harm on 03/02/26 when Certified Nursing Assistant (CNA) #80 was observed via facility video footage physically assaulting Resident #70, a resident who was alert and oriented and totally dependent on staff for all activities of daily living (ADL). On 03/02/26 at approximately 11:35 P.M. facility video footage captured CNA #80 entering Resident #70's room without knocking and proceeding to begin providing Resident #70 incontinence care without permission from the resident. At 11:37 P.M., CNA #80 rolled Resident #70 onto his left side toward the wall and then rolled him onto his back in a rough manner. At 11:38 P.M., CNA #80 struck Resident #70 in the face with her right hand, appeared to be yelling at Resident #70 and pointing her fingers in his face. CNA #80 continued with Resident #70's care and rolled him onto his right side and again rolled him onto his back in a rough manner and struck him in the face a second time. CNA #80 struck Resident #70 a third time in the face and was noted to throw a pillow directly over Resident #70's face during the altercation while continuing to point her finger in his face. As a result of the physical assault/abuse, Resident #70 sustained a bloody right nostril and a deviated nose. Resident #70 was subsequently transferred to the hospital for a nine-day hospital stay and was diagnosed with a comminuted left nasal bone fracture with minimal displacement, nondisplaced right nasal bone fracture, left lateral deviation of the nose, and a perforated nasal septum. On 03/30/26 at 2:54 P.M., the Administrator and Regional Director of Clinical Operations (RDCO) #500 were notified Immediate Jeopardy began on 03/02/26 at approximately 11:35 P.M. when facility video footage captured CNA #80 physically assaulting/abusing Resident #70. Following the incident, CNA #80 continued to work the remainder of her shift. The resident's family member visited the next morning and was informed of the incident by the resident. The CNA was then suspended and subsequently arrested and charged with felonious assault and patient abuse. This affected one resident (#70) of three residents reviewed for abuse. The facility census was 69. The Immediate Jeopardy was removed on 03/03/26 and continued at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) until it was subsequently corrected on 03/06/26 when the facility implemented the following corrective actions: -On 03/03/26 the Regional Director of Clinical Services (RDCS) #501 completed a head to toe assessment on Resident #70 including a pain assessment. -On 03/03/26 the Administrator initiated an investigation, a Self-Reported Incident (SRI) for potential physical abuse was submitted to the State agency at 9:28 A.M., and a statement was obtained from CNA #80. The CNA was suspended pending investigation. The facility concluded their SRI investigation on 03/06/26 at 2:54 P.M substantiating that physical abuse had occurred. CNA #80 was terminated following the conclusion of the investigation. -On 03/03/26 at 8:53 A.M. the Director of Nursing (DON) authored a progress note indicating Resident (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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>#70's physician was notified of the physical abuse allegation and the resident asked to go to the hospital. The physician indicated the resident could be transferred to the hospital if he requested to go. -On 03/03/26 at 9:27 A.M. the Administrator notified local police of the incident. The report referenced when staff arrived for day shift on 03/03/26 at approximately 7:00 A.M., they were told by Resident #70 that he had been assaulted by a staff member during the early morning hours. The report indicated Resident #70 named CNA #80 as the staff who had assaulted him and stated she was rough with him and struck him in the nose and face. The police report noted the resident had what appeared to be dried blood in the corner of his right nostril, and his nose appeared to be deviated to the right. The police report noted the resident requested medical attention and facility staff indicated they would arrange transport to the hospital for evaluation. -On 03/03/26 at 1:46 P.M. Resident #70 was transferred to the local hospital for an evaluation of his facial injuries. -On 03/03/26 the Director of Nursing (DON)/designee completed interviews related to abuse and neglect for 45 residents who had a Brief Interview for Mental Status (BIMS) greater than 09. -On 03/03/26 Licensed Practical Nurse (LPN) #419, ADON #510, and Former DON #507 completed a whole house audit of skin assessments to identify any potential injuries or signs of abuse. Out of 64 in-house residents on 03/03/26, 60 skin assessments were completed with Residents #24, #66, #71, and #72 refusing to have their skin assessed. -On 03/03/26 Human Resource (HR) Director #403/designee reviewed all staff files to ensure all staff were currently in good standing to work at the facility. HR Director #403 rechecked all staff through the Nurse Aide Registry. Shift Seekers Agency (CNA #80's employer) completed the same audit. -Beginning on 03/03/26 and completed on 03/06/26 Mobile Administrator and RDCS #500 completed a Root Cause Analysis (RCA) regarding the incident with Resident #70. The root cause noted the facility was unable to prevent resident abuse due to lack of empathy for the resident's condition because she (CNA #80) had a lack of understanding to care for residents with behavioral issues. It stated the staff was unable to separate personal feelings from resident behaviors and there was a lack of comprehension of education. -On 03/03/26 and 03/04/26 the Administrator/designee educated current staff on the facility abuse/neglect policy, including rough care, and reporting protocols. This included the Admissions Director, one dietitian, one security staff, one social service director, two activity staff members, four environmental services staff members, six registered nurses (RN), eight dietary staff, eight licensed practical nurses (LPN), and 23 certified nursing assistants (CNAs). The community's internal agency staff were educated by Shift Seekers management on the abuse/neglect policy, including rough care, and reporting protocols. Those employees not educated during that time would be educated prior to their next shift. New facility and new agency employees would be educated on the facility's abuse procedures during new hire orientation prior to working directly with residents. -Beginning on 03/03/26 the facility implemented a plan to monitor and maintain ongoing compliance. The Director of Nursing (DON)/designee would complete interviews of five capable residents weekly for four weeks then monthly for two months related to abuse and neglect. Negative findings would be addressed and Ad-Hoc education would be completed as needed. The results of the audits would be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations. -Beginning on 03/03/26 to monitor and maintain ongoing compliance the Director of Nursing (DON)/designee would complete body checks on five residents who were unable to be interviewed, weekly for four weeks then monthly for two months to ensure there were no signs or symptoms of abuse/neglect. Negative findings would be addressed and Ad-Hoc education would be completed as needed. The results of the audits would be forwarded to the facility QAPI committee for further review and recommendations. -Beginning on 03/03/26 to monitor and maintain ongoing compliance Social Worker (SW) #415/designee would quiz employees weekly for four weeks then monthly for two months to verify understanding of the abuse/neglect policy and reporting requirements. Negative findings would be addressed and Ad-Hoc education would be completed as needed. The results of the audits would be forwarded to the facility QAPI committee for further review and recommendations. -Beginning on (continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>03/03/26 to monitor and maintain ongoing compliance the DON/designee will review behavior observations five days a week for four weeks then monthly for two months to ensure staff provide two caregivers in high behavior situations. Negative findings would be addressed and Ad-Hoc education would be completed as needed. The results of the audits would be forwarded to the facility QAPI committee for further review and recommendations. -On 03/04/26, an Ad-Hoc QAPI meeting was held with the Interdisciplinary Team (IDT) including Medical Director #503, the Administrator, Admissions #464, Minimum Data Set (MDS) Nurse #430, HR #403, ADON #510, Activities #426, Maintenance Director #448, SW #415, and the DON to review the incident/event and the QAPI plan put into place. -On 03/04/26 through 03/05/26 Minimum Data Set (MDS) Nurse #430 and the DON assessed all residents who were considered at high risk for any type of behavior. Ten residents (#20, #29, #33, #44, #50, #54, #62, #65, #66, and #70) were identified with behaviors, with one resident (#66) identified with aggressive behaviors. The resident's care plan was updated to include the requirement for two caregivers in high behavior/aggressive situations. High behavior situations were determined by observations including but not limited to verbal aggression, physical aggression, refusal of care. A list would be maintained at the nurses' stations that identified any residents with behaviors, and this information was also included on the nursing staff's home screen in the electronic medical record (EMR). The facility additionally implemented a behavior charting section for CNAs to chart whether all residents had or did not have behaviors on their shift. -On 03/05/26, the Administrator, DON, Assistant Director of Nursing (ADON) and Corporate Nurse Educator #502 conducted all staff training to the Admissions Director, one dietitian, one security staff, one social service director, two activity staff members, four environmental services staff members, six RNs, eight dietary staff, eight LPNs, and 23 CNAs which included various topics such as customer service, sensitivity training, dignity and respect, deescalation of behaviors, managing of behaviors, and resident rights. The education topics included staff education about the two-caregiver requirement during high behavior situations, how those situations were determined, and that the information was maintained at the nurses' station in the EMR. Additionally, RN #505 from Shift Seekers Agency educated all Shift Seekers staff regarding the same topics. New facility and new agency employees would be educated on the facility's procedures during new hire orientation prior to working directly with residents. -On 03/06/26 CNA #80's employment with Shift Seekers was terminated for reasons of physical and verbal abuse of a resident. Findings include: Review of Resident #70's closed medical record revealed an admission date of 04/01/25 and a discharge date of 03/03/26. Resident #70's diagnoses included multiple sclerosis (MS), quadriplegia, muscle weakness, falls, failure to thrive and dysphagia (difficulty swallowing). Review of the care plan dated 01/14/26 revealed Resident #70 had hearing loss. Interventions included to face the resident when speaking, obtain the resident's attention before speaking, speak clearly and adjust tone as needed. The resident had a plan of care reflecting he was at risk for altered mood related to depression and medical diagnoses. Interventions included administer medications as ordered, allow resident to vent through feelings, approach in a calm and relaxed manner, re-direct when resistive of care, ensure resident was safe and leave for a short period of time and reapproach to assist with care, attempt to reduce stressors as much as possible, explain all procedures and care before beginning to assist and ensure resident feels safe in the environment. Resident #70 had a plan of care related to incontinence of bowel and bladder. Interventions included to check for incontinence at regular intervals and provide incontinence care as needed. Resident #70 also had a plan of care for self-care deficits related to MS and quadriplegia. Interventions included to assist with activities of daily living (ADL) that included dressing, grooming, toileting, and feeding, and mechanical lift transfers. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #70 had intact cognition. The assessment revealed Resident #70 had behaviors that included rejection of care. It noted he was dependent with eating, toileting, bathing and personal hygiene and was incontinent of bowel and bladder. Review of a progress note dated 02/24/26 timed 1:05 P.M. and authored by Former Director of Nursing (DON) #507 (continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>revealed Resident #70 had increased behaviors that included cursing at staff upon providing care. Review of the progress note dated 03/03/36 timed 8:31 A.M. and authored by Former (DON) #507 revealed Resident #70's family member had stated at approximately 12:00 A.M. an aide was providing care and was rough while turning him. Resident #70 complained of facial pain specific to his nose area and Resident #70 had alleged the aide had stuck him on the nose. The resident's physician, representative, and police were notified and an investigation had been initiated. Review of the progress note dated 03/03/26 timed 8:53 A.M. authored by Former DON #507 revealed the resident's physician had been notified of the allegation and Resident #70's request to be taken to the hospital. The physician ordered to send Resident #70 to the hospital per the resident's request. Review of facility self-reported incident (SRI) tracking number 271645 dated 03/03/26 revealed Resident #70's family member had reported an aide (identified to be CNA #80) had handled the resident in a rough manner and he had gotten hit in the nose by the aide while she was providing care. Upon assessment, Resident #70 had a small amount of blood under his nostril and his nose appeared to be deviated. Resident #70 was transported to the hospital and was admitted with multiple facial fractures. The SRI facility investigation revealed the facility conducted staff interviews, obtained staff statements, resident interviews and skin assessments, the resident's family and physician were notified, the police were notified, education regarding abuse and neglect was provided to all staff, and CNA #80 was suspended pending the results of the investigation. Additionally, the SRI results substantiated abuse had occurred. Review of police report #26-07370 dated 03/03/26 timed 9:27 A.M. revealed Resident #70 had reported a night shift aide (CNA #80) had punched him in the face. Interview with Resident #70 by the local police revealed Resident #70 was unable to write a statement and spoke in a very low tone equivalent to a whisper. Resident #70 stated just after midnight, CNA #80 had entered his room to change him, and she had been moving in an aggressive manner and Resident #70 had informed CNA #80 she had been rough with him. It noted CNA #80 had struck him in the face, specifically his nose with a closed fist. The report included photos had been taken and Resident #70 had what appeared to be dried blood in the corner of his right nostril and his nose appeared to be deviated to the right. During the on-site investigation, observation of facility video footage timestamped 03/02/26 at 11:35 P.M. (with Regional Director of Clinical Services (RDCO) #500) revealed the facility camera had no audio and was angled in the hallway outside Resident #70's room so there was a view of Resident #70's bed against the wall by the door. Resident #70 was asleep while wearing glasses. CNA #80 entered Resident #70's room, without knocking, used the bed controller to lower the head of the bed and lower the bed toward the ground then removed the sheets and lifted Resident #70's hospital gown exposing his incontinence brief while Resident #70 was still asleep. CNA #80 slightly closed the door; however, Resident #70 and Resident #70's bed could still be viewed from the facility hallway camera. CNA #80 then opened Resident #70's brief while he was still asleep. At 11:37 P.M., CNA #80 rolled the resident on his left side towards the wall, removed the incontinence brief and applied a new incontinence brief underneath him. CNA #80 rolled the resident onto his back in a rough manner as he had quickly fallen onto the mattress, and she secured the brief. At 11:38 P.M., CNA #80 made a swift, swinging motion with both of her hands (unable to determine open palms or closed fists) toward Resident #70's face which resulted in the resident's body and mattress shaking from the force of the slap/hit. CNA #80 stepped out of view of the camera then came back into view and was standing/hovering over Resident #70 and his bed while CNA #80 was pointing her right pointer finger, then appeared to touch his face with her right pointer finger which slightly shook the resident's body from the force. CNA #80 then pointed to herself then back to him while still standing/hovering over him. CNA #80's mouth was moving while pointing at him. CNA #80 adjusted the resident's brief then was observed to slap Resident #70 with an open palm to his upper chest and/or face (unable to determine as the wall was now blocking the view of his head) with her left hand and his body and pillow shook from the force. CNA #80 used both hands to roll the resident on his right side then let go of him to roll him back onto his back, then used a closed left fist to hit his (continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>right upper shoulder, right upper chest and/or face (unable to determine as the wall blocked the view of his head). CNA #80 adjusted his brief again and covered his brief with the hospital gown. CNA #80 was then observed to throw a pillow at Resident #70's upper chest and face and left the pillow there as CNA #80 was applying the resident's sheets, she covered his body and the pillow on his face with the sheet. At 11:39 P.M., CNA #80 hit Resident #70 in the chest with the pillow using her left hand, then pointed at him with her left hand while the pillow was removed, then held the pillow with force over his face with her right hand for approximately two seconds then removed her hand; however, she left the pillow on his face. CNA #80 then raised the head of the bed with the pillow still on Resident #70's face. After CNA #80 raised the head of the bed, CNA #80 removed the pillow from Resident #70's upper chest and face area and [NAME] the pillow at the foot of the bed. RN #511 was seen walking from the nurses' station with her hands behind her back towards Resident #70's room then she peeked into Resident #70's cracked doorway. CNA #80 appeared to be wiping Resident #70's face. At 11:40 P.M., RN #511 entered Resident #70's room. CNA #80 pointed her right finger at or on Resident #70's mouth then held up a cloth when it appeared Resident #70 spit at CNA #80. Review of the progress note dated 03/03/26 timed 1:46 P.M. and authored by ADON #510 revealed Resident #70 had been transported to the hospital. Review of the progress note dated 03/03/26 timed 4:40 P.M. and authored by Former DON #507 revealed Resident #70 was admitted to the hospital for facial fractures. Review of hospital paperwork dated 03/03/26 revealed Resident #70 presented to the emergency department with reports of an assault at the facility. Upon admission to the hospital, computed tomography (CT) imaging revealed a comminuted left nasal bone fracture with minimal displacement, nondisplaced right nasal bone fracture, left lateral deviation of the nose and perforated nasal septum. Discharge planning included a request for transfer to a new facility. Review of CNA #80's undated statement revealed she had provided routine care for Resident #70 and at no time had she treated him like a rag doll or hit him. CNA #80 further stated at approximately 7:00 P.M. she had entered Resident #70's room and introduced herself and she proceeded to check if he needed incontinence care and Resident #70 had immediately begun using racial slurs and derogatory language. At 11:00 P.M. CNA #80 stated she had provided Resident #70 with routine care, and he had begun calling her derogatory and racial names and spit on her. CNA #80 stated she had maintained appropriate technique and ensured Resident #70's safety. CNA #80 stated an unnamed nurse had heard Resident #70 and had entered to de-escalate. CNA #80 denied she or the nurse had observed any blood from Resident #70's face. CNA #80 further stated due to Resident #70's escalating verbal aggression and spitting during her rounds at 4:00 A.M. she had called the unnamed nurse on duty to assist. Upon arriving to Resident #70's room, he had proceeded to call her derogatory names and spit on her at which time the nurse had advised her to discontinue care and they had left the room. Review of Registered Nurse (RN) #511's statement dated 03/04/26 timed 8:42 P.M. revealed on 03/02/26 at approximately 8:30 P.M. she had entered Resident #70's room to administer medications and Resident #70 was calm and cooperative. At approximately 11:00 P.M. she had been informed by CNA #80 that during care, Resident #70 had begun yelling at her. RN #511 stated she had entered Resident #70's room and he had begun to yell at her and CNA #80, and was using inappropriate language and had asked them to leave his room. At approximately 4:45 A.M., RN #511 had returned to Resident #70's room to administer medications; however, Resident #70 was asleep. At 5:15 A.M., RN #511 returned to Resident #70's room per CNA #80's request and Resident #70 was verbally aggressive and had refused his medications and care. The statement documented staff had remained calm and professional throughout the interactions. Review of Former DON #507 undated statement revealed at 8:30 A.M. Resident #70 had been interviewed and alleged a night shift aide had punched him in the nose, stated the aide had thrown me around like a rag roll and Resident #70 had told the aide to take it easy. Resident #70 had communicated as he was laying on his back, the aide had then punched him in the nose. Resident #70 had a small amount of blood underneath his right nostril and his septum was deviated to the right. Review of the termination letter dated 03/06/26 revealed CNA #80 was (continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>terminated due to physical or verbal abuse of a resident. Review of an indictment dated 03/19/26 revealed CNA #80 was indicted for knowingly causing serious physical harm to another and was charged with felonious assault, a felony in the second degree, knowingly caused or attempted to cause physical harm to another and the offense was committed by a caretaker against a person with a functional impairment, a felony in the fourth degree and committed abuse against a resident of the facility, an offense in the fourth degree. Interview on 03/30/26 at 10:35 A.M. and 12:15 P.M. with RDCO #500 revealed Resident #70 had a history of behaviors by using explicative language and racial slurs especially towards females and African American females. On the morning of 03/03/26, Resident #70's family member stopped in to visit Resident #70 which was normal for him to do. Resident #70's family member told an unnamed facility staff that Resident #70 stated that an aide was mean and rough with him. Former Administrator #504 interviewed Resident #70 that morning then opened an SRI. RDCO #500 verified the SRI for resident abuse was substantiated after viewing the video footage of CNA #80 and Resident #70. RDCO #500 also verified CNA #80 did not knock on the door prior to entering Resident #70's room, then CNA #80 held a pillow over Resident #70's face, slapped and/or hit Resident #70, and stood over Resident #70 while pointing at him during the altercation. An interview on 04/01/26 at 7:57 A.M. with RDCO #500 revealed she had reviewed the footage and had informed RN #511 of the inconsistencies in her written statement; however, RN #511 continued to state she had assisted CNA #80 with Resident #70's care and abuse had not occurred. RDCO #500 further stated RN #511 had been terminated due to her false statement and not cooperating with the investigation and CNA #80 had also been terminated for resident abuse. RDCO #500 stated the police had been notified of the incident and Resident #70 requested to go to the hospital after he had spoken with the police. RDCO #500 stated Resident #70 was admitted to the hospital for facial fractures and had not returned to the facility. A telephone interview on 04/01/26 at 8:36 A.M. with Resident #70's family member revealed he had arrived at the facility on the morning of 03/03/26 at approximately 8:30 A.M. and Resident #70 had stated at around midnight an aide had been rough with him during care, Resident #70 stated to the aide to settle down and she punched him in the face. Resident #70's family member further stated the resident knew his nose was broken and it was painful and he wanted to go to the hospital. Resident #70's family member stated he had immediately informed the Administrator of what Resident #70 had said. On 04/01/26 at 9:08 A.M. Resident #70's family member arrived to the facility to speak with the surveyor. The family member was asked how Resident #70 was doing, and he stated he would rather not give any information about where Resident #70 was residing due to Resident #70 was fearful CNA #80 would come to the new facility. Resident #70's family member further stated when he had arrived at the facility [on 03/03/26] he had observed dried blood under Resident #70's nose but no other apparent injuries. Resident #70's family member divulged that Resident #70 had stated the aide had hit him with a closed fist after he had asked her to take it easy. Resident #70 had stated he wanted to press charges and stated the police were called. Interview on 04/01/26 at 11:27 A.M. with RDCO #501 revealed she had reviewed the camera footage and confirmed she had observed CNA #80 strike Resident #70. RDCO #501 stated Former Administrator #504 had initiated an SRI and the police had been called. RDCO #501 stated staff statements were obtained, and RN #511 had been terminated due to her false statement of being in Resident #70's room during care and stated CNA #80 had also been terminated for resident abuse. A telephone interview on 04/02/26 at 1:16 P.M. with Former DON #507 revealed on the morning of 03/03/26 at approximately 8:30 A.M., Resident #70's family member had informed staff of the allegation of abuse. Former DON #507 stated she immediately went to Resident #70's room and Resident #70 stated at approximately 11:00 P.M. to 11:30 P.M. an aide had punched him in the face. The Former DON stated she had observed a small amount of dried blood under his nose and Resident #70 was asked if he was having pain and had stated Duh. Former DON #507 stated she immediately contacted the police who arrived shortly after and had taken Resident #70's statement. Former DON #507 stated Resident #70 also requested to be taken to the hospital. Former DON #507 stated she (continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>reviewed the camera footage and observed CNA #80 strike Resident #70. She further stated she observed RN #511 had not been present in the room during care and CNA #80 and RN #511 had been suspended during the investigation and then were terminated. A telephone interview on 04/02/26 at 2:35 P.M. with RN #511 revealed she had been terminated by the facility because they had said she had lied on her statement regarding the incident with Resident #70. RN #511 stated on the evening of 03/02/26 at approximately 8:30 P.M. she administered Resident #70's medications and he was calm and cooperative. RN #511 stated later in the shift between 11:00 P.M. and 11:30 P.M., CNA #80 informed her Resident #70 was agitated and had been calling her names and refused care. RN #511 stated she had not observed CNA #80 strike Resident #70 or being rough with him and Resident #70 had not expressed any concerns. RN #511 stated she then returned to Resident #70's room with CNA #80 at approximately 4:00 A.M. and Resident #70 was sleeping. She went back to the resident's room at approximately 5:15 A.M. to administer his medications and he refused. RN #511 stated she had not observed any injuries or any blood on his face and Resident #70 had not expressed any concerns. Review of facility policy titled Ohio Resident Abuse Policy reviewed 07/02/25 revealed facility staff must immediately report all allegations to the Administrator and will immediately begin an investigation. Physical abuse was defined as hitting, slapping and included controlling behaviors through corporal punishment. Prevention and identification included the assessment, care planning and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors. This deficiency represents non-compliance investigated under Master Complaint Number 2806407 and Complaint Number 2804863.</p>		

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  04/09/2026
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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, record review, policy review, and video camera footage. the facility failed to ensure residents were assessed following reported aggressive behaviors. This affected one resident (#70) of three (#11, #66 and #70) reviewed for aggressive behaviors. The facility census was 69. Findings Include: Findings include: Review of Resident #70's closed medical record revealed an admission date of 04/01/25 and a discharge date of 03/03/26. Resident #70's diagnoses included multiple sclerosis (MS), quadriplegia, muscle weakness, falls, failure to thrive and dysphagia (difficulty swallowing). Review of the care plan dated 01/14/26 revealed Resident #70 had hearing loss. Interventions included to face the resident when speaking, obtain the resident's attention before speaking, speak clearly and adjust tone as needed. The resident had a plan of care reflecting he was at risk for altered mood related to depression and medical diagnoses. Interventions included administer medications as ordered, allow resident to vent through feelings, approach in a calm and relaxed manner, re-direct when resistive of care, ensure resident was safe and leave for a short period of time and reapproach to assist with care, attempt to reduce stressors as much as possible, explain all procedures and care before beginning to assist and ensure resident feels safe in the environment. Resident #70 had a plan of care related to incontinence of bowel and bladder. Interventions included to check for incontinence at regular intervals and provide incontinence care as needed. Resident #70 also had a plan of care for self-care deficits related to MS and quadriplegia. Interventions included to assist with activities of daily living (ADL) that included dressing, grooming, toileting, and feeding, and mechanical lift transfers. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #70 had intact cognition. The assessment revealed Resident #70 had behaviors that included rejection of care. It noted he was dependent with eating, toileting, bathing and personal hygiene and was incontinent of bowel and bladder. Review of a progress note dated 02/24/26 timed 1:05 P.M. and authored by Former Director of Nursing (DON) #507 revealed Resident #70 had increased behaviors that included cursing at staff upon providing care. Review of facility self-reported incident (SRI) tracking number 271645 dated 03/03/26 revealed Resident #70's family member had reported an aide (identified to be CNA #80) had handled the resident in a rough manner and he had gotten hit in the nose by the aide while she was providing care. Upon assessment, Resident #70 had a small amount of blood under his nostril and his nose appeared to be deviated. Resident #70 was transported to the hospital and was admitted with multiple facial fractures. The SRI facility investigation revealed the facility conducted staff interviews, obtained staff statements, resident interviews and skin assessments, the resident's family and physician were notified, the police were notified, education regarding abuse and neglect was provided to all staff, and CNA #80 was suspended pending the results of the investigation. Additionally, the SRI results substantiated abuse had occurred. During the on-site investigation, observation of facility video footage timestamped 03/02/26 at 11:35 P.M. (with Regional Director of Clinical Services (RDCO) #500) revealed the facility camera had no audio and was angled in the hallway outside Resident #70's room so there was a view of Resident #70's bed against the wall by the door. Resident #70 was asleep while wearing glasses. CNA #80 entered Resident #70's room, without knocking, used the bed controller to lower the head of the bed and lower the bed toward the ground then removed the sheets and lifted Resident #70's hospital gown exposing his incontinence brief while Resident #70 was still asleep. CNA #80 slightly closed the door; however, Resident #70 and Resident #70's bed could still be viewed from the facility hallway camera. CNA #80 then opened Resident #70's brief while he was still asleep. At 11:37 P.M., CNA #80 rolled the resident on his left side towards the wall, removed the incontinence brief and applied a new incontinence brief underneath him. CNA #80 rolled the resident onto his back in a rough manner as he had quickly fallen onto the mattress, and she secured the brief. At 11:38 P.M., CNA #80 made a swift, swinging motion with both of her hands (unable to determine open palms or closed fists) toward Resident #70's face (continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>which resulted in the resident's body and mattress shaking from the force of the slap/hit. CNA #80 stepped out of view of the camera then came back into view and was standing/hovering over Resident #70 and his bed while CNA #80 was pointing her right pointer finger, then appeared to touch his face with her right pointer finger which slightly shook the resident's body from the force. CNA #80 then pointed to herself then back to him while still standing/hovering over him. CNA #80's mouth was moving while pointing at him. CNA #80 adjusted the resident's brief then was observed to slap Resident #70 with an open palm to his upper chest and/or face (unable to determine as the wall was now blocking the view of his head) with her left hand and his body and pillow shook from the force. CNA #80 used both hands to roll the resident on his right side then let go of him to roll him back onto his back, then used a closed left fist to hit his right upper shoulder, right upper chest and/or face (unable to determine as the wall blocked the view of his head). CNA #80 adjusted his brief again and covered his brief with the hospital gown. CNA #80 was then observed to throw a pillow at Resident #70's upper chest and face and left the pillow there as CNA #80 was applying the resident's sheets, she covered his body and the pillow on his face with the sheet. At 11:39 P.M., CNA #80 hit Resident #70 in the chest with the pillow using her left hand, then pointed at him with her left hand while the pillow was removed, then held the pillow with force over his face with her right hand for approximately two seconds then removed her hand; however, she left the pillow on his face. CNA #80 then raised the head of the bed with the pillow still on Resident #70's face. After CNA #80 raised the head of the bed, CNA #80 removed the pillow from Resident #70's upper chest and face area and [NAME] the pillow at the foot of the bed. RN #511 was seen walking from the nurses' station with her hands behind her back towards Resident #70's room then she peeked into Resident #70's cracked doorway. CNA #80 appeared to be wiping Resident #70's face. At 11:40 P.M., RN #511 entered Resident #70's room. CNA #80 pointed her right finger at or on Resident #70's mouth then held up a cloth when it appeared Resident #70 spit at CNA #80. Review of CNA #80's undated statement revealed she had provided routine care for Resident #70 and at no time had she treated him like a rag doll or hit him. CNA #80 further stated at approximately 7:00 P.M. she had entered Resident #70's room and introduced herself and she proceeded to check if he needed incontinence care and Resident #70 had immediately begun using racial slurs and derogatory language. At 11:00 P.M. CNA #80 stated she had provided Resident #70 with routine care, and he had begun calling her derogatory and racial names and spit on her. CNA #80 stated she had maintained appropriate technique and ensured Resident #70's safety. CNA #80 stated an unnamed nurse had heard Resident #70 and had entered to de-escalate. CNA #80 denied she or the nurse had observed any blood from Resident #70's face. CNA #80 further stated due to Resident #70s' escalating verbal aggression and spitting during her rounds at 4:00 A.M. she had called the unnamed nurse on duty to assist. Upon arriving to Resident #70's room, he had proceeded to call her derogatory names and spit on her at which time the nurse had advised her to discontinue care and they had left the room. Review of Registered Nurse (RN) #511's statement dated 03/04/26 timed 8:42 P.M. revealed on 03/02/26 at approximately 8:30 P.M. she had entered Resident #70's room to administer medications and Resident #70 was calm and cooperative. At approximately 11:00 P.M. she had been informed by CNA #80 that during care, Resident #70 had begun yelling at her. RN #511 stated she had entered Resident #70's room and he had begun to yell at her and CNA #80, and was using inappropriate language and had asked them to leave his room. At approximately 4:45 A.M., RN #511 had returned to Resident #70's room to administer medications; however, Resident #70 was asleep. At 5:15 A.M., RN #511 returned to Resident #70's room per CNA #80's request and Resident #70 was verbally aggressive and had refused his medications and care. The statement documented staff had remained calm and professional throughout the interactions. Telephone interview on 04/02/26 at 1:16 P.M. with Former Director of Nursing (DON) #507 revealed RN #511 should have assessed Resident #70 for the aggressive behaviors CNA #80 had reported to her, and she should have also reported his behaviors accordingly. Review of facility policy titled Ohio Resident Abuse Policy reviewed 07/02/25 revealed facility staff must immediately report all (continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>allegations to the Administrator and will immediately begin an investigation. Physical abuse was defined as hitting, slapping and included controlling behaviors through corporal punishment. Prevention and identification included the assessment, care planning and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors. Review of facility policy titled Behavior Management Program revised 03/02/26 revealed if a resident presents with behaviors that will harm others, the facility will immediately implement keep safe interventions, notify the provider and follow and specific state protocols required. This deficiency represents non-compliance investigated under Complaint Number 2806407.</p>		