STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365072	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anna Maria of Aurora	889 North Aurora Road 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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, resident interview, staff interview, and facility policy review, the facility failed to ensure assistive hearing devices were in place to maintain hearing abilities. This affected one resident (#20) of one resident reviewed for assistive devices. The facility census was 87.Findings include: Review of the medical record for Resident #20 revealed she was admitted to the facility on [DATE] with diagnoses including paroxysmal atrial fibrillation, gastro-esophageal reflux disease without esophagitis, and chronic kidney disease.Review of the physician orders dated 06/01/25 revealed an order to place Resident #20's bilateral hearing aids in ears and lock hearing aids in medication cart as needed per request.Review of the care plan dated 09/16/25 revealed Resident #20 had potential for impaired communication and/or disorientation related to hard of hearing and wearing bilateral hearing aids. Interventions included assistance with the use of hearing aids as needed and place bilateral hearing aids in ears every morning and removed every night and lock in medication cart.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 12 that indicated she was alert and oriented with some cognition impairment. Review of the MDS assessment revealed Resident #20 required assistance from staff for activities of daily living (ADL).Review of the progress note dated 12/03/25 at 12:48 P.M. revealed Resident #20's new hearing aids with the new ear molds arrived to the facility.Observation and interview on 12/15/25 at 10:59 A.M. revealed Resident #20 seated in her wheelchair with family visiting. Resident #20 was observed yelling when asked questions and had trouble understanding family and state surveyor. Resident #20 stated speak louder, I can't hear what you're saying. Family revealed that Resident #20 had trouble hearing and had new hearing aids that were to be placed in her ears daily. Family revealed the facility staff were aware of Resident #20 hearing aids and the request to have them in daily. Family revealed the facility staff did not put them in Resident #20's ears as requested. Observation revealed Resident #20 did not have hearing aids in her ears at the time of the interview.Interview on 12/17/25 at 11:41 A.M. with Licensed Practical Nurse (LPN) #501 revealed Resident #20 was hard of hearing and wore hearing aids that were kept in the medication cart. LPN #501 revealed Resident #20 received a new set of hearing aids recently, approximately three weeks ago. LPN #501 revealed Resident #20's hearing aids were removed due to Resident #20 always brushing her hair behind her ears, which in return caused the hearing aids to fall out. LPN #501 revealed Resident #20's family requested staff to have the hearing aids placed in her ears. LPN #501 revealed she did not ask Resident #20 if she wanted her hearing aids placed in her ear.Observation and interview on 12/17/25 at 12:08 P.M., approximately 34 minutes later, Resident #20 was observed in her room seated in her wheelchair attempting to put a hearing aid into her left ear. Resident #20 stated no one helps me put them in. I'm trying to put them in. Resident #20 was observed continuously trying to place hearing aids in her ears with shaky hands. Resident #20 appeared upset and stated, I can't hear anyone talk.Interview and observation on (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/17/25 at 12:09 A.M. with LPN #501 revealed she was unaware that Resident #20 was upset and attempting to put her hearing aids in her ears. LPN #501 stated I'll get the batteries and head down. LPN #501 confirmed and verified the above findings at the time of the interview and observations.Review of the undated facility document titled Resident Vision and Hearing Screening revealed the facility had a policy in place to identify, treat and monitor residents who have potential for hearing needs as indicated by assessments and/or resident and family. Review of the policy revealed the facility would ensure implementation of care plan interventions and monitoring. Review of the document revealed the facility did not implement the policy.

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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 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 the proper delivery of oxygen and accurately document its administration according to the physician orders and the resident's comprehensive care plans. This affected two residents (Resident #01 and Resident #17) out of four residents reviewed for oxygen/respiratory therapy. This had the potential to affect 15 additional residents (Residents #06, #07, #08, #22, #25, #37, #43, #49, #52, #53, #56, #62, #69, #80, and #82) with orders for oxygen. The facility census was 87.Findings include:1. Resident #01 was admitted on [DATE] with diagnoses of chronic diastolic congestive heart failure, chronic obstructive pulmonary disease (COPD), shortness of breath (SOB), and anemia. Review of the comprehensive care plan dated 08/29/25 for altered respiratory status related to a diagnosis of COPD, and SOB when lying flat at times. Intervention dated 10/02/25 included oxygen at two liters per minute via nasal cannula (a flexible plastic tube with two prongs that fit into the nostrils to deliver oxygen) for SOB and comfort as ordered. Additionally, the care plan documented an oxygen weaning program was initiated on 12/02/25 and failed. The care plan revealed there was no intervention for oxygen tubing changes. Review of December 2025 physician orders revealed a physician order dated 10/01/25 at 7:00 A.M. for Resident #01 to have oxygen at two liters per nasal cannula for SOB and comfort every shift. Resident #01 also had a physician order dated 10/07/25 at 11:00 P.M., for his oxygen tubing to be changed every Tuesday, every week on the night shift. Review of the December 2025 Medication Administration Record (MAR) revealed the oxygen at two liters per nasal cannula was signed off as administered each shift from 12/01/25 (day shift) through 12/15/25 (night shift). The evening shift of 12/06/25 was left blank on the MAR. Review of the December 2025 Treatment Administration Record (TAR) revealed the oxygen tubing was initialed as completed by Licensed Practical Nurse (LPN) #901 on 12/02/25 and 12/09/25. Review of the telephone order in the medical record revealed an order dated 12/02/25 at 9:30 A.M. for oxygen at two liters per nasal cannula for comfort and SOB. Review of the MAR for Resident #01 dated 12/02/25 at 12:00 P.M. revealed an order to check the pulse oximetry (a non-invasive device clipped on finger to check the percentage of oxygen in the blood) every four hours for 24 hours. Review of the December MAR pulse oximetry readings ranged from 95 percent to 99 percent during this time. Review of the MAR for Resident #01 dated 12/02/25 at 3:00 P.M. revealed an order to wean the oxygen as tolerated, with a goal for oxygen saturation to be maintained greater than 90 percent, document every shift regarding respiratory status, and include pulse oximetry for three days, every shift. Review of the nursing note dated 12/03/25 at 6:17 A.M. revealed the resident remained off oxygen the entire night shift, with a pulse oximetry of 97 percent on room air. Review of the nursing note dated 12/04/25 at 5:32 P.M. revealed Resident #01 remained on room air with a pulse oximetry of 97 percent. Review of the progress note dated 12/04/25 completed by Nurse Practitioner (NP) #424 revealed (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #01's oxygen saturation had been stable on room air. Review of the quarterly Minimum Data Set (MDS) 3.0, dated 12/04/25 Section O: Special Treatments, Procedures, and Programs revealed no documentation of oxygen therapy delivered. Review of the nursing note dated 12/06/25 at 10:30 A.M. revealed an oxygen saturation of 96 percent on room air. Observation on 12/15/25 at 2:58 P.M. revealed Resident #01 in his room seated in his wheelchair. The oxygen concentrator was next to the bed and not in use. The tubing on the concentrator was dated 11/26/25. Interview on 12/15/25 at 3:10 P.M. with the Director of Nursing (DON) verified the oxygen tubing in Resident #01's room was dated 11/26/25, and the TAR for oxygen tubing change was signed off on 12/02/25 and 12/09/25 by LPN #901 as being changed. The DON verified this documentation was not accurate in Resident #01's medical record. The DON also verified he was not wearing his oxygen. Observation on 12/16/25 at 12:45 P.M. revealed the oxygen tank in Resident #01's room was shut off, and in the room at the bedside. Observation at 12:48 P.M. revealed Resident #01 seated in the dining room eating lunch with his wife present. Resident #01 was not wearing oxygen per nasal cannula as ordered. Interview on 12/16/25 at 12:49 P.M. with Resident #01's wife revealed Resident #01 had not worn his oxygen for quite some time. The family member stated the resident was off the oxygen because the facility tested him and he did not need it. Interview on 12/16/25 at 12:55 P.M. with LPN #720 revealed Resident #01's current oxygen order was for two liters continuous per nasal cannula for SOB and comfort every shift, and he was not wearing his oxygen. Interview on 12/16/25 at 1:00 P.M. with the DON verified the current oxygen order dated 10/01/25 and 12/02/25 was for Resident #01 to have oxygen at two liters per nasal cannula continuous for SOB and comfort every shift. The DON verified the physician order dated 12/02/25 to check his pulse oximetry every four hours for 24 hours with attempt to wean off his oxygen was completed and his pulse oximetry readings were above 95 percent but confirmed that his oxygen order was not changed to an as needed basis. The DON confirmed his continuous oxygen order was signed off as administered on the MAR from 12/01/25 to 12/15/25, and he was not wearing it as documented in the nursing notes and observations. Interview on 12/16/25 at 2:05 P.M. with the DON verified the care plan documented an oxygen weaning program was initiated on 12/02/25 and that Resident #01 had failed the program, but she verified this was not accurate as his pulse oximetry readings were 95 percent or above. She also verified that the MDS documentation that the oxygen was not delivered during the assessment period was not accurate. 2. Review of medical record for Resident #17 revealed an admission date of 06/17/24 and her diagnoses included Alzheimer's disease, anemia, and dysphagia (difficulty swallowing). She did not have any respiratory diagnosis listed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of care plan dated 09/20/24 revealed Resident #17 had altered respiratory status related to complaints of SOB with exertion at times. Interventions included oxygen at two liters as needed per nursing judgement for comfort, and change oxygen tubing as ordered. Review of quarterly MDS assessment dated [DATE] revealed Resident #17 was cognitively impaired and used oxygen. Review of December 2025 physician order revealed Resident #17 had an order dated 05/02/25 for oxygen at two liters per nasal cannula as needed per nursing judgement for comfort. She had an order dated 06/12/25 to have her oxygen tubing changed every Tuesday on night shift. Review of December 2025 TAR revealed the oxygen tubing was initialed as replaced by LPN #901 on 12/02/25 and 12/09/25. Observation and interview on 12/15/25 at 10:14 A.M. revealed Resident #17 were sitting in her recliner, and she had an oxygen concentrator sitting next to her bed not in use. The nasal cannula connected to the concentrator had a piece of tape on the tubing dated 11/26/26. Interview with Resident #17 revealed she was unable to indicate when she wore her oxygen and/or when the last time she did due to cognitive impairment. Interview on 12/15/25 at 3:08 P.M. with the DON verified the oxygen tubing in Resident #17's room was dated 11/26/25. She verified Resident #17 had an order to change the tubing weekly, and the TAR was initialed as the tubing was changed on 12/02/25 and 12/09/25 by LPN #901. The DON verified this documentation was not accurate in Resident #17's medical record as the tubing in her room was dated 11/26/25, indicating the last time it was changed. Review of the facility policy labeled, Oxygen Administration, dated March 2004, revealed the purpose of the policy was to provide guidelines for safe oxygen administration. The policy revealed the nurse was to verify the physician's order, review the care plan and assemble the equipment. There was no documentation in the policy regarding changing oxygen tubing.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and facility policy review, the facility failed to maintain clean medication storage in the North and South medication carts. This affected 50 residents (Residents #01, #04, #05, #07, #09, #11, #13, #17, #18, #20, #22, #23, #27, #29, #32, #35, #37, #38, #40, #42, #43, #45, #46, #47, #48, #49, #51, #52, #53, #54, #59, #63, #64, #68, #69, #70, #74, #76, #78, #79, #80, #81, #82, #83, #85, #86, #87, #88, #99, #100) out of 50 residents on the North and South medication carts, and had the potential to affect all 87 residents residing in the facility.Findings include:Observation on 12/16/25 at 7:55 A.M. of the North medication cart with Licensed Practical Nurse (LPN) #720 revealed 18 unidentified pills on the bottom of the first and second drawers collectively, and powdered pill residue along the bottom and corners of the first and second medication cart drawers. Interview on 12/16/25 at 8:02 A.M. with LPN #720 for the North medication cart verified the number of loose medications, and the pill residue in the first and second medication cart drawers.Observation on 12/16/25 at 8:42 A.M. of the South medication cart with LPN #501 revealed two unidentified pills on the bottom of the second drawer. Interview on 12/16/25 at 8:42 A.M. with LPN #501 for the South medication cart, verified the two unidentified loose pills in the second drawer.Review of the undated facility document titled, Medication Storage in the Facility revealed medication storage areas are to be kept clean, well lit, and free of clutter.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of the kitchen cleaning logs, interviews and facility policy review, the facility failed to ensure the kitchen was maintained in a clean sanitary manner. The facility also failed to ensure the unit refrigerators for resident use were maintained as required. This had the potential to affect all 87 residents who received meals from the facility kitchen. The facility indicated there were no residents who received nothing by mouth. The facility census was 87.Findings include:1. Initial kitchen tour on 12/15/25 at 8:45 A.M. with Dietary Manager (DM) #700 revealed the following concerns:A. In the walk-in refrigerator there was:-a metal container of leftover egg salad with a use by date of 12/10/25-a metal container of leftover cranberry sauce with a use by date of 11/10/25-a metal container of leftover pumpkin puree with a use by date of 11/24/25-a Ziploc bag of leftover sliced turkey lunchmeat with a use by date of 12/12/25B. No thermometer was found in the walk-in freezerC. Scoops were located inside both the flour and sugar rolling bin carts sitting submerged in both the flour and sugar products.Observation on 12/15/25 at 9:00 A.M. with DM #700 revealed the six-burner gas stove was heavily soiled in and around the burner grates as well as the area around the griddle. The front of the stove was soiled with dried spills on the front and side of the stove. The area below the stove and surrounding the perimeter of the stove were heavily soiled and black in color. Observation on 12/15/25 at 9:02 A.M. with DM #700 revealed the convection oven was heavily soiled inside on the bottom below the racks.Observation on 12/15/25 at 9:05 A.M. with DM #700 of the two utensil drawers along the wall across from the oven revealed crumbs in the bottom of the drawers and the bottom of the right drawer had a dried white spill of unknown origin.Observation on 12/15/25 at 9:08 A.M. with DM #700 revealed hanging on the wall leading into the dish machine area was the three-compartment-sink sanitizer log for November and December 2025. The November log revealed 11/01/25 through 11/10/25 were completed and no additional dates for November were recorded. December 2025 log revealed only 12/06/25 and 12/07/25 were completed.Observation on 12/15/25 at 9:10 A.M. with DM #700 of the dish machine temperature log for December 2025 hanging on the wall leading into the dish machine area revealed it was supposed to be completed after each meal prior to starting the dish machine. Breakfast was not completed on 12/01/25 and 12/14/25. Lunch was not completed on 12/01/25. Dinner was not completed 12/01/25, 12/02/25, 12/03/25, 12/04/25, 12/06/25, 12/07/25 and 12/14/25.Interview on 12/15/25 at 9:14 A.M. with DM #700 confirmed all of the above areas of concern. Dietary Manager #70 stated staff were not supposed to keep leftovers and were not supposed to leave scoops in the flour or sugar bins. Staff were supposed to complete daily cleaning tasks. DM #700 confirmed there was no posted cleaning task schedule or place for staff to sign off as they completed their cleaning tasks. DM #700 stated staff were trained when they were oriented and knew what tasks they were to complete daily. DM #700 stated she does spot checks to ensure staff are completing their scheduled cleaning tasks. DM #700 confirmed the dish machine temperature logs and the three compartment sink sanitizer logs were not completed as required. DM #700 also confirmed the ovens had not recently been cleaned and were supposed to be cleaned every two weeks but was unable to state when they were last cleaned.2. Observation on 12/16/25 at 9:20 A.M. with Administrator in Training (AIT) #422 of the unit refrigerators revealed the following concerns:-the South unit refrigerator shelves were sticky, and two plastic bags were found tied but had no date or name on the bags. Inside the bags revealed an open, undated eight-ounce container of French onion dip, an open, undated unlabeled eight-ounce container of chive and onion dip, an open, unlabeled partially eaten five and quarter ounce container of turtle cheesecake with a best if used by date of 12/12/25, and an opened 11-ounce container of pre-prepared beef pot roast with a use by (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	date of 12/12/25. -the memory care unit had an unlabeled plastic container of leftover soup with a use by date of 12/15/25.Interview on 12/16/25 at 9:33 A.M. with AIT #422 confirmed the above findings in the unit refrigerators and also confirmed the sign on the front of each refrigerator stated it would be cleaned weekly on Fridays not every three days as the facility policy stated.Review of the undated Dietary Services policy titled Sanitation Policy revealed the purpose is to maintain a clean, safe, and sanitary environment in all dietary and food service areas to prevent contamination and illness. All dietary staff, contractors, and volunteers shall follow sanitation procedures in accordance with federal, state and local regulations. All food contact surfaces must be cleaned, rinsed, sanitized and air-dried. Surfaces must be sanitized before use and after meal service. Floors must be swept and mopped daily. Storage areas must remain clean and organized. The policy was vague and did not provide specific instructions and frequency for all types of cleaning. Review of the undated facility cleaning checklist titled Main Kitchen Closing Checklist- Cooks revealed both ovens are to be cleaned top to bottom. Utensil drawer cleaned and organized (no crumbs).Review of the undated facility cleaning checklist titled Main Kitchen End of Shift Checklist-Server 2 revealed sanitizer log to be completed.Review of the undated facility cleaning checklist titled Main Kitchen End of Shift Checklist- Server 3 revealed dish machine temperate log to be completed. Review of the untitled, undated facility sign on the front of the unit refrigerators revealed For Residents: name and date must be on food. All Food and liquids must be dated once opened. If there is no date on the food, it will be tossed out. The refrigerator will be cleaned every Friday.Review of the undated facility policy titled Food Safety Information revealed if families or friends bring in treats and favorite foods and if the items need to store or re-heated, please store the food in closed microwave-safe containers labeled with your loved one's name, contents and the date. Staff will show you where items may be kept. Food may be held for three days before it is discarded due to food safety concerns.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, staff interview and facility policy review, the facility failed to ensure the dumpster/refuse area was maintained in a clean and sanitary condition. This had the potential to affect all residents residing in the facility. The facility census was 87.Findings include:Observation during the initial kitchen tour completed on 12/15/25 at 9:16 A.M. with Dietary Manager (DM) #700 revealed the dumpster lid was open, the dumpster was overflowing, and there were four bags of garbage on the ground surrounding the dumpster. Interview at the time of the observation with DM #700 confirmed the dumpster was supposed to emptied daily, was not covered, and garbage bags should not have been lying on the ground.Review of the undated facility policy called; Sanitation Policy under the section waste disposal and pest control stated trash must be removed frequently but did not specify any specifics as to the frequency trash was to be taken out or how often the dumpster would be emptied.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, observation, and review of the facility policy, the facility failed to ensure medical records contained accurate documentation. This affected three (Residents #1, #17, and #45) out of 22 residents for accuracy of medical records. The facility census was 87.Findings include:1. Review of the medical record for Resident #45 revealed an admission date of 06/01/23 with diagnoses including paranoid schizophrenia, anxiety disorder and wounds to his left medial ankle and heel. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #45 had intact cognition and had one vascular wound. Review of the November 2025 and December 2025 Physician Orders revealed Resident #45 had the following orders: an order dated 09/20/25 to irrigate his left medial ankle with normal saline and apply anacept gel (a clear antimicrobial gel that kills bacteria and assists with debridement) to the wound. The order to his left medial ankle was discontinued and changed on 12/05/25 to Dakins (a diluted bleach solution for cleaning a wound and killed bacteria) one forth strength solution apply moistened gauze to left medial ankle and dermaseptin (a skin protectant ointment that created a barrier to prevent irritation) to peri wound (skin surrounding the wound) and cover with foam adhesive dressing every evening. In addition, Resident #45 had an order dated 11/13/25 to irrigate his left heel with normal saline, apply betadine (an antiseptic solution), abdominal (ABD) pad and wrap with Kerlix gauze every evening shift. Review of the November 2025 Treatment Administration Record (TAR) revealed an order dated 09/20/25 to irrigate his left medial ankle with normal saline and apply anacept gel to wound. The nurse was then to apply dermaseptin to the macerated outer skin of the wound, and cover with foam adhesive every evening shift. The TAR was blank on 11/07/25 and 11/22/25 indicating the treatment was not done. Resident #45 also had an order dated 11/13/25 to irrigate his left heel with normal saline, apply betadine, ABD pad and wrap with Kerlix gauze every evening shift. The TAR was blank on 11/22/25 indicating the treatment was not done. Review of the care plan last revised 11/19/25 revealed Resident #45 was at risk for further skin breakdown and/ or pressure injury related to impaired mobility, and weakness. He had a vascular wound (an ulcer due to poor circulation) to his left ankle and a deep tissue injury (a pressure ulcer caused by damage to soft tissue beneath intact skin) to his left heel. Interventions included encourage Prevalon boots (heel protector) while in bed, pressure relieving mattress to bed, and treatments as ordered. Review of the December 2025 TAR revealed Resident #45 had an order dated 09/20/25 to irrigate his left medial ankle with normal saline and apply anacept gel to wound. The nurse was then to apply dermaseptin to the macerated outer skin of the wound, and cover with foam adhesive every evening shift. The TAR was blank 12/01/25, 12/02/25, and 12/03/25 indicating the treatment was not done. The order to his left medial ankle was discontinued and changed on 12/05/25 to Dakins one forth strength solution apply moistened gauze to left medial ankle and dermaseptin to peri wound outer skin and cover with foam adhesive dressing every evening. The TAR was blank on 12/06/25. Resident #45 also had an order dated 11/13/25 to irrigate his left heel with normal saline, apply betadine, ABD pad and wrap with Kerlix gauze every evening shift. The TAR was blank 12/01/25, 12/02/25, 12/03/25, and 12/06/25 indicating the treatment was not done. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365072	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anna Maria of Aurora	889 North Aurora Road Aurora, OH 44202

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/15/25 at 10:53 A.M. and 12/17/25 at 11:44 A.M. with Resident #45 revealed he felt his treatments were completed as ordered. Interview on 12/17/25 at 11:40 A.M. with MDS/ Licensed Practical Nurse (LPN) #513 verified on Resident #45's November 2025 and December 2025 TARs that the treatments were blank for the following dates: 11/07/25, 11/22/25, 12/01/25, 12/02/25,12/03/25 and 12/06/25 indicating the treatments were not completed. She revealed she felt the treatment was completed, but that the nurse did not document accurately the completion of the treatments. Review of the witness statement dated 12/18/25 and completed by LPN #712 revealed on 12/02/25 she had changed Resident #45's foot treatments to assist the other nurse but forgot to sign off the treatment. Review of the witness statement dated 12/19/25 and completed by LPN #621 revealed on 12/01/25 she performed Resident #45's treatments but did not chart. 2. Resident #01 was admitted on [DATE] with diagnoses of chronic diastolic congestive heart failure, chronic obstructive pulmonary disease (COPD), shortness of breath, and anemia. Review of Resident #01's care plan for altered respiratory status initiated on 08/29/25 revealed no intervention for oxygen tubing changes. Review of the physician orders dated 10/01/25 at 7:00 A.M. revealed an order for oxygen at two liters per nasal cannula for shortness of breath and comfort, every shift for comfort and shortness of breath. Physician orders dated 10/07/25 at 11:00 P.M., revealed an order for the oxygen tubing change every Tuesday, every week on the night shift. Review of the TAR for December 2025 revealed the oxygen tubing was initialed as replaced by LPN #901 on 12/02/25 and 12/09/25. Observation on 12/15/25 at 2:58 P.M. revealed Resident #01 in his room seated in his wheelchair. The oxygen concentrator was next to the bed and not in use. The tubing on the concentrator was dated 11/26/25. Interview on 12/15/25 at 3:10 P.M. with the Director of Nursing (DON) verified the oxygen tubing in Resident #01's room was dated 11/26/25, and the TAR for oxygen tubing change was signed off on 12/02/25 and 12/09/25 by LPN #901. The DON verified this documentation was not accurate in Resident #01's medical record. 3. Review of the medical record for Resident #17 revealed an admission date of 06/17/24 with diagnoses including Alzheimer's disease, anemia, and dysphagia (difficulty swallowing). She did not have any respiratory diagnoses listed. Review of the care plan dated 09/20/24 revealed Resident #17 had altered respiratory status related to complaints of shortness of breath with exertion at times. Interventions included oxygen at two liters as needed per nursing judgement for comfort, and change oxygen tubing as ordered. Review of the quarterly MDS assessment dated [DATE] revealed Resident #17 was cognitively impaired and used oxygen. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the December 2025 physician order revealed Resident #17 had an order dated 05/02/25 for oxygen at two liters per nasal cannula as needed per nursing judgement for comfort. She had an order dated 06/12/25 to have her oxygen tubing changed every Tuesday on night shift. Review of the December 2025 TAR revealed the oxygen tubing was initialed as replaced by LPN #901 on 12/02/25 and 12/09/25. Observation and interview on 12/15/25 at 10:14 A.M. revealed Resident #17 was sitting in her recliner, and she had an oxygen concentrator next to her bed not in use. The nasal cannula connected to the concentrator had a piece of tape on the tubing dated 11/26/26. Interview with Resident #17 revealed she was unable to indicate when she wore her oxygen and/or when the last time she did due to cognitive impairment. Interview on 12/15/25 at 3:08 P.M. with the DON verified the oxygen tubing in Resident #17's room was dated 11/26/25. She verified Resident #17 had an order to change the tubing weekly, and the TAR was initialized as the tubing was changed on 12/02/25 and 12/09/25 by LPN #901. The DON verified this documentation was not accurate in Resident #17's medical record as the tubing in her room was dated 11/26/25, indicating the last time it was changed. Review of the facility policy labeled, Oxygen Administration, dated March 2004, revealed the purpose of the policy was to provide guidelines for safe oxygen administration. The policy revealed the nurse was to verify the physician's order, review the care plan and assemble the equipment. There was no documentation in the policy regarding changing oxygen tubing. Review of the facility policy labeled, Clean Dressing Change, dated 02/26/20, revealed the nurse was to check the physician order for the current treatment order. There was no documentation in the policy regarding ensuring the treatment was documented in the TAR as completed. Review of the facility policy labeled, Charting, dated March 2025, revealed the DON or designee would review all skilled and long-term charting to ensure continuity of care, nursing care was appropriate, timely and complete.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record review, observation, interview, review of Centers for Disease Control and Prevention (CDC) guidelines and facility policy review, the facility failed to ensure droplet infection control precautions (infection control measures to stop germs spreading by respiratory droplets from coughing, sneezing and/or talking that travel short distances about three to six feet) were followed for Resident #82. This affected one (Resident #82) of one resident with a physician order for droplet precautions. The facility census was 87.Findings include:Review of the medical record for Resident #82 revealed an admission date of 11/22/25 with diagnoses including chronic respiratory failure and hypoxia, COVID-19, chronic congestive heart failure, and obstructive sleep apnea. Review of the nursing note dated 12/11/25 at 10:42 A.M. and completed by Registered Nurse (RN)/ Minimum Data Set (MDS) #812 revealed Resident #82 tested positive for COVID-19 and was on droplet precautions. Review of the physician order dated 12/11/25 revealed Resident #82 had a physician order for droplet precaution isolation due to COVID-19 and may discontinue (12/21/25) after ten days with improvement of sign and symptoms. Review of the care plan dated 12/11/25 revealed Resident #82 was at risk for complications related to diagnosis of COVID-19 and was on droplet precautions. Interventions included droplet precautions for all services in her room due to COVID-19 and monitor for signs of respiratory distress. Observation on 12/16/25 at 11:42 A.M. revealed the x-ray technician (XRT) #423 left the room of Resident #82 with a face shield and surgical face mask. Interview on 12/16/25 at 11:42 A.M. with XRT #423 revealed that she was wearing a gown, gloves, face shield and surgical mask (a mask that covers the mouth and nose and acts as a barrier to transmission of infectious agents) while delivering x-ray services. Further, XRT #423 revealed she did not know the rules regarding what type of mask and did not ask staff prior to entering the room. She verified she had worn only a surgical mask in the room while within six feet of Resident #82 as she took her x-ray. Observation of the isolation cart third (bottom) drawer revealed a supply of N95 masks. XRT #423 verified the availability of N95 (a disposable filtering facepiece respirator that was designed to protect the wearer from airborne particles) masks.Observation on 12/16/25 at 11:42 A.M. revealed signage on the room door for Resident #82 indicated special droplet/contact precautions (Washington State Hospital Association and Washington State Department of Health, last revised 03/09/20). Detailed precautions included to (a) Clean hands when entering and leaving room, wear face mask, eye protection (face shield or goggles), and gown and glove at door. (b)When doing aerosolizing procedures fit tested N95 with eye protection or higher required. (c) Keep door closed. (d) Use patient dedicated or disposable equipment. (e) Clean and disinfect shared equipment. (The signage did not indicate to wear an N95 mask at all times when in the room for all services).Interview on 12/16/25 at 12:00 P.M. with the Director of Nursing (DON) confirmed that Resident #82 was on droplet precautions for COVID-19 and required an N95 mask for any staff and/ or vendor that entered the room. Interview on 12/18/25 at 9:00 A.M. RN/ Infection Control Designee #411 verified the signage on Resident #82's door indicated special droplet/contact precautions that included clean hands when entering and leaving room, wear face mask, wear eye protection (face shield or goggles), and gown and glove at door. The signage also indicated during aerosolizing procedures to wear an N95. She revealed the signage should have indicated wearing an N95 during all services not just aerosols. She verified that all staff/ vendors were to wear an N95 mask when in a room with a resident positive for COVID-19 including XRT #423 should have worn one. Review of x-ray service agreement with the facility dated 06/01/10 does not include infection control practices or following facility infection control policies.Review of the facility document titled, Isolation, Initiating Transmission-Based Precautions, last revised 11/04/24, revealed droplet precautions included COVID-19 in the list of examples (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requiring droplet precautions within the policy. The policy revealed in addition to standard precautions, put on a mask (and eye protection if recommended) when entering the room or cubicle. The policy does not include type of mask to be used. Review of the facility policy labeled, Infection Control Policy, dated 01/23/24, revealed the facilities infection control policies and practices apply equally to all personnel, consultants, residents, visitors, volunteers and all general public alike. Review of CDC guidelines labeled, Infection Control Guidance: SARS-CoV-2 (COVID-19) revealed staff that enter the room of a patient with suspected or confirmed COVID-19 should adhere to standard precautions and use an approved N95 mask, gown, gloves and eye protection.