

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Hanover Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 435 Avis Avenue NW Massillon, OH 44646	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review and interview, the facility failed to ensure the resident and resident's representative's preferences were followed regarding having side rails on his bed. This affected one (Resident #113) of three residents reviewed for preferences. The facility census was 112. Findings include: Review of the closed medical record for Resident #113 revealed an admitted [DATE] with diagnoses including diabetes mellitus, end stage renal disease and congestive heart failure. Resident #113 was discharged on [DATE]. Review of the form titled, Installation of Bed Rail or Assist Bar Not Used as a Restraint, signed by Resident #113's representative on 03/26/24, indicated the resident requested both right and left half side rails. Review of the facility assessment titled, Bed Safety Evaluation, dated 03/26/24 revealed Resident #113 wanted grab rails but had not expressed the desire to have bed rails or an assist device on their bed. This assessment was completed by Licensed Practical Nurse (LPN) #205 and the request for side rails from the Installation of Bed Rail or Assist Bar Not Used as a Restraint form did not transfer to the assessment. Interview on 06/05/24 at 12:15 P.M. with LPN #205 revealed the facility did not have half siderails to provide to the resident as they do not have them in the facility. She verified Resident #113's representative had signed a form provided by the facility for half side rails to be placed on his bed on 03/26/24. Interview on 06/06/24 at 8:56 A.M. with Assistant Director of Nursing (ADON) #207 verified Resident #113 should have had side rails on his bed per preference on admission. However, she stated the referral to therapy and maintenance to apply the siderails was not done until 04/29/24. Review of the facility policy titled, Safe Use of Bed Rails, dated 03/01/24 revealed residents had the right to utilize bed rails if they expressed a desire for bed rails and if the resident or resident representative signed an informed consent. This deficiency represents non-compliance investigated under Complaint Number OH00153869.		

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review and interview, the facility failed to follow the direction of the telehealth nurse practitioner timely for a change in pain medication for a resident. This affected one (Resident #113) out of three residents reviewed for pain medication. The facility census was 112. Findings include: Review of the closed medical record for Resident #113 revealed an admitted [DATE] with diagnoses including diabetes mellitus, end stage renal disease and congestive heart failure. Resident #113 was discharged on [DATE]. Review of Resident #113's care plan dated 04/20/24 revealed he had a complaint of pain related to impaired mobility, multiple medical issue and normal aging process. Interventions included to notify the medical provider and resident representative if interventions were unsuccessful. Review of the physician's orders for Resident #113 revealed he had an order dated 04/23/24 for Hydrocodone-Acetaminophen 5/325 milligrams (mg) (Norco) one tablet every four hours as needed for pain for seven days. A new order for Oxycodone 5 mg one tablet every four hours as needed for acute pain for 14 days was received on 04/25/24 at 9:30 A.M. Review of the Medication Administration Record (MAR) for April 2024 revealed Resident #113 received Norco on the dates listed below: On 04/24/24 at 8:21 A.M. for pain of seven (on a scale of 0-10), medication was effective. On 04/24/24 at 4:06 P.M. for pain of eight, medication was effective. On 04/24/24 at 8:33 P.M. for pain at four, medication was ineffective. On 04/25/24 at 12:38 A.M. for pain of five, medication was ineffective. On 04/25/24 at 5:37 A.M. for pain of five, medication was effective. Review of the pain level summary for Resident #113 revealed his pain ranged from zero to nine. On 04/24/24 at 8:33 P.M. his pain was noted to be a four, on 04/25/24 at 12:09 A.M. it was a nine and on 04/25/24 at 12:35 A.M. it was a five. Review of the nursing progress note dated 04/24/24 at 10:37 P.M. by telehealth Nurse Practitioner (NP) #215 revealed the facility nurse was requesting a change in pain medication for Resident #113 from Norco to Percocet. The note stated the resident had been receiving Percocet for years and the switch to Norco was ineffective for pain relief. NP #215 had stated Resident #113's daughter wanted the medication switched back and NP #215 informed her the nurse would have to speak to the medical director related to starting a new narcotic order. NP #215 stated the nurse was aware to call the medical director for requested pain medication order. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing progress note dated 04/24/24 at 11:36 P.M. by Registered Nurse (RN) #210 revealed she had updated the on-call nursing manager, Licensed Practical Nurse (LPN) #209, of the telehealth visit with NP #215. RN #210 stated that LPN #209 advised her not to call the medical director as it was off-hours. RN #210 updated Resident #113's daughter who was upset and requested that she call the facility in-house nurse practitioner. An attempt was made but it went to voicemail and there was no response noted. RN #210 stated she would pass this along to the next nurse on duty, meaning dayshift on 04/25/24. Review of the Medicare five-day Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #113 revealed he received scheduled pain medication, as needed pain medication and non-medication interventions for pain. He stated over the previous five days he had pain almost constantly and stated the pain was an eight. He stated the pain occasionally made it hard for him to sleep at night and occasionally interfered with his day-to-day activities. Interview on 06/05/24 at 9:53 A.M. with NP #208 revealed she had prescribed Resident #113 Norco on 04/23/24 for pain. She verified Physician #211 had prescribed Percocet for Resident #113 on 04/25/24. She stated after 5:00 P.M. and on weekends, the nursing staff had to reach out to the facility's telehealth company as she was not on-call during those times. Interview on 06/05/24 at 12:08 P.M. with the Director of Nursing (DON) revealed Physician #211 and NP #208 were on-call from 8:00 A.M. to 5:00 P.M. Monday through Friday. She stated after hours and on the weekend, the nursing staff were to use the telehealth company the facility contracted with. However, she stated if there is something that does not get resolved, she is able to contact the medical director. Interview on 06/05/24 at 12:19 P.M. with LPN #209 verified she was the manager on-call on 04/24/24. She stated RN #210 had called her and she advised her to call the medical director's office to page him or the on-call physician. LPN #209 stated she did not tell the nurse not to call the medical director. Interview on 06/05/24 at 12:53 P.M. with RN #210 revealed she had updated her on-call nurse manager, LPN #209, on 04/24/24 at 11:36 P.M. about Resident #113's pain medication. She stated she updated LPN #209 that the telehealth nurse practitioner directed her to call the medical director as it was a new narcotic prescription for Resident #113's pain. RN #210 stated LPN #209 told her not to call the medical director and the nursing staff would address it the following day. She stated she documented what she was directed by LPN #209. Review of the facility policy titled, Pain Management and Assessment, dated 04/16/24, revealed the facility would ensure residents received the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. This deficiency represents non-compliance investigated under Complaint Number OH00153869.		

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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** 43063 Based on record review and interview, the facility failed to ensure accurate documentation in the medical record for medication administration. This affected one (Resident #113) of three residents reviewed for accurate medical records. The facility census was 112. Findings include: Review of the closed medical record for Resident #113 revealed an admitted [DATE] with diagnoses including diabetes mellitus, end stage renal disease and congestive heart failure. Resident #113 was discharged on [DATE]. Review of the physician's orders for Resident #113 revealed an order dated for 04/29/24 for nursing staff to obtain his blood sugar before meals (7:00 A.M., 11:00 A.M. and 4:00 P.M.) and to administer Insulin Lispro (medication for diabetes) per the sliding scale directions. Review of the medication administration record (MAR) for Resident #113 revealed he was to have his blood sugar obtained at 7:00 A.M. The nursing staff had not documented this as completed in his medical record. Review of the nursing progress note dated 04/30/24 at 8:25 A.M. revealed the nurse checked his blood sugar at that time, which was later than the physician had ordered. Interview on 06/06/24 at 8:52 A.M. with the Director of Nursing (DON) verified nursing staff had not documented that Resident #113's blood sugar was obtained per the physician's orders. Review of the facility policy titled, Liberalized Medication Administration, dated 04/16/24, revealed any medication ordered by the physician for a specific time would be given at that time.		