

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

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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 07/29/2024
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28701 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, medical record review, fire and police department report review, hospital record review, facility investigation review, policy review and interview, the facility failed to provide adequate supervision to Resident #112, who was admitted to the facility on [DATE] due to being an elopement risk with a need for placement on a secured unit, had verbalized his desire to leave the facility, was identified as an elopement risk on admission and received a recent diagnosis of dementia with psychosis, from exiting the second floor secured unit without staff knowledge. This affected one resident (#112) of four residents reviewed for staff supervision and elopement. The facility census was 110. Findings include: Review of Resident #112's medical record revealed an admitted [DATE] with admission diagnoses including right clavicle fracture, vascular dementia with psychotic disturbance and diabetes mellitus. Review of the physician's orders dated 06/07/24 revealed Physician #175 ordered placement for the resident on the secured unit; however, the order did not specify why the resident needed placement on the secured unit. Review of the admission nursing assessment completed on 06/07/24 by Licensed Practical Nurse (LPN) #141 revealed Resident #112 was at risk for elopement due to history of prior elopement attempts and required secured unit placement for safety. Review of an admission nursing note dated 06/07/24 at 12:45 P.M. by LPN #145 revealed Resident #112 was transferred from a different local skilled nursing facility to this facility (for placement on a secured unit). (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 365292	Facility ID: 365292 If continuation sheet Page 1 of 7

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A plan of care dated 06/07/24 revealed Resident #112 was an elopement risk and required a secured unit for safety related to dementia. Interventions for elopement risk included assess for hunger, thirst, ambulation and toileting needs, completed wandering evaluation upon admission/re-admission, quarterly and as needed, educate resident of the need for secured unit to maintain safety, evaluate for need of secured unit, notify medical provider as needed, notify staff of elopement risk, obtain current photograph and list of identifiable characteristics and place in the elopement risk identification book, provide diversionary activities as needed, and provide structured activities at times of increased elopement risk, diversional tasks, redirection of ambulation patten and utilization of safe wandering areas. An evaluation by Physician #175 on 06/10/24 indicated Resident #112 was seen for a complaint of difficulty sleeping. Physician #175 indicated Resident #112 utilized a wheelchair at this time. Review of a nursing note dated 06/12/24 at 3:18 P.M. and authored by Registered Nurse (RN) #177 revealed Resident #112 was not accepting admission to the facility, calling multiple people and places, offering them \$50.00 to come get him. Attempted to call grandson to speak with a family member regarding this matter. The grandson's phone numbers (both) were no longer in service. No number was listed for the resident's son. Review of a care plan for Resident #112 dated 06/13/24 revealed the resident was placed on a secured unit for deficit in memory, judgment, decision making and thought process. Admit to secured unit for safety. An additional nurse's note on 06/20/24 at 7:26 P.M. and authored by RN #177 revealed Resident #112 was fixated today on trying to get out of here. The resident stated that someone took his license, as he could not locate it. He was also fixated on trying to call his insurance company to cancel his insurance to get out of here. Threatening to break windows and call the police if staff do not allow him to leave. This nurse assisted the resident in calling his insurance company, as the resident was noted to be his own (responsible person) self, allowed him to speak with them. Information relayed to unit manager, social worker, and administrator. Record review revealed the facility failed to implement any new safety interventions/monitoring or updated/revised interventions following verbalizations of the resident wanting to leave the facility. Review of the Minimum Data Set (MDS) assessment with a reference date of 07/02/24 revealed Resident #112 had intact cognition and required minimal (staff) assist to independence with ambulation and transfers and utilized a wheelchair for ambulation. Review of the Psychiatric Nurse Practitioner (PNP) #225 progress note dated 07/03/24 revealed Resident #112 was evaluated by the PNP and was delusional and had altered thought process and dementia. Review of a physician progress note dated 07/03/24 and authored by Physician #175 revealed the resident was independent with functional status and assistance with activities of daily living. The note revealed the resident had impaired memory and impaired judgement. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nursing progress note dated 07/12/24 at 8:23 A.M. and authored by LPN #141 documented Resident #112 came down the unit hallway and asked staff for a sandwich and went back to his room. At 6:24 A.M. the first-floor nurse (not identified) called and asked if we were missing any of our residents because the fire department called stating they had a male identifying himself as Resident #112. The note revealed LPN #141 went down to the resident's room and found his window wide open; towels and sheets had been tied together and hanging out the window, the mattress was removed from his bed and was laying on the ground below with pillows. This nurse and an (unidentified) aide ran outside and did not see said resident. Local police came and obtained pictures and the resident's medication list for the hospital, which was where the resident was transported to. The Telehealth physician was notified. This nurse was unable to get in contact with the resident's emergency contacts. A telehealth physician's progress note dated 07/12/24 at 7:29 A.M. and authored by Physician #186 revealed Resident #112 had eloped - the resident tied sheets and towels together and used them to leave through the window. The resident was found by the fire department staff and taken to an emergency department. Review of Google Maps revealed from the facility to the residence Resident #112 was located was approximately 0.2 miles by streets. Review of the police department report dated 07/12/24 revealed a call received on 07/12/24 at 6:02 A.M. for a welfare check on a person calling for help on the front porch of a residence. Police arrived on scene at 6:07 A.M. The person was found to be in need of medical attention and the fire department was called and the person (identified to be Resident #112) was then transported to the hospital for further treatment. Review of the fire department report dated 07/12/24 revealed on 07/12/24 at 6:16 A.M. (emergency) staff assessed Resident #112 and found swelling and pain to the right ankle and five lacerations to the resident's right forearm. Resident #112 had delusions and was providing inaccurate information. After determining Resident #112 had been from the nursing facility, he was transported to the hospital for further medical treatment. Review of a facility investigation completed on 07/12/24 for the elopement of Resident #112 revealed the facility determined the resident used a butter knife to remove the security device from his window. He then threw a mattress out of the window to the ground below. He tied sheets together to scale down the wall to the ground below. Resident #112 was last seen between 3:00 A.M. and 3:30 A.M. when he asked (staff) for and was provided a sandwich by LPN #141 at the nurse's station. Resident #112 returned to his room at this time. At 6:24 A.M. the first-floor nurse received a call from the police department questioning if they were missing a resident. The first-floor nurse transferred the call to LPN #141 who at that time checked Resident #112's room and determined he had eloped from his room using sheets tied together as a rope. A root cause analysis completed with the investigation determined the facility should have placed additional interventions for Resident #112 expressed desire to leave the facility including increased monitoring. Review of the hospital records for the dates of 07/12/24 to 07/19/24 for Resident #112 revealed the resident was evaluated and determined to have a fractured right calcaneus (heel). Resident #112 was referred to a trauma surgeon and admitted to the hospital for an open reduction and internal fixation of the fracture. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nurse progress note dated 07/14/24 at 2:00 P.M. and authored by LPN #145 revealed the local hospital called (the facility) requesting a medication list for Resident #112 and updated (facility) staff that the resident was awaiting surgery and (the hospital was) attempting to communicate with the resident's family but getting no answers from phone numbers provided by the resident. Interview with the facility Administrator on 07/23/24 at 9:30 A.M. verified Resident #112 eloped from the facility. The Administrator indicated the facility had determined the resident utilized a butter knife to remove the window securement device, tie together bed sheets and towels as a rope, mattress and pillows thrown on the ground below and climbed out the window. The Administrator indicated they had no information except for gossip on where the resident went to but indicated the resident was currently at the local hospital. The Administrator added that the local hospital would not provide any medical information to the facility as the resident was considered confidential at this time. Observation on 07/23/24 at 10:33 A.M. of Resident #112's room revealed a second story room located at the end of the hallway approximately 100 feet from the central nurse's station. The window in the resident's room measured approximately 60 inches by 60 inches and was approximately 15 feet above ground level. The window was a sliding type of window with a securement device located in the top rail of the window frame to prevent opening more than six inches. The securement device was held in place by two Phillip's head screws. On 07/23/24 at 10:35 A.M. interview with Housekeeper #125 revealed Resident #112 verbalized his desire to the leave the facility frequently during his stay in the facility. On 07/23/24 at 10:37 A.M. interview with Activity Aide #131 revealed Resident #112 verbalized his desire to leave the facility frequently during his stay in the facility. On 07/23/24 at 10:44 A.M. interview with LPN #141 revealed Resident #112 was an elopement risk and placed on the secured unit for safety. The LPN revealed Resident #112 was assessed as an elopement risk and also assessed to be appropriate for placement on the facility secured unit. LPN #141 indicated she was working the night shift during the time of the elopement incident. The LPN revealed Resident #112 had come to the nurse's station at approximately 3:30 A.M. requesting a snack and was provided a sandwich at that time and then returned to his room. At 6:24 A.M. the first-floor nurse's station transferred a phone call from the police department asking about a missing resident. The LPN stated upon entering Resident #112's room the resident was not there, and she had identified he had eloped out the window. On 07/23/24 at 10:48 A.M. interview with LPN #145 revealed Resident #112 verbalized his desire to leave the facility frequently during his stay in the facility. On 07/23/24 at 1:12 P.M. interview with Admissions Coordinator #151 revealed Resident #112 was transferred from another facility due to elopement risk and need for a secured unit. On 07/24/24 at 1:25 P.M. interview with RDCO #153 verified staff failed to follow their facility policy for elopement prevention for Resident #112 by not adding interventions in an individualized manner, failing to identify monitoring of the resident as an intervention, failing to prevent the actual elopement and failing to monitor the resident every two hours as per facility protocol. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/25/24 at 10:12 A.M. interview with LPN #141 revealed Resident #112 had been using a wheelchair for mobility in the facility. On 07/25/24 at 5:30 P.M. interview with Physician #175 (the resident's primary physician while in the facility) revealed Resident #112 never expressed any type of exit seeking behaviors during evaluation. The physician indicated the resident displayed impaired cognition due to a delusional thought process and was not safe in the community alone due to this. Physician #175 stated the resident utilized a wheelchair independently but was also able to ambulate without assistance. The resident required a secured unit due to safety concerns related to previous exit seeking behaviors, impaired cognition and impaired safety awareness. On 07/29/24 at 3:05 P.M. interview with the Administrator revealed the resident had not returned to the facility and the family was not planning for the resident to return to the facility. Review of the undated facility policy titled Elopement Prevention and Management Overview indicated: Identify residents who are at risk for elopement. Determine elopement risk factors. Document risk factors. Develop and document individualized interventions to manage risk factors. Discuss interventions and goals with resident and/or representative. Communicate risk factors and interventions with caregiving staff. Evaluate effectiveness of interventions during clinical meetings. Modify goals and interventions as indicated and communicate changes to the caregiving team, resident and/or representative. Review of the facility policy titled Behavior Management: Elopement Preventative Guidelines with a review date of 10/10/22 indicated staff were to account for the resident's presence every two hours and at shift change - more often if need be. The deficiency was corrected on 07/12/24 when the facility implemented the following corrective actions: On 07/12/24, at 6:24 A.M., the facility was notified by the local fire department that an individual was found who may potentially be a resident at the facility. The Director of Nursing (DON), who worked night shift on the first floor, announced the facility notification code for a missing resident. On 07/12/24 at 6:24 A.M., the facility was searched and Resident #112's room window, located on the second floor, was discovered opened by Licensed Practical Nurse (LPN) #141. The window security lock had been removed from the window and the resident's mattress was observed on the ground below. The bed sheets had been tied together and tied to a chair that was in the resident's room. The facility determined the tied sheets were used for the resident to exit his window and scale down the side of the building. The resident was subsequently transported to the hospital. On 07/12/24 at 6:25 A.M., the exterior grounds were searched by State tested Nursing Assistant (STNA) #191 and #195 and no residents were located. On 07/12/24 at 6:27 A.M., the Administrator, Regional Director of Operations (RDO) #201 and Regional Director of Clinical Operations (RDCO) #153 were notified, by the DON, of Resident #112's elopement. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/12/24 at 6:33 A.M., STNA #191, STNA #195, STNA #211, STNA #212, STNA #213, STNA #214, LPN #215 and LPN #216, led by the DON and LPN #141, conducted a head count of the residents currently in the facility. All residents, except Resident #112, were present. On 07/12/24 at 6:51 A.M., facility staff, which included LPN #141, STNA #191, STNA #195, STNA #211, STNA #212, STNA #213, STNA #214, LPN #215 and LPN #216, participated in a facility elopement drill that was conducted and evaluated by the DON. Staff responded appropriately and no concerns were identified with the elopement drill. On 07/12/24 at 7:28 A.M., Telehealth Physician #186 was updated by LPN #141 regarding Resident #112's elopement. On 07/12/24 at 7:30 A.M. Maintenance Technician #205 conducted resident room window audits of all resident rooms in the facility, for a total of 73 rooms. All other safety locks were intact. On 07/12/24 beginning at 7:40 A.M., LPN #141 began to reassess the remaining 34 residents (#60, #77, #78, #79, #80, #81, #82, #83, #84, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #103, #104, #105, #106, #107, #108, #109, #110, and # 111) on the secured unit for elopement risk. The facility identified no changes were identified and all resident interventions for elopement risk remained appropriate. On 07/12/24 beginning at 8:00 A.M., the DON began education of all staff regarding the facility elopement policy and notifying the nurse or unit manager with any changes in the residents' condition. Staff were provided with a copy of the facility elopement policy. As of 07/23/24, 93 of 101 total employees had completed their education. Remaining employees (STNA #227, #238 #240 and #245; Dietary Staff #229; RN #231 and LPN #243) had not worked since the incident due to work status (as needed or on vacation). These staff were notified via text message that they could not work until the in-service was complete. On 07/12/24 at 8:30 A.M., the DON informed Medical Director #201 and Resident #112's attending physician, (Physician #175), of the incident of elopement. On 7/12/24 at 8:30 A.M., LPN #141 reviewed the Elopement Binder, and determined it was up to date. The binder included Resident #60, #77, #78, #79, #80, #81, #82, #83, #84, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #103, #104, #105, #106, #107, #108, #109, #110, #111, and #112. On 07/12/24 at 10:00 A.M., an ad hoc (not scheduled, usually regarding a particular situation) Quality Assurance Performance Improvement (QAPI) meeting was held via Zoom. Those in attendance included the Administrator, the DON, RDCO #153, RDO #201 and Medical Director #201. The subject of the QAPI meeting included a Root Cause Analysis and prevention of potential repeat elopements. At 10:30 A.M. the QAPI team determined the root cause analysis identified the facility should have implemented additional interventions, when Resident #112 expressed desire to leave, which included increased monitoring. On 07/12/24 at 3:20 P.M., the Administrator sent a message to all staff via OnShift informing them to read and sign the elopement policy training before beginning their next shift. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/12/24 an investigation was initiated by the DON and concluded Resident #112 used a butter knife to remove the safety lock from the window in his room and successfully eloped from the facility. The investigation was reviewed and approved by the Administrator on 7/12/2024. The facility implemented a plan for all new hires to review the facility elopement policy during their first day of orientation. The facility implemented a plan for the Maintenance Director/designee to conduct window audits every shift for four weeks to ensure the window locks were intact beginning 07/29/24. Findings would be reported to the QAPI committee. The facility implemented a plan for nurses to monitor and document behaviors in the progress notes every shift for Resident #60, #77, #78, #79, #80, #81, #82, #83, #84, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #103, #104, #105, #106, #107, #108, #109, #110, and #111. Monitoring would be daily for four weeks and the findings would be reported to the QAPI Committee. The facility implemented a plan for DON/LPN #141/designee to audit progress notes/records daily to ensure residents were monitored for exit seeking behaviors, interventions were implemented with new admissions/changes in condition, assessments were correct and, if needed, interventions were updated. This would continue for four weeks, and the audit findings would be reported to the QAPI Committee. This would begin on 07/29/24. This deficiency represents non-compliance investigated under Master Complaint Number OH00155942.		