STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365292	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hanover Healthcare Center	435 Avis Avenue NW Massillon, OH 44646

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, policy review, and interview, the facility failed to ensure the nurse practitioner or physician were notified of a resident's low blood pressure reading prior to administering a medication with anti-hypertensive properties. This affected one (Resident #103) of three residents reviewed for medication administration. Findings include: Review of Resident #103's medical record revealed diagnoses including hypertensive heart disease, paroxysmal atrial fibrillation (irregular heart rhythm), atherosclerotic heart disease, malignant neoplasm of the scrotum and prepuce (a movable sheath of skin that covers the head of the penis), and pleural effusion. On 05/29/25 orders were started for midodrine HCL (a medication that belongs to the class of medications called alpha-adrenergic agonists. It works by causing blood vessels to tighten, which increases blood pressure.) 5 milligrams (mg) three times a day with instructions to hold the medication for a systolic blood pressure (top number of the blood pressure) was greater than 120 millimeters of Mercury (mm Hg) and metoprolol tartrate (a medication used to treat angina, high blood pressure and a number of conditions involving an abnormally fast heart rate) 12.5 mg twice a day. Review of Resident #103's June Medication Administration Record (MAR) revealed the blood pressure the morning of 06/11/25 was 70/50 mm Hg (normal blood pressure is 120/60 mm Hg) and the pulse was 59 beats per minute (bpm) (average [NAME] rate is 60-90 bpm) The midodrine and metoprolol tartrate were administered. A nursing note dated 06/11/25 at 10:30 A.M. revealed a manual blood pressure of 70/50 was obtained. The nurse practitioner was notified. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Nurse Practitioner (NP) #230's progress note dated 06/11/25 indicated Resident #103 was seen for hypoxia (low levels of oxygen in body tissues). Resident #103 had shortness of breath, wheezing was auscultated (sound heard through use of a medical device such as a stethoscope), gurgling was noted when Resident #103 was trying to cough, and the oxygen saturation was 60% on four liters of oxygen. Resident #103 was not answering questions appropriately and his systolic blood pressure was in the 60's and heart rate in the 40's. Resident #103 received a DuoNeb (medication used to prevent bronchospasm) with oxygen saturation down to the 80's and dropping into the 60's. The note indicated Resident #103 did not receive dialysis on 06/09/25 due to hypotension (low blood pressure) with the systolic blood pressure in the 60's. The note indicated Resident #103's pulse was 42 at 10:30 A.M. and blood pressure was 64/50. An oxygen saturation of 62%b (normal greater than 90%) was recorded. The physical part of the exam indicated expiratory and inspiratory wheezing was auscultated in both lungs and was on four liters of oxygen. Resident #103 had trace edema in both legs. The oxygen saturation had gone from 60% to low 89% with the use of the DuoNeb and then went back down to the 60's on four liters of oxygen. The note indicated Resident #103 did receive metoprolol and midodrine that morning. Resident #103 was lethargic. Lisinopril and bumex were held. 911 was called and Resident #103 was transferred to the hospital for evaluation and treatment. A nursing note dated 06/11/25 at 11:10 A.M. indicated Resident #103 was placed on four liters of oxygen via a non-rebreather mask (a type of oxygen mask used in emergencies or hospital settings. It provides a high concentration of oxygen to the patient but doesn't allow them to breathe in any outside or room air. The mask covers both the nose and mouth and has one-way valves to prevent exhaled air or outside air from entering the oxygen supply.) and his oxygen saturation increased from 72 to 85. Pulse was recorded as 48 and 911 was called. On 06/16/25 at 3:20 P.M., the Director of Nursing (DON) was unable to provide an explanation why the metoprolol which could lower blood pressure with a recorded blood pressure of 70/50 was administered. On 06/16/25 at 3:27 P.M., Registered Nurse (RN) #235 verified she administered the metoprolol to Resident #103 when he had a blood pressure of 70/50. RN #235 stated she did so without contacting the physician or nurse practitioner at the time because she had been told to administer metoprolol to other residents in the past with similar vital signs. When asked, RN #235 was unable to provide a resident's name or time frame. On 06/17/25 at 3:22 P.M., NP #230 stated RN #235 should have contacted her prior to administering the metoprolol because of the blood pressure reading. Although the metoprolol was used as a beta blocker it also had the potential to lower the blood pressure even further. Because the pulse was 59 she definitely would have instructed RN #235 to hold the metoprolol. Even if the pulse would have been elevated she would have held the metoprolol until she determined if the midodrine would raise the blood pressure. The metoprolol should not have been administered. On 06/18/25 at 1:35 P.M., NP #230 added that she had not been made aware of Resident #103 not receiving dialysis on 06/09/25 due to low blood pressure until 06/11/25. NP #230 stated at that time she went to talk to Resident #103 and his blood pressure could hardly be heard and she spoke to the nurse. Resident #103 was in critical condition. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Notification of Change in Condition policy (undated) revealed the facility must consult with the resident's medical practitioner when there was a change requiring notification. Circumstances requiring notification included deterioration of health status and a need to alter treatment. This is an incidental finding discovered during the investigation.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on medical record review, policy review and interview, the facility failed to report allegations of misappropriation of money to the State Survey Agency. This affected one (Resident #49) of three residents reviewed for missing property. Findings include: Review of Resident #49's medical record revealed diagnoses including congestive heart failure (CHF), atherosclerotic heart disease, type two diabetes, bipolar disorder, and anxiety disorder. A nursing note by Licensed Practical Nurse (LPN) #215 dated 06/15/25 at 12:55 A.M. indicated Resident #49 returned to the facility from a leave of absence (LOA) and informed the nurse when he got into his lock box he had $350.37 missing from his box. Resident #49 stated he had the box locked all day in his room and had the key on his bag out with him all day. Police were informed and took a report from Resident #49. A social service note dated 06/16/25 at 8:48 A.M. indicated Resident #49 had voiced concerns which were documented on appropriate forms. Resident #49 wanted out of the facility and indicated the prior two days were tough as staff were reminding him of rules, including watching when he turned the chair. The note indicated Resident #49 felt staff were on him too much. No Facility Reported Incident was noted indicating the allegation of missing/stolen money was reported to the State Survey Agency. During an interview on 06/17/25 at 9:59 A.M., Licensed Social Worker (LSW) #220 revealed Resident #49 informed him of the missing money when they spoke about other concerns on 06/16/25. LSW #220 stated he called Resident #49's fiance to determine if Resident #49 had the money. The fiance had not returned his phone call. LSW #220 was unable to state why the State Survey Agency was not notified pending an investigation. On 06/17/25 at 11:07 A.M., Resident #49 stated he was unsure how long the money had been missing as he did not get into his lock box every day. Resident #49 stated there were times when he left his keys in his bag on the floor in his room and once he recalled leaving the key in the lock. During an interview on 06/17/25 at 12:26 P.M., the Administrator stated he had not been informed of the allegations of money missing from Resident #49's lock box until that morning so the information had not been reported to the State Survey Agency prior to 06/17/25. During an interview on 6/18/25 at 3:53 P.M., LPN #215 reported she informed the Director of Nursing (DON) of the missing money within five minutes of Resident #49 reporting the missing money to her. LPN #215 stated she also reported the information to Registered Nurse (RN) Unit Manager (UM) #225. On 06/23/25 at 6:18 A.M., the DON verified he had been informed of the allegation of missing money by LPN #215. The DON indicated he also contacted RN UM #225 who texted/informed the Administrator. The DON was unable to state the reason the State Survey Agency was not notified. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/23/25 at 6:50 A.M., RN UM #225 verified she had communicated back and forth with the Administrator via text on 06/14/25 regarding Resident #49's allegation of stolen money. Review of the texts revealed the Administrator was notified on 06/14/25 at 9:12 P.M. of Resident #49's allegation that someone stole $350 from his lock box in the last 36 hours. The Administrator responded on 06/14/25 at 9:12 P.M. indicating the facility did not give residents that kind of money. A follow up text from the Administrator on 06/14/25 at 11:22 P.M. inquired if Resident #49 called the police. Review of the facility's Abuse, Neglect and Misappropriation policy (not dated) revealed reports of misappropriation of property would be reported to the supervisor and investigated timely. The supervisor or designee would notify the DON and Administrator of the allegation immediately. Required notification of agencies would be completed. This deficiency represents non-compliance investigated under Complaint Number OH00166349.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on medical record review, policy review and interview, the facility failed to initiate a thorough investigation of allegations of a resident's stolen money. This affected one (Resident #49) of three residents reviewed for missing property. Findings include: Review of Resident #49's medical record revealed diagnoses including congestive heart failure (CHF), atherosclerotic heart disease, type two diabetes, bipolar disorder, and anxiety disorder. A nursing note by Licensed Practical Nurse (LPN) #215 dated 06/15/25 at 12:55 A.M. indicated Resident #49 returned to the facility from a Leave of Absence (LOA) and informed the nurse when he got into his lock box he had $350.37 missing from his box. Resident #49 stated he had the box locked all day in his room and had the key on his bag out with him all day. Police were informed and took a report from Resident #49. A social service note dated 06/16/25 at 8:48 A.M. indicated Resident #49 had voiced concerns which were documented on appropriate forms. Resident #49 wanted out of the facility and indicated the prior two days were tough as staff were reminding him of rules, including watching when he turned the chair. The note indicated Resident #49 felt staff were on him too much. No Facility Reported Incident was observed indicating the allegation of missing/stolen money was reported to the State Survey Agency or that an investigation had been initiated. During an interview on 06/17/25 at 9:59 A.M., Licensed Social Worker (LSW) #220 revealed Resident #49 informed him of the missing money when they spoke about other concerns on 06/16/25. LSW #220 stated he called Resident #49's fiance to determine if Resident #49 had the money. The fiance had not returned his phone call. LSW #220 indicated he was unaware of the allegation until 06/16/25 when he spoke with Resident #49 so he was unaware of any other investigative action taken. On 06/17/25 at 11:07 A.M., Resident #49 stated he was unsure how long the money had been missing as he did not get into his lock box every day. Resident #49 stated there were times when he left his keys in his bag on the floor in his room and once he recalled leaving the key in the lock. During an interview on 06/17/25 at 12:26 P.M., the Administrator stated he had not been informed of the allegations of money missing from Resident #49's lock box until that morning so he submitted a FRI and an investigation would be started. During an interview on 6/18/25 at 3:53 P.M., LPN #215 reported she informed the Director of Nursing (DON) of the missing money within five minutes of Resident #49 reporting the missing money to her. LPN #215 stated she also reported the information to Registered Nurse (RN) Unit Manager (UM) #225. On 06/23/25 at 6:18 A.M., the DON verified he had been informed of the allegation of missing money by LPN #215. The DON indicated he also contacted RN UM #225 who texted/informed the Administrator. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/23/25 at 6:50 A.M., RN UM #225 verified she had communicated back and forth with the Administrator and LPN #215 the night of 06/14/25. Review of a text dated 06/14/25 at 9:08 P.M. revealed LPN #215 informed RN UM #225 that Resident #49 alleged someone stole $350 from his lock box within the past 36 hours. RN UM #225 responded on 06/14/25 at 9:09 P.M. revealed that was an Administrator thing. At 9:10 P. M., LPN #215 indicated via text she was calling the police so Resident #49 could write a report. At 9:11 P.M., RN UM #225 reminded LPN #215 to obtain the police case number and instructed her to get statements from everyone in the building at the time. A text from RN UM #225 to the Administrator on 06/14/25 at 9:12 P.M. revealed the Administrator was notified of Resident #49's allegation that someone stole $350 from his lock box in the last 36 hours. The Administrator responded on 06/14/25 at 9:12 P.M. indicating the facility did not give residents that kind of money. A follow up text from the Administrator on 06/14/25 at 11:22 P.M. inquired if Resident #49 called the police. Review of the facility's Abuse, Neglect and Misappropriation policy (not dated) revealed reports of misappropriation of property would be reported to the supervisor and investigated timely. The supervisor or designee would notify the DON and Administrator of the allegation immediately. Required notification of agencies would be completed. This deficiency represents non-compliance investigated under Complaint Number OH00166349.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to provide restorative nursing programs to maintain a resident's ability to ambulate. This affected two (Residents #26 and #82) of three residents reviewed for restorative services. Findings include: 1. Review of Resident #26's medical record revealed diagnoses including cerebrovascular disease, hypertension, dizziness and giddiness, type two diabetes mellitus, unsteadiness on her feet, lumbar region intervertebral disc degeneration, discogenic back pain, and generalized weakness related to a stroke. A Physical Therapy (PT) Discharge summary dated [DATE] revealed a restorative nursing program had been completed for ambulation with the interdisciplinary team to facilitate Resident #26 maintaining her current level of performance and to prevent decline. A care plan initiated 03/14/25 indicated Resident #26 was on a restorative ambulation program to increase confidence and safety with gait once daily six to seven times per week for 15 minutes per day. Stand by assistance and verbal cues were to be provided with ambulation 125 to 200 feet as tolerated with staff offering encouragement and reassurance. Review of restorative program delivery notes revealed in the prior 30 days, Resident #26 received the ambulation program once on 05/28/25 at which time she was recorded as ambulating 240 feet. A restorative evaluation dated 06/12/25 indicated Resident #26 participated in the restorative ambulation program with a goal to maintain strength and be without decline. The restorative ambulation program was to be continued. On 06/18/25 at 11:55 A.M., Resident #26 was observed sitting in a recliner in her room with three daughters visiting. All four individuals were in agreement that Resident #26 did not walk well and they had a fear she would fall. On 06/23/25 at 8:54 A.M., Resident #26 stated she used to ambulate with Restorative Aide #265 but she retired and nobody else did the program. On 06/23/25, Certified Nursing Assistant (CNA) #270 verified the restorative aide had retired. CNA #270 stated there was not enough time for aides to provide restorative programs in addition to all the other care residents required. On 06/23/25 at 10:45 A.M., Regional Nurse #275 verified Resident #26's documentation revealed she received the restorative ambulation program once in the past 30 days. Upon investigation, she discovered the ambulation program was entered into the aides' task section to provide the service as necessary instead of six to seven times a week for 15 minutes a day. On 06/23/25 at 12:57 P.M., CNA #280 stated she was unsure which residents were on restorative programs or the type of programs which were to be provided. CNA #280 stated the only way nurse aides would have time to provide restorative programs was if there were always two aides to each hall which did not happen on a consistent basis. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #82's medical record revealed diagnoses including hemiplegia and hemiparesis (paralysis or weakness on one side of the body) following cerebrovascular disease, diabetes mellitus, chronic kidney disease, depression, chronic obstructive pulmonary disease, anxiety disorder, low back pain, peripheral vascular disease, and cognitive communication deficit. A plan of care initiated 12/09/24 indicated Resident #82 was on a restorative ambulation program to ambulate 50 to 100 feet with a quad cane with contact guard assistance to minimum assistance to maintain strength in lower extremities once a day for 6-7 days a week. Resident #82 required minimal instruction but staff were to encourage and praise participation. One of the interventions was to reassess quarterly and as needed. Review of restorative ambulation program delivery records revealed the week of 05/25/25 - 05/31/25 the service was offered/provided five times. The week of 06/01/25 - 06/07/25, the service was provided three times. The week of 06/08/25 - 06/14/25, the ambulation program was refused once. There was no other indication of the program being offered. The week of 06/15/25 to 06/21/25, the program was documented with one refusal and no other offers to provide it were documented. Review of a restorative evaluation dated 06/13/25 indicated Resident #82 participated in the program as ordered. The goal was to maintain current ambulation status and be without decline by the next review date. The program would be re-evaluated quarterly and as necessary. On 06/23/25 at 12:36 P.M., the Director of Nursing (DON) acknowledged records did not reflect Resident #82's restorative ambulation program was offered in accordance with orders/plans of care/assessments. This deficiency represents non-compliance investigated under Complaint Number OH00164989.

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F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. Based on record review and interview, the facility failed to ensure the activities program was directed by a qualified professional. This had the potential to affect all 101 residents residing in the facility. Findings include: Review of the personnel file for Activities Director #260 revealed a hire date of 09/22/99 in the role of Certified Nursing Assistant (CNA). On 09/07/21 she applied and accepted the role of an activity assistant. On 06/17/25, it was noted the position description for Activities Leader was signed by Activities Director #260. Review of the position description for Activities Leader revealed she must be a qualified therapeutic recreation specialist or an activities professional who is licensed by the state and is eligible for certification as a recreation specialist or as an activities professional; or must have a minimum of two years experience in a social or recreation program within the last five years, one of which was full-time in a patient activities program in a health care setting; or must be a qualified occupational therapist or occupational therapy assistant; or must have completed a training course approved by this state. There was no evidence in Activities Director #260's employee file to prove she had the qualifications. Review of the timeline of activities directors provided by the facility from 01/01/25 through 06/23/25 revealed Activities Director #260 assumed the role on 02/09/25. Review of the invoice for a certified activities director course for Activities Director #260 revealed she started the course on 04/21/25. Interview on 06/23/25 at 12:04 P.M. with Divisional Director of Activities #255 verified Activities Director #260 was not certified. She stated she had not assisted Activities Director #260 with overseeing the activities program as she had started her employment with the corporation who owned the facility two months ago. Divisional Director of Activities #255 stated she had started working with this facility on 06/20/25. Interview on 06/23/25 at 12:38 P.M. with Activities Director #260 verified she did not have the qualifications as listed in the position description above. She stated she had been doing the activities director position since 02/09/25. Interview on 06/23/25 at 12:49 P.M. with the Regional Administrator #250 verified Activities Director #260 did not have the qualifications required for activities director. This is an incidental finding discovered during the complaint investigation.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on medical record review and interview, the facility failed to ensure medications were administered in accordance with physician orders and set parameters. This affected one (Resident #103) of three residents reviewed for medication administration. Findings include: Review of Resident #103's medical record revealed diagnoses including hypertensive heart disease, paroxysmal atrial fibrillation (irregular heart rhythm), atherosclerotic heart disease, malignant neoplasm of the scrotum and prepuce (a movable sheath of skin that covers the head of the penis), and pleural effusion. On 05/29/25 orders were started for midodrine HCL (a medication that belongs to the class of medications called alpha-adrenergic agonists. It works by causing blood vessels to tighten, which increases blood pressure.) 5 milligrams (mg) three times a day with instructions to hold the medication for a systolic blood pressure (top number of the blood pressure) greater than 120. Review of Resident #103's June Medication Administration Record (MAR) revealed midodrine was administered the morning of 06/03/25 with a blood pressure of 137/78 millimeters of mercury (mm Hg), the morning of 06/06/25 with a blood pressure of 137/74 mm Hg and the morning of 06/07/25 with a blood pressure of 138/74 mm Hg. All three of the doses were signed as administered by Registered Nurse (RN) #225. On 06/16/25 at 3:07 P.M., RN #225 was unable to provide an explanation regarding why the midodrine was administered outside parameters in the orders. On 6/16/25 at 3:20 P.M., the Director of Nursing (DON) had no explanation for why midodrine was administered outside set parameters on 06/03/25, 06/06/25 or 06/07/25 when systolic blood pressures were recorded greater than 120. On 06/18/25 at 1:35 P.M., Nurse Practitioner (NP) #230 stated it was probably okay to administer the midodrine with a systolic blood pressure greater than 120 on dialysis days (one of the three days it was administered) occasionally but it could lead to issues depending on a resident's overall condition. NP #230 stated the three days it was administered outside parameters resulted in no adverse consequences. This deficiency represents non-compliance investigated under Complaint Number OH00166349 and Complaint Number OH00164924.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to provide restorative range of motion (ROM) programs in accordance with physician orders for one (Resident #96) of three residents reviewed for restorative services. Findings include: Review of Resident #96's medical record revealed diagnoses including hemiplegia (paralysis/weakness of one side of the body) affecting the right dominant side, type two diabetes mellitus with diabetic neuropathy, morbid obesity, need for assistance with personal care, generalized anxiety disorder and depression. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #96 was cognitively intact with no rejection of care. Resident #96 had impaired functional ROM of both the upper and lower extremity on one side of her body. Review of a care plan initiated 02/27/23 indicated Resident #96 was on a restorative program for active/passive range of motion. Interventions indicated passive range of motion (PROM) (movement of a joint or body part without any effort from the individual) to the right upper extremity in all planes once a day, six to seven days for 15 minutes a day to increase range of motion to the right upper extremity. The care plan indicated Resident #96 required maximal assistance with minimal verbal cues. Interventions included reassessment of the program quarterly and as needed. Review of restorative program delivery records revealed the program was delivered five times the week of 05/25/25 - 05/31/25, four times the week of 06/01/25 and 06/07/25, five times the week of 06/08/25 and 06/14/25, and five times the week of 06/15/25 to 06/21/25. A restorative evaluation dated 06/13/25 indicated Resident #96 participated in the restorative PROM program as ordered. The goal was to maintain current ROM and be without decline. The assessment indicated Resident #96's restorative program would be re-evaluated quarterly and as necessary. On 06/23/25 at 12:36 P.M., the Director of Nursing (DON) verified documentation did not reflect the program was offered a minimum of six times a week in accordance with the order and care plan. This deficiency represents non-compliance investigated under Complaint Number OH00164924.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365292	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hanover Healthcare Center	435 Avis Avenue NW Massillon, OH 44646

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to provide sufficient staff to provide restorative nursing programs on a consistent basis. This affected three (Residents #26, #82, and #96) of three residents reviewed for restorative services. The facility identified 41 residents with orders for one or more restorative programs (Residents #1, #2, #3, #4, #6, #7, #11, #15, #18, #24, #26, #32, #34, #37, #41, #42, #43, #48, #51, #56, #61, #67, #68, #69, #70, #73, #75, #79, #81, #82, #86, #87, #90, #91, #92, #93, #94, #95, #96, #98 and #100). Findings include: 1. On 06/18/25 at 11:55 A.M., Resident #26 was observed sitting in a recliner in her room with three daughters visiting. All four individuals were in agreement that Resident #26 did not walk well and they had a fear she would fall. Review of Resident #26's medical record revealed diagnoses including cerebrovascular disease, hypertension, dizziness and giddiness, type two diabetes mellitus, unsteadiness on her feet, lumbar region intervertebral disc degeneration, discogenic back pain, and generalized weakness related to a stroke. A Physical Therapy (PT) Discharge summary dated [DATE] revealed a restorative nursing program had been completed for ambulation with the interdisciplinary team to facilitate Resident #26 maintaining her current level of performance and to prevent decline. A care plan initiated 03/14/25 indicated Resident #26 was on a restorative ambulation program to increase confidence and safety with gait once daily six to seven times per week for 15 minutes per day. Stand by assistance and verbal cues were to be provided with ambulation 125 to 200 feet as tolerated with staff offering encouragement and reassurance. Review of restorative program delivery notes revealed in the prior 30 days, Resident #26 received the ambulation program once on 05/28/25 at which time she was recorded as ambulating 240 feet. A restorative evaluation dated 06/12/25 indicated Resident #26 participated in the restorative ambulation program with a goal to maintain strength and be without decline. The restorative ambulation program was to be continued. On 06/23/25 at 8:54 A.M., Resident #26 stated she used to ambulate with Restorative Aide #265 but she retired and nobody else did the program. On 06/23/25, Certified Nursing Assistant (CNA) #270 verified the restorative aide had retired. CNA #270 stated there was not enough time for aides to provide restorative programs in addition to all the other care residents required. On 06/23/25 at 10:45 A.M., Regional Nurse #275 verified Resident #26's documentation revealed she received the restorative ambulation program once in the past 30 days. Upon investigation, she discovered the ambulation program was entered into the aides' task section to provide the service as necessary instead of six to seven times a week for 15 minutes a day. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/23/25 at 12:57 P.M., CNA #280 stated she was unsure which residents were on restorative programs or the type of programs which were to be provided. CNA #280 stated the only way nurse aides would have time to provide restorative programs was if there were always two aides to each hall which did not happen on a consistent basis. 2. Review of Resident #82's medical record revealed diagnoses including hemiplegia and hemiparesis (paralysis or weakness on one side of the body) following cerebrovascular disease, diabetes mellitus, chronic kidney disease, depression, chronic obstructive pulmonary disease, anxiety disorder, low back pain, peripheral vascular disease, and cognitive communication deficit. A plan of care initiated 12/09/24 indicated Resident #82 was on a restorative ambulation program to ambulate 50 to 100 feet with a quad cane with contact guard assistance to minimum assistance to maintain strength in lower extremities once a day for 6-7 days a week. Resident #82 required minimal instruction but staff were to encourage and praise participation. One of the interventions was to reassess quarterly and as needed. Review of restorative ambulation program delivery records revealed the week of 05/25/25 - 05/31/25 the service was offered/provided five times. The week of 06/01/25 - 06/07/25, the service was provided three times. The week of 06/08/25 - 06/14/25, the ambulation program was refused once. There was no other indication of the program being offered. The week of 06/15/25 to 06/21/25, the program was documented with one refusal and no other offers to provide it were documented. Review of a restorative evaluation dated 06/13/25 indicated Resident #82 participated in the program as ordered. The goal was to maintain current ambulation status and be without decline by the next review date. The program would be re-evaluated quarterly and as necessary. On 06/23/25 at 12:36 P.M., the Director of Nursing (DON) acknowledged records did not reflect Resident #82's restorative ambulation program was offered in accordance with orders/plans of care/assessments. 3. Review of Resident #96's medical record revealed diagnoses including hemiplegia (paralysis/weakness of one side of the body) affecting the right dominant side, type two diabetes mellitus with diabetic neuropathy, morbid obesity, need for assistance with personal care, generalized anxiety disorder and depression. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #96 was cognitively intact with no rejection of care. Resident #96 had impaired functional ROM of both the upper and lower extremity on one side of her body. Review of a care plan initiated 02/27/23 indicated Resident #96 was on a restorative program for active/passive range of motion. Interventions indicated passive range of motion (PROM) (movement of a joint or body part without any effort from the individual) to the right upper extremity in all planes once a day, six to seven days for 15 minutes a day to increase range of motion to the right upper extremity. The care plan indicated Resident #96 required maximal assistance with minimal verbal cues. Interventions included reassessment of the program quarterly and as needed. Review of restorative program delivery records revealed the program was delivered five times the week of 05/25/25 - 05/31/25, four times the week of 06/01/25 and 06/07/25, five times the week of 06/08/25 and 06/14/25, and five times the week of 06/15/25 to 06/21/25. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A restorative evaluation dated 06/13/25 indicated Resident #96 participated in the restorative PROM program as ordered. The goal was to maintain current ROM and be without decline. The assessment indicated Resident #96's restorative program would be re-evaluated quarterly and as necessary. On 06/23/25 at 12:36 P.M., the Director of Nursing (DON) verified documentation did not reflect the program was offered a minimum of six times a week in accordance with the order and care plan. The facility identified 41 residents with orders for one or more restorative programs (Residents #1, #2, #3, #4, #6, #7, #11, #15, #18, #24, #26, #32, #34, #37, #41, #42, #43, #48, #51, #56, #61, #67, #68, #69, #70, #73, #75, #79, #81, #82, #86, #87, #90, #91, #92, #93, #94, #95, #96, #98 and #100). This is an incidental finding disovered during the investigation.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, review of physician orders, policy review, and interview, the facility failed to ensure medications were administered as ordered. Two medication errors were identified out of 27 opportunities resulting in a 7.4% medication error rate. This affected one (Resident #74) of two residents observed for medication administration. Findings include: On 06/17/25 at 7:57 A.M., Licensed Practical Nurse (LPN) #200 was observed administering medication to Resident #74. Among medications administered were divalproex sodium (three 250 milligram tablets and one 500 milligram tablet) and vitamin B-6 100 milligrams (mg). Review of Resident #74's physician orders revealed an order dated 02/20/25 for pyridoxine HCl (vitamin B-6) 50 mg every day. There were orders dated 05/08/25 for three divalproex sodium tablet delayed release tablets to be administered in the morning for mood disorder and one divalproex sodium extended release tablet 500 mg in the evening for mood disorder. On 06/18/25 at 9:40 A.M., LPN #200 verified she administered all medications that had been included in the medication packet dated 06/17/25 in the morning. LPN #200 verified Resident #74 had an order for divalproex sodium 750 mg total in the morning and 500 mg in the evening. However, the amount included in the packet totaled 1250 mg. On 06/18/25 at 9:49 A.M., Registered Nurse (RN) #205 stated she had not administered Resident #74's morning medications yet. Observations of the morning medication packets revealed it contained three 250 mg and one 500 mg tablets of divalproex sodium which was an incorrect dose. RN #205 also confirmed only 100 mg tablets of vitamin B-6 were available and she had to split the tablet to give the correct dose. On 06/18/25 at 9:55 A.M., LPN #200 verified she had administered a whole 100 mg tablet of vitamin B-6 to Resident #74, stating the tablets were not scored (A scored tablet is a tablet that has a debossed line or indentation across its surface, allowing it to be easily cut into smaller portions.). On 06/18/25 at 3:18 P.M., Pharmacist #210 reviewed Resident #74's medication profile and stated in February 2025 Resident #74 had an order for divalproex sodium 500 mg twice a day. On 05/08/25 an order was received for divalproex sodium three tablets of 250 mg every morning. The 500 mg dose was not canceled. Since 05/08/25, pharmacy had been sending the three 250 mg tablets as well as the 500 mg tablet for the morning medication administration. Pharmacist #210 stated Resident #74 should have a new depakote (divalproex sodium) level obtained. Review of the facility's Medication Administration policy (no implementation date listed) revealed medications were to be administered only as prescribed by the provider. Nurses were instructed to observed the right dose was administered. The policy instructed nurses not to split or alter tablets. Pharmacy was to be contacted for correct dosage. For emergency purposes, the tablet might be split if the pill was scored. Unscored or coated pills would not be split. This deficiency represents non-compliance investigated under Complaint Number OH00166349 and Complaint Number OH00164924.