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 03/17/2026
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review, the facility failed to provide a safe, clean, comfortable homelike environment for all residents. This affected three residents (#6, #45, and #85) reviewed for environment. The facility census was 113. Findings include:1. On 03/09/26 at 7:30 A.M., an observation of Resident #45 in bed. Observation of the room revealed disarray and smelled of urine. He had dirty clothes on a chair with clean linen on top. There were soiled underwear in the corner and trash on the floor. His bed controller was on the floor at the foot of the bed, out of his reach. On 03/09/26 at 7:40 A.M., an interview with the Director of Nursing (DON) confirmed the urine smell in Resident #45's room, as well as dirty linens, dirty clothes, trash, and general disarray of the room. 2. On 03/10/26 at 8:40 A.M., an observation of Resident #6's room revealed the sheets at the head of the bed were soiled with dark substance. The medical equipment, which included two suction machines and an oxygen concentrator were splashed with dark substances, and the canister of one of the suction machines had fluid in it. The top of the refrigerator had a layer of dust on it. The inside of the refrigerator had sticky substances covering most of the surfaces of the refrigerator. On 03/10/26 at 8:41 A.M., an interview with Resident #6 revealed most of the time he changed his own sheets if they were changed. He indicated he had asked for his clothing to be washed for over a week and this had not been done. He was down to his last clean shirt and pair of pants (which were visibly soiled), and his dirty clothes were stacked up in his closet. On 03/10/26 at 9:00 A.M., an interview with Licensed Practical Nurse (LPN) #642 verified the observations of Resident #6's room. LPN #642 stated the resident had asked her to get his clothing washed and she had not had a chance to let anyone know. She indicated the certified nurse aides (CNA) changed the resident room linens, and she was not sure who was responsible for making sure the medical equipment was clean. On 03/10/26 at 9:05 A.M., an interview with housekeeper (HK) #571 revealed she had cleaned Resident #6's room about one hour before. She indicated housekeeping cleaned the floors, dusted the surfaces of cabinets, dressers, and refrigerators, and on deep cleaning days, they would change the privacy curtains of the rooms. HK #571 stated CNAs were responsible for changing bed linens, but she was not sure who was supposed to clean the medical equipment. 3. On 03/09/26 at 1:24 P.M., an interview with Resident #85 revealed she had fallen twice in the bathroom a couple weeks ago due to toilet seat not being attached to the toilet. She stated a work order was put in for it to be fixed. She also stated the toilet would not flush and she had to use a plunger every time. In addition, she said the sink leaked onto the floor because the pipe just hung down under the sink. (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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	365292	A. Building B. Wing	03/17/2026

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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/09/26 at 1:40 P.M., an observation Resident #85's bathroom revealed a toilet with a loose set that slid to the side when pressure was placed on the hand rails over the toilet seat. This was confirmed by DON at the time of the observation. This deficiency represents non-compliance investigated under Complaint Number 2726816 and 2691714.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review the facility failed to accommodate a resident with prosthetic arms which required assistive devices for self-feeding. This deficient practice affected one resident (Resident #105) out of one resident reviewed for activities of daily living. The facility census was 113. Findings Include:Review of Resident #105 medical record revealed admission date 02/07/23 with diagnoses including but not limited to dementia, traumatic amputation at right and left elbows, and Chronic Obstructive Pulmonary Disease (COPD).Review of Resident #105's annual Minimum Data Set (MDS) dated [DATE] revealed Resident #105 was cognitively intact with a Brief Interview Mental Status (BIMS) score of 14 out of possible 15 and required staff assistance with setting up for eating.Review of Resident #105's physician orders revealed an order dated 01/15/26 for bilateral upper arm prosthetic device on prior to breakfast and off immediately after dinner meal, as tolerated. Check skin integrity before application and after removal every shift.Review of Resident #105's Occupational Therapy (OT) service notes dated 12/03/25 to 02/06/26 revealed OT discharge recommendations for self-feeding including stand-by-assist by staff and use of a scoop plate.Observation on 03/09/26 from 7:30 A.M. to 8:05 A.M. revealed Resident #105 sitting at the dining room table with bilateral upper arm prosthesis, with bilateral grabber hooks, in place. Breakfast meal was served consisting of French toast and cold cereal with milk, cup of coffee and cup of milk with straws for use by Resident #105. On the bilateral upper arm prosthetics there were red and white colored plastic utensils attached to the prosthesis by loose fitting straps. Resident #105 pushed both plastic utensils up each of the prosthesis, out of the way of the grabber hooks. Resident #105 then bent over the plate of French taste and started eating without using any type utensil, scooping the food up with his mouth. Activities Assistant #605 approached Resident #105's table and encouraged him to use the utensils hanging from the prosthetic arms. Resident #105 continued to scoop food from the plate with his mouth.Observation on 03/10/26 at 7:50 A.M. revealed Resident #105 sitting at the dining room table eating breakfast meal using a regular spoon to eat cold cereal with milk. Resident #105 then put the spoon down, bent over the plate and started eating scrambled eggs by scooping them up with his mouth and not using utensils. Staff did not come over to assist Resident #105 or encourage him to use a fork. Interview on 03/12/26 at 1:15 P.M. with Therapy Director #601 revealed the red and white utensils are to be used when Resident #105 does not have the prosthesis on. Resident #105 prefers to use thin handled utensils and can hold the utensils with the grabber hooks on the prosthesis.Interview on 03/12/26 at 3:05 P.M. with Certified Nursing Assistant (CNA) #564 confirmed Resident #105 does not use utensils to eat with and prefers to scoop the food up with his mouth. CNA #564 stated it appears easier for Resident #105 to not use utensils and just eat the food right off the plate. CNA #564 stated Resident #105 has to be encouraged to use a spoon or fork daily.Reviewed the facility's policy titled Routine Resident Care undated revealed provide routine daily care by a certified nursing assistant under the supervision of a licensed nurse, routine care by a nursing assistant includes but not limited to the following, assisting or provides for personal care, eating and hydration.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide individualized activities of interest to Resident #18. This affected one resident (Resident #18) out of three residents reviewed for activities.Findings include:Review of the medical record for Resident #18 revealed an admission date of 09/15/27 with diagnoses to include Alzheimer's disease, major depressive disorder, and ataxia. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 had severe cognitive impairment and was dependent for activities of daily living. Music and doing things with other people was somewhat important to her and it was very important to do her favorite activities. Review of the activity preference assessment dated [DATE] revealed Resident #18 enjoys talking.Review of Resident #18's care plan dated 01/18/24 with a revision date of 02/06/24 revealed Resident #18 may continue to participate in group and/or 1:1 activity of her choice as tolerated. Review of Resident #18's medical record revealed no evidence the resident participated in 1:1 visits. Review of the activity department 1:1 list revealed Resident #18 was not on the list to have 1:1 visits.Observation and interview on 03/10/26 at 8:58 A.M. revealed Resident #18 was lying in bed with the bed against the wall, and the television (TV) was located on the opposite wall not within the resident's view. Resident #18 revealed activity staff do not visit her in her room.Interview on 03/11/26 at 3:20 P.M. with Activity Director (AD) #588 revealed activities are documented in the electronic chart and there was a one on one (1:1) visit binder. She stated she visits residents for 1:1 visits two to three times a week. AD #588 revealed Resident #18 used to come to BINGO, but the past several weeks she has been staying in bed due to pain. AD #588 revealed activities did not visit her on a 1:1 visit since she was staying in her room. There was no documentation that she was offered activities except for on 02/13/26 for a Valentines Day celebration. Interview on 03/11/26 at 4:35 P.M. with Activity Assistant (AA) #630 revealed she kept her own book of the residents she completes 1:1 visits for. AA #630 verified that Resident #18 was not on her list. Review of the undated facility policy titled, Activities Program, revealed that the facility will provide resident center care that meets the psychological, physical, and emotional needs and concerns of the residents.This deficiency represents non-compliance investigated under Complaint Number 2791091.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review the facility failed to prevent a fall while using a mechanical lift for Resident #123 and failed to ensure smoking interventions were followed for Residents #105 and #127. This affected one resident (Resident #123) of five residents reviewed for falls and affected two residents (Resident #105 and Resident #127) of four residents reviewed for smoking. The facility census was 113.Findings include: 1. Review of the medical record for Resident #123 revealed she was admitted to the facility on [DATE] with diagnoses that included right foot fracture, morbid obesity, back pain, diabetes mellitus type 2, and bipolar disorder. She was discharged from the facility on 07/11/25. Review of the care plan dated 05/03/25 revealed Resident #123 was at risk for falls related to impaired mobility, morbid obesity, and the mechanical lift tipped over interventions included to provide assistive devices as needed. Review of the Fall Risk Observation tool dated 05/20/25 at 6:33 A.M. revealed Resident #123 was at risk for falls and was a total mechanical lift for all transfers. Review of the progress note dated 05/22/25 at 3:10 P.M. revealed the mechanical lift tipped over while Resident #123 was being transferred from the bed to a stretcher for an orthopedic follow-up appointment. Review of the fall investigation dated 05/22/25 at 3:10 P.M. revealed Resident #123 fell to the floor while still connected to the mechanical lift. Review of the witness statement from Certified Nurse Aid (CNA) #612 dated 05/22/25 at 3:10 P.M. revealed that when Resident #123 was transferred with the mechanical lift it lost balance while turning and tipped over, Resident #123 had to be lifted from the floor. Review of the discharge Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #123 was cognitively intact, did not reject care, required maximal assistance for transfers, and had fallen while admitted to the facility. An interview on 03/16/2026 at 10:59 A.M. with CNA #612 verified that Resident #123 had fallen while being transferred using a mechanical lift. Review of the undated policy titled Mechanical Lift and Transfers revealed the facility would meet the psychosocial, physical, and emotional needs of residents and safety is a primary concern. 2. Review of the medical record for Resident #127 revealed he was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (lung disease), respiratory failure, heart disease, and amputation of the right hand. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #127 did not have sensory deficits, was cognitively intact, required setup assistance for eating and oral hygiene, and was dependent on staff for dressing, transferring, and bathing. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the smoking assessment dated [DATE] at 4:38 P.M. revealed Resident #127 was a supervised smoker that required a smoking apron due to a dexterity problem. An interview on 03/11/26 at 4:00 P.M. with Resident #127 revealed during his last smoking time staff did not provide a smoking apron. An interview on 03/11/26 at 4:38 P.M. with CNA #608 verified she did not put a smoking apron on Resident #127 on that smoking time. Review of the undated smoking policy titled Resident Smoking Guidelines, revealed the facility was to promote resident centered care, a safe smoking area for supervised smokers, and staff were to monitor supervised smokers. 3. Review of Resident #105's medical record revealed admission date 02/07/23 with diagnoses including but not limited dementia, traumatic amputation at right and left elbows with use of prosthesis, Chronic Obstructive Pulmonary Disease (COPD), and nicotine. Review of Resident #105's smoking care plan dated 11/26/25 revealed Resident #105 uses a smoking apron and is a supervised smoker. Review of Resident #105's annual MDS dated [DATE] revealed Resident #105 was cognitively intact with a Brief Interview Mental Status (BIMS) score of 14 out of possible 15 and required assistance from staff for completion of Activities of Daily Living (ADL) tasks. Review of Resident #105's smoking assessment dated [DATE] revealed Resident #105 requires adaptive equipment, one on one supervision, and to wear a smoking apron (a fire-resistant apron used to cover the torso or body and lap to aid in preventing cigarette ashes or dropped cigarettes from igniting clothing). Observation on 03/09/26 at 11:10 A.M. revealed Resident #105 sitting in his wheelchair in the smoking area with CNA #564 passing out cigarettes and assisting resident with lighting of their cigarettes. Resident #105 began smoking his cigarette without having a smoking apron in place, Resident #105 was observed scrapping the cigarette ashes off the end of his cigarette by using his left prosthesis with the ash falling on his lap and upper thighs. Interview on 03/09/26 at 11:25 A.M. with CNA #564 confirmed Resident #105 did not use a smoking apron while he was smoking a cigarette. CNA #564 stated she didn't know of anyone needing to use a smoking apron while smoking. Review of the facility policy titled Resident Smoking Guidelines undated revealed a Smoking Apron is a fire-resistant apron used to cover the torso or body and lap to aid in preventing cigarette ashes or dropped cigarettes from igniting clothing. It is the policy of this facility to promote resident centered care by providing a safe smoking area for residents that request to smoke and are capable of safe smoking behaviors either independently or with supervision.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and policy review, the facility failed to ensure its kitchen area was maintained in a clean and sanitary condition. This had the potential to affect 118 out of 119 residents who consumed meals from the facility's kitchen, as one resident (Resident #44) out of 119 residents received nothing by mouth. The census was 119.Findings include:Tour of the kitchen on 03/09/26 from 6:06 A.M. to 6:25 A.M. revealed in the prep area the microwave had dried food inside and the table it sat on was dirty with food crumbs. The shelf underneath had rice Krispies, cheerios, corn flakes, and frosted flakes in containers that were not dated. The reach-in refrigerator had five rusty shelves with shredded cheese not labeled or dated and butter that was in a one sixth hotel pan that was not wrapped properly, labeled or dated. The serving area had grease on the table where the toaster was placed. The plate warmer and pellet warmer had food splatter on them. The steam table had dried food on seven out of ten steam table wells with five lids dirty with dried food and gravy. The dish area had cracked [NAME] floor tiles. The clean area of the drain board of the dish machine had dried food and a salt packet on it. In the cooking area, the slicer had dried meat on it near the blade, the robot coupe had dried food around the base of the machine. There were cracked tiles and a hole in the wall where the food carts were stored. This was verified by [NAME] #575 on 03/11/26 at 6:25 A.M.Observation on 03/10/26 at 10:43 A.M. revealed [NAME] #536 rinsed out the robot coupe in the three-compartment sink without the proper washing and sanitizing process and revealed she only rinses it out.Review of the policy entitled Operation and Sanitation dated 05/20/20 revealed operating instructions and cleaning procedures are developed for all dining services equipment.Review of the closing checklist revealed that all equipment should be cleaned, and all food is wrapped, labeled and dated.This deficiency represents non-compliance investigated under Complaint Number 2746141.

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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, observations, interviews, and facility policy review the facility failed to maintain infection control by not disposing of used tracheostomy supplies and by not performing hand hygiene during incontinence care. These deficient practices affected two residents (Resident #12 and #44) out of nine residents reviewed for infection control. The facility census was 113.Findings Include: 1. Review of Resident #44's medical record revealed admission date 02/27/26 with diagnoses including but not limited to acute respiratory failure, epilepsy, kidney failure requiring hemodialysis, tracheostomy, and gastrostomy. Review of Resident #44's physician orders revealed an order dated 03/04/26 for tracheostomy care every shift. Review of Resident #44's care plan dated 03/06/26 revealed tracheostomy using Shiley (type of tracheostomy) size six extra-large with humidified air via trach collar. Review of Resident #44's Treatment Administration Record (TAR dated) 03/04/26 to 03/12/26 revealed the order for trach care was completed as ordered. Observation on 03/12/26 at 2:20 P.M. during trach care for Resident #44 revealed used trach collar with attached tubing laying on the table in the corner of Resident #44's room. There was a white washcloth laying on top of the used trach collar and no barrier underneath to where the used trach collar was laying on the tabletop. Interview on 03/12/26 at 2:40 P.M. with Registered Nurse #526 confirmed the used trach collar and attached tubing was laying on the table without a barrier underneath it between the tabletop and the trach collar. RN #526 stated the nurse must have removed the trach collar and tubing prior to Resident #44 going to dialysis. Review of the facility policy titled Infection Prevention Infection Control undated revealed standard precautions are universally applied in care and treatment of all residents regardless of their known or unknown infectious status. 2. On 03/09/26 at 8:49 A.M., an observation of incontinence care for Resident #12 revealed hand hygiene was not followed throughout the process. Certified Nurse Aide (CNA) #589 cleansed under the resident's panniculus (dense layer of excess subcutaneous fat and skin hanging from the lower abdomen) with gloves on. The area was reddened with chunks of old skin and powder being removed by the CNA. She proceeded to apply barrier cream to the resident and then to clean the resident's perineal area without performing hand hygiene or changing her gloves. She cleaned the resident, rolled her to her side, and with the assistance of CNA #587, she removed the resident from the bedpan. At that time she cleaned the bedpan, washed her hands and changed her gloves. She completed the remainder of the incontinence care including cleaning the resident's gluteal area without further hand hygiene until she had completed the care. On 03/09/26 at 9:10 A.M., an interview with CNA #589 confirmed she only completed hand hygiene one time during incontinence care for Resident #12. She stated she had been educated about hand hygiene but she could not remember when that was. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an undated facility policy titled Perineal Care-Male and Female, provided by the Director Nursing (DON), revealed the purpose of the policy was to provide personal care to promote a sense of well being and meet hygiene standards of care. The policy identified completing hand hygiene before applying gloves and beginning care. Hand hygiene would be performed after completing skin care and new gloves applied before completing bed care such as repositioning and cleaning the area. Once all care and clean-up was completed, the staff member should remove gloves and complete hand hygiene. Review of an undated facility policy titled Standard Precautions and Transmission Based Precautions, provided by the DON, revealed gloves were to be changed between clean and dirty tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Hand hygiene was to be performed each time gloves were removed and/or changed.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, and facility policy review the facility failed to ensure call lights within reach of residents. This deficient practice affected three residents (Residents #45, #112, and #116) out of three residents reviewed for call light use. The facility census was 113. Findings Include: 1. Review of Resident #112's medical record revealed admission date 11/22/24 with diagnoses including but not limited to dementia, depression and high blood pressure. Review of Resident #112's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #112 had impaired cognition with a Brief Interview of Mental Status (BIMS) score of three out of possible 15 and required limited assistance from staff for completion of Activities of Daily Living (ADL) tasks. Review of Resident #112's care plan dated 12/04/24 revealed Resident #112's primary language was Spanish and Resident #112 had self-care deficit requiring staff assistance related to language barrier and impaired mobility. Observation on 03/09/26 at 9:55 A.M. revealed Resident #112's bed located against the wall and Resident #112 was laying in the bed sleeping. Resident #112's call light was observed attached to the privacy curtain across the room for Resident #112's bed. Interview on 03/09/26 at 10:14 A.M. with Registered Nurse (RN) #576 confirmed Resident #112's call light was attached to the privacy curtain across the room for where Resident #113 was sleeping in bed. 2. Review of Resident #116's medical record revealed admission date 03/05/24 with diagnoses including but not limited Alzheimer's disease, depression, anxiety, and high blood pressure. Review of Resident #116's annual MDS dated [DATE] revealed Resident #116 had impaired cognition with a BIMS score of five out of possible 15 and required staff assistance with ADL tasks. Review of Resident #116's care plan dated 03/06/24 impaired communication related to dementia, functional incontinence of bowel and bladder, and impaired mobility requiring staff assistance. Observation on 03/09/26 at 9:15 A.M. revealed Resident #116 sleeping in bed with no call light in reach. Further observation revealed both call lights were attached to the roommate's bed. Interview on 03/09/26 at 10:14 A.M. with RN #576 confirmed Resident #116's call light was attached to the roommate's bed and not in reach for Resident #116 to use if needed. Review of the facility's policy tilted Resident Rights undated revealed the right to have a method to communicate needs to staff, call light or bell access will be within reach of the resident as one method to communicate needs to staff. 3. On 03/09/26 at 7:30 A.M., an observation of the call light for Resident #45 revealed it was wound up over the call light actuator box near his recliner, and he could not reach it from the bed. His bed (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	controller was on the floor at the foot of the bed, out of his reach. On 03/09/26 at 7:40 A.M., Director of Nursing confirmed Resident #45 could not reach his call light from his bed. He placed the call light within reach.