

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

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on medical record review, review of the grievance/complaint log, review of the facility investigation, and interview with staff the facility failed to thoroughly investigate an allegation that a staff member took photographs of Resident #102 with her cell phone and failed to investigate a missing electric razor for Resident #64. This affected two residents (Resident #64 and #102) of three resident reviewed who filed formal concerns with the facility. Findings include: 1. Review of the medical record revealed Resident #102 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, hypertension, spinal stenosis, anxiety disorder, major depressive disorder, and benign prostatic hyperplasia. Review of the grievance/complaint log dated 06/28/24 revealed Resident #102 had a complaint concerning pictures being taken of him. The resolution was to erase the pictures from the telephone. Review of the grievance form dated 06/28/24 revealed Resident #102 filed a formal complaint with Social Worker (SW) #878. Resident #102 reported State tested Nursing Assistant (STNA) #837 took his picture with her cell phone without his consent. The Administrator followed up and the staff denied taking pictures. STNA #837 stated she felt Resident #102 was saying this in retaliation. The staff was educated on Health Insurance Portability and Accountability Act (HIPPA) and resident rights. Review of the Social Service note dated 06/28/24 timed at 11:15 A.M. revealed Resident #102 was confronted by the Social Worker about pulling another resident behind him that day after he was asked not to do this the day before. Resident #102 was argumentative at first, he felt that the facility was quick to point out him doing wrong, but felt that a staff member taking his picture was not addressed and there was no consequences. Review of the facility investigation dated 07/01/24 revealed there was no documentation of interviews with other residents or staff about the incident. Review of the modification of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #102 had intact cognition. (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
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/12/24 at 4:00 P.M. an interview with Resident #102 revealed STNA # 837 took two pictures of him with her cell phone back in June 2024. He stated she told him his eyes looked funny, insinuating he was high. He told her his eyes always looked like that. He stated he told SW #878 about the incident but nothing had been done. He stated another resident saw her taking the picture. On 08/12/24 at 4:15 P.M. an interview with Resident #97 revealed he saw STNA #837 put her cell phone in Resident #102 face and she took his picture. She turned her cell phone around for Resident #102 to see and said to him, see look at your eyes. On 08/13/24 at 2:26 P.M. an interview with SW #878 revealed he had been speaking to Resident #102 about his court date and the resident brought up a concern about STNA #837 taking his picture and how she should not have done that. He stated he asked Resident #102 if he wanted to file a grievance and he stated yes. SW #878 stated he gave the grievance form to the Administrator. On 08/13/24 at 4:00 P.M. an interview with the Administrator revealed he had spoken to STNA #837 on the telephone the day Resident #102 reported the incident to the social worker and she denied taking any picture of Resident #102. Review of the handwritten signed witness statement by STNA #837 dated 08/14/24 revealed she indicated she never took any pictures of Resident #102. Review of the typed signed undated witness statement from Resident #97 revealed Resident #102 was at the exit door of the dining room on the C hall side. STNA #837 was implying that Resident #102 was high. STNA #837 took a picture of Resident #102 face and showed it to him. Resident #102 was nonchalant about having his picture taken. STNA #837 took Resident #102 picture twice. Review of the typed signed undated witness statement from Resident #102 revealed Resident #102 was in the doorway to the dining room next to C Hall. STNA #837 asked if he had Visine and that his eyes were red. STNA #837 stated to let her show him and she took his picture and showed him the picture. He stated his eyes were always red so he did not notice anything different. He felt she was implying that his eyes were red because he was doing something he was not supposed to do. STNA #837 took his picture a second time and he did not feel it was her place to take a picture since she was not a nurse. On 08/14/24 at 6:50 A.M. an interview with STNA #837 revealed on 06/05/24 at around 7:30 P.M. Resident #102 was yelling at her and saying all kinds of weird stuff, threatening her and her family , saying he was going to have people come to her house and hurt her and her family. She stated she just stayed away from him. The next day he was doing the same thing but it got worse with the threatening. There were several witnesses to what he was saying to her. STNA #837 told management on that day but nothing was done so she eventually she called the police and pressed charges against Resident #102. She stated she never took any pictures of him and she did not know where he got that from. On 08/14/24 at 10:40 A.M. an interview with the Administrator revealed he was not able to get other employee or resident interviews because Resident #102 did not tell him what day the incident happened. He stated he thought it was a HIPPA violation not abuse. 34298 (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record revealed Resident #64 was admitted on [DATE] with diagnoses that included anxiety, major depressive disorder, respiratory failure, and Alzheimer's disease. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #64 was cognitively intact. Review of Grievance Form dated 07/05/24 revealed Resident #64 reported an electric razor had been missing prior to his last hospital visit. The actions taken to resolve the grievance included the licensed social worker would address with maintenance in staff meeting on 07/08/24. Interview on 08/12/24 at 10:14 A.M. with Resident #64 revealed an electric razor was missing. Resident #64 stated he reported the electric razor missing but had not heard anymore about what was being done to locate the electric razor. Interview on 08/14/24 at 3:43 P.M. with Director of Plant Maintenance #877 verified he was not notified about Resident #64's missing electric razor and that would be more of a housekeeping or laundry issue. The Administrator was also interviewed at 3:43 P.M. and verified there had not been a follow up for Resident #64's missing electric razor and an investigation had not been completed.		

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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** 34297 Based on observation, record review and interview, the facility failed to ensure Resident #13, who required setup assistance with meals, received the breakfast meal and was assisted with set up in a timely manner. This affected one (Resident #13) of thirty-one residents who required setup assistance on the secured memory care unit (SMCU). The census on the SMCU was 34. Findings include: Review of Resident #13's medical record revealed the Resident #13 was admitted on [DATE] with diagnoses including senile degeneration of the brain, anxiety disorder and unspecified dementia with mood disturbance. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 exhibited severe cognitive impairment. Review of Resident #13's Nutritional Problem Care Plan revealed an intervention dated 04/05/24 to provide meals per the diet order (regular diet, dysphagia mechanical texture, thin liquids consistency with fortified pudding twice daily and fortified cereal daily). Resident #13 could have pleasure foods as tolerated per orders obtained by hospice services. Review of Resident #13's physician orders revealed an order dated 04/05/24 for a regular diet, dysphagia mechanical texture, thin liquids consistency with a two handled cup/lid, fortified pudding twice daily and fortified cereal daily. Observation on 08/12/24 at 10:32 A.M. revealed Resident #13 was rolled out of her room in a Broda chair and placed in hall. Resident #13 had not been provided a breakfast meal. Interview on 08/12/24 at 10:35 A.M. with State tested Nursing Assistant (STNA) #812 revealed Resident #13 refused to get out of bed earlier and was considered a choking hazard. Resident #13 was not provided her breakfast meal while in her room in bed because the SMCU had two STNAs available for the breakfast meal and that was not enough staff to observe or feed residents in their rooms. STNA #812 further revealed a third STNA came into the building around 9:00 A.M. and the residents were offered alternative breakfast foods when they were assisted out of their beds. STNA #812 confirmed Resident #13 required setup assistance with meals. Interview on 08/12/24 at 11:13 A.M. with Licensed Practical Nurse (LPN) Unit Manager #904 revealed the SMCU residents were encouraged to come to the dining room for their meals. The breakfast meal was delivered around 8:30 A.M. and LPN Unit Manager #904 was unaware Resident #13 was not provided a breakfast meal. Review of the Routine Resident Care policy revised 04/06/16 revealed daily care by a certified nursing assistant under the supervision of the licensed nurse included assisting with or providing routine personal care such as bathing, dressing, eating, hydration and toileting. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00156432.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 34298 Based on observation, record review and interview, the facility failed to ensure residents who required staff assistance and/or were dependent on staff for activities of daily living including grooming, hygiene, eating and/or toileting received adequate and timely assistance to maintain their highest practicable well-being. This affected four residents (#4, #51, #64 and #214) of five sampled residents reviewed for activities of daily living. The facility census was 104. Findings include: 1. Review of the medical record revealed Resident #4 was admitted on [DATE] with diagnoses that included schizophrenia, type 2 diabetes, seizures, dementia, extrapyramidal and movement disorder, and paraplegia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 scored a three on the Brief Interview for Mental Status (BIMS) which indicated severe cognitive impairment. The MDS also revealed Resident #4 was dependent for bathing and hygiene. Review of the Plan of Care dated 02/23/24 revealed Resident #4 had self-care deficit that required staff assistance. Interventions revealed Resident #4 was totally dependent on staff for personal hygiene. Observation on 08/12/24 at 1:36 P.M. revealed Resident #4 had long, dirty fingernails. Interview on 08/15/24 at 7:15 A.M. with the Director of Nursing (DON) verified Resident #4 had long finger nails that needed trimmed and cleaned. 2. Review of the medical record revealed Resident #64 was admitted on [DATE] with diagnoses that included anxiety, major depressive disorder, respiratory failure, and Alzheimer's disease. Review of the quarterly MDS assessment dated [DATE] revealed Resident #64 was cognitively intact. Resident #64 required substantial to maximal assistance for toileting and showers. Observations on 08/13/24 at 10:36 A.M. and 08/14/24 at 11:53 A.M. revealed Resident #64 had long fingernails with dark debris under the nails. Interview on 08/15/24 at 8:56 A.M. with the DON verified Resident #64's fingernails needed trimmed and cleaned. 3. Review of the medical record revealed Resident #214 was admitted [DATE] with diagnoses that included sepsis, anxiety, protein-calorie malnutrition, and dementia. Review of the Plan of Care dated 04/12/24 revealed Resident #214 had self-care deficit and was dependent on staff for all activities of daily living. Interventions included staff to provide total care for oral hygiene, toileting, and transfers. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medicare 5-day MDS assessment dated [DATE] revealed Resident #214 had a BIMS score of 10 which indicated Resident #214 had moderate cognitive impairment. The MDS also revealed Resident #214 was dependent for bathing. Observations on 08/12/24 at 12:17 P.M., 08/13/24 at 8:36 A.M. and 2:15 P.M., and on 08/14/24 at 8:03 A.M. revealed Resident #214 had dark debris under finger nails. Interview on 08/15/24 at 8:58 A.M. with the DON verified there was dark debris under Resident #214's finger nails and the fingernails needed cleaned. 34297 4. Review of Resident #51's medical record revealed Resident #51 was admitted on [DATE] with diagnoses including Alzheimer's disease, dementia and diabetes. Review of Resident #51's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #51 exhibited severe cognitive impairment. The assessment revealed Resident #51 was always incontinent of bowel and bladder. Review of Resident #51's physician orders revealed an order dated 05/17/24 for a regular diet, dysphagia mechanical texture, thin liquids with fortified cereal daily, fortified pudding twice daily, yogurt daily and whole milk three times a day. The resident also had a physician order, dated 05/30/24 for a mechanical lift with two-person assist for all transfers. a. Review of Resident #51's Self-Care with Activities of Daily Living (ADL) Care Plan revealed an intervention dated 04/30/24 which indicated Resident #51 was dependent with meals and the helper did all of the effort or two or more helpers assisting. Observation on 08/12/24 at 9:53 A.M. of Resident #51's morning care with State tested Nursing Assistant (STNA) #840 and STNA #847 revealed Resident #51 did not receive a breakfast meal. Interview on 08/12/24 at 10:35 A.M. with STNA #812 revealed Resident #51 refused to get out of bed, was considered a choking hazard, and she was not provided with the breakfast meal this morning. STNA #812 stated the secured memory care unit (SMCU) had two STNAs for the breakfast meal and that was not enough staff to observe or feed residents in their room. STNA #812 revealed a third STNA came into the building around 9:00 A.M. and the residents were offered alternative breakfast meals when they were assisted out of the bed. STNA #812 confirmed Resident #13 required setup assistance with meals. Interview on 08/12/24 at 11:13 A.M. with Licensed Practical Nurse (LPN) Unit Manager #904 revealed SMCU residents were encouraged to come to the dining room for the meals. LPN Unit Manager #904 indicated the breakfast meal was delivered around 8:30 A.M. and she was unaware Resident #51 was not provided a breakfast meal. Review of the Routine Resident Care policy revised 04/06/16 revealed daily care by a certified nursing assistant under the supervision of the licensed nurse included assisting with or providing routine personal care such as bathing, dressing, eating, hydration and toileting. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Review of Resident #51's Potential for Incontinence Care Plan revealed an intervention dated 03/28/24 to check the resident for incontinence. Wash, rinse and dry the perineum and change clothing after each incontinent episode. Observation on 08/12/24 at 12:11 P.M. revealed Resident #51 was sitting in the dining room and she asked Activity Aide #805 to go to the bathroom. Further observation revealed Activity Aide #805 reported to Licensed Practical Nurse (LPN) #886 that Resident #51 had to go to the bathroom and the nurse told her to tell the resident to use the incontinence brief and she would be changed later. Interview on 08/12/24 at 12:20 P.M. with LPN #886 indicated Resident #51 was a check and change and that even if the staff used a Hoyer (mechanical) lift to put the resident in bed in order to use a bedpan, the resident would not use the bedpan. Interview on 08/14/24 at 7:52 A.M. with LPN Unit Manager #904 revealed Resident #51 required a Hoyer lift and did not go to the bathroom. LPN Unit Manager #905 stated the staff should have attempted to put Resident #51 in bed and put the resident on a bedpan. Interview on 08/14/24 at 7:58 A.M. with Activity Aide #805 with LPN Unit Manager #804 in attendance revealed on 08/12/24 during the lunch meal, Resident #51 reported that she needed to use the bathroom and did not want to pee in her pants. Activity Aide #805 confirmed the nurse told Resident #51 to go in her brief and she would be changed at a later time. This deficiency represents non-compliance investigated under Complaint Number OH00156432.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review and interview, the facility failed to ensure Resident #62 received adequate and timely treatment, including the administrative of laxative medication to address constipation. This affected one (Resident #62) of one resident reviewed for bowel regimen. Findings include: Review of the medical record revealed Resident #62 was admitted on [DATE] with diagnoses that included dementia, major depression, delusional disorders, anxiety, and abnormal weight loss. Review of a physician order dated 08/29/22 revealed Resident #62 was ordered Milk of Magnesia Oral Suspension (laxative) five milliliter (ml) by mouth every 24-hours as needed for constipation. Review of the plan of care dated 09/18/23 revealed Resident #62 was a risk for constipation. Interventions included to monitor bowel movement and observe for signs and symptoms of complication of constipation. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 had a score of 00 on the Brief Interview for Mental Status (BIMS) which indicated Resident #62 had severe cognitive impairment. Review of the plan of care revised 05/29/24 revealed Resident #62 required staff assistance with activities of daily living and was dependent for toileting/hygiene. Review of the bowel movement documentation revealed Resident #62 did not have a bowel movement on 07/16/24, 07/17/24 or 07/18/24. Review of an alert note dated 07/19/24 timed at 11:47 A.M. revealed there was no documentation Resident #62 had a bowel movement for three days. Review of a nurse's note included Resident #62 did have a small formed bowel movement on 07/18/24. Review of bowel movement documentation revealed Resident #62 did not have a bowel movement on 07/19/24, 07/20/24, 07/21/24, or 07/22/24. Review of a nurse's note dated 07/22/24 at 12:56 P.M. revealed the physician was notified Resident #62 was vomiting after meals. The nurse's note included the resident's bowel sounds were present in all four quadrants and Resident #62's abdomen was soft and nondistended. Review of a nurse's note dated 07/22/24 at 1:18 P.M. revealed Resident #62 was refusing food and keeping saliva in mouth. The note included Resident #62 had not had a bowel movement and Milk of Magnesia five ml was administered. Review of the medication administration record revealed Resident #62 was administered Milk of Magnesia five ml on 07/22/24 at 1:15 P.M. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nurse's note dated 07/22/24 at 2:11 P.M. revealed new orders were received for Resident #62 to have a STAT abdominal x-ray, complete blood count with differential and basic metabolic panel laboratory testing. New orders were also obtained for medications including Omeprazole (proton-pump inhibitor) 20 milligram (mg) at bedtime, and Zofran (anti-nausea) 4 mg at breakfast and lunch for three days. Review of the abdominal x-ray result dated 07/22/24 timed at 11:06 P.M. revealed the x-ray was ordered due to nausea and vomiting. Multiple nondilated gas-filled loops of the resident's bowel were identified. No abnormal air-fluid levels or calcifications were noted. Stool was noted during the visualized colon to the level of the hepatic flexure. (The hepatic flexure, also known as the right colic flexure, is a sharp bend in the large intestine, or colon, that is located in the upper right abdomen, under the liver. It is where the ascending colon turns left to meet the transverse colon.) The impression indicated stool throughout the visualized colon. Follow-up to document resolution was recommended. Review of a nurse's note dated 07/23/24 at 9:24 A.M. revealed Resident #62 received Milk of Magnesia on 07/22/24 and did have a bowel movement. Resident #62 was in the dining room for breakfast. Resident #62 had no emesis or nausea. Review of a physician order dated 07/23/24 revealed Resident #62 was ordered Senna-Plus (laxative and stool softener to treat constipation) 8.6-50 milligram twice a day on this date. Interview on 08/15/24 at 9:42 A.M. with the Director of Nursing (DON) revealed the bowel movement documentation records reflected Resident #62 did not have a bowel movement from 07/16/24 until 07/23/24. The DON did state there was a nurse's note that revealed Resident #62 had a small bowel movement on 07/18/24. However, the DON verified Resident #62 went another four days without a bowel movement after 07/18/24 and had nausea and vomiting and the physician was notified. The physician ordered blood work, an abdominal x-ray, and medications to treat nausea and vomiting. The DON stated the nurses were alerted on the electronic record when a resident did not have a bowel movement for three days. The DON verified Milk of Magnesia was not administered to Resident #62 until 07/22/24 even though Resident #62 only had a small bowel movement in a seven day time period.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on medical record review and interview, the facility failed to provide vision care for Resident #27 in a timely manner. This affected one (Resident #27) of three residents reviewed for communication and sensory. Facility census was 104. Findings include: Review of the medical record revealed Resident #27 was admitted on [DATE] with diagnoses that included schizophrenia, anxiety, major depressive disorder, intellectual disabilities, and dementia. Review of the Plan of Care dated 04/10/24 revealed Resident #27 had impaired visual function. Interventions included to arrange consultation with eye care practitioner as needed and observe/document/report to medical provider acute eye problems. Review of an eye care group visit summary dated 04/26/24 revealed Resident #27 had new eyeglasses fitted. Review of a social service note dated 04/30/24 timed at 1:50 P.M. revealed Resident #27 stated even though he saw the eye doctor last week and got new glasses he was still having visual difficulties. Resident #27 stated he had a previous cataract diagnosis and wondered if the cataracts were getting worse. Resident #27 requested to see the eye doctor again. Licensed Social Worker (LSW) #878 told Resident #27 a request would be submitted to the nurse practitioner. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 scored a 12 on the Brief Interview for Mental Status (BIMS) which indicated moderate cognitive impairment. Resident #27 had adequate vision and wore corrective lenses. During interview on 08/12/24 at 1:06 P.M. Resident #27 stated his eyeglasses were not helping with foggy vision and he wanted to see an eye doctor. Interview on 08/14/24 at 8:35 A.M. with LSW #878 revealed it was discussed about getting an appointment with an ophthalmologist for Resident #27. Another interview on 08/14/24 at 10:59 A.M. with LSW #878 revealed a request for additional vision services for Resident #27 was submitted to the nurse practitioner (NP) on 04/30/24. A follow up interview on 08/15/24 at 7:04 A.M. with LSW #878 verified Resident #27 had not had any type of follow up and Resident #27 had not seen any type of eye doctor since the referral request was sent to the NP on 04/30/24.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on observation, record review, and interview, the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to ensure skin impairment for Resident #64 was accurately assessed at the time of identification and to promote optimal healing. This affected one (Resident #64) of three residents reviewed for skin concerns. Facility census was 104. Findings include: Review of the medical record revealed Resident #64 was admitted on [DATE] with diagnoses that included congestive heart failure, anxiety, major depressive disorder, respiratory failure, Alzheimer's disease, right knee osteoarthritis, and impulse disorder. Review of the plan of care dated 05/27/24 revealed Resident #64 was at risk for impaired skin integrity related to impaired mobility and need for assistance with most activities of daily living. Interventions included to complete Skin at Risk assessment as needed, weekly skin checks, educate on the need for turning, encourage to turn and reposition every two hours and as needed, and peri care as ordered. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #64 was cognitively intact had no pressure ulcers and required substantial to maximal assistance for toileting and showers. Resident #64 was dependent on staff for transfers. Review of the skin and wound note authored by the wound nurse practitioner (WNP) dated 08/06/24 timed at 11:02 A.M. revealed Resident #64 had no open wounds. Review of the skin assessment note dated 08/06/24 timed at 4:15 P.M. authored by Assistant Director of Nursing (ADON)/Licensed Practical Nurse (LPN) #855 revealed Resident #64 had no skin concerns and did not need to be seen weekly by the wound team. Review of a nurse note dated 08/11/24 timed at 4:30 P.M. revealed a State tested Nursing Assistant (STNA) called the nurse to observe Resident #64's buttocks. The nurse discovered eight Stage II pressure ulcers measuring between one to two centimeters (cm) on bilateral buttocks and sacrum. The physician was notified and a new treatment was put in place. Review of the physician note dated 08/11/24 timed at 4:02 P.M. revealed a nurse called to report Resident #64 had several open Stage II pressure ulcers to bilateral buttocks and sacrum. Triad paste (a sterile coating that can be used on broken skin, keeping the wound covered and protected from incontinence) was ordered and the wound team was to follow up with Resident #64 in the morning. Record review revealed no evidence Resident #64 was seen by the wound care team on 08/12/24. Review of the treatment administration record (TAR) revealed on 08/12/24 a treatment was started to Resident #64's bilateral buttocks and sacrum. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/14/24 at 9:36 A.M. with ADON/LPN #855 verified the WNP had not observed Resident #64 since the open areas were identified on 08/11/24. ADON/LPN #855 stated she believed the areas were not Stage II pressure ulcers as documented by the the nurse on 08/11/24. However, no additional information was provided to explain how this was determined. In addition, ADON/LPN #855 had not assessed the open areas until 08/14/24. ADON/LPN #855 stated the areas of skin impairment were to Resident #64's mid lower back and not the buttocks or sacrum. Review of a Skin Grid Non-Pressure form dated 08/14/24 timed at 9:57 A.M. completed by ADON/LPN #855 revealed Resident #64 was assessed to have moisture associated skin dermatitis (MASD) to his mid lower back. The MASD was documented as diffuse with partial thickness skin loss. The area was to be cleansed with normal saline, patted dry, Triad paste applied and the area left open to air. Observation on 08/14/24 at 11:41 A.M. revealed Resident #64 had four open areas to the left buttock, an open area to sacrum, and scabbed/dried areas to right buttock and mid lower back. During an interview and observation of Resident #64's buttocks/back/sacrum on 08/14/24 at 3:46 P.M. with ADON/LPN #855 she verified Resident #64 had an open area to the sacrum which appeared to be a pressure ulcer. ADON/LPN #855 was not aware of the pressure ulcer to Resident #64's sacrum until this observation. Interview on 08/14/24 at 9:36 A.M. with ADON/LPN #855 verified the wound nurse practitioner had not seen Resident #64 since the open areas were identified on 08/11/24. ADON/LPN #855 stated the nurse that documented that Resident #64 had Stage II pressure ulcers to buttocks and sacrum on 08/11/24 was incorrect. ADON/LPN #855 stated the open areas were to Resident #64's mid lower back, not the buttocks or sacrum, and were not pressure ulcers. ADON/LPN #855 also verified 08/14/24 was the first she had assessed the wounds that were identified on 08/11/24. Interview on 08/14/24 at 11:41 A.M. with Resident #64 revealed he was told there was a concern with his back related to moisture. Resident #64 denied any concerns with not receiving incontinence care and denied any pain the back, buttocks, or sacrum. Review of a nurse's note dated 08/14/24 timed at 4:06 P.M. revealed the skin to Resident #64's sacrum and buttocks was re-assessed. Resident #64 was assessed to have a pressure area to sacrum and MASD to left buttock. Resident #64 would be placed on an air mattress and the wound team would follow weekly until the wound was healed. Review of the Skin Grid Pressure form dated 08/14/24 timed at 4:10 P.M. revealed Resident #64 had a Stage III pressure ulcer to sacrum that measured 0.5 centimeters (cm) in length x 0.5 cm in width and was 0.2 cm deep. Slough was present on the wound bed. The wound was to be cleansed with normal saline, patted dry, Medihoney (an antibacterial and anti-inflammatory product with debriding effects) and silver alginate (highly absorbent, antimicrobial dressing) to placed to the open area and then covered with a border foam. The treatment was to be completed every day and as needed. Review of the wound assessment dated [DATE] authored by the WNP revealed Resident #64 had a Stage III pressure ulcer to the sacrum that measured 1.0 cm x 0.4 cm and had a depth of 0.2 cm. Interview on 08/15/24 with the WNP verified Resident #64 had a Stage III pressure ulcer to sacrum. WNP stated today was the first observation of the open areas to Resident #64's buttocks and sacrum.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on observation, record review, interview, and policy review the facility failed to ensure newly hired employees were screened for tuberculosis (TB) prior to their first day of work, the blood glucose testing (BGT) machine was sanitized and disinfected appropriately after use, appropriate infection control was maintained during Resident #30's wound care, and staff donned appropriate personal protective equipment during tracheostomy care. This affected one resident (Resident #106) on the secured memory care unit (SMCU) who required BGT testing and had the potential to affect two additional residents (Residents #96 and #3) who required BGT testing on the second floor SMCU, one (Resident #30) of two residents reviewed for pressure wounds, one (Resident#100) of one resident reviewed for tracheostomies, and the lack of employee TB screening had the potential to affect all residents who resided in the building. The facility census was 104. Findings include: 1. Review of eight employee files revealed Human Resource (HR) Director #880 (hired 02/05/24), Clinical Manager Registered Nurse (RN) #856 (hired 03/19/24) and Culinary Director #876 (hired 07/22/24) were not screened for TB prior to the first day or on the first day of work per the facility policy. Interview on 08/15/24 at 8:46 A.M. with HR Director #880 confirmed she was not screened for TB prior to her first day of work and Culinary Director #876, Clinical Manager RN #856 were not screened for TB testing prior to their first day of work as required. Review of the facility's TB Symptom Screen Policy-Employee revised 01/23/23 revealed employees, healthcare workers, volunteers, and healthcare providers were to be screened at a minimum upon hire and annually for signs/symptoms of TB using the TB Screening Tool for Healthcare Workers. Document signs and symptoms on the form and for any yes answer, refer the individual to a healthcare provider for follow-up testing as indicated. 2. Review of Resident #106's medical record revealed Resident #106 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, type two diabetes and dementia in other diseases classified elsewhere. Review of Resident #106's MDS 3.0 assessment dated [DATE] revealed Resident #106 exhibited intact cognition. Review of Resident #106's physician orders revealed an order dated 07/18/24 for accuchecks twice daily. Observation on 08/12/24 at 12:26 P.M. revealed Licensed Practical Nurse (LPN) #886 checked Resident #106's BGT while a result of 364. Observation on 08/12/24 at 12:55 P.M. revealed LPN #886 administering divalproex 250 milligrams (mg) and alprazolam 0.5 mg to Resident #106. LPN #886 then administered two units of Humalog fast acting insulin into Residents #106's left arm. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further observation on 08/12/24 at 12:56 P.M. revealed LPN #886 placing the BGT machine on the SMCU medication cart. LPN #886 did not sanitize and disinfect the BGT machine at any point. Interview on 08/12/24 at 12:44 P.M. with LPN #886 revealed she had checked Resident #3's BGT prior to checking Resident #106's BGT. LPN #886 confirmed she did not clean the BGT machine at any point because she worked on the SMCU and sanitizing wipes were not permitted on the SMCU medication administration carts. Review of the Cleaning and Disinfection of Glucose Meter policy revised 10/08/18 indicated it was the policy of the facility to provide resident centered care. The purpose of the policy was to provide guidance for the proper use of personal protection devices (PPEs) and hand hygiene prior to performing any procedure that could expose or potentially expose the worker to infectious materials including point-of-care testing devices and to prevent the spread of pathogens to others. The facility used shared devices for glucose testing and would perform cleaning and disinfection procedures between each resident. 35765 3. Review of the medical record revealed Resident #30 was admitted to the facility on [DATE]. Diagnoses included diabetes, hypertension, obstructive sleep apnea, atrial fibrillation, bipolar disorder, low back pain, obstructive and reflux uropathy, anxiety disorder, major depressive disorder, insomnia, schizoaffective disorder, disorder of kidney and ureter, peripheral vascular disease, and asthma. Review of the physician's orders revealed Resident #30 had an order to cleanse the area to the right gluteal fold with normal saline, pat dry, apply collagen with silver to wound bed and cover with border gauze dressing everyday and as needed dated 08/13/24. Observation on 08/14/24 at 11:45 A.M. revealed Registered Nurse (RN) #855 provided wound care to Resident #30. RN #855 washed her hands, set up her clean field, washed her hands, donned gloves, removed the old dressing, discarded the old dressing, poured normal saline on a sterile four by four, cleaned the right gluteal fold, picked up the piece of collagen with silver with her soiled gloves and placed it directly on Resident #30's wound bed. RN #855 covered the wound with a border foam dressing. An interview on 08/14/24 at 12:02 P.M. with RN #855 verified she had not changed her gloves or washed her hands after removing the old dressing and cleaning the wound and before applying the clean dressing. 49774 4. Review of the medical record revealed Resident #100 was admitted [DATE] and had diagnoses of nontraumatic intracerebral hemorrhage, respiratory failure, encephalopathy, and tracheostomy status. Review of the physician orders revealed Resident #100 had an order for enhanced barrier precautions related to an indwelling medical device, tracheostomy care every shift and as needed, and suctioning every shift and as needed. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #100 required total care and was dependent with bathing, dressing, mobility, eating, and toileting. Observation on 08/14/24 at 4:43 P.M. revealed Resident #100 received tracheostomy care from Licensed practical nurse (LPN) #886. While LPN #886 exercised proper hand hygiene and wore a mask, she did not wear a gown while providing tracheostomy care which included suctioning and applying a clean dressing around the tracheostomy tube opening in the skin. Interview on 08/15/24 at 1:36 P.M. with LPN #886 revealed that she was unaware a gown was required when providing tracheostomy care. LPN #866 stated I don't believe that's an enhanced barrier for trachs. Interview on 08/15/24 at 1:59 P.M. with the Director of Nursing revealed nurses were supposed to use enhanced barrier precautions when providing tracheostomy care. Review of the facility's Enhanced Barrier Precautions policy revealed that gowns and gloves were required when providing high contact resident care activities such as device care, use for central lines, catheters, feeding tubes, tracheostomy/ventilator, or wound care. Wound care included any skin opening requiring a dressing even if the resident was not known to have an infection. Review of the Centers for Medicare and Medicaid Services Center for Clinical Standards and Quality, Safety, and Oversight Group memorandum dated 03/20/24 revealed Enhanced Barrier Precautions included the use of gowns and gloves for residents with chronic wounds or indwelling devices during high contact resident care activities		