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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365838	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hennis Care Centre of Dover	1720 Cross Street Dover, OH 44622

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 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. 26706 Based on record review, policy review, and interview, the facility failed to ensure residents representatives were informed of changes in condition including new skin impairments. This affected two residents (#11 and #78) of three residents reviewed. Findings include; 1. Review of Resident #78's medical record revealed a 07/19/19 admission with diagnoses including Alzheimer's disease, chronic atrial fibrillation, combined systolic and diastolic congestive heart failure, sick sinus syndrome, hyperlipidemia, major depressive disorder, osteoporosis, history of urinary tract infections, bulbous pemphigoid, low back pain, repeated falls, dementia, atherosclerosis of coronary artery bypass grafts, cardiomegaly, personal history of transient ischemic attack and cerebral infarction without residual affects, unsteadiness on feet, dependence on wheelchair, protein calorie malnutrition, gastroesophageal reflux disease, and anxiety disorder. The resident resided on the secured memory care unit, Homestead. The 10/07/24 Five Day Medicare Minimum Data Set (MDS) Assessment included the resident was severely impaired for daily decision making, was dependent on staff for oral hygiene, toileting, bathing, rolling side to side, sitting to standing, sitting to lying and lying to sitting. Review of the progress notes dated 09/29/24 at 7:28 A.M. revealed a Late Entry that on 09/28/24 at 10:30 A. M. Staff informed this nurse that the resident had bleeding from her left leg. This nurse assessed wound to left knee. V-shaped laceration noted. Measures six (6) centimeters (cm) x 1 cm x .02 cm on one side and 8 cm x 1 cm x 0.5 cm on the other. On call notified. On call Certified Nurse Practitioner (CNP) paged. No return call. Steri strips & dressing applied. Patient resting in bed comfortably showing no signs or symptoms of distress. There was no evidence the resident' representative was notified of the injury. Interview on 10/21/24 at 5:04 P.M. with Resident #78's emergency contact/representative revealed he was not called about his mother's knee being lacerated until after three (3) in the morning (on 09/29/24) when they sent her to the emergency room . He was then surprised to see the extent of the injury. (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/21/24 at 5:50 P.M. with Registered Nurse #90 revealed she was the nurse who assessed Resident #78 on 09/28/24. She verified she did not notify the family of the laceration. She included a son usually comes in on Saturdays and she was going to tell him then but he did not come in. Review of the facility's policy, Accident and Incidence Investigating and Reporting policy (revised April 2013) revealed all accidents or incident involving residents, employees, visitors, vendors, etc. occurring on our premises shall be investigated and reported to the administrator. The incident report is to include the date time the injured person's family was notified and by whom. 2. Review of Resident #11's medical record revealed an 11/11/21 admission with diagnoses including Alzheimer's disease, atherosclerotic heart disease, nonrheumatic aortic stenosis, paroxysmal atrial fibrillation, chronic diastolic congestive heart failure, nonexudative age related macular degeneration, benign prostatic hyperplasia, major depressive disorder, mixed hyperlipidemia, chronic kidney disease Stage 3, hypertension, dementia, anxiety disorder, insomnia, senile degeneration of brain, abnormalities of gait and mobility, repeated falls, restlessness and agitation, osteoarthritis, presence of a cardiac pacemaker, and long term use of anticoagulants. Review of a 10/06/24 Significant Change MDS included the resident was severely impaired for daily decision-making. He had no functional limitations upper or lower extremities. He utilized the wheelchair. He was independent for eating, dependent on oral care, toileting, showering, dressing, putting on and taking off footwear and dependent on personal hygiene. He was partial to moderate assist for rolling from side to side, sitting to lying, substantial maximum assist lying to sitting on side of bed, and sitting to standing. Review of the progress notes included a note dated 10/20/24 at 6:54 A.M. incident note that revealed State tested Nurse Aides (STNAs) were assisting the resident into a wheelchair and during the course of transferring/positioning the resident, he obtained two 4 cm x 0.1 cm skin tears above his right elbow. The area was cleansed with normal saline, skin well approximated, adaptic and foam dressing applied. Hospice notified and request to remove broda chair for resident safety. There was no evidence of Resident #11's son, resident representative/ emergency contact being notified. Interview on 10/21/24 at 6:27 P.M. with Resident #11's responsible party, his son, revealed he did not receive a call that his father was injured. He included he received a call that they were calling hospice in to look at him. He was not told about the skin tears. Interview on 10/22/24 at 9:48 A.M. with the Administrator and the Director of Nursing revealed they spoke to the nurse and verified the family was not notified of the skin tear. This deficiency represents non-compliance investigated under Complaint Number OH00158594.

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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** 26706 Based on record review, review of the facility standing orders, and interview, the facility failed to provide appropriate treatment of a skin laceration. This affected one resident (#78) of three residents reviewed. The census was 83. Findings include: Review of Resident #78's medical record revealed a 07/19/19 admission with diagnoses including Alzheimer's disease, chronic atrial fibrillation, combined systolic and diastolic congestive heart failure, sick sinus syndrome, hyperlipidemia, major depressive disorder, osteoporosis, history of urinary tract infections, bulbous pemphigoid, low back pain, repeated falls, dementia, atherosclerosis of coronary artery bypass grafts, cardiomegaly, personal history of transient ischemic attack and cerebral infarction without residual affects, unsteadiness on feet, dependence on wheelchair, protein calorie malnutrition, gastroesophageal reflux disease, and anxiety disorder. The resident resided on the secured memory care unit, Homestead. The 10/07/24 Five Day Medicare Minimum Data Set (MDS) Assessment included the resident was severely impaired for daily decision making, was dependent on staff for oral hygiene, toileting, bathing, rolling side to side, sitting to standing, sitting to lying and lying to sitting. Review of the progress notes dated 09/29/24 at 7:28 A.M. revealed a Late Entry that on 09/28/24 at 10:30 A. M. Staff informed this nurse that the resident had bleeding from her left leg. This nurse assessed wound to left knee. V-shaped laceration noted. Measures six (6) centimeters (cm) x 1 cm x .02 cm on one side and 8 cm x 1 cm x 0.5 cm on the other. On call notified. On call Certified Nurse Practitioner (CNP) paged. No return call. Steri strips & dressing applied. Patient resting in bed comfortably showing no signs or symptoms of distress. Review of the undated Pinnacle Standing Wound Orders revealed there were no standing orders for a laceration. There was no evidence of the on call nurse practitioner returned the call from the facility. Review of the physician orders revealed there was not a physician order to apply steri strips and a dressing. There was not a physician order for any treatment to the left knee laceration. Review of the treatment administration record (TAR) revealed there was not a treatment signed for the application of steri strips and a dressing to Resident #78's laceration. Review of the medical record revealed on 09/29/24 between 3:00 A.M. and 3:30 A.M. the nurse placed a call to the on call nurse practitioner without a return call. After consult with the on call facility manager, Resident #78 was sent to the emergency room without a physician order related to the appearance of her left knee laceration. The resident was admitted to the hospital 09/29/24 with diagnoses including acute metabolic encephalopathy likely secondary to UTI (culture result negative), acute kidney disease and mild hypernatremia. The resident received a dose of Rocephin, an antibiotic. The resident was discharged back to the facility on [DATE]. (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 the facility's Transfer Form revealed it was completed 09/29/24 at 1:20 P.M. by Registered Nurse (RN) #90. The Transfer Form included Resident #78 was transferred on 09/29/24 at 1:19 P.M. when the progress notes revealed the resident was transferred on 09/29/24 at 3:29 A.M. when RN #90 was not on duty. Review of Resident #78's medical record revealed there was a 10/02/24 order for wound care to left lower leg cleanse with wound wash, pat dry with a 4 x 4 then place a dime thick layer of Bactroban onto wound bed, cover with sterile gauze and wrap with Kerlix two times a day for wound care until healed. Review of the October 2024 TAR revealed the dressing change to the left knee for 10/02/24 at 9:00 P.M. was not signed off as completed. There was no evidence the treatment was competed as ordered on 10/02/24 at 9:00 P.M. Review of the medical record revealed on 10/02/24 there was a physician order for Doxycycline Hyclate (antibiotic) 100 milligrams one tablet twice a day for cellulitis (area not specified). Interview on 10/21/24 at 2:24 P.M. with State tested Nurse Aide (STNA) #94 revealed she was the aide that noticed Resident #78's knee laceration. She said she had cleaned her up and dressed her for breakfast. She wheeled her to the dining room and put her at the head of a table. She brought a resident in a tilt in space wheelchair and put him at the table at a 90 degree angle to Resident #78. She lowered his wheelchair to the sitting flat position and must have hit the resident's (#78) knee under the table while doing that. Resident #78 did not make any sound to alert her anything had happened. After Resident #78 ate her breakfast, she wheeled her to the lounge and saw blood on the resident's pants. She then alerted the nurse. Interview on 10/21/24 at 5:04 P.M. with Resident #78's representative/emergency contact revealed he was not called about his mother's knee being lacerated until after three (3) in the morning (on 09/29/24) when they sent her to the emergency room . He was then surprised to see the extent of the injury. He indicated since 20 hours had passed since the laceration they were unable to place stitches. Interview on 10/21/24 at 5:50 P.M. with Registered Nurse (RN) #90 revealed she was the nurse who assessed Resident #78 on 09/28/24. She verified she called the on call number for the physician and did not get a call back. She included she did not place a second call on her 12 hour shift because she was busy. She verified she placed steri- strips on the laceration and a dry dressing without an order. She included there was not enough skin to cover the adipose tissue and the steri strips were on the adipose tissue. She verified she did not put a progress note in the electronic documentation until the next day because she was busy. She did fill out an incident report but did not get statements from the other staff on duty. She verified she did not notify the family of the laceration. RN #90 had no explanation as to why she filled out the hospital transfer sheet on dayshift at 1:20 P.M. (09/29/24) when the resident was transferred at 3:30 A.M. Interview on 10/21/24 at 6:08 P.M. with the Director of Nursing (DON) verified the 10/02/24 at 9:00 P.M. wound dressing was not documented as completed. This deficiency represents non-compliance investigated under Complaint Number OH00158594.

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F 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or arrange emergency care by a doctor 24 hours a day. 26706 Based on record review, Physician Communication Book review, and interview, the facility failed to ensure physician services responded to facility requests for resident care 24 hours a day. This affected one resident (#78) of three residents reviewed with the potential to affect all 83 residents in the facility. Findings include: Review of Resident #78's medical record revealed a 07/19/19 admission with diagnoses including Alzheimer's disease, chronic atrial fibrillation, combined systolic and diastolic congestive heart failure, sick sinus syndrome, hyperlipidemia, major depressive disorder, osteoporosis, history of urinary tract infections, bulbous pemphigoid, low back pain, repeated falls, dementia, atherosclerosis of coronary artery bypass grafts, cardiomegaly, personal history of transient ischemic attack and cerebral infarction without residual affects, unsteadiness on feet, dependence on wheelchair, protein calorie malnutrition, gastroesophageal reflux disease, and anxiety disorder. The resident resided on the secured memory care unit, Homestead. The 10/07/24 Five Day Medicare Minimum Data Set (MDS) Assessment included the resident was severely impaired for daily decision making, was dependent on staff for oral hygiene, toileting, bathing, rolling side to side, sitting to standing, sitting to lying and lying to sitting. Review of the progress notes dated 09/29/24 at 7:28 A.M. revealed a Late Entry that on 09/28/24 at 10:30 A. M. Staff informed this nurse that the resident had bleeding from her left leg. This nurse assessed wound to left knee. V-shaped laceration noted. Measures six (6) centimeters (cm) x 1 cm x .02 cm on one side and 8 cm x 1 cm x 0.5 cm on the other. On call notified. On call Certified Nurse Practitioner (CNP) paged. No return call. Steri strips & dressing applied. Patient resting in bed comfortably showing no signs or symptoms of distress. There was no evidence the on call nurse practitioner returned the call. Review of the medical record revealed there was no evidence of the facility received a return call on Saturday 09/28/24 or Sunday 09/29/24 from the on call nurse practitioner and physician related to the care needs of Resident #78. Review of the medical record revealed on 09/29/24 between 3:00 A.M. and 3:30 A.M. the nurse placed a call to the on call nurse practitioner without a return call. After consult with the on call facility manager, Resident #78 was sent to the emergency room without a physician order related to the appearance of her left knee laceration. The resident was admitted to the hospital 09/29/24 with diagnoses including acute metabolic encephalopathy likely secondary to UTI (culture result negative), acute kidney disease and mild hypernatremia. (continued on next page)

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F 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/21/24 at 4:44 P.M. with the Administrator and the Director of Nursing revealed they had an issue earlier in the year with the responsiveness of the physician services after hours. It was part of their June 2024 Quality Assurance and Performance Improvement program. They thought they came up with a way to fix the issue but it apparently was not working. They had tried a third party provider to answer calls and changed providers. Their medical director owns the Pinnacle system and employs the physician and nurse practitioners. They have a nurse practitioner who comes to the facility Monday through Friday except holidays. Interview on 10/21/24 at 5:04 P.M. with Resident #78's representative/emergency contact revealed he was not called about his mother's knee being lacerated until after three (3) in the morning when they sent her to the emergency room . He was then surprised to see the extent of the injury. He indicated since 20 hours had passed since the laceration the wound was old and there was not enough skin left to place stitches. Interview on 10/21/24 at 5:50 P.M. with Registered Nurse (RN) #90 revealed she was the nurse who assessed Resident #78 on 09/28/24. She verified she called the on call number for the physician and did not get a call back. She included she did not place a second call on her 12 hour shift because she was busy. She verified she placed steri strips on the laceration and a dry dressing without an order. She included there was not enough skin to cover the adipose tissue and the steri strips were on the adipose tissue. RN #90 included there are times she doesn't get a return call from the on call nurse practitioner. Once the on-call nurse practitioner was out of the area and did not call back until later. There have been other times when she has not received a return call from the nurse practitioner. The nurse revealed she did not have a direct number to call the nurse practitioner. She had to call the answering service. She does not have a phone number for the physician or the Medical Director. Interview on 10/21/24 at 6:02 P.M. with the Administrator and the Director of Nursing (DON) revealed all the residents have the same physician. The Administrator and the DON verified the nursing staff do not have access to the resident's physician, the facility's Medical Director's or on call staff's phone numbers. The Administrator verified he called the Medical Director to inform him of the lack of response of on call staff. Review of the facility Communication Book with instructions revealed that to put orders to be signed, pharmacy recommendations into a notebook. There was a telephone number provided for the nurse practitioner assigned to the facility and an email provided for the Primary Care Coordinator, a Registered Nurse. Residents and families were to call the office with questions and were not to be given the phone number of the Pinnacle Staff Members. Their nurse practitioner was to be called between 3:00 and 4:00 P.M. with all issues in a batch call and as needed for emergent issues only from 6:00 A.M. till 8:00 P.M. Monday through Friday and Saturday/Sundays and Holidays call office answering service for the on-call nurse practitioner. Do not call or fax the office unless directed to do so. This deficiency represents non-compliance investigated under Complaint Number OH00158594.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on observation, record review, policy review, and interview, the facility failed to ensure infection control practices were maintained during a wound dressing change. This affected one resident (#78) of two residents observed for wound care. The census was 83. Findings include: Review of Resident #78's medical record revealed a 07/19/19 admission with diagnoses including Alzheimer's disease, chronic atrial fibrillation, combined systolic and diastolic congestive heart failure, sick sinus syndrome, hyperlipidemia, major depressive disorder, osteoporosis, history of urinary tract infections, bulbous pemphigoid, low back pain, repeated falls, dementia, atherosclerosis of coronary artery bypass grafts, cardiomegaly, personal history of transient ischemic attack and cerebral infarction without residual affects, unsteadiness on feet, dependence on wheelchair, protein calorie malnutrition, gastroesophageal reflux disease, and anxiety disorder. The resident resided on the secured memory care unit, Homestead. The 10/07/24 Five Day Medicare Minimum Data Set (MDS) Assessment included the resident was severely impaired for daily decision making, was dependent on staff for oral hygiene, toileting, bathing, rolling side to side, sitting to standing, sitting to lying and lying to sitting. Review of the progress notes dated 09/29/24 at 7:28 A.M. revealed a Late Entry that on 09/28/24 at 10:30 A. M. Staff informed this nurse that the resident had bleeding from her left leg. This nurse assessed wound to left knee. V-shaped laceration noted. Measures six (6) centimeters (cm) x 1 cm x .02 cm on one side and 8 cm x 1 cm x 0.5 cm on the other. Review of the medical record revealed a physician order dated 10/02/24 for Doxycycline Hyclate (antibiotic) 100 milligrams one tablet twice a day for cellulitis (no area specified). Review of the medical record revealed a physician order dated 10/08/24 to cleanse left knee with house wound wash, apply xeroform, dry dressing daily and as needed for laceration. Review of the medical record revealed the last assessment dated [DATE] included the left knee laceration had minimal drainage, no signs of infection, 100 percent granulation with light exudate serosanguineous drainage measuring 2.8 centimeters (cm) length, x 4.2 cm width and 0.3 cm depth. Observation on 10/21/24 at 2:03 P.M. of the dressing change to the left knee laceration revealed Registered Nurse (RN) #93 washed her hands, gowned and gloved. She elevated the height of the resident's bed and explained to the resident what she was doing. RN #93 dated the dressing and said she never saw the wound previously. RN #93 removed the old dressing dated 10/20/24. There was some serosanguineous drainage on the dressing. RN #93 did not remove her soiled gloves. She sprayed the wound with wound cleanser and dabbed the wound with a 4 x 4 gauze. She removed her gloves/washed hands and re-gloved. She folded up a xeroform and placed it over the wound. There was no drainage noted post cleansing. RN #93 removed her gloves and washed her hands, re-gloved and put a foam dressing over the laceration. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/21/24 at 2:26 P.M. with RN #93 verified she did not remove her gloves and wash her hands after removing the soiled dressing. She verified she cleansed the wound with the gloves she had on when she removed the soiled dressing. Review of the facility's Dressing Change policy (reviewed June 2016) included remove soil dressing, discard soil dressing in an appropriate receptacle and discard gloves. Wash hands, open dressing and spread the exterior wrap touching the exterior surface. Put on gloves This deficiency represents non-compliance investigated under Complaint Number OH00158594.