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	04/17/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review, observation, and interview, the facility failed to provide a dignified dining experience for Resident #20 who received a blood glucose check at the dining room table with other residents present. This affected one resident (Resident #20) out of five residents (#20, #38, #49, #54, and #326) observed for dining on the Gardens unit. Findings include: Review of the medical record revealed Resident #20 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia, type two diabetes, history of traumatic brain injury, and dementia. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #20 had moderately impaired cognition. Review of Resident #20's physician order dated 04/08/25 revealed the resident was to have a fingerstick blood glucose check twice a day. Observation on 04/14/25 at 11:28 A.M. revealed Resident #20 was sitting at the head of the table in the dining room with Resident #28, #49, #54, and #326. Resident #20, #28, #49, #54, and #326 had the lunch meal in front of them and had started eating when Registered Nurse (RN) #232 used a small disposable needle-like device to prick a finger on Resident #20's left hand to force blood for the glucose check. The nurse then applied a drop of Resident #20's blood to a glucose test strip. The glucose test strip was placed inside the glucometer to read the residents level of glucose. Interview on 04/14/25 at 11:32 A.M. with RN #232 verified she had checked Resident #20's blood glucose level at the table in the dining room. RN #232 verified Resident #20's blood glucose level should not have been checked in the dining room at the table where other residents were eating.

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on record review, staff interview, and Resident Assessment Instrument (RAI) Manual review, the facility failed to accurately complete the Minimum Data Set (MDS) Nutritional Status section for a resident receiving additional fluid intake via a percutaneous endoscopic gastrostomy (PEG) tube. This affected one resident (Resident #13) out of five residents reviewed for nutrition. The facility census was 75. Findings Include: Review of the medical record for Resident #13 revealed admitted on 11/19/24 and re-admitted on 02/07/25 with diagnoses including, but not limited to, paranoid schizophrenia, type two diabetes, major depression, personality disorder, high blood pressure, and osteomyelitis of vertebra. Review of Resident #13's care plan dated 02/21/25 revealed Resident #13 had a percutaneous endoscopic gastrostomy (PEG) tube with interventions to provide local care to the G-tube site as ordered and monitor for signs and symptoms of infection. Review of Resident #13's physician orders revealed an order dated 02/07/25 for low concentrated sweets diet, regular texture, regular/thin consistency for liquids, and an order dated 02/13/25 for 200 milliliters (ml) of water flush twice daily per PEG tube every shift for PEG patency and hydration. Further review of Resident #13's physician orders revealed the discontinued order from 02/08/25 to 02/13/25 for 100 ml water flush twice daily per PEG every shift for PEG patency and hydration. Review of Resident #13's February 2025 Medication Administration Record (MAR) dated 02/08/25 to 02/13/25 revealed the order for 100 ml water flush twice daily per PEG every shift for PEG patency and hydration was marked as completed. Resident #13 would have received a total of 200 ml of additional water per day. Further review of Resident #13's MAR from 02/13/25 to 02/28/25 revealed the order for 200 ml of water flush twice daily per PEG tube every shift for PEG patency and hydration was marked as being completed. Resident #13 would have received a total of 400 ml's of additional water per day. Review of Resident #13's quarterly MDS dated [DATE] revealed section K (Swallowing/Nutrition Status) provided three different response options to be marked; a) 500 cubic centimeter (cc) (also converted to the same measurement as a milliliter) per day or less, b) 501 cc/day or greater, or c) not assessed/no information. Section K was not marked as Resident #13 receiving a percentage of average fluid intake per day by tube feeding. Review of Resident #13's March 2025 MAR dated 03/01/25 to 03/31/25 revealed the order for 200 ml of water flush twice daily per PEG tube every shift for PEG patency and hydration was marked as being completed. Resident #13 would have received a total of 400 ml's of additional water per day. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #13's quarterly MDS dated [DATE] revealed section K (Swallowing/Nutrition Status) provided three different response options to be marked; a) 500 cubic centimeter (cc) (also converted to the same measurement as a milliliter) per day or less, b) 501 cc/day or greater, or c) not assessed/no information. Section K was not marked as Resident #13 receiving a percentage of average fluid intake per day by tube feeding. Review of Resident #13's April 2025 MAR dated 04/01/25/to 04/16/25 revealed the order for 200 ml of water flush twice daily per PEG tube every shift for PEG patency and hydration was marked as being completed. Resident #13 would have received a total of 400 ml's of additional water per day. An interview on 04/16/25 at 11:36 A.M. with Dietician #157 confirmed section K in Resident #13's quarterly MDS assessments, dated 02/14/25 and 03/28/25, were not coded/completed to reflect the additional hydration Resident #13 was receiving daily per PEG tube. Dietician #157 stated section K should have been coded/completed to show Resident #13's percentage of additional water intake per PEG tube per day. Review of the Resident Assessment Instrument (RAI) Manual for Section K - Percent Intake by Artificial Route - Average Fluid intake per day by intravenous (IV) or Tube Feeding, dated 10/25/24, revealed to calculate the average of fluid intake per day, add up the total amount fluid received each day by IV and/or tube feedings only and divide the week's total fluid intake by 7. It stated the code was for the average number of cc's per day of fluid the resident received via IV and/or tube feeding, either 500 cc/day or less, or 501 cc/day or more.

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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** 34298 Based on medical record review, observation, and interview, the facility failed to ensure infection control practices were followed when medications were being administered. This affected one (Resident #29) out of five residents observed for medication administration. The facility also failed to ensure enhanced barrier precautions were implemented for Resident #13 and Resident #276. This affected two (Resident #13 and #276) out of three residents reviewed for infection control. The facility census was 75. Findings include: 1. Review of the medical record revealed Resident #29 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included congestive heart failure, asthma, type two diabetes, and depression. Observation of medication administration on 04/15/25 at 7:34 A.M. revealed Registered Nurse (RN) #232 used her bare fingers to extract Lyrica (a medication used to treat nerve and muscle pain) from the packaging and placed it into Resident #29's medication cup for administration. Resident #29 then consumed the contaminated medication. Interview on 04/15/25 at 7:37 A.M., RN #232 verified she used her bare fingers to remove the Lyrica medication from the packaging and placed it in Resident #29's medication cup for consumption. 47569 2. Review of the medical record for Resident #13 revealed an admitted [DATE] and a re-admitted [DATE] with diagnoses including, but not limited to, paranoid schizophrenia, type two diabetes, major depression, personality disorder, high blood pressure, and osteomyelitis of vertebra. Review of Resident #13's care plan dated 02/21/25 revealed Resident #13 has a percutaneous endoscopic gastrostomy (PEG) tube with interventions to provide local care to the gastrostomy (G) tube site as ordered and monitor for signs and symptoms of infection. Review of Resident #13's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had intact cognition with a Brief Interview of Mental Status (BIMS) score of 13. Resident #13 required moderate assistance from staff to complete activities of daily living (ADL) tasks including personal hygiene. Resident #13 was dependent on staff for transfers by a mechanical lift. Review of Resident #13's physician orders revealed an order dated 03/06/25 for Enhanced Barrier Precautions (EBP): gown and glove use required during high contact resident care activities every shift and an order dated 02/13/25 for 200 milliliters (ml) of water flush twice daily per PEG tube. Review of Resident #13's Treatment Administration Record (TAR) revealed the order for Enhanced Barrier Precautions (EBP): gown and glove use required during high contact resident care activities every shift, was marked as completed from 03/06/25 through 03/31/25 and from 04/01/25 to 04/16/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/14/25 at 10:42 A.M. revealed Resident #13 sitting in the wheelchair watching television in her room. There was a PEG tube visible under the hem of her shirt. There was no personal protective equipment (PPE) cart outside the door, there was no notification sign for EBP, and there was no bin in the room for soiled linen. An interview on 04/15/25 at 1:40 P.M. with Unit Manager (UM) #208 confirmed Resident #13 did not have EBP's implemented even though there was a physician's order for EBP's to be in place. UM #208 further stated Resident #13 should have EBP's in place due to having the indwelling PEG tube. Review of the facility's policy titled Enhanced Barrier Precautions dated 02/19/25 revealed the facility had implemented Enhanced Barrier Precautions (EBP) to prevent the spread of multidrug resistant organisms (MDRO's). Enhanced Barrier Precautions (EBP) were indicated for residents with indwelling medical devices including, but not limited to, feeding tubes. 51514 3. Review of Resident #276's medical record revealed the resident was admitted to the facility on [DATE]. Medical diagnoses included metabolic encephalopathy, urinary tract infection (UTI, an infection that can involve kidneys, ureters, bladder, or urethra), Alzheimer's disease, altered mental status, neuromuscular dysfunction of bladder (when nerves that control the bladder aren't working properly), and cerebrovascular disease (conditions that impact blood flow to the brain). Review of Resident #276's physician orders revealed an order dated 04/13/25 for Enhanced Barrier Precautions (EBP) (an infection control measure using a gown and gloves during high contact care activities for residents at risk of infection due to wounds or an indwelling medical device such as a urinary catheter): gown and glove use required during high contact resident care activities every shift for EBP Protocol, orders dated 04/13/25 for left and right Achilles wound care, and orders dated 04/13/25 for a urinary catheter with additional related orders for catheter care every shift, change the drainage bag as needed, and irrigate with 60 milliliters (ml) of normal saline as needed twice daily to maintain patency. Observation on 04/15/25 at 1:02 P.M. of Resident #276's wound care with Registered Nurse (RN) #199 and Unit Manager (UM) #208 revealed no EBP signage on Resident #276's door or in the resident's room indicating Resident #276 was in Enhanced Barrier Precautions, and there was not an equipment cart outside of the room containing personal protective equipment for use. Before wound care was initiated, Resident #276's urinary drainage catheter was noted to be present and hung on the resident bed. When wound care was provided to the left and right Achilles areas, neither RN #199 or UM #208 were noted to be wearing gowns as required by the physician's order of Enhanced Barrier Precautions during high contact resident care activities. Interview on 04/15/25 at 1:19 P.M. with RN #199 and UM #208 confirmed that Resident #276 was on EBP due to having a urinary catheter and also confirmed that gowns were not worn during Resident #276's wound care. (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 the facility's policy titled Enhanced Barrier Precautions dated 02/19/25 revealed the facility had implemented Enhanced Barrier Precautions (EBP) to prevent the spread of multidrug resistant organisms (MDRO's). Enhanced Barrier Precautions (EBP) were indicated for residents with indwelling medical devices including, but not limited to, urinary catheters. The policy stated EBP was required for activities such as providing hygiene, bathing, and wound care.