STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366200	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hennis Care Centre of Bolivar	300 Yant Street, NW Bolivar, OH 44612

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on record review, hospital record review, policy review and interview the facility failed to adequate monitor and seek timely medical intervention/hospitalization following a significant change in condition for Resident #31. This affected one resident (#31) of three reviewed for change in condition. Actual Harm occurred on 03/29/24 when Resident #31, who was severely cognitively impaired was transferred to the emergency room where he was intubated and admitted to the intensive care unit for respiratory failure and sepsis. On 03/11/24, Resident #31 was observed unresponsive and having seizure-like activity. He was a full code with no history of seizures. On 03/12/24 the resident's oxygen saturation dropped to 70 percent without oxygen, and he continued to steadily decline until he was eventually sent to the emergency roiagnom on [DATE], 19 days after the initial significant change in condition was first noted. Findings included: Review of the medical record revealed Resident #31 was admitted to the facility on [DATE]. Diagnoses included metabolic encephalopathy, severe sepsis with septic shock, extended spectrum beta lactamase resistant (ESBL), acute kidney disease, cerebral infarction, protein-calorie malnutrition, vascular Parkinsonism, aortic aneurysm, heart failure, obstructive sleep apnea, transient ischemic attack, hypokalemia, major depressive disorder, altered mental status, benign prostatic hyperplasia, anxiety disorder, and hypertension. Review of the laboratory test dated 12/07/23 revealed Resident #31 had a white blood cell (WBC) count of 10.3 which was normal (normal range of 4.5-10.8), hemoglobin of 14.0 which was normal (normal range of 14.0-18.0), and hematocrit 42.5 which was normal (normal range of 42.0-54.0). Review of the progress note dated 03/02/24 at 10:49 P.M. revealed Resident #31 was calling out for help. He stated he could not stop shaking and he was so cold. His temperature was 102.2 degrees Fahrenheit (F) and he was having body tremors. His lungs were clear, but his respirations were short and labored. The resident denied burning or pain with urination; however, he had a strong pungent odor of urine that was orange in color. His blood pressure was 120/67 and pulse was 102 beats per minute. He was given Tylenol (analgesic and fever reducer) and cold compresses for his fever. He had two episodes of diarrhea. The on-call physician was called. There was no documented evidence that his power of attorney (POA) was notified. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366200	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Hennis Care Centre of Bolivar		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Yant Street, NW Bolivar, OH 44612	

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the progress note dated 03/03/34 at 12:22 A.M. revealed there was no return call from the on-call physician, so the paging service called the Nurse Practitioner (NP) directly, and he was updated on the resident's condition with orders to send Resident #31 to the emergency room (ER) for evaluation and treatment. Attempts to call the POA twice went directly to voice mail. Review of the progress note dated 03/03/24 at 7:07 A.M. revealed Resident #31 was admitted to the intensive care unit for urinary tract infection (UTI) and sepsis. Further review of the medical record revealed Resident #31 was hospitalized until 03/08/24 at which time he was readmitted to the facility with orders for intravenous (IV) antibiotics for a UTI and sepsis. Review of the March 2024 physician's orders revealed Resident #31 had an order for Ertapenem Sodium (antibiotic) one gram IV at bedtime for 14 days related to severe sepsis with septic shock and Doxycycline monohydrate (antibiotic) 100 milligrams (mg) one tablet by mouth two times a day for UTI dated 03/08/24. Review of the physician's orders revealed Resident #31 had a code status of full code (if a person's heart stopped beating and/or they stopped breathing, all resuscitation measures will be provided) dated 03/11/24. Review of the Five-Day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had severely impaired cognition. He did not have a diagnosis of seizures. Review of the laboratory test dated 03/11/24 revealed Resident #31 had a WBC count of 11.2 which was high, hemoglobin 12.7 which was low, and hematocrit 37.6 which was low. Review of the progress note dated 03/11/24 at 9:07 P.M. revealed the nursing assistant walked by the room of Resident #31, and he was unresponsive and having seizure-like activity (lasting eight minutes). The resident was placed on his side. Vital signs included blood pressure 182/89, pulse 83, oxygen saturation level 94 percent on room air, respirations 18, and temperature 98.2 degrees F. The resident was not transferred to the emergency room at this time. Review of the progress note dated 03/11/24 at 9:15 P.M. revealed Resident #31 was having loud snoring-like breaths and was still unresponsive. NP #201 was contacted due to the resident's status, and she ordered Ativan 2 mg (antianxiety medication) intramuscularly (IM). The resident was not transferred to the emergency room at this time. Review of the skilled nursing note dated 03/11/24 at 9:15 P.M. revealed Resident #31's POA was notified of the seizure-like activity. Review of the progress note dated 03/11/24 at 9:25 P.M. revealed Resident #31 was now alert. He was able to look at staff, but his speech was garbled, and his breathing was labored, so oxygen was applied. He bit his tongue during the event, so there was blood coming out of his mouth. He was also incontinent of stool at this time. Vital signs included blood pressure 136/73, pulse 85, oxygen saturation level 92 percent on two liters of oxygen via nasal cannula, respirations 18, and temperature 98.2 degrees F. The resident was not transferred to the emergency room at this time. (continued on next page)

Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366200	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Hennis Care Centre of Bolivar		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Yant Street, NW Bolivar, OH 44612	

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the progress note dated 03/11/24 at 10:23 P.M. revealed the NP called for an update on Resident #31. A new order was received for vital signs every four hours for 24 hours then every shift for 72 hours, blood sugars every shift, and complete blood count (CBC) and basic metabolic panel (BMP) in the morning. Further review of the progress notes and skilled nursing notes revealed no documented evidence Resident #31's condition was monitored from 03/11/24 at 10:32 P.M. until 03/12/24 at 11:20 A.M., including the vital signs ordered by the NP to be checked every four hours. Review of the progress note dated 03/12/24 at 11:20 A.M. revealed NP #201 was in to see Resident #31, and a new order was received for a chest x-ray right now due to hypoxia post seizure. The POA was notified. Review of the NP note dated 03/12/24 revealed Resident #31 was reported to have a seizure episode last evening. He was given 2.0 mg of Ativan IM for one dose; he had laboratory tests ordered for the morning. A discussion with the family revealed no history of seizures, but he did have a history of ventriculoperitoneal shunt placement for past hydrocephalus. Resident #31 bit his tongue on the right side. He was found purple in color and nursing believed he may have aspirated. Since his seizure, he had required supplemental oxygen to maintain his oxygen levels. The resident's saturation was dropping to the 70 percents with his oxygen off. The note indicated the resident was back to his baseline mentation, (coherent but hard to understand) after a few hours. His neurological team was notified, and an appointment was scheduled for 03/19/24. Seizure precautions were in place. The note revealed chest x-ray to rule out aspiration and obtain a CBC to monitor WBCs, blood sugars every shift for the next 24 hours, and monitor extremely closely with our team within one to two days. Review of the chest x-ray results dated 03/12/24 revealed Resident #31 had mild congestive heart failure. Review of the laboratory results dated [DATE] revealed Resident #31 had a WBC of 13.5 which was high, hemoglobin 12.9 which was low, and hematocrit 38.9 which was low. Review of the NP note dated 03/13/24 revealed Resident #31 was seen post seizure. He had a follow-up appointment scheduled with neurology. A chest x-ray was obtained to rule out aspiration which was negative from a respiratory standpoint but did show mild congestive heart failure. The NP note revealed the resident's alertness was significantly improved, and he was working with therapy at the time of the examination. He showed good trunk control and denied dizziness or headache. Staff were to continue to monitor him closely. Review of the progress note dated 03/14/24 at 8:57 A.M. revealed Resident #31 was observed pocketing food and medications. Speech therapy was updated. Review of the laboratory test dated 03/15/24 revealed Resident #31 had WBC count of 6.3 which was normal, hemoglobin 11.9 which was low, and hematocrit 35.6 which was low. Review of the progress note dated 03/17/24 at 6:00 A.M. revealed Resident #31 remained lethargic today but was alert. He had audible crackles (abnormal lung sounds) heard when breathing, lungs were diminished in the right lower lobe, oxygen level 89-90 percent on oxygen, temperature was 97.2 degrees F. The note indicated the NP was updated on the resident's respiratory status today. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366200	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hennis Care Centre of Bolivar	300 Yant Street, NW Bolivar, OH 44612

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the progress note dated 03/17/24 at 1:29 P.M. revealed the NP was updated on Resident #31. He remained lethargic with audible crackles noted in bilateral lung bases. A new order was received for a follow-up chest x-ray on 03/18/24. The resident and POA were notified. There was no evidence the resident was transferred to the hospital for an evaluation at this time. Review of the skilled nursing note dated 03/17/24 at 10:40 P.M. revealed Resident #31 had a new onset of irregular heart rate and had an oxygen level of 90 percent on oxygen. He had a moist, loose productive cough with a moderate amount of yellow secretions. His right lung was diminished in the lower, middle, and anterior lobes. He had a new onset of incontinence and was wearing a brief. He had previously been continent. There was no documented evidence that the NP or physician were notified or evidence the resident was transferred to the hospital at this time. Review of a neurology note dated 03/19/24 revealed Resident #31 was seen due to new onset of seizure with a history of stroke and normal pressure hydrocephalus (NPH). The note indicated the resident was on the antibiotic, Ertapenem, which could lower seizure threshold. Infectious disease needed to be contacted as soon as possible, advised to stop the antibiotic, and use a different one. The plan would be to start an anti-seizure medication. If there was a second seizure, notify neurology so an anti-seizure medication could be started. They scheduled an electroencephalogram (EEG) on 03/27/24. Review of the progress note dated 03/19/24 at 11:28 A.M. revealed a call was placed to the infectious disease physician to clarify the Ertapenem order. A voice mail was left on the nurse's line. Awaiting a return call. Review of the progress note dated 03/19/24 at 6:30 P.M. revealed the infectious disease physician ordered the IV antibiotic to be stopped with no further antibiotics. The POA and NP were notified. Review of the progress note dated 03/19/24 at 7:00 P.M. revealed upon entering the room of Resident #31 he was noted to have had a large bowel movement, his head was turned to the right side, and he was not responding to verbal stimuli. His mouth was wide open with audible snoring noises. His eyes were open, and he was attempting to respond to the nurse. He was having trouble following simple commands. His pupils were reactive to light. Vital signs included blood pressure 129/85, pulse 81, respirations 18, Temperature 97. 3 degrees F, and oxygen saturation level of 94 percent on two liters of oxygen per nasal cannula. The NP was updated with the new orders to update the neurologist. A message was left for the on-call physician. Resident#31 was in bed with no signs or symptoms of distress. He was opening his eyes but unable to appropriately respond verbally. The resident was not transferred to the hospital for an evaluation at this time. Review of the progress note dated 03/19/24 at 7:25 P.M. revealed Resident #31 opened his eyes to verbal stimulation, but he was unable to follow commands. Awaiting a call back from the neurologist. Review of the progress note dated 03/19/24 at 9:03 P.M. revealed the neurologist returned a page at this time and ordered Keppra 500 mg (anticonvulsant) twice daily and to move his follow up appointment (04/30/24). The POA was notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366200	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Hennis Care Centre of Bolivar		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Yant Street, NW Bolivar, OH 44612	

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the skilled progress note dated 03/20/24 at 12:00 A.M. revealed Resident #31 did not obey commands with new onset or worsening weakness. Resident #31 was incoherent, and his speech was unclear. The right anterior lower, posterior lower and posterior middle lung lobes were diminished with a dry nonproductive cough. The resident was not transferred to the hospital for an evaluation at this time. Review of the progress notes dated 03/20/24 at 11:33 A.M. revealed the NP was in to see Resident #31. She ordered a Keppra level in two weeks and to start normal saline (NS) IV at 50 milliliters (ml) an hour. The resident and POA were notified. Review of the laboratory test dated 03/21/24 revealed Resident #31 had a WBC count of 5.1 (which was normal, hemoglobin 11.9 which was low and hematocrit 35.6 which was low. Review of the NP note dated 03/22/24 revealed Resident #31 was being seen due to a recent seizure and abnormal laboratory tests. Physical examination revealed his lungs were clear, fatigue with examination and appeared chronically ill. Resident #31 had two episodes of seizure activity over the past several weeks and was now on Keppra. He has had no further seizure activity since Keppra was started. He had a magnetic resonance imaging (MRI) and EEG scheduled with follow-up appointments with the neurologist. He has had some fatigue since starting the Keppra, and they would continue to monitor him closely. We would start weight checks three times a week for three weeks to ensure stability of weights with the increase in fatigue while he was adjusting to the Keppra, a Keppra level in two weeks after initiation with no further seizure activity; however, as he was high risk at this time, he would be monitored closely. Review of the vital signs flow sheet revealed Resident #31's oxygen saturation was between 92% and 96% on two liters of oxygen per nasal cannula from 03/23/24 through 03/26/24. Review of the weights revealed Resident #31 weighted 259.2 pounds on 03/11/24 and 248.4 on 03/25/24 for a 10.8-pound weight loss in 14 days. Review of the skilled progress note dated 03/27/24 at 11:40 P.M. revealed Resident #31 had a temperature of 100 .9 degrees F, rhonchi (abnormal lung sounds) auscultated in the left posterior upper lobe, right posterior upper lobe, left posterior lower lobe, right posterior middle lobe, right posterior lower lobe, and right anterior lower lobe. He had a moist nonproductive cough. There was no documented evidence that the physician or NP was notified. Review of the progress note dated 03/28/24 at 1:28 P.M. revealed NP #201 was in to see Resident #31, and she ordered Tamiflu 30 mg (antiviral) twice daily for five days and Amoxicillin (antibiotic) 500 mg twice daily for five days for bronchitis. Review of the laboratory test (this was already a scheduled laboratory test) dated 03/28/24 and reported at 4:51 P.M. revealed Resident #31 had a WBC count of 23.0 which was high , hemoglobin 12.2 which was low, and hematocrit 37.9 which was low. Review of the progress note dated 03/28/24 at 6:01 P.M. revealed the NP was called with laboratory results and she ordered NS 0.9 percent IV at 60 ml an hour, chest x-ray in the morning, and one time dose of Rocephin 2.0 grams IM (antibiotic). The resident and POA were notified. The resident was not transferred to the hospital for an evaluation at this time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366200	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Hennis Care Centre of Bolivar		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Yant Street, NW Bolivar, OH 44612	

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the chest x-ray dated 03/29/24 revealed Resident #31 had an elevated right hemidiaphragm, perihilar infiltrates, and left basilar atelectasis and pleural effusion. Review of the progress note dated 03/29/24 at 7:50 A.M. revealed Resident #31 was sweating profusely at this time, Tylenol was previously given for a temperature of 101.5 degrees F, his oxygen saturation levels were between 88 to 90 percent on two liters of oxygen via nasal cannula, and he was mouth breathing. A continuous positive airway pressure machine (CPAP) was applied at this time with a two-liter bleed in. His blood pressure was 98/56, pulse 76, oxygen saturation level 98 percent with CPAP. Review of the progress note dated 03/29/24 at 7:50 A.M. revealed Resident #31 was sitting up in the chair with the speech pathologist at bedside. He was pocketing his food. He was downgraded to a pureed diet with nectar thick liquids. His morning medications were crushed in pudding. He needed encouragement to swallow. His temperature was 99.6 F, blood pressure was 102/72, pulse was 89, oxygen saturation level was 97 percent on two liters of oxygen per nasal cannula. The resident was not transferred to the hospital for an evaluation at this time. Review of the progress note dated 03/29/24 at 1:05 P.M. revealed the NP was in to see Resident #31 with new orders to discontinue the Amoxicillin and start Levaquin (antibiotic) daily for seven days, laboratory test now, and DuoNeb aerosols (treat symptoms of wheezing and shortness of breath) four times a day. The resident and POA were notified. The resident was not transferred to the hospital for an evaluation at this time. Review of the progress note dated 03/29/24 at 5:08 P.M. revealed per the laboratory supervisor they could not find a phlebotomist to draw Resident #31's laboratory tests. The NP was notified and ordered the resident to be sent to the ER for evaluation. Review of the progress note dated 03/29/24 at 11:21 P.M. revealed Resident #31 was admitted to the intensive care unit for a urinary tract infection, sepsis, and respiratory failure. Review of the NP note dated 03/29/24 revealed Resident #31 was being evaluated for abnormal lung sounds and abnormal chest x-ray results. The chest x-ray results noted an elevated right hemi diaphragm perihilar infiltrate in the left basilar atelectasis and pleural effusion. New order for Rocephin 1-gram (order was 2 grams) IM times one dose. He was on Amoxicillin 500 mg twice daily for five days for bronchitis and Tamiflu 30 mg twice daily for five days. He was in droplet isolation precautions and two liters of oxygen per nasal cannula which was new for the resident. He had abnormal lab result on 03/28/24 of a WBC count of 23 with a prior of 5.1 last week. He was given IV NS at 60 ml per hour for two liters. The family stated he seemed out of it. He was started on Keppra 500 mg twice daily on 03/19/24 by the neurologist for seizure activity. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366200	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER: Hennis Care Centre of Bolivar		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 Yant Street, NW Bolivar, OH 44612	

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Emergency Department (ER) report dated 03/29/24 revealed Resident #31 presented to the ER via emergency medical service (EMS) from the nursing home secondary to lethargy confusion. The resident was recently discharged from the hospital on 03/08/24 after having ESBL in the urine and bacteremia. He had a history of cerebral vascular accidents with a shunt. Family stated he was usually awake and conversant but that had been altered throughout the day. They stated he had a seizure about a week and half ago that was thought to be secondary to the medication he was receiving for his infection. His chest x-ray showed some early pulmonary edema with infiltrates. His lungs appeared to be wet with some occasional rhonchi, a BiPAP was attempted but did not help so the resident was intubated (and placed on a ventilator) for airway protection and respiratory failure. On 04/05/24 at 3:35 P.M. an interview with Registered Nurse (RN) #200 revealed on 03/11/24, the nursing assistant came and got her and by the time she got back to the resident's room he was breathing really heavy. She stated he had bitten his tongue, so he was bleeding out of his mouth. She stated he was drooling, his eyes were rolled back into his head, and he had very labored breathing. She stated she then called the NP, and the NP gave an order to give him Ativan 2 mg IM. She stated the NP called her back after she gave the Ativan, and she asked the NP if she wanted him sent out and the NP stated since the issue was resolved and the resident was stable he did not need to be sent out. She stated she called the POA and updated her on what had happened and let her know the resident was stable at that time. She stated it was never discussed to send him out to the hospital. On 04/09/24 at 8:40 A.M. an interview with NP #201 revealed she had treated the seizure for Resident #31 in house and it resolved so there was no reason to send him out to the hospital. She stated they do not do active EEGs in the ER, so you would want to treat it in house and not wait for him to go to the ER. She stated that going out to the hospital this last time on 03/29/24 was totally unrelated to the resident's seizure activity. She stated the resident did have a secondary seizure after the first one that the neurologist handled. She stated he then had some respiratory symptoms starting. She indicated she gave him Tamiflu prophylactically and antibiotics. She stated the family was in the building, she spoke to them and asked the ex-wife if she wanted him to go to the hospital, and she said no she was going to keep him at the facility. She stated his WBC went up and she told the family if they did not see a response from the Tamiflu and antibiotic then he had to go to the hospital. She stated the facility called her and stated the lab did not have the staff to come out and do the blood draw, so she sent him to the ER. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366200	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Hennis Care Centre of Bolivar		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Yant Street, NW Bolivar, OH 44612	

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 04/09/24 at 3:40 P.M. an interview with Family Member #300, POA for Resident #31, revealed the resident had come back from the hospital in early March 2024 from septic shock. She stated he was on an IV antibiotic. She stated he never really made a recovery from that hospitalization . She stated they called to tell her Resident #31 had an eight-minute seizure. She stated she asked if they were going to send him out to the hospital, but the nurse stated they felt the ER would not do anything they could not do at the nursing home. She stated they told her they gave him Ativan and were going to watch him. She stated she had told them if he had another seizure, she wanted him sent out to the ER, but when he did have another seizure, they did not send him out. She stated he just never got better. She stated he used to be talkative and joked around, but he was just lethargic and never really talked much after the seizure. She stated then on Good Friday (03/29/24) she was at the facility around 12:30 P.M. when the NP came in and told her his laboratory results were not good. She told her she was going to do some STAT (immediate) labs and if they were not any better, she was going to send him out to the ER. She stated by 3:30 P.M. they had not come to do the labs so she asked what was going on, and the nurse stated they had not had anybody pick up the lab work yet to do the labs, but she could call another lab to come do it. She stated at 5:00 P.M. the nurse came in and stated she spoke to a supervisor at the lab, and they could not get anyone to come into the do the lab work the whole weekend, so she let the NP know. She stated at 5:30 P.M. the NP called back and said to send him to the hospital. Review of the facility policy titled, Change in a Resident's Condition and Status, dated 05/15/20 revealed the facility would promptly notify the resident, the attending physician, and the responsible party of any changes in the resident's condition or status. Except for medical emergency the physician and family notification would be made within 24 hours of a change in condition. In the event of a medical emergency or a rapid deterioration in a resident's condition, family and physician notification would be made immediately. Faxes to the physician were not an acceptable means of communication in the event of a rapid change in condition, regardless of the day, time, or shift the change occurred. An acceptable notification time frame during a medical emergency or rapid change of condition can vary. The resident's immediate needs would be met, and the resident would be made as comfortable as possible. A direct call to the attending physician to responsive answering service would be made in the event of an emergency or rapid change in condition. As of the day of the survey the resident remained hospitalized for continued medical care and treatment. This deficiency represents non-compliance investigated under Complaint Number OH00152068.