STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365292	A. BUILDING _____ B. WING _____	05/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HANOVER HOUSE	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.

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on review of a closed medical record, an open medical record, the facility incident investigation, self-reported incident (SRI), the emergency department discharge summary, the facility policy and procedure on abuse and mistreatment, the local police department incident report and staff interviews, the facility failed to ensure one resident (Resident #1) was free from physical abuse. Life threatening harm and death occurred on [DATE] when Resident #2 was observed punching Resident #1 repeatedly in the face while he sat in his specialized, full body support chair in his room. This resulted in Immediate Jeopardy when Resident #1 sustained a fractured nasal bone, a fractured right orbital bone and a subdural bleed of the brain. Resident #1 subsequently died at the facility on [DATE]. The cause of death was a subdural hematoma on the right side of the head resulting from [MEDICATION NAME] force trauma. This affected one resident, Resident #1, of four residents reviewed for abuse. The facility census was 148. On [DATE] at 12:00 P.M. the Administrator was notified Immediate Jeopardy began on [DATE] at 7:30 A.M. when Resident #2 was witnessed, by Laboratory Technician (LT) #400, assaulting Resident #1 repeatedly in the face with his closed fist. Resident #1 had nasal bleeding and swelling of the right eye. Resident #1 was sent out to the emergency department and returned the same day with a discharge [DIAGNOSES REDACTED]. Resident #1 was placed on Hospice care (end of life care) upon returning to the facility and expired five days later, on [DATE]. On [DATE] at 1:08 P.M., telephone interview with Detective #410 revealed the final cause of death for Resident #1 was a subdural hematoma, resulting from [MEDICATION NAME] force trauma to the right side of his head. Detective #410 verified Coroner #413 said this would be the official cause of death listed on the coroner's report once completed. Resident #1 remained in the facility and was under 24-hour, 1:1 observation. The Immediate Jeopardy was removed, and the deficient practice corrected on [DATE] at 3:00 P.M. when the facility implemented the following corrective actions: On [DATE] at 7:30 A.M., Resident #1 and Resident #2 were physically separated. LT #400 remained in the room and went to the doorway to call for assistance from facility staff. Licensed Practical Nurse (LPN) #418 immediately responded. On [DATE] at 7:31 A. M., Resident #2 was placed on 1:1 supervision and placed in a private room. The 1:1 supervision will continue indefinitely pending criminal law enforcement charges. Interview on [DATE] at 3:30 P.M. with the Administrator revealed if no criminal charges were filed, Resident #1 would continue with 1:1 supervision indefinitely as this is the only way he could assure the safety of the other residents. On [DATE] at 7:35 A.M., Resident #1 and Resident #2 were assessed for pain and injury by LPN #401 and LPN #418. Resident #1 was provided immediate treatment for [REDACTED].#1. On [DATE] at 7:35 A.M., the physician for Resident #1 was notified of the incident by LPN #401 and the physician for Resident #2 was notified by LPN #418. The Power of Attorney and guardians for each resident were notified along with hospice services for Resident #1 at these times. On [DATE] at 7:35 A.M., Resident #2 was assessed by Psychiatrist #402 via telecommunication. an order for [REDACTED]. On [DATE] at approximately 7:35 A.M., LPN #403 notified the Director of Nursing (DON) of the incident. The DON immediately called the Administrator. Then at approximately 7:40 A.M., the Administrator notified Regional Director of Operations #415 and Regional Director of Clinical Operations #416 of the incident. On [DATE] at 7:45 A.M. the facility initiated and submitted a facility SRI to the State Agency. On [DATE] at 7:50 A.M., the local police department was notified of the incident. On [DATE] at 7:55 A.M., the behavior history of Resident #2 was reviewed and no history of aggression towards other residents since his admission to the facility were identified. On [DATE] at 8:45 A.M., Resident #1 was transported to the emergency department for further evaluation and treatment. On [DATE] at 9:00 A.M., the facility implemented daily audits of all residents with behaviors to reduce potential escalation of aggression. These audits will be completed by the DON or designee. The results of the audits will be reviewed every morning during morning meeting and reported to the Quality Assurance Performance Improvement (QAPI) Committee at least monthly. On [DATE] at 9:30 A.M. all working employees were educated on the abuse policy and procedure and all other staff were educated before the beginning of their next scheduled shift. The education of all facility staff was completed by the DON or her designee as of [DATE] at 3:00 P.M. On [DATE] at 10:00 A.M. interviews were completed with all interviewable residents with regards to abuse concerns. No concerns were identified. On [DATE] at 10:00 A.M. skin sweeps were conducted on all non-interviewable residents to assess for signs of abuse with no concerns identified. On [DATE] at 1:30 P.M. Resident #2 was assessed by Nurse Practitioner (NP) #404 and all current interventions were reviewed and maintained including the assessment and anticipation of his needs, the assessment of his understanding of the situation and allowing time for the resident to express himself, involve resident in choices regarding care and activities, monitoring and documentation of any observed behaviors and attempted interventions, analysis of what escalates his feelings, assessment of and evaluation of his medications including possible side effects, providing positive feedback for good behavior, emphasize the positive aspects of compliance. Staff are to intervene before agitation escalates and guide resident away from the source of distress, and engage resident calmly in conversation. If Resident #2 becomes aggressive, staff are to calmly walk away and re-approach later. If Resident #2 becomes overly stimulated, inform the nurse to locate a quiet area for him to retreat. Psychiatric consults would be provided as indicated. Interviews were completed on [DATE] from 2:40 P.M. through 3:35 P.M. with Licensed Social Worker (LSW) #407, LPN #408, the Assistant Director of Nursing, State tested Nursing Assistant (STNA) #450, STNA #451 and STNA #452. These staff members verified they received in-service and education related to abuse between [DATE] and [DATE]. The education provided included the knowledge of signs or symptoms displayed by residents that could lead to an abuse situation. Findings include: Review of the medical record for Resident #1 revealed a date of birth [DATE] with the most recent admitted on [DATE]. [DIAGNOSES REDACTED]. He was receiving palliative care, comfort care, through hospice services. Review of the Minimum Data Set (MDS) 3.0 comprehensive assessment, dated [DATE] revealed staff completed a brief interview for mental status (BIMS). Resident #1 scored a zero on a scale of zero to 15, with zero indicating severe cognitive impairment. The MDS section for hearing and speech revealed Resident #1 had unclear speech and was sometimes understood by others when he spoke and usually understood others when they spoke. The behavioral assessment revealed the resident would often have verbal behavioral symptoms directed toward others four to six days of the week. Resident #1 was dependent on staff for all Activities of Daily Living (ADLs). Resident #1 did not ambulate and was often in his Broda chair. Review of the care plan dated [DATE] and updated on [DATE] for Resident #1 included focus areas of social interaction and behaviors related to cognitive deficits, communication difficulty related to slurred speech, mood and anxiety behaviors related to dementia including verbal and physical outburst and constant talking to imaginary people. Review of the medical record for Resident #1 revealed no prior outbursts of yelling or crying. Resident #1 expired in the facility on [DATE] as a result of [MEDICATION NAME] force trauma to his head. Review of a nursing note for Resident #1, authored by LPN #401, dated [DATE] at 2:41 P.M., indicated at 7:30 A.M. Resident #1 was seated in his Broda chair in his

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

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) room. His roommate, Resident #2, became agitated with Resident #1's verbal outburst. A physical altercation occurred. Resident #1 was immediately removed from the situation to a safe place. Notifications were made to the physician, hospice staff, and his guardian. Resident #1 was sent to the emergency department for evaluation and treatment per the request of the physician and guardian. Review of the medical record for Resident #2 revealed a date of birth of [DATE] and admission to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the MDS assessment dated [DATE] revealed a BIMS score of 15 on a scale of zero to 15 indicating the resident was cognitively intact. The MDS assessment reflected no physical or verbal outbursts directed at others or himself. Resident #2 was ambulatory and independent with ADLs. Resident #2 received mental health services along with the use of antipsychotic and antidepressant medications at the time of the incident. Review of the nursing notes and medical record for Resident #2 from [DATE] through [DATE] revealed no other incidents of physical abuse towards any other residents or staff. Review of Resident #2's care plan initiated [DATE] with the latest revision on [DATE], addressed the focus areas for the potential to demonstrate verbal or physically abusive behaviors related to mental and emotional illness and related diagnoses. Behaviors specifically identified on the care plan included: running in the facility, repeated calls for mother, sleeping, refusal of care, twitching, pacing, impulsive decisions and leaving to find a quiet place. Review of the facility SRI dated [DATE] revealed at 7:50 A.M. an investigation was started related to resident to resident physical abuse between Resident #1 and Resident #2. The investigation indicated the abuse was reported to the Administrator by the DON on [DATE] at 7:40 A.M. Resident #2 had struck Resident #1 in his face while in their shared room on [DATE] at approximately 7:30 A.M. The residents were separated and assessments for pain and injury were completed. First aid was administered to Resident #1 for a bloody nose and he was later transferred to the hospital for further evaluation. Resident #2 was placed under continuous 1:1 staff supervision. Physicians and guardians for each resident were notified. Review of the discharge form from the emergency room titled, Discharge instructions, dated [DATE], for Resident #1 revealed he was now listed as having a Do Not Resuscitate (DNR), an order for [REDACTED].#1 sustained a 2.5 millimeter (mm) right subdural hematoma, right-sided orbital fracture and a nasal bone fracture. Review of a nursing note for Resident #2 dated [DATE] at 10:45 A.M., authored by the DON, provided a summary of the incident from [DATE] at 7:30 A.M. The DON indicated LPN #403 notified her via telephone on the handwritten witness statement, dated [DATE] at 7:30 A.M. The DON indicated she was informed Resident #2 had a physical altercation with his roommate. Resident #2 was separated from Resident #1. Resident #2 denied any pain and no skin issues were noted. Psychologist (PSY) #402, was notified and medications were adjusted for Resident #2. A urinalysis and laboratory blood test for Resident #2 were ordered. Resident #2 was immediately placed on continuous 1:1 staff supervision. Resident #2 apologized for the incident. The primary care provider and responsible party were notified. Review of the email statement dated [DATE], obtained from LT #400, revealed she was leaving the room of another resident after completing a blood draw. She said she was walking in the hall and noticed in a room, a man standing over another patient and he was repeatedly punching him. She said hey and Resident #2 stopped. She proceeded to obtain assistance from the nursing staff and found Resident #1 beaten up and bleeding all down his face. His right eye was swollen, and a bruise was forming. When asked what happened, Resident #2 said Resident #1 was laughing and would not shut up. Review of the written witness statement from LPN #403, dated [DATE] indicated at 7:30 A.M., during her medication pass, she was informed by LT #400, that a resident was hitting another resident. She entered the resident room and found Resident #1 sitting in his Broda chair, bleeding from his nose and mouth. LPN #403 asked Resident #2 what happened and Resident #2 stated his roommate was laughing at him. Review of the police report titled, Ohio Uniform Incident Report, #,[DATE], dated [DATE], listed Resident #1, as the victim of the offenses of assault. LPN #403 had notified the police department of the alleged assault via telephone on [DATE] at 7:50 A.M. Detective #410 responded to the call. Review of the mortician document dated [DATE] revealed Resident #1's body was released to the County Coroner's office. Review of the document received from Detective #412, titled, Narrative Supplement, dated [DATE] revealed on [DATE] she had contacted the coroner's office related to the completion date of the autopsy for Resident #1. Later the same day, Detective #412 was contacted by County Coroner #413 and indicated the autopsy on Resident #1 was complete and the preliminary cause of death was a subdural hematoma on the right side of Resident #1's head and the preliminary manner of death was homicide. On [DATE] at 2:00 P.M., interview with the Administrator and DON verified Resident #2 had struck and assaulted Resident #1 in the face/head on [DATE]. Both staff denied any known history of abusive behavior from Resident #2 prior to this incident. An interview was completed with Resident #2 on [DATE] at 4:20 P.M. Resident #2 stated he hit Resident #1 in the face a couple of times because, I thought he was laughing at me. Interview completed on [DATE] at 5:04 P.M. with the Medical Director verified the incident and stated NP #404 had been to the facility to assess Resident #2 after the incident on [DATE]. The Medical Director was not aware of any past problems of aggression related to Resident #2. The county coroner's office was contacted on [DATE] at 5:08 P.M. and the coroner's report was not complete and not available at the time of the investigation. Interview completed on [DATE] at 5:10 P.M. with the physician for Resident #1, Physician #405, stated he had not been aware of Resident #1 having been physically abused by any resident or staff member in the past. Interview on [DATE] at 5:15 P.M. with Physician #406, the primary care physician for Resident #2, revealed he had not been aware of any prior episodes of aggression. He said Resident #2 was very nice when he had visited him. Interview completed on [DATE] at 5:20 P.M. with NP #404 revealed the Medical Director and she were notified promptly of the incident between Resident #1 and Resident #2. NP #404 stated she assessed Resident #2 on the morning of [DATE]. She said he had no prior aggressive behaviors. Interview completed via telephone on [DATE] at 8:40 A.M. with the Administrator revealed he had no knowledge of Resident #2 requesting any room changes or reporting any problems with his roommate. The behaviors on [DATE] were out of the ordinary and he had no idea what triggered Resident #2 to hit his roommate. A second interview was completed with Resident #2 on [DATE] at 8:45 A.M. Resident #2 stated they (Resident #1 and Resident #2) had been roommates for several years. He said nothing out of the ordinary had happened. He said Resident #1 would not shut up. When asked if Resident #1 was laughing at him Resident #2 stated, It wasn ' t that. He said Resident #1 was yelling and would not shut up. He yells all the time. Resident #2 stated he had never asked for a room change or notified the staff of any concerns or problems with Resident #1. Interview was completed via telephone on [DATE] at 8:50 A.M. with Assistant Director of Nursing (ADON) #409. She stated nothing out of the ordinary happened on the morning of the incident. Resident #1 was his usual self and she had no knowledge of outbursts of laughter or yelling as that would have not been normal or baseline behavior for Resident #1 as he was pleasant. She said Resident #2 had never asked for a room change to her knowledge. Interview completed via telephone on [DATE] at 9:26 A.M. with Detective #410 in charge of the case indicated no specifics could be discussed as it was an open case. A summary of the incident was obtained verifying the assault allegation on the victim, Resident #1. An interview was completed via telephone on [DATE] at 9:35 A.M. with LT #400, who witnessed the incident involving Resident #1 and Resident #2 on [DATE]. LT #400 stated she was walking down the hallway and saw Resident #2 standing over Resident #1 and hitting him in the face. LT #400 said hey and the resident stopped as LT #400 secured help. She stated Resident #2 hit Resident #1 at least three times in the face. Resident #2 had blood on his left hand. She did not hear any laughing or yelling out before witnessing the assault. She was just walking by the room and the door was open. LT #400 stated, Resident #2 went and laid back in his bed and stated, he was laughing and would not shut up. Interview completed via telephone on [DATE] at 10:02 A.M. with LPN #401, the unit nurse manager, revealed Resident #2 was brought down to her unit for assessment and monitoring. She completed the assessment and the police department arrived shortly thereafter. LPN #401 stated Resident #2 had no prior behavioral outburst prior to the incident. Interview via telephone was completed on [DATE] at 2:00 P.M. with the Administrator and the timeline of events and corrective actions listed above were verified. On [DATE] at 10:30 A.M. the coroner's office was contacted, and the call was received by Administrative Secretary (AS) #411 who stated Coroner #413 oversaw the case and was not in the office the week of the survey. She could not verify the cause of death and stated it would be four to six weeks before the toxicology results were received back, and a final report was generated. No other information was provided. Interview on [DATE] at 10:39 A.M. with the lead detective for the case, Detective #412, revealed she did not have a final coroner's report but verified the preliminary report from Coroner #413 stated the cause of death for Resident #1 was a subdural hematoma to the right side of the head. Review of the facility's policy and standard procedure for Abuse, Neglect and Misappropriation, last revised [DATE], revealed abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Page four of the policy, under the section titled Policy, indicated it was the policy of the facility to prevent the abuse, mistreatment or neglect of residents. This deficiency substantiates Complaint Number OH 265.