STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365838	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0553 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Allow resident to participate in the development and implementation of his or her person-centered plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review the facility failed to ensure Resident #64 was provided the right to participate in the development and implementation of her person-centered plan of care. This affected one resident (#64) of two residents reviewed for care conferences. Findings include: Review of Resident #64's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #64's most current Minimum Data Set 3.0 assessment revealed the resident was cognitively intact. Interview on 03/09/20 at 11:14 A.M. with Resident #64 revealed she had never been to a care conference or any type of meeting regarding her care since admission. Interview on 03/11/20 at 11:41 A.M. with Social Service Worker #19 revealed the facility had not set up quarterly care conferences for the resident as of this date and she must have been missed since her admission in September 2019. Review of the facility policy titled, Care Plan Conference Policy, dated 11/28/16 revealed the resident was an integral part of the care planning process, as their individual needs and requests for care were vital.
F 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review the facility failed to ensure Advanced Directives were consistent between facility documentation and accurately reflected on Resident #64, #107 and #110's medical chart. This affected three residents (#64, #107 and #110) of five residents reviewed for advanced directives. Findings include: 1. Review of Resident #64's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the resident's [DATE] physician's orders [REDACTED]. However, review of the facility hard/paper chart revealed a paper stating to, Proceed with CPR. Interview on [DATE] at 4:23 P.M. with the DON confirmed the inaccurate/inconsistent code status documentation for Resident #64. Review of the undated facility policy titled Resuscitation Code Status revealed it was the policy of the facility to provide resuscitative efforts, including, but not limited to cardiopulmonary resuscitation, (CPR), for all patients when their cardiovascular, respiratory or other systems fail unless the physician of record has written a Do Not Resuscitate order. Orders to withhold resuscitative interventions must be made in accordance with this policy. Upon admission to the facility a DNR identification From was reviewed and completed with the admitting nurse. This form becomes part of the resident's medical record. The DNR status was then reviewed at the time of the initial care conference within seven days of admission and thereafter the DNR status was reviewed and updated as needed and quarterly at care conferences. 2. Review of Resident #110's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the resident's [DATE] physician's orders [REDACTED]. However, review of the nursing report sheet revealed Resident #110 was a full code. Interview on [DATE] at 4:24 PM with Licensed Practical Nurse #36 revealed the nurse would check either the computer or the nursing report sheets to determine a residents code status. Interview on [DATE] at 4:23 P.M. with the Director of Nursing (DON) confirmed the inaccurate/inconsistent code status for Resident #110. Review of the undated facility policy titled Resuscitation Code Status revealed it was the policy of the facility to provide resuscitative efforts, including, but not limited to cardiopulmonary resuscitation, (CPR), for all patients when their cardiovascular, respiratory or other systems fail unless the physician of record has written a Do Not Resuscitate order. Orders to withhold resuscitative interventions must be made in accordance with this policy. Upon admission to the facility a DNR identification From was reviewed and completed with the admitting nurse. This form becomes part of the resident's medical record. The DNR status was then reviewed at the time of the initial care conference within seven days of admission and thereafter the DNR status was reviewed and updated as needed and quarterly at care conferences. 3. Review of the medical record revealed Resident #107 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Review of the DNR Identification Form dated [DATE] revealed Resident #107 had an checkmark on both the Do Not Resuscitate Comfort Care (DNRCC) and DNRCC Arrest (DNRCC-A) with the DNRCC circled and a dated of [DATE] beside DNRCC-A. Interview on [DATE] at 3:53 P.M. the Director of Nursing revealed she was not sure what the code status was for Resident #107 by looking at the DNR Identification Form. She also verified Resident #107 had a code status order of DNRCC dated [DATE]. Review of the undated facility policy titled Resuscitation Code Status revealed it was the policy of the facility to provide resuscitative efforts, including, but not limited to cardiopulmonary resuscitation, (CPR), for all patients when their cardiovascular, respiratory or other systems fail unless the physician of record has written a Do Not Resuscitate order. Orders to withhold resuscitative interventions must be made in accordance with this policy. Upon admission to the facility a DNR identification From was reviewed and completed with the admitting nurse. This form becomes part of the resident's medical record. The DNR status was then reviewed at the time of the initial care conference within seven days of admission and thereafter the DNR status was reviewed and updated as needed and quarterly at care conferences.
F 0582 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure Resident #15 and Resident #117, remaining in the facility received the required liability notices once Medicare Part A services ended. This affected two residents (#15 and #117) of three residents reviewed for liability notices. Findings include: 1. Review of Resident #117's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Notice of Medicare Non-coverage (NOMNC) revealed the resident's skilled services would end on 12/08/19, and the resident would remain in the facility. It was further noted the facility had not completed and issued a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) to the resident at the time services ended. Interview on 03/11/20 at 9:22 A.M. with Assistant Administrator #14 confirmed the facility failed to complete and provide a SNFABN to Resident #117 and/or his representative at the time services ended on 12/08/19 as required. 2. Review of Resident #15's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Notice of Medicare Non-coverage (NOMNC) revealed the resident's skilled

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

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F 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) services would end on 12/2[DATE]9 and the resident would reside in the facility. It was further noted the facility had not completed and issued a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) to the resident at the time services ended. Interview on 03/11/20 at 9:22 A.M. with Assistant Administrator #14 confirmed the facility failed to complete and provide a SNFABN to Resident #15 and/or her representative at the time services ended on 12/2[DATE]9.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observation, staff interview and policy review the facility failed to ensure Resident #53 and Resident #108's wheelchairs were maintained in a clean and sanitary manner. This affected two residents (#53 and #108) of two residents reviewed for equipment. Findings include: Observation on 03/09/20 at 8:50 A.M.,10:25 A.M. and 3:22 P.M. and on 0[DATE] at 8:24 A.M. revealed Resident #53's wheelchair was observed to be very dirty with dust and food debris on it. Observation on 03/09/20 at 8:33 A.M.,10:41 A.M. and 3:30 P.M. and on 0[DATE] at 8:35 A.M. revealed Resident #108's wheelchair was very dirty with dust, food debris and an unknown white substance on it. Interview on 0[DATE] at 11:42 A.M. with Registered Nurse (RN) #21 verified the condition of Resident #53 and 108's were very dirty. The RN revealed resident wheelchairs were supposed to be cleaned on midnight shift. Interview on 0[DATE] at 4:10 P.M. with the Director of Nursing (DON) revealed the task of cleaning the wheelchairs was given to the housekeepers to free up some tasks from the nursing assistants. She indicated the facility was having trouble getting enough nursing assistants hired and working so they thought if they gave the wheelchair cleaning task to the housekeepers it would help the nursing assistants. The DON stated they were trying to hire more nursing assistants. Review of the facility policy titled Wheelchair Cleaning, dated 03/01/20 revealed each unit would be responsible for the cleaning of the wheelchairs that were used by the residents on their units. Schedules would be developed and monitored to ensure the task was completed. Effective 03/01/20 the responsibility for cleaning the wheelchairs throughout the facility would be assigned to the housekeeping staff. Additional housekeeping staff would be hired to help accomplish this task.
F 0640 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure quarterly Minimum Data Set (MDS) 3.0 assessment were submitted timely as required. This affected ten residents (#2, #3, #5, #6, #7, #8, #10, #12, #20, and #23) of ten residents reviewed for MDS assessments. Findings include: 1. Record review revealed Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #2's quarterly MDS 3.0 assessment, dated 01/26/20 revealed the MDS was not submitted until 03/04/20, which was ten days late. 2. Record review revealed Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #3's quarterly MDS 3.0 assessment, dated 01/22/20 revealed the MDS was not submitted until 03/04/20, which was 14 days late. 3. Record review revealed Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident 35's quarterly MDS 3.0 assessment, dated 01/22/20 revealed the MDS was not submitted until [DATE], which was 13 days late. 4. Record review revealed Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #6's quarterly MDS 3.0 assessment, dated 01/20/20 revealed the MDS was not submitted until [DATE], which was 15 days late. 5. Record review revealed Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #7's quarterly MDS 3.0 assessment, dated 01/23/20 revealed the MDS was not submitted until 03/04/20, which was 13 days late. 6. Record review revealed Resident #8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #8's quarterly MDS 3.0 assessment, dated 01/28/20 revealed the MDS was not submitted until 03/04/20, which was eight days late. 7. Record review revealed Resident #10 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #10's MDS 3.0 assessment, dated 02/01/20 revealed the MDS was not submitted until 03/06/20, which was six days late. 8. Record review revealed Resident #12 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #12's MDS 3.0 assessment, dated 02/02/20 revealed the MDS was not submitted until 03/06/20, which was five days late. 9. Record review revealed Resident #20 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #20's MDS 3.0 assessment, dated 01/28/20 revealed the MDS was not submitted until 03/04/20, which was eight days late. 10. Record review revealed Resident #23 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #23's MDS 3.0 assessment, dated 02/03/20 revealed the MDS was not submitted until 03/06/20, which was four days late. Interview on 03/11/20 at 12:31 P.M., with Registered Nurse (RN) #1119 confirmed the MDS 3.0 assessments for Resident #2, #3, #5, #6, #7, #8, #10, #12, #20, and #23 were submitted late as noted above and not within the 28-day time frame as required.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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** Based on observation, record review and staff interview the facility failed to ensure Resident #53, #107 and #108, who required staff assistance for activities of daily living (ADL) received timely and necessary care to maintain proper grooming/hygiene related to fingernail care. This affected three residents (#53, #107 and #108) of three residents reviewed for ADL care. Findings include: 1. Medical record review revealed Resident #53 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 12/17/19 revealed Resident #53 had severely impaired cognition and required total assistance from staff for personal hygiene. Review of the nursing progress notes from 01/01/20 to present date (0[DATE]) revealed no evidence the resident refused nail care. Observation on 03/09/20 at 8:50 A.M.,10:25 A.M. and 3:22 P.M. and on 0[DATE] at 8:24 A.M. and 2:00 P.M. revealed Resident #53 had long, jagged dirty fingernails. Review of the shower sheets revealed Resident #53 received a whirlpool bath on 02/03/20 and bed baths on 02/06/20, 02/07/20, 02/08/20, 02/09/20, [DATE], 02/20/20, 02/21/20, 02/22/20, 02/23/20, 0[DATE], 0[DATE], [DATE], 02/29/20, 03/02/20, [DATE], 03/05/20, 03/06/20, 03/07/20, [DATE] and 0[DATE] with no evidence of the resident's fingernail being trimmed or cleaned. Interview on 0[DATE] at 2:00 P.M. with Registered Nurse (RN) #21 verified the fingernails of Resident #53 were long and dirty. 2. Medical record review revealed Resident #107 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the annual MDS 3.0 assessment, dated 01/08/20 revealed Resident #107 had moderately impaired cognition and required extensive assistance from staff for personal hygiene. Review of the nursing progress notes from 01/01/20 to present date (0[DATE]) revealed no evidence the resident refused nail care. Review of the shower sheets revealed Resident #107 had a bed bath on 0[DATE], [DATE], 03/07/20, 03/06/20, 03/05/20 and [DATE] with no evidence of the resident's fingernails being trimmed or cleaned. Review of the Hospice shower sheets revealed Resident #107 had a shower on 02/04/20, 02/06/20, 02/11/20, 02/13/20, [DATE], 02/20/20, 02/25/20, 0[DATE], [DATE], 03/05/20 and 0[DATE] with no evidence of the resident's fingernails being trimmed or cleaned. Observations on 03/09/20 at 8:42 A.M. and on 0[DATE] at 2:00 P.M. revealed the Resident #107's fingernails were long and dirty. During an interview on 0[DATE] at 2:12 P.M. Registered Nurse (RN) #21 verified the fingernails of Resident #107 were long and dirty. 3. Medical record review revealed Resident #108 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the annual MDS 3.0 assessment, dated 01/08/20 revealed Resident #108 had severely impaired cognition and required extensive assistance from staff for personal hygiene. Review of the nursing progress notes from 01/01/20 to present date (0[DATE]) revealed no evidence the resident refused nail care. Observations on 03/09/20 at 8:33 A.M., 10:41 A.M. and 3:30 P.M. and on 0[DATE] at 8:35 A.M. revealed Resident #108's fingernails were long and dirty. Interview on 0[DATE] at 3:00 P.M. with RN #21 verified the fingernails of Resident #108 were long and dirty.

F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) Based on record review, interview and policy review the facility failed to ensure Hospice care was accurately reflected, care planned and coordinated for Resident #427 and failed to ensure an effective bowel regimen and/or bowel monitoring was completed for Resident #64, Resident #90 and Resident #110. This affected one resident (#427) of one resident reviewed for Hospice services and three residents (#64, #90 and #110) of five residents reviewed for unnecessary medication use. Findings include: 1. Record review revealed Resident #427 was admitted to the facility on [DATE] with stage four [MEDICAL CONDITION]. Medical record documentation revealed the resident was admitted with Hospice services. However, further review of Resident #427's medical record revealed no evidence of a Hospice certification. There was no evidence the type of Hospice services the resident required including frequency of nursing, aides, chaplain or social service visits. Interview on [DATE] from 11:15 A.M. to 12:44 P.M. with Registered Nurse (RN) #20 verified Resident #427's record did not contain a Hospice certification. The RN reported she did not know the frequency of visits the hospice nurse, aides, chaplain or social service were to make or what services they were to provide. She confirmed the Hospice plan of care that was developed for the resident was not resident specific and did not include this information. RN #20 called the Hospice provider on this date to obtain a copy of the Hospice certification. The Hospice provider faxed the certification, which upon review revealed it expired on [DATE]. RN #20 then called the provider back and they sent another certification, which expired [DATE] and reflected the resident was living at home with his daughter. RN #20 then reported the Hospice provider finally sent another certification, dated [DATE] to [DATE]. This certification revealed the the resident had chronic and acute [MEDICAL CONDITION] and required Hospice services. The certification still indicated the resident was living at home with his daughter (versus in a skilled nursing facility), however Hospice was able to provide RN #20 with a meeting review note, dated [DATE] that included the resident's diagnoses, medication list, durable medical supplies, diet, allergies [REDACTED]. During the interview, RN #20 revealed she wished Hospice would report to the unit mangers after each visit to coordinate care instead of reporting to the floor nurses as the floor nurses could float throughout the building. RN #20 revealed the facility State tested Nursing Assistants (STNA) did not have access to the Hospice plan of care and verified there were concerns regarding coordination of care between the facility and Hospice for Resident #427 after receiving a copy of the current certification and meeting minutes. Interview on [DATE] at 12:55 P.M. and 1:18 P.M. with Hospice Staff #37 revealed the last verification on file indicated the resident was living at home with his daughter and it had expired on [DATE]. Hospice #37 reported she would get medical records and fax an updated certification to the facility as soon as possible. Interview on [DATE] at 1:12 P.M. with STNA #400 revealed Hospice staff usually don't report or talk with the STNA staff at the facility. She reported in the past the Hospice aides visited on Tuesday and Thursday and she assumed the Hospice aides provide activities of daily living care to the residents, however she was not sure. 2. Review of Resident #64's medical record revealed and admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #64's current Minimum Data Set (MDS) 3.0 assessment revealed she was cognitively intact. Review of the resident's current plan of care, (initiated [DATE]) revealed the resident would have have regular bowel movements which was considered to be every two-three days. Review of Resident #64's Bowel Movement Record revealed the facility did not document the resident had any bowel movements from [DATE] to [DATE] or from [DATE] to [DATE]. Review of the [DATE] Medication Administration Record [REDACTED]. The February 2020 MAR indicated [REDACTED]. Interview on [DATE] at 3:22 P.M. with RN #20 confirmed the facility was not accurately tracking bowel movements or providing as needed medications to help prevent constipation for Resident #64. Review of the undated policy titled, Preventing Constipation, Doing Your Part revealed for any resident who had not had a bowel movement for greater than 72 hours, administer as needed medications as ordered for the resident. 3. Review of Resident #110's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the MDS 3.0 assessment, dated [DATE] revealed the resident was cognitively intact. Review of the resident's physician's orders [REDACTED]. Review of the resident's bowel movement form revealed the resident did not have a bowel movement from [DATE] to [DATE], [DATE] to [DATE], [DATE] to [DATE] or [DATE] to [DATE]. Review of MAR indicated [REDACTED]. In February she only received Lubiprostone on [DATE] and [MEDICATION NAME] 5 mg on [DATE]. Interview on [DATE] at 2:00 P.M. with Resident #110 revealed she occasionally has problems with constipation. Interview on [DATE] at 03:19 P.M. with RN #20 revealed the resident was not documented to have had a bowel movement during the dates noted above and the nurses were not providing as needed medication for constipation as it was ordered for the resident. Review of the undated policy titled Preventing Constipation, Doing Your Part revealed for any resident who has not had a bowel movement for greater than 72 hours, administer as needed medications as ordered for the resident. 4. Review of Resident #90's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Further review of the medical record including tracking of bowel movements revealed bowel movement tracking was not completed daily and/or every shift. Review of the State tested Nurse Aide (STNA) care tracker records revealed for the month of February 2020, there was no evidence of documentation regarding bowel movements recorded on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] [DATE] and [DATE]. Interview with RN #22 on [DATE] at 2:25 P.M. verified the above dates with no results recorded for bowel movements for Resident #90.
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** Based on observation, record review and interview the facility failed to ensure pressure ulcer treatments and/or pressure revealing interventions were implemented as ordered/care planned. This affected two residents (#115 and #427) of five residents reviewed for pressure ulcers. Findings include: 1. Record review revealed Resident #115 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident 115's current orders, dated 03/2020 revealed on 02/13/20 orders were received to cleanse pressure ulcer on left great toe daily with normal saline, apply [MEDICATION NAME] AG (absorbent dressing) to wound bed and cover with dry dressing, and apply Kerlix daily. Review of Resident #115's medication/treatment administration record dated 02/13/20 to 03/12/20 revealed no evidence a treatment was administered daily to the left great toe. Observation on 03/12/20 at 10:25 A.M., with Registered Nurse (RN) #401 revealed the resident had an undated dressing that was intact to the left foot. RN #401 removed the undated dressing from the resident's left foot. The resident's left great toenail was only attached at the bottom left corner and a lima bean size scab was noted at the tip of the left toenail. Interview on 03/12/20 at 12:02 P.M., with RN #22 confirmed there was no evidence a treatment had been preformed to Resident #115's left great toe from 02/2020 to 03/12/20. The RN reported the nurse created an order; however, the order was not included on the treatment administration record to ensure it was being completed as ordered. 2. Record review revealed Resident #427 was admitted to the facility on [DATE] with stage four [MEDICAL CONDITION], abnormal weight loss, difficulty walking and [MEDICAL CONDITION]. The resident was admitted under Hospice services. Review of Resident #427's Braden scale assessment, dated [DATE] revealed the resident was at risk for skin breakdown. Review of Resident #427's paper (not electronic) Hospice notes/orders dated [DATE] revealed the resident was to have heel boots to bilateral feet daily while in bed for skin protection. Further review revealed on 03/05/20 the resident should be placed in a specialized (Broda) chair as tolerated. Review of Resident #427's electronic medical record orders revealed no evidence of orders for the heel boots, Broda chair or nay type of gel cushion/cushion for pressure reduction. Review of Resident #427's electronic medical record plan of care revealed no evidence of a plan related to the use of heel boots, a Broda chair or gel cushion. Resident #427 was observed on 03/11/20 at 8:28 A.M. and 10:48 A.M. At the time of the observations, the resident's heel boots were observed sitting on a chair in the corner of the room. The resident was observed in bed with no boots in place. Interview with State tested nursing assistant (STNA) #50 at the time of the observation at 10:48 A.M. revealed she had never seen the resident wear the boots and did not know the resident was supposed to wear them. A Broda chair was observed sitting in the hallway but the STNA wasn't sure who the chair belonged to. The chair did not have a gel cushion in it. Interview on 03/11/20 at 1:12 P.M. with STNA #400 revealed she had not applied the resident's heel boots because it was not included on the resident's plan of care. Interview on 03/11/20 at 11:15 AM with RN #20 verified the Hospice recommendation for heel boots and Broda chair were not included on the facility plan of care and the STNA staff did not have access to the Hospice plan of care. The RN revealed on 03/06/20 Hospice had ordered a gel cushion which the facility did not have. Interview on 03/12/20 at 9:43 AM with RN #20 revealed she called Hospice last night regarding the gel cushion for the chair and Hospice brought one in last night.

F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview and policy review, the facility failed to ensure residents were

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) re-weighed timely when weight loss of greater than five pounds was identified and failed to document residents' meal intakes. This affected two (#37 and #49) five residents reviewed for nutrition. Findings include: 1. Medical record review revealed Resident #37 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment, dated 12/08/19 revealed Resident #37 had severely impaired cognition, required supervision with meals, weighed 111 pounds and did not have weight loss. Review of the weights for Resident #37 revealed the following weights: On 09/03/19- 117 pounds On 10/03/19- 115.7 pounds On 11/06/19- 114.6 pounds On 12/03/19- 110.6 pounds On 12/31/19- 111 and 97.8 pounds were both documented (with no reweight of the 97.8 pounds) Review of a weight variance report, dated 01/23/20 revealed Resident #37 ate her meals in the dining room however, her intakes varied between 25 to 50 percent, her diet was appropriate/adequate to meet her needs, but her intakes did not meet her needs at this time. The report revealed the resident may benefit from additional supplement and they would follow up with a reweight. Continued review of the resident's weights revealed: On 02/05/20- 110.7 pounds (with no reweight documented) On 03/05/20- 101.6 pounds with no reweigh until 03/09/20 which was 99 pounds and assessed to be a significant weight loss of 15.7 percent (%) in six months. Review of the meal intake records from 01/01/20 to 03/09/20 revealed numerous meal intakes were not documented in the resident's medical record. Review of the March 2020 physician's orders [REDACTED].M. with Registered Dietitian #27 verified Resident #37's documented as noted above. Registered Dietitian #27 also verified Resident #37 should have been reweighed for a weight change of more than five pounds per the facility policy (with 24 hours). In addition, Registered Dietitian #27 verified there were numerous meal intakes not documented in the medical record for Resident #37 and indicated it was very important for the meal intakes to be documented so nutritional interventions could be implemented timely when the resident was not eating. During the interview, Registered Dietitian #27 also revealed either him or the diet technician would hang a list at the different nurse's stations of the weights to be completed for the whole month. He indicated all weights were usually done the first week of the month except for the residents who required weekly weights. He would also have the previous weights listed so the staff would know if the resident had a weight loss or weight gain. He stated the residents were to be reweighed if there was five-pound weight variance from the previous weight. The weights were put into the computer by the nursing staff and ideally the weights documented should be the correct weight after a reweigh. Observation on 03/11/20 at 12:05 P.M. revealed Resident #37 was in her room feeding herself. The resident ate only 25 percent of her meal. An interview at the time of the observation with State tested Nursing Assistant (STNA) #100 revealed the resident indicated she was done eating and did not want anything else to eat. 2. Medical record review revealed Resident #49 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #49 had severely impaired cognition, required supervision with eating and had a weight loss. Review of the weights for Resident #49 revealed the following documented weights: On 09/06/19- 117.5 pounds On 10/01/19- 108.5 pounds with no reweight obtained On 10/17/19- 105.6 pounds On 11/05/19- 114.6 pounds with no reweight obtained On 11/18/19- 112.5 pounds On 0[DATE]- 107.9 pounds with no reweight obtained On [DATE]- 103 pounds with no reweight obtained On [DATE]- 102.2 pounds On 03/09/20- 104.9 pounds (which reflected a weight loss of 10.7 percent in six months) Review of on the meal intake records from 01/01/20 to 03/09/20 revealed numerous meal intakes were not documented in the medical record. Review of the bedtime snack intake records from 01/01/20 to 03/09/20 revealed numerous snack intakes were not documented in the medical record. Review of the March 2020 physician's orders [REDACTED]. Interview on 03/11/20 at 10:44 A.M. with Registered Dietitian #27 verified Resident #49's as documented above and verified Resident #49 should have been reweighed for a weight change of more than five pounds per the facility policy. Registered Dietitian #27 also verified there were numerous meal intakes and bedtime snacks missing in the medical record for Resident #49 and indicated it was very important for the meal intakes to be documented so nutritional interventions could be implemented timely as needed. Review of the undated facility policy titled Weight Loss Management revealed residents would be reweighed for a weight variance of five pounds or more within 24 hours.
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review the facility failed to ensure weights, fluid restriction monitoring and access site assessments were completed for Resident #59 related to [MEDICAL TREATMENT]. This affected one resident (#59) of one resident reviewed for [MEDICAL TREATMENT]. Findings include: Review of Resident #59's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the resident's 12/29/19 Minimum Data Set (MDS) 3.0 assessment revealed the resident was cognitively intact. Review of Resident #59's March 2020 physician's orders revealed the resident was on an 1800 milliliter (ml) fluid restriction and the resident was to receive daily weights. Interview on 03/09/20 at 10:05 A.M. with Resident #59 revealed he had a fistula in his left arm that was used for [MEDICAL TREATMENT] treatments. The resident reported the nurses only assessed the site sometimes. Review of the Weekly Audit of [MEDICAL TREATMENT] Quality Check Sheets for January, February, and March 2020 revealed the facility was not consistently monitoring the resident's fluid intake, the resident's access site/fistula for bruit and thrill or obtaining daily weights. In January 2020 the resident's intake was not recorded on 19 of 31 days. In February 2020 the resident's intake was not recorded on 17 of 29 days. In March 2019 the resident's intake was not recorded at all. In January 2020 the resident's weight was not recorded on 16 of 31 days. In February 2020 the resident's weight was not record for 17 of 29 days. In March 2020 the resident's weight was not recorded on 6 days. In January 2020 the resident's bruit and thrill were not record on 20 of 31 days. In February 2020 the resident's bruit and thrill was not recorded on 17 of 29 days. In March 2020 the resident's bruit and thrill were not recorded on five days. Interview on 03/11/20 at 8:52 A.M. with Registered Nurse #20 confirmed the facility was not consistently monitoring the resident's intake, the nurses were not consistently checking for bruit and thrill or obtaining daily weights. Review of the facility policy titled End Stage [MEDICAL TREATMENT] Care dated 10/15/16 revealed all [MEDICAL TREATMENT] residents were monitored within the facility for intake and output, if on fluid restriction. The facility was to monitor fistula and check graph and fistula for bruit and thrill and call physician immediately if none.
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information every day.** Based on review of the daily nursing postings, interview and policy review the facility failed to ensure the daily nursing posting was accurate and included all required information. This had the potential to affect all 121 residents residing in the facility. Findings include: Review of the daily nurse staffing posting, dated 03/05/20 revealed there was only two Licensed Practical Nurses (LPN) for 24 hours, two Registered Nurses (RN) for 21.5 hours, and three State tested Nursing Assistants (STNA) for 9.5 hours from 3:00 A.M. to 11:00 P.M. The listed census was 133. Review of the daily nurse staffing posting, dated 03/06/20 revealed there was one LPN for 12 hours, two RNs for 21.5 hours, and three STNAs for 13.5 hours from 5:00 A.M. to 11:00 P.M. The listed census was 129. Review of the daily nurse staffing posting, dated 03/07/20 revealed there was one LPN for 12 hours, one RN for 12 hours from 3:00 A.M. to 11:00 P.M. There was no evidence of the number or hours of STNAs. The listed census was 129. Review of the daily nurse staffing posting, dated [DATE] revealed there were two LPNs for 24 hours. There was no evidence of the number or hours of RNs or STNAs. The listed census was 128. Review of the daily nurse staffing posting, dated 03/09/20 revealed there were four LPNs for 39 hours, two RNs for 21.5 hours and two STNAs for eight hours from 3:00 A.M. to 11:00 P.M. The posting indicated the census was 130, however the resident rooster and the completed facility CMS form 672 indicated the census was 121. Review of the daily nurse staffing posting, dated 0[DATE] revealed there was one LPN for 12 hours, one RN for 12 hours, and two STNAs for 8.5 hours. The listed census was 130. Review of the daily nurse staffing posting, dated 03/11/20 revealed there were two LPNs for 24 hours and two RNs for 21.5 hours from 3:00 A.M. to 11:00 P.M. There was no evidence of the number or hours of STNAs. The listed census was 130. Interview on 03/11/20 at 8:00 A.M. and 9:45 A.M. with the Director of Nursing (DON) and Human Resource (HR) #34 verified the above daily nurse staffing postings were inaccurate and did not include an accurate account and hours of LPNs, RNs, and STNAs who provided direct care for those days. HR #34 reported she tried to schedule one nurse on the Garden unit, three nurses on Rehab unit, and two on Homestead unit on day shift, which were 12 hours shifts. On night shift, which were 12 hour shifts also, she scheduled one nurse on Garden and Homestead units and two on the Rehab unit. The STNAs usually worked eight hours shifts. On the Rehab unit she scheduled four to five on days, four on afternoon shift and two on night shift. On the Garden unit she scheduled four on days and evening shift and two on night shift. On the Homestead unit she usually scheduled five to six on day shift, four to five on afternoon shift and two to three on night shift. Review of the staffing policy, dated 10/0[DATE]5 revealed on Garden unit there would be one nurse on days and afternoon shift, five STNAs on day shift, four STNAs on evening shift and two STNAs on night shift. On the Homestead unit there would be two nurses on day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365838	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	(continued... from page 4) shift, one nurse 7:00 P.M. to 11:00 P.M., and one nurse on night shift. The Homestead unit would have seven STNAs on day shift, five STNAs on evening shift and three STNAs on night shift. The Rehab unit would have three nurses on days and two on nights. The Rehab unit would have five STNAs on day shift, four on evening shift, and two STNAs on night shift. Staffing would be adjusted by census and acuity. All call offs would be attempted to be replaced.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and staff interview the facility failed to ensure the kitchen was maintained in a clean and sanitary manner to prevent contamination. This had the potential to affect 114 of 114 residents receiving nutritional services from the kitchen. The facility identified seven residents (#32, #56, #68, #90, #93, #102 and #117) not receiving nutritional services from the facility kitchen. The facility census was 121. Findings include: Observation of the kitchen on 0[DATE]20 at 10:45 A.M. revealed a suspended heating unit above the food cook/prep area with a large amount of dust and grease build up and an extremely dirty air filter. Additional observation of the flat top back splash also revealed a moderate amount of grease and dust build up. Additional observation and interview with Dietary Staff #121 on 03/11/2020 at 9:00 A.M. verified the grease and dust to the suspended heating unit, dirty air filter to the heating unit and greasy and dusty flat top back splash.
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** Based on observation, record review, interview and policy review the facility failed to ensure proper infection control practices were maintained following perineal care for Resident #56 to prevent the spread of infection. This affected one resident (#56) of one resident observed for catheter care. Findings include: Review of Resident #56's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the resident's March 2020 physician's orders [REDACTED]. Observation of perineal care on 0[DATE] at 1:06 P.M. revealed State tested Nursing Assistant (STNA) #50 washed her hands, gathered supplies, applied gloves and began perineal care. After completing perineal care, prior to removing her soiled gloves, STNA #50 began repositioning the resident by lifting his arms onto pillows. She then used the remote on the side of the bed to raise the resident's head of bed and finally opened the bathroom door. She then removed the soiled gloves and washed her hands. Interview on 0[DATE] at 1:17 P.M. with STNA #50 verified she did not follow correct infection control practices after perineal care was given. Review of the facility undated policy titled Hand Washing revealed hand washing should be done whenever hands were obviously soiled, after handling contaminated equipment and after coming in contact with blood, body fluids, and secretions.
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement a program that monitors antibiotic use.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review the facility failed to ensure Resident #16, who received antibiotics for urinary tract infections was comprehensively assessed to determine appropriate indication for antibiotic use via the antibiotic stewardship program. This affected one resident (#16) of seven residents reviewed for antibiotic use. Findings include: Review of Resident #16's medical record revealed an admission date of [DATE] with admission [DIAGNOSES REDACTED]. Further review of the medical record revealed antibiotic use on 0[DATE]20, [DATE], 09/17/2019, 08/02/2019 and 06/25/2019 for urinary tract infections. However, there was no evidence of any assessment completed to determine the appropriate indication for antibiotic use was found within the medical record. Interview with Resident #16 on 03/09/2020 at 10:55 A.M. revealed she had several urinary tract infections and it would not go away. Review of the facility policy, titled Infection Tracking and Surveillance and Antibiotic Stewardship Policy, dated 01/2020 revealed physicians and nurse practitioners were educated on McGreer's criteria. The policy did not indicate any assessment should/would be completed to determine the appropriateness for antibiotic use. On 3/11/2020 at 2:25 P.M. interview with Registered Nurse (RN) #22 revealed staff were to utilize McGreer's criteria to determine appropriate indication for antibiotic use. RN #22 stated a flowsheet for criteria was kept at the nurse's station which staff were to use to ensure antibiotic use was appropriate. RN #22 verified no individual assessment was completed for Resident #16 at the time antibiotics were prescribed to determine if the antibiotic use was appropriate.