STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305020	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hanover Terrace Health and Rehabilitation	49 Lyme Road Hanover, NH 03755

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on interview and record review, it was determined that the facility failed to develop a water management program that identified where in the facility that Legionella, or other opportunistic waterborne pathogens, could grow and spread and did not include established ways to intervene when control limits were not met. This failure had the potential to affect the facility census of 52 residents.Findings include:Review on 12/3/25 of the facility's Legionella Water Management Plan dated 10/10/25 revealed .III. Areas Where Legionella Could Grow and Spread: Dead legs and areas where water is used very little (Empty Rooms) . V. Ways to Intervene When Control Limits Are Not Met . was coded N/A or Not Applicable. The plan did not identify where the dead legs were in the facility and did not identify additional areas such as ice machine, eye wash stations and resident equipment (CPAP (Continuous Positive Pressure Airway)). Interview on 12/4/25 at 8:33 a.m. with Staff D (Maintenance Director) confirmed that the plan did not identify where the dead legs were or ways to intervene if control limits were not met. Staff D revealed that the facility had two shower rooms that each had a capped dead leg. Staff D revealed that the facility used the CDC (Centers for Disease Control and Prevention) for standards and guidance. Review on 12/4/25 of the CDC's Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings dated September 30, 2025 revealed, .3. Identify Areas Where Legionella Could Grow & Spread .Once you have developed your process flow diagram, identify where potentially hazardous conditions could occur in you building water systems . Each potentially hazardous condition should be addressed individually with a control point, measure, and limit . 5. Establish Ways to Intervene When Control Limits Are Not Met . You should plan for your monitoring results to vary over time and be prepared to apply corrective actions. Corrective actions are taken in response to systems performing outside of control limits . Review on 12/4/25 of the CDC's Toolkit for Controlling Legionella in Common Sources of Exposure (Legionella Control Toolkit revealed, . Any Device that Contains Nonsterile Water Can Grow Legionella. In the absence of control, Legionella can grow in almost any system or equipment containing nonsterile water, such as tap water, at temperatures favorable to Legionella growth. Devices that may grow Legionella in the absence of control include the following . eyewash stations . medical equipment (e.g., .CPAP) . Ice machines .

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview and record review, it was determined that the facility failed to implement the facility's antibiotic stewardship program and antibiotic use protocols for 6 of 6 months of antibiotic use reviewed. Findings include:Review on 12/4/25 of the facility's policy titled Infection Prevention and Control Program dated May 30, 2023 revealed, . Infection Control Preventionist Duties include: Conducts surveillance for facility associated infections and/or communicable diseases . Surveillance. Ongoing surveillance is recognized as fundamental component of a strong effective infection control and prevention program. The Infection Preventionist will perform ongoing surveillance to identify opportunities to prevent and/or reduce the rate of infections within residents, employees, and visitors. The Mcgeer's criteria will be used to standardize the definition and criteria for infection. Standardized logs will be used for line listing infections throughout the month. These will be reviewed regularly by the facility Infection Control Preventionist for any trends that need to be addressed before the month ends . Surveillance activities will be ongoing and documented for the purposes of tracking, trending and identifying needs . Surveillance activities will be part of the Infection Control Sub-committee's report to the facility wide Quality Assurance Performance Improvement committee . Interview on 12/4/25 at 11:02 a.m. with Staff E (Director of Nursing) revealed the above policy was current through 10/31/25 when the facility had change of ownership. Staff E revealed the following policies took effect on 11/1/25. Review on 12/4/25 of the facility's policy, dated September 2023 and titled Antibiotic Stewardship - Antibiotic Orders revealed, . 3. Appropriate indications for use of antibiotics include: a. Criteria met for clinical definition of active infection or suspected sepsis . 4. Empirical use of an antibiotic based on clinical criteria of suspected sepsis may be appropriate. The staff and practitioner will document the specific criteria that support the suspicion in the resident's clinical record . Review on 12/4/25 of the facility's policy, dated September 2023 and titled Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes revealed, Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship . 1. As part of the facility Antibiotic Stewardship Program, all clinical infections treated with antibiotics will undergo review by the Infection Preventionist, or designee . 4. All resident antibiotic regimens will be documented on the facility -approved antibiotic surveillance tracking form . Review on 12/4/25 of the facility's Infection Control Line Listing Detail revealed that the antibiotic line listings included the resident's name; room; category; date of onset; symptoms; culture date; site and result; treatment; total number of treatment days; if was re-evaluated for potential early stop due to lab results/resident status; infection cleared; comments and final status count. The antibiotic line listings did not indicate if the antibiotics were appropriate for use or if McGeer Criteria were utilized. Further review revealed the following:For June 2025, there were twelve residents on antibiotics. For July 2025, there were eight residents on antibiotics. For August 2025, there were four residents on antibiotics. For September 2025, there were eight residents on antibiotics.There were no antibiotic line listings for October and November 2025 Review on 12/4/25 of a list of residents with physician's orders for antibiotics, provided by Staff E, revealed that there were three residents in October 2025 and four residents in November 2025 who received antibiotics. Interview on 12/03/2025 at 2:08 p.m. with Staff E confirmed that above line listings did not indicate if antibiotic use met criteria and that there was no surveillance done for October and November 2025. Interview on 12/4/25 at 11:53 a.m. with Staff F (Administrator) revealed there was no antibiotic stewardship data presented in QAPI or discussion about antibiotic use, such as tracking and trending of appropriateness of antibiotic treatments in the past four months.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, it was determined that the facility failed to complete a Preadmission Screening and Resident Review (PASARR) for an individual who required greater than 30 days of nursing services (Resident identifier is #6).Findings include:Review on 12/2/2025 of Resident #6's PASARR dated 9/30/2025 (date of resident admission) revealed in Section 6. Exemption/Exclusion that this PASARR was for a Hospital Discharge that will require less than 30 days of nursing services. For a long-term care stay longer than 30 days a new PASARR would be required to be submitted by 11/9/2025.Interview on 12/3/2025 at approximately 12:50 p.m. with Staff C (Social Worker) confirmed a second PASARR was not completed by 11/9/25.