

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395016	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Hanover Hall for Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 267 Frederick Street Hanover, PA 17331	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, it was determined that the facility failed to maintain adequate personal hygiene and grooming of residents who are dependent on staff for assistance with these activities of daily living for two of four residents reviewed (Residents 2 and 3). Findings include: Review of Resident 2's clinical record documented diagnoses that included anxiety (a feeling of worry, nervousness, or unease), depression (feelings of severe despondency and dejection), Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills, eventually affecting the ability to carry out daily tasks), vascular dementia (a condition characterized by progressive loss of intellectual functioning, impairment of memory and abstract thinking), bipolar (a mental health condition alternating periods of elation and depression), and hallucinations (a false perception of sight, sound, smell [NAME] or touch that seems real but has no external stimulus). Further clinical record review revealed that Resident 2 was dependent, one-person physical assistance, for bathing/showering and was scheduled for showers on Tuesdays and Fridays on day shift. Review of task documentation revealed she received a bed bath, not a shower, on October 20th, 22nd, 23rd, and 24th, 2025, and was washed up at the sink on the 21st. The clinical record failed to include documentation for bathing on October 28th and 31st, 2025, and November 4th, 7th, and 11, 2025. During an interview with the Director of Nursing (DON) on November 19, 2025, at 3:15 PM, it was revealed that the family voiced concerns that included Resident 2 was not receiving showers. In response to the concern, the facility obtained statements from staff. Statements revealed Resident 2 would refuse to get out of bed, refused showers, and at times morning care was provided by night shift. Resident 2 was on Occupational Therapy (OT) and the DON witnessed OT providing a shower on one instance: November 14th, 2025. Review of Resident 3's clinical record documented diagnoses that included dementia with behavioral disturbances, vascular parkinsonism (cause by brain damage and symptoms may include gait disturbance, slowness, stiffness and cognitive issues), and adjustment disorder with mixed anxiety and depressed mood with disturbance of emotions and conduct. Further clinical record review revealed that Resident 3 was dependent, two-person physical assistance due to combativeness, for bathing/showering and was scheduled for showers on Tuesdays and Fridays on evening shift. Review of task documentation revealed she received a shower on October 31st, 2025, and was washed up at the sink on October 28th, 2025, and November 7th, 2025. The clinical record failed to include documentation for bathing on October 21st and 24th, 2025, and November 4th, 11th, and 14th, 2025. During an interview with the Nursing Home Administrator and DON on November 19, 2025, at 3:15 PM, it was revealed she felt that Resident 3 has had bathing completed but staff hadn't documented it. It was also revealed that Resident 3 had verbal and physical behaviors, as well as being up for several days. If the Resident is sleeping after long periods of being awake, the staff will let her sleep. 28 Pa code 211.12.(d)(1)(5) Nursing services</p>

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)
<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure a urinalysis and urine culture and sensitivity were completed timely for one of two resident records reviewed (Resident 4). Findings include: Review of Resident 4 clinical record revealed diagnoses that included history of urinary tract infection. Review of Resident 4's physician orders included: obtain UA (urinalysis) C&S (culture and sensitivity) one time only for 2 Days, started October 7, 2025, at 5:30 PM. Review of the Medication Administration Record documented 15 (resident refused and requested the urine be collected on day shift) on December 7th, 2025. Further review of the physician orders included obtain UA/ C&S discontinue once completed, started October 13th, 2025, at 3:00 PM, and discontinued October 13th, 2025, at 4:39 PM. Review of the urinalysis report dated October 13, 2025, at 6:20 PM, revealed the specimen was taken October 13th, 2025, at 10:19 AM, was received at 3:57 PM, and the result was available at 4:22 PM. The results revealed urine appeared turbid, trace protein, and 2+ glucose and protein; however, there was no bacteria present. Due to no bacteria, a C & S was not preformed. During an interview with the Nursing Home Administrator and Director of Nursing on November 19, 2025, at 3:30 PM, it was confirmed that Resident 4's urine sample should've been collected prior to October 13th, 2025, per physician order. It was also revealed that the Resident had requested the urine be collected on day shift. The Nurse completed the Medication Administration Record and didn't extend the order to include the following day; therefore, the order appeared like it was completed in the electronic record. 28 Pa code 211.12 (d)(1)(5) Nursing Services</p>