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 02/19/2026
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)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on clinical record review, hospital records, staff interviews, and review of the facility incident report, it was determined that the facility displayed past non-compliance in it's failure to ensure that care and services were provided timely and consistent with professional standards of practice following a fall with fracture which resulted in harm as evidenced by fracture-related pain and delayed corrective treatment for one of three residents reviewed (Resident 1).Findings Include: Review of the facility policy, titled Falls Management System, last reviewed July 25, 2025, stated the following: Any fall that involves an actual head injury and all un-witnessed falls will include follow-up neurological checks. Neurological checks will be documented. The investigation and appropriate interventions will be evaluated at the time of the fall and reviewed by Nursing Management or the Interdisciplinary Team (IDT). When the resident sustains a fall, an evaluation for injury by a licensed nurse is completed and the results are documented in the clinical record. The attending physician and family/responsible party are notified of the fall and the resident status. Other follow-up to a resident fall will be conducted depending on the nature of any injury sustained and in keeping with accepted standards of practice. Review of the facility policy, titled Acute Condition Changes-Clinical Protocol, last reviewed July 25, 2025, stated the nurse shall assess and document/report the following baseline information:Vital signs.Neurological status.Current level of pain, and any recent changes in pain level.Level of consciousness.Cognitive and emotional status.Resident's age and sex.Onset, severity, and duration.Recent labs.History of psychiatric disturbances, mental illness, depression etc.All active diagnoses.All current medication.Phone calls to the attending or on-call physician should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident/patient's current symptoms and status. Review of Residents 1's clinical record revealed diagnoses that included osteoarthritis (a degenerative joint disease that occurs when the cartilage that cushions the joints wears down over time, leading to pain, stiffness, and loss of mobility), legal blindness as defined in USA (20/200 or worse in the better eye with correction, or a field of view less than or equal to 20 degrees), and a comminuted fracture of the distal right radius (severe wrist injury where the forearm bone is broken into multiple pieces). Review of Resident 1's Quarterly Minimum Data Set (MDS - a periodic assessment of care needs) dated November 13, 2025, indicated the diagnoses were current. Resident BIMS (brief interview of mental status) score was 14, indicating she was cognitively intact. The MDS also revealed that Resident 1 required a 1-person assist to ambulate for toileting. Review of Residents R1's care plan dated February 2026, revealed Resident 1 was high risk for falls related to vision impairment and chronic pain syndrome with muscle weakness. Interventions included responding immediately to calls, maintaining call light within reach, wear non-skid socks, physical therapy evaluation effective February 5, 2026, and occupational therapy evaluation effective February 9, 2026. Facility document review revealed Resident 1 had an unwitnessed fall on February 6, 2026, at 9:45 PM. Employee 1 (Licensed Practical Nurse [LPN]) entered a (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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	late entry progress note written on February 7, 2026, at 11:27 AM, which was based on a verbal report from Employee 2 (Registered Nurse [RN]). Employee 2 worked from 3 PM until 11 PM on February 6, 2026. The progress note stated that on February 6, 2026, at 9:45 PM, Resident 1 was found on the floor next to her bed and leaning up against the bed. Legs were extended. Resident stated that she went to take herself to the bathroom and fell. Employee 1 questioned resident if she had any pain or hit her head and resident denied. NA (Nursing Assistant) came into room and took resident to the bathroom. Review of the clinical record revealed that Employee 1 did not document the events of the fall or any assessment for Resident 1. A statement written by Employee 3 (NA) on February 8, 2026, stated that on February 6, 2026, at approximately 9:45 PM, I [Employee 3] heard what sounded like a call for help. I went to see who needed help. I walked towards the end of the hall when I heard another noise and realized it came from Resident 1's room. As I walked in, I saw Resident 1 on the floor beside her bed. Employee 2 (RN) was also in the room. I went to Resident 1 and asked her what happened. Resident 1 said she couldn't wait anymore to go to the bathroom and tried to get up herself. I asked her if anything hurt. Resident 1 stated her right wrist was hurting. I took a look at it. There was a bump on the top of her wrist. Resident 1 said she really had to go to the bathroom. I asked Employee 2 if it was OK to take her to the bathroom (I went into the hallway to ask Employee 2 at the med cart outside Resident 1's door). Employee 2 nodded yes. I went back into the room. Resident 1 stated her back was hurting. I took a look and saw a thick scrape on the mid upper part of her back on the left side. I went back out to the hallway to find an Aide to help me pick Resident 1 off the floor. We got Resident 1 off the floor, and I helped her to the bathroom. I wasn't able to hold her right hand due to her wrist, so I held my arm under her right armpit. In the bathroom Resident 1 wasn't able to use her wrist or hand to hold onto the railing to sit on the toilet. I let Resident 1 know I would give her some time to use the bathroom and that I would be back. As I went back to finish care on another resident, I let Employee 2 know of the injuries and pain Resident 1 had stated to me. I finished up with the other resident (10 minutes) and went back to get Resident 1 out of the bathroom. Resident 1 stated that her head hurt as well. I looked at her head and found a bump on the right side of her head that had a cut at the top of it and was bleeding. I also noticed another bump on her right wrist, on the left side. I cleaned her bottom and helped her back to bed, putting her brief on and making sure she was comfortable. After I left the room, I let Employee 2 know about the second bump on Resident 1's wrist and the bump on her head. A written statement by Employee 5 dated February 7, 2026, states, On February 6, 2026, during report (change of shift) it was reported to me by Employee 2 that Resident 1 had fallen to the floor because she had gotten up by herself to use the bathroom. Employee 2 stated she did not report it because the resident was already on neuro checks and she did not have time for it due to being on both carts. She said she instructed Employee 3 (Nurse Aide) to get Resident 1 off the floor. Employee 3 mentioned a resident falling with complaints of her wrist hurting. During my 11-7 shift it was reported that a resident asked for help getting a drink d/t wrist hurting which aides were not aware of or did not notice any issues with her wrist at the time. Resident 1 rang later in the shift and light was answered and Resident 1 complained of excruciating pain in right wrist, upon evaluation the writer noted visual deformity and bruising to wrist. Resident 1 stated she hurt it when she fell earlier in the night. Reported findings to Registered Nurse Supervisor and Director of Nursing. A written statement by Employee 4 (NA) on February 7, 2026, stated, Resident 1 rang her light at 2:55 AM. I answered it. Resident 1 told me she was in a lot of pain and that she wanted to go to the hospital. I told her I would tell the nurse, and I reported it to Employee 5 (Licensed Practical Nurse). A review of the progress notes dated February 7, 2026, (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	revealed Resident 1 reported a pain score of 8/10 prior to being sent to the hospital. The physician was notified and provided an order to send Resident 1 to the hospital emergency department on February 7, 2026, at 3:15 AM. A review of the hospital record revealed the results were obtained on February 7, 2026, at 4:54 AM, revealing a comminuted fracture of the distal right radius. On February 7, 2026, at 4:07 AM, the progress notes stated, Attempt made to call emergency contact (father) voicemail full could not leave message, called second emergency contact nephew, updated on situation, was thankful. Updated that father was also in hospital. Resident 1 was discharged back to the facility on February 7, 2026, at approximately 8:30 AM, with a hard splint to be worn continuously and instructions to follow-up with orthopedics as soon as possible. On return from hospital, the Resident's pain score was 10/10. Provider notified and Resident 1 was ordered Tramadol (narcotic pain medication) every 12 hours as needed for acute pain. The Resident was seen by Orthopedics February 10, 2026, and received orders as follows: cast at all times: occupational therapy, splint right upper extremity, recommend tramadol for pain control, NWB (no weight bearing) to right upper extremity, okay for digital motion. Follow-up 2 weeks with x-rays in brace. Clinical record review revealed there was no documentation of vital signs on the neurological evaluation flow record and no progress note entered regarding the fall for Resident 1 on the 3-11 shift on February 6, 2026. There was no documentation to show any notification to the physician or responsible persons on February 6, 2026. There was no documentation regarding a pain score or assessment of the resident's wrist. A review of the Medication Administration Record (MAR) revealed Resident 1 had current orders to administer acetaminophen (pain medication aka Tylenol) 325 milligram tablets, give two tabs by mouth for a pain score of 4 to 10. The MAR was blank, indicating medication was not administered on February 6, 2026. A fall investigation was initiated by the Nursing Home Administrator (NHA) on February 7, 2026. During an interview with the NHA on February 17, 2026, the NHA said that she attempted calling Employee 2 for follow-up regarding Resident 1's fall. Employee 2 sent an email stating that she was overwhelmed by her workload with administering medications and that she asked Resident 1 twice if she hit her head or had any pain, and the Resident denied both times. Employee 2 added that Resident 1 was already on neuro checks from a previous fall on February 4, 2026, so neuro checks were not initiated. Employee 2 confirmed she did not go back in and re-assess Resident 1 after receiving concerns about her wrist, head, or back, and she did not notify the RN Supervisor. Additional emails and phone calls were attempted by the NHA with no response from Employee 2. The facility implemented a plan of correction on February 7, 2026, that included: February 7, 2026- The NHA and ADON (Assistant Director of Nursing) met with all Department Managers to review the incident and review the immediate plan of correction. February 7, 2026- A full facility audit was completed on all falls that occurred in the past 30 days. Reviewed for completion of all incident reports, documentation of assessments, and notifications to physicians and responsible persons. February 9, 2026- Education was completed to all licensed staff on the fall policy, pain clinical protocol policy, change in condition, responding to complaints of pain, incident reports, and notifications of responsible persons and physicians. February 9, 2026- weekly audits were performed on February 9, 2026, and will continue 5 x weekly for 2 weeks, 3 x weekly x 2 weeks, and 10 monthly audits x 1 month. QAPI (Quality Assessment Performance Review) is scheduled for further review. February 13, 2026- Review of POC revealed that the education and audits were completed and compliance date is February 13, 2026. During a telephone interview with Employee 1 on February 19, 2026, at 9:30 AM, Employee 1 confirmed that she received education based on the concerns identified with Resident 1's incident on February 6, 2026. Employee 1 added that she would have notified the RN Supervisor of the fall, completed an incident report, restart a new neurological (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	assessment form, assess for pain, and notify the responsible person(s) while the RN Supervisor notified the physician. During a telephone interview with Employee 7 (LPN) on February 19, 2026, at 9:40 AM, Employee 7 confirmed that she received education based on the concerns identified with Resident 1's incident on February 6, 2026. Employee 7 said that she would have notified the RN Supervisor of the fall and not move the Resident until the RN Supervisor arrived, restart a new neurological assessment form, obtain vital signs, assess for pain and administer prescribed medication, and with any further change in condition would notify the RN Supervisor. During a telephone interview with Employee 8 (RN Supervisor) on February 19, 2026, at 9:50 AM Employee 8 confirmed that she received a review of the fall policy, pain clinical protocol policy, change in condition, responding to complaints of pain, incident reports, and notifications of responsible persons and physicians. Employee 8 added that she hasn't had any concerns with being notified timely when any incident occurs. Employee 8 added that when notified of a fall or change in condition, she performs the assessment on the resident, if unwitnessed fall starts neurological flow record, notifies the physician, and documents any changes and adds incident to the shift-to-shift report. During an interview with the NHA on February 17, 2026, at 1:00 PM, the NHA stated that Employee 2 was suspended pending outcome of the investigation but added that she doesn't expect Employee 2 to return to the facility. The NHA added that she would expect Employee 2 to follow the policy to assess Resident 1 initially and initiate the incident investigation form, reassess Resident 1 when the change in condition was reported, document in the progress notes, initiate a new neurological evaluation flow record, provide pain management, and contact the Registered Nurse Supervisor. The facility displayed past non-compliance in its failure to provide services consistent with professional standards, which resulted in harm as evidenced by a delay in reassessment with a change in condition, a lack of pain assessment and management that caused pain and suffering for Resident 1. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services