

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  02/27/2025
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33305</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for three of 28 residents reviewed (Residents 6, 41, and 99).</p> <p>Findings include:</p> <p>Review of the clinical record for Resident 6 revealed diagnoses that included lymphedema (swelling in the legs caused by lymphatic system blockage) and peripheral vascular disease (circulatory condition which narrowed blood vessels reduce blood flow to the limbs).</p> <p>Review of Resident 6's physician orders revealed an order for Oxycodone 10 mg (opioid medication) twice a day for severe pain that was initiated July 14, 2023.</p> <p>Review of Resident 6's December 6, 2024, quarterly MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) revealed that the assessment was not coded to indicate that he received an opioid medication.</p> <p>During an interview with the Nursing Home Administrator (NHA) on February 26, 2025, at 11:40 AM, the NHA confirmed that Resident 6's MDS was coded incorrectly.</p> <p>Review of Resident 41's clinical record revealed diagnoses that included vascular dementia (problems with reasoning, planning, judgement, memory, and other thought processes caused by impaired blood flow to the brain) with agitation and anxiety disorder (excessive and persistent worry, fear, and nervousness that significantly interferes with daily life).</p> <p>Review of Resident 41's physician orders revealed an order for Seroquel 75 mg (milligrams) one time a day.</p> <p>Review of Resident 41's quarterly minimum data set (MDS - assessment tool utilized to identify a residents' physical, mental, and psychosocial needs) dated February 7, 2025, revealed section N was coded no, indicating a general dose reduction (GDR) had not been attempted.</p> <p>Review of Resident 41's psychotherapy notes dated December 30, 2024, revealed, Plan: reduce Seroquel 75mg daily.</p> <p>(continued on next page)</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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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident 41's physician orders revealed that her dose of Seroquel had been reduced from 100 mg daily to 75 mg daily on January 4, 2025.</p> <p>During an interview with the NHA and Director of Nursing (DON), on February 27, 2025 at 11:15 AM, the NHA revealed that Resident 41's quarterly MDS dated [DATE], had been coded incorrectly and a modification had been done. The NHA stated it was her expectation that MDS assessments be coded correctly.</p> <p>Review of Resident 99's clinical record revealed diagnoses that included end stage renal disease (condition where one's kidneys are functioning below 10 percent of their normal function) and dependence on renal dialysis (treatment that removes extra fluid and waste products from the blood when the kidneys are not able to function properly).</p> <p>Review of Resident 99's physician orders revealed an order for dialysis services every Monday, Wednesday, and Friday, effective November 5, 2024.</p> <p>Review of Resident 99's December 31, 2024, quarterly MDS revealed that the assessment was not coded to indicate that he received dialysis services while a resident at the facility.</p> <p>During an interview with the NHA on February 26, 2025, at 11:40 AM, she confirmed that Resident 99's MDS was coded incorrectly.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37116</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement a baseline care plan for each resident within 48 hours of the resident's admission for one of 28 residents reviewed (Resident 99).</p> <p>Findings include:</p> <p>Review of Resident 99's clinical record revealed diagnoses that included end stage renal disease (condition where one's kidneys are functioning below 10 percent of their normal function) and dependence on renal dialysis (treatment that removes extra fluid and waste products from the blood when the kidneys are not able to function properly).</p> <p>Further review of Resident 99's clinical record revealed that he was admitted to the facility on [DATE], was discharged home on October 3, 2024, then was readmitted to the facility on [DATE].</p> <p>Review of Resident 99's order summary revealed an order for dialysis services three times per week, effective September 26, 2024. A second order for dialysis services three times per week was written upon his second admission and was effective October 16, 2024.</p> <p>Review of Resident 99's care plan failed to reveal that a baseline care plan addressing his need for dialysis services, with corresponding intervention/precautions was developed within 48 hours of his September 26, 2024, and October 15, 2024, admissions. Further review of Resident 99's care plan revealed that a dialysis care plan was not initiated until November 4, 2024.</p> <p>During an interview with the Nursing Home Administrator on February 26, 2025, at 1:38 PM, she revealed the expectation that Resident 99's need for dialysis services should have been included in his baseline care plan.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>37116</p> <p>Based on observations, clinical record review, as well as resident and staff interviews, it was determined that the facility failed to ensure that a comprehensive, person-centered care plan was developed for each resident for two of 28 residents reviewed (Residents 63 and 99).</p> <p>Findings include:</p> <p>Review of Resident 63's clinical record revealed diagnoses that included quadriplegia (partial or total loss of use of all four limbs) and muscle weakness.</p> <p>Observation of Resident 63 on February 24, 2025, at 12:20 PM, revealed that contractures (permanent shortening and tightening of muscle fibers that reduces flexibility and makes movement difficult) were present in both of his hands. Resident 63 was observed wearing a splinting device on his right hand.</p> <p>During an immediate interview with Resident 63, he confirmed he had contractures and utilized splinting devices to prevent further functional loss.</p> <p>Review of Resident 63's physician orders revealed an order to cleanse both hands and check placement of cushion pad/brace that is worn at all times for contractures each shift, effective June 1, 2023.</p> <p>Review of Resident 63's occupational therapy discharge summary (focuses on helping individuals perform everyday activities), dated December 18, 2024, revealed that the therapist educated and communicated with nursing staff on Resident 63's splint wearing schedule and the need to assess his skin.</p> <p>Review of Resident 63's care plan revealed that his use of splints for hand contractures and related interventions/precautions was not included in his plan of care until February 25, 2025.</p> <p>During an interview with the Nursing Home Administrator on February 27, 2025, at 12:09 PM, she revealed the expectation that this information should have been included in Resident 63's care plan prior to that date.</p> <p>Review of Resident 99's clinical record revealed diagnoses that included end stage renal disease (condition where one's kidneys are functioning below 10 percent of their normal function) and type II diabetes mellitus (impairment in the way the body regulates and uses sugar [glucose] as a fuel, resulting in too much sugar circulating in the bloodstream).</p> <p>Review of Resident 99's physician orders revealed an order for Novolin (insulin - hormone produced by the body which allows the body to use sugar) before each meal at at bed time for diabetes mellitus, effective December 2, 2024.</p> <p>Review of Resident 99's care plan failed to reveal any information related to his diagnosis of diabetes mellitus or his use of insulin.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an email received from the Director of Nursing on February 27, 2025, at 12:23 PM, she confirmed that there was no present or past care plan for Resident 99's diagnosis of diabetes or his use of insulin, but that his care plan would be updated with this information.</p> <p>28 Pa. Code 211. 12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>34631</p> <p>Based on observations, policy review, and staff and resident interviews, it was determined that the facility failed to ensure residents unable to carry out activities of daily living receive the necessary services to maintain good grooming and personal hygiene for four of 28 residents reviewed (Residents 3, 15, 17, and 93).</p> <p>Findings Include:</p> <p>Activities of Daily Living (ADLs) refer to basic self-care tasks that people typically perform daily.</p> <p>A review of the facility's policy, titled Activities of Daily Living (ADL's), revised March 2018, read, in part, Appropriate care and services will be provided for residents who are unable to carry out ADLs, including appropriate support and assistance with hygiene [bathing, dressing, grooming and oral care].</p> <p>A review of Resident 3's clinical record revealed diagnoses that included hypertension (elevated blood pressure) and quadriplegia (a condition characterized by the complete or partial loss of motor and sensory function in all four limbs [arms and legs]).</p> <p>An observation of Resident 3, on February 24, 2025, at 1:10 PM, revealed facial hair including hair on her upper lip and chin areas. An immediate interview with Resident 3 revealed she does not like having hair on her face and would prefer to be assisted with shaving by staff.</p> <p>A review of Resident 3's interdisciplinary plan of care revealed the need for staff assistance with personal hygiene, including ADLs.</p> <p>An interview with the Social Services Director (Employee 4) and the Nursing Home Administrator (NHA) on February 26, 2025, at 11:00 AM, revealed Resident 3's family had been contacted regarding supplying an electric razor, and the facility has no documentation of such requests made to the family.</p> <p>Review of Resident 15's clinical record revealed diagnoses that included muscle weakness (decreased ability of muscles to generate force) and chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing).</p> <p>During an interview with Resident 15 on February 24, 2025 at 11:25 AM, Resident 15 stated that she is scheduled for showers twice a week, but staff only give her a bed bath and sometimes she goes weeks without having her hair washed. She stated that she is told that there are not enough staff to assist her with her showers.</p> <p>Review of Resident 15's clinical record revealed she is scheduled for showers on the 7 AM - 3 PM shift on Wednesdays and Saturdays.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 15's shower documentation for August 2024 - February 2025 revealed Resident 15 is documented as receiving four showers since her admission in August 2024: September 9, 2024; October 5, 2024; December 28, 2024; and February 22, 2025.</p> <p>During an interview with the NHA and Director of Nursing (DON), on February 26, 2025 at 1:50 PM, the DON revealed she had no additional information as to why Resident 15 was not getting showers.</p> <p>A review of Resident 17's clinical record revealed diagnoses that included muscle weakness and dementia (a group of neurological disorders characterized by a progressive decline in cognitive abilities, such as memory, thinking, reasoning, and problem-solving).</p> <p>An observation of Resident 17, on February 24, 2025, at 1:23 PM, revealed a significant amount of facial hair covering her upper lip and chin areas.</p> <p>An immediate interview with Resident 17 revealed she does not like having facial hair and stated, It's like they can't do nothing about it.</p> <p>A continued review of Resident 17's clinical record revealed she requires, at times, limited, extensive, or total dependence with her hygiene care.</p> <p>An interview with the DON on February 25, 2025, at 1:03 PM, revealed the facility staff have been going back and forth with the family regarding supplying an electric razor. However, the facility could not produce documentation of such discussions with Resident 17's family.</p> <p>An additional observation of Resident 17 on February 27, 2025, at 10:39 AM, revealed no change in her facial hair.</p> <p>An interview with the Nurse Aide (Employee 7) on February 27, 2025, at approximately 10:45 AM, revealed she would assist Resident 17 today with shaving her facial hair.</p> <p>Review of Resident 93's clinical record revealed diagnoses that included peripheral vascular disease (narrowing of the arteries causing reduced blood flow to the limbs) and acquired absence of left foot (surgical removal of the foot).</p> <p>During an interview with Resident 93 on February 24, 2025, at 11:11 AM, Resident 11 stated that she is scheduled for showers twice a week but, usually only receives one shower a week. She stated she required staff assistance in the shower, and she is told that there are not enough staff to assist her with her showers.</p> <p>Review of Resident 93's clinical record revealed she is scheduled for showers on the 7 AM - 3 PM shift on Tuesdays and Fridays.</p> <p>Review of Resident 93's shower documentation for December 2024 - February 2025 revealed Resident 93 is documented as receiving a bed bath instead of a shower on the following dates: December 3 and 27, 2024; January 7, 10, 17, 21, 24, and 31, 2025; and February 7 and 25, 2025. Resident 93's shower is documented as not applicable on December 17, 2024, and January 28, 2025; and there is no documentation Resident 93 received a shower on December 6, 13, and 20, 2025; and February 14 and 18, 2025.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the NHA and DON on February 26, 2025, at 1:50 PM, the DON revealed she had no additional information as to why Resident 93 was not getting showers.</p> <p>28 Pa. Code 211.12 (d) (1) (5) Nursing services</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>33305</p> <p>Based on clinical record review, and interviews with staff and residents, it was determined that the facility failed to provide care and services as ordered by the physician for two of 28 residents reviewed (Residents 6 and 99).</p> <p>Findings Include:</p> <p>Review of the clinical record for Resident 6 revealed diagnoses that included lymphedema (swelling in the legs caused by lymphatic system blockage) and peripheral vascular disease (circulatory condition which narrowed blood vessels reduce blood flow to the limbs).</p> <p>During an interview with Resident 6 on February 24, 2024, at 11:14 AM, the Resident was asked about his lymphedema pumps (pumps that use compressed air to apply pressure to the affected limb to force excess fluid out of the limb) that were lying in his room. Resident 6 stated that the pumps are to be applied twice a day but they are never done twice a day and sometimes goes a week without it being done.</p> <p>Review of Resident 6's physician orders dated February 2025, stated, lymphedema pumps to bilateral lower extremities: cover legs with pillowcases before putting boots on. To perform for 1 hour twice a day- can do three times a day. Pressure setting at 35 mmHg (millimeters of mercury-unit of measure for pressure) due to open wounds. Use foam wedge under legs.</p> <p>Further review of Resident 6's physician orders dated February 2025, required staff to cleanse both lower legs with soap and water, apply A&amp;D ointment or Vaseline (per availability) twice a day and leave open to air every dayshift and evening shift.</p> <p>Review of Resident 6's TAR (Treatment Administration Record) for February 2024, revealed that the order for lymphedema pumps was not signed as administered on February 1, 5, 7, 10, 13, 14, 18, 19, and 22, 2025, on dayshift.</p> <p>Further review of the TAR for February 2025 revealed the order for cleansing the lower legs and applying A&amp;D or Vaseline was not signed off as completed on dayshift February 1, 5, 6, 7, 10, 13, 14, and 19, 2025; and not signed off as completed February 24, 2025, evening shift.</p> <p>During an interview with the Director of Nursing (DON) on February 27, 2025, at 11:20 AM, the DON informed the surveyor that staff assigned to apply the lymphedema pumps and perform treatment to the lower legs, on the above dates, were unable to provide the treatment because they were too busy covering as house supervisor.</p> <p>Review of Resident 99's clinical record revealed diagnoses that included end stage renal disease (condition where one's kidneys are functioning below 10 percent of their normal function) and type II diabetes mellitus (impairment in the way the body regulates and uses sugar [glucose] as a fuel resulting in too much sugar circulating in the bloodstream).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 99's physician orders revealed an order for Novolin (insulin - hormone produced by the body which allows the body to use sugar), inject per sliding scale before each meal and at bedtime related to diabetes mellitus, effective December 2, 2024. Further review of the order revealed instructions to notify the physician if Resident 99's blood sugar reading was greater than 351.</p> <p>Review of Resident 99's February 2025 MAR (Medication Administration Record - form used to document physician orders as well as when and how medications are administered to a resident) revealed that a blood sugar reading of 365 was recorded on February 17, 2025.</p> <p>Review of Resident 99's clinical record revealed no evidence that the physician was notified of this blood sugar reading on that date.</p> <p>During an interview with the DON on February 27, 2025, at 9:30 AM, she revealed that she was unable to locate evidence that the practitioner was notified of Resident 99's blood sugar reading on February 17, 2025.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>49123</p> <p>Based on observation, policy review, staff interviews, and record review, it was determined that the facility failed to ensure that a resident with a pressure ulcer received care consistent with professional standards of practice for one of three Residents reviewed for pressure ulcers (Resident 8).</p> <p>Findings include:</p> <p>A review of the facility wound care policy, titled Dry/Clean Dressings, last reviewed July 2024, read, in part, 17. Apply the ordered dressing and secure with tape or bordered dressing per order.</p> <p>Review of Resident 8's clinical record revealed diagnoses that included unstageable pressure ulcer of left buttock (type of sore that occurs due to prolonged pressure on a specific area) and chronic kidney disease, stage 3 (moderate level of kidney damage where the kidney are not filtering waste effectively).</p> <p>Review of Resident 8's physician orders included an order to cleanse the left buttock wound with normal sterile saline and apply a hydrocolloid dressing (moisture retentive dressing) three times a week (Monday, Wednesday, Friday) on day shift and PRN (as needed).</p> <p>Observation of wound care on February 27, 2025, at 10:35 AM, revealed no dressing was in place to Resident 8's left buttock.</p> <p>An interview with Employee 10 (Registered Nurse) revealed a dressing should have been in place and that Resident 8's scheduled dressing change had been the previous day, but staff should notify the nurse if the dressing comes off during incontinence care and a PRN dressing should be done.</p> <p>During an interview with the Nursing Home Administrator and Director of Nursing (DON) on February 27, 2025, at 11:15 AM, the DON confirmed Resident 8 should have had a dressing in place.</p> <p>28 Pa. Code 211.12(d)(1)(2)(5) Nursing services</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>37116</p> <p>Based on observation, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure that residents with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for one of three residents reviewed for mobility (Resident 63).</p> <p>Findings Include:</p> <p>Review of Resident 63's clinical record revealed diagnoses that included quadriplegia (partial or total loss of use of all four limbs) and muscle weakness.</p> <p>Review of Resident 63's physician orders revealed an order to cleanse both hands and check placement of cushion pad/brace that is worn at all times for contractures each shift, effective June 1, 2023.</p> <p>Observation of Resident 63 on February 24, 2025, at 12:20 PM, revealed that contractures (permanent shortening and tightening of muscle fibers that reduces flexibility and makes movement difficult) were present in both of his hands. Resident 63 was observed wearing a splinting device on his right hand.</p> <p>During an immediate interview with Resident 63, he confirmed he had contractures and utilized splinting devices to prevent further functional loss. He also revealed that he had concerns that staff did not consistently apply his splinting devices, especially on night shift, and he was worried that he would lose mobility, specifically in his left hand which he used to feed himself. Resident 63 also stated that, at times, nurse aide staff have told him that it was not their job to apply his splints.</p> <p>During an interview with Employee 8 (Nurse Aide) on February 26, 2025, at 2:21 PM, she confirmed that Resident 63 had reported concerns to her related to night shift staff not consistently applying his splints, and that she finds that all applicable splints are only on one to two days per week when she arrives to start her shift. Employee 8 revealed that, at these times, she has offered to apply Resident 63's missing splint(s) until breakfast (the left splint is then removed so Resident 63 can feed himself).</p> <p>Review of Resident 63's occupational therapy discharge summary (focuses on helping individuals perform everyday activities), dated December 18, 2024, revealed that the therapist educated and communicated with nursing staff on Resident 63's splint wearing schedule and the need to assess his skin. A corresponding undated education signature page was provided, which included specific information on Resident 63's splint types and schedule.</p> <p>During an interview with the Nursing Home Administrator on February 27, 2025, at 11:12 AM, she confirmed that the names signed on the aforementioned education form were all nurse aides. She also revealed the expectation that if nurse aides were the ones educated on application of Resident 63's splints, then they should be applying them.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Hanover Hall for Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 267 Frederick Street Hanover, PA 17331	

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F 0688  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>34631</p> <p>Based on clinical record review, policy review, and staff interview, it was determined that the facility failed to ensure the resident environment remains free of accident hazards and that each resident receives adequate supervision and assessment for two of three residents reviewed for use of enabler bars (Residents 3 and 39).</p> <p>Findings Include:</p> <p>A review of the facility's policy, titled Use of Bed Rails, revised September 2022, read, in part, Facility staff, in conjunction with the Attending Physician, will assess and document the resident's risk for injury due to neurological disorders or other medical conditions. Also, The resident will be checked periodically for safety relative to bed rail use.</p> <p>According to the policy, examples of bed rails included, Grab bars and assist bars.</p> <p>A review of Resident 3's clinical record revealed diagnoses that included hypertension (elevated blood pressure) and quadriplegia (a condition characterized by the complete or partial loss of motor and sensory function in all four limbs [arms and legs]).</p> <p>A review of Resident 3's interdisciplinary plan of care revealed documentation for the use of bilateral enabler bars for impaired bed mobility.</p> <p>A review of the facility's form, titled Nursing Evaluation (Admit/Readmit/Quarterly/COC [change of condition]), revealed a Quarterly assessment for Resident 3's use of bilateral enabler bars dated October 17, 2024.</p> <p>A review of Resident 39's clinical record revealed diagnoses that included hypertension and muscle weakness.</p> <p>A review of Resident 39's interdisciplinary plan of care revealed documentation for the use of bilateral enabler bars for bed mobility assistance.</p> <p>A review of the facility's Nursing Evaluation form revealed the most recent Quarterly assessment for the continued use of enabler bars was dated August 19, 2024.</p> <p>An interview with Nursing Home Administrator on February 26, 2025, at 1:36 PM, revealed Residents 3 and 39 did not have a recent Quarterly assessment for the continued use of the bilateral enabler bars.</p> <p>28 Pa. Code 211.12 (d) (1) (2) (5) Nursing services</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>40010</p> <p>Based on review observations, policy review, and resident and staff interviews, it was determined that the facility failed to provide respiratory services for one of 28 residents reviewed (Resident 90).</p> <p>Findings include:</p> <p>Review of facility provided policy, titled Oxygen Administration, last revised October 2010, revealed in a step called Preparation, 1. Verify that there is a physician's order for the procedure. Review the physician's orders or facility protocol for oxygen administration.</p> <p>Review of Resident 90's clinical record revealed diagnoses that included obstructive sleep apnea (a sleep disorder characterized by recurrent episodes of complete or partial blockage of the upper airway during sleep, leading to reduced or absent breathing) and diabetes mellitus (a group of diseases that result in too much sugar in the blood [high blood glucose]).</p> <p>Observation of Resident 90 on February 24, 2025, at 11:57 AM, revealed the Resident sitting in their bed. On the side of the bed was an oxygen concentrator and the oxygen concentrator, providing the Resident supplemental oxygen at 2 liters per minute.</p> <p>Review of Resident 90's physician's orders on February 24, 2025, at 12:35 PM, failed to reveal a current physician order for supplemental oxygen.</p> <p>Review of Resident 90's care plan on February 24, 2025, at 12:35 PM, revealed a care plan with a focus area of, the resident has oxygen therapy related to respiratory condition, with a revision date of February 20, 2025.</p> <p>Interview with Resident 90 on February 26, 2025, at 12:45 PM, revealed that she uses supplemental oxygen at night and when she is sleeping in bed.</p> <p>Interview with the Nursing Home Administrator on February 26, 2025, at 1:22 PM, revealed that Resident 90 needed supplemental oxygen and the order had ended when the Resident was at the hospital and should have been reordered upon return, but a new order was never entered.</p> <p>28 Pa. Code 211.12(d)(3) Nursing services</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>34631</p> <p>Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure that residents who required dialysis services received such services consistent with professional standards of practice for two of two residents reviewed for dialysis (Residents 80 and 99).</p> <p>Findings include:</p> <p>A review of facility policy, End-Stage Renal Disease, Care of a Resident with, revised September 2010, revealed, Agreements between this facility and the contracted ESRD [End Stage Renal Disease] facility include all aspects of how the resident's care will be managed and may include: how information will be exchanged between the facilities.</p> <p>A review of Resident 80's clinical record revealed diagnoses that included hypertension (elevated blood pressure) and chronic end-stage or end-stage kidney (a severe and irreversible condition where the kidneys lose their ability to function).</p> <p>A review of Resident 80's physician orders revealed an order for dialysis treatments every Monday, Wednesday, and Friday.</p> <p>A review of Resident 80's dialysis communication forms (documents pre-dialysis, dialysis center, and post-dialysis information and vitals) for February 2025 revealed either incomplete or non-existent communication forms with the dialysis center on February 3, 7, 19, 21, and 24, 2025.</p> <p>Continued review of Resident 80's physician orders revealed an order for daily weights for Health Monitoring Notify MD [Medical Doctor] if 4 lb. [pound] or greater weight gain.</p> <p>A review of Resident 80's Medication Administration Record for the month of February 2025 revealed missing weights on February 1, 3, 7, 9, 12, 17, 19, 25, and 26, 2025.</p> <p>Interviews with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) on February 27, 2025, at 9:35 AM, confirmed the lack of completion of Resident 80's dialysis communication forms and confirmed staff had not documented the daily weights as ordered by the physician.</p> <p>A review of Resident 99's clinical record revealed diagnoses that included end-stage renal disease (a condition where one's kidneys are functioning below 10 percent of their normal function) and dependence on renal dialysis (treatment that removes extra fluid and waste products from the blood when the kidneys are not able to function properly).</p> <p>A review of Resident 99's physician orders revealed an order for dialysis every Monday, Wednesday, and Friday effective November 5, 2024.</p> <p>A review of dialysis communication forms revealed that forms were only present for the following dates: February 10, 12, 14, and 17, 2025; and that the forms were not completed in their entirety on February 12, 14, and 17, 2025.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the DON and NHA on February 27, 2025, at 9:39 AM, they confirmed that they could not locate any additional dialysis communication forms for Resident 99. They also revealed the expectation that the forms should have been fully completed each time Resident 99 received dialysis services.</p> <p>A review of Resident 99's physician orders also revealed an order for daily weights for health monitoring, effective October 19, 2024.</p> <p>A review of Resident 99's January 2025 and February 2025 MARs (Medication Administration Records - a form used to document physician orders as well as when and how medications are administered to a resident) revealed that daily weights (or refusal of) were not recorded on four dates in January 2025 and on six dates in February 2025.</p> <p>During an interview with the DON and NHA on February 26, 2025, at 1:20 PM, they revealed they were unable to locate any additional information about the missing weights.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>34631</p> <p>Based on resident and staff interviews, clinical record review, and policy review, it was determined that the facility failed to provide sufficient nursing staff to provide nursing and related services for two of 26 residents reviewed (Residents 15 and 93). Review of the facility assessment and documentation determined that the facility failed to meet the staffing needs of their residents.</p> <p>Findings Include:</p> <p>Review of the facility's document, titled Facility Assessment, approved August 9, 2024, revealed its purpose is to determine what resources are necessary to care for our residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>The document continued, This assessment addresses . The care required by the resident population using evidence-based, data driven methods that consider the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistend with and informed by individual resident assessments.</p> <p>Also, The facility assessment will be used to inform staffing decisions to ensure there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs and consider specific staff needs for each resident unit in the facility and adjust as necessary based on any changes to its resident population.</p> <p>According to the section, titled Skilled Acuity .October-December 2024, the facility assessed its population to include 20 residents as Special Care High; 15 Clinically Complex residents; 13 Orthopedic residents; 4 Major Joint Replacement or Spinal Surgery residents; 51 Medical Management residents; 46 residents with a Function score between 10-23; and 13 Other Orthopedic residents.</p> <p>Resident acuity affecting the Nurse Aide staff revealed 97 residents Assistance Provided with Dressing and Bathing; 83 residents Assistance Provided with Transfers; 88 residents Assistance Provided with Toileting; and 72 residents Assistance with Mobility, to name a few.</p> <p>Review of the documented staffing needs per shift for Nurse Aide staff revealed 12 Nurse Aide staff required for the day shift.</p> <p>Review of day shift staffing information dated February 22, 2025, revealed there were 8.57 Nurse Aide staff working that day shift; 7.80 on February 23, 2025; and 7.37 on February 24, 2025.</p> <p>Therefore, based on the Facility Assessment, the facility was not meeting its assessed staffing needs of its residents.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility policy, titled Activities of Daily Living (ADLs), Supporting, reviewed July 2024, revealed, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care).</p> <p>Review of Resident 15's clinical record revealed diagnoses that included muscle weakness (decreased ability of muscles to generate force) and chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing).</p> <p>During an interview with Resident 15 on February 24, 2025, at 11:25 AM, Resident 15 stated that she is scheduled for showers twice a week, but staff only give her a bed bath and sometimes she goes weeks without having her hair washed. She stated that she is told that there are not enough staff to assist her with her showers.</p> <p>Review of Resident 15's clinical record revealed she is scheduled for showers on the 7 AM - 3 PM shift on Wednesdays and Saturdays.</p> <p>Review of Resident 15's shower documentation for August 2024 - February 2025 revealed Resident 15 is documented as receiving four showers since her admission in August 2024: September 9, 2024; October 5, 2024; December 28, 2024; and February 22, 2025.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON), on February 26, 2025, at 1:50 PM, the DON revealed she had no additional information as to why Resident 15 was not getting showers. The NHA acknowledged that there have been staffing issues.</p> <p>Review of Resident 93's clinical record revealed diagnoses that included peripheral vascular disease (narrowing of the arteries causing reduced blood flow to the limbs) and acquired absence of left foot (surgical removal of the foot).</p> <p>During an interview with Resident 93 on February 24, 2025, at 11:11 AM, Resident 11 stated that she is scheduled for showers twice a week but, usually only receives one shower a week. She stated she requires staff assistance in the shower, and she is told that there are not enough staff to assist her with her showers.</p> <p>Review of Resident 93's clinical record revealed she is scheduled for showers on the 7 AM - 3 PM shift on Tuesdays and Fridays.</p> <p>Review of Resident 93's shower documentation for December 2024 - February 2025 revealed Resident 93 was documented as receiving a bed bath instead of a shower on the following dates: December 3 and 27, 2024; January 7, 10, 17, 21, 24, and 31, 2025; and February 7 and 25, 2025. Resident 93's shower was documented as not applicable on December 17, 2024, and January 28, 2025; and there was no documentation Resident 93 received a shower on December 6, 13, and 20, 2025; and February 14 and 18, 2025.</p> <p>During an interview with the NHA and DON on February 26, 2025, at 1:50 PM, the DON revealed she had no additional information as to why Resident 93 was not getting showers. The NHA acknowledged that there have been staffing issues.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interviews with Employees 5, 6, and 7, on February 27, 2025, at approximately 12:30 PM, they stated that there are not enough staff to assist residents with care, especially showers and that typically there are only two nurse aides to cover the entire unit.</p> <p>28 Pa code 211.12(d)(1)(5) Nursing services</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>33305</p> <p>Based on observation, staff interviews, and Infection Control Preventionist (ICP) credential review, it was determined that in addition to the role of the Director of Nursing (DON), the DON was also the ICP and worked on the unit caring for residents as the nursing supervisor.</p> <p>Findings include:</p> <p>Review of facility staffing information revealed that the DON was serving as the ICP. Observation during the full health survey revealed four residents that required personal protective equipment (PPE) and signage for enhanced barrier precautions (EBP) due to wounds, dialysis, colostomy and catheter, no PPE or signage was present at the time of screening process. Additionally, two staff were observed entering a Resident's room who had signage designating contact precautions, and no PPE was worn while direct care was being provided.</p> <p>During an interview with the DON on February 25, 2025, at 1:00 PM, the DON confirmed that she should be functioning as the DON on a full-time basis. The DON has been doing the role of DON, ICP, and, on multiple occasions, covering as house supervisor with direct bedside care assignment since June 2024, due to the ICP leaving in May 2024.</p> <p>During an interview with the Nursing Home Administrator (NHA) on February 25, 2025, the NHA said she was unaware that the DON could not be the ICP and that, currently, there is no back-up ICP to share the functions of the ICP.</p> <p>On February 26, 2025, at 1:43 PM, both the NHA and DON agreed that the infection control program needs more focus.</p> <p>Pa Code 211.12(b)(c) Nursing services</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>49123</p> <p>Based on facility policy review, clinical record reviews, and staff interview, it was determined that the facility failed to act upon the licensed pharmacist's report of a medication irregularity for two of five residents reviewed for unnecessary medications (Residents 8 and 41).</p> <p>Findings Include:</p> <p>Review of facility policy, titled Antipsychotic Medication Use, last reviewed July 2024, read, in part, Antipsychotic medication will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review .18. The physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences.</p> <p>Review of Resident 8's clinical record revealed diagnoses that included dementia (decline in cognitive abilities that interferes with daily life) and anxiety disorder (excessive and persistent worry, fear, and nervousness that significantly interferes with daily life).</p> <p>Review of the pharmacist medication regimen review document dated October 5, 2024, revealed a recommendation to evaluate if the PRN (as needed) lorazepam can be discontinued or add a stop/reassess date.</p> <p>Further review of the document revealed the physician had not responded to or signed the document.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on February 27, 2025, at 11:15 AM, the DON revealed no additional information could be provided as to why the physician did not respond. She stated it was the expectation of the facility that physicians respond to pharmacy recommendation timely.</p> <p>Review of Resident 41's clinical record revealed diagnoses that included vascular dementia (problems with reasoning, planning, judgement, memory, and other thought processes caused by impaired blood flow to the brain) with agitation and anxiety disorder (excessive and persistent worry, fear, and nervousness that significantly interferes with daily life).</p> <p>Review of Resident 41's physician orders revealed an order for Seroquel 75 mg (milligrams) one time a day.</p> <p>Review of the pharmacist medication regimen review document dated January 11, 2025, revealed a recommendation to consider an attempted dose reduction or trial discontinuation.</p> <p>Further review of the document revealed the physician had not responded to or signed the document.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the NHA and DON on February 27, 2025 at 11:15 AM, the DON revealed no additional information could be provided as to why the physician did not respond. She stated it was the expectation of the facility that physicians respond to pharmacy recommendation timely.</p> <p>28 Pa. code 211.9 (a)(1) Pharmacy services</p> <p>28 Pa. Code 211.12(c)(d)(3)(5) Nursing services</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>40010</p> <p>Based on observation, facility policy review, product packaging review, and staff interview, it was determined that the facility failed to store medication in accordance with manufacture guidelines for one of three medication carts reviewed (D-2 medication cart).</p> <p>Findings Include:</p> <p>Review of facility provided policy, titled Medication Storage in the Facility, most recently reviewed July 2024, revealed, Medications requiring 'refrigeration' or 'temperatures between 2 C (36 F) and 8 C (46 F)' are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage 'in a cool place' are refrigerated unless otherwise directed on the label. And, Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from the pharmacy, if a current order exists.</p> <p>Observation of the C-2 medication cart on February 26, 2025, at 10:17 AM, revealed two Tresiba (insulin) pen unopened and not dated; one Lantus (insulin) Solostar pen with an open date of November 25, 2024; one Novolog (insulin) pen with no open date; and 2 Fiasp (insulin) pens unopened with no date removed from refrigeration.</p> <p>Review of Tresiba product packaging on February 26, 2025, revealed unopened medication should be stored in a refrigerator at a temperature between 36 to 46 degrees Fahrenheit (F) and should be discarded 8 weeks after removed from refrigeration.</p> <p>Review of Lantus product packaging on February 26, 2025, revealed when opened or removed from refrigeration Lantus should be discarded after 28 days.</p> <p>Review of Novolog product packaging on February 26, 2025, revealed unopened medication should be stored in a refrigerator at a temperature between 36 to 46 degrees F and should be discarded 28 days after removed from refrigeration.</p> <p>Review of Fiasp product packaging on February 26, 2025, revealed unopened medication should be stored in a refrigerator at a temperature between 36 to 46 degrees F and should be discarded 28 days after removed from refrigeration even if unopened.</p> <p>Interview with the Director of Nursing on February 26, 2025, at 1:35 PM, revealed an expectation that the product instructions would be followed, and the medication would be stored properly.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy services</p>		

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  02/27/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>37116</p> <p>Based on observations, facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure staff implemented infection control policies and practices to prevent the spread of infection by using PPE (personal protective equipment) for four of 26 residents reviewed (Residents 32, 63, 96, and 99).</p> <p>Findings Include:</p> <p>Review of facility policy, titled Isolation- Multi Route Transmission-Based Precautions, last revised October 2018, revealed that staff and visitors will wear clean, disposable gloves and a disposable gown when entering the room of a resident on contact precautions.</p> <p>Review of Resident 96's clinical record revealed diagnoses that included clostridium difficile (bacterium that causes an infection of the colon) and chronic kidney disease (condition where the kidneys stop filtering waste from the blood).</p> <p>Observation on February 24, 2025, at 10:29 AM, revealed Employee 3 (Licensed Practical Nurse [LPN]) and Employee 2 entering Resident 96's room to help the Resident find their television remote and change the Resident's sheets. Neither Employee 3 or Employee 2 were wearing gloves or a gown when they entered the room to assist the Resident. Further observation at that time revealed a sign on the Resident's room door indicating that Resident 96 was on contact precautions.</p> <p>Review of Resident 96's physician orders on February 24, 2025 at 11:30 AM, failed to reveal a current physician's order for contact precautions.</p> <p>Review of Resident 96's care plan on February 24, 2025, at 11:30 AM, failed to reveal a current care plan for contact precautions due to clostridium difficile recurrent infections.</p> <p>Interview with Employee 1 on February 24, 2025, at 10:17 AM, revealed that the sign on Resident 96's room door indicated that Resident 96 was on contact precautions for recurrent clostridium difficile.</p> <p>Interview of the Director of Nursing on February 26, 2025, at 11:15 AM, revealed Resident 96 was on contact precautions at the time of the observation and that she would expect Employee 3 and Employee 2 to follow the facility policies and guidance regarding residents on contact precautions. She also revealed was that there should have been a current physician order and care plan for contact precautions.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Hanover Hall for Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 267 Frederick Street Hanover, PA 17331	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility policy, titled Enhanced Barrier Precautions, dated August 2022, revealed, Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents .EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices .EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk .Communication related to EBP precautions will be by either signage, Kardex, or assignment sheets. PPE is available at the resident's room for use.</p> <p>Review of Resident 32's clinical record revealed diagnoses that included neuroleptic induced parkinsonism (movement disorder that is caused by taking medication that interferes with dopamine transmission in the brain) and</p> <p>asthma (condition in which the airways narrow and swell and may produce extra mucus).</p> <p>Review of Resident 32's physician orders and care plan revealed that she had an active wound to her left thumb requiring treatment and actively received nutrition through a feeding tube (tube passed into the stomach through the abdominal wall to provide a means of feeding when oral intake is not adequate).</p> <p>Further review of Resident 32's care plan and orders failed to reveal information regarding implementation of enhanced barrier precautions as a result of her wound and use of a feeding tube.</p> <p>Review of Resident 63's clinical record revealed diagnoses that included quadriplegia (partial or total loss of use of all four limbs) and neuromuscular dysfunction of bladder (urinary bladder problems due to disease or injury of the central nervous system or peripheral nerves involved in the control of urination).</p> <p>Review of Resident 63's physician orders and care plan revealed the presence of an indwelling catheter (small, flexible tube that can be inserted through the urethra and into the bladder, allowing urine to drain).</p> <p>Further review of Resident 63's care plan and orders failed to reveal information regarding implementation of enhanced barrier precautions as a result of his indwelling catheter.</p> <p>Review of Resident 99's clinical record revealed diagnoses that included end stage renal disease (condition where one's kidneys are functioning below 10 percent of their normal function) and dependence on renal dialysis (treatment that removes extra fluid and waste products from the blood when the kidneys are not able to function properly).</p> <p>Review of Resident 99's physician orders and care plan revealed that he actively received dialysis services three times per week. Further review of Resident 99's care plan and orders failed to reveal information regarding implementation of enhanced barrier precautions as a result of his indwelling dialysis access port.</p> <p>Observation on February 24, 2025, at 10:30 AM, revealed no enhanced barrier signage or PPE available for use in or around Resident 32, 63, or 99's rooms.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Hanover Hall for Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 267 Frederick Street Hanover, PA 17331	

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on February 24, 2025, at 2:06 PM, revealed that enhanced barrier signage and PPE bins were placed at Resident 32, 63, and 99's rooms.</p> <p>During an interview with Employee 9 (LPN) on February 24, 2025, at 2:06 PM, she confirmed that the bins and signage had just been placed.</p> <p>During an interview with the Nursing Home Administrator on February 26, 2025, at 1:43 PM, she stated that the enhanced barrier program was not where it needed to be.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>