

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2025
NAME OF PROVIDER OR SUPPLIER  Hanover Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8139 Lee Davis Road Mechanicsville, VA 23111	
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 0726  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.  (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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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, clinical record review, and facility documentation review, the facility staff failed to ensure that staff have the appropriate competencies and skill sets to provide adequate nursing care for one (1) Resident #1 in a survey sample of 5 residents, resulting in immediate jeopardy and harm to Resident #1. The findings include: For Resident #1, the facility failed to ensure all nurses were competent in the care and use of LVAD (Left Ventricular Assistive Device, an implanted cardiac pump) which resulted in Immediate Jeopardy past non-compliance with harm for Resident #1. Resident #1 was re-admitted to the facility on [DATE] with diagnoses that included but were not limited to chronic systolic heart failure, hypertension, presence of LVAD (Left Ventricular Assist Device), stage 3 chronic kidney disease, diabetes type 2, history of traumatic brain injury related to frequent falls, and history of subdural hematoma. Resident #1's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of [DATE] scored the resident as having a BIMS score of 8 out of 15 indicating moderate cognitive impairment. On [DATE] at interview was conducted with the Administrator who stated, I filed the incident report on [DATE] when I got a phone call from [MD name redacted] from [Hospital name redacted]. He said the hospital was filing a complaint to the state for neglect but did not want to give me details until we meet face to face. He came to facility on the 1st of oct. In the meeting he told me that the Social Worker and the Emergency Dept. physician filed the initial complaint that they were concerned when he [Resident #1] arrived at the hospital because the LVAD was disconnected. The controller for the device was sent to manufacturer to recover the recording. We were not given the information from the device as there was an active investigation going on at [Hospital name redacted] regarding the LVAD and the Resident. [MD name redacted] that the drive line was disconnected, and the alarm had been silenced 44 times and the stopped recording altogether 12:45 am. A review of the facility documentation revealed the following nurses note dated [DATE] stated that at 7:47 a.m. a Code Blue was called and staff responded, CPR initiated at 7:49 am, Emergency services was called, as was the on-call physician, and the resident's family. The resident was transported to the hospital via rescue squad at 7:56 a.m. A review of the hospital emergency room record revealed the following note: [DATE] 8:41 a.m. - The ED Triage note does not agree with what EMS told me at bedside. Medic reported patient had LVAD turned off and no CPR for 10 minutes prior to EMS arrival. LVAD was still not running. He has been in asystole with no cardiac activity. Pt's skin tone is gray with unreactive pupils. Further resuscitation not indicated. On [DATE] at 2:15 pm, an interview with LPN #3 in Resident #2's room (Resident #2 also has an LVAD). LPN #3 demonstrated care of the LVAD - checking settings, connection, battery charges, and the purpose of the LVAD, and actions if alarms. On [DATE] at 3:03 pm, an interview with LPN #2 was conducted regarding her knowledge of care of a resident with an LVAD. LPN #2 explained the purpose of the LVAD and demonstrated checking device settings with other nurses at the beginning of the shift, ensuring the batteries were functioning. On [DATE] at 4:16 pm, Resident #2 was up in w/c and had recently returned from therapy, LVAD at side; settings noted; battery charge station green lights indicating charging successfully. On [DATE] at 5:15 a.m., an interview was conducted with LPN #5, who stated that she had worked at the facility for a couple of years now. She stated that she was trained on the LVAD when the first patient arrived at the facility with an LVAD, and then last October and last week. On [DATE] at 6:45 a.m. CNA #5 was interviewed, and she stated that CNAs are supposed to make sure the alarms are not ringing and that the batteries are plugged in. She said that she was trained before she started working on the unit. On [DATE] at 7:00 a.m. CNA #'s 4 and #7 both were able to verbalize the training they received regarding the LVAD. They both stated that CNAs are supposed to ensure the batteries are plugged into the red outlet and that the alarms are not sounding. If alarms sound, they are to notify the nurse immediately. [DATE], a review of Resident #1's care plan stated LVAD care as ordered. [DATE] - Monitor Q shift- LVAD Alarm- Document if it sounded Yes or No. If YES, document if LVAD Coordinator was notified and instructions given Observe for signs and symptoms of cardiac complications dizziness, shortness of breath. A review of the MAR / TAR for [DATE] revealed the following: VAD Care Battery - Check battery level and change to new set of batteries. Place old batteries on the charger for next use. Instructions : Change one Battery at a time. 1 Hold battery in one hand and cip in other. 2. Press battery release button and withdraw battery. 3. Insert fully charged battery into battery clip and push until the battery clicks into place. 4. Repeat steps 1-3 as needed for connection. Monitor Q Shift every shift LVAD Alarm - Document if it sounded yes or no. If YES document if LVAD</p>		