STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395016	A. BLDG: __--_____ B. WING: _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HANOVER HALL FOR NURSING AND REHABILITATION STATE LICENSE NUMBER: **590102**	**267 FREDERICK STREET HANOVER, PA 17331**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on February 12, 2025, at Hanover Hall for Nursing and Rehabilitation, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

Certified End Page

HANOVER HALL FOR NURSING AND REHABILITATION

STATE LICENSE NUMBER: 590102

SURVEY EXIT DATE: 02/12/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

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	395016	A. BLDG: 01 B. WING:	02/12/2025

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K 0000	INITIAL COMMENT Facility ID #590102 Component 01 "A" Building Based on a Medicare/Medicaid Recertification Survey completed on February 12, 2025, it was determined that Hanover Hall for Nursing and Rehabilitation it was determined there were no deficiencies identified under the requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a two-story, Type V (111), protected wood frame structure, which is fully sprinklered.	K 0000		

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K 0000	INITIAL COMMENT Facility ID #590102 Component 02 Main Building-B, C, D Wings Based on a Medicare/Medicaid Recertification Survey completed on February 12, 2025, it was determined that Hanover Hall for Nursing and Rehabilitation was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a two-story, Type II (000), unprotected noncombustible structure, with a basement, which is fully sprinklered.	K 0000		
K 0211 SS=E		K 0211		

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K 0211 SS=E	Continued from page 1 NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K 0211	1. Facility cannot retroactively correct this concern. Sign was obtained for the isolation cart when it was observed to be missing. 2. Education will be provided to staff on storage of trash containers, and isolation carts needing signage. 3. Maintenance director/designee will complete audits of corridors to ensure trash containers are not stored in corridors, and all isolation carts have signs. Audits will be 3x/week x4 weeks, then 5x monthly x 2 months to ensure compliance. Audits will be reviewed at QAPI to ensure compliance.	Completion Date: **03/24/2025** Status: **APPROVED** Date: **03/11/2025**

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K 0211 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain exit access corridors to be clear and unobstructed, on two of seven smoke compartments within the component. Findings include: 1. Observation on February 12, 2025, between 12:30 PM and 1:30 PM, revealed various items were stored in the egress corridor, at the following locations: a. 12:30 PM, 2nd floor, soiled-linen containers, between Resident Room 226 and 228; b. 1:05 PM, 2nd floor, trash containers, between Resident Room 222 and 224; c. 1:30 PM, 1st floor, an isolation cart, without signage, outside Resident Room 121. Interview with the Director of Maintenance on February 12, 2025, at 1:30 PM, confirmed the facility failed to maintain the corridor to be clear and unobstructed.	K 0211		

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K 0211 SS=E	Continued from page 3	K 0211		
K 0281 SS=E	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by:	K 0281	1. Stairwell exit light was repaired. 2. Facility audited stairwell lighting to ensure proper illumination 3. Maintenance director/ designee will conduct monthly audits of stairwell lighting to ensure proper illumination. Audits will be reviewed at QAPI to ensure compliance	Completion Date: **03/24/2025** Status: **APPROVED** Date: **03/11/2025**

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K 0281 SS=E	Continued from page 4 Based on observation and interview, it was determined the facility failed to maintain illumination of means of egress continuously, for one of five stairtowers within the component. Findings include: 1. Observation on February 12, 2025, at 2:30 PM, revealed light fixtures were did not illuminate the exit, by Component 1. Interview with the Director of Maintenance on February 12, 2025, at 2:30 PM, confirmed the light fixtures were not illuminated.	K 0281		
K 0321 SS=E		K 0321		

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K 0321 SS=E	Continued from page 5 NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)	K 0321	1. NGP9990 fire and smoke seal will be added to door. Second door was adjusted to ensure it positively latched. 2. Facility has conducted an audit to ensure other hazardous area doors compliance with regulation. 3. Maintenance director/designee will conduct monthly inspections of doors to ensure they positively latch, and gaps are within appropriate parameters. Audits will be reviewed at QAPI to ensure compliance.	Completion Date: **03/24/2025** Status: **APPROVED** Date: **03/19/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0321 SS=E	Continued from page 6 This REQUIREMENT is not met as evidenced by:	K 0321		

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K 0321 SS=E	Continued from page 7 Based on observation and interview, it was determined the facility failed to maintain hazardous area doors to positively latch, and be within the allowed gap margins, on two of seven smoke compartments within the component. Findings include: 1. Observation on February 12, 2025, at 11:45 AM revealed the basement Laundry Room rated door had gaps exceeding 3/16 inch. Interview with the Director of Maintenance on February 12, 2025, at 2:30 PM, confirmed the Laundry Room door exceeded the allowed gap margins. 2. Observation on February 12, 2025, at 2:20 PM, revealed the 1st floor hazardous area door, by the elevator and Nurses' Station, did not positively latch, when closed.	K 0321		

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K 0321 SS=E	Continued from page 8 Interview with the Director of Maintenance on February 12, 2025, at 2:30 PM, confirmed the hazardous area door did not positively latch.	K 0321		
K 0363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke	K 0363	Facility has repaired the door so it does positively latch. 2. Facility has conducted an audit to ensure corridor doors were within compliance of regulation. 3. Maintenance director/designee will conduct monthly inspections to ensure they positively latch. Audits will be reviewed at QAPI to ensure compliance.	Completion Date: **03/24/2025** Status: **APPROVED** Date: **03/12/2025**

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K 0363 SS=E	Continued from page 9 compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 0363		

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K 0363 SS=E	Continued from page 10 Based on observation and interview, it was determined the facility failed to maintain corridor doors to positively latch, on one of seven smoke components within the component. Findings include: 1. Observation on February 12, 2025, at 1:15 PM, revealed the second floor Resident Room 207 corridor door to did not positively latch, when closed. Interview with the Director of Maintenance on February 12, 2025, at 1:15 PM, confirmed the corridor door did not positively latch.	K 0363		
K 0918 SS=D		K 0918		

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K 0918 SS=D	Continued from page 11 NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10	K 0918	1. Multiplier was removed and existing receptable is now being utilized. 2. Facility has completed an audit to ensure no other multipliers are being used. 3. Maintenance director/designee will conduct monthly inspections to ensure no multipliers are being utilized. Audits will be reviewed at QAPI to ensure compliance	Completion Date: **03/24/2025** Status: **APPROVED** Date: **03/11/2025**

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K 0918 SS=D	Continued from page 12 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to monitor the use of outlet multipliers, affecting one of seven smoke compartments within the component. Findings include: 1. Observation on February 12, 2025, at 11:48 AM, revealed a receptacle multiplier was being used in the basement Laundry, by the dryers. Interview with the Director of Maintenance on February 12, 2025, at 11:48 AM, confirmed the use of a receptacle multiplier.	K 0918		
K 0929 SS=E		K 0929		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HANOVER HALL FOR NURSING AND REHABILITATION STATE LICENSE NUMBER: **590102**	**267 FREDERICK STREET HANOVER, PA 17331**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
K 0929 SS=E	Continued from page 13 NFPA 101 Gas Equipment - Precautions for Handling Oxyg Gas Equipment - Precautions for Handling Oxygen Cylinders and Manifolds Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99) 11.6.2 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0929	1. Cylinders were placed back into proper storage area after observation. 2. Facility will provide re-education to staff regarding appropriate storage of oxygen cylinders. 3. Maintenance director/designee will complete audits of storage areas monthly to ensure they are properly stored. Audits will be reviewed at QAPI to ensure compliance	Completion Date: **03/24/2025** Status: **APPROVED** Date: **03/12/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395016	A. BLDG: __02_____ B. WING: _____	02/12/2025

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K 0929 SS=E	Continued from page 14 Based on observation and interview, it was determined the facility failed to secure portable oxygen cylinders, affecting one of seven smoke compartments within the component. Findings include: 1. Observation on February 12, 2025, at 2:00 PM, revealed five unsecured "E" size portable oxygen cylinders outside the Oxygen Storage Room, within a 1st floor room by SC-5. Interview with the Director of Maintenance on February 12, 2025, at 2:00 PM, confirmed the unsecured portable oxygen cylinders.	K 0929		

Certified End Page

HANOVER HALL FOR NURSING AND REHABILITATION

STATE LICENSE NUMBER: 590102

SURVEY EXIT DATE: 02/12/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY