| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495266 | A. BUILDING _____ B. WING _____ | 05/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HANOVER HEALTH AND REHABILITATION CENTER | 8139 LEE DAVIS ROAD MECHANICSVILLE, VA 23111 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>A COVID-19 Focused Emergency Preparedness Survey was conducted onsite 05/19/2022 and continued with offsite review through 05/20/2022. The facility was in substantial compliance with 42 CFR Part 483.73(b)(6) emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19.<br><br>The census in this 120 certified bed facility was 109 at the time of the survey. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A COVID-19 Focused Infection Control Survey was conducted onsite 05/19/2022 and continued with offsite review through 05/20/2022. Corrections are required for compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The survey sample consisted of 5 residents. No complaints were investigated during the survey.<br><br>The census in this 120 certified bed facility was 109 at the time of the survey. The survey sample consisted of 5 resident reviews and 3 employee reviews. | F 000 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and | F 880 | | 6/7/22 |

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

Electronically Signed | 06/01/2022

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495266 | A. BUILDING _____ B. WING _____ | 05/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HANOVER HEALTH AND REHABILITATION CENTER | 8139 LEE DAVIS ROAD MECHANICSVILLE, VA 23111 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 1 | F 880 | | |

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495266 | A. BUILDING _____ B. WING _____ | 05/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HANOVER HEALTH AND REHABILITATION CENTER | 8139 LEE DAVIS ROAD MECHANICSVILLE, VA 23111 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 2<br>circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, facility documentation review, and staff interview the facility staff failed to adhere to infection control measures in accordance with the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) recommendations to prevent the spread of COVID-19 for 2 out of 11 staff members.<br><br>The findings included:<br><br>For the two staff members Staff G, and Staff H the facility staff failed to screen them prior to entry to the facility on 05/19/22.<br><br>On 5/19/22 at approximately 9:45 a.m. while | F 880 | The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F880 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495266 | A. BUILDING _____ B. WING _____ | 05/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HANOVER HEALTH AND REHABILITATION CENTER | 8139 LEE DAVIS ROAD MECHANICSVILLE, VA 23111 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 3<br>surveyors B and C were standing at the East Wing nursing station conducting an interview, Surveyor B heard a door bell ring. Resultantly, noted two individuals to the outside of the facility attempting to gain entrance directly to the interior of the facility through a corridor containing resident's rooms.<br><br>In response to the doorbell ignition, Surveyor C observed a facility staff go to the door and grant entrance to Staff G and Staff H. Staff G and Staff H were wearing were not wearing N95 masks. Instead, Staff G and Staff H each wore surgical masks.<br><br>Upon entrance of Staff G and Staff H, Surveyor C interviewed Staff G. Staff G made the following responses: as to the protocol for entering the facility. Staff G made known that for transportation staff the facility had directed them to come to the ambulance entrance door versus the main entrance to the front of the building. For the record, Staff G confirmed that the ambulance entrance door is the door which Surveyor B noted Staff G and Staff H to enter the facility.<br><br>The ambulance entrance door was not equipped with screening materials.<br><br>Staff G further expressed that the administrator stated that the transportation team was to come directly the ambulance door for entrance versus entering through the front door and screening at the kiosk.<br><br>Staff G and Staff H proceeded to the East Wing's nursing station. From the East Wing's nursing station Staff G and Staff H proceeded to the West Wing (COVID-19 Unit). | F 880 | 1-. A sign was posted on the back ambulance entrance of the facility notifying staff, visitors and vendors of the COVID status and PPE requirements. A sign was also posted to direct all visitors to enter through the main lobby for screening before entering the facility.<br>2- The facility is at risk for deficient practice related to infection control practices not being followed to prevent the spread of COVID-19 within the facility. The Administrator or designee will check the entrances to ensure that proper signage is in place to notify staff and visitors of proper procedures to follow before entering the facility, COVID status and PPE requirements.<br>3- The Administrator or designee will educate all staff on prompting visitors, staff and vendors to complete the screening process before entering the facility and on the proper PPE requirements for visitors, vendors and staff when entering the facility.<br>4- The Administrator, or designee will monitor the screening log on a daily basis to ensure that visitors and vendors are completing the screening process when entering the facility. The Administrator, or designee will check facility entrances each week to ensure that the proper signage is in place and complete weekly observations to ensure that staff, visitors and vendors are wearing appropriate PPE when entering the facility. Results of the audits will be presented to the QAPI Committee for review and recommendation<br>5-Completion date June 7, 2022. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495266 | A. BUILDING _____ B. WING _____ | 05/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HANOVER HEALTH AND REHABILITATION CENTER | 8139 LEE DAVIS ROAD MECHANICSVILLE, VA 23111 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 4<br><br>On 5/19/22 at approximately 10:00 a.m. an interview was conducted with the Assistant Administrator. The Assistant administrator declined to confirm or deny that the transportation staff were directed to enter directly into the facility through the ambulance door without being screened. The Assistant Administrator deferred to the Administrator.<br><br>On 5/19/22 at approximately 12:45 p.m. in an interview with Administrator, the Administrator denied having given a directive to circumvent screening at the front door via the kiosk to gain entry to the facility.<br><br>On 5/20/22 upon review of COVID-19 Screening Kiosk data for staff who entered the building via the front door, Staff G and Staff H were not present on the list. | F 880 | The Administrator will be responsible for implementing the plan of correction. | |