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 _____	C 04/28/2022

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 An unannounced Emergency Preparedness survey was conducted 4/26/2022 through 4/28/2022. The facility was in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/26/2022 through 4/28/2022. One complaint was investigated during the survey. VA00053095 was substantiated without related deficencies. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 109 at the time of the survey. The survey sample consisted of 30 current resident reviews and 2 closed record reviews.	F 000		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 580		6/7/22

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

Electronically Signed | 05/17/2022

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 _____	C 04/28/2022

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 580	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to notify the physician that medications were not available for administration	F 580	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported	

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 _____	C 04/28/2022

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 580	Continued From page 2 for four of 30 residents, Resident #303, Resident #304, Resident #306, and Resident #307. Findings were: 1. Resident #303 was recently admitted to the facility with the following diagnoses, including but not limited to: Hypertension, heart failure, chronic kidney disease, and anxiety. A full MDS (minimum data set) had not been completed at the time of the survey, but an admission nursing assessment from 04/15/2022, described Resident #303 as oriented to person, place, and time. The clinical record was reviewed on 04/26/2022 at approximately 2:00 p.m. The MAR (medication administration record) for April 2022 documented that Resident #303 did not receive the following medications as ordered by the physician: Sertaline 50 mg at 9:00 p.m. on 04/17/2022. Gabapentin 100 mg at 9:00 a.m. on 04/17/2022 and 04/18/2022, and at 5:00 p.m. on 04/17/2022. The medications were coded on the MAR with the number "9" indicating "other see progress notes" or "15" indicating no coverage required. Documentation from the EMAR (Electronic medication administration record) indicated the medications were on order. There was no documentation in the clinical record of physician notification that the medications were not available for administration. 2. Resident #304 was admitted to the facility with	F 580	conversations and other information cited in support of 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. F580 1-Residents #303, 304, 306 and are receiving their medications as ordered. Resident #307 was discharged from the facility. 2- The DON, or designee will review the Medication Administration record of current residents to determine if medications are available for administration and ensure that the physician is notified appropriately. 3-The DON/designee will educate the Licensed Nurses on the process to follow to obtain medications from the Pharmacy, utilize the STAT medication system and review of the House Stock medication list to obtain medications and notification to the physician of medications not available for administration. 4-The ADON/designee will complete of the Medication Administration Record report and Progress notes three times weekly to determine any issues with medications not available for Administration and that the physician was notified appropriately. 5-Results of the audit will be presented to	

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 _____	C 04/28/2022

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 580	Continued From page 3 the following diagnoses, including but not limited to: diabetes mellitus, atrial fibrillation, chronic kidney disease, and anxiety. A full MDS (minimum data set) had not been completed at the time of the survey, but an admission nursing assessment from 04/15/2022, described Resident #304 as oriented to person, place, time, and situation. On 04/26/2022 at approximately 11:45 a.m., Resident #304 and her son were interviewed about life at the facility and her care. The son stated, "I don't think she or her roommate are getting their medicines right...I heard one of nurses telling her (pointing to roommate) that they didn't have her medicine here to give..." Resident #304's clinical record was reviewed at approximately 12:30 p.m. The MAR (medication administration record) for April 2022, documented that Resident #304 did not receive the following medication as ordered by the physician: Levothyroxine 50 mcg at 6:00 a.m. on 04/17/2022 and 04/18/2022. The medications were coded on the MAR with the number "9" indicating "other see progress notes." The EMAR documented "Awaiting medication from the pharmacy." There was no documentation in the clinical record that the medications were not available for administration. 3. Resident #306 was admitted to the facility with the following diagnoses, including but not limited to: heart failure, respiratory failure, stage III sacral pressure ulcer, and adult failure to thrive.	F 580	the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, audits will be conducted on a random basis. 5- Completion date 6/7/22 The Admin/DON are responsible for implementation of the plan of correction.	

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 _____	C 04/28/2022

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 580	Continued From page 4	F 580		

A full MDS (minimum data set) had not been completed at the time of the survey, but an admission nursing assessment from 04/13/2022, described Resident #306 as oriented to person, place, and time.

Review of the clinical record was conducted on 04/27/2022 at approximately 9:30 a.m. The MAR (medication administration record) for April 2022 documented that Resident #306 did not receive the following medication per physician orders: Gabapentin 400 mg at 9:00 a.m. on 04/17/2022 and 04/18/2022, and at 2:00 p.m. on 04/17/2022 and 04/18/2022.

The medications were coded on the MAR with the number "9" indicating "other see progress notes" or "15" indicating no coverage required. Documentation from the EMAR (Electronic medication administration record) indicated the medications were on order or not available.

There was no documentation in the clinical record that the medications were not available for administration.

4. Resident #307 was admitted to the facility with the following diagnoses including but not limited to: Cerebral infarction (stroke), type 2 diabetes mellitus, peripheral vascular disease, and dementia.

A full MDS (minimum data set) had not been completed at the time of the survey, but an admission nursing assessment from 04/20/2022, described Resident #303 as oriented to person, place, and time.

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 _____	C 04/28/2022

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 580	Continued From page 5	F 580		

The clinical record was reviewed on 04/27/2022 at approximately 11:30 a.m.. The MAR documented the following medications were not given per physician orders:

Atorvastatin 40 mg QD (every day) on 04/23/2022, 04/24/2022 or 04/26/2022.

Januvia 100 mg HS (hour of sleep) not given from 04/20/2022 through 04/26/2022; a total of seven missed doses.

Clopidrogel 75 mg QD (once a day) on 04/21/2022 and 04/22/2022.

Nicotine patch QD not applied from 04/20/2022 through 04/27/2022; a total of 8 missed doses.

Zetia 10 mg QD on 04/21/2022 and 04/22/2022.

Dronabinol 2.5 mg twice a day not given 04/20/2022 through 04/26/2022; a total of 13 missed doses.

The EMAR notes contained information that the above medications were not available, on order, awaiting order from pharmacy.

There was no documentation in the clinical record that the medications were not available for administration.

The above information for all four residents was discussed during an end of the day meeting on 04/27/2022 at approximately 5:15 p.m. with the DON (director of nursing), the administrator, the corporate nurse consultant, and the ADON (assistant director of nursing). The administrator stated that they had identified a problem with

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 _____	C 04/28/2022

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 580	Continued From page 6 medications being unavailable and had been working on it over the last quarter. They were asked if the physician should be notified when medications are not available for administration. The corporate nurse consultant stated, "Yes." The policy for "Medication Unavailability" contained the following: "If medications are determined to be unavailable for administration, licensed nurse will notify the provider of unavailability....will document notification to the provider...in the medical record....will notify the provider...and request an alternate treatment if possible. If alternate treatment is not available, then licensed nurse will activate backup pharmacy process and procedures..." On 04/28/2022 at 8:30 a.m., the administrator presented an inservice/education record. She stated, "We started inservicing the nurses last night about what to do when medications aren't available." The objectives listed on the inservice record included but were not limited to: "Notifying the provider to obtain a hold order or alternate treatment for patients." No further information was obtained prior to the exit conference on 04/28/2022.	F 580		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident	F 655		6/7/22

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 _____	C 04/28/2022

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 655	Continued From page 7 that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document	F 655	F655 1-The baseline care plan was completed	

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 _____	C 04/28/2022

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 655	Continued From page 8 review, the facility failed to develop a baseline care plan and provide a summary of the care plan to the resident responsible party for four of 30 resident's, Resident's #202, #207, #349, and #249. The findings Include: 1. Resident #202 was admitted with diagnoses that included: fractured femur, muscle weakness, reflux, and difficulty walking. The most current MDS (minimum data set) was an entry assessment with an ARD (assessment reference date) of 4/21/22. Resident #202's cognitive score had not been assessed at time of survey. On 4/27/22 Resident #202's medical record was reviewed and evidenced a baseline care plan was created for "Falls" on 4/23/22, but no additional care areas. On 04/27/22 at 11:20 a.m. the director of nursing (DON) was asked about the he components that make up a baseline care plan. The nurse consultant who was also present, looked at Resident #202's care plan and stated the baseline care plan should be made up of any services and treatments for a resident's immediate care and agreed that the care plan was not complete. On 04/27/22 at 6:11 p.m. during a meeting with the administrator, DON, and nurse consultant, the above information was presented. When asked about the timeliness of a baseline care plan the nurse consultant said it should be completed within 48 hours of admission. On 04/28/22 at 9:00 a.m. the administrator stated	F 655	for Resident #202.A Summary of the care plan was provided to the resident responsible party for Resident #202. Resident # 349, and #207. Resident #249 were discharged from the facility. 2- Current residents admitted in the past 30 days were reviewed by the DON, or designee to ensure that the baseline care plan was developed and that a copy of the care plan summary was provided to the resident responsible party. 3-The Regional Director of Clinical Services, or designee will educate Nursing Leadership/MDS Staff on the development of a baseline care plan and provide a summary of the care plan to the resident and resident responsible party. 4-The DON, or designee will complete weekly audits of new resident Admissions to ensure that a baseline care plan was developed and that a copy of the care plan summary was provided to the resident responsible party. 5- Results of the audit will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, audits will be conducted on a random basis 6- Completion date 6/7/22 The Admin/DON are responsible for implementation of the plan of correction.	

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 _____	C 04/28/2022

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 655	Continued From page 9	F 655		

an audit of baseline care plans had been reviewed and indicated that the facility is in the process of completing all baseline care plans.

No other information was presented prior to exit conference on 4/28/22.

2. Resident #207 was admitted to the facility with diagnoses that included: diabetes, chronic kidney disease, end stage renal disease, and kidney transplant. The most current MDS (minimum data set) was an entry assessment with an ARD (assessment reference date) of 4/18/22. Resident #207's cognitive score had not been assessed at time of survey.

On 4/27/22 Resident #207's medical record was reviewed evidenced a baseline care plan was created for "Nutrition Risk" on 4/20/22, with the rest of the baseline care plan created on 4/26/22 (eight days after admission).

On 04/27/22 at 2:20 p.m. the administrator was asked where documentation of a baseline care plan would be found in the medical record for a newly admitted resident. The administrator stated all care plans were completely electronic and said the facility does not do a paper form of a baseline care plan.

On 04/27/22 at 6:11 p.m. during a meeting with the administrator, DON, and nurse consultant, the above information was presented. When asked about the timeliness of a baseline care plan the nurse consultant said it should be completed within 48 hours of admission.

On 04/28/22 at 9:00 a.m. the administrator stated an audit of baseline care plans had been

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 _____	C 04/28/2022

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 655	Continued From page 10	F 655		

reviewed and indicated that the facility is in the process of completing all baseline care plans.

No other information was presented prior to exit conference on 4/28/22.

3. Resident # 249 was admitted to the facility after a ground level fall in the community. The admission MDS (minimum data set) assessment dated 4/12/22 had Resident # 249 as cognitively intact with a score of 15 out of 15.

On 4/26/22 at approximately 3:30 p.m. clinical record review evidenced that Resident # 249's baseline care plan was not completed until 3 days after admission.

On 4/27/22 at 10:34 a.m. the discharge planner, identified as other staff (OS) # 1 was interviewed about the care plan. She stated she did the initial care plans, but the care plan was not done within the 48 hour timeframe, and residents were not given a handwritten or computerized copy of the baseline care plan. OS # 1 stated the care plan is done electronically, not hand written, but again, no copy given to the residents.

The administrator, DON (director of nursing), ADON (assistant director of nursing, nurse consultant, and vice president of clinical operations were informed of the above findings during a meeting with facility staff 4/28/22 beginning at 10:55 a.m.

No further information was provided prior to the exit conference.

4. Resident #349 was admitted to the facility with diagnoses that included dementia without behavioral disturbances, history of falling, hypertension, hyperlipidemia, type 2 diabetes,

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 _____	C 04/28/2022

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 655	Continued From page 11	F 655		

multiple left side rib fractures, muscle weakness and major depressive disorder. The most recent minimum data set (MDS) dated 04/16/22 was the 5-day admission assessment and assessed Resident #349 as severely impaired for daily decision making with a score of 4 out of 15.

Resident #349 was interviewed on 04/27/2022 at 8:30 a.m. regarding quality of life and care stay since being admitted to the facility. Resident #349 was asked if she had received a copy of her baseline care plan. Resident #349 stated, "I don't know about that. My daughter takes care of all the paperwork."

Resident #349's electronic care plans were reviewed. According to the electronic care plan tab the care plans were created on 04/19/2022.

On 04/27/2022 at 9:45 a.m., the facility's director of nursing (DON) was asked where the baseline care plans were located. The DON stated all care plans were completed electronically and were located under the care plan tab in the electronic record. The DON was asked if the facility reviewed the baseline care with the resident and/or responsible party and provided them a summary. The DON stated the discharge planner was responsible for this task and would have additional information.

On 04/27/2022 at 10:34 a.m., the discharge planner (OS #1) was interviewed regarding the baseline care plans. OS #1 stated the resident and/or the responsible party were not provided a copy of the baseline care plans. OS #1 stated, "I've been working by myself for awhile and just got an assistant; so no that hasn't been done."

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 _____	C 04/28/2022

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 655	Continued From page 12 On 04/27/2022 at 2:37 p.m., the DON was interviewed again about the baseline care plans. The DON was asked if the baseline care plans were handwritten and stored somewhere other than the electronic record. The DON stated, "The facility is totally electronic and the care plans in the electronic record are all we have. We don't handwrite any care plans." The DON was advised Resident #349's baseline care plan was not created until four days after admission. The DON was advised the baseline careplans should be completed within 48 hours of admission. The DON stated again, "Our baseline care plans are in the computer, we don't have anything else." The above findings were reviewed with the administrator, DON, ADON, and corporate nurse consultant during a meeting on 04/27/2022 at 5:16 p.m. The corporate nurse consultant stated the expectation was for the baseline care plan to be completed within 48 hours of admission and to include provision of care needs." A review of the facility's Care Planning policy (11/01/2019) documented the following: "1. The computerized baseline Care Plan is initiated and activated within 48 hours. "2. The Center will provide the patient and the representative(s) with a summary of the baseline care plan that includes, but is not limited to: the initial goals of the patient, a summary of the patient's medications list, the patient's dietary instructions; any services and treatments to be administered by the Center and personnel acting on the behalf of the Center; and any updated information based on the details of the comprehensive care plan..."	F 655		
F 656	Develop/Implement Comprehensive Care Plan	F 656		6/7/22

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 _____	C 04/28/2022

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 656 SS=D	Continued From page 13 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		

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 _____	C 04/28/2022

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 656	Continued From page 14 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility document review, the facility staff failed to develop a comprehensive care plan (CCP) for 1 of 30 residents in the survey sample, Resident #5. Resident #5's CCP did not include a focus area with goals and interventions for the use of anticoagulants. The findings include: Resident #5 was admitted to the facility with diagnoses that included anxiety disorder, type 2 diabetes, congestive heart failure, cerebral palsy, schizoaffective disorder, spinal stenosis, right side hemiplegia/hemiparesis, major depressive disorder, bipolar disorder, and urine retention. The most recent minimum data set (MDS) dated 04/06/2022 was a quarterly assessment and assessed Resident #5 as moderately impaired for daily decision making with a score of 10 out of 15. Under Section N - Medications, the MDS documented Resident #5 received anticoagulants. Resident #5's clinical record was reviewed on 04/27/2022. Observed on the order summary report was the following order: " Apixaban (Eliquis) Tablet 5mg. Give 1 tablet by mouth every 12 hours for pe (pulmonary embolism). Order Date: 05/15/2021. Start Date: 05/19/2021." Resident #5's medication administration record (MAR) was reviewed and documented Resident	F 656	F656 1- The care plan was revised to include the focus area, goals and interventions for the use of an anticoagulant for Resident #5. 2-Current residents on anticoagulant therapy will be reviewed to ensure that the anticoagulant is addressed on the resident□s care plan. 3-The DON, or designee will educate Nursing Leadership/MDS staff on including a focus area, goal and interventions on the resident care plan to address the use of anticoagulant medications. 4-The DON, or designee will complete weekly audits of new orders for anticoagulant medications to ensure that the anticoagulant is addressed on the care plan. 5- Results of the audit will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, audits will be conducted on a random basis 6- Completion date 6/7/22. The Admin/DON are responsible for implementation of the plan of correction.	

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 _____	C 04/28/2022

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 656	Continued From page 15 #5 received the Apixaban (Eliquis) as ordered. Resident #5's CCP was reviewed and did not include a focus area with goals and interventions for the use of the anticoagulant medication, Apixaban (Eliquis). On 04/27/2022 at 3:30 p.m. the MDS coordinator, registered nurse (RN) #2 was interviewed regarding Resident #5's CCP. RN #2 reviewed Resident #5's electronic health record and stated a care plan should have been developed for the use of the anticoagulant medication. The above findings were reviewed with the administrator, DON, ADON, and corporate nurse consultant during a meeting on 04/27/2022 at 5:16 p.m. A review of the facility's Care Planning policy (11/01/2019) documented the following: "....6. Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment...."	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		6/7/22

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 _____	C 04/28/2022

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 657	Continued From page 16 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to review and revise a comprehensive care plan (CCP) for 1 of 30 in the survey sample, Resident #15. Resident #15's CCP was not reviewed and revised for the discontinuation of enteral feedings (tube feedings). The findings include: Resident #15 was admitted to the facility with diagnoses that included polymyositis, heart failure, adult failure to thrive muscle weakness, sleep apnea, dysphasia, hypertension, and gastronomy attention. The most recent minimum data set (MDS) dated 02/17/2022 was a quarterly assessment and assessed Resident #15 as cognitively intact for daily decision making with a score of 15 out of 15.	F 657	F657 1- The care plan was revised to indicate that the resident no longer requires enteral tube feeding for Resident #15. 2- An audit of current residents with Enteral feedings to ensure that the care plans are updated appropriately to ensure the care plan reflect when enteral feedings have been discontinued. 3-The DON, or designee will educate the Nursing Leadership/MDS staff on revising comprehensive care plans with resident changes of Enteral Feeding requirements. 4-The Interdisciplinary team/designee will complete weekly audits of resident care plans to ensure that any resident Enteral feeding changes are updated on the care plan. 5- Results of the audit will be presented to the QAPI committee for review and	

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 _____	C 04/28/2022

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 657	Continued From page 17 Resident #15 was interviewed on 04/26/2022 at 4:30 p.m regarding her quality of care and quality of life at the facility. Resident #15 stated, "I'm doing do better now that the tube feeding has been stopped and removed this month. I'm just glad I can eat 100% by mouth now." Resident #15's clinical record was reviewed on 04/26/2022. The clinical record documented the tube feeding was removed by the nurse practitioner on 04/01/2022. A review of medication administration record (MAR) documented the enteral feeding order was discontinued on 04/01/2022. Resident #15's CCP was reviewed. Observed was the following focus area including goals and interventions: "The resident requires tube feeding r/t (related to) Dysphasia. Created/Revision on 07/02/2020..." On 04/27/2022 at 3:30 p.m. the MDS coordinator (RN #2) was interviewed regarding Resident #15's CCP. RN #2 reviewed Resident #15's clinical record and stated, "I know she was eating and receiving her medications PO (by mouth). The care plan should have been updated when the tube feeding was removed." The above findings were reviewed with the administrator, DON, ADON, and corporate nurse consultant during a meeting on 04/27/2022 at 5:16 p.m. A review of the facility's Care Planning policy (11/01/2019) documented the following: "....6. Computerized care plans will be updated by each discipline on an ongoing basis as changes	F 657	recommendations. Once the QAPI determines the problem no longer exists, audits will be conducted on a random basis 6- Completion date 6/7/22. The Admin/DON are responsible for implementation of the plan of correction.	

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 _____	C 04/28/2022

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 657	Continued From page 18 in the patient occur, and reviewed quarterly with the quarterly assessment...."	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on a medication pass and pour observation, staff interview, clinical record review, and facility document review, the facility staff failed to follow professional standards of practice for one of 30 residents in the survey sample, Resident # 210. Resident # 210 was administered the incorrect dose of a medication. Findings include: Resident # 210 was admitted to the facility with diagnoses to include, but were not limited to: unstable angina (a type of chest pain), chest pain, and heart disease. The most recent MDS (minimum data set) was the admission assessment dated 4/11/22. Resident # 210 was coded with moderate impairment in cognition with a score of 12 out of 15. A medication pass and pour observation was conducted on 4/27/22 beginning at 8:00 a.m. with LPN (licensed practical nurse) # 1. LPN # 1 was observed administering a heart medication, Carvidilol 3.125 mg to Resident # 210.	F 658	F658 1-Resident #210 was discharged from the facility. LPN #1 was educated on the 5 R(s) of Medication Administration. 2- Current residents receiving medications in the center have the potential to be affected. 3-The DON, or designee will educate Licensed Nurses on the 5 R(s) of Medication Administration and the process of removing discontinued medications from the Medication cart to prevent medication errors. 4-The Unit Manager, or designee will complete medication administration observation for 3 licensed nurses weekly to ensure medications are being given observing the 5 R(s) of medication administration. 5- Results of the audit will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, audits will be conducted on a random basis 6-Completion date 6/7/22.	6/7/22

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 _____	C 04/28/2022

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 658	Continued From page 19 On 4/27/22 at approximately 9:30 a.m. the medications were reconciled with the physician orders in the clinical record. The current POS (physician order summary) included two orders for the Carvidilol. One order with a start date of 4/7/22, directed "Carvidilol 3.125 mg Give one tablet twice per day." That order included a discontinuation date of 4/9/22. The second order, dated 4/9/22, had the medication changed to 6.25 mg twice a day. On 4/27/22 at approximately 9:50 a.m. LPN # 1 was interviewed about the dose given, and asked if she would pull the medication card. LPN # 1 pulled the medication cards. There were three cards rubberbanded together; 2 cards of Carvidilol 3.125, and 1 card of 6.25. The card of the 6.25 dosage had 2 pills missing. The cards with 3.125 dosage had multiple pills missing. LPN # 1 then pulled up Resident # 210's MAR (medication administration record) and stated, "Yes, I did give 1 of the 3.125; that's my mistake...they were all 3 rubber-banded together, and I gave the first one in the stack. Looks like the order changed on 4/9/22..." On the MAR, the 3.125 mg was discontinued on 4/9/22, and the new order for 6.25 mg was included. Staff documented the medication was picked up on the 10th, but there was only two of the 6.25 mg pills missing. LPN # 1 stated "I think he must have been given the 3.125..." On 4/27/22 at approximately 10:15 a.m. the administrator was asked for the facility policy for discontinuation of medications. The policy, "Discontinued Medications" included: "Procedures: 1. The nurse documents the order to discontinue the medication in the resident's	F 658	The Admin/DON are responsible for implementation of the plan of correction.	

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 _____	C 04/28/2022

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 658	Continued From page 20 record. The Physician's Order Sheet (POS) and the Medication Administration Record (MAR) are updated to indicate the order is discontinued...2. Medications are removed from the medication cart or active supply immediately upon receipt of an order to discontinue (to avoid inadvertent administration." The administrator was informed of the findings 4/27/22 at approximately 10:15 a.m. when the policy was requested. No further information was provided prior to the exit conference.	F 658		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to follow physician orders regarding medication administration for four of 30 residents, Resident #303, Resident #304, Resident #306, and Resident #307. The facility also failed to do an admission skin assessment and provide treatment for an aterial wound for one of 30 residents, Resident #210.	F 684	F684 1-Residents #303, 304, 306 are receiving their medications as ordered. Resident # 307 and resident #210 are no longer residents in the center. 2- An audit of current residents in the center will be conducted for the last 30 days to ensure medications are being administered/completed as per physician orders. In addition, the audit will include	6/7/22

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 _____	C 04/28/2022

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 684	Continued From page 21 Findings were: 1. Resident #303 was recently admitted to the facility with the following diagnoses, including but not limited to: Hypertension, heart failure, chronic kidney disease, and anxiety. A full MDS (minimum data set) had not been completed at the time of the survey, but an admission nursing assessment from 04/15/2022, described Resident #303 as oriented to person, place, and time. The clinical record was reviewed on 04/26/2022 at approximately 2:00 p.m. The MAR (medication administration record) for April 2022, was reviewed. Resident #303 did not receive the following medications as ordered by the physician: * Sertaline 50 mg at 9:00 p.m. on 04/17/2022 * Gabapenting 100 mg at 9:00 a.m. on 04/17/2022 and 04/18/2022, 5:00 p.m. on 04/17/2022 The medications were coded on the MAR with the numbers "9"- "Other see progress notes" or "15"-no coverage required. The progress notes section was reviewed, the documentation from the EMAR (Electronic medication administration record) provided information that the medications were on order. 2. Resident #304 was admitted to the facility with the following diagnoses, including but not limited to: diabetes mellitus, atrial fibrillation, chronic kidney disease, and anxiety. A full MDS (minimum data set) had not been completed at the time of the survey, but an	F 684	ensuring admission skin assessments have been completed on new/readmissions to the center and orders were obtained for wound care for residents with wounds. 3-The DON, or designee will educate Licensed nurses on the 5 R(s) of Medication Administration and the process of obtaining medications from the STAT medication box, house stock supply and notifying the pharmacy of the need for medications. In addition, the education on completion of admission skin assessments and obtaining treatment orders for wounds. 4-The Unit Manager, or designee will complete weekly audits of the Medication Administration report to ensure that medications are available for administration. In addition, the Unit Manager/designee will observe 3 licensed nurses weekly during medication administration to ensure the 5 R(s) of medication administration are being conducted. The Unit Manager, or designee will complete weekly audits of new resident admissions to ensure that skin assessments are completed and that wound treatment orders are obtained for residents with wounds. 5- Results of the audit will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, audits will be conducted on a random basis 6-Completion date 6/7/22. The Admin/DON are responsible for	

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 _____	C 04/28/2022

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 684	Continued From page 22	F 684		

admission nursing assessment from 04/15/2022, described Resident #304 as oriented to person, place, time, and situation.

On 04/26/2022 at approximately 11:45 a.m., Resident #304 and her son were interviewed about life at the facility and her care. The son stated, "I don't think she or her roommate are getting their medicines right...I heard one of nurses telling her (pointing to roommate) that they didn't have her medicine here to give..."

Resident #304's clinical record was reviewed at approximately 12:30 p.m. The MAR (medication administration record) for April 2022, was reviewed. Resident #304 did not receive the following medication as ordered by the physician:
* Levothyroxine 50 mcg at 6:00 a.m. on 04/17/2022 and 04/18/2022

The medications were coded on the MAR with the numbers "9"- "Other see progress notes" The progress notes section was reviewed, the documentation from the EMAR was "Awaiting medication from the pharmacy."

3. Resident #306 was admitted to the facility with the following diagnoses, including but not limited to: heart failure, respiratory failure, stage III sacral pressure ulcer, and adult failure to thrive.

A full MDS (minimum data set) had not been completed at the time of the survey, but an admission nursing assessment from 04/13/2022, described Resident #306 as oriented to person, place, and time.

Review of the clinical record was conducted on

implementation of the plan of correction.

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 _____	C 04/28/2022

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 684	Continued From page 23	F 684		

04/27/2022 at approximately 9:30 a.m. The MAR (medication administration record) for April 2022 was reviewed. Resident #306 did not receive the following medication per physician orders:
* Gabapentin 400 mg at 9:00 a.m. on 04/17/2022 and 04/18/2022, or at 2:00 p.m. on 04/17/2022 and 04/18/2022.

The medications were coded on the MAR with the numbers "9"- "Other see progress notes" or "15"-no coverage required. The progress notes section was reviewed, the documentation from the EMAR provided information that the medications were on order or not available.

4. Resident #307 was admitted to the facility with the following diagnoses including but not limited to: Cerebral infarction (stroke), type 2 diabetes mellitus, peripheral vascular disease, and dementia.

A full MDS (minimum data set) had not been completed at the time of the survey, but an admission nursing assessment from 04/20/2022, described Resident #303 as oriented to person, place, and time.

The clinical record was reviewed on 04/27/2022 at approximately 11:30 a.m., the MAR was reviewed. The following medications were not given per physician orders:
* Atorvastatin 40 mg QD (every day) not given 04/23/2022, 04/24/2022 or 04/26/2022
* Januvia 100 mg HS (hour of sleep) not given from 04/20/2022 through 04/26/2022, total of seven missed doses.
* Clopidrogel 75 mg QD not given 04/21/2022 or 04/22/2022
* Nicotine patch QD not applied from 04/20/2022

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 _____	C 04/28/2022

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 684	Continued From page 24	F 684		

through 04/27/2022, total of 8 missed doses.
* Zetia 10 mg QD not given 04/21/2022 or 04/22/2022
* Dronabinol 2.5 mg twice a day- not given 04/20/2022 - 04/26/2022- total of 13 missed doses.

The EMAR notes contained information that the above medications were not available, on order, awaiting order from pharmacy.

At approximately 12;30 p.m., the corporate nurse consultant and the DON were asked if they could ascertain why Resident #307 was not receiving his Januvia at night or his Dronabinol.

At approximately 4:45 p.m., the medication cart containing Resident #307's medication was observed with RN (registered nurse) #3. The following medications ordered for Resident #307 were not on the medication cart:
* Januvia
* Atorvastatin
* Nicotine patch
* Dronabinol

RN #3 looked at Resident #307's medication list and stated, "The nicotine patch is stock, I don't know why he hasn't been getting that....it looks like his meds were ordered on 04/20/2022...I don't know why they aren't here....it looks like he got his Dronabinol earlier today but it isn't in the narc box." LPN (licensed practical nurse) # at the nurse's station and had given medications to Resident #307 earlier in the day. She stated, "That is kept in the refrigerator." She went to the refrigerator and returned with a medication card for Dronabinol. One pill was missing from the card. She stated, "I gave the one that's missing

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 _____	C 04/28/2022

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 684	Continued From page 25	F 684		

earlier today." She was asked when the medication had been delivered to the facility. She looked at the label and stated, "It looks like it was dispensed on 04/22/2022." She and RN #4 were asked why if the medication was in house it had not been given as ordered. LPN #4 stated "I don't know, maybe they didn't know to look in the refrigerator."

The above four resident information was discussed during an end of the day meeting on 04/27/2022 at approximately 5:15 p.m. with the DON (director of nursing), the administrator, the corporate nurse consultant, and the ADON (assistant director of nursing). The administrator stated that they had identified a problem with medications being unavailable and had been working on it over the last quarter. The DON stated that a report was run every morning regarding medication availability, it was discussed in morning meetings and the unit manager followed up by checking the medication carts. She was asked how medications were obtained at the time of admission. She stated, "Once we know we are getting an admission the pharmacy is notified. Once the resident arrives, the medications are verified with the physician and then the pharmacy fills the prescriptions and delivers them here." The administrator stated, "If the medication isn't here the nurses can go to the (name of machine) and get what they need...we are working to make sure there is a wide variety of medications available for them to choose from as needed."

The corporate nurse consultant stated, "We called the pharmacy...when the medications were ordered on 04/22/2022, the pharmacy was told to deliver all medication except the house stock

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 _____	C 04/28/2022

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 684	Continued From page 26	F 684		

meds. The person at the pharmacy abbreviated house stock as "HS"...this was miscommunicated as HS- hour of sleep and the evening medications were not delivered. That's why the Januvia isn't here."

The policy for "Medication Unavailability" was obtained and contained the following:
"If medications are determined to be unavailable for administration, licensed nurse will notify the provider of unavailability....will document notification to the provider...in the medical record....will notify the provider...and request an alternate treatment if possible. If alternate treatment is not available, then licensed nurse will activate backup pharmacy process and procedures..."

On 04/28/2022 at 8:30 a.m., the administrator presented an inservice/education record. She stated, "We started inservicing the nurses last night about what to do when medications aren't available." The objectives listed on the inservice record were: "...steps for obtaining unavailable medication for patients. The purpose of the (name of machine) to deliver patient's medications. Notifying the supervisor of medication being unavailable. Notifying the provider to obtain a hold order or alternate treatment for patients." She stated, "All our full time nurses have access to (name of machine) to get medication if they aren't here, we also have a back up pharmacy (name of chain) right down the street, the agency nurses are also given access to the (name of machine) for 10 days at a time...there is never a time that someone in house doesn't have access....we are moving to a 100% MAR and TAR audit to get this resolved."

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 _____	C 04/28/2022

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 684	Continued From page 27 No further information was obtained prior to the exit conference on 04/28/2022.	F 684		

5. Failed to complete an admission skin audit and provide treatment for an arterial foot wound upon admission for Resident #210.

The Findings Include:

Diagnoses for Resident #210 include; Peripheral vascular disease, major depression, difficulty walking, right below knee amputation, and arterial foot wounds. The most current MDS (minimum data set) was a 5 day assessment with an ARD (assessment reference date) of 4/18/22. Resident #210's was assessed with a cognitive score of 12 indicating cognitively intact.

On 04/26/22 at 1:07 PM during an interview, Resident #210 verbalized that the facility has not been taking care of the wounds on his left foot, is having pain at times and can make it difficult to do physical therapy. Observation of Resident #210's wounds evidenced dark nacrotic/scabbed tissue from the great toe to the ball of the foot approximately 3 inches long by 1 inch width and also a dime size nacrotic/scabbed area to the heal of the foot. When asked how long has he had the wounds, Resident #210 verbalized the wounds have been there for a long time before coming to the facility and said he had peripheral

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 _____	C 04/28/2022

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 684	Continued From page 28	F 684		

arterial disease which resulted in a right leg amputation.

Review of Resident #210'S medical record documented admission on 4/7/22 a skin observation audit was completed on 4/8/22 and did not indicated Resident #210 had any wounds. review of the physicians admission assessment also did not indicate Resident #210 had any skin wounds. And a hospital discharge summary dated 4/7/22 did not indicate any wounds.

Review of the facilities contracted wound agencies skin assessment dated 4/13/22 documented Resident #210's foot wounds were "present on admission" indicating a wound to the left medial foot was 8.05 centimeters (cm) in length and 2.85 cm in with and without depth and also a wound to the left heel 2.23 cm in length 2.74 cm wide and without depth.

Resident #210's physician order set was then reviewed. A physician's order dated 4/14/22 documented to do wound care with skin prep three times daily (the order date correlated with the contracted agencies assessment) there were no other skin treatments ordered prior to the assessment completed on 4/13/22.

On 04/27/22 at 9:57 AM the facilities nurse consultant was interviewed regarding responsibility for skin audits. The nurse consultant verbalized the admitting nurses should be doing a head to toe body audit and documenting their findings a contracting agency also comes in and does an assessment on new admissions weekly. The nurse consultant reviewed the admission skin audit for Resident #210 and verbalized that the form wasn't

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 _____	C 04/28/2022

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 684	Continued From page 29	F 684		

completed.

On 04/27/22 at 10:23 AM the wound care agencies nurse practitioner (other staff, OS #3) was interviewed. When asked about Resident #210's wounds being present on admission versus acquired in house, OS #3 said Resident #201 came from another facility were OS #3 was taking care of the wounds in that facility. OS #3 then pulled out her cell phone and provided pictures, assessments and dates of Resident #210's foot wounds prior to the admission to the facility.

On 04/27/22 at 6:11 PM the above information was presented to the administrator, director of nurses, and nurse consultant. The administrator verbalized in regards to skin assessments, when a new admission comes in the nurses are supposed to do an initial skin assessment, the resident is also put on a list to be seen when the agency wound clinic comes in. If wounds are present the agency will put them on a list to be seen weekly and weekly skin assessments are done by the agency. If wounds are not present then the nursing staff will do a weekly assessment.

On 04/28/22 at 8:39 AM OS #2 (facilities nurse practitioner) was interviewed. OS #2 said when a new admission comes into the facility they are seen by the physician within 72 hours and a physical assessment is performed based on diagnoses, history, hospital discharge summary and admission assessments and what the resident is saying. When asked about Resident #210's foot wounds, OS #2 verbalized review of the hospital discharge summary did not indicate any wounds and the nurses body audit did not

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 _____	C 04/28/2022

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 684	Continued From page 30 indicate any wounds. OS #2 said if Resident #210 had verbalized a problem with wounds it would have certainly been looked at and treatment would have been started, but the physician was unaware of any concerns to the foot. No other information was provided prior to exit conference on 4/28/22.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and resident interview, the facility staff failed to ensure a dressing was in place for a Stage III pressure ulcer for one of 30 residents, Resident #306. Findings were: Resident #306 was admitted to the facility with the following diagnoses, including but not limited to: heart failure, respiratory failure, stage III	F 686	F686 1-Resident #306 is receiving treatment for her pressure ulcer as ordered. 2.Current residents in the center with wounds have the potential to be affected. 3-The DON, or designee will educate licensed nurses on following physician orders for treatments of wounds and to ensure timely replacement of dressings when they come off.	6/7/22

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 _____	C 04/28/2022

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 686	Continued From page 31 sacral pressure ulcer, and adult failure to thrive. A full MDS (minimum data set) had not been completed at the time of the survey, but an admission nursing assessment from 04/13/2022, described Resident #306 as oriented to person, place, and time. On 04/26/2022 at approximately 3:45 p.m., Resident #306 was interviewed about life at the facility and her care. She stated, "Things aren't going so well today." She was asked to explain. Resident #306 stated she had a wound on her "backside". The dressing had come off earlier in the day due to two episodes of diarrhea. She stated that when she had been cleaned up from that, her "patch" had come off because it was dirty. She stated therapy had been in and because she told them the wound was open they didn't get her up in her wheelchair for therapy. She stated she had her therapy in the bed. She was asked how she normally had therapy. She stated, "They usually get me up in the wheelchair and we do it in here, but they didn't want to get me up since that patch is off." She was asked if the nurses were aware that her wound was not covered, She stated, "I don't know, I don't feel like that's my responsibility to tell them....but I also don't want it to get infected because the patch isn't over it." The staff at the nurse's station were asked who was providing care to Resident #306. LPN (licensed practical nurse) #4 stated she was taking care of Resident #306. She was asked if she was aware that Resident #306's wound did not have a dressing in place. She stated, "No, I'm not doing wound care. (Name of LPN #5) is doing that today.	F 686	4-The Unit Manager, or designee will complete weekly audits of residents with wounds to ensure that the dressings are in place, as ordered. 5- Results of the audit will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, audits will be conducted on a random basis 6-Completion date 6/7/22. The Admin/DON are responsible for implementation of the plan of correction.	

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 _____	C 04/28/2022

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 686	Continued From page 32	F 686		

LPN #5 was came to the nurse's station and she was asked if she was aware that Resident #306 did not have a dressing in place over her sacral wound. She stated, "No, I didn't know that. I have been up the hall in another room. I'll do it now." She went to the computer and looked at the physician orders. She stated, "That's normally done at night...I would have gone down there if I had known." She gathered her supplies and stated, "There's a lack of communication around here."

LPN #5 went to Resident #306's room. The dressing change was done per the physician order at approximately 4:00 p.m. She was asked how the wound looked. She stated, "I've never seen it before." The wound was observed on Resident #306's sacrum, it was clean, without drainage, and LPN #5 described it as a "Stage III". Resident #306 stated, "I got that place from laying in pee and poop, I want it to get better...I'm sure they told my nurse it was off..I know the therapist did."

At 4:05 p.m., Other staff #3 was interviewed. She stated, that she had been in Resident #306's room to provide therapy before lunch. She did not get Resident #306 up to her wheelchair since the resident had reported that her dressing was off of her wound. She stated that when she finished the session she told Resident #306's nurse that the dressing was off. She was asked who she told. She pointed down the hall and identified LPN #4.

LPN #4 was interviewed and asked if the therapist had told her Resident #306's wound was not covered. She stated, "I don't know, maybe....I already told you I'm not doing wound care

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 _____	C 04/28/2022

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 686	Continued From page 33 today....(Name of LPN #5) is doing it...I figured she would get to it." The above information was discussed during an end of the day meeting on 04/27/2022 at approximately 5:15 p.m. with the DON (director of nursing), the administrator, the corporate nurse consultant, and the ADON (assistant director of nursing). On 04/28/2022 at approximately 10:30 a.m. Resident #306 was sitting in bed. She stated, "I wasn't trying to get anybody in trouble the other day about that patch being off...but I'll tell you it is off again today....it came off while (Name of certified nursing assistant (CNA) #1) was cleaning me up earlier." CNA #1 was interviewed at approximately 10:40 a.m. She was asked if she had told the nurse that Resident #306's dressing was off of her wound. She stated, "No, I forgot, I'll tell her now." The above information was discussed with the corporate nurse consultant at approximately 10:55 a.m. She agreed that the nurses should be informed when the dressing was off a wound so it could be replaced as soon as possible. No further information was obtained prior to the exit conference on 04/28/2022.	F 686		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5	F 759		6/7/22

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 _____	C 04/28/2022

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 759	Continued From page 34 percent or greater; This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, staff interview, clinical record review, and facility document review the facility staff failed to ensure a medication error rate less than 5 percent. There were three errors out of 41 opportunities resulting in a medication error rate of 7.32 percent. Findings include: A medication pass and pour observation was conducted in the facility 4/27/22 beginning at 8:00 a.m. with LPN (licensed practical nurse) # 1. Medications were prepared for Resident # 210, and directions on the label recorded. A heart medication, Carvidilol, was recorded as 3.125, one tablet. LPN # 1 was observed administering the medications. On 4/27/22 at approximately 9:30 a.m. the medications recorded were reconciled with the physician orders in the clinical record. It was noted the current POS (physician order summary) included two orders for the Carvidilol. One order for the medication, with a start date of 4/7/22, directed "Carvidilol 3.125 mg Give one tablet twice per day." That order included a discontinuation date of 4/9/22. The second order, dated 4/9/22, had the medication changed to 6.25 mg twice a day. On 4/27/22 at approximately 9:50 a.m. LPN # 1 was asked about the dose given, and asked if she would pull the medication card. LPN # 1 pulled the medication cards; there were three cards rubberbanded together; 2 cards of	F 759	F759 1-LPN #1 and LPN #2 were educated on the 5 R(s) of Medication Administration. 2-Current residents in the center receiving medications have the potential to be affected. 3-The DON, or designee will educate Licensed Nurses on the 5 R(s) of Medication Administration. In addition, the education will include removing discontinued medications from the medication cart and following the protocol for administration of respiratory medications. 4-The Unit Manager, or designee will observe medication administration for 3 licensed nurses weekly to ensure the 5 R(s) of medication administration is being conducted. In addition, a weekly review of the medication carts to ensure discontinued medications have been removed. 5- Results of the audit will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, audits will be conducted on a random basis 6-Completion date 6/7/22. The Admin/DON are responsible for implementation of the plan of correction.	

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 _____	C 04/28/2022

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 759	Continued From page 35	F 759		

Carvidilol 3.125, and 1 card of 6.25. The card of the 6.25 dosage had 2 pills missing; the cards with 3.125 dosage had multiple pills missing. LPN # 1 then pulled up Resident # 210's MAR (medication administration record) and stated "Yes, I did give 1 of the 3.125; that's my mistake.....they were all 3 rubberbanded together, and I gave the first one in the stack. Looks like the order changed on 4/9/22, ..." On the MAR, the 3.125 mg was d/c'd on 4/9, and the new order for 6.25 was included, staff documentation picked up on the 10th, but there was only 2 pills missing of 6.25, and LPN # 1 stated "I think he must have been given the 3.125....."

On 4/27/22 at approximately 10:15 a.m. the administrator was asked for the facility policy for discontinuation of medications. The policy, "Discontinued Medications" included: "Procedures: 1. The nurse documents the order to discontinue the medication in the resident's record. The Physician's Order Sheet (POS) and the Medication Administration Record (MAR) are updated to indicate the order is discontinued..... 2. Medications are removed from the medication cart or active supply immediately upon receipt of an order to discontinue (to avoid inadvertent administration."

The administrator was informed of the findings 4/27/22 at approximately 10:15 a.m. when the policy was requested.

No further information was provided prior to the exit conference.

2. On 4/27/22 beginning at 8:40 a.m. a medication pass and pour observation was conducted with LPN (licensed practical nurse) #

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 _____	C 04/28/2022

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 759	Continued From page 36 2. LPN # 2 prepared medications for Resident # 305, who was sitting in his doorway getting ready to leave for therapy. Medications recorded for Resident # 305 included "Flonase 50 mcg 2 spays in each nostril one time per day and Wixela 250/50 (an inhaled asthma medication) one puff per day. LPN # 2 was observed administering the medications, and did not administer 2 spays of Flonase per nostril, only one. LPN # 2 also did not have the resident to rinse out his mouth after using the inhaler. After administration, LPN # 2 was asked about the the Flonase and the Wixela. LPN # 2 stated "Did I only do one spray? Yes, he should have rinsed; that's my fault.....he was talking and ready for therapy....." On 4/27/22 at 10:15 a.m. the administrator was asked for the policy on medicated nebulizer's. The policy, "Nursing Policies and Procedures" included "Medicated Nebulizer Treatment 6. Post treatment have the patient rinse mouth with water....." The administrator was informed of the above findings 4/27/22 at approximately 10:15 a.m. when the policy was requested. No further information was provided prior to the exit conference.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		6/7/22

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 _____	C 04/28/2022

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 761	Continued From page 37 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review the facility staff failed to ensure medications and biologicals were labeled and stored correctly on one of 3 medication carts inspected, and in one of 2 medication rooms. The East wing refrigerator included a vial of tuberculin solution (PPD), and a bottle of Vancomycin; both were open and not dated. The medication cart on the 400 north hall contained 5 open vials of insulin, which were not dated. Findings include: On 4/28/22 at 8:40 a.m. the East wing medication room was inspected with LPN (licensed practical nurse) # 2. The medication room refrigerator was inspected, and observed to include an open vial of PPD solution which was not dated. There was	F 761	F761 1-The PPD solution, bottle of Vancomycin and the open vials of Insulin were all removed from the medication carts and medication refrigerator and discarded. 2-Current residents in the center have the potential to be affected. 3-The DON, or designee will educate Licensed Nurses on proper storage of medications in the medication carts and medication room refrigerators, including dating of medications when opened. 4-The Unit Manager, or designee will complete weekly inspections of the medication carts and medication room refrigerators to ensure that medications are stored properly and dated when opened.	

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 _____	C 04/28/2022

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 761	Continued From page 38 also an open bottle of Lorazepam liquid which was not dated. LPN # 2 was asked about the PPD solution. She stated "It should be dated when opened..." LPN # 2 did not respond immediately to the question about the Lorazepam, so the package insert was taken out of the box. The package insert included storage instructions to include "Discard opened bottle after 90 days." LPN # 2 stated she did not know when the bottle had been opened, and removed it from the refrigerator. On 4/28/22 at approximately 9:00 a.m. the medication cart on the 400 north hall was inspected with LPN # 4. Four vials of Lantus insulin and one bottle of Humalog insulin were located in the cart. All of the vials were identified as currently in use. The vials were not dated with an open date. LPN # 4 stated "I don't know who opened these, but they should be dated when opened...." The administrator was asked for the policy on storage of medications and biologicals. The policy "Storage of Medications" included "Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier.....5. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 5 a. The nurse will place a 'date opened' sticker on the medication and record the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days from opening, unless the manufacturer recommends another date or regulations/guidelines require different dating."	F 761	5- Results of the audit will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, audits will be conducted on a random basis 6-Completion date 6/7/22. The Admin/DON are responsible for implementation of the plan of correction.	

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 _____	C 04/28/2022

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 761	Continued From page 39 The administrator, DON (director of nursing), ADON (assistant director of nursing, nurse consultant, and vice president of clinical operations were informed of the above findings during a meeting with facility staff 4/28/22 beginning at 10:55 a.m. No further information was provided prior to the exit conference.	F 761		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident;	F 790		6/7/22

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 _____	C 04/28/2022

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 790	Continued From page 40 (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview, and staff interview, the facility failed to obtain routine dental care for two of 30 residents in the survey sample, Residents # 13 and 47, who were assessed as having dental problems. During the Group Meeting, Residents # 13 and 47 expressed a desire to see a dentist. The findings include: 1. Resident # 13 was admitted to the facility with diagnoses that included atrial fibrillation, acute systolic and diastolic heart failure, hypertension, peripheral vascular disease, left below the knee amputation, diabetes mellitus, and depression. According to the most recent Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/7/2022, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 13 out of 15. Under Section L (Oral/Dental Status), the resident was assessed at Item L0200 (D) as having obvious or likely cavity or broken natural teeth.	F 790	F790 1-Resident #13 and 47 have been scheduled to see a Dentist. 2-Current residents in the center with dental needs have the potential to be affected. 3-The Administrator, or designee will educate the Interdisciplinary Team on Dental services requirements for the residents and include education on the process of providing Dental services for the residents. 4-The DON/designee will notify the discharge planner on a weekly basis on any resident requiring dental services, so appointments can be scheduled. The DON/designee will follow up weekly to ensure the appointments have been made and residents have been transported to the scheduled appointments. 5- Results of the audit will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, audits will be conducted on a random	

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 _____	C 04/28/2022

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 790	Continued From page 41 During the Group Meeting at 10:30 a.m. on 4/27/2022, Resident # 13 expressed a desire to see the dentist. At approximately 3:30 p.m. on 4/27/2022, the Social Worker/Discharge Planner, who was identified as the staff member responsible for making resident dental appointments, was interviewed. According to the Social Worker, dental services are contracted to (name of provider). The Social Worker explained that dental services are provided about every 60 days. When a resident needs the dentist, the resident's name is placed on a list that is provided to the dental services provider. A copy of the Dental Group Schedule for the most recent visit on 2/25/2022 was reviewed. Resident # 13 was not listed on the Dental Group Schedule of residents to be seen. In a subsequent interview at 9:15 a.m. on 4/28/2022, the Social Worker was asked if there were any residents on the Dental Group Schedule that were not on the schedule for 2/25/2022. The Social Worker said that she did not think there was anyone on the schedule for the next visit that was not on the previous schedule. Asked how a resident gets on the dental list, the Social Worker said, "The only way a resident gets to see the dentist is if they come to me, complain to a nurse, or the doctor." When asked if she reviews a resident's MDS at Section L (Oral/Dental Status) for dental problems, the Social Worker responded, "No." 2. Resident # 47 was admitted with diagnoses that included cerebral vascular accident with right	F 790	basis 6-Completion date 6/7/22. The Admin/DON are responsible for implementation of the plan of correction.	

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 _____	C 04/28/2022

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 790	Continued From page 42	F 790		

side hemiplegia, anemia, hypertension, peripheral vascular disease, benign prostatic hyperplasia, renal insufficiency, obstructive uropathy, diabetes mellitus, arthritis, aphasia, seizure disorder, traumatic brain injury, and depression. According to the most recent Annual MDS, with an ARD of 3/8/2022, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 10 out of 15.

Under Section L (Oral/Dental Status), the resident was assessed at Item L0200 (D) as having obvious or likely cavity or broken natural teeth.

During the Group Meeting at 10:30 a.m. on 4/27/2022, Resident # 47 expressed a desire to see the dentist.

According to a review of the Dental Group Schedule for the most recent visit on 2/25/2022, Resident # 47 was not on the list of residents to be seen.

Resident # 47's care plan included the following problem, "The resident has potential oral/dental health problems." The goal for the problem was, "The resident will be free of infection, pain or bleeding in the oral cavity by review date." The interventions to the stated problem were, "Monitor/document/report PRN (as needed) any s/sx (signs and symptoms) of oral/dental problems needing attention: Pain, (gums, toothache, palate), abscess, debris in mouth, lips cracked or bleeding, teeth missing, loose, broken, eroded, decayed, tongue (black, coated, inflamed, white, smooth), ulcers in mouth lesions; and, Provide mouth care as per ADL (Activities of Daily Living), personal hygiene." The problem,

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 _____	C 04/28/2022

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 790	Continued From page 43 goal and interventions were created on 3/18/2022. Review of the Progress Notes in Resident # 47's Electronic Health Record (EHR) revealed the following entry: 2/3/2022 - Discharge Planning Progress Note - "...Resident remains in LTC. Questions were addressed regarding the resident being seen for podiatry and dental services. Social Worker to update (name of resident's relative) on resident service dates to ensure resident be (sic) seen..." There was no documentation Resident # 47's EHR that the resident was ever seen by the dentist. The findings were discussed during a meeting held at 5:15 p.m. on 4/27/2022 that included the Administrator, Director of Nursing, Assistant Director of Nursing, Nurse Consultant.	F 790		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842		6/7/22

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 _____	C 04/28/2022

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 842	Continued From page 44	F 842		

must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

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 _____	C 04/28/2022

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 842	Continued From page 45 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for one of 30 residents, Resident #303. Findings were: Resident #303 was recently admitted to the facility with the following diagnoses, including but not limited to: Hypertension, heart failure, chronic kidney disease, and anxiety. A full MDS (minimum data set) had not been completed at the time of the survey, but an admission nursing assessment from 04/15/2022, described Resident #303 as oriented to person, place, and time. The clinical record was reviewed on 04/26/2022 at approximately 2:00 p.m. Resident #303 had been a resident in the facility in 2019 and was discharged home 07/2019. The MAR (medication administration record) for April 2022, was reviewed. The following	F 842	F842 1-The medication administration record for Resident #303 includes the correct medication orders. 2- Current resident in the center, who had prior admissions have the potential to be affected. 3-The DON, or designee will educate Licensed Nurses on proper discontinuation of Medication orders when a resident is discharged from the facility. 4-The Unit Manager, or designee will complete weekly audits of residents discharged from the facility to ensure that the Medication orders were discontinued from the clinical record appropriately. 5 - Results of the audit will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, audits will be conducted on a random basis 6-Completion date 6/7/22. The Admin/DON are responsible for	

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 _____	C 04/28/2022

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 842	Continued From page 46	F 842		

medications were observed on the MAR with the initial order date of 07/2019, the dates of a previous admission to the facility:

Bumetadine 1 mg
Flomax 4 mg
Multivitamin
Nifedipine ER 90 mg
Potassium Chloride 20 meq
Colace 100mg
Pantoprazole 20 mg
Hydralazine 100 mg
Metoclopramide 10 mg
Metoprolol 100 mg

Each of the above listed medication had duplicate times of administration listed on the MAR (2 lines for the 9:00 a.m. dose, 2 lines for the 2:00 p.m. dose, etc). The medications were signed off on one of the lines as not available and on the second line as given.

The DON (director of nursing) was asked at approximately 3:00 p.m., how medications from a previous admission could show up on the MAR to be given.

On 04/28/2022 at approximately 11:00 a.m., the corporate nurse consultant was interviewed. She stated, "It looks like when (Name of Resident #303) was discharged in 2019, the medications were never discontinued....the nurses have to go in and either click discontinue all meds or discontinue them one at a time...from what we can tell that didn't happen...when she was readmitted, the medications pulled back over on the new MAR...I don't know and have no way of knowing if they were given or not...I really think it is inaccurate documentation."

implementation of the plan of correction.

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 _____	C 04/28/2022

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 842	Continued From page 47 No further information was obtained prior to the exit conference on 04/28/2022.	F 842		