PRINTED: 07/14/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495266	B. WING _		-	06/30/2023
	ROVIDER OR SUPPLIER R HEALTH AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STA 8139 LEE DAVIS ROAD MECHANICSVILLE, VA 2		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORREC' CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)	
E 000	Initial Comments		E	000		
	Survey was conduct facility was in substated Part 483.475(b)(6) or regulations, and has for Medicare & Medicare Control recoprepare for COVID-	20 certified bed facility was				
F 000	110 at the time of the INITIAL COMMENT	e survey.	F	000		
	was conducted onsigner required for come 483.80 infection configuration of Timedicaid Services a Control recommend.	ed Infection Control Survey te on 6/30/2023. Corrections upliance with 42 CFR Part trol regulations, for the he Centers for Medicare & and Centers for Disease ed practices to prepare for blaints were investigated				
F 883 SS=D	110 at the time of the consisted of 5 reside review. Influenza and Pneur	20 certified bed facility was e survey. The survey sample ent reviews and 1 employee mococcal Immunizations	F 8	83		7/20/23
	§483.80(d) Influenza immunizations §483.80(d)(1) Influe policies and procedu (i) Before offering the each resident or the receives education r	a and pneumococcal		TITLE		(X6) DATE

Electronically Signed 07/13/2023

Facility ID: VA0098

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVE' COMPLETED	Y
		495266	B. WING _		06/30/202	23
	ROVIDER OR SUPPLIER R HEALTH AND REHAB	BILITATION CENTER	•	STREET ADDRESS, CITY, STATE, 8139 LEE DAVIS ROAD MECHANICSVILLE, VA 231		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVI CROSS-REFERENCEI	E ACTION SHOULD BE COMP	X5) PLETION ATE
F 883	(ii) Each resident is immunization Octobe annually, unless the contraindicated or to immunized during the contraindicated or to immunized during the contraindicated or to has the opportunity (iv) The resident's medocumentation that following: (A) That the resider was provided educated and potential side elimmunization; and (B) That the resider immunization or didimmunization or didimmunization due to refusal. §483.80(d)(2) Pneumust develop policit that- (i) Before offering the immunization, each representative recebenefits and potent immunization; (ii) Each resident is immunization, unles medically contraind already been immunication that following:	offered an influenza per 1 through March 31 e immunization is medically the resident has already been his time period; the resident's representative to refuse immunization; and hedical record includes indicates, at a minimum, the ht or resident's representative ation regarding the benefits ffects of influenza ht either received the influenza hot receive the influenza hot medical contraindications or hococcal disease. The facility hes and procedures to ensure he pneumococcal resident or the resident's hives education regarding the hial side effects of the hoffered a pneumococcal his the immunization is his cated or the resident has	F	883		

		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495266	B. WING		06/30/2023	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HANOVER HEALTH AND REHABILITATION	ON CENTER		8139 LEE DAVIS ROAD MECHANICSVILLE, VA 23111		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 883 Continued From page 2 was provided education regand potential side effects of immunization; and (B) That the resident either pneumococcal immunizatio the pneumococcal immunizatio contraindication or refusal. This REQUIREMENT is not by: Based on staff interview, cland facility documentation residents, Residents #2, #3 residents reviewed for influence and facility staff failed to provaccine for 1 resident, Resiresidents reviewed for pneummunization. The findings included: 1. The facility staff failed to immunization, to include edrisks/benefits about influence Residents #2, #3, and #5. On 6/30/23 at approximatel record reviews were performation following: A. For Resident #2, the clin revealed Resident #2, who facility on 10/8/22, had receimmunization on 10/26/21. documentation of the flu varefused, contraindicated, or current year, 2022. B. For Resident #3, the clin	f pneumococcal received the on or did not receive ration due to medical of met as evidenced dinical record review, review, the facility staff raccines for 3 8, and #5, out of 5 enza immunization ovide a pneumococcal ident #5, out of 5 umococcal provide influenza ducation of za immunization, for ly 2:30 PM, clinical med and revealed the nical record review was admitted to the evived influenza There was no occine being offered, r administered for the	F 88	The facility sets forth the following pla correction to remain in compliance with federal and state regulations. The facility has taken or will take the actions set for in the plan of correction. The following plan of correction constitutes the facility allegation of compliance. All deficient cited have been or will be corrected by date or dates indicated. F883 Influenza and Pneumococcal Immunizations 1. Residents #2, #3 and #5 were provided education with documentation the clinical record about vaccinations declined by the facility Administrator or 6/30/2023. 2. Current residents in the center has the potential to be affected. An audit we conducted by the DON on 7/1/23 on al current residents to verify education of risk/benefit was provided for flu immunization and pneumococcal vaccadministered if criteria met and documented in clinical record. Any deficient practice found was corrected the facility DON and/or IP by 7/12/23. 3. The Staff Development Coordinated designee will educate all licensed nurson the flu vaccination process during floating and state of the staff process during floating float	n all lity orth l yus ies the n in n we as I ine by or or es	

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	IPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495266	B. WING _			06/30/2023
	ROVIDER OR SUPPLIER R HEALTH AND REHAB	ILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CO 8139 LEE DAVIS ROAD MECHANICSVILLE, VA 23111	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 883	on 4/21/22. Resided vaccine on 10/20/22 evidence of education for influenza immunities. For Resident #5, revealed Resident # on 8/26/22. Resided vaccine on 10/20/22 evidence of education for influenza immunities. On 6/30/23 at approximaterview was conducted. Wursing (DON) who for the residents sarfindings. The Infection for influenza immunities. The Infection for the residents sarfindings. The Infection for the residents and stated, "it [no of educate] appears to DON and IP acknown immunization education immunization education for the facility informed decision requested and received and received facility policy enterprise facility enterprise facility policy en	3 was admitted to the facility of #3 refused to have a flu the however there was no on regarding the risks/benefits ization. the clinical record review 5 was admitted to the facility of #5 refused to have a flu the however there was no on regarding the risks/benefits ization. Eximately 2:45 PM, a group facted with the Director of accessed the clinical records inpled and verified the for Preventionist (IP) is no additional information of fer to vaccinate and/or in the home prevention is the providing tion to residents who may be an initial offer to vaccinate, in them to be able to make a initial offer to vaccinate, in them to be able to make a initial offer to vaccinate, in them to be able to make a initial offer to vaccinate, in them to be able to make a initial offer to vaccinate, in them to be able to make a initial offer to vaccinate, in them to be able to make a initial offer to vaccinate, in them to be able to make a initial offer to vaccinate, in them to be able to make a initial offer to vaccinate, in them to be able to make a initial offer to vaccinate, in them to be able to make a initial offer to vaccinate, in them to be able to make a initial offer to vaccinate, in them to be able to make a initial offer to vaccinate, in them to be able to make a initial offer to vaccinate, in them to be able to make a initial offer to vaccinate, in the providing them.	F8	season that includes docume resident solinical record for flu vaccine, and education of The Staff Development Coordesignee will educate all lic on the pneumococcal vaccinand criteria for administration documentation of education risks/benefits provided to the and/or RP. 4. The IP (Infection Preventions are offered durand documentation of education risk/benefits was provided. (Infection Preventionist) or complete a weekly audit of admissions to ensure the provaccine is administered if cand documented in clinical audits will be done weekly.) Results of the review will be the QAPI committee for reverecommendation. Once the determines the problem not the review will be conducted basis. 5. Date of compliance: 76	or offering the of risk/benefits. ordinator or ensed nurses ne process on and n of the resident of the residen	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495266	B. WING _		06/30/2023
	ROVIDER OR SUPPLIER R HEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8139 LEE DAVIS ROAD MECHANICSVILLE, VA 23111	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 883	Continued From pag	e 4	F 8	83	
	[Responsible Party] electronic medical re	.document education in the cord".			
	Administrator and Di	kimately 3:15 PM, the Facility rector of Nursing were made . No further information was			
		iled to include education of oneumococcal immunization,			
	record review was per revealed Resident #5 pneumococcal vaccion was no evidence of 6	kimately 2:30 PM, a clinical erformed for Resident #5 and 5 refused to have a ne on 3/6/23, however there education regarding the numococcal immunization.			
	interview was conduct Nursing (DON) who are for the residents same findings. The Infection confirmed there was and stated, "it [no varies and oversight". Both acknowledged that preducation to resident refuse the initial offer beneficial for them to	n Preventionist (IP) no additional information ccine education] appears to			
	the facility policy enti	kimately 3:00 PM, a review of tled, "Pneumococcal ve date 5/01/23, was			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION IG		OATE SURVEY OMPLETED
		495266	B. WING _			06/30/2023
	ROVIDER OR SUPPLIER R HEALTH AND REHABII	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8139 LEE DAVIS ROAD MECHANICSVILLE, VA 23111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 883 F 887 SS=D	patient and or RP [Reeducation in the election of 6/30/23 at approximate Administrator and Diraware of the findings provided. COVID-19 Immunization (CFR(s): 483.80(d)(3)	inder the subtitle, e, 1 read, "Educate the esponsible Party]document ironic medical record". imately 3:15 PM, the Facility ector of Nursing were made . No further information was	F 8			7/20/23
	LTC facility must deviand procedures to en (i) When COVID-19 v facility, each resident is offered the COVID-immunization is mediresident or staff memimmunized; (ii) Before offering Comembers are provide regarding the benefits effects associated wii (iii) Before offering Coresident or the resident or the resident or the resident ceves education regists and potential side the COVID-19 vaccina (iv) In situations when requires multiple dos resident representation provided with current additional doses, include the covided with the	elop and implement policies sure all the following: raccine is available to the and staff member -19 vaccine unless the cally contraindicated or the ber has already been OVID-19 vaccine, all staff id with education is and risks and potential side the the vaccine; OVID-19 vaccine, each interpresentative regarding the benefits and de effects associated with ee; re COVID-19 vaccination res, the resident, we, or staff member is information regarding those uding any changes in the				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY PLETED
		495266	B. WING		06	/30/2023
	ROVIDER OR SUPPLIER R HEALTH AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8139 LEE DAVIS ROAD MECHANICSVILLE, VA 23111	, 30	10012020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 887	member has the opp COVID-19 vaccine, a (vi) The resident's modocumentation that in the following: (A) That the resident was provided educat benefits and potential COVID-19 vaccine; a (B) Each dose of CO to the resident; or (C) If the resident did vaccine due to medic contraindications or revision (vii) The facility main to staff COVID-19 varincludes at a minimu (A) That staff were provided to the provided with COV (B) Staff were offered information on obtain (C) The COVID-19 varielated information and Healthcare Safety Nethics REQUIREMENT by: Based on staff intervand facility documen failed to provide COV 2 residents, Resident	dent representative, or staff ortunity to accept or refuse a and change their decision; edical record includes indicates, at a minimum, or resident representative ion regarding the ill risks associated with and VID-19 vaccine administered if not receive the COVID-19 call refusal; and tains documentation related accination that in, the following: rovided education regarding ential risks refully a vaccine; and accine status of staff and accine status of staff and accine status of staff and is indicated by the Centers for Prevention's National etwork (NHSN). To is not met as evidenced view, clinical record review, tation review, the facility staff VID-19 bivalent education for its #1, and #5, out of 5 or COVID-19 bivalent	F 8	F887 COVID-19 Immunization 1. Residents #1 and Residen educated about the risk/benefit COVID-19 Vaccine by the Facil Administrator on 6/30/23. 2. Current residents in the ce the potential to be affected. An conducted by the DON on 7/1/2 current residents to verify eductions.	s of the ity nter have audit was 23 on all	

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		E SURVEY PLETED
		495266	B. WING _		06	6/30/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	•	
HANOVE	DUEALTH AND DELIAL	DILITATION CENTED		8139 LEE DAVIS ROAD		
HANOVE	R HEALTH AND REHAI	BILITATION CENTER		MECHANICSVILLE, VA 23111		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 887	Continued From pa	ge 7	F 8	87		
	The facility staff fail risks/benefits about Residents #1, and	ed to provide education of t COVID-19 immunization, for		risk/benefit was provided for vaccine declinations. Any de practice found was corrected facility DON and/or IP by 7/13. The Staff Development	eficient d by the 12/23.	
	record reviews wer following:	e performed and revealed the , the clinical record review		designee will educate all lice on the COVID-19 bivalent va process that includes document the resident so clinical record	ensed nurses accination nentation in	
	revealed Resident : COVID-19 bivalent there was no evide	#1 refused to have a vaccine on 3/3/23, however nce of education regarding the OVID-19 immunization.		risk/benefits provided. 4. The IP (Infection Prevel designee will complete a we new admissions to verify CC bivalent vaccination education)	ntionist) or ekly audit of OVID-19	
	revealed Resident : COVID-19 bivalent there was no evide	, the clinical record review #5 refused to have a vaccine on 3/6/23, however nce of education regarding the OVID-19 immunization.		risk/benefits was provided a documented in the resident record x 30 days. Results of will be presented to the QAF for review and recommenda committee determines the p	∃s clinical the review PI committee tion. Once the	
	interview was cond Nursing (DON) who for the residents sa findings. The Infect confirmed there wa and stated, "it [no v be an oversight". B acknowledged that education to reside refuse the initial off beneficial for them	oximately 2:45 PM, a group ucted with the Director of a accessed the clinical records impled and verified the ion Preventionist (IP) is no additional information accine education] appears to oth the DON and IP providing immunization into who may be unsure, or er to vaccinate, may be to be able to make a fully A facility policy was requested		longer exists, the review will on a random basis. 5. Date of compliance : 7/3	be conducted	
	the facility policy er	ctive date 5/01/23, was				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1, ,	ATE SURVEY OMPLETED
		495266	B. WING _			06/30/2023
	ROVIDER OR SUPPLIER	LITATION CENTER	•	STREET ADDRESS, CITY, STATE, 3 8139 LEE DAVIS ROAD MECHANICSVILLE, VA 2311	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 887	Control and Preventice everyone stay up to devaccination" and item or refused, document immunization record, and/or RP [Responsil education regarding trisks associated with The CDC (Centers for Prevention) document Considerations for Ust the United States", up 2, "Recommendations vaccines", read, "COV recommended for every colder in the United States" of the United States of the Unite	CDC [Centers for Disease on] recommends that late with COVID-19 2c read, "If contraindicated in the patient's including that the patient ole Party] was provided the benefits and potential the COVID-19 vaccine". T Disease Control and it titled, "Interim Clinical se of COVID-19 Vaccines in odated May 12, 2023, page is for the use of COVID-19 vaccination is eryone ages 6 months and lates for the prevention of commends that people lider receive at least 1	F8	387		