STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HANOVER NURSING CENTER	410 W LAGRANGE RD HANOVER, IN 47243

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00254578. Complaint IN00254578 - Substantiated. Federal/State deficiencies are cited at F689. Survey dates: February 22 and 23, 2018 Facility number: 000115 Provider number: 155208 AIM number: 100291080 Census Bed Type: SNF/NF: 53 Residential: 9 Total: 62 Census Payor Type: Medicare: 5 Medicaid: 47 Other: 10 Total: 62 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 27, 2018.	F 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective March 7th, 2018 for the complaint conducted on February 22nd And February 23rd 2018	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to adequately supervise residents who resided on a unsecured unit. This deficient practice effected 1 of 3 residents residing on Wings 3 and 4. This deficient practice had the potential to affect 36 residents who resided on wings 3 and 4. (Resident B). Findings include: During an observation on 02/23/18 at 09:48 A.M., Resident B was sitting in his wheelchair in his room facing the door on the secured unit. The resident showed no sign or symptoms of distress. The clinical record for Resident B was reviewed on 02/23/18 at 11:15 A.M. The most recent quarterly MDS (Minimum Data Set) assessment dated 01/24/18 indicated the resident was cognitively moderately impaired. Active diagnoses included, but were not limited to, anxiety and unspecified dementia without behavioral disturbance. There was no wondering exhibited during the assessment period. A facility reported incident dated 02/17/18 was provided by the DON (Director of Nursing) on 02/23/18 at 10:43 A.M. and reviewed at that time. The report indicated RN (Registered Nurse) 2 was notified by a visitor at 06:25 P.M. on 02/16/18 that Resident B was across the street and was continuing to walk with his walker in the opposite direction of the facility...A CNA (Certified Nurse Aide) searched outside the perimeter of the facility. The Administrator and DON were notified. The resident was last seen inside the facility at 06:00 P.M., during dinner. The local police	F 0689	F 689 The facility does maintain a resident environment that is as free of accident hazards as is possible and Residents B is being provided with supervision and assistance to prevent accidents. Resident B has had his elopement assessment revised and has been placed on the secured unit. All residents are at risk for elopement and they all have been re-assessed for elopement risk with review of social service history. All residents have an updated elopement assessment and according to the scores their care plans and assignment sheets will be updated accordingly by a member or members of the IDT. Social Service Designee has been educated on adding resident hx of elopement on current assessment even if it was at prior facility. Social Service Designee has been educated to contacting prior facility regarding prior status if a referral has been made on a patient that has had previous placement elsewhere. DON /Designee will audit 5 resident elopement assessments a week x 4 weeks, then 5 residents elopement assessments monthly X 5 months. Corrective	03/07/2018

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	returned Resident B to the facility at 06:35 P.M. The resident was moved to a secured unit upon return to the facility. An Elopement Risk Assessment for Resident B was provided by the DON on 02/23/18 at 10:54 A.M., and reviewed at that time. The assessment dated 01/25/18 indicated, "...Resident has a history of wandering per the family/legal representative or resident is known to wander aimlessly..." was answered no, with "history" written beside question number two. "...If determined to be "at risk", document below facility intervention/recommendation and awareness/response of legal representative...Resident has has [sic] a history at another facility due to not liking it there, resident has had no attempts since admission here..." A Social Service progress note dated 01/25/18 indicated Resident B has not tried to elope or leave the nursing facility. Family indicated it was a history at a past nursing facility. Resident B's Wandering Care Plan was dated 02/16/18. During an interview on 02/23/18 at 12:27 P.M., the Social Service Director indicated upon admission the family informed her Resident B had once been found out by the road at his previous facility. On the Elopement Risk Assessment dated 01/25/18, question two should have been marked "yes" indicating Resident B had a history of elopement. The current facility policy titled "Elopement Risk Notebook" was provided by the Administrator on 02/23/18 at 11:13 A.M. and was reviewed at that time. The policy indicated, "...If the assessment determines that a resident is at risk for elopement		actions will be taken immediately of any concern. DON/Designee will report the findings to the QA/QAPI committee meeting monthly X 6months if 100% of compliance is not met with the accuracy of the elopement assessments then DON/Designee will continue to audit elopement assessments until 6 months of 100% accuracy is maintained. Date of Completion is 3/ 7/18	

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	the facility Care Plan Team and Administrative Staff will be notified and the resident's name added to the Potential Elopement List Form and a Missing Person Report Part 1 form completed...The resident's care plan is to be updated to ensure wandering and potential for elopement interventions are included..." This Federal tag relates to Complaint IN00254578. 3.1-45(a)(2)			