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	11/29/2016

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00214705 and IN00215068. Complaint IN00214705 - Substantiated. Federal/state deficiencies related to the allegations are cited at F221. Complaint IN00215068 - Substantiated. Federal/state deficiencies related to the allegations are cited at F221. Survey dates: November 28 and 29, 2016 Facility number: 000115 Provider number: 155208 AIM number: 100291080 Census bed type: SNF/NF: 52 Residential: 7 Total: 59 Census payor type: Medicare: 2 Medicaid: 43 Other: 7 Total: 52 Sample: 3	F 0000	¿¿ Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me. ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿	

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 determined that other safegaurds 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.

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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 34233 on November 30, 2016.		¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿ ¿ ¿	
F 0221 SS=D Bldg. 00	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on interview and record review, the facility failed to ensure a resident was free from unnecessary physical restraint (Resident B). Findings include: Resident B's closed clinical record was reviewed on 11/28/2016 at 11:38 p.m. Diagnoses included, but were not limited to, multiple sclerosis and history of falls.	F 0221	F221 Requires the facility to ensure a resident is free from unnecessary physical restraint. 1. Resident B restraint was removed and not reapplied. 2. All residents have the potential to be affected. Rounds were conducted to ensure residents were restraint free or are in the least restrictive environment. No concerns were noted. See below for corrective measures.	11/30/2016

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	Resident B's most recent quarterly Minimum Data Set (MDS) assessment, dated 10/13/2016, indicated a Brief Interview for Mental Status (BIMS) score of 11; indicating he was moderately cognitively impaired. The resident had no physical, verbal, or other behaviors and did not reject care. The resident was non-ambulatory and required total, 2+ person assist for transfers and locomotion (via wheelchair) on and off the unit. A current Care Plan for Resident B, dated 11/4/2016, indicated, "The resident will intentionally slide out of their [sic] wheelchair or chair and onto the floor - Attention-seeking behavior..." There was no evidence anywhere in Resident B's clinical record, or provided by facility staff, which indicated a Physician's Order for restraint use. Resident B's family member was interviewed on 11/28/2016 at 11:46 a.m. and provided photographs of the resident in a wheelchair with a white cloth-like material, which appeared to be a bed sheet, wrapped around his waist and tied behind the back of the wheelchair. The family member indicated they found the resident sitting by an exit door, which led to the smoking area, with 4-5 other		3. The Restraint Use policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the on the above procedure. **4.** The DON or her designee will conduct rounds of the facility to ensure residents are restraint free or are in the least restrictive environment. The DON or her designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is maintained and obtained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before November 30th, 2016 .	

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	residents with the nurse half-way down the hallway. Resident B's family member indicated, "I asked him what he was doing tied up and he said, 'I don't know.' Then his roommate [sitting next to him in the hallway] asked me why he was tied up and I said, I don't know and I got the nurse." Registered Nurse (RN) 2 was interviewed on 11/28/2016 at 12:40 p.m. She indicated she was on duty on 11/14/2016 and observed Resident B sliding down in his wheelchair multiple times during the day. The resident had tardive dyskinesia (involuntary, repetitive body movements), so it was not uncommon for him to slide in his chair. At least two residents observed Resident B tied in his wheelchair and were "upset." Licensed Practical Nurse (LPN) # 3 called her following the incident and told her she had restrained the resident with a sheet and indicated she thought it was a "really bad judgement call." Resident D was interviewed on 11/28/2016 at 12:28 p.m. She indicated she observed Resident B outside in the smoking area with a sheet tied around his waist in his wheelchair. "We were out smoking and they [staff] brought him out with the sheet. It was tight on his stomach and he was pulling at it...I witnessed it for about 15-20 minutes and			

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	they brought the nurse out and she said, 'I know. I did it. I made a mistake.' The family was extremely distraught and some of the staff were just mad." The Social Services Director (SSD) was interviewed on 11/28/2016 at 1:00 p.m. She indicated she came into the facility the evening of the occurrence and saw photos of Resident B tied in the wheelchair, spoke to family members, who were upset about the incident, and interviewed the resident. The SSD indicated, "I almost hit the ceiling [due to restraint use]. I voiced my opinion to [ED] and [DON]. They told me they tied him in because he was sliding down." The SSD indicated Resident B indicated to her he did not remember giving consent to be restrained, and indicated, "He said he didn't like it [being tied up]. They did [tied] him in back so he couldn't get out." The SSD indicated staff alleged the resident was restrained in the wheelchair because the wheelchair was broken. The SSD indicated she had the Maintenance Director inspect the wheelchair the following morning and "there was nothing wrong with it." The Maintenance Director was interviewed on 11/28/2016 at 1:18 p.m. He indicated he inspected Resident B's wheelchair the morning after the incident			

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	and indicated, "Everything seemed like it worked to me." The Maintenance Director indicated the facility had a storage room on Wing One with "all types" of wheelchairs which staff had access to at all times in the event a resident needed a different wheelchair. The Director of Nursing (DON) was interviewed on 11/28/2016 at 2:15 p.m. The DON indicated, "We should do everything we can not to restrain them [residents]. Restraint is the very last thing. I felt it was a bad choice...It was tied behind him... that would be correct, he couldn't release it. It was tied in back...[Resident B's] family was upset...I really didn't see that it was abuse. I looked at it that it could have gone one of two ways; the family could have came [sic] in and saw he was tied and they could have thanked her [nurse] because he was safe and he got to smoke before bed." The Executive Director (ED) was interviewed on 11/28/16 2:35 p.m. He indicated, "She [LPN 3] tried to protect the resident, but it was wrong." A copy of a written statement by Resident B's daughter, an employee of the facility, dated 11/14/2016 at 9:00 p.m., was provided by the ED on			

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	11/28/2016 at 2:41 p.m. The statement indicated, "I...went to take the clients out to smoke and I seen [sic] my dad [Resident B] tied in his wheelchair [and] asked the nurse whey he was like that [and] she told me that his wheelchair was broke [sic]." A copy of a written statement by LPN 3, dated 11/14/2016 [no time indicated], was provided by the ED on 11/28/2016 at 2:41 p.m. The statement indicated, "This is regarding [Resident B] restrain [sic] to chair without an order...tried to get wheel chair to lean back some it would not budge so I asked him if he wanted to lay down he said he wanted to smoke first...So I took a flat sheet and loosely put around resident and tied in back of chair tilt after he smoked..." A copy of a written timeline by the DON, dated 11/14/2016, was provided by the ED on 11/28/2016 at 2:41 p.m. The document indicated, "7:29 p.m. - Rec'd [received] pics [pictures] of [Resident B] in his WC [wheelchair] [with] flat sheet tied around him. Pics sent from ADON [Assistant Director of Nursing]. Pics were sent to her from Resident's [B] daughter...8:05 p.m. - Interviewed [Resident B]. When asked what happened [he] stated 'They tied me in my chair.' When asked who 'they' were,			

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	[Resident B] stated he didn't know. Asked why they tied him in [he] stated 'I don't know. I guess so I wouldn't fall'...When asked him how it felt [he] stated 'Not good'..." The ADON was interviewed on 11/29/2016 at 10:59 a.m. She indicated the facility policy was not to restrain residents and indicated, "There were a million other things they could have done [rather than tie him to his wheelchair with a sheet]." A copy of the current Restraint Use (Physical) Policy and Procedure was provided by the Executive Director on 11/28/2016 at 1:55 p.m. The document indicated, "Policy: Restraint use will be employed only by order of physician with the type of restraint specified in the order. Restraint use will be limited to circumstances in which the resident has a medical symptom that warrants the use of restraint(s). A restraint shall be applied per nursing personnel trained in proper application...Less restrictive measures must have been attempted...shown to be ineffective...Informed consent...must be obtained..." A copy of the current Abuse Prohibition, Reporting and Investigation Policy and Procedure was provided by the Executive			

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	Director on 11/28/2016 at 12:10 p.m. The document indicated, "This facility shall prohibit and prevent abuse, neglect...This includes...freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. Abuse is the willful inflicting of injury, unreasonable confinement...with resulting...mental anguish..." This Federal tag relates to Complaints IN00214705 and IN00215068. 3.1-3(w)			