		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155208	A. BUILDIN B. WING	·	COMPLETED 03/08/2023	
	PROVIDER OR SUPPLIER		410	EET ADDRESS, CITY, STATE, ZIP W LAGRANGE RD NOVER, IN 47243	COD	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	DRRECTION (X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFI	CROSS-REFERENCED TO THE	E APPROPRIATE CONTENTION	
TAG E 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
Bldg	conducted by the Ir accordance with 42 Survey Date: 03/08 Facility Number: 0 Provider Number: 100 At this Emergency Nursing Center was	8/23 000115 155208	E 0000	By submitting the end material, we are not a truth or accuracy of a finding or allegations any proceedings and these responses purs regulatory obligations. The facility requests to forcection be consullegation of complian 4/12/23	admitting the ny specific as part of d submit suant to our chat the plan idered our	
	Medicare and Medi and Suppliers, 42 C The facility has 125 the survey, the cens Quality Review con	icaid Participating Providers CFR 483.73.  5 certified beds. At the time of sus was 66.  mpleted on 03/14/23  42 CFR, Subpart 483.73 is NOT				
E 0039 SS=F Bldg	441.184(d)(2), 48 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requi §416.54(d)(2), §4 §460.84(d)(2), §4 §483.475(d)(2), § §485.625(d)(2), § (2), §491.12(d)(2)	18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)				
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Laura Mace Consultant 04/05/2023

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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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/08/2023	
	PROVIDER OR SUPPLIED			410 W L	DDRESS, CITY, STATE, ZIP COD AGRANGE RD ER, IN 47243		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:  (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:  (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based						
	functional exercise every 2 years; or (B) If the [facility] experiences an actual						
		ade emergency that requires					
		emergency plan, the [facility]					
		ngaging in its next required					
		l or individual, facility-based					
	functional exercis	e following the onset of the					
	actual event.						
	` '	lditional exercise at least					
		posite the year the full-scale					
		cise under paragraph (d)(2)					
		is conducted, that may tilmited to the following:					
	· ·	scale exercise that is					
	` '	d or individual, facility-based					
	functional exercis						
	(B) A mock disast						
		ercise or workshop that is					
	led by a facilitator	and includes a group					
	discussion using						
	1	emergency scenario, and a					
		atements, directed					
		pared questions designed					
	to challenge an e						
		acility's] response to and					
		ntation of all drills, tabletop					
	exercises, and emergency events, and revise						

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Event ID:

044I21

Facility ID: 000115

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		155208	B. W	NG		03/08	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			_AGRANGE RD		
HANOVE	ER NURSING CENT	ΓER		HANOVER, IN 47243			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the [facility's] eme	rgency plan, as needed.					
	*r=	440,440/101					
	*[For Hospices at	·					
	. ,	spices that provide care in					
		e. The hospice must					
	conduct exercises to test the emergency plan at least annually. The hospice must do						
	the following:						
	(i) Participate in a full-scale exercise that is						
	community based every 2 years; or						
		nunity based exercise is not					
	accessible, conduct an individual facility						
	based functional exercise every 2 years; or						
	(B) If the hospice experiences a natural or						
	man-made emerg	ency that requires activation					
	of the emergency	plan, the hospital is					
	exempt from enga	aging in its next required full					
	scale community-	based exercise or individual					
		ctional exercise following the					
	onset of the emer						
	, ,	dditional exercise every 2					
		e year the full-scale or					
		e under paragraph (d)(2)(i)					
		conducted, that may					
		limited to the following:					
	' '	scale exercise that is					
		or a facility based					
	functional exercise (B) A mock disas						
	' '	ercise or workshop that is					
	, ,	and includes a group					
	discussion using a	• .					
	_	emergency scenario, and a					
	set of problem sta	•					
		pared questions designed					
	to challenge an er						
	]						
	(3) Testing for hos	spices that provide inpatient					
	care directly. The	hospice must conduct					
	exercises to test t	he emergency plan twice					

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Event ID:

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED 03/08/2023	
	F PROVIDER OR SUPPLIE		410 W	T ADDRESS, CITY, STATE, ZIP COD V LAGRANGE RD DVER, IN 47243	•	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPR	D BE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	1 ' '	spice must do the following:				
		an annual full-scale exercise				
	that is community					
	' '	nunity-based exercise is not uct an annual individual				
		ctional exercise; or				
		experiences a natural or				
		gency that requires activation				
		plan, the hospice is				
	exempt from enga	aging in its next required				
		nity based or facility-based				
		e following the onset of the				
	emergency event					
	(ii) Conduct an additional annual exercise that may include, but is not limited to the					
	following:	but is not limited to the				
	•	-scale exercise that is				
	' '	d or a facility based				
	functional exercis	-				
	(B) A mock disas					
	` '	kercise or workshop led by a				
	facilitator that incl	ludes a group discussion				
	-	clinically-relevant				
		ario, and a set of problem				
		ted messages, or prepared				
	· ·	ed to challenge an				
	emergency plan.	pospicals response to and				
		nospice's response to and ntation of all drills, tabletop				
		nergency events and revise				
		ergency plan, as needed.				
	· '	<u> </u>				
		441.184(d), Hospitals at				
	§482.15(d), CAH:	· , , <u>-</u>				
	` '	PRTF, Hospital, CAH] must				
		s to test the emergency				
	CAH] must do the	ar. The [PRTF, Hospital,				
	_	an annual full-scale exercise				
	(1) i di dopate il i	an annual fair board oxoroide	1			I

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Event ID:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155208		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	TE SURVEY  MPLETED  08/2023	
	PROVIDER OR SUPPLIEF		410 W	ADDRESS, CITY, STATE, ZIP LAGRANGE RD VER, IN 47243	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	accessible, condu- facility-based funct (B) If the [PRTF, I- an actual natural of that requires activ- plan, the [facility] its next required from individual, facility following the onset (ii) Conduct accessed or and the limited to the follor (A) A second full- community-based facility-based function (B) A moderate (C) A tableton is led by a facilitate discussion, using clinically-relevant set of problem star messages, or precedent to challenge an endition (B) Analyze the conduction and revise the [fact and maintain document to the following that its community (C) Testing. The Fronduct exercises plan at least annuor or ganization must (i) Participate in a that is community (A) When a community (A) When a community (A) When a community (B) the fact and the fact a	nunity-based exercise is not an annual individual, ctional exercise; or Hospital, CAH] experiences or man-made emergency ation of the emergency is exempt from engaging in cull-scale community based ty-based functional exercise of the emergency event. In an [additional] annual that may include, but is not wing: escale exercise that is or individual, a ctional exercise; or lock disaster drill; or exercise or workshop that for and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. The [facility's] response to the included of				

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Facility ID: 000115

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. BUILI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/08/2023	
NAME OF I	PROVIDER OR SUPPLIE	3			DDRESS, CITY, STATE, ZIP COD AGRANGE RD		
HANOVE	ER NURSING CEN	TER	ŀ	HANOVER, IN 47243			
(X4) ID		STATEMENT OF DEFICIENCIE		D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E APPROPRIATE COM I	
TAG	<b>†</b>	R LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)		DATE
		ctional exercise; or					
		xperiences an actual natural ergency that requires					
	activation of the emergency plan, the PACE is exempt from engaging in its next required						
	full-scale commun						
	facility-based fund						
	onset of the emer						
		an additional exercise every					
	2 years opposite						
	functional exercise under paragraph (d)(2)(i)						
		conducted that may include,					
	but is not limited t						
	(A) A second full-						
	community-based or individual, a facility						
	based functional	exercise; or					
	(B) A mock disas	ter drill; or					
	(C) A tabletop ex	ercise or workshop that is					
		and includes a group					
	discussion, using						
	•	emergency scenario, and a					
		atements, directed					
		pared questions designed					
	to challenge an e						
		PACE's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
	ule PACE'S emer	gency plan, as needed.					
	*[For LTC Facilitie	es at §483.73(d):]					
	_	ity] must conduct exercises					
	to test the emerge	ency plan at least twice per					
	year, including un	announced staff drills using					
		ocedures. The [LTC facility,					
	ICF/IID] must do t	•					
	1 ' '	an annual full-scale exercise					
	that is community						
	` '	nunity-based exercise is not					
		ıct an annual individual,					
	facility-based functional exercise.						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/08/2023	
	PROVIDER OR SUPPLIER	ER	410 W I	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD /ER, IN 47243	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	actual natural or n requires activation LTC facility is exerequired a full-sca individual, facility-following the onse (ii) Conduct an act that may include, following:  (A) A second full-community-based based functional exercises for problem stares of problem star	ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a tements, directed bared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency ethe [LTC facility] facility's as needed.  483.475(d)]: CF/IID must conduct me emergency plan at least e ICF/IID must do the			

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PRINTED: 04/13/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPI	LETED
		155208	B. WING		03/08	/2023
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	3		LAGRANGE RD		
HANOVE	ER NURSING CENT	ΓER		/ER, IN 47243		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	l '	ngaging in its next required				
		nity-based or individual,				
	facility-based fund	ctional exercise following the				
	onset of the emer	gency event.				
	(ii) Conduct an ad	lditional annual exercise				
	that may include,	but is not limited to the				
	following:					
	(A) A second full-	scale exercise that is				
	community-based or an individual, facility-based functional exercise; or					
(B) A mock disaster drill; or						
	(C) A tabletop exercise or workshop that is					
	led by a facilitator	and includes a group				
	discussion, using					
	clinically-relevant	emergency scenario, and a				
	set of problem sta					
	messages, or pre	pared questions designed				
	to challenge an e					
	(iii) Analyze the IC	CF/IID's response to and				
	maintain docume	ntation of all drills, tabletop				
		nergency events, and revise				
	the ICF/IID's eme	rgency plan, as needed.				
	   *[For HHAs at §48	34.102]				
	-	e HHA must conduct				
		he emergency plan at				
		e HHA must do the				
	following:					
	(i) Participate in a	full-scale exercise that is				
	community-based					
		ommunity-based exercise				
	` '	conduct an annual				
		based functional exercise				
	every 2 years; or.					
		A experiences an actual				
	` '	ade emergency that requires				
		mergency plan, the HHA is				
		aging in its next required				

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full-scale community-based or individual, facility based functional exercise following the

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ì í	ULTIPLE CO JILDING	ONSTRUCTION 	(X3) DATE COMPI	
		155208	B. W.	ING		03/08	/2023
	PROVIDER OR SUPPLIEF			410 W I	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD (ER, IN 47243		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCE		DATE
	onset of the emer						
	` '	ditional exercise every 2					
		e year the full-scale or					
		e under paragraph (d)(2)(i) conducted, that may					
	of this section is c						
	include, but is not limited to the following:  (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or						
	(B) A mock disaster drill; or						
	\ ,	o exercise or workshop that					
	, ,	•					
	is led by a facilitator and includes a group discussion, using a narrated,						
	clinically-relevant emergency scenario, and a						
	set of problem sta						
	1	pared questions designed					
	to challenge an er	· · · · · · · · · · · · · · · · · · ·					
		HA's response to and					
	. , .	ntation of all drills, tabletop					
		nergency events, and revise					
		ency plan, as needed.					
		, p.a, ao					
	*[For OPOs at §48	86.360]					
	(d)(2) Testing. The	e OPO must conduct					
	exercises to test t	he emergency plan. The					
	OPO must do the	following:					
	(i) Conduct a pape	er-based, tabletop exercise					
	or workshop at lea	ast annually. A tabletop					
	exercise is led by	a facilitator and includes a					
	group discussion,	using a narrated, clinically					
	relevant emergen	cy scenario, and a set of					
	problem statemen	its, directed messages, or					
	prepared question	ns designed to challenge an					
	emergency plan. I	If the OPO experiences an					
	actual natural or n	nan-made emergency that					
		n of the emergency plan, the					
	OPO is exempt fro	om engaging in its next					
	1	xercise following the onset					

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of the emergency event.

(ii) Analyze the OPO's response to and

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CON	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	<del></del>	COMPL	ETED
		155208	B. WING			03/08/	2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	)	DROVIDEDIC DI AN OF CORDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TA	.G	DEFICIENCY)	16	DATE
	maintain documer exercises, and em the [RNHCl's and needed.  *[RNCHIs at §403 (d)(2) Testing. The exercises to test the RNHCl must do the (i) Conduct a paper at least annually. A group discussion I narrated, clinically scenario, and a sed directed message designed to challe (ii) Analyze the RN maintain documer exercises, and em the RNHCl's emer Based on record reversited to conduct explan at least twice punannounced staff of procedures. The LT following:  (i) Participate in an is community-based a. When a community-based function in the LTC facility or man-made emergence.	atation of all tabletop bergency events, and revise OPO's] emergency plan, as  3.748]: a RNHCI must conduct the emergency plan. The be following: ber-based, tabletop exercise a tabletop exercise is a bed by a facilitator, using a ber-relevant emergency bet of problem statements, ber, or prepared questions bergency events, and revise bergency events, and revise bergency plan, as needed. bergency plan, as needed. bergency plan, as needed. bergency events, and revise bergency plan, as needed. bergency events, and revise bergency plan, as needed. bergency plan,		G	CROSS-REFERENCED TO THE APPROPRIA	ere ed will ng ased	
	of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following				been scheduled for completion	n on	
					4-17-23 The Administrator or designed	. vazill	
					The Administrator or designee monitor that the exercise is	WIII	
	the onset of the actu	-					
		itional exercise that may			completed according to the	ill	
					regulation. This monitoring w		
1	menuae, out is not if	imited to the following:	1		occur weekly times four weeks	j .	

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Facility ID: 000115

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. BUIL	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/08/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID REFIX TAG	ΓE	(X5) COMPLETION DATE		
IAG	a. A second full-sca community-based of functional exercise. b. A mock disaster of c. A tabletop exercifacilitator that inclu a narrated, clinically and a set of problem messages, or prepar challenge an emerge (iii) Analyze the LT maintain documentate exercises, and emer LTC facility's emergaccordance with 42 This deficient praction the facility.  Findings include:  Based on review of plan on 03/08/23 be with the Administrate Activity Director provide documentated dated 06/22/22, how provide documentated exercise performed period. This was correcord review.	le exercise that is r an individual, facility-based drill; or se or workshop that is led by a des a group discussion, using y-relevant emergency scenario, a statements, directed ed questions designed to ency plan.  C facility's response to and ation of all drills, tabletop gency events, and revise the gency plan, as needed in		IAG	then monthly times 5 months. he findings of the monitoring was be reported to the QAPI committee monthly at the QAPI meeting by the maintenance director or designee times six months. if 100% compliance hand been achieved this will continue until the threshold is met.	PI	DATE	
E 0041 SS=F Bldg	conference.  482.15(e), 483.73 Hospital CAH and §482.15(e) Condit (e) Emergency an							

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Facility ID: 000115

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	(X2) MULT A. BUILD B. WING		NSTRUCTION	(X3) DATE : COMPL 03/08/	ETED
	ROVIDER OR SUPPLIER		4	10 W L	DDRESS, CITY, STATE, ZIP COD AGRANGE RD ER, IN 47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	emergency plan s this section and in	et forth in paragraphs (b)(1)					
	The [LTC facility a implement emerge systems based on	625(e) d standby power systems. and the CAH] must ency and standby power the emergency plan set (a) of this section.					
	Emergency gener generator must be the location requir Care Facilities Co Interim Amendme 12-4, TIA 12-5, an Code (NFPA 101 Amendments TIA	e located in accordance with rements found in the Health de (NFPA 99 and Tentative nts TIA 12-2, TIA 12-3, TIA ad TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new r when an existing					
	Emergency gener The [hospital, CAI implement the em inspection, testing requirements foun	3.73(e)(2), §485.625(e)(2) ator inspection and testing. H and LTC facility] must ergency power system I, and [maintenance] Ind in the Health Care FPA 110, and Life Safety					
	Emergency gener and LTC facilities] source to power e	3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel mergency generators must w it will keep emergency					

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	MENT OF DEFICIENCIES  AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION  G <u></u>	COM	te survey ipleted 08/2023
	OF PROVIDER OR SUPPLIED		410	EET ADDRESS, CITY, STATE, ZIP CO W LAGRANGE RD NOVER, IN 47243	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE AI	OULD BE	(X5) COMPLETION DATE
		perational during the				
	§483.73(g), and O The standards incomposed the section are apprehensed by the I Federal Register 552(a) and 1 CFF the material from You may inspect Information Reson Boulevard, Baltim Archives and Recomposed (NARA). For information this material at Nargo to: http://www.archive_of_federal_regul If any changes in incorporated by redocument in the Federal announce the chargonic (1) National Fire Federal Batterymarch Parel Quincy, MA 0216 1.617.770.3000. (i) NFPA 99, Head 2012 edition, issued (iii) Technical interest NFPA 99, issued (iii) TIA 12-3 to NI 2012. (iv) TIA 12-4 to NI 2013. (v) TIA 12-5 to NF 2013.	Protection Association, 1 rk, 9, www.nfpa.org, Ith Care Facilities Code, ed August 11, 2011. rim amendment (TIA) 12-2 to				

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PRINTED: 04/13/2023 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB N	IO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SUR	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155208	B. WING	·	03/08/20	23
NAME OF I	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD		
				LAGRANGE RD		
HANOVE	ER NURSING CENT	IER	HANO	VER, IN 47243		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	С	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	'E	DATE
	(vii) NFPA 101, Li	fe Safety Code, 2012				
	edition, issued Au					
		IFPA 101, issued August				
	11, 2011.					
	(ix) TIA 12-2 to NF	FPA 101, issued October				
	30, 2012.	•				
	(x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013.					
	(xiii) NFPA 110, S	tandard for Emergency and				
	Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.					
	Based on record rev	view and interview, the facility	E 0041	The facility ensures that there	is a 0	04/12/2023
	failed to implement	the emergency power system		written record of weekly		
	inspection, testing,	and maintenance requirements		inspections for the generator.		
	found in the Health	Care Facilities Code, NFPA		1). This testing ensures that t	here	
	110, and Life Safety	y Code in accordance with 42		is a plan in place for how it wil	I	
	CFR 483.73(e)(2).			keep emergency power system	ns	
				operational during emergencie	es	
	Based on record	review and interview, the		2).The generator was tested a	ind a	
	facility failed to ens	sure a written record of weekly		written record of monthly gene	rator	
	inspections for 1 of	1 generator was maintained		load testing will be completed		
		Chapter 6-4.4.1.3 of 2012		monthly.		
	NFPA 99 requires b	patteries for on-site generators		The maintenance department	will	
		in accordance with NFPA 110,		receive re-education in servici		
		lard for Emergency and		on testing the generator wee	kly	
	, ,	tems. 8.3.7 requires storage		and conduct the additional wri	tten	
		electrolyte levels or battery		load testing monthly .		
	~ .	nnection with systems shall be		To ensure weekly testing and		
		nd maintained in full		monthly load testing is comple		
		anufacturer's specifications.		as required , the Administrator	or	
		tive batteries shall be repaired		designee will monitor that the		
	_	ately upon discovery of		testing is completed according	·	
		5.4.2 of NFPA 99 requires a		the regulation. This monitoring	-	
		spection, performance,		will occur weekly times four we	eeks	
		and repairs shall be regularly		then monthly times 5 months.		
		ilable for inspection by the		The findings of the monitoring	will	
	authority having jur	risdiction. This deficient		be reported to the QAPI		

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Event ID:

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	lì í	UILDING	NSTRUCTION	(X3) DATE COMPL 03/08/	ETED		
	PROVIDER OR SUPPLIEF			410 W I	ADDRESS, CITY, STATE, ZIP COD _AGRANGE RD 'ER, IN 47243				
(X4) ID PREFIX TAG	(EACH DEFICIEN	EFICIENCY MUST BE PRECEDED BY FULL		SUMMARY STATEMENT OF DEFICIENCIE EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	practice could affect visitors.  Findings include:  Based on review of reports on 03/08/23 p.m. with the Admi Activity Director produce of the most recent of interview at the times and the generator deveck, however, the person on a consist several months to devercises.  This finding was redirector, and Compare the conference.  3.1-19(b)  2. Based on record facility failed to mand of monthly generate generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of the generator during 4 of 6.4.4.1.1.4(a) of 20 testing of 6.4.4.1.1.4(a) of 20 te	It the generator inspection between 9:15 a.m. and 4:00 mistrator-In-Training (AIT) and resent, there was no lable to show the emergency exted/tested weekly during 12 i2 week period. Based on e of record review, the AIT loes start automatically every re has not been a maintenance ent basis during the past ocument the weekly generator  viewed with the AIT, Activity bany Consultant during the exit  review and interview, the intain a complete written record or load testing for 1 of 1 of the past 12 months. Chapter 12 NFPA 99 requires monthly ator serving the emergency be in accordance with NFPA or Emergency and Standby hapter 8. Chapter 6.4.4.2 of a written record of inspection, ising period, and repairs for the ularly maintained and available			committee monthly at the QAI meeting by the maintenance director or designee times six months. if 100% compliance in not been achieved this will continue until the threshold is met.	기			
	jurisdiction. Chapt	er 6-4.4.1.3 of 2012 NFPA 99 or on-site generators shall be							

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155208	 JILDING	NSTRUCTION	COMPL 03/08/	ETED
	PROVIDER OR SUPPLIER		410 W L	ddress, city, state, zip cod AGRANGE RD ER, IN 47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Edition, Standard for Power Systems. 8.3 including electrolytused in connection of inspected weekly are compliance with ma 8.3.7.2 states defect or replaced immedia defects. Chapter 6.3 written record of insexercising period, a maintained and availauthority having jurpractice could affect.  Based on record revalum, and 4:00 p.m. Administrator-In-Trunicator present, the load test documenta and December of 20 of 2023. Based on review, the AIT conference with the previously ment 2023. Based on intereview, the AIT said maintenance person the past several mongenerator load test have a several mongenerator load test for the previously was review.	riew on 03/08/23 between 9:15 with the raining (AIT) and Activity ere was no monthly generator tion available for November 122, and January and February interview at the time of record affirmed there was no or load test documentation for ioned months in 2022 and erview at the time of record at there has not been a on a consistent basis during this to ensure a monthly				

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	OF CORRECTION  OF CORRECTION  155208	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/08/2023
	PROVIDER OR SUPPLIER ER NURSING CENTER	410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0000				
Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).  Survey Date: 03/08/23  Facility Number: 000115 Provider Number: 155208 AIM Number: 100291080  At this Life Safety Code survey, Hanover Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA)101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.  This one story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 125 and had a census of 66 at the time of this visit.  All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has a detached wooden storage garage and a detached wooden building housing the emergency generator which were not sprinkled.  Quality Review completed on 03/14/23	K 0000	By submitting the enclosed material, we are not admitting truth or accuracy of any specifinding or allegations as part any proceedings and submit these responses pursuant to regulatory obligations.  The facility requests that the of correction be considered or allegation of compliance effect 4/12/23	ific of t our plan ur

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	COM	TE SURVEY MPLETED 08/2023
	PROVIDER OR SUPPLIEF		410 W	ADDRESS, CITY, STATE, ZIP C LAGRANGE RD /ER, IN 47243	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 0222 SS=E Bldg. 01	be equipped with requires the use of egress side unless special locking and CLINICAL NEEDS LOCKING Where special locking and used, only one lock permitted on each be made for the raby: remote control locks or keys carnother such reliable staff at all times. 18.2.2.2.5.1, 18.2. 19.2.2.2.6 SPECIAL NEEDS ARRANGEMENT Where special lock safety needs of the the Clinical or Secare being met. In electrical locks that release upon loss building is protect automatic sprinkles space is protected detection system at an attended lock space); and both in the clinical locks that release is protected detection system at an attended lock space); and both in the clinical locks that release is protected detection system at an attended lock space); and both in the clinical locks that release is protected detection system at an attended lock space); and both in the clinical locks that release is protected detection system at an attended lock space); and both in the clinical locks that release upon loss building is protected detection system at an attended lock space); and both in the clinical locks that release upon loss building is protected detection system at an attended lock space); and both in the clinical locks that release upon loss building is protected detection system at an attended lock space); and both in the clinical locks that release upon loss building is protected detection system at an attended lock space); and both in the clinical locks that release upon loss building is protected detection system at an attended lock space).	king arrangements for the geds of the patient are sking device shall be a door and provisions shall apid removal of occupants of locks; keying of all ged by staff at all times; or a means available to the second of power to the locks must be at fail safely so as to of power to the device; the ged by a supervised or system and the locked of by a complete smoke (or is constantly monitored station within the locked of the sprinkler and detection ged to unlock the doors successful as a complete smoke (as a constantly monitored station within the locked of the sprinkler and detection ged to unlock the doors successful as a complete smoke (as a complete smoke) (as a complete smok				

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/08/2023
	PROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	systems installed 7.2.1.6.1 shall be assemblies servin contents in buildin an approved, supe detection system of automatic sprinkled 18.2.2.2.4, 19.2.2. ACCESS-CONTR LOCKING ARRAN Access-Controlled installed in accord be permitted. 18.2.2.2.4, 19.2.2. ELEVATOR LOBE LOCKING ARRAN Elevator lobby exi accordance with 7 on door assemblied throughout by an a automatic fire dete approved, supervi system. 18.2.2.2.4, 19.2.2. Based on observation	g low and ordinary hazard gs protected throughout by ervised automatic fire or an approved, supervised or system.  2.4  OLLED EGRESS  NGEMENTS  I Egress Door assemblies ance with 7.2.1.6.2 shall  2.4  BY EXIT ACCESS  NGEMENTS  I access door locking in 1.2.1.6.3 shall be permitted es in buildings protected approved, supervised ection system and an seed automatic sprinkler  2.4  on and interview, the facility	K 0222	The facility ensures the mean	
	11 locked exit doors residents, staff, and	means of egress through 1 of s was readily accessible for visitors. This deficient t at least 20 residents, as well		egress of locked exit doors ar readily accessible for residen staff, and visitors. the code was posted on the keypad. All exit doors (11) audited. Co	ts,
	during a tour of the Director, the smokin magnetically locked entering a code on a	ons on 03/08/23 at 11:55 a.m. facility with the Activity ag area exit door was and could only be opened by a keypad located adjacent to ode to open the exit door was		were posted at each keypad. Any resident visitors or staff in area of the 11 exit doors have potential to be affected by this finding. There were no advers effects reported by residents' visitors, or staff.	n the the se

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JENTERS FOR	MEDICARE & MEDIC	AID SERVICES				<u>OM</u>	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155208	B. WI	ING		03/08/	/2023
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP COD  LAGRANGE RD		
HANOVE	R NURSING CENT	ΓER		HANO\	VER, IN 47243		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	'E	DATE
	not posted anywher	re near the keypad. Based on			To ensure Codes are posted, t	the	
	interview at the time	e of observation, the Activity			Administrator or designee will		
		the code was not posted			monitor that the codes, accord		
	anywhere near the l	-			to the regulation are posted at	_	
	,	31			each exit door that has a		
	This finding was re	viewed with the			keypad. This monitoring will		
	_	raining, Activity Director, and			occur daily times four weeks,		
		nt during the exit conference.			weekly times 4 weeks then		
					monthly times 4 months.		
	3.1-19(b)				Internally arrives i menane.		
	5.1 15(0)				The findings of the monitoring	will	
					be reported to the QAPI		
					committee monthly at the QAF	)	
					meeting by the maintenance		
					director or designee times six		
					months. if 100% compliance h	as	
					not been achieved this will	40	
					continue until the threshold is		
					met.		
					inet.		
K 0281	NFPA 101						
SS=E	Illumination of Me	ans of Egress					
Bldg. 01	Illumination of Me	ans of Egress					
	Illumination of me	ans of egress, including exit					
	discharge, is arrar	nged in accordance with 7.8					
	and shall be eithe	r continuously in operation					
	or capable of auto	matic operation without					
	manual intervention						
	18.2.8, 19.2.8						
	Based on observation	on and interview, the facility	K 0	281	The facility ensures the exit		04/12/2023
	failed to ensure 1 of	f 11 exit means of egress was			means of egress are properly		
		d would not leave the area in			lighted and will not leave the		
		1.4 requires illumination shall			facility in darkness.		
		that the failure of any single			The exit across the small dinir	ng	
	_	ot result in an illumination			room now provides exterior lig	•	
		2 foot-candle in any			outside of the exit door.	9	
		nis deficient practice could			An audit was conducted at ea	ch	
		sidents as well as staff and			exit to assure adequate lighting		
	visitors in the event				provided	9 15	

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The maintenance director will

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	l í	UILDING	nstruction 01	(X3) DATE : COMPL 03/08/	ETED
	PROVIDER OR SUPPLIER			410 W L	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD (ER, IN 47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	during a tour of the Director, the exit ac Room was not provoutside the exit door time of observation, there needs to be ex outside this exit door	ons on 03/08/23 at 11:40 a.m. facility with the Activity ross from the Small Dining ided with exterior lighting r. Based on interview at the the Activity Director agreed terior lighting provided or.			receive in service education the alerts him to this regulation. the administrator or designee monitor ongoing compliance weekly times four weeks then monthly times five months. The monitoring will be conduct monthly times six months, the findings of the monitoring will reported to the Qapi committ monthly at the QAPI meeting the main as director or his designee pe if 100% compliant has not been achieved this will continue until the threshold has been met.	will ted  be ee by ce	
K 0324 SS=E Bldg. 01	Ventilation Contro Commercial Cook * residential cooking appliances such a toasters) are used cooking in accorda 19.3.2.5.2 * cooking facilities smoke compartme patients comply w 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer patients conditions under 1 Cooking facilities NFPA 96 per 9.2.3	IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ing equipment (i.e., small s microwaves, hot plates, for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer ith the conditions under 5.3, or in smoke compartments atients comply with 8.3.2.5.4, 19.3.2.5.4. orotected according to 3 are not required to be dous areas, but shall not					

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044121

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	A. B	IULTIPLE CO UILDING 'ING	onstruction 01	(X3) DATE COMPI <b>03/08</b>	LETED
	PROVIDER OR SUPPLIER			410 W I	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD /ER, IN 47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION 1.18.3.2.5.4.19.3.2.5.1		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE PRIATE	(X5) COMPLETION DATE
	through 19.3.2.5.8 Based on observation failed to ensure the Room was shut off LSC 19.3.2.5.4 stat residential or commis used to prepare in shall be permitted, in facility complies with the space contains not a sleeping root (2). The space contains not a sleeping root (2). The space contains and the separated from from the space contains and the separated from from the space contains and (13). The requirement and (13) are met. 19.3.2.5.3(9) states following is provided (a). A locked switch restricted location, facility that deactive (b). The switch is used or range whenever supervision.  This deficient pract residents while in the same of the Director, there was activity Room. Withis stove top appliate the individual cook interview at the time.	on and interview, the facility cook top in 1 of 1 Activity at the switch when not in use. The switch when not in use are within a smoke compartment, and also for 30 or fewer persons provided that the cooking equipment that the following conditions: the all the following conditions: the all the following equipment form.  In the cooking equipment form the corridor by partitions 3.6.2 through 19.3.6.5. The of 19.3.2.5.3(1) through (10)  A switch meeting all the edd:  In or a switch located in a set is provided within the cooking for the kitchen is not under staff the kitchen is not under staff the Activity Room.  The Activity Room.  The Activity Room is not in use, ance was not deactivated from top power source. Based on the of observation, the Activity the cooktop stove was not	K	0324	The facility ensures that the cooktop stove is shut off word in use.  The cook top stove was soff immediately.  Any residents in the Activity room could have potential been affected by this finding All activities staff received servicing to ensure that the cook top stove is disengate when not in use. The administrator or design will monitor to ensure that cook top stove is turned of when not used. The monitor will take place weekly Time four weeks then monthly the five months.  The findings of the monitor will be reported to the QAF committee monthly at the meeting by the administrated designee times six months 100% compliance is not achieved this will occur unthe threshold has been meeting by the administrated achieved this will occur unthe threshold has been meeting by the administrated achieved this will occur unthe threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the administration of the threshold has been meeting by the admin	when hut ity ly ng. l re-in ne ged gnee the ff oring es imes oring Pl QAPI tor or s. if	04/12/2023

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/08/2023
	PROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		viewed with the raining, Activity Director, and nt during the exit conference.			
K 0347 SS=F Bldg. 01	spaces open to consider the spaces open to consider the spaces open to consider the spaces of the spaces open to consider the spaces open to consider the spaces of the spaces open to compare the spaces open to compare the spaces open to compare the spaces open the spaces open to compare the spaces open the spaces ope	complete for the preventative of 79 battery operated smoke doms, plus an unknown perated smoke alarms in other the facility. NFPA 101 in ing life safety features obvious required by the Code, shall be efficient practice could affect all staff and visitors.	K 0347	The facility ensures documentation is completed for the preventative maintenance battery-operated smoke alarm resident rooms.  The battery-operated smoke alarms have been tested in all resident sleeping rooms, with documentation.  All residents had the potential be affected by this finding.  The maintenance director has received in service training relito monthly testing and documentation of all battery-operated smoke alarms. The administrator or designee monitor that battery operated smoke alarms testing is being conducted and completed as required.  The monitoring will be conducted monthly times six months, the findings of the monitoring will be reported to the QAPI commit monthly at the QAPI meeting is	of s in  to  ated  s will  cted  be tee

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE S COMPLI 03/08/2	ETED
	PROVIDER OR SUPPLIER ER NURSING CENT		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	during a tour of the Director, battery op observed in all resid This finding was re Director, and Comp conference.	en 9:15 a.m. and 4:00 p.m. facility with the Activity erated smoke alarms were dent sleeping rooms.  viewed with the AIT, Activity pany Consultant during the exit		the main as director or his designee if 100% compliance has not be achieved this will continue unt threshold has been met.		
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location ar	<u> </u>				
	coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, 1. Based on record interview; the facili system inspections for 1 of 1 dry sprink weeks. NFPA 25, S. Testing, and Mainte Protection Systems,	•	K 0353	The facility does inspect and document dry sprinkler system gauges weekly per regulation sprinkler control valves month The facility does ensure ceiling sprinklered smoke compartme are maintained to allow sprink heads to function to their full	and ly. gs in ents	04/12/2023

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 03/08/2023	
	ROVIDER OR SUPPLIER		410 W	CADDRESS, CITY, STATE, ZIP COD V LAGRANGE RD OVER, IN 47243	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		y to ensure that normal air and being maintained. Section		capacity.  All residents had the potentia	ul to
	5.1.2 states valves a	_		be affected by this finding.	11 10
		e inspected, tested, and		The dry sprinkler system gau	ges
		dance with Chapter 13.		were inspected with	
		tes Table 13.1.1.2 shall be		documentation and continue	to be
		on, testing and maintenance of		done weekly; the sprinkler co	
	valves, valve compo	onents and trim. Section 4.3.1		valve was inspected with	
	states records shall	be made for all inspections,		documentation and is done	
	tests, and maintenar	nce of the system and its		monthly.	
	components and sha	all be made available to the		The Wing 2 DR ceiling drywa	ıll
		risdiction upon request. This		patch was repaired and the	
deficient practice could affect all residents, staff,			opening properly sealed as w	<i>r</i> as	
and visitors in the facility.			the other noted opening. The	е	
				holes in the ceiling in the	
	Findings include:			Electrical Room across from	the
				large DR were repaired and t	l l
		view on 03/08/23 between 9:15		holes around the water lines/	
	a.m. and 4:00 p.m.			and wire bundles were prope	rly fire
		raining (AIT) and Activity		stopped.	
	-	ere was no documentation		The maintenance director ha	
		ne facility's dry sprinkler		received in service training re	
		inspected weekly during the		to inspecting dry sprinkler sy	stem
		l, and sprinkler control valves		gauges and sprinkler control	
		past 12 month period. Based		valves as well as ensuring ce	eilings
		time of record review, the AIT s no documentation available		in sprinklered smoke	.
				compartments are maintaine	
		ility's sprinkler gauges have ast weekly during the past 52		The administrator or designe	e wiii
	•	ast weekly during the past 32  akler control valves inspected		monitor the inspecting dry	
	_	ring the past 12 month period.		sprinkler system gauges and sprinkler control valves as we	
	_	ons with the Activity Director		ensuring ceilings in sprinkler	
		facility between 9:15 a.m. and		smoke compartments are	- C
	_	y had four pressure gauges at		maintained.	
	the sprinkler riser.	J To al Problem Gauges at		The monitoring will be condu	ucted
	sprimerer riser.			monthly times six months. the	
	This finding was re	viewed with the		findings of the monitoring will	l l
	_	raining, Activity Director, and		reported to the QAPI comm	
		nt during the exit conference.		monthly at the QAPI meeting	
	• •	C		the main as director or his	

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPL		ETED		
		155208	B. WING 03/08/2023			/2023	
			I	STDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				AGRANGE RD		
ΗΔΝΟ\/⊏	R NURSING CENT	FR		l	'ER, IN 47243		
IIANOVE	IN NORGING CENT	LIX		IIANOV	LIX, IIV 41240		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3.1-19(b)				designee		
					if 100% compliance has not b		
		ation and interview, the			achieved this will continue unti	I the	
	_	ure the ceiling in 2 of 10			threshold has been met.		
	_	compartments was maintained					
	-	eads to function to their full					
		icient practice could affect at					
	least 30 residents, st	taff, and visitors.					
	Findings include:						
	D 1 1 2	02/00/22 1 / 0.15					
		ons on 03/08/23 between 9:15					
	_	during a tour of the facility with					
	•	r, the following was noted:					
	_	ng room had approximately a					
	-	t ceiling drywall patch that was					
		d. The edge of the drywall					
	_	d leaving a three foot long by					
		the attic space. Also, there					
		ich opening along another					
	edge.						
		oom across from the large					
	_	o, six inch holes in the ceiling					
		es and wire bundles running					
	_	The holes around the water					
		bundles were not properly					
	fire stopped.						
	Based on interview						
		tivity Director acknowledged					
		les into the attic space at the					
		ed areas of the facility and					
	agreed they were no	ot properly fire stopped.					
	This finding was rev						
		raining, Activity Director, and					
	Company Consultar	nt during the exit conference.					
	3.1-19(b)						
			1				I

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155208		A. BUILDING B. WING	01	COMPLETED 03/08/2023	
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243	4	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0355 SS=F Bldg. 01	installed, inspected accordance with N Portable Fire Extir 18.3.5.12, 19.3.5.1. Based on observation of the Director, the ABC to in the Supply Room Office had affixed in the Extinguishers with the agency performed as Decenerating under the extinguisher with the Supply Room Office had affixed in the Extinguishers in the Extinguisher with the Supply Room Office had affixed in the Extinguishers in the extinguisher extinguishers in the extinguisher	anguishers guishers are selected, d, and maintained in IFPA 10, Standard for aguishers.  12, NFPA 10 ation and interview, the ure 1 of 31 portable fire ocumented annual ordance with NFPA 10. LSC and fire extinguishers shall be anspected and maintained in IPA 10. NFPA 10, Standard for guishers, 2010 Edition, Section extinguishers shall be subject attervals of not more than one anydrostatic test, or when ad by an inspection or son. Section 7.3.3 states each all have a tag or label securely test the month and year the extromed, identifies the person at an identifies the name of the test of the section	K 0355	The facility ensures all portable extinguishers have documented annual maintenance in accordance with the rule.  1). the ABC type portable fire extinguisher in the supply root across from the maintenance office was tested by Any resident near the Supply Room near the Maintenance of had the potential to be affected this finding.  2). All portable fire extinguished were identified and inspected. This finding has the potential affect all residents.  3). The K class fire extinguish the kitchen near the service of door was immediately unobstructed BY Removing the large floor fan.  This finding has the potential affect any resident near the kitchen.  The maintenance director has received in service training related to the annual inspection required fall portable fire extinguisher monthly inspection of portable extinguishers and ensuring fire extinguishers are not blocked. Dietary staff in serviced	m  office d by  ers to er in r hall he to slated red ers; erfire ee

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 03/08/2023	
	PROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEECURED.	
TAG	recent annual maint December of 2022. of observation, the acknowledged the a extinguisher did not maintenance within period.  This finding was re Administrator-In-To Company Consultant 3-1.19(b)  2. Based on observer facility failed to instead extinguishers each in month period. NFP Fire Extinguishers, extinguishers shall by means of an electron minimum of 30-day periodic inspection extinguishers shall in following items: (1) Location in desitive (2) No obstruction to (3) Pressure gauge to operable range or periodic inspection to (4) Fullness determined for the self expelling-type of cartridge-operated extinguishers in spection of 7.2.4.1 state inspections shall ke extinguishers inspections shall ke extinguishers inspections shall ke extinguishers inspections.	enance was performed as Based on interview at the time Activity Director forementioned portable fire thave documented annual the most recent twelve month  viewed with the raining, Activity Director, and at during the exit conference.  ation and interview, the pect 31 of 31 portable fire month during the past 12 A 10, Standard for Portable Section 7.2.1.2 states fire be inspected either manually or stronic device/system at a vintervals. Section 7.2.2 states or electronic monitoring of fire include a check of at least the gnated place to access or visibility reading or indicator in the osition ined by weighing or hefting for extinguishers, extinguishers, and pump tanks es, wheels, carriage, hose, and extinguishers inrechargeable extinguishers	TAG TAG	obstructing fire extinguishers The administrator or designe monitor that the fire extinguis monthly inspections, annual inspections and that all are fi from blockage. this monitoring will take place monthly times six months the findings of the monitoring wil reported to the QAPI commit the monthly QAPI meeting by administrator or designee tim six months if 100% complian has not been achieved, this is continue until the threshold in been met. Completion date	DATE  DATE  DATE  DATE  DATE  DATE  DATE  DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/08/2023	
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	E COMPLETION
TAG	where at least monticonducted, the date performed and the inperforming the inspection 7.2.4.4 requare conducted, reconshall be kept on a tarextinguisher, on an maintained on file, of Section 7.2.4.5 required monstrate that at inspections have be practice could affect visitors in the facility. Findings include:  Based on observational many of 2023. The Activity Director facility were not inspections by the performed in Deceminatory of 2023. The performed in Deceminatory at the time Director acknowled portable fire extinguishers by the performed in Deceminatory at the time Director acknowled portable fire extinguishers by the performed in Deceminatory at the time Director acknowled portable fire extinguishers by the performed in Deceminatory at the time Director acknowled portable fire extinguishers by the performed in Deceminatory at the time Director acknowled portable fire extinguishers by the performance of th	the manual inspections are the manual inspection was nitials of the person ection shall be recorded. the where manual inspections are stored for manual inspections are or label attached to the fire inspection checklist or by an electronic method. This deficient is all residents, staff and by.  Ons on 03/08/23 between 9:15 during a tour of the facility with or, all 31 fire extinguisher in the effected monthly in January and of the annual inspection of all fire in annual inspection of all fire in annual inspection of all fire in the effected monthly in January and of the annual inspection of all fire in the effect of 2022. Based on the of observation, the Activity ged the aforementioned with the raining, Activity Director, and ant during the exit conference.	TAG	CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	DATE

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155208  AND PLAN OF CORRECTION  A. BUILDING  B. WING			COMPLETED 03/08/2023		
	PROVIDER OR SUPPLIER		410 W I	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD 'ER, IN 47243	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ed where they will be readily	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	accessible and immo	ediately available in the event nt practice could affect kitchen n the adjacent dining room.			
	Findings include:				
	during a tour of the Director, the K Clas kitchen near the Ser with a large floor fa time of observation.	ons on 03/08/23 at 11:36 a.m. facility with the Activity s fire extinguisher in the vice Hall door was obstructed n. Based on interview at the the Activity Director agreed was obstructing the K Class fire			
		viewed with the raining, Activity Director, and at during the exit conference.			
	3.1-19(b)				
	facility failed to ensextinguishers had praceptable range. It provisions of Chapt 4.6.12.4 requires an condition, arrangem fire-resistive construction requiring periodic to ensure its mainterinspected, or operat NFPA standards. Neortable Fire Exting 7.2.2 requires periodic extinguishers shall it reading or indicator position. When an extinguishers had provided to the standards or indicator position.	ation and interview, the ure 1 of 31 portable fire ressure gauge readings in the SC 33. 1.1.3 states the er 4, General, shall apply. LSC y device, equipment, system, ent, level of protection, action, or any other feature esting, inspection, or operation nance shall be tested, ed as specified in applicable FPA 10, the Standard for guishers, 2010 Edition, Section dic inspection of fire include pressure gauge in the operable range or inspection of any emical fire extinguisher reveals			

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155208		A. BUILDING B. WING	01	COMPLETED 03/08/2023	
NAME OF PROVIDER OR SUPPLIER  HANOVER NURSING CENTER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	extinguisher shall be maintenance proced could affect at least visitors.	ion 7.2.2(3) or 7.2.2(4), the e subjected to applicable ures. This deficient practice 10 residents, staff and			
	during a tour of the Director, the pressur extinguisher in the c the extinguisher was interview at the time Director agreed the	ons on 03/08/23 at 11:10 a.m. facility with the Activity re gauge on the portable fire corridor near room 110 showed is undercharged. Based on the of observation, the Activity fire extinguisher in the corridor stated the fire extinguisher was			
		viewed with the raining, Activity Director, and at during the exit conference.			
K 0363 SS=E Bldg. 01	than required enclexits, or hazardous of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la	corridor openings in other osures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material g fire for at least 20 fully sprinklered smoke only required to resist the corridor doors and doors in g flammable or corrials have positive latching atches are prohibited by hese requirements do not			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155208		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 03/08/2023	
	ROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD /ER, IN 47243	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	flammable or com Clearance betwee covering is not ext doors complying v if provided with a ce the door closed w applied. There is closing of the door release when the permitted. Nonrate unlimited height at meeting 19.3.6.3.6 frames shall be lat other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restri resistance of glass assemblies.  19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratin devices, etc.	en bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors of are permitted. Door beled and made of steel or compliance with 8.3, compartment is fire window assemblies are a sprinklered compartments citions in area or fire so or frames in window  Parts 403, 418, 460, 482, and a sings, automatics closing			
	failed to ensure 1 of impediment to closi	on and interview, the facility  4 kitchen doors had no  ng. This deficient practice  staff in the Service Hall.	K 0363	The facility ensures that smok barrier doors are not propped at any time.  The kitchen door that was bein held wide open with a 5-gallor	open ng
	during a tour of the Director, the dishwa Service Hall corrido	ons on 03/08/23 at 11:45 a.m. facility with the Activity ashing room door to the or was held wide open with a Based on interview at the time		bucket that was removed immediately. An audit was conducted of all smoke barrier doors to ensure none were propped open. Any resident near the service had the potential to be affecte	hall
	_	the Activity Director agreed		this finding.	~ ~y

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/08/2023	
	PROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD /ER, IN 47243	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BITTE
	the five gallon buck  This finding was re  Administrator-In-Ti			Dietary staff received in service training related to not proppin open smoke barrier doors.  The maintenance director or designee will monitor all smoke barrier doors to ensure that not are propped open weekly x 4 weeks then monthly times five months.  The findings of the monitoring be reported to the QAPI committee monthly at the Qapt meeting by the maintenance director or designee times six months if 100% compliance had not been achieved this will continue until the threshold had been met	g  Ke  pone  g  g  will  pi  as
K 0374 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Doors 2012 EXISTING Doors in smoke baselid bonded wood construction that r Nonrated protectivare permitted. Door fixed fire window as are self-closing or require latching, as in the direction of provides a minimulator swinging or house the self-closing or remained by the self-closing or require latching, as in the direction of provides a minimulator swinging or house 19.3.7.6, 19.3.7.8, Based on observation failed to ensure 1 of	esists fire for 20 minutes. The plates of unlimited height one are permitted to have assemblies per 8.5. Doors automatic-closing, do not are not required to swing egress travel. Door opening arm clear width of 32 inches rizontal doors.	K 0374	The facility ensures smoke badoors closed to form a smoke resistant barrier.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155208		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED  03/08/2023
	PROVIDER OR SUPPLIER ER NURSING CENTER	410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD /ER, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect up to 20 residents, as well as staff and visitors.  Findings include:  Based on observations on 03/08/23 at 12:15 p.m. during a tour of the facility with the Activity Director, the set of smoke barrier doors near the Director of Nursing (DON) office did not close completely when tested. There was a one inch gap between the set of doors when closed fully. The south door was rubbing at the top of the door frame which caused it not to close fully. Based on interview at the time of observation, the Activity Director agreed the set of smoke barrier doors near the DON office did not close completely when tested.  This finding was reviewed with the Administrator-In-Training, Activity Director, and Company Consultant during the exit conference.		the set of smoke barrier doors near the director of nursing off that did not close was adjusted and the gap between the set of doors closed fully. Any resident near the DON off could be affected by this finding the maintenance director or designee received in service training related to ensuring the smoke barrier doors close propand allow no gap that prohibits door from closing fully. The maintenance director or designee will monitor that door close without gaps weekly time four weeks and then monthly times five months the findings the monitoring will be reported the QAPI committee monthly at the QAPI meeting by the maintenance director or designing times six months if 100% compliance has not been achieved, this will continue unthe threshold has been met completion date	rice d d of f fice ag at perly s the as of t to at nee
K 0500 SS=E Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208			JILDING	onstruction <u>01</u>	(X3) DATE COMPL <b>03/08</b> /	ETED	
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER			410 W I	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD /ER, IN 47243			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY	TE	(X5) COMPLETION
TAG	Based on observation failed to ensure 1 of current inspection of heater was in safe of 101, Section 19.1.1. It to be designed, comperated to minimize emergency requiring. This deficient practive residents, staff and Findings include:  Based on observation during a tour of the Director, the fuel-fit Mechanical Room has an inspection date of expired by 01/13/22 time of observation confirmed the inspectate of the tank water heater.  This finding was readministraator-in-Time Company Consultations at 10 of 20	on and interview, the facility of 1 fuel-fired water heater had a certificate to ensure the water perating condition. NFPA 3.1 requires all health facilities structed, maintained, and the the possibility of a fire g the evacuation of occupants. the could affect at least 20 visitors in the facility.  The perating condition of occupants. The possibility of a fire g the evacuation of occupants. The possibility of a fire g the evacuation of occupants. The possibility of a fire g the evacuation of occupants. The possibility of a fire g the evacuation of occupants. The possibility of a fire g the evacuation of occupants. The possibility of a fire g the evacuation of occupants. The possibility of a fire g the evacuation of occupants. The possibility of a fire g the evacuation of occupants. The possibility of a fire g the evacuation of occupants. The possibility of a fire g the evacuation of occupants. The possibility of a fire g the evacuation of occupants. The possibility of a fire g the evacuation of occupants. The possibility of a fire g the evacuation of occupants. The possibility of a fire g the evacuation of occupants. The possibility of a fire g the evacuation of occupants. The possibility of a fire g the evacuation of occupants. The possibility of a fire g the evacuation of occupants. The possibility of a fire g the evacuation of occupants. The possibility of a fire g the evacuation of occupants. The possibility of a fire g the possi	K 0	TAG 500	K500 The facility ensures that the further fired water heater has a currer inspection certificate to ensure that the water heater is in safe operating condition The facility now has a current Boiler Pressure Vessel H-Star (permit) and is displayed near Hot Water Vessel. This finding has the potential traffect at least 20 residents Monitoring of this finding will be conducted by the administrator monthly times six months The findings of the monitoring be reported to the QAPI committee monthly at the QAF meeting by the maintenance director or designee times six months if 100% compliance has not been achieved, this will continue until threshold has be met	nt e and np the o e r will	DATE 04/12/2023
K 0511 SS=D Bldg. 01	complies with NFF Code, electrical w complies with NFF	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in to hazard to life.					

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEFICIENCIES X1) PROVIDER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SU	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/08/2023
	PROVIDER OR SUPPLIER	410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0712 SS=F Bldg 01	Based on observation and interview, the facility failed to ensure 1 electrical receptacle in a staff room was provided with a cover plate and was protected from damage. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect one staff while in the Wing 2 Supply Storage Room.  Findings include:  Based on observations on 03/08/23 at 11:16 a.m. during a tour of the facility with the Activity Director, the Wing 2 Supply Storage Room had an electrical receptacle on the wall not provided with a cover plate. Wires were exposed from this electrical receptacle. Based on interview at the time of observation, the Activity Director acknowledged the lack of a cover plate on the electrical receptacle in the Wing 2 Supply Storage Room.  This finding was reviewed with the Administrator-In-Training, Activity Director, and Company Consultant during the exit conference.  3.1-19(b)  NFPA 101  Fire Drills  Fire Drills	K 0511	The facility ensures electrical receptacles are provided with a cover plate and protected from damage.  The electrical receptacle in the staff room was provided with the cover plate to protect ith from damage.  An audit was conducted to ensure covers are positione accordingly.  The maintenance director or designee received in service education related to providing cover plates two all electrical receptacles.  The maintenance director or designee will monitor their electrical receptacles in all areas are covered weekly times 4 weeks then monthly times 5 months the findings of the monitoring will be reported to the QAPI committee monthly at the QAPI committee	the h
Bldg. 01	Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155208 B. WING 03/08/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 410 W LAGRANGE RD HANOVER NURSING CENTER HANOVER. IN 47243 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the K 0712 The facility conducts fire drills on 04/12/2023 facility failed to provide quarterly fire drill every shift at least quarterly. documentation for 1 of 3 shifts during 3 of 4 A fire drill was conducted and quarters. This deficient practice could affect all complete documentation was residents, as well as staff and visitors in the added. facility. a re-education in service was conducted with the maintenance Findings include: department to ensure fire drills are completed as required with proper Based on review of the facility's fire drill reports documentation. on 03/08/23 between 9:15 a.m. and 4:00 p.m. with All residents had the potential to the Administrator-In-Training (AIT) and Activity be affected by this finding. Director present, the facility lacked fire drill the maintenance man received in documentation for the following shift and quarters service education on the during the past 12 month period: necessities of conducting the fire Third shift (night) of the third quarter (July, drills quarterly at unexpected August, and September), and fourth quarter times with complete (October, November, and December) of 2022, and documentation. first quarter (January, February, and March) of in addition, a calendar has been 2022 and so far for 2023. Based on interview at completed to aid in monitoring the time of record review, the AIT confirmed the random dates. lack of fire drill reports during the previously The administrator or designee will mentioned shift and quarters. monitor that the fire drills are being conducted and completed as This finding was reviewed with the AIT, Activity required. Director, and Company Consultant during the exit The monitoring will be conducted conference. monthly times six months. the findings of the monitoring will be 3.1-19(b) reported to the QAPI committee monthly at the QAPI meeting by 2. Based on record review and interview, the the main as director or his facility failed to provide complete fire drill designee

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	ROVIDER OR SUPPLIER		410 W I	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD /ER, IN 47243	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	during the past 12 n	of 13 fire drills performed nonth period. This deficient tall residents in the facility.		if 100% compliance has not be achieved this will continue unt threshold has been met.	l l
	on 03/08/23 betwee the Administrator-In Director present, 5 of performed during the include the names at participated in the first at the time of record lack of staff signatured during the past 12 m.	the facility's fire drill reports in 9:15 a.m. and 4:00 p.m. with in-Training (AIT) and Activity of 13 documented fire drills are past 12 month period did not ind signatures of staff that fire drills. Based on interview if review, the AIT confirmed the res on 5 of 13 fire drill reports month period.  Viewed with the AIT, Activity any Consultant during the exit			
K 0781 SS=E Bldg. 01	prohibited in all he except, unless use employee areas w do not exceed 212 degrees Celsius). 18.7.8, 19.7.8 Based on observation	eaters eating devices shall be ealth care occupancies, ed in nonsleeping staff and where the heating elements degrees Fahrenheit (100) on and interview, the facility	K 0781	The facility ensures that they	04/12/2023
	procedure regarding ensure 1 of 1 portab not used in a staff an could affect staff in	r own verbal policy and g portable space heaters to ble space heater observed was rea. This deficient practice the Medical Records room, within the same smoke		follow their policy and procedures regarding portable space heaters.  the portable space heater the was in the medical records office was removed	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/08/2023				
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER			410 W	STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	03/08/23 between 9 asked, the Administ she could not locate policy and procedur think the facility all. Based on observation of the facility with the a portable space hear Records room while was acknowledged time of observation.	at the time of record review on :15 a.m. and 4:00 p.m., when rator-In-Training (AIT) said a portable space heater re, but, indicated she didn't cowed portable space heaters. Ons at 12:35 p.m. during a tour he Activity Director, there was not staff was present. This by the Activity Director at the viewed with the AIT, Activity any Consultant during the exit		immediately. An audit of the building was conducted, and no other spate heater was found This finding has the potential affect any resident in this smoke compartment area. all staff received inservice training related to the policy that prohibits all space heater in the facility. the maintenance director or designee will monitor that not space heaters are in the facil weekly x four weeks then monthly times five months. the findings of the monitorin will be reported to the QAPI committee monthly at the QAM meeting by the maintenance director or designee times smonths. if 100% compliance has not achieved this will continue until the threshold has been met	ers D Lity g API			
K 0918 SS=F Bldg. 01	System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the safety and critical and testing of the	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power ated equipment is capable be within 10 seconds. If the n is not met during the pocess shall be provided to nis capability for the life branches. Maintenance generator and transfer ormed in accordance with						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	(3) DATE SURVEY		
			<b>'</b>		f '	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			COMPLETED	
		155208	B. WING	WING 03/08/2023		
NAME OF F	DOWNDED OF GIRDLIE		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEI	A.	410 W	LAGRANGE RD		
HANOVE	R NURSING CEN	TER	HANO	VER, IN 47243		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
	NFPA 110.					
	Generator sets ar	e inspected weekly,				
	exercised under le	oad 30 minutes 12 times a				
	year in 20-40 day	intervals, and exercised				
	once every 36 mc	onths for 4 continuous hours.				
	Scheduled test ur	nder load conditions include				
	a complete simula	ated cold start and				
	automatic or man	ual transfer of all EES				
	loads, and are co	nducted by competent				
		enance and testing of stored				
	energy power sou	ırces (Type 3 EES) are in				
	accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained					
	and readily availa	ble. EES electrical panels				
	and circuits are marked, readily identifiable,					
	and separate fron	n normal power circuits.				
	Minimizing the po	ssibility of damage of the				
	emergency power	r source is a design				
	consideration for					
	6.4.4, 6.5.4, 6.6.4	(NFPA 99), NFPA 110,				
	NFPA 111, 700.1					
	1. Based on record review and interview, the		K 0918	The facility ensures a writter		
	1	sure a written record of weekly		record of weekly inspections	<b>S</b>	
	-	1 generator was maintained		for the generator is		
	for 12 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and			maintained.		
				1) A written record		
				inspection of the generator	was	
				completed and is now		
		stems. 8.3.7 requires storage		completed and documented		
		electrolyte levels or battery		weekly.		
	-	nnection with systems shall be		2) A complete written reco	ord	
		nd maintained in full		of monthly generator load		
	•	anufacturer's specifications.		testing was completed and i	s	
		tive batteries shall be repaired		now done every month.		
	_	ately upon discovery of		This finding has the potentia	il to	
I	L defects Chapter 6	5.4.2 of NFPA 99 requires a	1	affect recidents	1	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING 01 COMPLE					
155208		B. W	'ING		03/08/2023			
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
		spection, performance,			the maintenance director or			
		nd repairs shall be regularly			designee received re inservi	ce		
		ilable for inspection by the			education related to the			
		risdiction. This deficient			requirements of maintaining			
	practice could affect	et all residents, staff and			the generator.			
	visitors.				the administrator or designe	е		
	Findings include:				will monitor monthly times s months that these inspection	ns/		
	Događ om maviany of	the computer inspection			test with written documentat	ion		
		the generator inspection between 9:15 a.m. and 4:00			is being completed. findings of the monitoring w	iii		
	_	nistrator-In-Training (AIT) and			be reported to the QAPI	""		
	Activity Director pr	- · · · · · · · · · · · · · · · · · · ·			committee at the monthly			
		lable to show the emergency			QAPI meeting by the			
	generator was inspected/tested weekly during 12 of the most recent 52 week period. Based on interview at the time of record review, the AIT said the generator does start automatically every week, however, there has not been a maintenance person on a consistent basis during the past				administrator or designee .			
					If 100% compliance has not been achieved this will			
					continue until the threshold	haa		
						nas		
					been met			
	_							
	several months to document the weekly generator exercises.							
	This finding was re	viewed with the AIT, Activity						
	_	pany Consultant during the exit						
	conference.	and the community was and the community was a second community with the community was a second community with the second community was a second community with a second community was a second community with a second community was						
	3.1-19(b)							
	2. Based on record	review and interview, the						
	facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 4 of the past 12 months. Chapter							
		12 NFPA 99 requires monthly						
		ator serving the emergency						
		be in accordance with NFPA						
		or Emergency and Standby						
		hapter 8. Chapter 6.4.4.2 of						
		written record of inspection,	1					
	performance, exercising period, and repairs for the							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING 01			COMPLETED		
155208		B. WI	ING	03/08/	08/2023			
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER			•	STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROUDERIG TVV or control		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE	DATE	
	generator to be regu	larly maintained and available						
	for inspection by th	e authority having						
	jurisdiction. Chapte	er 6-4.4.1.3 of 2012 NFPA 99						
	-	or on-site generators shall be						
		dance with NFPA 110, 2010						
		or Emergency and Standby						
	•	3.7 requires storage batteries,						
		e levels or battery voltage,						
		with systems shall be						
		nd maintained in full anufacturer's specifications.						
	_	tive batteries shall be repaired						
		•						
	or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a							
	written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.  Findings include:							
	Based on record rev	view on 03/08/23 between 9:15						
	a.m. and 4:00 p.m.							
	•	raining (AIT) and Activity						
		ere was no monthly generator						
	_	ation available for November						
	and December of 20	022, and January and February						
	of 2023. Based on	interview at the time of record						
	review, the AIT confirmed there was no emergency generator load test documentation for the previously mentioned months in 2022 and 2023. Based on interview at the time of record							
		d there has not been a						
		on a consistent basis during						
	_	nths to ensure a monthly						
	generator load test l	nas been completed.						
	This finding was re	viewed with the AIT, Activity						
	Director, and Company Consultant during the exit							

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2023 FORM APPROVED OMB NO. 0938-039

	1 '						(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155208			A. BUILDING <u>01</u> B. WING			COMPLETED 03/08/2023		
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	CROSS-REFERENCED TO THE APPROPR			(X5)		
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ATE	COMPLETION	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	conference. 3.1-19(b)							

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 044I21 Facility ID: 000115 If continuation sheet Page 43 of 43