STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		· /	X2) MULTIPLE CONSTRUCTION  A. BUILDING  O		(X3) DATE SURVEY COMPLETED		
		155208	B. WI	NG		04/25/	/2024
	ROVIDER OR SUPPLIEI		•	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 DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
F 0000 Bldg. 00	IN00431249 and IN Complaint IN0043 the allegations were Complaint IN00430 related to the allegat Unrelated deficience Survey dates: April Facility number: 10 Provider number: 10 AIM number: 1002 Census Bed Type: SNF/NF: 65 Residential: 5 Total: 70 Census Payor Type Medicare: 2 Medicaid: 62 Other: 1 Total: 65 These deficiencies accordance with 41	1249 - No deficiencies related to e cited.  0588- State/Federal deficiency ation is cited at F740.  cies cited  124 and 25, 2024.  00115 55208 191080	F 00	000	This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions of forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.=""span="">span=""">span=""">span=""">span=""">	of ot ement the	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A) Reporting of Alleg		F 06	500			05/10/2024

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

TITLE

(X6) DATE

Any defiency statement 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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/25/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		investigations and outcomes of			I. What corrective action(s) wi		
	_	vere reported to the Indiana			accomplished for those reside		
		Ith (IDOH), within 5 working t, for 9 of 9 reported incidents.			found to have been affected b	y tne	
	1	-			deficient practice; The	d=	
	(Residents B, C, D,	E, F, G, H, J, K, L, M, and N)			administrator conducted a 60	•	
	Findings include:				look back of abuse investigation		
	rindings include.				to ensure final follow-ups were completed and submitted to the		
	1 On 02/15/24 at 2	:23 P.M., a possible drug			state agency.	ic	
		ved Residents F and Resident			II. How other residents having	the	
		DOH. The 5 day follow-up			potential to be affected by the		
		estigation was not reported			same deficient practice will be		
	until 04/24/24.	songuiton was not reperted			identified and what corrective		
					action(s) will be taken; all		
	2. On 03/08/24 at 1	:01 P.M., a resident to resident			residents who have a allegation	on of	
		esident H and Resident J was			abuse have the potential to be		
	reported to IDOH.	The 5 day follow-up outcome			affected.		
	1 -	was not reported until			III. What measures will be put	into	
	04/24/24.	-			place and what systemic char		
					will be made to ensure that the	-	
	3. On 03/14/24 at 1	:01 P.M., a resident to resident			deficient practice does not rec	:ur;	
	incident between R	esident B and Resident C was			the Regional Vice President o	f	
	reported to IDOH.	The 5 day follow-up outcome			Operations re-educated the		
	of the investigation	was not reported until			administrator on the timeline f	or	
	04/24/24.				alleged abuse investigations;	to	
					include the following: 1. Ensu	ring	
		0:01 P.M., a resident fall with			that all alleged violations invol	_	
		l Resident J was reported to			abuse neglect, exploitation or		
		The 5 day follow-up outcome			mistreatment, including injurie	s of	
		was not reported until			unknown source and		
	04/24/24.				misappropriation of resident		
					property, are reported	_	
		2:30 A.M., a resident to visitor			immediately, but no later than		
		ed Resident N was reported to			hours after the allegation is m	ade,	
	1	ollow-up outcome of the			if the events that cause the	14. *	
	investigation was n	ot reported until 04/24/24.			allegation involve abuse or res		
	6 0 02/21/24 4 4	OS D.M. o moddout to moddout			serious bodily injury, or not lat		
		:05 P.M., a resident to resident			than 24 hours if the events the		
		esident D and Resident E was			cause the allegation do not in		
	reported to IDOH.	The 5 day follow-up outcome			abuse or do not result in serio	uS	

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CENTERS FOR	ENTERS FOR MEDICARE & MEDICAID SERVICES					OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155208	B. Wl	ING		04/25/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	Ł		410 W I	LAGRANGE RD		
APERIO	N CARE HANOVER	2		HANOV	/ER, IN 47243		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	CY 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
	1	was not reported until			bodily injury, to the administration		
	04/24/24.				of the facility and to other offic	ıals	
	7.0.04/05/24 + 14	0.15 A.M			in accordance with State law	•	
		0:15 A.M., a resident to resident esident B and Resident K was			through established procedure	es. 2.	
		The 5 day follow-up outcome			The administrator reports the		
		was not reported until			results to officials in accordant with State law, including to the		
	04/24/24.	was not reported until			State Survey Agency within 5	<del>,</del>	
	0 1/2 1/2 1.				working days of the incident.		
	8. On 04/06/24 at 8	:01 A.M., a resident to resident			IV. How the corrective action(s	3)	
		esident H and Resident M was			will be monitored to ensure the	,	
		The 5 day follow-up outcome			deficient practice will not recur		
	of the investigation	was not reported until			i.e., what quality assurance		
	04/24/24.				program will be put into place;	The	
					administrator will report and re	eview	
	9. On 04/07/24 at 3	:15 P.M., a resident fall with			all initial investigation with the		
		Resident L was reported to			Regional Nurse Consultant/an	d or	
		ollow-up outcome of the			the Regional Vice President of		
	investigation was no	ot reported until 04/24/24.			Operations and the 5 day follo	-	
					report to ensure compliance w	rith	
		on 04/25/24 at 1:51 P.M., the			the reporting timeline. The		
		ated she was behind on			administrator will track all		
		llow-ups completed and would			investigations and log on an a	udit	
	lollow the State and	l Federal regulation.			tool; if issues are identified		
	The current undete	d, facility policy titled,			corrective action will be taken		
		AL ABUSE ALLEGATION			immediately.  The results of these audits will	l he	
		ENT QUALITY ASSURANCE			reviewed in Quality Assurance		
		s provided by the Administrator			Meeting monthly for 6 months		
	on 04/25/24 at 6:01	-			until an average of 100%		
		TIGATION/PREVENTATIVE			compliance or greater is achie	eved	
		l report toISDH [Indiana State			x4 consecutive weeks. The Q		
	Department of Heal	-			Committee will identify any tre		
					or patterns and make		
	3.1-28(e)				recommendations to revise the	е	
					plan of correction as indicated		

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483.40

Behavioral Health Services

F 0740

SS=D

Bldg. 00

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155208 B. WING 04/25/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 410 W LAGRANGE RD APERION CARE HANOVER 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 Based on observation, interview, and record F 0740 05/10/2024 review, the facility failed to administer medications What corrective action(s) will be and monitor and residents with behavioral health accomplished for those residents concerns for 2 of 4 residents reviewed for found to have been affected by the behavioral health. (Residents B and D) deficient practice; Findings include: 1a. During an observation and interview on 04/24/24 at 9:59 A.M., Resident B was sitting in Resident B: This his recliner in his room. The resident indicated he resident continues to be monitored felt safe and liked his new room. In March there by psych services; NP and was an incident where he had accidentally psychologist and due to resident bumped into another resident's wheelchair and request the ADON conducting that resident was rude to him. psycho social visits. Since resident returned from psych in The clinical record for Resident B was reviewed patient stay all medication been on 04/24/24 at 10:45 A.M. A Quarterly MDS given has prescribed and no (Minimum Data Set) assessment, dated 02/20/24, suicidal ideations indicated the resident was cognitively intact. The Resident C: No new interventions diagnoses included, but were not limited to, indicated for this resident: there Huntington's Disease, anxiety, depression, and has not been any conflict with psychotic disorder. other residents and all medications been given as A physician's order, dated 03/13/24 through prescribed. On going 03/14/24, indicated the resident was to receive psychological evaluations and Haldol (an antipsychotic medication) 2 mg monitoring conducted by the (milligrams) in the morning for psychosis related psych provider and social service to Huntington's Disease. director/designee. Resident D: Psychosocial visit A physician's order, dated 03/13/24 through conducted, and facility secured 04/18/24, indicated the resident was to receive placed at a local assisted living Haldol 5 mg, at bedtime for psychosis related to community; discharge is pending Huntington's Disease. as state guardian coordinating discharge date. On going The March 2024 EMAR/ETAR (Electronic psychological evaluations and Medication Administration Record/Electronic monitoring conducted by the

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Treatment Administration Record) lacked

documentation the resident had received the

Haldol medication on the following dates and

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Resident E: Based on

director/designee.

psych provider and social service

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155208 B. WING 04/25/2024

NAME OF I	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
∧DEDI∩I	N CARE HANOVER			LAGRANGE RD /ER, IN 47243			
APERIO	N CARE HANOVER		HANOV	/ER, IN 47243			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	times:			psychosocial visit resident			
				expressed happy with move to unit			
	- 03/13/24 at bedtime,			1; guardian in agreement with			
	- 03/14/24 in the morning and at bedtime.			move to unit 1 and validates			
				resident is adjusting well.			
	The resident had been administered a STAT dose			II. How other residents having the			
	of Haldol 2 mg on 03/15/24 at 2:48 P.M.			potential to be affected by the			
				same deficient practice will be			
	A Facility Reported Incident, dated 03/14/24 at			identified and what corrective			
	1:01 P.M., indicated Resident B had bumped into			action(s) will be taken; residents			
	Resident C's wheelchair with his walker due to the			re-admitting or newly admitting			
	hallway being crowded. Resident C yelled "I'll			from a psychiatric inpatient stay			
	beat the brakes off you", towards Resident B. The			have the potential to be affected.			
	residents were separated immoderately. The			III. What measures will be put into			
	psychologist was present in the building a met			place and what systemic changes			
	with the residents. Resident C expressed remorse			will be made to ensure that the			
	for his reaction and committed to it not happening			deficient practice does not recur;			
	again and due to the prior history with Resident B			Licensed nurses was re-educated			
	he agreed to not engage verbally with the resident			on medication management;			
	and to report any concerns related to Resident B			specifically related to ensuring			
	to the nurse. Resident B also agreed to refrain			residents receive medication as			
	from communicating with Resident C and to report			prescribed; policy Reducing Risk			
	to the nurse if there were future issues regarding			for Medication Errors: Following			
	Resident C or other residents. After the incident,			the 5 Rights of Medication			
	each resident calmed down and there were no			Administration; always documents			
	further negative interactions.			on the Emer after administering			
				the medication.			
	Neither Resident B or Resident C were placed on			The Social Service Director was			
	increased monitoring and Resident B had moved			re-educated on policy; Behavioral			
	rooms.			Health Services; specifically			
				related to establishing a system			
	A Social Service Progress Note, dated 03/14/24 at			for identifying behaviors and			
	3:44 P.M., indicated the Social Service Director			implementing appropriate			
	(SSD) spoke with the resident regarding moving			inventions consistent with the			
	rooms. The resident agreed to the room move.			individualized plan of care and to			
				ensure that each resident receives			
	A Social Service Progress Note, dated 03/15/24 at			appropriate treatment and services			
	3:25 P.M., indicated the SSD spoke with the			to attain the highest practicable			
	resident regarding his well-being. The resident			mental and psychosocial			

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well-being; specifically related to

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remained hyper-fixated on another resident. The

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 04/25/2024 155208 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 410 W LAGRANGE RD APERION CARE HANOVER 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 resident expressed frustration regarding the other readmission and/or admission resident and his frustration regarding the SSD and from an inpatient psychiatric stay. the Administrator. The SSD and Administrator IV. How the corrective action(s) will be monitored to ensure the consulted with Psychiatric Nurse Practitioner (NP) regarding the recent behaviors of the resident. deficient practice will not recur The Psychiatric NP reviewed the resident's i.e., what quality assurance medications and increased the resident's program will be put into place; The anti-psychotic medication. DON/Designee will audit the EMAR 5x/ week for 4 weeks. 3 x/ A Social Service Progress Note, 03/18/24 at 12:57 week for 4 weeks and 2 x / week P.M., indicated the SSD spoke with the resident. for 4 weeks and weekly for 12 The resident continued to express frustration with week . If issues identified, issue the SSD and Administrator. The SSD asked how will be corrected and if warranted he was doing with his room change and resident will initiate re-education up to responded he had a lawyer and was going to sue disciplinary action. the facility. The Medical Records Director will audit re-admissions after inpatient During an interview on 04/24/24 at 12:00 P.M., psych hospital stay to ensure the LPN (Licensed Practical Nurse) 4 indicated in psychosocial evaluation to March Resident C was sitting at the nurse's completed upon return. These station and she wasn't sure what happened. There audits will be completed within 48 were words that were exchanged, and they hrs of the next business day. The immediately separated the residents and alerted audits will continue for 6 months. the SSD and Administrator. They were both The results of these audits will be placed one on one observations (one staff to one reviewed in Quality Assurance resident) until management staff were present. Meeting monthly for 6 months or There was no physical altercation, and no other until an average of 100% threats were made after that. She was unsure if the compliance or greater is achieved x4 consecutive weeks. The QA residents were placed on 15-minute monitoring. Committee will identify any trends During an interview on 04/24/24 at 12:10 P.M., or patterns and make LPN 5 indicated in March Resident C was sitting recommendations to revise the in the hallway and Resident B walked by, bumped plan of correction as indicated. his wheelchair, and started cussing at the resident. LPN 4 took Resident C to his room, and she stayed with Resident B until the SSD came. Resident B had instigated the incident. She was unsure what happened after that. All resident medications were to be documented in the EMAR/ETAR.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155208	B. W	ING		04/25/	2024
				_			
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					AGRANGE RD		
APERIO	N CARE HANOVER	₹		HANOV	ER, IN 47243		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROUDERIG BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	1b. A Social Servic	e Progress Note, dated 04/11/24					
		cated Resident B was in the					
		a wall. The Psychologist went					
		sident to discuss why he was					
	1 -	ogist reported to the SSD that					
		ving homicidal ideation's					
		esident and members of the					
		vas upset to the point he					
		le multiple times while talking					
	to the psychologist.						
	· · · · · · · · · · · · · · · · · · ·						
	A Social Service Pr	rogress Note, dated 04/11/24 at					
		ed Resident B would be					
		ppsychiatry Hospital.					
		F-7					
	A Nursing Progress	Note, dated 04/19/24 at 1:50					
		resident returned to the facility					
	from the Neuropsyo	-					
		,					
	There were no Soci	al Service Follow-Up visits to					
		return from Neuropsychiatry					
		as seen by the Psychiatric NP					
		e Psychologist on 04/25/24.					
		,					
	During an interview	v on 04/24/24 at 2:00 P.M., the					
	1	Iarch Resident B was going					
		nd bumped into Resident C's					
	I	vere some words that were					
		residents were able to be					
	_	dent B had moved rooms, but					
		ber if the residents were placed					
		Resident B did go out to the					
		and when he returned, he was					
		e check monitoring. Since his					
	1 -	ad any behaviors. She didn't					
		talked to the resident from a					
		dpoint since he returned to the					
		rigger for him, but she believed					
		of Nursing) could talk with him.					
	me DOM (Director	or ransing, could talk with min.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	ETED
		155208	B. W	NG		04/25	/2024
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIER	2			AGRANGE RD		
ADEDIO	N CARE HANOVER	1			ER, IN 47243		
APERIO	V CARE HANOVER	X.		HANOV	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
	2. During an observ	vation on 04/24/24 at 2:21 P.M.,					
	Resident D was lyir	ng in her bed on the skilled					
	unit. She was upset	about not being able to live in					
	her residential apart	tment due to an incident that					
	happened between l	her and another resident that					
	resulted in her havin	ng to go out to a behavioral					
	psychiatric hospital						
	The clinical record	for Resident D was reviewed					
	on 04/24/24 at 11:2	2 A.M. The resident admitted to					
	the skilled nursing	facility on 04/11/24. The					
	diagnoses included,	, but were not limited to,					
	dementia, anxiety, a	and depression.					
	The clinical record	lacked any Social Service Visits					
	since the resident re	eturned from the					
	Neuropsychiatry Ho	ospital on 04/11/24.					
	_	v on 04/24/24 at 2:00 P.M., the					
		dent D had a physical					
		sident E while they lived on the					
		iving Side. Resident D had					
		psychiatry Hospital and					
	returned on 4/11/24	On 4/11/24, upon return the					
	resident was moved	l to the skilled unit. The					
	resident has had no	behaviors since her return to					
	the facility and rem	ained on 15-minute check					
	monitoring. She wa	s able to review behaviors					
	every morning thro	ugh progress notes.					
	A Progress Note, da	ated 04/22/24 at 9:39 A.M.,					
		D went to the nurse's station					
		emale resident says anything					
		ing to beat the sh*t out of her,					
	I'm not putting up v	vith it"					
		on 04/25/24 at 12:03 P.M., the					
		dent D was taken off her					
	15-minute checks the	ne prior evening due to the IDT					1

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155208	B. W	ING		04/25	/2024
		_		STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
NAME OF F	PROVIDER OR SUPPLIEF	₹			LAGRANGE RD		
APERION	N CARE HANOVER	₹			/ER, IN 47243		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		am) agreeing to her being taken					
	off them, but she w	•					
		he Psychologist visited today					
		placed back on 15-minute he resident's depression. There					
		04/22/24 when Resident E had					
		nents to Resident D. Resident E					
	was then moved to						
	was then moved to	'' mg 1.					
	During an interview	v on 04/25/24 at 1:21 P.M., the					
		ated she had visited with the					
		4 and 04/25/24. She had					
	recommended to re	start the 15-minute monitoring					
		impulsivity and recent					
		e resident knows what to say to					
	keep herself out of	the hospital.					
	_	v on 04/25/24 at 1:51 P.M., the					
		cated the Resident D required					
	_	ue to her conflicts with other					
		Resident E was moved to a					
		felt the 15-minute monitoring					
		but the psychologist wanted to					
	start it back the nex	t day.					
	During an interview	v on 04/25/24 at 5:54 P.M., the					
		cated residents should have a					
		ation when they return to the					
		opsychiatry hospital stay.					
	incline, and a neur	eps, many neoptian stay.					
	The current, undate	ed, facility policy titled,					
		Medication Errors: Following					
	1	dication Administration" was					
	_	ministrator on 04/25/24 at 5:05					
		dicated, "ALWAYS					
	DOCUMENT ON	THE EMAR AFTER					
	ADMINISTERING	THE MEDICATION"					
	I	policy titled, "Behavioral					
	Health Services" w	ith a revision date of 10-24-22,					

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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 155208	ľ	JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/25/2024	
	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 LISC 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
F 0812 SS=E Bldg. 00	was provided by the 4:58 P.M. The polic system for identifyi implementing appro with the individuali that each resident re and services to attai mental and psychos  This citation relates  3.1-37(a)  483.60(i)(1)(2) Food Procurement,Stor Based on observation review, the facility sanitary kitchen for This deficient pract	e Administrator on 04/25/24 at cy indicated, "To establish a ng behaviors and opriate interventions consistent zed plan of care and to ensure exceives appropriate treatment in the highest practicable	F 08		I. What corrective action(s) wi accomplished for those reside found to have been affected b deficient practice; the cardboard box of cheerios was removed from the	ents by the	05/10/2024
	the following was of a the following the foll	ay doors that lead to the The dishwasher room door as open and no staff were from lead to the main kitchen between the rooms and no The main kitchen door was and 42 feet from the kitchen			the trash can between the milk cooler and the secured. The steam tables were cleaned and under the steam tables were cleaned  the administrator ensured the doors were close kitchen, dish room, and exteriodoors; staff trained on closing doors	lid re d to or	

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debris.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
		155208	B. W	ING		04/25/2	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			LAGRANGE RD		
ΔPERI∩!	N CARE HANOVER	9			/ER, IN 47243		
AI LINIOI	TOAKE HANOVER		_	TIANO	, LIX, IIX 47240	T.	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	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
		29 1 1 1 1 1					
		en a milk cooler and the ice			cleaning		
	machine was overflowing with trash and the lid was lying on the floor.				completed behind the stove		
					Cleaning scheduled and deep		
	D 11 1.1	1			clean schedules reviewed and	1	
		was an open and empty jelly			updated daily		
		erous dried cooked green			II. How other residents having		
	beans and other foo	ou deoris.			potential to be affected by the		
	The service	contained stoom taking O			same deficient practice will be	;	
	_	contained steam tables. One poon and 2 packages of flour			identified and what corrective	nto	
	_	. Under the steam tables were			action(s) will be taken; Reside	ents	
	various food crumb				who receive food/beverages	_	
	various 1000 cruino	s and insulation.			prepared in the dietary kitcher		
	The kitchen cleanin	ng schedules were provided by			have the potential to be affect	eu	
		)4/25/24 at 9:28 A.M. The			by this finding.	into	
	-	ne following cleaning:			III. What measures will be put place and what systemic char		
	scheduled lacked th	ic following cleaning.			will be made to ensure that the	-	
	P.M. Cook Cleanin	a Schedule #4:			deficient practice does not rec		
		leaning on 04/12/24, 04/15/24,			Dining Service re-educated by		
	04/20/24, and 04/21				administrator on kitchen sanita		
		lean of the floor and			and cleaning schedules to en		
		aind tables on 04/02/24,			that all food is stored, prepare		
	04/08/24, 04/15/24,				and distributed in accordance		
	0 0 0.2 ., 0 12.2 .,	, and 0 1/2/2 11			professional standards for foo		
	A.M. Cook Cleanin	ng Schedule #1:			service safety and review of the		
		leaning or weekly deep			cleaning schedules and logs	.	
		8/24 through 04/24/24.			affecting sanitation. Dietary	,	
		5			staff aware of location of clear		
	A.M. Aide Cleanin	g Schedule #2:			schedules.	١	
	- No documented cl	leaning or weekly deep			IV. How the corrective action(	s)	
		8/24 through 04/24/24.			will be monitored to ensure the	· .	
	_	-			deficient practice will not recu	r l	
	During an interview	v on 04/25/24 at 9:22 A.M.,			i.e., what quality assurance		
	_	Aide 2 indicated there were			program will be put into place;	; The	
	-	dules to be checked off, but			Dining Service Manager will		
	they had been unable to check them because they				monitor the cleaning schedule	es	
	-	ey always made sure their			and will tour the kitchen to ins		
	-	leted but didn't always			for cleanliness daily 5 x a wee	·	
		were unsure where the current			4 weeks, 3 times a week for 4		

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 04/25/2024	
	ROVIDER 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
	Administrator indic schedules were read Manager left for vaccleaning schedules at the following was of the following was of the cardboard box from the floor.  The trash can between the trash can between the floor and interview Administrator indic kitchen policy and here.	y on 04/25/24 at 1:51 P.M., the ated she thought the cleaning by to go when the Dietary cation on Friday, 04/20/24. The should be completed.  on on 04/25/24 at 2:34 P.M.,		weeks, 2 times a week for 4 weeks and weekly for 12 weeks and weekly for 12 weeks to ensure on going compliance. Any concerns will be corrected immediately and initiate re-education up to disciplinary action as warranted. Additional the Administrator will round weekly in the kitchen area to monitor for pest control and of cleanliness of the area; this wongoing. The results of these audits will reviewed in Quality Assurance Meeting monthly for 6 months until an average of 100% compliance or greater is achieved and the complete weeks. The Committee will identify any treatment of correction as indicated	e. d d d d d d d d d d d d d d d d d d d
F 0925 SS=F Bldg. 00	Based on observation review, the facility is pest control program facility was free of that the potential to resided in the facility.  Findings include:  During an observation	e Pest Control Program on, interview, and record failed to ensure an effective in was maintained and the rodents. This deficient practice affect 65 of 65 residents that y.  on and interview on 04/24/24 in the Social Service Director's	F 0925	I. What corrective action(s) wi accomplished for those reside found to have been affected be deficient practice; administrator contacted pest control the day of mouse	ents
	(SSD) office a gray	colored mouse ran from the baseboard of the wall, towards		observation	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3		X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155208	B. W	ING		04/25/	2024
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			LAGRANGE RD		
∧DEDI∩I	N CARE HANOVER				/ER, IN 47243		
AI LINO	V CAIL HANOVEI	`		TIANOV			
(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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		the office, behind a filing			cardbo	ar	
		pologized and indicated there			d box of cheerios was remove	d	
		ad ran across the room and			from the		
		l company had been there to			floor		
		office, but she didn't feel like it					
	was doing any good.				box of cheerios was		
					removed from the		
	~	ion on 04/25/24 at 9:03 A.M.,			floor		
	the following was o	observed:					
	TEN ' 1 11	1 1 1 1 1					
		ay doors that lead to the			l		
	_	The dishwasher room door			the trash can between		
		vas open and was 44 feet from			milk cooler and the ice machin		
		ffice and no staff were present.			emptied and the lid secured. the		
		to the main kitchen with the			steam tables were cleaned an	a	
	_	the rooms and no staff were			under the steam tables were		
	1 ~	citchen door was open to the			cleaned		
	I -	t from the kitchen door an pen. The opened kitchen door			the enductivistants		
		ne social service office,			the administrator ensured the doors were close	d to	
	was oo leet from th	le social service office,					
	The dry storage re	oom had wire racks around the			kitchen, dish room, and exterio	וכ	
		shelf contained a cardboard			doors; staff trained on closing doors		
		e crusts that were wrapped in			doors		
	_	he top of the pie crust there					
		ze hole going into the pie where			cleaning		
		vere visible. A second shelf			completed behind the		
		plastic tote that was half full of			stove		
	_	packages of croutons. A few			5.576		
	· ·	t the bottom of the container					
		noles in them. There was			cleaning schedules and deep		
	_	ouse droppings throughout the			clean schedules reviewed and		
		niner. There was a cardboard			updated		
		the floor. The bottom of the			daily		
		floor were black with food			,		
		ere visible mouse baits in the					
	room.						
					the dry		
	- A trash can betwe	een a milk cooler and the ice			storage room was cleaned by	the	
		lowing with trash and the lid			Housekeeping Supervisor, the		
	I	~			l ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155208	B. WI	NG		04/25/	
					_		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
				1	LAGRANGE RD		
APERIO	N CARE HANOVER	8		HANOV	/ER, 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'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	was lying on the floor,.				open pie crust , croutons and t	toes	
					discarded		
	- Behind the stove was an open and empty jelly				II. How other residents having	the	
	container and numerous dried cooked green				potential to be affected by the		
	beans and other food debris.				same deficient practice will be		
					identified and what corrective		
	- The serving room	contained steam table were			action(s) will be taken; Reside	ents	
	various food crumb	s and insulation were under			who reside at the community h		
	the table lying on the	ne floor. There was a shelf on			the potential to be affected by	this	
	the wall that had 16	open black storage bins, one			alleged practice.		
	storage bin had soft	jelly packets and visible			III. What measures will be put	into	
	mouse droppings.				place and what systemic chan	ges	
					will be made to ensure that the	e	
	During an interview	v on 04/25/24 at 9:22 A.M.,			deficient practice does not rec	ur;	
	Cook 3 indicated sh	ne was unsure if the facility had					
	any pest issues.						
	_	v on 04/25/24 at 9:24 A.M.,			On 4/25/24 the new pest contr	ol	
	-	cated she had not seen the			vendor started and rounded th	e	
		ny for about a month. They			exterior to ensure any outside		
	_	sues and the prior pest control			openings are protected agains	t the	
	company wasn't fix	ing the problem.			entrance of insects/rodents; ar		
					areas identified were immedia		
		on 04/25/24 at 9:39 A.M., the			secured. The new vendor wil		
		e into the kitchen and indicated			begin 2 x a month service for t	the	
		npany came to the facility			next 3 months and will be		
		a call out to them today about			re-evaluated at that time.		
	_	en in the SSD office. They had			The Maintenance Director was		
	_	e kitchen with cockroaches			re-educated by the administrate	tor	
		had been taken care of. She			on general pest control, to		
		mouse concerns in the			ensure the monitoring for hole		
	-	ontrol logs were requested at			walls while doings weekly rour	nds,	
		.M., the Administrator			to round with the pest control		
		to time pest concerns do come			representative to ensure issue	:S	
		ble to call the pest control			identified on the logs are		
		them come. They were here a			addressed and to review the n		
		the mouse in the SSD office			from all pest control visits with	the	
		kitchen. The Dietary Manager			administrator to ensure pest		
		pest control company on her			control issues are resolved	_	
	own without notify	the Administrator. She had			timely. Additionally, new vend	dor	

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	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155208		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/25/2024			
NAME OF PROVIDER OR SUPPLIER  APERION CARE HANOVER			STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
R 0000	also placed a call to get the records from  During an interview Dietary Aide 2 indie had put sticky traps mice. It seemed like been bad for about a salads with crouton not had to throw a left to the survey.  The pest control log the survey.  The current facility with a revision date the Administrator of policy indicated, " under contract with program will be conneeded basisEmpl promptly report all department heads protected against the tight-fitting, self-cle screening, controlle meansAll building and free of breaks such condition and	the pest control company to a their visits.  y on 04/25/24 at 3:25 P.M., cated the Maintenance Director out and had caught several at it was getting better but had a month and a half. They had searlier in the week. They had		provided the facility with pest control logs that are kept at enursing station, kitchen and froffice on the logs are communicated to the vendor. IV. How the corrective action will be monitored to ensure the deficient practice will not recuive., what quality assurance program will be put into place Maintenance Director will consinternal and external rounds of facility; including the kitchen week for 4 weeks, 3x week for weeks, 2 x a week for 4 week and 1 time a week for 12 week and 1 time a week for 12 week and 1 time a week for 12 week and mediately. Additionally, the Administrator will round week the kitchen area to monitor for pest control and overall cleanliness of the area; this wongoing. The results of these audits wireviewed in Quality Assurance Meeting monthly for 6 months until an average of 100% compliance or greater is achieved and the summer of the committee will identify any treatment of the committee will identify any treatment of the committee will identify any treatment of the commendations to revise the plan of correction as indicated	ach ont  s) e r ; The duct of the ox a r 4 s ks. d e ly in r r ill be e s or eved QA ends e			
Bldg. 00	This visit was for th IN00431249 and IN	ne Investigation of Complaints 100430588.	R 0000	This Plan of Correction is the center's credible allegation of compliance.				

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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 04/25/2024				
NAME OF PROVIDER OR SUPPLIER  APERION CARE HANOVER			STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243					
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	Complaint IN00431249 - No deficiencies related to the allegations were cited.  Complaint IN00430588- State/Federal deficiency related to the allegation is cited at F740.  Unrelated deficiencies cited.  Survey dates: April 24 and 25, 2024.  Facility number: 000115  Residential Census: 5  These State Residential Findings are cited in accordance with 410 IAC 16.2-5.  Quality review completed on May 3, 2024.		TAG	Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions of forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.=""span="">=""span="">=""	of ot ment the			
R 0149 Bldg. 00	Based on observation review, the facility pest control program facility was free of the second secon	on, interview, and record failed to ensure an effective m was maintained and the rodents. This deficient practice affect 5 of 5 residents that	R 0149	I. What corrective action(s) wi accomplished for those reside found to have been affected be deficient practice;	ents			
	During an observation and interview on 04/24/24 at 2:14 P.M., while in the Social Service Director's (SSD) office a gray colored mouse ran from the doorway along the baseboard of the wall, towards the back corner of the office, behind a filing cabinet. The SSD apologized and indicated there was a mouse that had ran across the room and that the pest control company had been there to set up a trap in her office, but she didn't feel like it			administrator contacted pest control the day of mouse observation cardboard to of cheerios was removed from floor box of cheerios was remove from the floor the floor the floor the floor the floor the floor the milk controls the milk controls the milk controls the floor trash can between the milk controls the floor trash can be tween the milk controls the floor trash can be tween the milk controls the floor trash can be tween the milk controls the floor trash can be tween the milk controls the floor trash can be tween the milk controls the floor trash can be tween the milk controls the floor trash can be tween the milk controls the floor trash can be tween the milk controls the floor trash can be tween the milk controls the floor trash can be tween the milk controls the floor trash can be tween the milk controls the floor trash can be tween the milk controls the floor trash can be tween the milk controls the floor trash can be tween the milk controls the floor trash can be tween the milk controls the floor trash can be tween the milk controls the floor trash can be tween the milk controls the floor trash can be tween the milk controls the floor trash can be tween the milk controls the milk contro	n the			

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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	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  04/25/2024					
NAME OF PROVIDER OR SUPPLIER  APERION CARE HANOVER			410 W	STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE				
	was doing any good.  During an observation on 04/25/24 at 9:03 A.M., the following was observed:			and the ice machine emptied the lid secured. the steam tak were cleaned and under the stables were cleaned	oles				
	- The service hallway doors that lead to the kitchen were open. The dishwasher room door from the hallway was open and was 44 feet from the social service office and no staff were present. The dish room lead to the main kitchen with the door open between the rooms and no staff were present. The main kitchen door was open to the hallway and 42 feet from the kitchen door an exterior door was open. The opened kitchen door was 86 feet from the social service office,			the administrator ensured doors were closed to kitchen, room, and exterior doors; startrained on closing doors  cleanic completed behind the stove	dish ff				
	walls. A wire rack s box, that had six pic sealed plastic. On the was a half-dollar siz mouse droppings we contained a clear, p	om had wire racks around the chelf contained a cardboard corusts that were wrapped in the top of the pie crust there are hole going into the pie where ere visible. A second shelf lastic tote that was half full of packages of croutons. A few		cleaning schedules and deep clean schedules reviewed an updated daily					
	crouton packages at had eaten through h visible food and mo bottom of the conta box of cheerios on t baseboard and the f	the bottom of the container oles in them. There was use droppings throughout the iner. There was a cardboard he floor. The bottom of the loor were black with food re visible mouse baits in the		the dry storage room was cleaned by Housekeeping Supervisor, th open pie crust, croutons and discarded II. How other residents having potential to be affected by the same deficient practice will be identified and what corrective	e toes g the				
	machine was overfl was lying on the flo - Behind the stove v	vas an open and empty jelly rous dried cooked green		action(s) will be taken; Resid who reside at the community the potential to be affected by alleged practice.  III. What measures will be pu place and what systemic char will be made to ensure that the	ents have tinto nges				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/25/2024			
NAME OF PROVIDER OR SUPPLIER  APERION CARE HANOVER			_	STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	various food crumbe the table lying on the table lying on the table lying on the wall that had 16 storage bin had soft mouse droppings.  During an interview Cook 3 indicated shany pest issues.  During an interview Dietary Aide 2 indipest control compare had been having issues company wasn't fix.  During an interview Administrator came the pest control commonthly. They had the mouse being se issues recently in the under a sink, but it was unaware of any kitchen. The pest control company had been having issues recently in the under a sink, but it was unaware of any kitchen. The pest control company and have few weeks ago for and concerns in the was able to call the own without notify also placed a call to get the records from During an interview.	or on 04/25/24 at 9:39 A.M., the entrol the kitchen and indicated inpany came to the facility a call out to them today about en in the SSD office. They had not kitchen with cockroaches had been taken care of. She with mouse concerns in the control logs were requested at at 2.M., the Administrator ento to time pest concerns do come to the company of the mouse in the SSD office kitchen. The Dietary Manager pest control company on her the Administrator. She had the pest control company to			On 4/25/24 the new pest contrivendor started and rounded the exterior to ensure any outside openings are protected agains entrance of insects/rodents; and areas identified were immediated secured. The new vendor will begin 2 x a month service for the matter and will be re-evaluated at that time. The Maintenance Director was re-educated by the administration of general pest control, to ensure the monitoring for hole walls while doings weekly rour to round with the pest control representative to ensure issue identified on the logs are addressed and to review the infrom all pest control visits with administrator to ensure pest control issues are resolved timely. Additionally, new vene provided the facility with pest control logs that are kept at earnursing station, kitchen and from office on the logs are communicated to the vendor. IV. How the corrective action(swill be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Maintenance Director will condinternal and external rounds of facility; including the kitchen 5	rol ie st the ny tely I the stor s in nds, es the dor ach ont s) e The duct f the		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			ETED
		155208	B. WING		_	04/25/2024	
NAME OF PROVIDER OR SUPPLIER  APERION CARE HANOVER			STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)	DEFICIENCY)	
		out and had caught several			week for 4 weeks, 3x week for		
		e it was getting better but had			weeks, 2 x a week for 4 weeks		
		a month and a half. They had			and 1 time a week for 12 week		
		s earlier in the week. They had			Any concerns will be corrected	l	
	not had to throw a le	ot of foods out.			immediately. Additionally, the		
					Administrator will round weekly		
		s were never provided during			the kitchen area to monitor for		
	the survey.				pest control and overall		
	The assument feethers	policy titled, "Pest Control",			cleanliness of the area; this wi	ıı be	
	_	of 9-1-22 and was provided by			ongoing. The results of these audits will	ho	
		n 04/25/24 at 4:58 P.M. The			reviewed in Quality Assurance		
		A pest control service shall be			Meeting monthly for 6 months		
		the facilityThe pest control			until an average of 100%	OI .	
		nducted on a regular and as			compliance or greater is achie	ved	
		loyees are instructed to			x4 consecutive weeks. The Q		
	_	observations of pests to their			Committee will identify any tre		
	department heads	Outside openings shall be			or patterns and make		
	protected against the	e entrance of insects by			recommendations to revise the	9	
	tight-fitting, self-clo	osing doors, closed windows,			plan of correction as indicated	•	
	screening, controlle	d air currents or other					
	_	g openings shall be tight-fitting					
		The facility shall be kept in					
		cleaning procedures used to					
		ge or feeding of insects or					
	rodents						
R 0154	410 IAC 46 2 F 4	5/k)					
IN U 134	410 IAC 16.2-5-1.						
Bldg. 00	Sanitation and Sa	fety Standards - Deficiency					
Diag. 00	Based on observation	on, interview, and record	R 0154	1	I. What corrective action(s) wil	l he	05/10/2024
		failed to provide a clean and	1 1 0132	т	accomplished for those reside		03/10/2024
	_	2 of 2 kitchen observation.			found to have been affected by		
	-	ice had the potential to affect 5			deficient practice;	,	
	•	esided in the facility.			the cardboard box of cheerios was removed from the	;	
	Findings include:				floor		
	During an observation the following was o	on on 04/25/24 at 9:03 A.M., bserved:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155208		ľ í	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  04/25/2024			
NAME OF PROVIDER OR SUPPLIER  APERION CARE HANOVER			41	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 PREF TA	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	<ul> <li>The service hallway doors that lead to the kitchen were open. The dishwasher room door from the hallway was open and no staff were present. The dish room lead to the main kitchen with the door open between the rooms and no staff were present. The main kitchen door was open to the hallway and 42 feet from the kitchen door an exterior door was open.</li> <li>The dry storage room had a cardboard box of cheerios on the floor. The bottom of the baseboard and the floor were black with food debris.</li> <li>A trash can between a milk cooler and the ice machine was overflowing with trash and the lid was lying on the floor.</li> <li>Behind the stove was an open and empty jelly container and numerous dried cooked green beans and other food debris.</li> <li>The serving room contained steam tables. One steam table had a spoon and 2 packages of flour tortillas sitting in it. Under the steam tables were various food crumbs and insulation.</li> <li>The kitchen cleaning schedules were provided by Dietary Aide 2 on 04/25/24 at 9:28 A.M. The scheduled lacked the following cleaning:</li> <li>P.M. Cook Cleaning Schedule #4: <ul> <li>No documented cleaning on 04/12/24, 04/15/24, 04/20/24, and 04/21/24.</li> <li>No weekly deep clean of the floor and underneath and behind tables on 04/02/24, 04/08/24, 04/15/24, and 04/21/24.</li> </ul> </li> </ul>				the trash can between the milk cooler and ti ice machine emptied and the secured. the steam tables we cleaned and under the steam tables were cleaned the administrator	lid re		
					ensured the doors were close kitchen, dish room, and exteri doors; staff trained on closing doors	or		
					cleaning completed behind the stove Cleaning scheduled and deep clean schedules reviewed and			
					updated daily II. How other residents having potential to be affected by the same deficient practice will be	•		
					identified and what corrective action(s) will be taken; Reside who receive food/beverages prepared in the dietary kitcher have the potential to be affect	ents n		
					by this finding.  III. What measures will be put place and what systemic char will be made to ensure that the	into nges		
					deficient practice does not recommon Dining Service re-educated by administrator on kitchen sanitand cleaning schedules to ensure that all food is stored, prepare and distributed in accordance	y the ation sure ed		
	A.M. Cook Cleanin	g Schedule #1:			professional standards for foo service safety and review of the			

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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 <u>00</u> B. WING			COMPLETED 04/25/2024		
		155208	B. W			04/25/	2024	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD					
APERIO	N CARE HANOVER	L .		HANOV	/ER, IN 47243			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DELICIPATION OF			COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	- No documented cleaning or weekly deep				cleaning schedules and logs			
	cleaning from 04/08	3/24 through 04/24/24.			affecting sanitation. Dietary			
	A.M. A.1. Cl	6.1.11.1/2			staff aware of location of cleaning			
	A.M. Aide Cleaning				schedules.	- \		
		eaning or weekly deep 8/24 through 04/24/24.			IV. How the corrective action(s	•		
	cleaning from 04/06	8/24 tillough 04/24/24.			will be monitored to ensure the deficient practice will not recur			
	During an interview	on 04/25/24 at 9:22 A.M.,			i.e., what quality assurance			
	_	Aide 2 indicated there were			program will be put into place;	The		
	-	dules to be checked off, but			Dining Service Manager will	1110		
		le to check them because they			monitor the cleaning schedule	s		
	were short help. They always made sure their			and will tour the kitchen to inspect				
	_	eted but didn't always			for cleanliness daily 5 x a wee			
	document it. They v	vere unsure where the current		4 weeks, 3 times a week for 4				
	weeks cleaning schedules were located.				weeks, 2 times a week for 4			
					weeks and weekly for 12 wee	ks		
	_	on 04/25/24 at 1:51 P.M., the			to ensure on going compliance	Э.		
		ated she thought the cleaning	Any concerns will be corrected					
		ly to go when the Dietary			immediately and initiate			
	_	cation on Friday, 04/20/24. The			re-education up to disciplinary			
	cleaning schedules	should be completed.			action as warranted. Additiona	ally,		
	]	04/05/04 + 0.04 7.35			the Administrator will round			
		on on 04/25/24 at 2:34 P.M.,			weekly in the kitchen area to			
	the following was o	bserved:			monitor for pest control and ov			
	The cordboord box	x of cheerios was removed			cleanliness of the area; this wi	ıı be		
	from the floor.	t of chechos was fellioved			ongoing.  The results of these audits wil	l ho		
	nom me noor.				reviewed in Quality Assurance			
	- The trash can bety	veen a milk cooler and the ice			Meeting monthly for 6 months			
				until an average of 100%				
	machine was emptied and the lid was on top.		compliance or greater is achieved					
	During an interview on 04/25/24 at 5:54 P.M., the				x4 consecutive weeks. The Q			
	Administrator indicated she was unable to find a				Committee will identify any tre			
	kitchen policy and had contacted corporate				or patterns and make			
		ras not provided upon exit.			recommendations to revise the	е		
		-			plan of correction as indicated			

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