STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00431249 and IN00430588. 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 Provider number: 155208 AIM number: 100291080 Census Bed Type: SNF/NF: 65 Residential: 5 Total: 70 Census Payor Type: Medicare: 2 Medicaid: 62 Other: 1 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 3, 2024.	F 0000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set 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="">	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on record review and interview, the facility	F 0609		05/10/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failed to ensure all investigations and outcomes of the investigations were reported to the Indiana Department of Health (IDOH), within 5 working days of the incident, for 9 of 9 reported incidents. (Residents B, C, D, E, F, G, H, J, K, L, M, and N) Findings include: 1. On 02/15/24 at 2:23 P.M., a possible drug diversion that involved Residents F and Resident G was reported to IDOH. The 5 day follow-up outcome of the investigation was not reported until 04/24/24. 2. On 03/08/24 at 1:01 P.M., a resident to resident incident between Resident H and Resident J was reported to IDOH. The 5 day follow-up outcome of the investigation was not reported until 04/24/24. 3. On 03/14/24 at 1:01 P.M., a resident to resident incident between Resident B and Resident C was reported to IDOH. The 5 day follow-up outcome of the investigation was not reported until 04/24/24. 4. On 03/22/24 at 10:01 P.M., a resident fall with injury that involved Resident J was reported to IDOH on 03/26/24. The 5 day follow-up outcome of the investigation was not reported until 04/24/24. 5. On 03/27/24 at 12:30 A.M., a resident to visitor incident that involved Resident N was reported to IDOH. The 5 day follow-up outcome of the investigation was not reported until 04/24/24. 6. On 03/31/24 at 4:05 P.M., a resident to resident incident between Resident D and Resident E was reported to IDOH. The 5 day follow-up outcome		I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The administrator conducted a 60 day look back of abuse investigations to ensure final follow-ups were completed and submitted to the state agency. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; all residents who have a allegation of abuse have the potential to be affected. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; the Regional Vice President of Operations re-educated the administrator on the timeline for alleged abuse investigations; to include the following: 1. Ensuring that all alleged violations involving abuse neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse or do not result in serious	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of the investigation was not reported until 04/24/24. 7. On 04/05/24 at 10:15 A.M., a resident to resident incident between Resident B and Resident K was reported to IDOH. The 5 day follow-up outcome of the investigation was not reported until 04/24/24. 8. On 04/06/24 at 8:01 A.M., a resident to resident incident between Resident H and Resident M was reported to IDOH. The 5 day follow-up outcome of the investigation was not reported until 04/24/24. 9. On 04/07/24 at 3:15 P.M., a resident fall with injury that involved Resident L was reported to IDOH. The 5 day follow-up outcome of the investigation was not reported until 04/24/24. During an interview on 04/25/24 at 1:51 P.M., the Administrator indicated she was behind on getting the 5-day follow-ups completed and would follow the State and Federal regulation. The current, undated, facility policy titled, "VERBAL/MENTAL ABUSE ALLEGATION STAFF TO RESIDENT QUALITY ASSURANCE CHECKLIST", was provided by the Administrator on 04/25/24 at 6:01 P.M. The policy indicated..."INVESTIGATION/PREVENTATIVE MEASURES...Final report to...ISDH [Indiana State Department of Health]..." 3.1-28(e)		bodily injury, to the administrator of the facility and to other officials in accordance with State law through established procedures. 2. The administrator reports the results to officials in accordance with State law, including to the State Survey Agency within 5 working days of the incident. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The administrator will report and review all initial investigation with the Regional Nurse Consultant/and or the Regional Vice President of Operations and the 5 day follow up report to ensure compliance with the reporting timeline. The administrator will track all investigations and log on an audit tool; if issues are identified corrective action will be taken immediately. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 100% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation, interview, and record review, the facility failed to administer medications and monitor and residents with behavioral health concerns for 2 of 4 residents reviewed for behavioral health. (Residents B and D) Findings include: 1a. During an observation and interview on 04/24/24 at 9:59 A.M., Resident B was sitting in his recliner in his room. The resident indicated he felt safe and liked his new room. In March there was an incident where he had accidentally bumped into another resident's wheelchair and that resident was rude to him. The clinical record for Resident B was reviewed on 04/24/24 at 10:45 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 02/20/24, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, Huntington's Disease, anxiety, depression, and psychotic disorder. A physician's order, dated 03/13/24 through 03/14/24, indicated the resident was to receive Haldol (an antipsychotic medication) 2 mg (milligrams) in the morning for psychosis related to Huntington's Disease. A physician's order, dated 03/13/24 through 04/18/24, indicated the resident was to receive Haldol 5 mg, at bedtime for psychosis related to Huntington's Disease. The March 2024 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) lacked documentation the resident had received the Haldol medication on the following dates and	F 0740	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident B:** This resident continues to be monitored by psych services; NP and psychologist and due to resident request the ADON conducting psycho social visits. Since resident returned from psych in patient stay all medication been given has prescribed and no suicidal ideations **Resident C**: No new interventions indicated for this resident; there has not been any conflict with other residents and all medications been given as prescribed. On going psychological evaluations and monitoring conducted by the psych provider and social service director/designee. **Resident D:** Psychosocial visit conducted, and facility secured placed at a local assisted living community; discharge is pending as state guardian coordinating discharge date. On going psychological evaluations and monitoring conducted by the psych provider and social service director/designee. **Resident E:** Based on	05/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident expressed frustration regarding the other resident and his frustration regarding the SSD and the Administrator. The SSD and Administrator consulted with Psychiatric Nurse Practitioner (NP) regarding the recent behaviors of the resident. The Psychiatric NP reviewed the resident's medications and increased the resident's anti-psychotic medication. A Social Service Progress Note, 03/18/24 at 12:57 P.M., indicated the SSD spoke with the resident. The resident continued to express frustration with the SSD and Administrator. The SSD asked how he was doing with his room change and resident responded he had a lawyer and was going to sue the facility. During an interview on 04/24/24 at 12:00 P.M., LPN (Licensed Practical Nurse) 4 indicated in March Resident C was sitting at the nurse's station and she wasn't sure what happened. There were words that were exchanged, and they immediately separated the residents and alerted the SSD and Administrator. They were both placed one on one observations (one staff to one resident) until management staff were present. There was no physical altercation, and no other threats were made after that. She was unsure if the residents were placed on 15-minute monitoring. During an interview on 04/24/24 at 12:10 P.M., LPN 5 indicated in March Resident C was sitting in the hallway and Resident B walked by, bumped 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.		readmission and/or admission from an inpatient psychiatric stay. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The DON/Designee will audit the EMAR 5x/ week for 4 weeks. 3 x/ week for 4 weeks and 2 x / week for 4 weeks and weekly for 12 week . If issues identified, issue will be corrected and if warranted will initiate re-education up to disciplinary action. The Medical Records Director will audit re-admissions after inpatient psych hospital stay to ensure the psychosocial evaluation to completed upon return. These audits will be completed within 48 hrs of the next business day. The audits will continue for 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 100% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1b. A Social Service Progress Note, dated 04/11/24 at 11:34 A.M., indicated Resident B was in the dining room hitting a wall. The Psychologist went to speak with the resident to discuss why he was upset. The Psychologist reported to the SSD that the resident was having homicidal ideation's regarding another resident and members of the staff. The resident was upset to the point he pounded on the table multiple times while talking to the psychologist. A Social Service Progress Note, dated 04/11/24 at 11:24 A.M., indicated Resident B would be admitted to a Neuropsychiatry Hospital. A Nursing Progress Note, dated 04/19/24 at 1:50 P.M., indicated the resident returned to the facility from the Neuropsychiatry Hospital. There were no Social Service Follow-Up visits to Resident B after his return from Neuropsychiatry Hospital until he was seen by the Psychiatric NP on 04/24/24 and the Psychologist on 04/25/24. During an interview on 04/24/24 at 2:00 P.M., the SSD indicated in March Resident B was going down the hallway and bumped into Resident C's wheelchair. There were some words that were exchanged but the residents were able to be calmed down. Resident B had moved rooms, but she couldn't remember if the residents were placed on any monitoring. Resident B did go out to the psychiatric hospital and when he returned, he was placed on 15-minute check monitoring. Since his return he had not had any behaviors. She didn't believe anyone had talked to the resident from a Social Service standpoint since he returned to the facility. She was a trigger for him, but she believed the DON (Director of Nursing) could talk with him.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. During an observation on 04/24/24 at 2:21 P.M., Resident D was lying in her bed on the skilled unit. She was upset about not being able to live in her residential apartment due to an incident that happened between her and another resident that resulted in her having to go out to a behavioral psychiatric hospital. The clinical record for Resident D was reviewed on 04/24/24 at 11:22 A.M. The resident admitted to the skilled nursing facility on 04/11/24. The diagnoses included, but were not limited to, dementia, anxiety, and depression. The clinical record lacked any Social Service Visits since the resident returned from the Neuropsychiatry Hospital on 04/11/24. During an interview on 04/24/24 at 2:00 P.M., the SSD indicated Resident D had a physical altercation with Resident E while they lived on the facilities Assisted Living Side. Resident D had went out to a Neuropsychiatry Hospital and returned on 4/11/24. On 4/11/24, upon return the resident was moved to the skilled unit. The resident has had no behaviors since her return to the facility and remained on 15-minute check monitoring. She was able to review behaviors every morning through progress notes. A Progress Note, dated 04/22/24 at 9:39 A.M., indicated Resident D went to the nurse's station and said "...If this female resident says anything to me today, I'm going to beat the sh*t out of her, I'm not putting up with it..." During an interview on 04/25/24 at 12:03 P.M., the SSD indicated Resident D was taken off her 15-minute checks the prior evening due to the IDT			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(Interdisplinary Team) agreeing to her being taken off them, but she was not a part of that discussion. When the Psychologist visited today wanted the resident placed back on 15-minute monitoring due to the resident's depression. There was an incident on 04/22/24 when Resident E had made snarky comments to Resident D. Resident E was then moved to Wing 1. During an interview on 04/25/24 at 1:21 P.M., the Psychologist indicated she had visited with the resident on 04/18/24 and 04/25/24. She had recommended to restart the 15-minute monitoring due to the resident impulsivity and recent hospitalization. The resident knows what to say to keep herself out of the hospital. During an interview on 04/25/24 at 1:51 P.M., the Administrator indicated the Resident D required more supervision due to her conflicts with other residents. Because Resident E was moved to a different unit, they felt the 15-minute monitoring could be removed, but the psychologist wanted to start it back the next day. During an interview on 04/25/24 at 5:54 P.M., the Administrator indicated residents should have a psychosocial evaluation when they return to the facility after a neuropsychiatry hospital stay. The current, undated, facility policy titled, "Reducing Risk for Medication Errors: Following the 5 Rights of Medication Administration" was provided by the Administrator on 04/25/24 at 5:05 P.M. The policy indicated, "...ALWAYS DOCUMENT ON THE EMAR AFTER ADMINISTERING THE MEDICATION..." The current facility policy titled, "Behavioral Health Services" with a revision date of 10-24-22,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was provided by the Administrator on 04/25/24 at 4:58 P.M. The policy indicated, "...To establish a system for identifying behaviors and implementing appropriate interventions consistent with the individualized plan of care and to ensure that each resident receives appropriate treatment and services to attain the highest practicable mental and psychosocial well-being..." This citation relates to Complaint IN00430588. 3.1-37(a)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to provide a clean and sanitary kitchen for 2 of 2 kitchen observation. This deficient practice had the potential to affect 63 of 65 residents that resided in the facility. Findings include: During an observation on 04/25/24 at 9:03 A.M., the following was observed: - 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. - 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.	F 0812	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; the cardboard box of cheerios was removed from the floor the trash can between the milk cooler and the ice machine emptied and the lid secured. the steam tables were cleaned and under the steam tables were cleaned the administrator ensured the doors were closed to kitchen, dish room, and exterior doors; staff trained on closing doors	05/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- A trash can between a milk cooler and the ice machine was overflowing with trash and the lid was lying on the floor. - Behind the stove was an open and empty jelly container and numerous dried cooked green beans and other food debris. - 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. 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: P.M. Cook Cleaning Schedule #4: - No documented cleaning on 04/12/24, 04/15/24, 04/20/24, and 04/21/24. - No weekly deep clean of the floor and underneath and behind tables on 04/02/24, 04/08/24, 04/15/24, and 04/22/24. A.M. Cook Cleaning Schedule #1: - No documented cleaning or weekly deep cleaning from 04/08/24 through 04/24/24. A.M. Aide Cleaning Schedule #2: - No documented cleaning or weekly deep cleaning from 04/08/24 through 04/24/24. During an interview on 04/25/24 at 9:22 A.M., Cook 3 and Dietary Aide 2 indicated there were daily cleaning schedules to be checked off, but they had been unable to check them because they were short help. They always made sure their cleaning was completed but didn't always document it. They were unsure where the current		cleaning completed behind the stove Cleaning scheduled and deep clean schedules reviewed and updated daily II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Residents who receive food/beverages prepared in the dietary kitchen have the potential to be affected by this finding. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Dining Service re-educated by the administrator on kitchen sanitation and cleaning schedules to ensure that all food is stored, prepared and distributed in accordance with professional standards for food service safety and review of the cleaning schedules and logs affecting sanitation. Dietary staff aware of location of cleaning schedules. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The Dining Service Manager will monitor the cleaning schedules and will tour the kitchen to inspect for cleanliness daily 5 x a week for 4 weeks, 3 times a week for 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	weeks cleaning schedules were located. During an interview on 04/25/24 at 1:51 P.M., the Administrator indicated she thought the cleaning schedules were ready to go when the Dietary Manager left for vacation on Friday, 04/20/24. The cleaning schedules should be completed. During an observation on 04/25/24 at 2:34 P.M., the following was observed: - The cardboard box of cheerios was removed from the floor. - The trash can between a milk cooler and the ice machine was emptied and the lid was on top. During an interview on 04/25/24 at 5:54 P.M., the Administrator indicated she was unable to find a kitchen policy and had contacted corporate support. A policy was not provided upon exit. 3.1-21(i)(3)		weeks, 2 times a week for 4 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. Additionally, the Administrator will round weekly in the kitchen area to monitor for pest control and overall cleanliness of the area; this will be ongoing. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 100% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated	
F 0925 SS=F Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program Based on observation, interview, and record review, the facility failed to ensure an effective pest control program was maintained and the facility was free of rodents. This deficient practice had the potential to affect 65 of 65 residents that resided in the facility. Findings include: 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	F 0925	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; administrator contacted pest control the day of mouse observation	05/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 was doing any good. During an observation on 04/25/24 at 9:03 A.M., the following was observed: - 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 dry storage room had wire racks around the walls. A wire rack shelf contained a cardboard box, that had six pie crusts that were wrapped in sealed plastic. On the top of the pie crust there was a half-dollar size hole going into the pie where mouse droppings were visible. A second shelf contained a clear, plastic tote that was half full of individual, 0.25 oz packages of croutons. A few crouton packages at the bottom of the container had eaten through holes in them. There was visible food and mouse droppings throughout the bottom of the container. There was a cardboard box of cheerios on the floor. The bottom of the baseboard and the floor were black with food debris and there were visible mouse baits in the room. - A trash can between a milk cooler and the ice machine was overflowing with trash and the lid		cardboar d box of cheerios was removed from the floor box of cheerios was removed from the floor the trash can between the milk cooler and the ice machine emptied and the lid secured. the steam tables were cleaned and under the steam tables were cleaned the administrator ensured the doors were closed to kitchen, dish room, and exterior doors; staff trained on closing doors cleaning completed behind the stove cleaning schedules and deep clean schedules reviewed and updated daily the dry storage room was cleaned by the Housekeeping Supervisor, the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was lying on the floor,. - Behind the stove was an open and empty jelly container and numerous dried cooked green beans and other food debris. - The serving room contained steam table were various food crumbs and insulation were under the table lying on the floor. There was a shelf on the wall that had 16 open black storage bins, one storage bin had soft jelly packets and visible mouse droppings. During an interview on 04/25/24 at 9:22 A.M., Cook 3 indicated she was unsure if the facility had any pest issues. During an interview on 04/25/24 at 9:24 A.M., Dietary Aide 2 indicated she had not seen the pest control company for about a month. They had been having issues and the prior pest control company wasn't fixing the problem. During an interview on 04/25/24 at 9:39 A.M., the Administrator came into the kitchen and indicated the pest control company came to the facility monthly. They had a call out to them today about the mouse being seen in the SSD office. They had issues recently in the kitchen with cockroaches under a sink, but it had been taken care of. She was unaware of any mouse concerns in the kitchen. The pest control logs were requested at that time. At 1:51 P.M., the Administrator indicated from time to time pest concerns do come up and they were able to call the pest control company and have them come. They were here a few weeks ago for the mouse in the SSD office and concerns in the kitchen. The Dietary Manager was able to call the pest control company on her own without notify the Administrator. She had		open pie crust , croutons and toes discarded II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Residents who reside at the community have the potential to be affected by this alleged practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; On 4/25/24 the new pest control vendor started and rounded the exterior to ensure any outside openings are protected against the entrance of insects/rodents; any areas identified were immediately secured. The new vendor will begin 2 x a month service for the next 3 months and will be re-evaluated at that time. The Maintenance Director was re-educated by the administrator on general pest control, to ensure the monitoring for holes in walls while doings weekly rounds, to round with the pest control representative to ensure issues identified on the logs are addressed and to review the notes from all pest control visits with the administrator to ensure pest control issues are resolved timely. Additionally, new vendor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	also placed a call to the pest control company to get the records from their visits. During an interview on 04/25/24 at 3:25 P.M., Dietary Aide 2 indicated the Maintenance Director had put sticky traps out and had caught several mice. It seemed like it was getting better but had been bad for about a month and a half. They had salads with croutons earlier in the week. They had not had to throw a lot of foods out. The pest control logs were never provided during the survey. The current facility policy titled, "Pest Control", with a revision date of 9-1-22 and was provided by the Administrator on 04/25/24 at 4:58 P.M. The policy indicated, "...A pest control service shall be under contract with the facility...The pest control program will be conducted on a regular and as needed basis...Employees are instructed to promptly report all observations of pests to their department heads...Outside openings shall be protected against the entrance of insects by tight-fitting, self-closing doors, closed windows, screening, controlled air currents or other means...All building openings shall be tight-fitting and free of breaks...The facility shall be kept in such condition and cleaning procedures used to prevent the harborage or feeding of insects or rodents... 3.1-19(f)(4)		provided the facility with pest control logs that are kept at each nursing station, kitchen and front office on the logs are communicated to the vendor. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The Maintenance Director will conduct internal and external rounds of the facility; including the kitchen 5 x a week for 4 weeks, 3x week for 4 weeks, 2 x a week for 4 weeks and 1 time a week for 12 weeks. Any concerns will be corrected immediately. Additionally, the Administrator will round weekly in the kitchen area to monitor for pest control and overall cleanliness of the area; this will be ongoing. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 100% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00431249 and IN00430588.	R 0000	*This Plan of Correction is the center's credible allegation of compliance.*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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.		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set 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="">	
R 0149 Bldg. 00	410 IAC 16.2-5-1.5(f) Sanitation and Safety Standards - Deficiency Based on observation, interview, and record review, the facility failed to ensure an effective pest control program was maintained and the facility was free of rodents. This deficient practice had the potential to affect 5 of 5 residents that resided in the facility. Findings include: 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	R 0149	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; administrator contacted pest control the day of mouse observation cardboard box of cheerios was removed from the floor box of cheerios was removed from the floor the trash can between the milk cooler	05/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was doing any good. During an observation on 04/25/24 at 9:03 A.M., the following was observed: - 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 dry storage room had wire racks around the walls. A wire rack shelf contained a cardboard box, that had six pie crusts that were wrapped in sealed plastic. On the top of the pie crust there was a half-dollar size hole going into the pie where mouse droppings were visible. A second shelf contained a clear, plastic tote that was half full of individual, 0.25 oz packages of croutons. A few crouton packages at the bottom of the container had eaten through holes in them. There was visible food and mouse droppings throughout the bottom of the container. There was a cardboard box of cheerios on the floor. The bottom of the baseboard and the floor were black with food debris and there were visible mouse baits in the room. - A trash can between a milk cooler and the ice machine was overflowing with trash and the lid was lying on the floor,. - Behind the stove was an open and empty jelly container and numerous dried cooked green beans and other food debris.		and the ice machine emptied and the lid secured. the steam tables were cleaned and under the steam tables were cleaned the administrator ensured the doors were closed to kitchen, dish room, and exterior doors; staff trained on closing doors cleaning completed behind the stove cleaning schedules and deep clean schedules reviewed and updated daily the dry storage room was cleaned by the Housekeeping Supervisor, the open pie crust , croutons and toes discarded II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Residents who reside at the community have the potential to be affected by this alleged practice. III. What measures will be put into place and what systemic changes will be made to ensure that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- The serving room contained steam table were various food crumbs and insulation were under the table lying on the floor. There was a shelf on the wall that had 16 open black storage bins, one storage bin had soft jelly packets and visible mouse droppings. During an interview on 04/25/24 at 9:22 A.M., Cook 3 indicated she was unsure if the facility had any pest issues. During an interview on 04/25/24 at 9:24 A.M., Dietary Aide 2 indicated she had not seen the pest control company for about a month. They had been having issues and the prior pest control company wasn't fixing the problem. During an interview on 04/25/24 at 9:39 A.M., the Administrator came into the kitchen and indicated the pest control company came to the facility monthly. They had a call out to them today about the mouse being seen in the SSD office. They had issues recently in the kitchen with cockroaches under a sink, but it had been taken care of. She was unaware of any mouse concerns in the kitchen. The pest control logs were requested at that time. At 1:51 P.M., the Administrator indicated from time to time pest concerns do come up and they were able to call the pest control company and have them come. They were here a few weeks ago for the mouse in the SSD office and concerns in the kitchen. The Dietary Manager was able to call the pest control company on her own without notify the Administrator. She had also placed a call to the pest control company to get the records from their visits. During an interview on 04/25/24 at 3:25 P.M., Dietary Aide 2 indicated the Maintenance Director		deficient practice does not recur; On 4/25/24 the new pest control vendor started and rounded the exterior to ensure any outside openings are protected against the entrance of insects/rodents; any areas identified were immediately secured. The new vendor will begin 2 x a month service for the next 3 months and will be re-evaluated at that time. The Maintenance Director was re-educated by the administrator on general pest control, to ensure the monitoring for holes in walls while doings weekly rounds, to round with the pest control representative to ensure issues identified on the logs are addressed and to review the notes from all pest control visits with the administrator to ensure pest control issues are resolved timely. Additionally, new vendor provided the facility with pest control logs that are kept at each nursing station, kitchen and front office on the logs are communicated to the vendor. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The Maintenance Director will conduct internal and external rounds of the facility; including the kitchen 5 x a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	had put sticky traps out and had caught several mice. It seemed like it was getting better but had been bad for about a month and a half. They had salads with croutons earlier in the week. They had not had to throw a lot of foods out. The pest control logs were never provided during the survey. The current facility policy titled, "Pest Control", with a revision date of 9-1-22 and was provided by the Administrator on 04/25/24 at 4:58 P.M. The policy indicated, "...A pest control service shall be under contract with the facility...The pest control program will be conducted on a regular and as needed basis...Employees are instructed to promptly report all observations of pests to their department heads...Outside openings shall be protected against the entrance of insects by tight-fitting, self-closing doors, closed windows, screening, controlled air currents or other means...All building openings shall be tight-fitting and free of breaks...The facility shall be kept in such condition and cleaning procedures used to prevent the harborage or feeding of insects or rodents...		week for 4 weeks, 3x week for 4 weeks, 2 x a week for 4 weeks and 1 time a week for 12 weeks. Any concerns will be corrected immediately. Additionally, the Administrator will round weekly in the kitchen area to monitor for pest control and overall cleanliness of the area; this will be ongoing. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 100% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency Based on observation, interview, and record review, the facility failed to provide a clean and sanitary kitchen for 2 of 2 kitchen observation. This deficient practice had the potential to affect 5 of 5 residents that resided in the facility. Findings include: During an observation on 04/25/24 at 9:03 A.M., the following was observed:	R 0154	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; the cardboard box of cheerios was removed from the floor	05/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- 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. - 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. - A trash can between a milk cooler and the ice machine was overflowing with trash and the lid was lying on the floor. - Behind the stove was an open and empty jelly container and numerous dried cooked green beans and other food debris. - 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. 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: P.M. Cook Cleaning Schedule #4: - No documented cleaning on 04/12/24, 04/15/24, 04/20/24, and 04/21/24. - No weekly deep clean of the floor and underneath and behind tables on 04/02/24, 04/08/24, 04/15/24, and 04/22/24. A.M. Cook Cleaning Schedule #1:		the trash can between the milk cooler and the ice machine emptied and the lid secured. the steam tables were cleaned and under the steam tables were cleaned the administrator ensured the doors were closed to kitchen, dish room, and exterior doors; staff trained on closing doors cleaning completed behind the stove Cleaning scheduled and deep clean schedules reviewed and updated daily II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Residents who receive food/beverages prepared in the dietary kitchen have the potential to be affected by this finding. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Dining Service re-educated by the administrator on kitchen sanitation and cleaning schedules to ensure that all food is stored, prepared and distributed in accordance with professional standards for food service safety and review of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	04/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- No documented cleaning or weekly deep cleaning from 04/08/24 through 04/24/24. A.M. Aide Cleaning Schedule #2: - No documented cleaning or weekly deep cleaning from 04/08/24 through 04/24/24. During an interview on 04/25/24 at 9:22 A.M., Cook 3 and Dietary Aide 2 indicated there were daily cleaning schedules to be checked off, but they had been unable to check them because they were short help. They always made sure their cleaning was completed but didn't always document it. They were unsure where the current weeks cleaning schedules were located. During an interview on 04/25/24 at 1:51 P.M., the Administrator indicated she thought the cleaning schedules were ready to go when the Dietary Manager left for vacation on Friday, 04/20/24. The cleaning schedules should be completed. During an observation on 04/25/24 at 2:34 P.M., the following was observed: - The cardboard box of cheerios was removed from the floor. - The trash can between a milk cooler and the ice machine was emptied and the lid was on top. During an interview on 04/25/24 at 5:54 P.M., the Administrator indicated she was unable to find a kitchen policy and had contacted corporate support. A policy was not provided upon exit.		cleaning schedules and logs affecting sanitation. Dietary staff aware of location of cleaning schedules. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The Dining Service Manager will monitor the cleaning schedules and will tour the kitchen to inspect for cleanliness daily 5 x a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 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. Additionally, the Administrator will round weekly in the kitchen area to monitor for pest control and overall cleanliness of the area; this will be ongoing. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 100% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	