STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLET			ETED
		155208	B. WI	NG		09/27/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				LAGRANGE RD		
HANOVE	R NURSING CENT	ER			/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 APPROPRIATE		ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
F 0000							
Bldg. 00	IN00417850, IN004 IN00417850, IN004 IN00415026. This v Focused Infection C Complaint IN00417 related to the allegar F725, F740, and F92 Complaint IN00416 related to the allegar F679, and 804. Complaint IN00415 related to the allegar Complaint IN00415 related to the allegar and 880. Survey dates: Septes 27, 2023 Facility number: 100 Provider number: 1: AIM number: 10029 Census Bed Type: SNF/NF: 71 Residential: 7 Total: 78 Census Payor Type: Medicare: 4	7850 - Federal/State deficiencies tions are cited at F600, F689, 21. 6781 - Federal/State deficiencies tions are cited at F725, F689, 6518 - Federal/State deficiencies tions are cited at F725 6026 - Federal/State deficiencies tions are cited at F725, F564, 6026 - Federal/State deficiencies tions are cited at F725, F564, 6026 - Federal/State deficiencies tions are cited at F725, F564, 6026 - Federal/State deficiencies tions are cited at F725, F564, 6026 - F6026 - F	F 00	000	Preparation and or execution of this plan does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth the statement of deficiencies. In plan of correction is prepared to or executed solely as required.	e s n on This and	
	Medicaid: 64						
	Other: 3						
	Total: 71						
	10111. / 1						

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

TITLE (X6) DATE

Marlene Powell Regional Director of Operations 10/23/2023

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7GGW11 Facility ID: 000115 If continuation sheet Page 1 of 65

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE (X		X3) DATE SURVEY COMPLETED 09/27/2023		
	PROVIDER OR SUPPLIER		410 V	T ADDRESS, CITY, STATE, ZIP COD V LAGRANGE RD DVER, IN 47243	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
	These deficiencies accordance with 41	reflect State Findings cited in			
F 0564 SS=E Bldg. 00	§483.10(f)(4)(vi) A following requirem (A) Inform each re representative, where visitation rights and procedures, in safety restriction of consistent with the subpart, the reason limitation, and to when he or she is rights under this s (B) Inform each resto his or her consequence whom he or she do not limited to, a speame-sex spouse (including a same-another family mether right to withdrate any time. (C) Not restrict, ling visitation privilege color, national origination of the consequence of the color of	Rights/Equal Visitation Prvl A facility must meet the ments: esident (or resident mere appropriate) of his or as and related facility policy including any clinical or or limitation on such rights, erequirements of this ons for the restriction or whom the restrictions apply, informed of his or her other ection. esident of the right, subject ent, to receive the visitors lesignates, including, but bouse (including a), a domestic partner -sex domestic partner -sex domestic partner), ember, or a friend, and his or aw or deny such consent at mit, or otherwise deny is on the basis of race, gin, religion, sex, gender ientation, or disability. I visitors enjoy full and ivileges consistent with ces. and record review, the facility late a resident receiving familial	F 0564	What Corrective Action(s) W Be Accomplished For Those	
	_	t for 16 of 71 residents ion. (Dementia Unit/Wing 1)		Residents Found To Have B	een

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Event ID:

7GGW11 Facility ID: 000115

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,	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> COMPLETED	
155208 B. WING 09/27/2023	1
STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER 410 W LAGRANGE RD	
HANOVER NURSING CENTER HANOVER, IN 47243	
TIANOVER, IN 47240	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)
CROSS-REFERENCED TO THE APPROPRIATE	IPLETION
	DATE
Practice:	
Findings include: No residents will be affected by	
this alleged deficient practice. The	
During a confidential interview on 9/21/23 at 9:23 sign on the Dementia Unit (Wing	
a.m., a resident's family member indicated they 1) entrance/exit door stating	
received a call from the facility a few days ago. visiting hours are 8a-8p has been	
The facility indicated they could not visit their removed.	
family member on the unit since there was a Covid How Other Residents Having	
outbreak. The Potential To Be Affected	
By The Same Deficient	
The Health Status Note, dated 8/19/2023 at 8:10 Practice Will Be Identified And	
p.m., indicated Resident H's visitors at this time What Corrective Action(s) Will	
were asked to leave by nightshift QMA (Qualified Be Taken:	
Medication Aide) on duty. All residents have the potential to	
be affected, no other residents	
The Health Status Note, dated 8/19/2023 at 8:15 were affected by this alleged	
p.m., indicated Resident H's visitors were asked deficient practice. The sign on the	
again to leave the facility per new guidelines Dementia Unit (Wing 1)	
regarding visiting hours. entrance/exit door stating visiting	
During an observation on 9/25/23 at 10:10 a.m., hours are 8a-8p has been removed.	
During an observation on 9/25/23 at 10:10 a.m., there was an 8 inch by 11 inch paper sign on the What Measures Will Be Put Into	
taped on the inside facing outside. The sign indicated visiting hours were restricted to 8:00 Changes Will Be Made To Ensure That The Deficient	
a.m. to 8:00 p.m. Practice Does Not Recur:	
All staff including management will	
During an interview with LPN (Licensed Practical be in-serviced over the facility's	
Nurse) 12 on 9/25/23 at 10:11 a.m., she indicated visitation policy and procedures.	
visiting hours are restricted due to Covid and one How The Corrective Action(s)	
resident's family member. Will Be Monitored To Ensure	
The Deficient Practice Will Not	
During an observation on 9/27.23 at 12:35 p.m., Recur:	
there was a sign posted on the outside entrance Administrator/Designee will	
door to the Dementia unit on Wing 1. The sign monitor entrance/exit doors to the	
indicated the visiting hours were restricted to 8:00 facility and each wing to ensure	
a.m. to 8:00 p.m. that visitation is not being	
restricted and to ensure that signs	
The current facility policy titled "Visitation" with a stating restricted visitation is not	
revised date of December 2013, was provided by posted weekly times 4 weeks,	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. BUILDING 00 COMPLETED		(X3) DATE SURVEY COMPLETED 09/27/2023	
	ROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 0600 SS=J Bldg. 00	the Administrator of indicated, "The fator all individuals visit residentDenying a inebriated or disrupt. This Federal tag reliable. This Federal tag reliable. The sederal tag reliable tag relia	and Neglect from Abuse, Neglect, and the right to be free from isappropriation of resident oitation as defined in this udes but is not limited to	TAG	then two times a month times months, then monthly times 3 months. Any negative finding be corrected immediately and forwarded to the RDO. A repoprogress will be forwarded to QAPI committee ongoing mofor a minimum of 6 months. It patterns are identified at the monthly QAPI meeting, an acplan will be written by the committee. Any written action plan will be monitored by the administrator/designee month until resolved and substantial compliance is achieved at 95 greater.	DATE S 2 S s will d ort of the nthly f any etion
	resident's medical §483.12(a) The fa				
	or physical abuse, involuntary seclus Based on interview failed to ensure resi occur related to sex	use verbal, mental, sexual, corporal punishment, or ion; and record review, the facility dent to resident abuse did not ual abuse resulting in a resident and a cognitive	F 0600	What Corrective Action(s) W Be Accomplished For Those Residents Found To Have B Affected By The Deficient	e

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Event ID:

7GGW11 Facility ID: 000115

If continuation sheet

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PRINTED: 11/13/2023

EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	LTIPLE C	PLE CONSTRUCTION (X3) DATE SURVEY			
	OF CORRECTION	IDENTIFICATION NUMBER			00	COMPI		
THIND I LITTLE	or conduction	155208		A. BUILDING <u>00</u> B. WING			/2023	
		100200	D. WII			03/21	72023	
NAME OF PROVIDER OR SUPPLIER				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF TROVIDER OR SOLITEIER		N.		410 W LAGRANGE RD				
HANOVE	HANOVER NURSING CENTER			HANO	VER, IN 47243			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	Ε	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	resident found in a	n unsupervised sexual			Practice:			
	situation for 2 of 5	residents reviewed for abuse.			Resident D and Resident C	were		
	(Resident C and Re	esident D)			separated by staff when resi	dents		
					were observed in the central			
	The immediate jeo	pardy began on 8/24/23, when			bathroom together. (Resider	ıt D		
		o prevent resident to resident			does have a history of makir			
	sexual abuse when	a cognitively alert male			false accusations toward sta	-		
	resident was found	with a severely cognitively			AEB: sexual comments or			
	impaired female resident in an inappropriate sexual position. The DON, ADON, MDSC, and the consultant were notified of the immediate				gestures to and about staff a	ınd		
					other residents). Resident D			
					started on Cimetidine oral ta			
	ieopardy on 9/22/2	3 at 2:55 p.m. The Immediate			and placed on 15-minute che			
		oved on 9/27/23, but			No further incidents occurred			
		nained at the lower scope and			between the two residents.	•		
	_	l, no actual harm with potential			Resident D has a BIMS of 13	3		
	· ·	mal harm that is not immediate			indicating intact cognition an			
	jeopardy.				resident C has a BIMS of 1,	u .		
	Jesparay.				indicating severely impaired			
	Findings include:				cognition (inability to consen	t)		
	I mamga maraas				Resident C has been care-pl	•		
	1 The clinical reco	ord for Resident C was reviewed			for inability to consent to sex			
		7 p.m. A Quarterly MDS			activity due to cognitive	uui		
		et) assessment, dated 7/3/23,			impairment.			
	`	ent was severely cognitively			impairment.			
		red supervision for locomotion			How Other Residents Havir	na		
		location to another). Her			The Potential To Be Affecte	· .		
					By The Same Deficient	·u		
	diagnoses included, but were not limited to: Huntington's disease, chorea (neurological disorder), psychosis, bipolar disorder,				Practice Will Be Identified	Δnd		
					What Corrective Action(s)			
	, . . .	lent behavior, and dementia.			Be Taken:	*****		
	Semzopinema, viol	Silverior, and demonition.			All Resident's BIMS scores			
	A review of the FN	MAR (Electronic Medical			reviewed. Residents with a E	RIMS		
		3 at 2:19 p.m., lacked a consent			score of 13, 14, or 15 will be			
		wer of Attorney) for the resident			planned for their ability to co			
	to have any sexual				to sexual activity based on the			
	io nave any sexual	activities.			-			
	The Core Dien det	ed 2/5/22, indicated the resident			intact cognitive status. Resi	uenis		
	I THE Care Flam, date	ca 2/3/22, maicated the residefit			with a BIMS score of 8-12		1	

had the potential for resident-to-resident abuse

related to Huntington's disease, impulsiveness,

psychosis, bipolar disorder, schizophrenia,

made by the Medical

(moderately intact cognition) will

have the determination to consent

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(7/2) 14	X2) MULTIPLE CONSTRUCTION			(Y2) DATE CHRVEY		
			l í	· /			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00			COMPLETED		
		155208	B. W	ING		09/27	/2023	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
				410 W LAGRANGE RD				
HANOVE	R NURSING CENT	ΓER		HANOVER, IN 47243				
(X4) ID		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 DEFICIENCY)	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE	
		dering into other residents'			Director/Practitioner or psychi			
		tions were to follow up with			provider based on their expert	tise		
		irector or designee or			in the area, including their abi	lity		
	1	s. Staff were to investigate the			to measure resident knowledg	ge of		
	_	resident to resident abuse per			relevant info such as risk and			
	the facility policy.	They were to monitor residents			benefits, understanding, ratior	nale		
	involved in an actua	al or suspected resident to			reasoning and resident			
	resident abuse per t	he facility policy. Staff were to			volunteeredness. The			
	notify the administrator, director of nursing, the				determination will be docume	nted		
	physician, the POA, or Guardian immediately				in the resident's medical recor	rd.		
	upon actual or suspected resident-to-resident				The resident's care plan will b	е		
	abuse and they were to separate the residents				updated to reflect the			
	involved in resident-to-resident abuse as soon as				determination. Residents with	а		
	resident-to-resident abuse was reported or				BIMS score of 7 or below will	be		
	witnessed.			care planned for their inability to		to		
					consent to sexual activity due	to		
	A Behavior Note, d	lated 7/20/23, indicated			severe cognitive impairment.	A list		
	Resident C had a be	ehavior of going into the			will be maintained at each nur	se's		
	hallway naked. The	e reason for the behavior was			station, and updated as chang	ges		
	marked unknown.				occur, by the MDS Coordinate	or,		
					with the determined mental			
	A Progress Note, da	ated 8/24/23 at 5:50 p.m.,			capacity and ability to consen	t to		
	indicated a CNA (C	Certified Nurse Aide) reported			sexual activity of each resider			
	that a resident went	into the central bathroom to		BIMS scores will be comple				
	use the toilet. After	the resident had her pants			admission, re-admission, qua			
	pulled down, a mal	e resident entered the bathroom			and with any significant chang	-		
	and pulled the curta	ain behind him and pulled			condition. The MDSC/Designe	-		
	1 -	turned to face the female			will ensure that capacity			
	resident. The CNAs	s went into the bathroom to			determinations as related to			
	clean up the area ar	nd wash their hands when they			sexual activity are kept up to	date,		
		feet behind the curtain. The			as well as the resident care pl			
	female's skin was c	hecked immediately; and no			and nursing station lists.			
		The residents were separated,			l ~			
		ervice Director) was called to			What Measures Will Be Put I	nto		
		esident. The physician was			Place and What Systemic			
	. ^	lent. The staff called the			Changes Will Be Made To			
		left a voicemail to return a call.			Ensure That The Deficient			
					Practice Does Not Recur:			
	A Progress Note. da	ated 9/7/23 at 3:48 p.m.,			All facility staff educated on th	ie		
		ent was pulling her hair out and			Facility abuse policy with a foo			
ı	I	1 0	1		,, and princy mini a lov		i e	

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155208		(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/27/2023	
NAME OF F	ROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD)	
HANOVE	R NURSING CEN	TER		/ LAGRANGE RD IVER, IN 47243		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	CTION (X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE COMPLETION ROPRIATE	
TAG		R LSC IDENTIFYING INFORMATION	TAG		5.112	
	-	excessively. She recently had		on resident's mental capa	- I	
	visitors and the behaviors began following the			related to sexual interact		
	recent visit.			abuse prevention with HI		
	During on observet	ion on 0/27/22 at 4:00 n m		behavior. The DON, MDS	l l	
	-	ion on 9/27/23 at 4:09 p.m., nding by the common		ADON in-serviced on ens	<u> </u>	
		ere were no staff visible from		mental capacity has been		
		was standing. At 4:11 p.m., the		determined by the physic and/or psychiatric provide		
		behind the medication cart and		residents with a BIMS sc	l l	
		She would have been able to		8-12 (moderately impaire		
				is documented in the res		
see the resident if she looked to her right.				medical record, care plar		
	2. The clinical record for Resident D was reviewed on 9/21/23 at 11:21 a.m. A Quarterly MDS (minimum data set) assessment, dated 8/29/23,			a running list is kept at ea		
				nurse's station with the c		
				consent ability of each re		
	, ,	ent was cognitively intact and		SSD in-serviced on revie		
		n for locomotion. His		behavior logs daily at mo	-	
		but were not limited to,		meeting (Mon-Fri. Mond	-	
	-	d affective disorder, anxiety,		include a review of the w	- I	
	-	t hyperactivity disorder.		logs) and following up on		
		31		notations made of inappr	•	
	The Behavior Man	agement Record for Resident D		sexual behavior to ensure	•	
		igust, and September indicated		has not occurred. Any po		
	the following:			findings will be reported t		
				Administrator immediatel		
	- On July 5, 6, 20, 2	27, 29, August 3, 5, 6, 9, and 11,		Residents with a BIMS so	core of	
		was using vulgar/explicit		13, 14 or 15 will be care	planned	
	language around or	towards another resident.		for their ability to consent	t to	
				sexual activity based on	their	
	- On August 3, 202	3, the resident knowingly		intact cognitive status. Re	esidents	
	entered the bathroo	m shower room with a		with a BIMS score of 8-1	2	
	half-naked female	resident.		(moderately intact cognit	ion) will	
				have the determination to	o consent	
		23, the resident indicated he		made by the Medical		
	was in a relationshi	p with a certain staff member.		Director/Practitioner or pa	•	
				provider based on their e	•	
		1 16, 2023, the resident		in the area, including the	-	
		to the bathroom with a female		to measure resident know	wledge of	
	resident exposed.			relevant info such as risk		
	·			benefits, understanding,	rationale	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208 A. BUILDING B. WING OO COMPLETED 09/27/2023 STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION DATE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243 (X5) PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243 (X5) PREFIX COMPLETION COMPLETION	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				ETED	
HANOVER NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X6) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X7) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			155208	B. W	ING		09/27/	2023
HANOVER NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X6) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X7) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE					OTD FET	ADDRESS OF A STATE SID COD		
HANOVER NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL) (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	NAME OF P	PROVIDER OR SUPPLIER	₹					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE COMPLETION	1144101/5		ren					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION	HANOVE	ER NURSING CENT	IER		HANOV	/ER, IN 4/243		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OE CODDECTION		(X5)
TAG DEGLII ATORY OR LSC IDENTIFYING INFORMATION TAG	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD		(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG REGULATORT OR ESCRIPENTIFTING INFORMATION TAG SERVICES DATE	TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
- On August 26, 2023, the resident was following reasoning and resident		- On August 26, 202	23, the resident was following			reasoning and resident		
residents. volunteeredness. The		-	,			_		
determination will be documented							nted	
- On August 27, 2023, the resident was sleeping in in the resident's medical record.		- On August 27, 202	23, the resident was sleeping in					
		another resident's bed.						
updated to reflect the						· · · · · · · · · · · · · · · · · · ·		
The Behavior Note, dated 8/11/23 at 7:27 p.m., determination. Residents with a		The Rehavior Note	dated 8/11/23 at 7:27 n m				2	
indicated Resident D was making fun of other BIMS score of 7 or below will be		-						
residents and indicated he was dating another care planned for their inability to			_					
female. Care planned for their mability to			and he was damig another			l · · ·		
		iciliaic.				-		
Severe cognitive impairment. A list		The Behavior Note, dated 8/12/23 at 11:30 a.m.,						
indicated the writer was on the unit taking an item station, and updated as changes		_						
to another resident. On their way to the door to go occur, by the MDS Coordinator,			•			_	ır,	
back to Wing 1, Resident D stopped her and with the determined mental		_						
stated, "Heywait! I have a girlfriend." He then capacity and ability to consent to		· ·	_					
proceeded to say, it was a staff member from sexual activity of each resident.								
activities. She loves me, and she kissed me. The BIMS scores will be completed at								
writer explained to resident that this was serious admission, re-admission, quarterly		_				-	-	
and inappropriate. He then said, "Oh hey! I was and with any significant change in								
just kidding. Can't you take a joke? She is not my condition. The facility will ensure			-					
girlfriend, and she did not kiss me. I was just an adequate number of staff are						· ·	re	
kidding." Nurse on call notified of resident's scheduled on the HD unit to		kidding." Nurse on	call notified of resident's					
statement. ensure abuse does not occur. In		statement.						
addition to the clinical staff, the								
The Behavior Note, dated 8/12/23 at 1:00 p.m., facility is seeking activity aides to			_				s to	
indicated after lunch service this writer spoke with work the unit during day and			-					
Resident D regarding the incident earlier in the evening hours daily, including		Resident D regarding	ng the incident earlier in the			evening hours daily, including		
shift when he told another staff member that he weekends, to assist with providing						weekends, to assist with provi	ding	
had been kissed by another staff member even additional supervision, a safe		had been kissed by	another staff member even			additional supervision, a safe		
though he insisted that he was "only joking when environment, and activities for the		though he insisted to	hat he was "only joking when			environment, and activities for	the	
I said that". This writer explained that it was residents. Any new staff will		I said that". This wr	riter explained that it was			residents. Any new staff will		
inappropriate to make untrue statements about receive education on the abuse		_				receive education on the abus	e	
staff members. That false accusations and policy, HD behaviors and sexual		staff members. That	t false accusations and			policy, HD behaviors and sexu	ual	
statements made against other residents or staff consent prior to working the HD		statements made ag	ainst other residents or staff			1 * *		
are not "just joking around". The comments are unit. The Admin/DON/SW will								
inappropriate and will not be tolerated. His meet with the staff who typically						meet with the staff who typical	lly	
privileges to attend activities with only one staff work the HD Unit 2 times per								
member present will not occur to protect staff from month to allow staff an opportunity						-	unitv	
false accusations. He verbalized understanding. to voice any concerns, discuss		_	-			1	-	

11/13/2023 PRINTED: FORM APPROVED 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 09/27/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 410 W LAGRANGE RD HANOVER NURSING CENTER HANOVER, IN 47243 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE He apologized for making up untrue statements improvements or worsening in about other residents and staff members. This reportable incidents, offer input on conversation with the resident was witnessed by improving the environment or other two other staff members. items as needed. The Administrator and DON will meet The SSD Note, dated 8/14/23 at 1:30 p.m., with HR a minimum of 2 times per indicated the SSD spoke with the resident week to review staffing needs and regarding the behaviors he had been exhibiting. progress towards filling and hiring SSD spoke with resident regarding the for vacant spots seriousness of false accusations and reminded him that unless something was true, he should not **How The Corrective Action(s)** say it even in a joking manner. Will Be Monitored To Ensure The Deficient Practice Will Not A Progress Note, dated 8/24/23 at 6:04 p.m., Recur: indicated the resident followed a female resident The Administrator/Designee will into the central bathroom and pulled the curtain audit to include: 1. Selecting 5 behind himself and the female resident. He pulled residents each week and checking his pants down and turned to face the female the MDS for the current BIMS resident. The two CNAs (Certified Nurse Aide) score and ensuring the appropriate went into the bathroom to clean and wash their care plan and/or action was taken hands when they noticed two sets of feet behind for ability to consent to sexual the curtain. When they opened the curtain both activity. (If BIMS 08-12, assuring residents had their pants pulled down. The staff the MD/Practitioner or immediately separated the male and female psychologist made a resident and did a skin check. There were no determination on ability to consent issues observed. The MD and POA were notified. to sexual activity and it is The resident was put on 15-minute checks until documented in the resident's further notice. medical record) 2. Review 10 resident's behavior logs weekly to A Progress Note, dated 8/24/23 at 4:18 p.m., ensure that potential abuse issues indicated the SSD spoke with the resident were reported to the Administrator regarding inappropriate sexual behavior towards immediately. 3. Question 10 another resident. The resident stated that he knew random staff weekly to verify what he had done was wrong. The SSD told the understanding of sexual abuse resident that he was not to be in the bathroom and consent, reporting of abuse with any other resident at any time. The resident and location of sexual consent stated he understood. list. Lack of understanding will be corrected immediately at the time A Progress Note, dated 9/12/23 at 4:27 p.m., noted. 4. Review the staff indicated the resident continued on 15-minute schedule daily during morning

STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 00 COMPLETED			ETED
		155208	B. WI	NG		09/27/	/2023
				_			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
			410 W LAGRANGE RD				
HANOVE	ER NURSING CENT	ΓER		HANOVER, IN 47243			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	·-	DATE
	checks The resident	t stated numerous times that			meeting (M-F) to ensure an		
	he watched porn all	the time.			adequate number of staff are		
					scheduled to provide a safe		
	A Progress Note, da	ated 9/13/23 at 10:52 a.m.,			environment and that all effort	s are	
	indicated the reside	nt was seen by staff being			made to schedule staff where		
	sexually inappropriate toward another staff				needed. 5. Review reportable		
	member.				incidents monthly from the HD	unit	
					to observe for increase in num	bers	
	The Care Plan, date	ed 6/5/23, indicated the resident			and any potential pattern. An		
	had exhibited sexua	ally inappropriate behaviors of			action plan will be created for	an	
	inappropriate comn	nents to staff, about staff, and			increase in reportables >10%	from	
	other residents. The interventions were for staff to				one month to the next or any		
	encourage the resid	ent to express his feelings.			identified patterns. 6. The		
	Staff were to explain to the resident that behavior				Admin/Designee will do walkir	ng	
	was not appropriate	e. They were to let the resident			rounds on the HD Unit daily,		
	know what kind of	behavior was expected and			varying shifts, to observe and	verify	
	what will be tolerat	ed. The staff were to notify the		that adequate supervision is being			
	MD as needed. Stat	ff were to talk to the resident			provided. All efforts will be ma	de to	
	about the feelings a	nd rights of others and about			secure staff for the Unit if		
	who are exposed to	his acting out.			adequate supervision is not		
					available. 7. The Admin/Desig	nee	
	The Care plan, date	ed 6/7/23, indicated the resident			will check the nurse's station		
	exhibited sexually i	nappropriate behavior. The			weekly to ensure the list of		
	interventions indica	ated staff were to administer			residents and their ability to		
	the resident's medic	cations as ordered. Staff were			consent to sexual activity is th	ere	
		naviors and reassure the			and that it is up to date. A rep	ort	
	resident it was okay	to talk of feelings or			of progress will be forwarded t	to the	
		ducated that inappropriate			QAPI committee ongoing mon	thly	
	behaviors were not	acceptable. The staff were to			for a minimum of 6 months. If	any	
		nappropriate behavior			patterns are identified at the		
	immediately per fac	cility policy.			monthly QAPI meeting, an act	ion	
					plan will be written by the		
	Review of the resident's EMAR on 9/22/23 at 2:19				committee. Any written action		
	p.m., indicated the resident lacked a care plan or				plan will be monitored by the		
	updated care plan related to the resident's sexual				administrator/designee month	ly	
	encounter on 8/24/23.				until resolved and substantial		
					compliance is achieved at 95%	% or	
	During an interview	v on 9/21/23 at 10:10 a.m., the			greater.		
		Director of Nursing) indicated					
	there was a reportal	ble on Resident D and					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 09/27/2023					
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	bathroom to wash their right, to the sir the sink and the mir toilet stall across fround a curtain pulled feet and a pair of pacurtain. They notice CNA opened the cupants down with no standing with his fe Resident C. The staresidents and report assessed both reside interviewed. When intended to do, he sche got caught. Resident context, and she did not seem dis on the end of the harmonic to around and the curtatoilet stall. She notice and asked if she needs peak, but she then Resident C was starcurtain and Resident to toilet. Resident to toilet. Resident of the punderwear were down aroused. When Resident C was doing, he said if got caught. The resident C resident C was doing, he said if got caught. The resident C aroused. When Resident C aroused. The resident C aroused C aroused. The resident C aroused C aroused. The resident C aroused C arouse	NAs went into the central heir hands. The CNAs walked hower room and turned to hower room showed a reflection of the both the sink. The bathroom stall and the CNAs saw a set of ints on the floor under the both a second pair of feet and the retain. Resident D had his brief or underwear on. He was et slightly apart and facing ff members separated the ed the incident. The ADON ents and Resident D was he was asked what he had he did not know, because the did not talk much in a not interview Resident C, but stressed. Resident D resided llway where it was all men. From 9/21/23 10:22 a.m., CNA 2 and CNA 3 went into the wash their hands, they turned hain was pulled in front of the ced Resident C's pants down and help. The resident did not noticed a second pair of feet. Inding with her back to the table D was standing in front of C's pants were down, and she lace. Resident D's pants and win, and he was sexually fully ident D was asked what he he did not know because he dents were immediately incident was reported to the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 09/27/2023				ETED		
		ROVIDER OR SUPPLIER			410 W L	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD (ER, IN 47243		
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		During an interview indicated when she central bathroom to noticed Resident C'did not usually pull into the bathrooms in CNA 2 asked her if head in the curtain at He had his pants to leaned back, and ha Resident C had her had her brief on. We and reported it. Our required feeding assessmeone with behards to be activitied usually have any result of the cameras were reprior owner took the company bought the incident. During an interview 2 indicated she was they found Residem bathroom. She was were seen on Wing together in the bath Nurse) 4 was working the LPN and had let two residents togeth C). She had immedia administration, and	and CNA 2 went into the wash their hands, CNA 2 s feet behind the curtain, she the curtain when she went tall, but the curtain was pulled. She needed help and stuck her and there stood Resident D. his ankles, hands on his hip, d a fully aroused p**is. pants to her ankles, but still e immediately separated them er half of the Wing 2 residents sistance, and if they have viors, then they would have to with the behaviors. There is on the unit. They do not all activities over there. You on 9/25/23 at 10:19 a.m., The intindicated the facility did not here a system in the building. Not hooked up to anything. The ele system boxes when the new ele building prior to this You on 9/25/23 at 10:23 a.m., CNA not sure of the actual time to D and Resident C in the not sure of the last time they 2 before they found them room. LPN (Licensed Practical ng on Wing 2 and had a N was covering on the wing for fit the floor when we found the ner (Resident D and Resident					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/27/2023				
	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	·	I her we had a situation. After the ADON returned, and we					
	indicated she had a Staff 5 to talk about Huntington's unit with She had been report about the need for resident D and Residen	w 9/25/23 at 10:32 a.m., LPN 4 meeting with the Corporate t the unit. Staff on the tere just stretched, too, thin. ting to corporate for months more help. The incident with sident C had to occur around of recall seeing either resident but it would have not been them. When the two CNAs dents out to smoke. "two staff that would normally leave one monitor all the residents during the only activities normally on the only activities normally on the only CNA working on Wing the endy CNA working on Wing the endy CNA working on Wing the unit. She indicated there was the unit. She indicated there was the are, monitor, and feed all the ther and the one nurse. The one of the vorking on Wing walking out into the hallway whe could not get him to stay all interview between 9/21/23 the member indicated there were who required assistance with					
		th 4 staff for 28 resident was ekends were the worst. When					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155208		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COM	TE SURVEY TPLETED 27/2023			
	PROVIDER OR SUPPLIEF		410 W	STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	monitor another res	resident and had to stop to ident or assist another at they were assisting to eat et.						
	9/21/23 and 9/25/23 there was not enoug needs on Wing 2. T that required feedin behaviors. The Hun not have consistent activities for the ag resident was on 15- keep them in a com work. The weekend were more staff and	al group interview between B, three staff members indicated gh staff to meet the residents' there were multiple residents g assistance and had attington's unit (Wing 2), did activities or appropriate e range of residents. When a minute checks, they tried to mon area, but this did not a shifts are the worst. If there I better activities it would be some of the aggressive						
	provided a current of "Abuse and Neglec 8/1/23. It included, "PolicyEach resid from abuse" The current facility Management" with 2015, was provided 09/27/23. The policy	a.m., the Regional Consultant copy of the policy titled t", and a revision date of but was not limited to, lent has the right to be free policy titled "Behavior a revised date of December by the Administrator on y indicated, "All Licensed						
	for documentation of Form and identifying redirect behaviors The Immediate Jeon	as, and C.N.A.s are responsible on the Behavior Monitoring ag interventions initiated to "" pardy that began on 8/24/23, 27/23, when the facility						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. BUILDING 00 COMPLETED B. WING 09/27/2023					
	PROVIDER OR SUPPLIER ER NURSING CENT		410 W I	STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	ability to consent to The residents' care pure the determination. A in-serviced on the F focus on the resident sexual interactions a Huntington/behavior education and under The Social Service I reviewing behavior meetings. The Immo on 9/27/23, but none lower scope and sev harm with potential that is not immediat Administrator or Deappropriate care planability to consent to walking round on the observe and verify a provided. This Federal tag related 3.1-27(a)(1)	wing: All residents' cognitive sexual activity was reviewed. It is blan will be updated to reflect all facility staff were acility abuse policy with a ts' mental capacity related to and abuse prevention with rs, Huntington disease estanding, and sexual abuse. Director was in-serviced on logs daily at morning ediate Jeopardy was removed compliance remained at the rerity of isolated, no actual for more than minimal harm to e jeopardy because the esignee will audit to ensure the ensure and or action was taken for sexual activity and will do the unit daily, varying shifts, to adequate supervision being sates to Complaint IN00417850					
F 0679 SS=E Bldg. 00	§483.24(c) Activitie §483.24(c)(1) The on the comprehen plan and the prefe ongoing program t choice of activities group and individu independent activi interests of and su and psychosocial	facility must provide, based sive assessment and care rences of each resident, an co support residents in their , both facility-sponsored					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) D	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> CO	OMPLETED	
	9/27/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD A40 ML ACRANGE DR		
410 W LAGRANGE RD		
HANOVER NURSING CENTER 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 APPROPRIATE	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE	
interaction in the community.		
Based on observation, interview, and record F 0679 What Corrective Action(s) Will	10/20/2023	
review, the facility failed to develop and Be Accomplished For Those		
implement individualized activities programming Residents Found To Have Been		
to meet individual resident needs for 2 of 3 Affected By The Deficient		
specialized resident units reviewed for activities. Practice:		
This deficient practice had the potential to affect No residents will be affected by		
42 of 71 resident that reside in the facility. this alleged deficient practice. The		
(Huntington's unit and the Dementia unit) facility will develop and implement		
individualized activities		
Findings include: programming to meet individual		
resident needs on the		
Review of the September activity schedule Huntington's Unit and Dementia		
indicated there was one monthly schedule for the Unit.		
whole facility. The activities planned for 9/23/23 How Other Residents Having		
(Saturday) were as followed: Daily Chronicle at The Potential To Be Affected		
9:30 a.m., Question Ball at 10:00 a.m., Exercise at By The Same Deficient		
11:00 a.m., and Musical Social at 1:00 p.m. Practice Will Be Identified And		
What Corrective Action(s) Will		
During an interview on 9/23/23 at 9:34 a.m., the Be Taken:		
Activity Director indicated today she was working All residents have the potential to		
as a CNA. The unit was short on staff, and she		
had to work the floor. They have been short were affected by this alleged		
staffed frequently and there was no possible way deficient practice. The facility will		
for her to provide activities to the whole facility. The facility had recently hired a staff member to develop and implement individualized activities		
schedule were for the whole facility. There was no current separated program for mental capacity or Huntington's Unit and Dementia Unit.		
age range. She was hopeful with another activity What Measures Will Be Put Into		
staff they could offer more specialized activities Place and What Systemic		
for the residents with Dementia unit (Wing 1) Changes Will Be Made To		
and/or Huntington's unit (Wing 2).		
Practice Does Not Recur:		
During an observation and interview on 9/23/23 at The facility will develop and		
10:15 a.m., there was no activities observed on implement individualized activities		
Wing 1 or Wing 2. programming to meet individual		
resident needs on the		
During an observation and interview on 9/23/23 at Huntington's Unit and Dementia		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155208	B. W	NG		09/27/	
				_	_		
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
			410 W LAGRANGE RD				
HANOVE	R NURSING CENT	TER		HANOV	OVER, IN 47243		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CIENCY 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
	· ·	unteers arrived at the facility.			Unit. Activity Aides designated	l to	
	They indicated they were there from a local				the Huntington's Unit and		
	_	20 indicated she was a physical			Dementia Unit will be hired. Th		
	_	teer 21 was a physical			Activity Director and Activity A	ides	
		hey indicated they try to come			will be in-serviced over the		
		ere were five residents			facility's Quality of Life-Reside	nt	
		exercise program. The five			Self Determination and		
		to enjoy the activity and most			Participation policy and		
		ng with the volunteers.			procedures.		
	-	ing up and talking with the			How The Corrective Action(s	s)	
	Volunteers when th	ey asked her to sit back in her			Will Be Monitored To Ensure		
	chair.				The Deficient Practice Will No	ot	
					Recur:		
	During an observati	ion and interview on 9/24/23 at			The Administrator/Designee w	/ill	
	10:30 a.m., there w	ere no activities observed on			monitor the activity departmen	ıt	
	Wing 2.				schedule to ensure an activity	aide	
					is designated each day for the		
	During an interview	v on 9/24/23 at 10:16 a.m., RN 7			Huntington's unit and Dementi	ia	
	indicated except for	two or three residents that go			Unit and the activity calendar t	to	
	to church there wer	e normally no activities on the			ensure appropriate activities a	re	
	weekends. If there v	was an activity it would be on			scheduled for the Huntington's	3	
	Wing 3, and the res	idents that could attend had to			Unit and Dementia Unit weekly	y	
	go off the unit to W	ing 3. There was not enough			times 8 weeks, then monthly		
	staff to take the resi	dents that needed supervision			times 3 months. Any negative		
	if they wanted to go	o. There were papers for the			findings will be corrected		
	residents to color or	r do word searches for			immediately and forwarded to	the	
	independent activiti	ies.			RDO. A report of progress will	be	
					forwarded to the QAPI commit	ttee	
	During an interview	v 9/25/23 at 10:32 a.m., LPN 4			ongoing monthly for a minimur	m of	
	indicated the only a	ctivities normally on the			6 months. If any patterns are		
	Huntington's unit w	as papers dropped off for the			identified at the monthly QAPI		
	residents to color or	r do cross word puzzles.			meeting, an action plan will be	•	
					written by the committee. Any		
	During a confidenti	al group interview between			written action plan will be		
	9/21/23 and 9/25/23	3, three staff members indicated			monitored by the		
	there was not enoug	gh staff to meet the residents'			administrator/designee monthl	ly	
	needs on Wing 2. T	There were multiple residents			until resolved and substantial	-	
		g assistance and had			compliance is achieved at 95%	6 or	
	_	atington's unit (Wing 2), did			greater.		
		activities or appropriate			j		

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 09/27/2023						
	ROVIDER OR SUPPLIER		410 W	STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
	_	e range of residents. When a						
		minute checks, they tried to						
	_	mon area, but this did not shifts are the worst. If there						
		better activities is would be						
		some of the aggressive						
	behaviors.	22						
	Cross Reference F6	89.						
	Cross Reference F7	25.						
	Resident Self Deter with a revised date	policy titled "Quality of Life - mination and Participation" of December 2016, was ministrator on 09/27/23. The						
	policy indicated, " choose activities, so	Each resident is allowed to hedules and health care that						
		his or her interests, values,						
	assessments, and plaincluding:Activiti	ans of care, es, hobbies and interests"						
	This Federal tag rela	ates to complaint IN00416781.						
	3.1-33(a)							
F 0689 SS=E Bldg. 00	- ',','	ents.						
		n resident receives sion and assistance devices nts.						
	Based on record rev	riew and interview, the facility	F 0689	What Corrective Action(s) V Be Accomplished For Those	I			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7GGW11 Facility ID: 000115

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155208	B. W	NG	_	09/27/	2023
				_	_		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					LAGRANGE RD		
HANOVE	ER NURSING CENT	TER		HANOV	HANOVER, IN 47243		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	failed to have adequ	ate supervision to prevent			Residents Found To Have Be	en	
	frequent resident falls and negative behaviors,				Affected By The Deficient		
	ensure a metal unit exit door was repaired timely				Practice:		
	and secured, chemicals and hazardous supplies				No residents will be affected b	y	
	were secured for 1 of 3 resident units reviewed for				this alleged deficient practice.	The	
	accidents. This deficient practice had the potential				exit door on Wing 2 leading to		
	to affect 26 of 71 re	esidents who reside in the			Wing 3 has been repaired. Th		
	facility. (Wing 2/H	untington's Unit)			glass door leading to the cour		
					has been repaired. Housekee	-	
	Finding includes:				carts will not have chemicals I	-	
					out on them and the carts will		
	1. During an observation on 9/21/23 at 1:58 p.m.,				be left on the units unattended		
	the exit door from the Huntington's unit/Wing 2 to				The central bathroom/shower	room	
		g with the door frame cracked			has been cleaned and all		
		om, hinges broken, and rubber			hazardous chemicals and		
	_	e door. There was a piece of			personal hygiene items will be	:	
		nat indicated to not use the			secured out of reach of reside		
	door.				Activity Aides designated to the		
					Huntington's Unit and Dement		
	During an interview	v on 9/21/23 at 10:28 a.m., the			Unit will be hired. Appropriate		
	_	Director of Nursing) indicated			nursing staff will be scheduled	for	
	· ·	ough the secured door leading			the Huntington's Unit. Food ar		
		On 9/9/23, Resident Q did a full			drinks will be served at the		
	_	oor and busted the frame, and			appropriate temperatures. For	od	
		anging by the top spring. The			trays will be delivered to the u		
	_	gh the broken door and out			at their scheduled times.		
		aff intervened and the police			How Other Residents Having		
	1	l also, broken the glass door			The Potential To Be Affected		
		d located by the SSD (Social			By The Same Deficient		
	Service Director's)	•			Practice Will Be Identified Ar	nd	
	,				What Corrective Action(s) W		
	Review on Residen	t Q's Behavior Management			Be Taken:		
		ne resident had behaviors of			All residents have the potentia	ıl to	
	·	or and unit door on the			be affected, no other residents		
		1, 9/2, 9/3, 9/9, 9/11, 9/12, 9/15,			were affected by this alleged		
	9/16, 9/17, and 9/18				deficient practice. The exit do	or on	
	, ,,,, una ,,,				Wing 2 leading to Wing 3 has	J. 011	
	2 a During a contir	nuous observation on 9/23/23			been repaired. The glass door		
		ugh 9:42 a.m., the housekeeping			leading to the courtyard has b		
		he hallway of Wing 1. The cart			repaired. Housekeeping carts		
	L cart was sitting III th	ic nanway or wing 1. The call	1		i repaired, mousekeeping Carts	vvIII	

11/13/2023 PRINTED: FORM APPROVED 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 B. WING 09/27/2023 155208 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 410 W LAGRANGE RD HANOVER NURSING CENTER HANOVER, IN 47243 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE was left unattended and contained cleaning check not have chemicals left out on chemicals in two spray bottles and cleaning them and the carts will not be left wipes. There was no staff around. CNA 10 walked on the units unattended. The by the cart and went out of the locked door. A few central bathroom/shower room has minutes later she returned to the unit and been cleaned and all hazardous continued to walk by the cart without chemicals and personal hygiene acknowledgment of the cart. There were multiple items will be secured out of reach residents waling in the hallway. of residents. Activity Aides designated to the Huntington's During an interview on 9/23/23 at 9:52 a.m., Unit and Dementia Unit will be Housekeeper 11 indicated he works every hired. Appropriate nursing staff will Saturday and Sunday. The cleaning cart was be scheduled for the Huntington's supposed to stay on the unit since several of the Unit. Food and drinks will be resident had Covid. He did not know that he was served at the appropriate supposed to secure the cleaning cart when it was temperatures. Food trays will be unattended. He was not sure where he was delivered to the units at their supposed to secure the cart. He had left the area scheduled times. to go to the laundry room to get linens. He went What Measures Will Be Put Into across the courtyard to the other side of the **Place and What Systemic** facility and left the cart on the unit unattended, **Changes Will Be Made To** with the supplies on the top of the cart, in the **Ensure That The Deficient** hallway. **Practice Does Not Recur:** Facility repairs will be completed b. During an observation on 9/23/23 at 9:43 a.m., in a timely manner and/or a of the central bathroom/shower room the timeline of a repair will be following items were sitting on an open three tier documented. Housekeeping carts cart. The items included a large jug containing two will not have chemicals left out on inches of a liquid cleaning chemical. On the label them and the carts will not be left of the chemical there was a warning statement. on the units unattended. The The label indicated the jug contained a multi central bathroom/shower room has peroxide disinfectant. The warning label in bold been cleaned and all hazardous letters indicated harmful "danger keep out of chemicals and personal hygiene reach of children". There was a disposable razor items will be secured out of reach lying on the top of a three-tier cart. At 9:45 a.m., of residents. Activity Aides Resident FF walked into and out of the central designated to the Huntington's bathroom. At 9:46 a.m., the Activity Manager Unit and Dementia Unit will be walked into the bathroom to the clean utility hired. Appropriate nursing staff will closet and out, she gathered a towel for the BOM be scheduled for the Huntington's (Business Office Manager) and walked out of the Unit. Food and drinks will be bathroom. served at the appropriate

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SUR	VEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETE	D	
		155208	B. W	ING _		09/27/202	23	
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIEF	₹			LAGRANGE RD			
HANO\/F	ER NURSING CENT	rer Ter		HANOVER, IN 47243				
	T. TORONO OLIVI							
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	DER'S PLAN OF CORRECTION DESCRIPTION SHOULD BE		
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	OMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE	
					temperatures. Food trays will	be		
	_	dential group interview between			delivered to the units at their			
		3, three staff members indicated			scheduled times. All staff will	ре		
		gh staff to meet the residents'			in-serviced over the facility's			
		There were multiple residents			Quality of Life-Resident Self			
	_	g assistance, frequent falls,			Determination and Participation			
		aviors. The Huntington's unit			Hazardous Areas in the Facili	-		
		ive consistent activities or			and Incident/Accident Reporti	-		
		es for the age range of			policy and procedures. All die	-		
		esident was on 15-minute			staff will be in-serviced over the			
		keep them in a common area,			facility's Food Temperatures of	on		
		k. The weekend shifts were			the Service line policy and			
		vere more staff and better			procedures. The Scheduler, D			
		ould possibly mitigate some of			and ADON will be in-serviced	over		
	the aggressive beha	viors.			ensuring adequate staff is			
					scheduled for the Huntington's	6		
		g 2 residents' recent falls			Unit.			
	indicated the follow	ving:			How The Corrective Action(s			
	0 (107/00) 5 10	2 2 2 1 . 7 6 1			Will Be Monitored To Ensure			
		2 p.m., Resident Z fell onto his			The Deficient Practice Will N	ot		
		s obtaining supplies from the			Recur:			
	business office.				The Maintenance			
	0.7/4/22 : 12.1	5 D 11 (DCH 4			Director/Designee will monitor			
		5 a.m., Resident P fell on the			timeliness of repairs and /or re	•		
	lioor in front of his	wheelchair and closet.			timelines weekly times 4 week			
	0.7/6/22 + 5.22	D 11 (AACH 13			then two times a month times	2		
		a.m., Resident AA fell while			months, then monthly times 3			
		he wheelchair to his bed. He			months. Housekeeping/Laund	-		
	fell face down onto	the bed.			Supervisor/Designee will mon	itor		
	0.7/6/22 + 6.22	D :1 47 C 1			housekeeping carts to ensure			
		a.m., Resident Z was found			chemicals are secured and ca			
		n a puddle of soda and minimal			are not left unattended weekly			
		had a one-inch laceration to			times 8 weeks, then two times	; a		
	his left eyebrow.				month times 2 months, then			
	On 7/10/22 + 11 /	20 a ma Danid Dalid			monthly times 2 months. The	_		
		20 a.m., Resident P slid out of			Dietary Manager/Designee wi			
	his wheelchair onto	ine noor.			complete a test tray on varying	-		
	0.7/11/02 + 0.24	5 D 11 (D 111 (C11			units at varying meals and mo			
		5 a.m., Resident P slid out of his			delivery times of meals on var			
	wheelchair onto the	e floor.			units at varying meals 3 times	a		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155208	B. Wl	ING		09/27/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			LAGRANGE RD		
HANOVE	R NURSING CENT	ER		HANOVER, IN 47243			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	0 7/24/22 4 2 22				week times 4 weeks, then 2 til	mes	
		3 a.m., Resident X was standing			a week times 4 weeks, then		
		almost fallen multiple times. I to get the resident to sit in a			weekly times 4 weeks, then 2		
	_	nt started punching her in the			times a month times 3 months		
	face and back of he				The DON/Designee will monit	OI	
	Tace and back of he	au.			the nursing schedule for appropriate amount of staff for	r the	
	- On 7/27/23 at 12:3	35 p.m., Resident AA was found			Huntington's unit daily on	แเษ	
		n his back with a laceration to			scheduled workdays times 4		
	1	oderate amount of bloody			weeks, then 2 times a week ti	mes	
	1	the laceration on his face.			4 weeks, then weekly times 4	1103	
	dramage noted from	the faction on his face.			months. The		
	- On 8/1/23 at 4:35 p.m., Resident Z went outside				Administrator/Designee will		
		I smoking. When he got out			monitor the activity departmer	nt	
		ad severed movements that			schedule to ensure an activity		
	_	n the wheelchair and the			is designated each day for the		
	resident flipped the				Huntington's Unit weekly time		
	• •				weeks, then monthly times 3		
	- On 8/6/23 at 5:54	a.m., Resident P fell in bathroom			months. Any negative findings	will	
	while transferring s	elf. The resident had a 1.5 cm			be corrected immediately and		
	laceration.				forwarded to the Administrator	r	
					and/or RDO.A report of progre	ess	
		30 a.m., Resident N had an			will be forwarded to the QAPI		
		ssion with Resident P (the			committee ongoing monthly fo	or a	
	resident stomped or	the other resident's hand).			minimum of 6 months. If any		
					patterns are identified at the		
		a.m., Resident N had a fall, the			monthly QAPI meeting, an act	ion	
		ng breakfast when he slid out			plan will be written by the		
		e floor, and he hit his left			committee. Any written action		
	_	or causing a laceration and			plan will be monitored by the		
	hematoma.				administrator/designee month	ly	
	0 9/21/22 0.1/	5 D1447.011 1.11 1			until resolved and substantial	/	
		5 p.m., Resident Z fell while he			compliance is achieved at 95%	∕o or	
		g and flipped his wheelchair.			greater.		
		he concrete. He had a 5 cm					
		forehead with 2 shallow					
	lacerations on either	r end of the abrasion.					
	- On 9/1/23 at 2:30	a.m., Resident AA was found					
	with dried blood on	his mid forehead. A laceration					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 09/27/2023			
	ROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD /ER, IN 47243	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	The resident indicat	d to the center of his forehead. ed he fell on his dresser.			
		5 p.m., Resident Z fell and was back with the wheelchair next mmate's bed.			
	transferring self from	07 a.m., Resident AA was m bed to wheelchair and the at from under him and he fell			
	lying face down on	20 a.m., Resident Z was found the floor with a pool of blood resident had a laceration to ose.			
	lying on his alarm n his bed. There was l laceration on his for	a.m., Resident AA was found nat with his face down next to blood on his face with a rehead. The resident was cription of the occurrence.			
	lying face down on wheelchair. When the	B a.m., Resident BB was found the floor next to her he resident was turned over her face and bruising on her			
	outside courtyard w in the smoking area	n 9/24/23 at 8:13 p.m., of the as very dark with no lighting. There were 5 residents (B, M, waiting on staff to smoke. No n the courtyard.			
	10 indicated she wa night shift. The resi	on 9/24/23 at 8:19 p.m., CNA s the only aide working the dents were outside waiting on em their smoking supplies.			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 09/27/2023			
	ROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
TAG	4. An observation of Wing 2 meal service Resident V were seemember walked down and went into Residestaff monitoring the residents still eating At 8:49 a.m., both so by Room 16. There the dining area and During an interview indicated Resident Showever there was at the residents needed. During an observation observation of the dining area and Puring an observation of the resident showever there was at the residents needed. During an observation observation of the property o	n 9/24/23 at 8:37 a.m., of the e indicated Resident M and rved at 8:37 a.m. Then the staff wn to the end of the hallway lent W's room. There were no e dining room with two g (Resident S and Resident U). It is taff were on the end of the hall were no staff supervising in Resident S was still eating. You 9/24/23 at 8:52 a.m., RN 7 S was a choking hazard, nothing she could do since all to be feed. It is tempted one of the last 5 served. The eggs tempted 87 and the resident's juice Fahrenheit. He indicated the red at that time and they are You 9/25/23 at 10:08 a.m., RN 7 s the resident do not receive 0:00 a.m., lunch by 1:00 p.m., ved at 4:00 p.m. and there have re still providing feeding 0 p.m. With 14 residents that sistance and multiple other be monitored for choking of enough staff to feed the food was cold. When you on and feed residents even cannot safely monitor all the	TAG		DATE
	_	a revised date of March 2010,			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 09/27/2023			ETED			
	PROVIDER OR SUPPLIER			410 W L	DDRESS, CITY, STATE, ZIP COD AGRANGE RD ER, IN 47243			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX		TEACH CORRECTIVE ACTION SHOULD BE COSS-REFERENCED TO THE APPROPRIATE		
TAG	was provided by the The policy indicated Committee shall red that residents cannot the facility" The current facility Incident Reporting October 2014, was a second control of the con	e Administrator on 09/27/2. d, "The facility's Safety commends measures to ensure at access hazardous areas in policy titled "Accident and with a revised date of provided by the Administrator		TAG	DEFICIENCY)		DATE	
	Accident/Incident R for all incidents inv							
	of June 2018, was p on 09/27/23. The po served at proper ten safetyIf temperatu levels and cannot be	privice Line" with a revised date provided by the Administrator olicy indicated, "Foods will be imperature to ensure food ares are not at acceptable a corrected in time for meal propriate menu substitution.						
	This Federal tag rel and IN00416781.	ates to Complaints IN00417850						
	3.1-45(a)							
F 0725 SS=E Bldg. 00	with the appropria sets to provide nu to assure resident maintain the highe mental, and psych resident, as detern	ent Staff. lave sufficient nursing staff te competencies and skills rsing and related services safety and attain or lest practicable physical, losocial well-being of each mined by resident individual plans of care and						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155208	B. WI	NG		09/27/	2023
	PROVIDER OR SUPPLIER			410 W L	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, 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	REFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
	in accordance with required at §483.7 §483.35(a)(1) The services by sufficing following types of basis to provide min accordance with (i) Except when withis section, licens (ii) Other nursing plimited to nurse air §483.35(a)(2) Except paragraph (e) of the designate a licens charge nurse on eased on observation review, the facility were adequate related ining assistance, in 42 of 71 residents read Wing 2) Findings include: 1. During an intervity ADON (Assistant Easident D and Resident D and Resid	e facility must provide ent numbers of each of the personnel on a 24-hour ursing care to all residents in resident care plans: aived under paragraph (e) of sed nurses; and personnel, including but not des. eept when waived under nis section, the facility must sed nurse to serve as a	F 07	725	What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice: No residents will be affected be this alleged deficient practice. Sufficient staffing will be scheduled on the Huntington's Unit and Dementia Unit included designated activity aide. 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 have the potential be affected, no other residents were affected by this alleged deficient practice. Sufficient staffing will be scheduled on the	een y sing a l ill sl to	10/20/2023

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Event ID: 7GGW11 Facility ID: 000115

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STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
155208		B. WING 09/27/2023			23		
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF P	NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
LIANO) (E	HANOVED NUIDONIO GENTED				LAGRANGE RD		
HANOVE	R NURSING CENT	ER		HANO	/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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	OMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION opened the curtain. Resident D had his pants			TAG	DEFICIENCY)		DATE
					Huntington's Unit and Dement	tia	
	down with no brief	or underwear on. He was			Unit including a designated ac	tivity	
	standing with his fe	et slightly apart and facing			aide.		
	Resident C. The sta	ff members separated the			What Measures Will Be Put I	nto	
	residents and report	ed the incident. The ADON			Place and What Systemic		
	assessed both reside	ents and Resident D was			Changes Will Be Made To		
	interviewed. When	he was asked what he			Ensure That The Deficient		
	intended to do, he s	aid he did not know, because			Practice Does Not Recur:		
		dent C did not talk much in			Sufficient staffing will be		
		l not interview Resident C, but			scheduled on the Huntington's	s	
	she did not seem dis	stressed. Resident D resided			Unit and Dementia Unit includ	ing a	
	on the end of the ha	llway where it was all men.			designated activity aide. The		
					Activity Director, Scheduler, D	ON,	
	_	on 9/25/23 at 10:23 a.m., CNA			and ADON will be in-serviced	over	
	2 indicated she was	not sure of the actual time			the facility's Staffing policy and	d	
	they found Residen	t D and Resident C in the		procedures.			
	bathroom. She was	not sure of the last time they			How The Corrective Action(s	5)	
	were seen on the un	it before they found them		Will Be Monitored To Ensure			
	together in the bath	room. LPN (licensed Practical			The Deficient Practice Will N	ot	
	Nurse) 4 was worki	ng on the unit (Wing 2) and			Recur:		
	had a meeting. The	ADON was covering on the			The DON/Designee will monit	or	
	unit for the LPN and	d had left the floor when we			the nursing schedule for		
	found the two reside	ents together (Resident D and			appropriate amount of staff for	r the	
	Resident C). She ha	d immediately tried to notify			Huntington's unit daily on		
	administration, and	the BOM (Business Office			scheduled workdays times 4		
	- ·	inting to find out what was			weeks, then 2 times a week ti	mes	
		her we had a situation. After			4 weeks, then weekly times 4		
	a couple of minutes	, the ADON returned, and we			months. The		
	notified her.				Administrator/Designee will		
					monitor the activity departmer		
	Cross reference F60	00			schedule to ensure an activity		
					is designated each day for the		
	_	ew on 9/23/23 at 9:34 a.m., the			Huntington's Unit weekly time	s 8	
	-	dicated today she was working			weeks, then monthly times 3		
		was short on staff, and she			months. Any negative findings		
		or. They have been short			be corrected immediately and		
		nd there was no possible way			forwarded to the Administrator		
	•	ctivities to the whole facility.			and/or RDO. A report of progr	ess	
		nt separated program for			will be forwarded to the QAPI		
	mental capacity or a	age range. She was hopeful			committee ongoing monthly fo	ora 📗	

		X1) PROVIDER/SUPPLIER/CLIA	r í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
		IDENTIFICATION NUMBER	A. BUILDING 00 B. WING		00	COMPLETED		
155208			B. WING 09/27/2023					
NAME OF P	NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
HANOVE	HANOVER NURSING CENTER				LAGRANGE RD /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 APPROPRIA DEFICIENCY)	TE C	OMPLETION	
TAG		LSC IDENTIFYING INFORMATION y staff they could offer more		TAG	minimum of 6 months. If any		DATE	
	specialized activities for the residents' with Dementia unit (Wing 1) and/or Huntington's unit				patterns are identified at the			
				monthly QAPI meeting, an action				
	(Wing 2).				plan will be written by the			
					committee. Any written action			
	_	on 9/24/23 at 8:15 a.m., CNA 6			plan will be monitored by the			
		een the only CNA working on rse since 8:00 a.m. This was her			administrator/designee month until resolved and substantial	ıy		
	_	on the unit. There was no way			compliance is achieved at 95%	6 or		
	_	nitor, and feed all the residents			greater.			
	with just her and the				Ŭ			
		y on 9/24/23 at 8:20 a.m., RN 7						
		from 4:00 p.m. till 5:00 p.m., aff member working. Resident						
	1	ovid and was positive. He was						
		e hallway without a mask						
	_	she could not get him to stay						
	in his room.	Z ,						
	D : CD :1	DID 1 ' M						
		D's Behavior Management e resident had behaviors of						
		nts on the following dates:						
	_	26, 6/27, 6/30, 7/2, 7/3, 7/5, 7/7,						
		17, 8/3, 7/28, 7/29, 7/30, 8/2, 8/3,						
	8/5, 8/9, 8/11, 8/15,	8/16, 8/26, 8/31, 9/9, 9/10, 9/11,						
	9/12, and 9/14/23.							
	Review of Resident	D's Behavior Management						
		e resident had behaviors of						
		the following dates: 6/18,						
	I -	7/7, 7/12, 7/17, 8/2, 8/3, 8/5, 8/6,						
	8/9, 8/11, and 8/16/							
	The Resident D's R	ehavior Management Record,						
		cated the resident's reason for						
		at he was bored and attention						
	seeking.							
	During an interview	y 9/25/23 at 10:32 a.m., LPN 4						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED			
155208			B. WING 09/27/2023				/2023	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	8			AGRANGE RD			
HANOVE	R NURSING CENT	ER			ER, IN 47243			
	Г		1	I	•		(X5)	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	CORRECTION		
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO THE APPROPR			COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	Dai relaver,		DATE	
		meeting with the Corporate the unit. Staff on the						
		ere just stretched too thin.						
	_	ting to corporate for months						
	_	nore help. The incident with						
		sident C had to occur around						
		ot recall seeing either resident						
		but it would have not been						
		hem. When the two CNAs						
		lents out to smoke for safety						
		normally leave one staff on						
		all the residents during the						
		nly activities normally on the						
		opped off for the residents to						
	color or cross word							
	During a confidenti	al interview between 9/21/23						
	and 9/25/23, a staff	member indicated there were						
	multiple residents w	who required assistance with						
	eating. Working wi	th 4 staff for 26 resident was						
		ekends are the worst. When						
	_	resident and had to stop to						
		ident or assist another						
		nt they were assisting to eat						
	would get very upse	et.						
	Desire - C1 -	-1 intermitant :						
	1	al group interview between						
		s, three staff members indicated sh staff to meet the residents'						
	· ·	there were multiple residents						
	1	g assistance, frequent falls,						
	_	g assistance, frequent falls, aviors. The Huntington's unit						
	1	ve consistent activities or						
		es for the age range of						
		esident was on 15-minute						
		keep them in a common area,						
		k. The weekend shifts were						
		vere more staff and better						
		uld possibly mitigate some of						
	the aggressive beha							
	and aggressive bella	v 1015.						

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

PRINTED: 11/13/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	E SURVEY PLETED 7/2023			
	PROVIDER OR SUPPLIER		410 W	STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	EECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE			
	through 9/26/23, St works with two CN work with one aide staff came into the office staff did not normally no activiting residents were able the residents would supervision if they enough staff to suppactivities. A continuous obserfalm, through 9:42 as sitting in the hallward unattended and conchemicals in two specifications were disinfectant wipes, went out of the lock she returned to the the cart without ack. There were multiplicant to go out to the the cart of the cart without ack. There were sitting on an orincluded a large jugiliquid cleaning check chemical there was indicated the jug condisinfectant. The windicated harmful "children". There was the cart CNA 10 va.m., she gathered as	al interview from 9/21/23 aff 10 indicated she normally As. Recently she was left to for part of the shift. The office facility to work, normally the come in to help. There were les on the weekends unless the to leave the unit. Several of require direct staff left the unit. There were not lervise the residents to go to vation on 9/23/23 from 9:36 .m., the housekeeping cart was by of Wing 2. The cart was left tained cleaning check bray bottles and cleaning CNA 10 walked by the cart and and door. A few minutes later unit and continued to walk by knowledgment of the cart. It is residents who walked by the recourtyard area. 9/23/23 at 9:43 a.m., of the hower room the following items open three tier cart. The items of containing two inches of a mical. On the label of the a warning statement. The label ontained a multi peroxide arning label in bold letters danger keep out of reach of as a disposable razor lying on valked into the bathroom at 9:44 a towel for the BOM (Business and walked out of the bathroom.							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/27/2023 155208 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 410 W LAGRANGE RD HANOVER NURSING CENTER HANOVER, IN 47243 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE During an observation and interview on 9/23/23 at 9:44 a.m., the Activity Manager walk to the BOM and handed her a dry towel. The BOM walked over to Resident N and wiped the oral drainage off his mouth. She then used the towel to wipe his drool off the floor with the same towel. The BOM indicated she did not have a CNA certificate, but she tried to help where she could. She was working on the unit today and just cleaned up the floor from a resident who was drooling on the During an interview on 9/23/23 at 9:46 a.m., CNA 10 indicated the razor and cleaning chemical should not have been left out and unsecured. Several of the residents walked in and out of the bathroom without supervision. During an interview on 9/23/23 at 9:52 a.m., The Housekeeping 11 indicated he worked every Saturday and Sunday. The cleaning cart was supposed to stay on the unit since several of the residents had Covid. He did not know that he was supposed to secure the cleaning cart when it was unattended. He was not sure where he was supposed to secure the cart. He had left the area to go to the laundry room to get linens, since the staff ran out of linens. He went across the courtyard to the other side of the facility and left the cart on the unit unattended in the hallway. During an interview on 9/23/23 at 10:01 a.m., Resident M indicated the staff just let the residents walk out of isolation and down the hallway. The resident (Resident D) who just walked down the hallway was Covid positive. The resident was not wearing a mask and now everyone will be sick. The staff are not around to stop the residents from just walking around without a mask.

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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>		00	COMPLETED			
155208			B. WING 09/27/2023						
N	NOTHER OF STATE		-	STREET A	ADDRESS, CITY, STATE, ZIP COD	•			
NAME OF P	PROVIDER OR SUPPLIEF	C .			LAGRANGE RD				
HANOVE	R NURSING CENT	TER		HANOV	/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 APPROPRIA	TE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	During on intervious	v on 9/24/23 at 8:15 a.m., CNA 6							
	-	rom an agency and the only							
		ing 2 since 8:00 a.m. This was							
	-	he did not know the residents.							
		she could care, monitor, and							
		s with just her and the one							
	nurse.	3							
	An observation on	9/24/23 at 8:32 a.m., of the							
	Wing 2 there was a	food tray from the evening							
	meal, the night before	ore (9/23/23), sitting on a							
		hallway. The tray was for							
		sident was in isolation and							
		n for dining. He was high risk							
	-	ood on the plate was							
		covered. The juice cup and							
	-	had sipper lids and were full.							
		ice and milk were dead flies.							
	There were three fla	ies flying over the tray.							
	During an interview	v on 9/24/23 at 8:34 a.m. CNA 6							
		ot know if the resident had							
	received his evenin	g meal or why the tray was still							
	sitting there.								
	An observation on 9	9/24/23 at 8:35 a.m., of the							
		n the breakfast trays arrived at					1		
		e had three females sitting at the							
		dent (Resident S) was served at							
		nd resident (Resident T) was							
		and the third resident (Resident							
		08 a.m. There were 5 flies flying					1		
	*	sidents were being served.							
	An observation on 9	9/24/23 at 8:37 a.m., of the							
		e indicated Resident M and					1		
	_	rved at 8:37 a.m. Then the staff							
		wn to the end of the hallway							
		lent W's room. There were no	1						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/27/2023					
	NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	PRIATE COMPLETION				
TAG	staff monitoring the residents still eating At 8:49 a.m., both s by Room 16. There the dining area and During an interview indicated Resident showever there was the residents needed. An observation on Resident P rolled his N. The resident (Refloor with his legs of floor. Resident P woof his wheelchair of staff were present in two staff members moved Resident P Resident N. An observation on Swing 2 dining room the unit (Wing 2) to residents. This left CNAs to help with An observation on Swing 2 Room 16's two staff members the resident walked the resident to go be address the resident to go be address the resident to Resident's concerns. During an interview indicated sometime	2/24/23 at 8:55 a.m., indicated s wheelchair over to Resident sident N) was sitting on the rossed and his head on the as leaning out of the right side ver the top of Resident N. No a the dining area. At 8:56 a.m. walked into the hallway and back from hanging over 2/24/23 at 8:57 a.m., of the a, CNA 13 from Wing 1 was on thelp staff with feeding the Wing 1 with one nurse and no	TAG	DEFICIENCY	DATE				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. BUILDING B. WING	00	COMPLE 09/27/2	ETED		
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER			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	PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		(X5) COMPLETION DATE	
	and then dinner arribeen times they wer assistance after 6:00 required feeding ass residents who must hazards there are no residents before the are bored, young an Resident N who sits area and tries to trip P had increased viol rammed the metal lehinges, and cracked pass medication and aides you cannot sat There have been fre unit. Review of the Wing indicated the follow - On 6/27/23 at 5:12 bottom when he was business office. - On 7/4/23 at 12:15 floor in front of his - On 7/6/23 at 5:38 trying to get from the fell face down onto - On 7/6/23 at 6:30 lying on the floor in blood. The resident his left eyebrow.	ved at 4:00 p.m. and there have re still providing feeding 0 p.m. With 14 residents that sistance and multiple other be monitored for choking re enough staff to feed the food was cold. The residents d nothing to do so they fight. The on the floor in the common reyou as you walk by, Resident let behaviors, and Resident Q recked door, busted it off the the frame. When you must I feed residents even with two fely monitor all the residents. The quent resident falls on the The p.m., Resident Z fell onto his to obtaining supplies from the The wheelchair and closet. The wheelchair to his bed. He the bed. The a.m., Resident Z was found The a puddle of soda and minimal thad a one-inch laceration to					

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 $7GGW11 \quad \text{Facility ID:} \quad 000115$

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/27/2023			
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER			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		
	wheelchair onto the						
	at nurses' desk had The CNA attempted	3 a.m., Resident X was standing almost fallen multiple times. If to get the resident to sit in a not started punching her in the ad.					
	lying on the floor o the left eyebrow. M	35 p.m., Resident AA was found in his back with a laceration to doderate amount of bloody in the laceration on his face.					
	to attend supervised onto the patio, he h	p.m., Resident Z went outside d smoking. When he got out ad severed movements that n the wheelchair and the wheelchair over.					
		a.m., Resident P fell in bathroom elf. The resident had a 1.5 cm					
	altercation of aggre	30 a.m., Resident N had an ssion with Resident P (the the other resident's hand).					
	resident was awaiti	O a.m., Resident N had a fall, the ng breakfast when he slid out e floor, and he hit his left or causing a laceration and					
	was outside smokir He hit his head on t abrasion to the mid	5 p.m., Resident Z fell while he g and flipped his wheelchair. he concrete. He had a 5 cm forehead with 2 shallow r end of the abrasion.					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/27/2023				
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER			410 W	STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION				
	REGULATORY OF On 9/1/23 at 2:30 with dried blood on of 2.5 cm was found. The resident indicated are considered by the resident indicated are considered by the resident's rood at 1:1:1 found lying on his left to the resident's rood at 12:1 transferring self frow wheelchair rolled of on his bottom. On 9/18/23 at 10:1 lying face down on under his face. The the bridged of his not be a considered by the bridged of his not be a considered by the bridged of his not be a considered by the bridged of his not be a considered by the bridged of his not be a considered by the bridged of his not be a considered by the bridged of his not be a considered by the bridged of his not be a considered by the bridged of his not be a considered by the bridged of his not be a considered by the bridged by the bridg	a.m., Resident AA was found the fell on wheelchair and the aut from under him and he fell on wheelchair and the tenter of with a pool of blood resident had a laceration to blood on his face with a rehead. The resident was found the face of his forehead.		CROSS-REFERENCED TO THE AF DEFICIENCY)	PPROPRIATE				
	lying face down on wheelchair. When t	3 a.m., Resident BB was found the floor next to her he resident was turned over her face and bruising on her							
	Cross Reference F6	89.							
	Cross Reference F8								
	Cross Reference F9								
		nd interview on 9/23/23 at at G walked out of her room on unit) and into the							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		f /		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		155208	B. WII	NG		09/27/	2023
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP COD		
					AGRANGE RD		
HANOVE	R NURSING CENT	EK		HANOV	ER, IN 47243		
(X4) ID		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 DEFICIENCY)	ATE	COMPLETION
TAG		a LSC IDENTIFYING INFORMATION area. The resident had a sign		TAG	DET CHENCY /		DATE
		ng she was on isolation. The					
		positive. There were no staff					
		or within sight on the hallway.					
	1 ~	n at the end of the hallway					
		station and not visible from					
	1	ursing staff indicated she was					
		per on Wing 1 at that time.					
		0/05/00 - 10 10 - 7777					
	1	on 9/25/23 at 10:10 a.m., LPN as currently the only staff					
		•					
		. She had one aide working					
	with her, but she was floating between Wing 1 and Wing 2.						
	and wing 2.						
	An observation on 9	9/25/23 at 10:11 a.m., of the					
	Wing 2, Resident K	was observed in Resident L's					
	room. Resident L ha	ad a sign on her door indicated					
	she was Covid posi	tive and in isolation. Resident					
	_	sitive. There currently were 10					
		olation for being Covid					
	positive on the Den	nentia Unit.					
	Cross Reference F8	80					
	4 Review of the for	cility assessment on 9/23/23 at					
		ed the daily average facility					
	_	of 66 residents. The profile					
		ies of daily living related to					
		ad the following: 11 residents					
		with eating, 41 required the					
	_	staff members to eat, and 14					
		dependent on staff for					
		oviding care including, but not					
		g, evaluation, planning and					
	1	ent care plans and responding					
		s, the facility indicated the					
		ed for the building was 1 RN, 2					
		nalified Medications Aide) and					
		s per day. The staffing plan					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155208	B. W	ING		09/27/	/2023
				CTREET	DDDECC CITY CTATE ZID COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
LIANOV/E	D NILIDOING OFNI	ren			AGRANGE RD		
HANOVE	ER NURSING CENT	IER		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)	16	DATE
	was for 1 RN, 3 LPNs or 1 LPN with 2 QMAs and						
	12 nurse aides.						
	The current facility	census indicated 16 residents					
	-	g 1, 26 residents were listed on					
		idents were listed on Wing 3.					
	Review of the as we	orked schedule from August					
		2023 indicated the following:					
	On 8/6/23 (Sunday)) night shift, Wing 2 had one					
		work from 6:00 p.m. to 6:00					
	a.m.	F					
	On 8/9/23 (Wednes	day) night shift, Wing 2 had					
	·	CNA work from 6:00 p.m. to					
	6:00 a.m.	or work from 0.00 p.m. to					
	0.00 u.m.						
	On 8/24/23 (Thurse	lay) night shift, Wing 2 had					
	·	A, and one CNA in training					
	work from 6:00 p.n						
	work from 0.00 p.n	i. to 0.00 a.m.					
	On 8/28/23 (Monds	ay) night shift, Wing 2 had one					
	,	work from 6:00 p.m. to 6:00					
		work from 0.00 p.m. to 0.00					
	a.m.						
	On 8/20/22 (Tuesde	ay) night shift, Wing 2 had one					
	,	work from 6:00 p.m. to 6:00					
		work from 6:00 p.m. to 6:00					
	a.m.						
	On 0/16/22 (S-to-1						
		ay) night shift, Wing 2 had one					
	nurse and one aide	from 6:00 p.m. to 6:00 a.m.					
	On 0/10/22 /T						
		ay) night shift, Wing 2 had one					
	nurse and one aide	from 6:00 p.m. to 6:00 a.m.					
	0 0/20/22 (337.1	1) '14 1'6 77' 11 1					
	·	esday) night shift Wing 1 had					
		arse from 6:00 p.m. to 6:00 a.m.					
	_	e was one nurse, one CNA					
	from 6:00 p.m. to 6	:00 a.m. and one CNA from 6:00					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G 00	CON	TE SURVEY MPLETED 27/2023
	PROVIDER OR SUPPLIER		410	EET ADDRESS, CITY, STATE, ZIP CO W LAGRANGE RD NOVER, IN 47243)D	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	CROSS-REFERENCED TO THE AF	OULD BE	(X5) COMPLETION
TAG	p.m. to 2:00 a.m.	LSC IDENTIFYING INFORMATION	TAG	BERGEROTT		DATE
	nurse from 6:00 p.n	ay) night shift, Wing 2 had one n. to 6:00 a.m., one aide from m., and one aide from 2:00 a.m.				
	On 9/23/23 (Sunday) night shift, Wing 2 had one nurse from 6:00 p.m. to 6:00 a.m. and one aide from 6:00 p.m. to 2:00 a.m.					
		on on 9/26/23, at 11:17 a.m., e and one aide working on the g1).				
	revised date of Apri Administrator on 09 "facility maintains shift to ensure that of services are met. Li licensed nursing sta	policy titled "Staffing" with a 1 2007, was provided by the 0/27/23. The policy indicated, is adequate staffing on each our resident's needs and censed registered nursing and iff are available to provide and y of resident care services"				
	IN00416781, IN004	ates to Complaints IN00417850, 115518, and IN00415026.				
F 0740 SS=D Bldg. 00	must provide the r care and services highest practicable psychosocial well- the comprehensiv care. Behavioral					

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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 09/27/2023		
	PROVIDER OR SUPPLIEI		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	to, the prevention and substance us Based on record refailed to ensure into appropriate intervery prevent recurrent reseeking behaviors (Resider Findings include: 1.a. The clinical recreviewed on 9/21/2 MDS (minimum da 8/29/23, indicated trequiring only super diagnoses included Huntington's, mood depression, and attendisorder. The Care Plan, date was at risk of psych related to being less interventions were encourage participal activities of interest. The Care Plan, date had exhibited sexual inappropriate commother residents. The encourage the resides Staff were to explainwas not appropriate to suppropriate to the superpopriate to explainwas not appropriate to explainwas not appropriate to explainwas not appropriate to explain the superpopriate to explain	view and interview, the facility erventions were effective and intions were implemented to esident aggressive/attention for 1 of 4 residents reviewed for int D) cord for Resident D was 3 at 11:21 a.m. A Quarterly sta set) assessment, dated the resident was cognitively independent with locomotion ervision oversight. His but were not limited to, affective disorder, anxiety, ention deficit hyperactivity and 6/5/23, indicated the resident inosocial well-being issues as than 55 years of age. The for the activities department to ution and offer resident	F 0740	What Corrective Action(s) We Be Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice: Resident D's care plan has be up-dated to reflect the incident 8/24/2023. Resident D's behas interventions have been up-dated to reflect the incident Practice Will Be Identified A What Corrective Action(s) We Be Taken: All residents have the potentiable affected, no other resident were affected by this alleged deficient practice. The behaving and interventions for resident residing on the Huntington's chave been reviewed and up-dwarranted. Care plans have be up-dated to reflect any change that were made. What Measures Will Be Put I Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: The SSD will review behavior daily at morning meeting (Mon-Fri. Monday will include review of the weekend logs) a following up on any notations made of inappropriate behavior	een een avioral ated. g i i nd /iii al to s ors s unit dated if been ees linto	10/20/2023

what will be tolerated. The staff were to notify the

ensure abuse has not occurred.

11/13/2023 PRINTED: FORM APPROVED 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 09/27/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 410 W LAGRANGE RD HANOVER NURSING CENTER HANOVER, IN 47243 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE MD as needed. Staff were to talk to the resident Any positive findings will be about the feelings and rights of others and about reported to the Administrator who are exposed to his acting out. immediately. SSD will also follow up on effectiveness of interventions The Care plan, dated 6/7/23, indicated the resident to all behaviors that occur and exhibited sexually inappropriate behavior. The up-date interventions when interventions indicated staff were to administer warranted. All staff will be the resident's medications as ordered. Staff were in-serviced over the facility's to document all behaviors and reassure the Behavior Management Program resident it was okay to talk of feelings or policy and procedures. thoughts. He was educated that inappropriate **How The Corrective Action(s)** behaviors were not acceptable. The staff were to Will Be Monitored To Ensure report any sexual inappropriate behavior The Deficient Practice Will Not immediately per facility policy. Recur: Administrator/Designee will The resident's clinical record was reviewed on monitor behavior logs for 9/22/23 at 2:19 p.m. The record lacked an appropriate interventions to additional care plan or care plan revision related to exhibiting behaviors weekly times the resident's sexual encounter on 8/24/23. 3 months then monthly times 3 months. Any negative findings will Review of Resident D's Behavior Management be corrected immediately and Record indicated the resident had behaviors of forwarded to the RDO. A report of using vulgar/explicit language around or towards progress will be forwarded to the residents, going into the bathroom with a female QAPI committee ongoing monthly resident exposed, verbally abusive towards for a minimum of 6 months. If any residents, and inappropriate with staff on the patterns are identified at the following dates: 7/5, 7/6, 7/17, 7/20, 7/27, 7/28, monthly QAPI meeting, an action 7/29, 7/30, 8/2, 8/5, 8/6, 8/9, 8/11, and 9/10/23. plan will be written by the committee. Any written action The interventions for the resident's behavior on plan will be monitored by the 7/5/23, were for staff to explain procedure, divide administrator/designee monthly larger groups into smaller groups, provide 1 to 1 until resolved and substantial to allow resident to speak with you about what compliance is achieved at 95% or may be causing the behavior; and remove from greater. stimulant/situation. The interventions were documented as not effective. The interventions for the resident's behavior on 7/6/23, were for staff to reorient the resident to person, time, and place when receptive; provide

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		09/27/	2023
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
114101/5	D NUIDOINO OENT				_AGRANGE RD		
HANOVE	R NURSING CENT	ER		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			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	TAG DEFICIENCY)		DATE
	one staff to one resi	dent (1 to 1) to allow resident					
	to speak with you a	bout what may be causing the					
	behavior; and offer	reassurance and validate					
	feelings. The interv	entions were documented as					
	not effective.						
	The interventions for	or the resident's behavior on					
	7/17/23, were for st	aff to provide one staff to one					
	resident (1 to 1) to a	allow resident to speak with					
	you about what may	y be causing the behavior;					
	offer reassurance ar	nd validate feelings, explain					
	procedures to the re	sident, and increase visibility.					
	The interventions w	vere documented as not					
	effective.						
	The interventions for	or the resident's behavior on					
	7/20/23, were for st	aff to provide one staff to one					
	resident (1 to 1) to a	allow resident to speak with					
	you about what may	y be causing the behavior;					
	offer reassurance, v	alidate feelings, and explain					
	procedures to reside	ent. The interventions were					
	documented as not	effective.					
	The interventions for	or the resident's behavior on					
	7/27/23, were for st	aff to reorient the resident to					
	person, time, and pl	ace when receptive; provide					
	one staff to one resi	dent (1 to 1) to allow resident					
	to speak with you a	bout what may be causing the					
	behavior; offer reas	surance and validate feelings,					
	explain procedures,	and offer snack. The					
	interventions were	documented as not effective.					
		or the resident's behavior on					
	7/28/23, were for st	aff to reorient the resident to					
	person, time, and pl	ace when receptive; provide					
	one staff to one resi	dent (1 to 1) to allow resident					
	to speak with you a	bout what may be causing the					
	behavior; offer reas	surance, validate feelings, and					
	explain procedures	to resident. The interventions					
	were documented a	s not effective.					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	IG	00	COMPL	ETED
		155208	B. WING			09/27/	
					_		
NAME OF F	PROVIDER OR SUPPLIER	Ł			DDRESS, CITY, STATE, ZIP COD		
					AGRANGE RD		
HANOVE	R NURSING CENT	ER	HA	NOV	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	PREF	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAC	ì	DEFICIENCY)		DATE
		or the resident's behavior on					
		aff to reorient the resident to					
		ace when receptive; provide					
		dent (1 to 1) to allow resident					
		bout what may be causing the					
		surance and validate feelings,					
		to resident, and offer snack.					
		vere documented as not					
	effective.						
		or the resident's behaviors on					
		were for staff to reorient the					
	_	time, and place when					
		one staff to one resident (1 to					
		to speak with you about what					
		behavior; offer reassurance					
		s, explain procedures to					
		ger groups into small groups,					
		e interventions were					
	documented as not	effective.					
	The interventions for	or the resident's behavior on					
		ff to reorient the resident to					
	· ·	ace when receptive; provide 1					
		nt to speak with you about					
		g the behavior; offer					
		idate feelings, explain					
		arger groups into smaller					
	_	eriod, change position, and					
		ne interventions were					
	documented as not						
	documented as not	criccuve.					
	The interventions for	or the resident's behavior on					
		ff to encourage activity					
		de 1 to 1 to allow resident to					
		ut what may be causing the					
		surance and validate feelings,					
	l '	to resident, and change					
		rentions were documented as					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY TPLETED 27/2023				
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE			
	8/9/23, were for star participation, provispeak with you about behavior; offer rease explain procedures and increase visibil documented as not. The interventions of 8/11/23, were for star participation, provispeak with you about behavior; offer rease and explain procedinterventions were. The interventions of 9/10/23, were for star resident, change poresisting care. The documentation if the effective. The SSD Note, data indicated the SSD star regarding the behave SSD spoke with respective seriousness of false him that unless son say it even in a joking another resident. The what he had done were seriousness of the star regarding inappropanother resident. The what he had done were seriousness of the star regarding inappropanother resident. The what he had done were seriousness of the star regarding inappropanother resident. The what he had done were seriousness of the star regarding inappropanother resident. The what he had done were seriousness of the star regarding inappropanother resident. The what he had done were seriousness of the star regarding inappropanother resident. The what he had done were seriousness of the star regarding inappropanother resident.	or the resident's behavior on the resident's behavior on the surface and validate feelings, the surface and validate feel							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	IG	00	COMPL	
		155208	B. WING			09/27/	/2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		DROVIDEDIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAC	j	DEFICIENCY)		DATE
		lent at any time. The resident					
	stated he understoo	d.					
	indicated the resider into the central bath behind himself and his pants down and resident. The two C went into the bathrochands when they not the curtain. When the curtain when the residents had their primmediately separar resident and did a slissues observed. The The resident was pufurther notice. A Progress Note, day	ated 8/24/23 at 6:04 p.m., and followed a female resident aroom and pulled the curtain the female resident. He pulled turned to face the female (NAs (Certified Nurse Aide) from to clean and wash their striced two sets of feet behind they opened the curtain both for pants pulled down. The staff ted the male and female kin check. There were no fee MD and POA were notified. It on 15-minute checks until mated 9/12/23 at 4:27 p.m.,					
	indicated the resider	nt continued on 15-minute					
		-4-10/12/22 -4 10:52					
		ated 9/13/23 at 10:52 a.m., nt was seen by staff being					
	sexually inappropris	ate toward another staff					
	member.						
	Record indicated th teasing other reside: 6/18, 6/21, 6/22, 6/27/7, 7/10, 7/14, 7/15	ent D's Behavior Management e resident had behaviors of nts on the following dates: 26, 6/27, 6/30, 7/2, 7/3, 7/5, 7/6, 5, 7/17, 8/3, 7/28, 7/29, 7/30, 8/2, 8/15, 8/16, 8/26, 8/31, 9/9, 9/10, 4/23.					
	were for staff to reo time, and place whe	or the resident's behaviors orient the resident to person, en receptive; provide one staff					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155208	B. W	ING		09/27/	2023
	ROVIDER OR SUPPLIER		-	410 W L	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD 'ER, IN 47243		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWING DE AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	with you about wha	t may be causing the					
	· ·	reassurance and validate					
	-	entions for the resident's					
		umented as not effective 15					
	out of 16 times.						
	c Review of Reside	ent D's Behavior Management					
		e resident had behaviors of					
		the following dates: 6/18,					
		7/7, 7/12, 7/17, 8/2, 8/3, 8/5, 8/6,					
	8/9, 8/11, and 8/16/	23.					
		or the resident's behaviors on					
	· · · · · ·	5/23, were for staff to reorient on, time, and place when					
	-	to 1 to allow resident to speak					
		it may be causing the					
	-	reassurance and validate					
		entions were documented as					
	not effective.						
		or the resident's behaviors on					
		vere for staff to reorient the					
	_	time, and place when to 1 to allow resident to speak					
		it may be causing the					
	-	surance and validate feelings,					
	· ·	to resident, and offer snack					
		ions were documented as not					
	effective.						
		4 21 4 1 2 2					
		or the resident's behavior on					
		ff to encourage activity de 1 to 1 to allow resident to					
		ut what may be causing the					
		reassurance and validate					
	feelings, and explai						
		documented as not effective.					
	The interventions for	or the resident's behavior on					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	(X2) MULTIPI A. BUILDIN B. WING	E CONSTRUCTION G 00		(X3) DATE SU COMPLE 09/27/2	TED		
	PROVIDER OR SUPPLIEI		410	STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAG	(EACH CORRECTI CROSS-REFERENC	PLAN OF CORRECTION IVE ACTION SHOULD BE CED TO THE APPROPRIAT FICIENCY)	E	(X5) COMPLETION DATE		
	provide 1 to 1 to all about what may be offer reassurance as	e resident to change position, low resident to speak with you causing the behavior; and nd validate feelings. The documented as not effective.							
	7/17/23, were for st resident to speak w causing the behavior validate feelings, ex	or the resident's behavior raff to provide 1 to 1 to allow ith you about what may be or; offer reassurance and explain procedures, and increase ventions were documented as							
	8/2/23, were for sta person, time, and p to 1 to allow reside what may be causir reassurance and val	or the resident's behavior on ff to reorient the resident to lace when receptive; provide 1 nt to speak with you about ng the behavior; offer lidate feelings and explain erventions were documented as							
	8/3/23, were for state person, time, and person, time, and person to 1 to allow reside what may be causing reassurance and value procedure, encourare remove stimulant/sinto smaller groups	or the resident's behavior on ff to reorient the resident to lace when receptive; provide 1 nt to speak with you about ng the behavior; offer lidate feelings, explain ge activity participations, ituation, divide larger groups , and offer snack. The documented as not effective.							
	8/5/23, were for sta person, time, and p to 1 to allow reside what may be causir	or the resident's behavior on ff to reorient the resident to lace when receptive; provide 1 nt to speak with you about g the behavior; offer lidate feelings, explain							

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155208	B. W	ING		09/27/	/2023
NAME OF I	DROVIDED OD CUIDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	C		410 W L	_AGRANGE RD		
HANOVE	ER NURSING CENT	ΓER		HANOV	'ER, IN 47243		
(X4) ID	SUMMARY			PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	*	arger groups into smaller					
		eriod, change position, and ne interventions were					
	documented as not						
	documented as not	effective.					
	The interventions for	or the resident's behavior on					
	8/6/23, were for sta	ff to encourage activity					
	participation, provide	de 1 to 1 to allow resident to					
		ut what may be causing the					
		surance and validate feelings,					
		to resident, and change					
	_	rentions were documented as					
	not effective.						
	The interventions for	or the resident's behavior on					
		ff to encourage activity					
		de 1 to 1 to allow resident to					
		ut what may be causing the					
		surance and validate feelings,					
	explain procedures	to resident, change position,					
	and increase visibil	ity. The interventions were					
	documented as not	effective.					
	The interventions for	or the resident's behavior on					
		aff to encourage activity					
		de 1 to 1 to allow resident to					
		ut what may be causing the					
		surance and validate feelings,					
		ures to resident. The					
	interventions were	documented as not effective.					
	The interventions for	or the resident's behavior on					
		raff to encourage activity					
		de 1 to 1 to allow resident to					
		ut what may be causing the					
		surance and validate feelings,					
		divide larger groups into					
		er rest period, change position,					
		n. The interventions were					
	documented as not						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/27/2023		
	ROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP COE LAGRANGE RD /ER, IN 47243)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	dated 9/25/23, indic his behavior was the seeking.	ehavior Management Record, eated the resident's reason for at he was bored and attention				
	Activity Director in as a CNA. The unit had to work the floo staffed frequently a for her to provide ac	or on 9/23/23 at 9:34 a.m., the dicated today she was working was short on staff, and she or. They have been short and there was no possible way etivities to the whole facility. In the separated program for age range.				
	indicated the only a	y 9/25/23 at 10:32 a.m., LPN 4 ctivities normally on the unit d off for the residents to color s word puzzles.				
	and 9/25/23, a staff were feeding a resident or another resident or a	al interview between 9/21/23 member indicated when staff dent and had to stop to monitor assist another resident, the assisting to eat would get very				
	9/21/23 and 9/25/23 there was multiple in behaviors. The Hun have consistent actifor the age range of was on 15-minute of in a common area, be were more staff and	al group interview between B, three staff members indicated residents with aggressive tington's unit (Wing 2) did not vities or appropriate activities residents. When a resident hecks they tried to keep them out this did not work. If there I better activities, then it could ome of the aggressive				
	The current facility	policy titled "Behavior				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/27/2023			
	ROVIDER OR SUPPLIER R NURSING CENT		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F 0804 SS=E Bldg. 00	2015, was provided the Administrator or indicated, "Reside may exhibit puzzlin The behaviors may staff and may involve should assess the bequantitative manner whether the behavior facility or whether on eededBehavior has do everything reason residents' lives have possible" This Federal tag relation and the state of the	d prepared by methods that value, flavor, and d and drink that is re, and at a safe and ature. and record review, the facility appropriate temperature and served for 1 of 3 resident for dietary services. (Wing 2) ice had the potential to affect	F 0804	What Corrective Action(s) W Be Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice: No residents will be affected by	een		

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		ŕ	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/27/2023		
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
HANOVE	R NURSING CENT	ER			AGRANGE RD ER, IN 47243		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		DROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFI	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	ì	DEFICIENCY)		DATE
	Huntington's unit.				this alleged deficient practice.		
	Findings in the 4				Foods and drinks will be serve		
	Findings include:				that are palatable, attractive,	and	
	Review of the curre	nt facility meal service			at a safe and appetizing temperature. Food carts will be		
	schedule indicated t				delivered at scheduled times		
		5			the wings.		
	- Breakfast was to b	be served to Wing 2 at 8:15			How Other Residents Having	9	
	a.m., Wing 3 at 8:20	a.m. and Wing 1 at 8:25 a.m.			The Potential To Be Affected	İ	
					By The Same Deficient		
		erved to Wing 2 at 12:15 p.m.,			Practice Will Be Identified A	nd	
	Wing 3 at 12:20 p.n	n., and Wing 1 at 12:25 p.m.			What Corrective Action(s) W	/ill	
					Be Taken:		
		served to Wing 2 at 5:15 p.m.,			All residents have the potentia		
	Wing 3 at 5:20 p.m.	., and Wing 1 at 5:25 p.m.			be affected, no other resident	S	
	During on interview	on 9/24/23 at 8:03 a.m., RN 7			were affected by this alleged deficient practice. Foods and		
	_	two to three staff to feed all 14			drinks will be served that are		
		red total assistance and the			palatable, attractive, and at a	cafe	
		must be monitored the food			and appetizing temperature.		
		cold" when they served the			carts will be delivered at	oou	
		red assistance were feed.			scheduled times on the wings	i.	
	•				What Measures Will Be Put I		
		on 9/24/23 at 8:15 a.m., CNA 6			Place and What Systemic		
		rom an agency and the only			Changes Will Be Made To		
		ing 2 since 8:00 a.m. This was			Ensure That The Deficient		
	· ·	he did not know the residents.			Practice Does Not Recur:		
		the could care, monitor, and			Foods and drinks will be serve		
		s with just her and the one			that are palatable, attractive,	and	
	nurse.				at a safe and appetizing	_	
	An observation on	9/24/23 at 8:32 a.m., of the			temperature. Food carts will be		
		food tray from the evening			delivered at scheduled times the wings. All dietary staff will		
	-	ore (9/23/23), sitting on a			in-serviced over the facility's I		
	_	hallway. The tray was for			Temperature on Service line,		
		ident was in isolation and			and Nutrition Services, ad Me		
		n for dining. He was high risk			hours policy and procedures.	•	
		ood on the plate was			How The Corrective Action(s	s)	
	_	covered. The juice cup and			Will Be Monitored To Ensure	-	
		had sipper lids and were full.	1		The Deficient Practice Will N		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155208	B. W	ING		09/27	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			LAGRANGE RD		
HANOVE	R NURSING CENT	ER	HANOVER, IN 47243				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ice and milk were dead flies.			Recur:		
	There were three fli	es flying over the tray.			The Dietary Manager/Designe		
		0/04/00 0.04			complete a test tray on varying	-	
	_	y on 9/24/23 at 8:34 a.m. CNA 6			units at varying meals and mo		
		ot know if the resident had			delivery times of meals on var		
		g meal or why the tray was still			units at varying meals 3 times		
	sitting there.				week times 4 weeks, then 2 til	mes	
	Am alagae	0/24/22 at 9.25 a mr£41 -			a week times 4 weeks, then		
		9/24/23 at 8:35 a.m., of the nthe breakfast trays arrived at			weekly times 4 weeks, then 2		
		had three females sitting at the			times a month times 3 months Any negative findings will be).	
		dent (Resident S) was served at			corrected immediately and		
		nd resident (Resident T) was			forwarded to the Administrator	. A	
		and the third resident (Resident			report of progress will be forward		
		08 a.m. There were 5 flies flying			to the QAPI committee ongoin		
	*	sidents were being served.			monthly for a minimum of 6	ıy	
	around winic the re-	sidents were being served.			months. If any patterns are		
	During an observati	ion and Interview on 9/24/23 at			identified at the monthly QAPI		
	_	tempted one of the last 5			meeting, an action plan will be		
		served. The eggs tempted 87			written by the committee. Any		
	-	and the resident's juice			written action plan will be		
	-	Fahrenheit. He indicated the			monitored by the		
		yed at that time and they are			administrator/designee month	lv	
	short staffed.				until resolved and substantial	· y	
					compliance is achieved at 95%	% or	
	During an interview	y on 9/25/23 at 10:08 a.m., RN 7			greater.	= :	
	_	s the resident do not receive			ľ		
		0:00 a.m., lunch by 1:00 p.m.,					
		ved at 4:00 p.m. and there have					
		re still providing feeding					
	_	p.m. With 14 residents that					
		sistance and multiple other					
		be monitored for choking					
	hazards there are no	ot enough staff to feed the					
	residents before the	food was cold. When you					
	must pass medication	on and feed residents even					
	with two aides you	cannot safely monitor all the					
	residents.						
	The current facility	policy titled "Food					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	ľ í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/27 /	ETED
	PROVIDER OR SUPPLIEF		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 R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	of June 2018, was p on 09/27/23. The po- served at proper ten- safetyIf temperatu- levels and cannot be- service, make an ap Follow [Reheating)	ervice Line" with a revised date provided by the Administrator policy indicated, "Foods will be imperature to ensure food ares are not at acceptable ecorrected in time for meal impropriate menu substitution. Temperature]"					
	2017, was provided 09/27/23. The polic provided with a not well-balanced diet to nutritional and specand nutrition staff v	with a revised date of October by the Administrator on y indicated, "Each resident is urishing, palatable, that meets his or her daily tial dietary needsThe food will be available and adequately dents with eating as					
	with a revised date the Administrator o indicated, "Dietar seeing that meal ho This Federal tag rel	policy titled "Meal Hours" of June 2018, was provided by n 09/27/23. The policy y Manager is responsible for ur deadlines are met" ates to Complaint IN00416781.					
F 0880 SS=E Bldg. 00	infection prevention designed to provide comfortable environt the development and the	on & Control					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COMI	(X3) DATE SURVEY COMPLETED 09/27/2023		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	OULD BE	(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	program. The facility must e	establish an infection entrol program (IPCP) that minimum, the following					
	identifying, reporticontrolling infection diseases for all revisitors, and other services under a conducted according reports.	ystem for preventing, ng, investigating, and ons and communicable sidents, staff, volunteers, individuals providing contractual arrangement icility assessment ing to §483.70(e) and d national standards;					
	and procedures for include, but are not include, but are not identify possible or infections before the persons in the fact (ii) When and to work communicable distributed by the persons in the fact (iii) When and to work communicable distributed by the persons in the fact (iii) When and to work communicable distributed and precautions to be of infections; (iv) When and how for a resident; include the type and of depending upon the depending upon the least restrictive under the circums	rveillance designed to ommunicable diseases or hey can spread to other illity; whom possible incidents of sease or infections should transmission-based followed to prevent spread visolation should be used uding but not limited to: duration of the isolation, he infectious agent or I, and that the isolation should be e possible for the resident					
	identifying, reportice controlling infection diseases for all revisitors, and other services under a cobased upon the faconducted accord following accepted §483.80(a)(2) Write and procedures for include, but are not (i) A system of suit identify possible or infections before the persons in the facount of	ing, investigating, and ons and communicable sidents, staff, volunteers, individuals providing contractual arrangement acility assessment ing to §483.70(e) and d national standards; then standards, policies, or the program, which must be limited to: eveillance designed to communicable diseases or hey can spread to other ility; whom possible incidents of the infections should transmission-based followed to prevent spread wisolation should be used uding but not limited to: duration of the isolation, the infectious agent or I, and that the isolation should be the possible for the resident trances. These under which the facility					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155208	B. WIN	NG		09/27/	2023
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			LAGRANGE RD		
HANOVE	ER NURSING CENT	TER			/ER, IN 47243		
11/114012	- TORONO OEM			11/11401	7 ETC, 114 47 240		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		sease or infected skin					
		t contact with residents or					
	1	t contact will transmit the					
	disease; and						
	. ,	ene procedures to be					
	· ·	nvolved in direct resident					
	contact.						
	. , , , ,	ystem for recording					
		d under the facility's IPCP					
		e actions taken by the					
	facility.						
	0400 00/-) 1 :	_					
	§483.80(e) Linens						
		andle, store, process, and					
		o as to prevent the spread					
	of infection.						
	§483.80(f) Annual	Lroviow					
	- ''	nduct an annual review of					
		ate their program, as					
	necessary.	ate their program, as					
	l necessary.		F 08	80	What Corrective Action(s) W	ill	10/20/2023
	Based on interview	, record review, and	1 00	80	Be Accomplished For Those		10/20/2023
		cility failed to follow			Residents Found To Have Be		
		on control guidelines related to			Affected By The Deficient		
		ovid for 10 of 35 residents			Practice:		
	_	ion Control. (Resident D,			Resident D is no longer on		
		nt H, Resident C, Resident J,			isolation. Resident J had the d	ral	
		nt B, Resident DD, Resident			drainage wiped from her mout		
	EE, and Resident C				Staff will use cleaner when		
					cleaning areas of the floor and	will	
	Findings include:				use proper cleaning utensil (e:		
					rag, mop, etc.). Tubing to smo		
	An observation on	the smoking area on 9/21/23 at			buckets will be placed in plast	-	
		s two smoking buckets with			bags at the end of each smoki		
	tubing in the courty	vard. The tubing with mouth			session and smoking mouth	-	
	pieces was lying on the ground. No covering or				pieces will be disinfected befo	re	
	cleaning of the mou	ath pieces was completed, prior			and after each use. Resident		
	to the resident's use	e. Staff were observed to pick			no longer on isolation. Reside	nt H	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155208	B. WI	NG		09/27/	2023
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD		
HANO\/E	R NURSING CENT	rep			/ER, IN 47243		
TIANOVE			_	TIANOV	/LIX, IIN 47243		
(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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	up the mouthpiece of the tubing off the ground				will be instructed on proper		
	and hand it to the re	esidents.			wearing of a mask. All meal tr	-	
		0/00/00			will be removed from the units		
	_	ion on 9/23/23 at 9:11 a.m.,			the meal completion to ensure		
		out into the hallway. He was			flies are not attracted to the a		
		ast tray. The resident was not			Resident CC is longer on isola	ation.	
	_	e carried his tray past the			Residents DD and EE will be		
	-	placed it in the food cart. RN 7			encouraged to practice social		
	_	sident and informed the			distancing. Staff will wear		
		to stay in his room. The			appropriate face covering for		
		near the end of the hallway			isolation rooms/units. Resider	nt	
	_	ion. The resident walked past			C's room will be cleaned with		
	•	rom one end of the hallway			proper cleaning wipes/chemic	als.	
	_	ion prior to being approached			Resident C is no longer on		
		ers. The resident's door had a			isolation. Resident K will be	4	
		resident was on isolation. He			encouraged and redirected as		
	9/18/23.	and placed on isolation on			to enter isolation rooms. Resid	dent	
	9/16/23.				G will be encouraged and	ماء ماء	
	During on observati	ion and interview on 9/23/23 at			redirected to not let others in the		
	_	vity Manager walked up to the			room when they are in isolation		
		fice Manager) and handed her			Resident B's tubing to smokin bucket will be placed in plastic	-	
	· ·	DM walked over to Resident J			bag at the end of each smoking		
	1	drainage off her mouth. She			session and smoking mouthpi	-	
	_	to wipe the large wet spot off			will be disinfected before and		
		ame towel. The BOM indicated			each use when resident smok		
		CNA certificate, but she tried			How Other Residents Having		
		ould. She was working on the			The Potential To Be Affected	_	
	-	cleaned up the floor from a			By The Same Deficient	•	
		large amount of oral drainage			Practice Will Be Identified A	nd	
		nouth and on the floor. No			What Corrective Action(s) W		
	cleaner was used or				Be Taken:		
					All residents have the potentia	al to	
	During an interview	v on 9/23/23 at 10:01 a.m.,			be affected, no other resident		
	_	ed the staff just let the			were affected by this alleged		
		of isolation and down the			deficient practice. All resident	s will	
	hallway. The resident (Resident D) who just				be educated, encouraged, an		
		allway was Covid positive. The			redirected to follow isolation		
	resident was not we	earing a mask and now			guidelines. Proper signage wi	ll be	
	everyone will be sid	ck. The staff are not around to			placed on resident doors if/wh		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/27/2023	
NAME OF I	PROVIDER OR SUPPLIEI	R			DDRESS, CITY, STATE, ZIP COD AGRANGE RD		
HANOVE	R NURSING CEN	TER			ER, IN 47243		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	rom just walking around			isolation is required. Proper		
	without a mask.				isolation carts will be placed		
	A1	0/22/22 -4 10:07 £41 -			outside isolation rooms if/when	า	
		9/23/23 at 10:07 a.m., of the			needed.	-4-	
	_	G walked out of her room and ing room area. The resident			What Measures Will Be Put II	110	
	_	oor indicating the resident was			Place and What Systemic Changes Will Be Made To		
	_	esident was Covid positive.			Ensure That The Deficient		
		f present in the area or visible			Practice Does Not Recur:		
	on the hallways.	present in the area of visione			The scheduler, ADON, and DO	NC	
					will be in-serviced over the	J. (
	During an interview	v on 9/23/23 at 10:09 a.m.,			facility's staffing policy and		
	_	ed the staff just let the			procedure. All staff will be		
	residents walk out	of isolation and down the			in-serviced over the facility's		
	hallway. The reside	ent (Resident G) who just			Pandemic-COVID-19 policy ar	nd	
	walked down the ha	allway was Covid positive. The			procedures. All staff will be		
		earing a mask and now			in-serviced over the facility's		
	1	ck. Resident H had a mask on			Infection Control policy and		
		e resident indicated he had			procedures. All housekeeping		
		e floor in the hallway by the			will be in-serviced over the pro	-	
	1	ce his roommate tested positive			cleaning chemicals for isolatio		
	so he did not get si	ck.			rooms; specifically, for COVID		
	D	0/24/22 4 9 20 PN 7			All staff will be educated over	the	
	_	v on 9/24/23 at 8:20 a.m., RN 7 r from 4:00 p.m. till 5:00 p.m.,			facility's smoking policy and	_	
		aff member working. Resident			procedures, specifically, for the		
		ovid and was positive. He was			smoking tubing and mouthpied on the smoking buckets.	JC3	
		e hallway without a mask			How The Corrective Action(s	`	
		she could not get him to stay			Will Be Monitored To Ensure	-	
	in his room.				The Deficient Practice Will N		
					Recur:		
	An observation on	9/24/23 at 8:32 a.m., of the			The DON/Designee will monitor	or	
	Wing 2 there was a	food tray from the evening			the nursing schedule for		
	meal, the night before	ore (9/23/23), sitting on a			appropriate amount of staff for	the	
		hallway. The tray was for			Huntington's unit daily on		
		sident was in isolation and			scheduled workdays times 4		
		n for dining. He was high risk			weeks, then 2 times a week tir	nes	
		food on the plate was			4 weeks, then weekly times 4		
		covered. The juice cup and			months. The DON/Designee w		
	chocolate milk cup	had sipper lids and were full.			question 5 random staff weekl	у	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DA			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COI			ETED	
		155208	B. W	B. WING			09/27/2023	
				CTREET	ADDRESS SITE STATE SID COD			
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
	D MUDOINO OFNI	TED			LAGRANGE RD			
HANOVE	R NURSING CEN	IER		HANOV	/ER, IN 47243			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
	On the top of the ju	lice and milk were dead flies.			times 8 weeks, then bi-weekly			
	There were three fl	lies flying over the tray.			times 8 weeks, then monthly			
					times 2 months to verify			
	An observation on	9/24/23 at 7:53 p.m., of Wing 1			understanding of the facility's			
	the QMA (Qualifie	ed Medication Aide) 13 was			Infection Control Policy and			
	standing at the nurs	ses' station by the common			Procedures and COVID-19 po	licy		
	area. Resident CC	was sitting in the common area			and procedures. The	·		
	with Resident DD	and Resident EE. Resident CC			Housekeeping/Laundry Super	visor		
	tested positive for	Covid on 9/21/23. The two			will randomly observe the clea			
	other residents (Re	sident EE and Resident DD)			of 3 rooms, including isolation			
	were not Covid pos	sitive. The QMA had no face			rooms, weekly times 3 months	S,		
	mask on and was v	vithin a few feet of all three			then monthly times 3 months.	The		
	residents.				DON/Designee will observe th	е		
					smoking buckets at random tir	nes		
	During an observat	tion on 9/24/23 from 7:57 p.m. to			daily on scheduled workdays			
	8:03 p.m., Residen	t D walked back in forth from his			times 4 weeks, then two times	a		
	room to the nurses'	station three times. No staff			week times 4 weeks, then wee	ekly		
	approached him or	tried to redirect him to stay in			times 4 months to ensure			
	his room. The resid	lent was Covid positive.			smoking tubing is placed in ba	ıgs		
					when not in use and the clean	ing		
	_	w and observation on 9/25/23 at			of smoking mouthpieces. Any			
		keeper 11 was observed walking			negative findings will be correc			
		room. RN 7 indicated to the			immediately and forwarded to			
		s using the wrong wipes to			Administrator. A report of prog	ress		
		room. The housekeeper			will be forwarded to the QAPI			
		ne only housekeep for the			committee ongoing monthly fo	ra		
		d did not know to that he had			minimum of 6 months. If any			
	to use a specific wi	ipe for the isolation rooms.			patterns are identified at the			
					monthly QAPI meeting, an act	ion		
	_	tion and interview on 9/25/23 at			plan will be written by the			
		2 indicated she was currently the			committee. Any written action			
		on Wing 1. She had one aide			plan will be monitored by the			
		but she was floating between			administrator/designee monthl	ıy		
		2. Resident K was observed in			until resolved and substantial	,		
		Resident G had a sign on her			compliance is achieved at 95%	∕o or		
	door. The sign indicated the resident was Covid				greater.			
	1 ~	ation. There was a total of 16						
	residents positive of	on the Dementia unit.						
		0/05/02 / 4.17						
	During an observat	tion on 9/25/23 at 4:17 p.m.,						

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	G	00	COMPLETED		
		155208	B. WING	B. WING			09/27/2023	
		ı	\$TDI	EET A	DDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	₹			AGRANGE RD			
ΗΔΝΟ\/Ε	R NURSING CENT	rer			ER, IN 47243			
IIANOVE	TO NOTION OF OFFICE		11/41	101	LIX, IIV 71270			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE	
		out of another resident's room						
		y. At 4:27 p.m. Resident D						
		nother resident's room. At 4:29						
	1 -	as in the hallway and the QMA						
	1	go back to his room. The						
		te was "bored". At 4:37 p.m., the hallway walking back and						
		to the nurses' station. At 4:52						
		as walking back and forth in the						
		m., Resident D was walking in						
	the hallway by the							
	the namway sy the h	narses station.						
	During an observati	ion on 9/25/23 at 4:33 p.m.						
	_	l into the courtyard. The						
		er to the ground drain and						
		nis pants down and relived						
	himself in the drain	-						
	During an observati	ion on 9/25/23 at 5:15 p.m., the						
	smoking mouthpied	ce and tubing was lying directly						
	on the ground.							
	_	ion on 9/26/23 at 2:24 p.m.,						
		ing in the main dining room						
		staff working on the unit do						
		dent. At 2:31 p.m., CNA 13						
		ecca and wiped her arm with a						
	towel. The CNA die	d not have a mask on.						
	During on absor	ion on 9/27/23 at 11:40 a.m.,						
	_	hpieces, and tubing was lying						
	_	and. At 11:41 a.m., Resident B						
	1	with two staff members, one						
		d up the smoking mouthpiece						
	_	e resident to smoke. The						
		cleaned prior to the resident's						
	use.		1					
	Review of the LTC	(Long Term Care) Respiratory	1					
		List, on 9/23/23, indicated the						

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/27/2023	
	PROVIDER OR SUPPLIEF		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD /ER, IN 47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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	
TAG	following number of Covid: one resident 9/11/23, two reside 9/14/23, two reside 9/15/23, one reside; 9/17/23, two reside 9/18/23, one reside residents tested post two residents tested post two residents tested facility. Cross reference F7/2 The current facility revised date of Octor Administrator on 00 indicated, "Licens nursing assistants a provide direct resident of July 2016, which was a provided from the current facility Procedure - Pander date of July 2016, which was a provided from the cough etiquette. Administrator on 00 "Adherence to impolicies and procedure cough etiquette. Administrator on 10 in policies and procedure of the current facility Control" provided to 12:36 p.m. The policies in fections in heap revented and control begrouped into state to applies to all patterns the control of the current facility control of the current f	of residents tested positive for tested positive for Covid on ants tested positive for Covid on ants tested positive for Covid on ant tested positive on 9/20/23, 5 itive for Covid on 9/21/23, and a positive on 9/21/23 in the description of the positive on 9/21/23 in the description of positive on 9/21/23. The policy indicated, description of positive of positiv				
	diagnosis or infecti	ous status, and additional				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155208	B. WI	NG		09/27/	2023
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID				(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	I C	DATE
F 0921 SS=E	specific to modes of droplet and contract This Federal tag rela 3.1-18(b)(1) 483.90(i)	ates to Complaint IN00415026.					
SS=E Bldg. 00	§483.90(i) Other E The facility must p sanitary, and comf residents, staff and Based on observation failed to maintain a related to wet floors gouged wall with ex door, flies around for tables on 1 of 3 unit Findings include: During an observation p.m., the metal exit unit to Wing 3 had to rubber shins under to were broken. During an observation 9:03 a.m., the clean locked. At 9:05 a.m. was supposed to be was now locked. During an interview indicated she was fr	on and interview, the facility sanitary and safe environment at missing privacy curtains, exposed wires, broken security bod, and damaged bed side is observed. (Wing 2) on on 9/21/23 at 1:58 p.m.2:21 door from the Huntington's the door frame cracked with the door. The door hinges on and interview on 9/23/23 at utility door was not shut and in, the CNA indicate the door shut and locked and the door	F 09	021	What Corrective Action(s) Wise Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice: No residents will be affected by this alleged deficient practice. metal exit door from the Huntington's Unit to Wing 3 has been repaired. The clean utility door was shut and locked. The meal tray was removed and the spill on the floor was cleaned used to the mower and gas can were removed from the courtyard. The mower and gas can were removed from the courtyard. The hole with exposed wires in roo 23 has been repaired. Rooms 16, 20, 21, and 22 have had the privacy curtains fixed or replace The broken bedside table has been removed from the unit. The	y The s / e old e up. he n 15, he ed.	10/20/2023
	side table in the hall	The food tray sitting on a bed way was from last night. The and two drink cups with dead			lock to the soiled utility room h been repaired. The sliding glas door to the courtyard		

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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 09/27/2023			
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER			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)	D BE COMPLETION DATE		
TAG	flies in the liquid. E 5 feet long and 2 fe floor. There were fl Beside the liquid w lying on the floor. During an observat: 10:28 a.m., the AD Nursing) indicated secured door leadin hall. Resident Q did and busted the fram ADON indicated the During an observat: residents secured co a.m., there was a pt full of gas. The AD contact the mainten and gas. During an observat: the Wing 2 dining r at 8:35 a.m. Table of the table. The first reserved at 8:36 a.m. T) was served at 8:36 (Resident U) was seffices flying around served. During an observat: the hallway by the rentrance to the coursign. The sign had a stuck out two feet. Walked past the sign keep walking without the sign had a stuck out two feet.	deside the food tray was an area et wide of a clear liquid on the ies flying around the tray. as an empty cup and 2 straws don and interview on 9/24/23 at ON (Assistant Director of staff cannot exit through the g to the dining in the main a full body ram into the door are and door was hanging. The is had occurred on 9/9/23. don and interview of the ourtyard on 9/24/23 at 10:35 ash mower and two-gallon jug ON indicated she would ance staff to secure the mower don on 9/25/23 at 8:35 a.m., of doom the breakfast trays arrived one had three females sitting at resident (Resident S) was The second resident (Resident Sea.m. and the third resident erved at 9:08 a.m. There were 5 while the residents were being don on 9/26/23 at 11:18 a.m., on nurses' station and the hallway tryard was a yellow caution callen flat on the ground and one of the housekeeper and CNA and an and stepped over the sign to out picking the sign up. At 11:19 a stepped over the sign then		TAG	How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified An What Corrective Action(s) Will Be Taken: All residents have the potential be affected, no other residents were affected by this alleged deficient practice. The metal edoor from the Huntington's Un Wing 3 has been repaired. The clean utility door was shut and locked. The od meal tray was removed and the spill on the fl was cleaned up. The mower a gas can were removed from the courtyard. The Housekeeper mopped the floor in Resident Froom again. The hoe with experimental properties in room 23 has been repaired. Rooms 15, 16, 20, 2 and 22 have had the privacy curtains fixed or replaced. The broken bedside table has been removed from the unit. The location of the soiled utility room has been repaired. All rooms on the Huntington's Unit will be audited for broken bedside tables and functioning privacy curtains. A broken bedside tables will be removed and replaced with probedside tables. Any nonfunctioning privacy curtain be replaced with a properly functioning bedside table. All rooms on the Huntington's Unit will be audited for holes and exposed wires, any negative	od ill I to sixit it to e cor nd lee FF's cosed 1, in ck to n ced lee coper will	DATE	
torned around and protect the sign up.					1			

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTI		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPL	ETED
		155208	B. WING			09/27/2023	
				CTDEET !	ADDRESS CITY STATE 710 COD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
HANOVED NUBBING OFFITED					LAGRANGE RD		
HANOVER NURSING CENTER				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)		DATE
					findings will be corrected.		
		ion on 9/26/23 at 2:27 p.m., the			What Measures Will Be Put I	nto	
	_	o the courtyard was wide		Place and What Systemic			
	open. There were tw	wo flies flying around the door.			Changes Will Be Made To		
					Ensure That The Deficient		
		ion on 9/26/23 at 2:29 p.m.,			Practice Does Not Recur:		
		served to be banging on the			Residents will be provided with	h a	
	metal door he had b	proken prior.			safe, clean, comfortable, and		
					homelike environment. All stat	ff are	
		ion of Residents FF room, on			expected to complete		
		m., the resident's room had just			maintenance work orders whe	en	
		usekeeper 15. At 11:35 a.m., the			equipment/items need to be		
		oss the room and sat down in		repaired or replaced. All staff will			
		vas very wet and shiny. There		be in-serviced over Quality of			
	was visible water standing on the floor. A nursing			Life-Homelike Environment and			
	staff member was asked if the flooring was				Maintenance Work Orders pol	-	
	supposed to be extremely wet. The staff indicated				and procedures. All housekee		
	the housekeeper was not wringing out his mop				staff will be in-serviced over th	ne	
		1:37 a.m., the Housekeeper was			proper way to mop the floor.		
	instructed by the nursing staff member to wring				How The Corrective Action(s	-	
	out his mop and re-mop the resident's room se he				Will Be Monitored To Ensure		
		or would not dry appropriately			The Deficient Practice Will N	ot	
	with being so wet.				Recur:		
					Maintenance Director/Designee		
		nt's fall IDT Note, dated 7/4/23,			will audit 10 rooms weekly tim		
	indicated the resident slipped on wet floor and				months, then every two weeks		
	fell. The resident claimed housekeeping left the				times 2 months, then monthly		
	floor too wet. It was determined that the resident				ongoing. The		
	spilled a drink on floor then slipped in it.				Housekeeping/Laundry Super		
	Dania - ·				will randomly observe the clea	•	
		nent observation on 9/27/23 at			of 3 rooms, including isolation		
	4:11 p.m., Resident Room 23 had a hole above the				rooms, weekly times 3 months	· I	
	resident's bed. The hole was approximately 4			then monthly times 3 months. Any		•	
	inches wide with exposed wires. There used to be		negative findings will be corrected				
	_	ned to the wall. In the hole the			immediately and forwarded to		
		the service and had plastic			Administrator. A report of prog	gress	
	screw caps attached. Rooms 22, 21, 20, 15, 16, and 18 all had broken/missing curtain hooks and/or				will be forwarded to the QAPI		
					committee ongoing monthly fo	or a	
	missing privacy curtains.				minimum of 6 months. If any		
			1		patterns are identified at the		I

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTR		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
155208		155208	B. WING			09/27/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					LAGRANGE RD		
HANOVER NURSING CENTER					/ER, IN 47243		
HANOVE	IN NUNCING CENT			TIANOV	- LIX, IIX +1 240		_
(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	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	ion on 9/27/23 at 4:12 p.m.,			monthly QAPI meeting, an act	ion	
		e table sitting outside Room			plan will be written by the		
		nfection control personal			committee. Any written action		
	-	sitting on the top of the table.			plan will be monitored by the		
	_	re missing the trim. The left			administrator/designee month	ly	
		d a big piece of the corning			until resolved and substantial		
	_	r had exposed sharp, pressed			compliance is achieved at 95%	6 or	
	board fragments sti	cking out.			greater.		
	_	ion on 9/27/23 at 1:15 p.m., the					
		tility room was broken. The					
		A staff member indicated it had					
	been broken for a w	hile.					
		policy titled "Emergency					
		nic COVID 19" with a revised					
	date of July 2016, v	-					
	Administrator on 09/27/23. The policy indicated,						
		fection prevention and control					
		ure is critical. Post signs for					
	cough etiquette. Ad						
		the care of a resident with					
		firmed case of pandemic					
	COVID-19 is a must"						
	77						
	The current facility policy titled "Infection						
	Control" provided by the ADON on 9/23/23 at						
	12:36 p.m. The policy indicated, "Transmission						
		Ith care facilities can be					
	_	rolled through the application					
		ontrol precautions which can					
	be grouped into standard precautions, with must						
	be applies to all patients at all times, regardless of						
	diagnosis or infectious status, and additional						
	(transmission-based) precautions which are specific to modes of transmission (airborne,						
	-						
droplet and contract)"		τ)¨					
	The assessed for 1114	maliary titlad "Complein - D-1:					
		policy titled "Smoking Policy - evised date of July 2017, was					
	residents with a l	crisca date of july 201/, was	1		i e e e e e e e e e e e e e e e e e e e		1

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

PRINTED: 11/13/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		155208	B. WING			09/27/2023	
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	DEFICIENCY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
	provided by the Administrator on 09/27/23. The policy indicated, "The facility shall establish and						
	maintain safe resident smoking practices"						
	This Federal tag rela	ates to Complaint IN00417850					
	3.1-19(a)(4)						

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