STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00417850, IN00416781, IN00415518, and IN00415026. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00417850 - Federal/State deficiencies related to the allegations are cited at F600, F689, F725, F740, and F921. Complaint IN00416781 - Federal/State deficiencies related to the allegations are cited at F725, F689, F679, and 804. Complaint IN00415518 - Federal/State deficiencies related to the allegations are cited at F725 Complaint IN00415026 - Federal/State deficiencies related to the allegations are cited at F725, F564, and 880. Survey dates: September 21, 22, 23, 24, 25, 26, and 27, 2023 Facility number: 000115 Provider number: 155208 AIM number: 100291080 Census Bed Type: SNF/NF: 71 Residential: 7 Total: 78 Census Payor Type: Medicare: 4 Medicaid: 64 Other: 3 Total: 71	F 0000	Preparation and or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marlene Powell	Regional Director of Operations	10/23/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 3, 2023.			
F 0564 SS=E Bldg. 00	483.10(f)(4)(vi)(A)-(D) Inform Visitation Rghts/Equal Visitation Prvl §483.10(f)(4)(vi) A facility must meet the following requirements: (A) Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this section. (B) Inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time. (C) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. (D) Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences. Based on interview and record review, the facility failed to accommodate a resident receiving familial visitors late at night for 16 of 71 residents reviewed for visitation. (Dementia Unit/Wing 1)	F 0564	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient**	10/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: During a confidential interview on 9/21/23 at 9:23 a.m., a resident's family member indicated they received a call from the facility a few days ago. The facility indicated they could not visit their family member on the unit since there was a Covid outbreak. The Health Status Note, dated 8/19/2023 at 8:10 p.m., indicated Resident H's visitors at this time were asked to leave by nightshift QMA (Qualified Medication Aide) on duty. The Health Status Note, dated 8/19/2023 at 8:15 p.m., indicated Resident H's visitors were asked again to leave the facility per new guidelines regarding visiting hours. During an observation on 9/25/23 at 10:10 a.m., there was an 8 inch by 11 inch paper sign on the exit door to the Dementia unit. The paper was taped on the inside facing outside. The sign indicated visiting hours were restricted to 8:00 a.m. to 8:00 p.m. During an interview with LPN (Licensed Practical Nurse) 12 on 9/25/23 at 10:11 a.m., she indicated visiting hours are restricted due to Covid and one resident's family member. During an observation on 9/27.23 at 12:35 p.m., there was a sign posted on the outside entrance door to the Dementia unit on Wing 1. The sign indicated the visiting hours were restricted to 8:00 a.m. to 8:00 p.m. The current facility policy titled "Visitation" with a revised date of December 2013, was provided by		**Practice:** No residents will be affected by this alleged deficient practice. The sign on the Dementia Unit (Wing 1) entrance/exit door stating visiting hours are 8a-8p has been removed. **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 to be affected, no other residents were affected by this alleged deficient practice. The sign on the Dementia Unit (Wing 1) entrance/exit door stating visiting hours are 8a-8p has been removed. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All staff including management will be in-serviced over the facility's visitation policy and procedures. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** Administrator/Designee will monitor entrance/exit doors to the facility and each wing to ensure that visitation is not being restricted and to ensure that signs stating restricted visitation is not posted weekly times 4 weeks,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the Administrator on 09/27/23. The policy indicated, "...The facility provides 24-hour access to all individuals visiting with the consent of the resident...Denying access to visitors who are inebriated or disruptive...." This Federal tag relates to Complaint IN00415026. 3.1-8(b)(7)		then two times a month times 2 months, then monthly times 3 months. Any negative findings will be corrected immediately and forwarded to the RDO. A report of progress will be forwarded to the QAPI committee ongoing monthly for a minimum of 6 months. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the committee. Any written action plan will be monitored by the administrator/designee monthly until resolved and substantial compliance is achieved at 95% or greater.	
F 0600 SS=J Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to ensure resident to resident abuse did not occur related to sexual abuse resulting in a severely cognitive resident and a cognitive	F 0600	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient**	10/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident found in an unsupervised sexual situation for 2 of 5 residents reviewed for abuse. (Resident C and Resident D) The immediate jeopardy began on 8/24/23, when the facility failed to prevent resident to resident sexual abuse when a cognitively alert male resident was found with a severely cognitively impaired female resident in an inappropriate sexual position. The DON, ADON, MDSC, and the consultant were notified of the immediate jeopardy on 9/22/23 at 2:55 p.m. The Immediate Jeopardy was removed on 9/27/23, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. The clinical record for Resident C was reviewed on 9/21/23 at 12:57 p.m. A Quarterly MDS (Minimum Data Set) assessment, dated 7/3/23, indicated the resident was severely cognitively impaired and required supervision for locomotion (walking from one location to another). Her diagnoses included, but were not limited to: Huntington's disease, chorea (neurological disorder), psychosis, bipolar disorder, schizophrenia, violent behavior, and dementia. A review of the EMAR (Electronic Medical Record) on 9/22/23 at 2:19 p.m., lacked a consent from the POA (Power of Attorney) for the resident to have any sexual activities. The Care Plan, dated 2/5/22, indicated the resident had the potential for resident-to-resident abuse related to Huntington's disease, impulsiveness, psychosis, bipolar disorder, schizophrenia,		**Practice:** Resident D and Resident C were separated by staff when residents were observed in the central bathroom together. (Resident D does have a history of making false accusations toward staff AEB: sexual comments or gestures to and about staff and other residents). Resident D was started on Cimetidine oral tablet and placed on 15-minute checks. No further incidents occurred between the two residents. Resident D has a BIMS of 13 indicating intact cognition and resident C has a BIMS of 1, indicating severely impaired cognition (inability to consent). Resident C has been care-planned for inability to consent to sexual activity due to cognitive impairment. **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 Resident's BIMS scores reviewed. Residents with a BIMS score of 13, 14, or 15 will be care planned for their ability to consent to sexual activity based on their intact cognitive status. Residents with a BIMS score of 8-12 (moderately intact cognition) will have the determination to consent made by the Medical	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dementia, and wandering into other residents' room. The interventions were to follow up with the social service director or designee or psychiatric services. Staff were to investigate the actual or suspected resident to resident abuse per the facility policy. They were to monitor residents involved in an actual or suspected resident to resident abuse per the facility policy. Staff were to notify the administrator, director of nursing, the physician, the POA, or Guardian immediately upon actual or suspected resident-to-resident abuse and they were to separate the residents involved in resident-to-resident abuse as soon as resident-to-resident abuse was reported or witnessed. A Behavior Note, dated 7/20/23, indicated Resident C had a behavior of going into the hallway naked. The reason for the behavior was marked unknown. A Progress Note, dated 8/24/23 at 5:50 p.m., indicated a CNA (Certified Nurse Aide) reported that a resident went into the central bathroom to use the toilet. After the resident had her pants pulled down, a male resident entered the bathroom and pulled the curtain behind him and pulled down his pants and turned to face the female resident. The CNAs went into the bathroom to clean up the area and wash their hands when they noticed two sets of feet behind the curtain. The female's skin was checked immediately; and no issues were noted. The residents were separated, and SSD (Social Service Director) was called to speak to the male resident. The physician was notified of the incident. The staff called the resident's POA and left a voicemail to return a call. A Progress Note, dated 9/7/23 at 3:48 p.m., indicated the resident was pulling her hair out and		Director/Practitioner or psychiatric provider based on their expertise in the area, including their ability to measure resident knowledge of relevant info such as risk and benefits, understanding, rationale reasoning and resident volunteeredness. The determination will be documented in the resident's medical record. The resident's care plan will be updated to reflect the determination. Residents with a BIMS score of 7 or below will be care planned for their inability to consent to sexual activity due to severe cognitive impairment. A list will be maintained at each nurse's station, and updated as changes occur, by the MDS Coordinator, with the determined mental capacity and ability to consent to sexual activity of each resident. BIMS scores will be completed at admission, re-admission, quarterly and with any significant change in condition. The MDSC/Designee will ensure that capacity determinations as related to sexual activity are kept up to date, as well as the resident care plan and nursing station lists. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All facility staff educated on the Facility abuse policy with a focus	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	scratching her face excessively. She recently had visitors and the behaviors began following the recent visit. During an observation on 9/27/23 at 4:09 p.m., Resident C was standing by the common bathroom door. There were no staff visible from where the resident was standing. At 4:11 p.m., the nurse walked from behind the medication cart and was on the phone. She would have been able to see the resident if she looked to her right. 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, indicated the resident was cognitively intact and required supervision for locomotion. His diagnoses included but were not limited to, Huntington's, mood affective disorder, anxiety, and attention deficit hyperactivity disorder. The Behavior Management Record for Resident D from June, July, August, and September indicated the following: - On July 5, 6, 20, 27, 29, August 3, 5, 6, 9, and 11, 2023, the resident was using vulgar/explicit language around or towards another resident. - On August 3, 2023, the resident knowingly entered the bathroom shower room with a half-naked female resident. - On August 11, 2023, the resident indicated he was in a relationship with a certain staff member. - On August 15 and 16, 2023, the resident knowingly went into the bathroom with a female resident exposed.		on resident's mental capacity related to sexual interactions and abuse prevention with HD behavior. The DON, MDSC and ADON in-serviced on ensuring mental capacity has been determined by the physician and/or psychiatric provider for residents with a BIMS score of 8-12 (moderately impaired), that it is documented in the resident's medical record, care planned, and a running list is kept at each nurse's station with the current consent ability of each resident. SSD in-serviced on reviewing behavior logs daily at morning meeting (Mon-Fri. Monday will include a review of the weekend logs) and following up on any notations made of inappropriate sexual behavior to ensure abuse has not occurred. Any positive findings will be reported to the Administrator immediately. Residents with a BIMS score of 13, 14 or 15 will be care planned for their ability to consent to sexual activity based on their intact cognitive status. Residents with a BIMS score of 8-12 (moderately intact cognition) will have the determination to consent made by the Medical Director/Practitioner or psychiatric provider based on their expertise in the area, including their ability to measure resident knowledge of relevant info such as risk and benefits, understanding, rationale	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- On August 26, 2023, the resident was following residents. - On August 27, 2023, the resident was sleeping in another resident's bed. The Behavior Note, dated 8/11/23 at 7:27 p.m., indicated Resident D was making fun of other residents and indicated he was dating another female. The Behavior Note, dated 8/12/23 at 11:30 a.m., indicated the writer was on the unit taking an item to another resident. On their way to the door to go back to Wing 1, Resident D stopped her and stated, "Hey...wait! I have a girlfriend." He then proceeded to say, it was a staff member from activities. She loves me, and she kissed me. The writer explained to resident that this was serious and inappropriate. He then said, "Oh hey! I was just kidding. Can't you take a joke? She is not my girlfriend, and she did not kiss me. I was just kidding." Nurse on call notified of resident's statement. The Behavior Note, dated 8/12/23 at 1:00 p.m., indicated after lunch service this writer spoke with Resident D regarding the incident earlier in the shift when he told another staff member that he had been kissed by another staff member even though he insisted that he was "only joking when I said that". This writer explained that it was inappropriate to make untrue statements about staff members. That false accusations and statements made against other residents or staff are not "just joking around". The comments are inappropriate and will not be tolerated. His privileges to attend activities with only one staff member present will not occur to protect staff from false accusations. He verbalized understanding.		reasoning and resident volunteeredness. The determination will be documented in the resident's medical record. The resident's care plan will be updated to reflect the determination. Residents with a BIMS score of 7 or below will be care planned for their inability to consent to sexual activity due to severe cognitive impairment. A list will be maintained at each nurse's station, and updated as changes occur, by the MDS Coordinator, with the determined mental capacity and ability to consent to sexual activity of each resident. BIMS scores will be completed at admission, re-admission, quarterly and with any significant change in condition. The facility will ensure an adequate number of staff are scheduled on the HD unit to ensure abuse does not occur. In addition to the clinical staff, the facility is seeking activity aides to work the unit during day and evening hours daily, including weekends, to assist with providing additional supervision, a safe environment, and activities for the residents. Any new staff will receive education on the abuse policy, HD behaviors and sexual consent prior to working the HD unit. The Admin/DON/SW will meet with the staff who typically work the HD Unit 2 times per month to allow staff an opportunity to voice any concerns, discuss	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	checks The resident stated numerous times that he watched porn all the time. A Progress Note, dated 9/13/23 at 10:52 a.m., indicated the resident was seen by staff being sexually inappropriate toward another staff member. The Care Plan, dated 6/5/23, indicated the resident had exhibited sexually inappropriate behaviors of inappropriate comments to staff, about staff, and other residents. The interventions were for staff to encourage the resident to express his feelings. Staff were to explain to the resident that behavior was not appropriate. They were to let the resident know what kind of behavior was expected and what will be tolerated. The staff were to notify the MD as needed. Staff were to talk to the resident about the feelings and rights of others and about who are exposed to his acting out. The Care plan, dated 6/7/23, indicated the resident exhibited sexually inappropriate behavior. The interventions indicated staff were to administer the resident's medications as ordered. Staff were to document all behaviors and reassure the resident it was okay to talk of feelings or thoughts. He was educated that inappropriate behaviors were not acceptable. The staff were to report any sexual inappropriate behavior immediately per facility policy. Review of the resident's EMAR on 9/22/23 at 2:19 p.m., indicated the resident lacked a care plan or updated care plan related to the resident's sexual encounter on 8/24/23. During an interview on 9/21/23 at 10:10 a.m., the ADON (Assistant Director of Nursing) indicated there was a reportable on Resident D and		meeting (M-F) to ensure an adequate number of staff are scheduled to provide a safe environment and that all efforts are made to schedule staff where needed. 5. Review reportable incidents monthly from the HD unit to observe for increase in numbers and any potential pattern. An action plan will be created for an increase in reportables >10% from one month to the next or any identified patterns. 6. The Admin/Designee will do walking rounds on the HD Unit daily, varying shifts, to observe and verify that adequate supervision is being provided. All efforts will be made to secure staff for the Unit if adequate supervision is not available. 7. The Admin/Designee will check the nurse's station weekly to ensure the list of residents and their ability to consent to sexual activity is there and that it is up to date. A report of progress will be forwarded to the QAPI committee ongoing monthly for a minimum of 6 months. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the committee. Any written action plan will be monitored by the administrator/designee monthly until resolved and substantial compliance is achieved at 95% or greater.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident C. Two CNAs went into the central bathroom to wash their hands. The CNAs walked into the bathroom/shower room and turned to their right, to the sink. There was a mirror above the sink and the mirror showed a reflection of the toilet stall across from the sink. The bathroom stall had a curtain pulled and the CNAs saw a set of feet and a pair of pants on the floor under the curtain. They noticed a second pair of feet and the CNA opened the curtain. Resident D had his pants down with no brief or underwear on. He was standing with his feet slightly apart and facing Resident C. The staff members separated the residents and reported the incident. The ADON assessed both residents and Resident D was interviewed. When he was asked what he intended to do, he said he did not know, because he got caught. Resident C did not talk much in context, and she did not interview Resident C, but she did not seem distressed. Resident D resided on the end of the hallway where it was all men. During an interview on 9/21/23 10:22 a.m., CNA 2 indicated when she and CNA 3 went into the central bathroom to wash their hands, they turned around and the curtain was pulled in front of the toilet stall. She noticed Resident C's pants down and asked if she needed help. The resident did not speak, but she then noticed a second pair of feet. Resident C was standing with her back to the curtain and Resident D was standing in front of the toilet. Resident C's pants were down, and she still had a brief in place. Resident D's pants and underwear were down, and he was sexually fully aroused. When Resident D was asked what he was doing, he said he did not know because he got caught. The residents were immediately separated, and the incident was reported to the nurse.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 9/25/23 at 9:33 a.m., CNA 3 indicated when she and CNA 2 went into the central bathroom to wash their hands, CNA 2 noticed Resident C's feet behind the curtain, she did not usually pull the curtain when she went into the bathroom stall, but the curtain was pulled. CNA 2 asked her if she needed help and stuck her head in the curtain and there stood Resident D. He had his pants to his ankles, hands on his hip, leaned back, and had a fully aroused p**is. Resident C had her pants to her ankles, but still had her brief on. We immediately separated them and reported it. Over half of the Wing 2 residents required feeding assistance, and if they have someone with behaviors, then they would have to stop feeding to deal with the behaviors. There needs to be activities on the unit. They do not usually have any real activities over there. During an interview on 9/25/23 at 10:19 a.m., The Regional Consultant indicated the facility did not have a working camera system in the building. The cameras were not hooked up to anything. The prior owner took the system boxes when the new company bought the building prior to this incident. During an interview on 9/25/23 at 10:23 a.m., CNA 2 indicated she was not sure of the actual time they found Resident D and Resident C in the bathroom. She was not sure of the last time they were seen on Wing 2 before they found them together in the bathroom. LPN (Licensed Practical Nurse) 4 was working on Wing 2 and had a meeting. The ADON was covering on the wing for the LPN and had left the floor when we found the two residents together (Resident D and Resident C). She had immediately tried to notify administration, and the BOM (Business Office Manager) called wanting to find out what was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	needed, and we told her we had a situation. After a couple of minutes, the ADON returned, and we notified her. During an interview 9/25/23 at 10:32 a.m., LPN 4 indicated she had a meeting with the Corporate Staff 5 to talk about the unit. Staff on the Huntington's unit were just stretched, too, thin. She had been reporting to corporate for months about the need for more help. The incident with Resident D and Resident C had to occur around 4:00 p.m. She did not recall seeing either resident out in the hallway, but it would have not been unusual to not see them. When the two CNAs would take the residents out to smoke. "two staff for safety reasons", that would normally leave one staff on the unit to monitor all the residents during the smoke break. The only activities normally on the unit were papers dropped off for the residents to color or cross word puzzles. During an interview on 9/24/23 at 8:15 a.m., CNA 6 indicated she was the only CNA working on Wing 2 with the nurse since 8:00 a.m. This was her first time working on the unit. She indicated there was no way she could care, monitor, and feed all the residents with just her and the one nurse. During an interview on 9/24/23 at 8:20 a.m., RN 7 indicated yesterday from 4:00 p.m. till 5:00 p.m., she was the only staff member working on Wing 2. Resident D was walking out into the hallway multiple times, and she could not get him to stay in his room. During a confidential interview between 9/21/23 and 9/25/23, a staff member indicated there were multiple residents who required assistance with eating. Working with 4 staff for 28 resident was very rough. The weekends were the worst. When			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	staff were feeding a resident and had to stop to monitor another resident or assist another resident, the resident they were assisting to eat would get very upset. During a confidential group interview between 9/21/23 and 9/25/23, three staff members indicated there was not enough staff to meet the residents' needs on Wing 2. There were multiple residents that required feeding assistance and had behaviors. The Huntington's unit (Wing 2), did not have consistent activities or appropriate activities for the age range of residents. When a resident was on 15-minute checks, they tried to keep them in a common area, but this did not work. The weekend shifts are the worst. If there were more staff and better activities it would be possible to mitigate some of the aggressive behaviors. Cross Reference F740. On 9/21/23 at 9:55 a.m., the Regional Consultant provided a current copy of the policy titled "Abuse and Neglect", and a revision date of 8/1/23. It included, but was not limited to, "Policy...Each resident has the right to be free from abuse..." The current facility policy titled "Behavior Management" with a revised date of December 2015, was provided by the Administrator on 09/27/23. The policy indicated, "...All Licensed Nurses, CMT/QMAs, and C.N.A.s are responsible for documentation on the Behavior Monitoring Form and identifying interventions initiated to redirect behaviors..." The Immediate Jeopardy that began on 8/24/23, was removed on 9/27/23, when the facility			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	conducted the following: All residents' cognitive ability to consent to sexual activity was reviewed. The residents' care plan will be updated to reflect the determination. All facility staff were in-serviced on the Facility abuse policy with a focus on the residents' mental capacity related to sexual interactions and abuse prevention with Huntington/behaviors, Huntington disease education and understanding, and sexual abuse. The Social Service Director was in-serviced on reviewing behavior logs daily at morning meetings. The Immediate Jeopardy was removed on 9/27/23, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy because the Administrator or Designee will audit to ensure the appropriate care plans and or action was taken for ability to consent to sexual activity and will do walking round on the unit daily, varying shifts, to observe and verify adequate supervision being provided. This Federal tag relates to Complaint IN00417850 3.1-27(a)(1)			
F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interaction in the community. Based on observation, interview, and record review, the facility failed to develop and implement individualized activities programming to meet individual resident needs for 2 of 3 specialized resident units reviewed for activities. This deficient practice had the potential to affect 42 of 71 resident that reside in the facility. (Huntington's unit and the Dementia unit) Findings include: Review of the September activity schedule indicated there was one monthly schedule for the whole facility. The activities planned for 9/23/23 (Saturday) were as followed: Daily Chronicle at 9:30 a.m., Question Ball at 10:00 a.m., Exercise at 11:00 a.m., and Musical Social at 1:00 p.m. During an interview on 9/23/23 at 9:34 a.m., the Activity Director indicated today she was working as a CNA. The unit was short on staff, and she had to work the floor. They have been short staffed frequently and there was no possible way for her to provide activities to the whole facility. The facility had recently hired a staff member to do activities with the residents, but she had not started yet. The activities on the monthly schedule were for the whole facility. There was no current separated program for mental capacity or age range. She was hopeful with another activity staff they could offer more specialized activities for the residents with Dementia unit (Wing 1) and/or Huntington's unit (Wing 2). During an observation and interview on 9/23/23 at 10:15 a.m., there was no activities observed on Wing 1 or Wing 2. During an observation and interview on 9/23/23 at	F 0679	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents will be affected by this alleged deficient practice. The facility will develop and implement individualized activities programming to meet individual resident needs on the Huntington's Unit and Dementia Unit. **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 to be affected, no other residents were affected by this alleged deficient practice. The facility will develop and implement individualized activities programming to meet individual resident needs on the Huntington's Unit and Dementia Unit. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** The facility will develop and implement individualized activities programming to meet individual resident needs on the Huntington's Unit and Dementia	10/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	10:26 a.m., two volunteers arrived at the facility. They indicated they were there from a local collage. Volunteer 20 indicated she was a physical therapist and Volunteer 21 was a physical therapist student. They indicated they try to come twice a month. There were five residents participating in the exercise program. The five residents appeared to enjoy the activity and most of them were smiling with the volunteers. Resident Q was sitting up and talking with the Volunteers when they asked her to sit back in her chair. During an observation and interview on 9/24/23 at 10:30 a.m., there were no activities observed on Wing 2. During an interview on 9/24/23 at 10:16 a.m., RN 7 indicated except for two or three residents that go to church there were normally no activities on the weekends. If there was an activity it would be on Wing 3, and the residents that could attend had to go off the unit to Wing 3. There was not enough staff to take the residents that needed supervision if they wanted to go. There were papers for the residents to color or do word searches for independent activities. During an interview 9/25/23 at 10:32 a.m., LPN 4 indicated the only activities normally on the Huntington's unit was papers dropped off for the residents to color or do cross word puzzles. During a confidential group interview between 9/21/23 and 9/25/23, three staff members indicated there was not enough staff to meet the residents' needs on Wing 2. There were multiple residents that required feeding assistance and had behaviors. The Huntington's unit (Wing 2), did not have consistent activities or appropriate		Unit. Activity Aides designated to the Huntington's Unit and Dementia Unit will be hired. The Activity Director and Activity Aides will be in-serviced over the facility's Quality of Life-Resident Self Determination and Participation policy and procedures. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Administrator/Designee will monitor the activity department schedule to ensure an activity aide is designated each day for the Huntington's unit and Dementia Unit and the activity calendar to ensure appropriate activities are scheduled for the Huntington's Unit and Dementia Unit weekly times 8 weeks, then monthly times 3 months. Any negative findings will be corrected immediately and forwarded to the RDO. A report of progress will be forwarded to the QAPI committee ongoing monthly for a minimum of 6 months. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the committee. Any written action plan will be monitored by the administrator/designee monthly until resolved and substantial compliance is achieved at 95% or greater.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	activities for the age range of residents. When a resident was on 15-minute checks, they tried to keep them in a common area, but this did not work. The weekend shifts are the worst. If there were more staff and better activities is would be possible to mitigate some of the aggressive behaviors. Cross Reference F689. Cross Reference F725. The current facility policy titled "Quality of Life - Resident Self Determination and Participation" with a revised date of December 2016, was provided by the Administrator on 09/27/23. The policy indicated, "...Each resident is allowed to choose activities, schedules and health care that are consistent with his or her interests, values, assessments, and plans of care, including:...Activities, hobbies and interests..." This Federal tag relates to complaint IN00416781. 3.1-33(a)			
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility	F 0689	**What Corrective Action(s) Will Be Accomplished For Those**	10/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failed to have adequate supervision to prevent frequent resident falls and negative behaviors, ensure a metal unit exit door was repaired timely and secured, chemicals and hazardous supplies were secured for 1 of 3 resident units reviewed for accidents. This deficient practice had the potential to affect 26 of 71 residents who reside in the facility. (Wing 2/Huntington's Unit) Finding includes: 1. During an observation on 9/21/23 at 1:58 p.m., the exit door from the Huntington's unit/Wing 2 to Wing 3 was hanging with the door frame cracked on the top and bottom, hinges broken, and rubber shins were under the door. There was a piece of paper on the door that indicated to not use the door. During an interview on 9/21/23 at 10:28 a.m., the ADON (Assistant Director of Nursing) indicated staff cannot exit through the secured door leading to the Wing 3 unit. On 9/9/23, Resident Q did a full body ram into the door and busted the frame, and the door was just hanging by the top spring. The resident went through the broken door and out the hallway. The staff intervened and the police were called. He had also, broken the glass door next to the courtyard located by the SSD (Social Service Director's) office. Review on Resident Q's Behavior Management Record, indicated the resident had behaviors of hitting the glass door and unit door on the following dates: 9/1, 9/2, 9/3, 9/9, 9/11, 9/12, 9/15, 9/16, 9/17, and 9/18/23. 2.a. During a continuous observation on 9/23/23 from 9:36 a.m. through 9:42 a.m., the housekeeping cart was sitting in the hallway of Wing 1. The cart		**Residents Found To Have Been Affected By The Deficient Practice:** No residents will be affected by this alleged deficient practice. The exit door on Wing 2 leading to Wing 3 has been repaired. The glass door leading to the courtyard has been repaired. Housekeeping carts will not have chemicals left out on them and the carts will not be left on the units unattended. The central bathroom/shower room has been cleaned and all hazardous chemicals and personal hygiene items will be secured out of reach of residents. Activity Aides designated to the Huntington's Unit and Dementia Unit will be hired. Appropriate nursing staff will be scheduled for the Huntington's Unit. Food and drinks will be served at the appropriate temperatures. Food trays will be delivered to the units at their scheduled times. **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 to be affected, no other residents were affected by this alleged deficient practice. The exit door on Wing 2 leading to Wing 3 has been repaired. The glass door leading to the courtyard has been repaired. Housekeeping carts will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.a. During a confidential group interview between 9/21/23 and 9/25/23, three staff members indicated there was not enough staff to meet the residents' needs on Wing 2. There were multiple residents that required feeding assistance, frequent falls, and aggressive behaviors. The Huntington's unit (Wing 2) did not have consistent activities or appropriate activities for the age range of residents. When a resident was on 15-minute checks they tried to keep them in a common area, but this did not work. The weekend shifts were the worst. If there were more staff and better activities, then it could possibly mitigate some of the aggressive behaviors. Review of the Wing 2 residents' recent falls indicated the following: - On 6/27/23 at 5:12 p.m., Resident Z fell onto his bottom when he was obtaining supplies from the business office. - On 7/4/23 at 12:15 a.m., Resident P fell on the floor in front of his wheelchair and closet. - On 7/6/23 at 5:38 a.m., Resident AA fell while trying to get from the wheelchair to his bed. He fell face down onto the bed. - On 7/6/23 at 6:30 a.m., Resident Z was found lying on the floor in a puddle of soda and minimal blood. The resident had a one-inch laceration to his left eyebrow. - On 7/10/23 at 11:20 a.m., Resident P slid out of his wheelchair onto the floor. - On 7/11/23 at 8:35 a.m., Resident P slid out of his wheelchair onto the floor.		temperatures. Food trays will be delivered to the units at their scheduled times. All staff will be in-serviced over the facility's Quality of Life-Resident Self Determination and Participation, Hazardous Areas in the Facility, and Incident/Accident Reporting policy and procedures. All dietary staff will be in-serviced over the facility's Food Temperatures on the Service line policy and procedures. The Scheduler, DON, and ADON will be in-serviced over ensuring adequate staff is scheduled for the Huntington's Unit. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director/Designee will monitor timeliness of repairs and /or repair timelines weekly times 4 weeks, then two times a month times 2 months, then monthly times 3 months. Housekeeping/Laundry Supervisor/Designee will monitor housekeeping carts to ensure chemicals are secured and carts are not left unattended weekly times 8 weeks, then two times a month times 2 months, then monthly times 2 months. The Dietary Manager/Designee will complete a test tray on varying units at varying meals and monitor delivery times of meals on varying units at varying meals 3 times a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- On 7/24/23 at 2:33 a.m., Resident X was standing at nurses' desk had almost fallen multiple times. The CNA attempted to get the resident to sit in a chair and the resident started punching her in the face and back of head. - On 7/27/23 at 12:35 p.m., Resident AA was found lying on the floor on his back with a laceration to the left eyebrow. Moderate amount of bloody drainage noted from the laceration on his face. - On 8/1/23 at 4:35 p.m., Resident Z went outside to attend supervised smoking. When he got out onto the patio, he had severed movements that doubled him over in the wheelchair and the resident flipped the wheelchair over. - On 8/6/23 at 5:54 a.m., Resident P fell in bathroom while transferring self. The resident had a 1.5 cm laceration. - On 8/11/23 at 11:30 a.m., Resident N had an altercation of aggression with Resident P (the resident stomped on the other resident's hand). - On 8/29/23 at 7:40 a.m., Resident N had a fall, the resident was awaiting breakfast when he slid out of the chair onto the floor, and he hit his left eyebrow on the floor causing a laceration and hematoma. - On 8/31/23 at 9:15 p.m., Resident Z fell while he was outside smoking and flipped his wheelchair. He hit his head on the concrete. He had a 5 cm abrasion to the mid forehead with 2 shallow lacerations on either 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		week times 4 weeks, then 2 times a week times 4 weeks, then weekly times 4 weeks, then 2 times a month times 3 months. The DON/Designee will monitor the nursing schedule for appropriate amount of staff for the Huntington's unit daily on scheduled workdays times 4 weeks, then 2 times a week times 4 weeks, then weekly times 4 months. The Administrator/Designee will monitor the activity department schedule to ensure an activity aide is designated each day for the Huntington's Unit weekly times 8 weeks, then monthly times 3 months. Any negative findings will be corrected immediately and forwarded to the Administrator and/or RDO.A report of progress will be forwarded to the QAPI committee ongoing monthly for a minimum of 6 months. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the committee. Any written action plan will be monitored by the administrator/designee monthly until resolved and substantial compliance is achieved at 95% or greater.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of 2.5 cm was found to the center of his forehead. The resident indicated he fell on his dresser. - On 9/10/23 at 1:15 p.m., Resident Z fell and was found lying on his back with the wheelchair next to the resident's roommate's bed. - On 9/16/23 at 12:07 a.m., Resident AA was transferring self from bed to wheelchair and the wheelchair rolled out from under him and he fell on his bottom. - On 9/18/23 at 10:20 a.m., Resident Z was found lying face down on the floor with a pool of blood under his face. The resident had a laceration to the bridged of his nose. - On 9/24/23 at 4:00 a.m., Resident AA was found lying on his alarm mat with his face down next to his bed. There was blood on his face with a laceration on his forehead. The resident was unable to give a description of the occurrence. - On 9/24/23 at 4:33 a.m., Resident BB was found lying face down on the floor next to her wheelchair. When the resident was turned over there was blood on her face and bruising on her right knee. b. An observation on 9/24/23 at 8:13 p.m., of the outside courtyard was very dark with no lighting in the smoking area. There were 5 residents (B, M, HH, JJ, FF) sitting waiting on staff to smoke. No staff were present in the courtyard. During an interview on 9/24/23 at 8:19 p.m., CNA 10 indicated she was the only aide working the night shift. The residents were outside waiting on someone to bring them their smoking supplies.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4. An observation on 9/24/23 at 8:37 a.m., of the Wing 2 meal service indicated Resident M and Resident V were served at 8:37 a.m. Then the staff member walked down to the end of the hallway and went into Resident W's room. There were no staff monitoring the dining room with two residents still eating (Resident S and Resident U). At 8:49 a.m., both staff were on the end of the hall by Room 16. There were no staff supervising in the dining area and Resident S was still eating. During an interview on 9/24/23 at 8:52 a.m., RN 7 indicated Resident S was a choking hazard, however there was nothing she could do since all the residents needed to be feed. During an observation and Interview on 9/24/23 at 9:29 a.m., the Cook tempted one of the last 5 resident trays to be served. The eggs tempted 87 degrees Fahrenheit, and the resident's juice tempted 51 degrees Fahrenheit. He indicated the trays cannot be served at that time and they are short staffed. During an interview on 9/25/23 at 10:08 a.m., RN 7 indicated sometimes the resident do not receive their breakfast till 10:00 a.m., lunch by 1:00 p.m., and then dinner arrived at 4:00 p.m. and there have been times they were still providing feeding assistance after 6:00 p.m. With 14 residents that required feeding assistance and multiple other residents who must be monitored for choking hazards there are not enough staff to feed the residents before the food was cold. When you must pass medication and feed residents even with two aides you cannot safely monitor all the residents. The current facility policy titled "Hazardous Area in the Facility" with a revised date of March 2010,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was provided by the Administrator on 09/27/2. The policy indicated, "...The facility's Safety Committee shall recommends measures to ensure that residents cannot access hazardous areas in the facility..." The current facility policy titled "Accident and Incident Reporting" with a revised date of October 2014, was provided by the Administrator on 09/27/2. The policy indicated, "...An Accident/Incident Report form is to be completed for all incidents involving residents..." The current facility policy titled "Food Temperatures on Service Line" with a revised date of June 2018, was provided by the Administrator on 09/27/23. The policy indicated, "...Foods will be served at proper temperature to ensure food safety...If temperatures are not at acceptable levels and cannot be corrected in time for meal service, make an appropriate menu substitution. Follow [Reheating Temperature]..." This Federal tag relates to Complaints IN00417850 and IN00416781. 3.1-45(a)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview, and record review, the facility failed to ensure staffing levels were adequate related to abuse prevention, falls, dining assistance, meal timing, and call lights for 42 of 71 residents reviewed for staffing. (Wing 1 and Wing 2) Findings include: 1. During an interview on 9/21/23 at 10:10 a.m., the ADON (Assistant Director of Nursing) indicated there was a reportable on 8/24/23 related to Resident D and Resident C. Two CNAs (Certified Nurse Aide) went into the central bathroom to wash their hands. The CNAs walked into the bathroom/shower room, and they turned to their right to face the sink. There was a mirror above the sink and the mirror showed a reflection of the bathroom stall across from the sink. The bathroom stall had a curtain pulled and the CNAs saw a set of feet and a pair of pants on the floor under the curtain. They noticed a second pair of feet and	F 0725	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents will be affected by this alleged deficient practice. Sufficient staffing will be scheduled on the Huntington's Unit and Dementia Unit including a 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 to be affected, no other residents were affected by this alleged deficient practice. Sufficient staffing will be scheduled on the	10/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	opened the curtain. Resident D had his pants down with no brief or underwear on. He was standing with his feet slightly apart and facing Resident C. The staff members separated the residents and reported the incident. The ADON assessed both residents and Resident D was interviewed. When he was asked what he intended to do, he said he did not know, because he got caught. Resident C did not talk much in context, and she did not interview Resident C, but she did not seem distressed. Resident D resided on the end of the hallway where it was all men. During an interview on 9/25/23 at 10:23 a.m., CNA 2 indicated she was not sure of the actual time they found Resident D and Resident C in the bathroom. She was not sure of the last time they were seen on the unit before they found them together in the bathroom. LPN (licensed Practical Nurse) 4 was working on the unit (Wing 2) and had a meeting. The ADON was covering on the unit for the LPN and had left the floor when we found the two residents together (Resident D and Resident C). She had immediately tried to notify administration, and the BOM (Business Office Manager) called wanting to find out what was needed, and we told her we had a situation. After a couple of minutes, the ADON returned, and we notified her. Cross reference F600 2. During an interview on 9/23/23 at 9:34 a.m., the Activity Director indicated today she was working as a CNA. The unit was short on staff, and she had to work the floor. They have been short staffed frequently and there was no possible way for her to provide activities to the whole facility. There was no current separated program for mental capacity or age range. She was hopeful		Huntington's Unit and Dementia Unit including a designated activity aide. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** Sufficient staffing will be scheduled on the Huntington's Unit and Dementia Unit including a designated activity aide. The Activity Director, Scheduler, DON, and ADON will be in-serviced over the facility's Staffing policy and procedures. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The DON/Designee will monitor the nursing schedule for appropriate amount of staff for the Huntington's unit daily on scheduled workdays times 4 weeks, then 2 times a week times 4 weeks, then weekly times 4 months. The Administrator/Designee will monitor the activity department schedule to ensure an activity aide is designated each day for the Huntington's Unit weekly times 8 weeks, then monthly times 3 months. Any negative findings will be corrected immediately and forwarded to the Administrator and/or RDO. A report of progress will be forwarded to the QAPI committee ongoing monthly for a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with another activity staff they could offer more specialized activities for the residents' with Dementia unit (Wing 1) and/or Huntington's unit (Wing 2). During an interview on 9/24/23 at 8:15 a.m., CNA 6 indicated she had been the only CNA working on Wing 2 with the nurse since 8:00 a.m. This was her first time working on the unit. There was no way she could care, monitor, and feed all the residents with just her and the one nurse. During an interview on 9/24/23 at 8:20 a.m., RN 7 indicated yesterday from 4:00 p.m. till 5:00 p.m., she was the only staff member working. Resident D was tested for Covid and was positive. He was walking out into the hallway without a mask multiple times, and she could not get him to stay in his room. Review of Resident D's Behavior Management Record indicated the resident had behaviors of teasing other residents on the following dates: 6/18, 6/21, 6/22, 6/26, 6/27, 6/30, 7/2, 7/3, 7/5, 7/7, 7/10, 7/14, 7/15, 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 Record indicated the resident had behaviors of attention seeking on the following dates: 6/18, 6/22, 6/26, 7/3, 7/5, 7/7, 7/12, 7/17, 8/2, 8/3, 8/5, 8/6, 8/9, 8/11, and 8/16/23. The Resident D's Behavior Management Record, dated 9/25/23, indicated the resident's reason for his behavior was that he was bored and attention seeking. During an interview 9/25/23 at 10:32 a.m., LPN 4		minimum of 6 months. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the committee. Any written action plan will be monitored by the administrator/designee monthly until resolved and substantial compliance is achieved at 95% or greater.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated she had a meeting with the Corporate Staff 5 to talk about the unit. Staff on the Huntington's unit were just stretched too thin. She had been reporting to corporate for months about the need for more help. The incident with Resident D and Resident C had to occur around 4:00 p.m. She did not recall seeing either resident out in the hallway, but it would have not been unusual to not see them. When the two CNAs would take the residents out to smoke for safety reasons, that would normally leave one staff on the unit to monitor all the residents during the smoke break. The only activities normally on the unit were papers dropped off for the residents to color or cross word puzzles. During a confidential interview between 9/21/23 and 9/25/23, a staff member indicated there were multiple residents who required assistance with eating. Working with 4 staff for 26 resident was very rough. The weekends are the worst. When staff were feeding a resident and had to stop to monitor another resident or assist another resident, the resident they were assisting to eat would get very upset. During a confidential group interview between 9/21/23 and 9/25/23, three staff members indicated there was not enough staff to meet the residents' needs on Wing 2. There were multiple residents that required feeding assistance, frequent falls, and aggressive behaviors. The Huntington's unit (Wing 2) did not have consistent activities or appropriate activities for the age range of residents. When a resident was on 15-minute checks they tried to keep them in a common area, but this did not work. The weekend shifts were the worst. If there were more staff and better activities, then it could possibly mitigate some of the aggressive behaviors.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During a confidential interview from 9/21/23 through 9/26/23, Staff 10 indicated she normally works with two CNAs. Recently she was left to work with one aide for part of the shift. The office staff came into the facility to work, normally the office staff did not come in to help. There were normally no activities on the weekends unless the residents were able to leave the unit. Several of the residents would require direct staff supervision if they left the unit. There were not enough staff to supervise the residents to go to activities. A continuous observation on 9/23/23 from 9:36 a.m. through 9:42 a.m., the housekeeping cart was sitting in the hallway of Wing 2. The cart was left unattended and contained cleaning check chemicals in two spray bottles and cleaning disinfectant wipes. CNA 10 walked by the cart and went out of the locked door. A few minutes later she returned to the unit and continued to walk by the cart without acknowledgment of the cart. There were multiple residents who walked by the cart to go out to the courtyard area. An observation on 9/23/23 at 9:43 a.m., of the central bathroom/shower room the following items were sitting on an open three tier cart. The items included a large jug containing two inches of a liquid cleaning chemical. On the label of the chemical there was a warning statement. The label indicated the jug contained a multi peroxide disinfectant. The warning label in bold letters indicated harmful "danger keep out of reach of children". There was a disposable razor lying on the cart.. CNA 10 walked into the bathroom at 9:44 a.m., she gathered a towel for the BOM (Business Office Manager) and walked out of the bathroom.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 floor. 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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

During an interview on 9/24/23 at 8:15 a.m., CNA 6 indicated she was from an agency and the only aide working on Wing 2 since 8:00 a.m. This was her first time, and she did not know the residents. There was no way she could care, monitor, and feed all the residents with just her and the one nurse.

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 (9/23/23), sitting on a bedside table in the hallway. The tray was for Resident R. The resident was in isolation and required supervision for dining. He was high risk for chocking. The food on the plate was untouched and still covered. The juice cup and chocolate milk cup had sipper lids and were full. On the top of the juice and milk were dead flies. There were three flies flying over the tray.

During an interview on 9/24/23 at 8:34 a.m. CNA 6 indicated she did not know if the resident had received his evening meal or why the tray was still sitting there.

An observation on 9/24/23 at 8:35 a.m., of the Wing 2 dining room the breakfast trays arrived at 8:35 a.m. Table one had three females sitting at the table. The first resident (Resident S) was served at 8:36 a.m. The second resident (Resident T) was served at 8:58 a.m. and the third resident (Resident U) was served at 9:08 a.m. There were 5 flies flying around while the residents were being served.

An observation on 9/24/23 at 8:37 a.m., of the Wing 2 meal service indicated Resident M and Resident V were served at 8:37 a.m. Then the staff member walked down to the end of the hallway and went into Resident W's room. There were no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	staff monitoring the dining room with two residents still eating (Resident S and Resident U). At 8:49 a.m., both staff were on the end of the hall by Room 16. There were no staff supervising in the dining area and Resident S was still eating. During an interview on 9/24/23 at 8:52 a.m., RN 7 indicated Resident S was a choking hazard, however there was nothing she could do since all the residents needed to be feed. An observation on 9/24/23 at 8:55 a.m., indicated Resident P rolled his wheelchair over to Resident N. The resident (Resident N) was sitting on the floor with his legs crossed and his head on the floor. Resident P was leaning out of the right side of his wheelchair over the top of Resident N. No staff were present in the dining area. At 8:56 a.m. two staff members walked into the hallway and moved Resident P back from hanging over Resident N. An observation on 9/24/23 at 8:57 a.m., of the Wing 2 dining room, CNA 13 from Wing 1 was on the unit (Wing 2) to help staff with feeding the residents. This left Wing 1 with one nurse and no CNAs to help with resident care. An observation on 9/24/23 at 9:14 a.m., of the Wing 2 Room 16's call light was on. At 9:35 a.m. two staff members were walking by the room when the resident walked out of the room. The staff told the resident to go back into his room and did not address the resident's call light. AT 9:48 a.m. the CNA walked into Room 16 and addressed the resident's concerns. During an interview on 9/25/23 at 10:08 a.m., RN 7 indicated sometimes the residents do not receive their breakfast till 10:00 a.m., lunch by 1:00 p.m.,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and then dinner arrived at 4:00 p.m. and there have been times they were still providing feeding assistance after 6:00 p.m. With 14 residents that required feeding assistance and multiple other residents who must be monitored for choking hazards there are not enough staff to feed the residents before the food was cold. The residents are bored, young and nothing to do so they fight. Resident N who sits on the floor in the common area and tries to trip you as you walk by, Resident P had increased violet behaviors, and Resident Q rammed the metal locked door, busted it off the hinges, and cracked the frame. When you must pass medication and feed residents even with two aides you cannot safely monitor all the residents. There have been frequent resident falls on the unit. Review of the Wing 2 residents' recent falls indicated the following: - On 6/27/23 at 5:12 p.m., Resident Z fell onto his bottom when he was obtaining supplies from the business office. - On 7/4/23 at 12:15 a.m., Resident P fell on the floor in front of his wheelchair and closet. - On 7/6/23 at 5:38 a.m., Resident AA fell while trying to get from the wheelchair to his bed. He fell face down onto the bed. - On 7/6/23 at 6:30 a.m., Resident Z was found lying on the floor in a puddle of soda and minimal blood. The resident had a one-inch laceration to his left eyebrow. - On 7/10/23 at 11:20 a.m., Resident P slid out of his wheelchair onto the floor.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- On 7/11/23 at 8:35 a.m., Resident P slid out of his wheelchair onto the floor. - On 7/24/23 at 2:33 a.m., Resident X was standing at nurses' desk had almost fallen multiple times. The CNA attempted to get the resident to sit in a chair and the resident started punching her in the face and back of head. - On 7/27/23 at 12:35 p.m., Resident AA was found lying on the floor on his back with a laceration to the left eyebrow. Moderate amount of bloody drainage noted from the laceration on his face. - On 8/1/23 at 4:35 p.m., Resident Z went outside to attend supervised smoking. When he got out onto the patio, he had severed movements that doubled him over in the wheelchair and the resident flipped the wheelchair over. - On 8/6/23 at 5:54 a.m., Resident P fell in bathroom while transferring self. The resident had a 1.5 cm laceration. - On 8/11/23 at 11:30 a.m., Resident N had an altercation of aggression with Resident P (the resident stomped on the other resident's hand). - On 8/29/23 at 7:40 a.m., Resident N had a fall, the resident was awaiting breakfast when he slid out of the chair onto the floor, and he hit his left eyebrow on the floor causing a laceration and hematoma. - On 8/31/23 at 9:15 p.m., Resident Z fell while he was outside smoking and flipped his wheelchair. He hit his head on the concrete. He had a 5 cm abrasion to the mid forehead with 2 shallow lacerations on either end of the abrasion.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- On 9/1/23 at 2:30 a.m., Resident AA was found with dried blood on his mid forehead. A laceration of 2.5 cm was found to the center of his forehead. The resident indicated he fell on his dresser. - On 9/10/23 at 1:15 p.m., Resident Z fell and was found lying on his back with the wheelchair next to the resident's roommate's bed. - On 9/16/23 at 12:07 a.m., Resident AA was transferring self from bed to wheelchair and the wheelchair rolled out from under him and he fell on his bottom. - On 9/18/23 at 10:20 a.m., Resident Z was found lying face down on the floor with a pool of blood under his face. The resident had a laceration to the bridged of his nose. - On 9/24/23 at 4:00 a.m., Resident AA was found lying on his alarm mat with his face down next to his bed. There was blood on his face with a laceration on his forehead. The resident was unable to give a description of the occurrence. - On 9/24/23 at 4:33 a.m., Resident BB was found lying face down on the floor next to her wheelchair. When the resident was turned over there was blood on her face and bruising on her right knee. Cross Reference F689. Cross Reference F804 Cross Reference F921 3. An observation and interview on 9/23/23 at 10:09 a.m., Resident G walked out of her room on Wing 1 (Dementia unit) and into the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dinning/living room area. The resident had a sign on her door indicating she was on isolation. The resident was Covid positive. There were no staff present in the area or within sight on the hallway. The nurse was down at the end of the hallway sitting at the nurses' station and not visible from the hallway. The nursing staff indicated she was the only staff member on Wing 1 at that time. During an interview on 9/25/23 at 10:10 a.m., LPN 12 indicated she was currently the only staff member on Wing 1. She had one aide working with her, but she was floating between Wing 1 and Wing 2. An observation on 9/25/23 at 10:11 a.m., of the Wing 2, Resident K was observed in Resident L's room. Resident L had a sign on her door indicated she was Covid positive and in isolation. Resident K was not Covid positive. There currently were 10 of 16 residents in isolation for being Covid positive on the Dementia Unit. Cross Reference F880 4. Review of the facility assessment on 9/23/23 at 12:36 p.m., indicated the daily average facility census was a total of 66 residents. The profile indicated for activities of daily living related to dining the facility had the following: 11 residents were independent with eating, 41 required the assistance of 1 to 2 staff members to eat, and 14 residents were total dependent on staff for feeding. The For providing care including, but not limited to, assessing, evaluation, planning and implementing resident care plans and responding to the resident needs, the facility indicated the staffing range needed for the building was 1 RN, 2 LPNs, 2 QMAs (Qualified Medications Aide) and 12 to 14 nurse aides per day. The staffing plan			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was for 1 RN, 3 LPNs or 1 LPN with 2 QMAs and 12 nurse aides. The current facility census indicated 16 residents were listed on Wing 1, 26 residents were listed on Wing 2, and 29 residents were listed on Wing 3. Review of the as worked schedule from August through September 2023 indicated the following: On 8/6/23 (Sunday) night shift, Wing 2 had one nurse and one CNA work from 6:00 p.m. to 6:00 a.m. On 8/9/23 (Wednesday) night shift, Wing 2 had one nurse and one CNA work from 6:00 p.m. to 6:00 a.m. On 8/24/23 (Thursday) night shift, Wing 2 had one nurse, one CNA, and one CNA in training work from 6:00 p.m. to 6:00 a.m. On 8/28/23 (Monday) night shift, Wing 2 had one nurse and one CNA work from 6:00 p.m. to 6:00 a.m. On 8/29/23 (Tuesday) night shift, Wing 2 had one nurse and one CNA work from 6:00 p.m. to 6:00 a.m. On 9/16/23 (Saturday) night shift, Wing 2 had one nurse and one aide from 6:00 p.m. to 6:00 a.m. On 9/19/23 (Tuesday) night shift, Wing 2 had one nurse and one aide from 6:00 p.m. to 6:00 a.m. On 9/20/23 (Wednesday) night shift Wing 1 had one CNA and no nurse from 6:00 p.m. to 6:00 a.m. and on Wing 2 there was one nurse, one CNA from 6:00 p.m. to 6:00 a.m. and one CNA from 6:00			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	p.m. to 2:00 a.m. On 9/23/23 (Saturday) night shift, Wing 2 had one nurse from 6:00 p.m. to 6:00 a.m., one aide from 6:00 p.m. to 2:00 a.m., and one aide from 2:00 a.m. to 6:00 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. During an observation on 9/26/23, at 11:17 a.m., There was one nurse and one aide working on the Dementia unit (Wing1). The current facility policy titled "Staffing" with a revised date of April 2007, was provided by the Administrator on 09/27/23. The policy indicated, "...facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services...." This Federal tag relates to Complaints IN00417850, IN00416781, IN00415518, and IN00415026. 3.1-17(a)			
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on record review and interview, the facility failed to ensure interventions were effective and appropriate interventions were implemented to prevent recurrent resident aggressive/attention seeking behaviors for 1 of 4 residents reviewed for behaviors. (Resident D) Findings include: 1.a. 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, indicated the resident was cognitively intact and he was independent with locomotion requiring only supervision oversight. His diagnoses included but were not limited to, Huntington's, mood affective disorder, anxiety, depression, and attention deficit hyperactivity disorder. The Care Plan, dated 6/5/23, indicated the resident was at risk of psychosocial well-being issues related to being less than 55 years of age. The interventions were for the activities department to encourage participation and offer resident activities of interest. The Care Plan, dated 6/5/23, indicated the resident had exhibited sexually inappropriate behaviors of inappropriate comments to staff, about staff, and other residents. The interventions were for staff to encourage the resident to express his feelings. Staff were to explain to the resident that behavior was not appropriate. They were to let the resident know what kind of behavior was expected and what will be tolerated. The staff were to notify the	F 0740	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident D's care plan has been up-dated to reflect the incident on 8/24/2023. Resident D's behavioral interventions have been up-dated. **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 to be affected, no other residents were affected by this alleged deficient practice. The behaviors and interventions for residents residing on the Huntington's unit have been reviewed and up-dated if warranted. Care plans have been up-dated to reflect any changes that were made. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** The SSD will review behavior logs daily at morning meeting (Mon-Fri. Monday will include a review of the weekend logs) and following up on any notations made of inappropriate behavior to ensure abuse has not occurred.	10/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	one staff to one resident (1 to 1) to allow resident to speak with you about what may be causing the behavior; and offer reassurance and validate feelings. The interventions were documented as not effective. The interventions for the resident's behavior on 7/17/23, were for staff to provide one staff to one resident (1 to 1) to allow resident to speak with you about what may be causing the behavior; offer reassurance and validate feelings, explain procedures to the resident, and increase visibility. The interventions were documented as not effective. The interventions for the resident's behavior on 7/20/23, were for staff to provide one staff to one resident (1 to 1) to allow resident to speak with you about what may be causing the behavior; offer reassurance, validate feelings, and explain procedures to resident. The interventions were documented as not effective. The interventions for the resident's behavior on 7/27/23, were for staff to reorient the resident to person, time, and place when receptive; provide one staff to one resident (1 to 1) to allow resident to speak with you about what may be causing the behavior; offer reassurance and validate feelings, explain procedures, and offer snack. The interventions were documented as not effective. The interventions for the resident's behavior on 7/28/23, were for staff to reorient the resident to person, time, and place when receptive; provide one staff to one resident (1 to 1) to allow resident to speak with you about what may be causing the behavior; offer reassurance, validate feelings, and explain procedures to resident. The interventions were documented as not effective.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The interventions for the resident's behavior on 7/29/23, were for staff to reorient the resident to person, time, and place when receptive; provide one staff to one resident (1 to 1) to allow resident to speak with you about what may be causing the behavior; offer reassurance and validate feelings, explain procedures to resident, and offer snack. The interventions were documented as not effective. The interventions for the resident's behaviors on 7/30/23 and 8/2/23, were for staff to reorient the resident to person, time, and place when receptive; provide one staff to one resident (1 to 1) to allow resident to speak with you about what may be causing the behavior; offer reassurance and validate feelings, explain procedures to resident, divide larger groups into small groups, and offer snack. The interventions were documented as not effective. The interventions for the resident's behavior on 8/5/23, were for staff to reorient the resident to person, time, and place when receptive; provide 1 to 1 to allow resident to speak with you about what may be causing the behavior; offer reassurance and validate feelings, explain procedure, divide larger groups into smaller groups, offer rest period, change position, and pain medication. The interventions were documented as not effective. The interventions for the resident's behavior on 8/6/23, were for staff to encourage activity participation, provide 1 to 1 to allow resident to speak with you about what may be causing the behavior; offer reassurance and validate feelings, explain procedures to resident, and change position. The interventions were documented as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not effective. The interventions for the resident's behavior on 8/9/23, were for staff to encourage activity participation, provide 1 to 1 to allow resident to speak with you about what may be causing the behavior; offer reassurance and validate feelings, explain procedures to resident, change position, and increase visibility. The interventions were documented as not effective. The interventions for the resident's behavior on 8/11/23, were for staff to encourage activity participation, provide 1 to 1 to allow resident to speak with you about what may be causing the behavior; offer reassurance and validate feelings, and explain procedures to resident. The interventions were documented as not effective. The interventions for the resident's behavior on 9/10/23, were for staff to explain procedure to resident, change position, and approach later if resisting care. The interventions lacked documentation if they were effective or not effective. The SSD Note, dated 8/14/23 at 1:30 p.m., indicated the SSD spoke with the resident regarding the behaviors he had been exhibiting. SSD spoke with resident regarding the seriousness of false accusations and reminded him that unless something was true, he should not say it even in a joking manner. A Progress Note, dated 8/24/23 at 4:18 p.m., indicated the SSD spoke with the resident regarding inappropriate sexual behavior towards another resident. The resident stated that he knew what he had done was wrong. The SSD told the resident that he was not to be in the bathroom			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with any other resident at any time. The resident stated he understood. A Progress Note, dated 8/24/23 at 6:04 p.m., indicated the resident followed a female resident into the central bathroom and pulled the curtain behind himself and the female resident. He pulled his pants down and turned to face the female resident. The two CNAs (Certified Nurse Aide) went into the bathroom to clean and wash their hands when they noticed two sets of feet behind the curtain. When they opened the curtain both residents had their pants pulled down. The staff immediately separated the male and female resident and did a skin check. There were no issues observed. The MD and POA were notified. The resident was put on 15-minute checks until further notice. A Progress Note, dated 9/12/23 at 4:27 p.m., indicated the resident continued on 15-minute checks. A Progress Note, dated 9/13/23 at 10:52 a.m., indicated the resident was seen by staff being sexually inappropriate toward another staff member. b. Review of Resident D's Behavior Management Record indicated the resident had behaviors of teasing other residents on the following dates: 6/18, 6/21, 6/22, 6/26, 6/27, 6/30, 7/2, 7/3, 7/5, 7/6, 7/7, 7/10, 7/14, 7/15, 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. The interventions for the resident's behaviors were for staff to reorient the resident to person, time, and place when receptive; provide one staff to one resident (1 to 1) to allow resident to speak			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with you about what may be causing the behavior; and offer reassurance and validate feelings. The interventions for the resident's behaviors were documented as not effective 15 out of 16 times. c. Review of Resident D's Behavior Management Record indicated the resident had behaviors of attention seeking on the following dates: 6/18, 6/22, 6/26, 7/3, 7/5, 7/7, 7/12, 7/17, 8/2, 8/3, 8/5, 8/6, 8/9, 8/11, and 8/16/23. The interventions for the resident's behaviors on 6/18, 6/21, and 6/26/23, were for staff to reorient the resident to person, time, and place when receptive; provide 1 to 1 to allow resident to speak with you about what may be causing the behavior; and offer reassurance and validate feelings. The interventions were documented as not effective. The interventions for the resident's behaviors on 7/3/23 and 7/5/23 were for staff to reorient the resident to person, time, and place when receptive; provide 1 to 1 to allow resident to speak with you about what may be causing the behavior; offer reassurance and validate feelings, explain procedures to resident, and offer snack were. The interventions were documented as not effective. The interventions for the resident's behavior on 7/7/23, were for staff to encourage activity participation, provide 1 to 1 to allow resident to speak with you about what may be causing the behavior; and offer reassurance and validate feelings, and explain procedures. The interventions were documented as not effective. The interventions for the resident's behavior on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	7/12/23, was for the resident to change position, provide 1 to 1 to allow resident to speak with you about what may be causing the behavior; and offer reassurance and validate feelings. The interventions were documented as not effective. The interventions for the resident's behavior 7/17/23, were for staff to provide 1 to 1 to allow resident to speak with you about what may be causing the behavior; offer reassurance and validate feelings, explain procedures, and increase visibility. The interventions were documented as not effective. The interventions for the resident's behavior on 8/2/23, were for staff to reorient the resident to person, time, and place when receptive; provide 1 to 1 to allow resident to speak with you about what may be causing the behavior; offer reassurance and validate feelings and explain procedure. The interventions were documented as not effective. The interventions for the resident's behavior on 8/3/23, were for staff to reorient the resident to person, time, and place when receptive; provide 1 to 1 to allow resident to speak with you about what may be causing the behavior; offer reassurance and validate feelings, explain procedure, encourage activity participations, remove stimulant/situation, divide larger groups into smaller groups, and offer snack. The interventions were documented as not effective. The interventions for the resident's behavior on 8/5/23, were for staff to reorient the resident to person, time, and place when receptive; provide 1 to 1 to allow resident to speak with you about what may be causing the behavior; offer reassurance and validate feelings, explain			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	procedure, divide larger groups into smaller groups, offer rest period, change position, and pain medication. The interventions were documented as not effective. The interventions for the resident's behavior on 8/6/23, were for staff to encourage activity participation, provide 1 to 1 to allow resident to speak with you about what may be causing the behavior; offer reassurance and validate feelings, explain procedures to resident, and change position. The interventions were documented as not effective. The interventions for the resident's behavior on 8/9/23, were for staff to encourage activity participation, provide 1 to 1 to allow resident to speak with you about what may be causing the behavior; offer reassurance and validate feelings, explain procedures to resident, change position, and increase visibility. The interventions were documented as not effective. The interventions for the resident's behavior on 8/11/23, were for staff to encourage activity participation, provide 1 to 1 to allow resident to speak with you about what may be causing the behavior; offer reassurance and validate feelings, and explain procedures to resident. The interventions were documented as not effective. The interventions for the resident's behavior on 8/16/23, were for staff to encourage activity participation, provide 1 to 1 to allow resident to speak with you about what may be causing the behavior; offer reassurance and validate feelings, explain procedure, divide larger groups into smaller groups, offer rest period, change position, and pain medication. The interventions were documented as not effective.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

The Resident D's Behavior Management Record, dated 9/25/23, indicated the resident's reason for his behavior was that he was bored and attention seeking.

During an interview on 9/23/23 at 9:34 a.m., the Activity Director indicated today she was working as a CNA. The unit was short on staff, and she had to work the floor. They have been short staffed frequently and there was no possible way for her to provide activities to the whole facility. There was no current separated program for mental capacity or age range.

During an interview 9/25/23 at 10:32 a.m., LPN 4 indicated the only activities normally on the unit were papers dropped off for the residents to color or independent cross word puzzles.

During a confidential interview between 9/21/23 and 9/25/23, a staff member indicated when staff were feeding a resident and had to stop to monitor another resident or assist another resident, the resident they were assisting to eat would get very upset.

During a confidential group interview between 9/21/23 and 9/25/23, three staff members indicated there was multiple residents with aggressive behaviors. The Huntington's unit (Wing 2) did not have consistent activities or appropriate activities for the age range of residents. When a resident was on 15-minute checks they tried to keep them in a common area, but this did not work. If there were more staff and better activities, then it could possibly mitigate some of the aggressive behaviors.

The current facility policy titled "Behavior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Management" with a revised date of December 15, 2015, was provided on 9/25/23. was provided by the Administrator on 09/27/23. The policy indicated, "...Residents in long term care facilities may exhibit puzzling and troublesome behaviors. The behaviors may become difficult to handle for staff and may involve other residents...The staff should assess the behaviors and document in a quantitative manner, to assist in determining whether the behaviors can be addressed in the facility or whether outside assistance may be needed...Behavior has meaning...It is important to do everything reasonable to assure that the residents' lives have quality and as little stress as possible..." This Federal tag relates to Complaint IN00417850 3.1-37(a)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on interview and record review, the facility failed to ensure the appropriate temperature and palatability of food served for 1 of 3 resident wings/units served for dietary services. (Wing 2) This deficient practice had the potential to affect 14 of 26 residents that resided on the	F 0804	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents will be affected by	10/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Huntington's unit. Findings include: Review of the current facility meal service schedule indicated the following: - Breakfast was to be served to Wing 2 at 8:15 a.m., Wing 3 at 8:20 a.m. and Wing 1 at 8:25 a.m. - Lunch was to be served to Wing 2 at 12:15 p.m., Wing 3 at 12:20 p.m., and Wing 1 at 12:25 p.m. - Dinner was to be served to Wing 2 at 5:15 p.m., Wing 3 at 5:20 p.m., and Wing 1 at 5:25 p.m. During an interview on 9/24/23 at 8:03 a.m., RN 7 indicated with only two to three staff to feed all 14 residents that required total assistance and the other residents who must be monitored the food was "almost always cold" when they served the residents that required assistance were feed. During an interview on 9/24/23 at 8:15 a.m., CNA 6 indicated she was from an agency and the only aide working on Wing 2 since 8:00 a.m. This was her first time, and she did not know the residents. There was no way she could care, monitor, and feed all the residents with just her and the one nurse. 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 (9/23/23), sitting on a bedside table in the hallway. The tray was for Resident R. The resident was in isolation and required supervision for dining. He was high risk for chocking. The food on the plate was untouched and still covered. The juice cup and chocolate milk cup had sipper lids and were full.		this alleged deficient practice. Foods and drinks will be served that are palatable, attractive, and at a safe and appetizing temperature. Food carts will be delivered at scheduled times on the wings. **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 to be affected, no other residents were affected by this alleged deficient practice. Foods and drinks will be served that are palatable, attractive, and at a safe and appetizing temperature. Food carts will be delivered at scheduled times on the wings. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** Foods and drinks will be served that are palatable, attractive, and at a safe and appetizing temperature. Food carts will be delivered at scheduled times on the wings. All dietary staff will be in-serviced over the facility's Food Temperature on Service line, Food and Nutrition Services, ad Meal hours policy and procedures. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On the top of the juice and milk were dead flies. There were three flies flying over the tray. During an interview on 9/24/23 at 8:34 a.m. CNA 6 indicated she did not know if the resident had received his evening meal or why the tray was still sitting there. An observation on 9/24/23 at 8:35 a.m., of the Wing 2 dining room the breakfast trays arrived at 8:35 a.m. Table one had three females sitting at the table. The first resident (Resident S) was served at 8:36 a.m. The second resident (Resident T) was served at 8:58 a.m. and the third resident (Resident U) was served at 9:08 a.m. There were 5 flies flying around while the residents were being served. During an observation and Interview on 9/24/23 at 9:29 a.m., the Cook tempted one of the last 5 resident trays to be served. The eggs tempted 87 degrees Fahrenheit, and the resident's juice tempted 51 degrees Fahrenheit. He indicated the trays cannot be served at that time and they are short staffed. During an interview on 9/25/23 at 10:08 a.m., RN 7 indicated sometimes the resident do not receive their breakfast till 10:00 a.m., lunch by 1:00 p.m., and then dinner arrived at 4:00 p.m. and there have been times they were still providing feeding assistance after 6:00 p.m. With 14 residents that required feeding assistance and multiple other residents who must be monitored for choking hazards there are not enough staff to feed the residents before the food was cold. When you must pass medication and feed residents even with two aides you cannot safely monitor all the residents. The current facility policy titled "Food		**Recur:** The Dietary Manager/Designee will complete a test tray on varying units at varying meals and monitor delivery times of meals on varying units at varying meals 3 times a week times 4 weeks, then 2 times a week times 4 weeks, then weekly times 4 weeks, then 2 times a month times 3 months. Any negative findings will be corrected immediately and forwarded to the Administrator.A report of progress will be forwarded to the QAPI committee ongoing monthly for a minimum of 6 months. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the committee. Any written action plan will be monitored by the administrator/designee monthly until resolved and substantial compliance is achieved at 95% or greater.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Temperatures on Service Line" with a revised date of June 2018, was provided by the Administrator on 09/27/23. The policy indicated, "...Foods will be served at proper temperature to ensure food safety...If temperatures are not at acceptable levels and cannot be corrected in time for meal service, make an appropriate menu substitution. Follow [Reheating Temperature]..." The current facility policy titled "Food and Nutrition Services" with a revised date of October 2017, was provided by the Administrator on 09/27/23. The policy indicated, "...Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs...The food and nutrition staff will be available and adequately staffed to assist residents with eating as needed...." The current facility policy titled "Meal Hours" with a revised date of June 2018, was provided by the Administrator on 09/27/23. The policy indicated, "...Dietary Manager is responsible for seeing that meal hour deadlines are met..." This Federal tag relates to Complaint IN00416781. 3.1-21(a)(2)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on interview, record review, and observation, the facility failed to follow appropriate infection control guidelines related to droplet isolation/Covid for 10 of 35 residents reviewed for Infection Control. (Resident D, Resident G, Resident H, Resident C, Resident J, Resident K, Resident B, Resident DD, Resident EE, and Resident CC) Findings include: An observation on the smoking area on 9/21/23 at 2:30 p.m., there was two smoking buckets with tubing in the courtyard. The tubing with mouth pieces was lying on the ground. No covering or cleaning of the mouth pieces was completed, prior to the resident's use. Staff were observed to pick	F 0880	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** Resident D is no longer on isolation. Resident J had the oral drainage wiped from her mouth. Staff will use cleaner when cleaning areas of the floor and will use proper cleaning utensil (ex. rag, mop, etc.). Tubing to smoking buckets will be placed in plastic bags at the end of each smoking session and smoking mouth pieces will be disinfected before and after each use. Resident G is no longer on isolation. Resident H	10/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	up the mouthpiece of the tubing off the ground and hand it to the residents. During an observation on 9/23/23 at 9:11 a.m., Resident D walked out into the hallway. He was carrying his breakfast tray. The resident was not wearing a mask. He carried his tray past the nurses' station and placed it in the food cart. RN 7 walked up to the resident and informed the resident he needed to stay in his room. The resident room was near the end of the hallway past the nurses' station. The resident walked past multiple residents from one end of the hallway past the nurses' station prior to being approached by any staff members. The resident's door had a sign to indicate the resident was on isolation. He was Covid positive and placed on isolation on 9/18/23. During an observation and interview on 9/23/23 at 9:44 a.m., the Activity Manager walked up to the BOM (Business Office Manager) and handed her a dry towel. The BOM walked over to Resident J and wiped the oral drainage off her mouth. She then used the towel to wipe the large wet spot 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 had a large amount of oral drainage hanging from her mouth and on the floor. No cleaner was used on the floor. 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		will be instructed on proper wearing of a mask. All meal trays will be removed from the units after the meal completion to ensure flies are not attracted to the area. Resident CC is longer on isolation. Residents DD and EE will be encouraged to practice social distancing. Staff will wear appropriate face covering for isolation rooms/units. Resident C's room will be cleaned with proper cleaning wipes/chemicals. Resident C is no longer on isolation. Resident K will be encouraged and redirected as not to enter isolation rooms. Resident G will be encouraged and redirected to not let others in their room when they are in isolation. Resident B's tubing to smoking bucket will be placed in plastic bag at the end of each smoking session and smoking mouthpiece will be disinfected before and after each use when resident smokes. **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 to be affected, no other residents were affected by this alleged deficient practice. All residents will be educated, encouraged, and redirected to follow isolation guidelines. Proper signage will be placed on resident doors if/when	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	stop the residents from just walking around without a mask. An observation on 9/23/23 at 10:07 a.m., of the Wing 2, Resident G walked out of her room and into the dinning/living room area. The resident had a sign on her door indicating the resident was on isolation. The resident was Covid positive. There were no staff present in the area or visible on the hallways. During an interview on 9/23/23 at 10:09 a.m., Resident H indicated the staff just let the residents walk out of isolation and down the hallway. The resident (Resident G) who just walked down the hallway was Covid positive. The resident was not wearing a mask and now everyone will be sick. Resident H had a mask on below his nose. The resident indicated he had been sleeping on the floor in the hallway by the courtyard, ever since his roommate tested positive so he did not get sick. During an interview on 9/24/23 at 8:20 a.m., RN 7 indicated yesterday from 4:00 p.m. till 5:00 p.m., she was the only staff member working. Resident D was tested for Covid and was positive. He was walking out into the hallway without a mask multiple times, and she could not get him to stay in his room. 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 (9/23/23), sitting on a bedside table in the hallway. The tray was for Resident R. The resident was in isolation and required supervision for dining. He was high risk for chocking. The food on the plate was untouched and still covered. The juice cup and chocolate milk cup had sipper lids and were full.		isolation is required. Proper isolation carts will be placed outside isolation rooms if/when needed. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** The scheduler, ADON, and DON will be in-serviced over the facility's staffing policy and procedure. All staff will be in-serviced over the facility's Pandemic-COVID-19 policy and procedures. All staff will be in-serviced over the facility's Infection Control policy and procedures. All housekeeping staff will be in-serviced over the proper cleaning chemicals for isolation rooms; specifically, for COVID-19. All staff will be educated over the facility's smoking policy and procedures, specifically, for the smoking tubing and mouthpieces on the smoking buckets. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The DON/Designee will monitor the nursing schedule for appropriate amount of staff for the Huntington's unit daily on scheduled workdays times 4 weeks, then 2 times a week times 4 weeks, then weekly times 4 months. The DON/Designee will question 5 random staff weekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On the top of the juice and milk were dead flies. There were three flies flying over the tray. An observation on 9/24/23 at 7:53 p.m., of Wing 1 the QMA (Qualified Medication Aide) 13 was standing at the nurses' station by the common area. Resident CC was sitting in the common area with Resident DD and Resident EE. Resident CC tested positive for Covid on 9/21/23. The two other residents (Resident EE and Resident DD) were not Covid positive. The QMA had no face mask on and was within a few feet of all three residents. During an observation on 9/24/23 from 7:57 p.m. to 8:03 p.m., Resident D walked back in forth from his room to the nurses' station three times. No staff approached him or tried to redirect him to stay in his room. The resident was Covid positive. During an interview and observation on 9/25/23 at 10:08 a.m., Housekeeper 11 was observed walking out of Resident C's room. RN 7 indicated to the housekeeper he was using the wrong wipes to clean an isolation room. The housekeeper indicated he was the only housekeep for the whole weekend and did not know to that he had to use a specific wipe for the isolation rooms. During an observation and interview on 9/25/23 at 10:10 a.m., LPN 12 indicated she was currently the only staff member on Wing 1. She had one aide working with her, but she was floating between Wing 1 and Wing 2. Resident K was observed in Resident G's room. Resident G had a sign on her door. The sign indicated the resident was Covid positive and in isolation. There was a total of 16 residents positive on the Dementia unit. During an observation on 9/25/23 at 4:17 p.m.,		times 8 weeks, then bi-weekly times 8 weeks, then monthly times 2 months to verify understanding of the facility's Infection Control Policy and Procedures and COVID-19 policy and procedures. The Housekeeping/Laundry Supervisor will randomly observe the cleaning of 3 rooms, including isolation rooms, weekly times 3 months, then monthly times 3 months. The DON/Designee will observe the smoking buckets at random times daily on scheduled workdays times 4 weeks, then two times a week times 4 weeks, then weekly times 4 months to ensure smoking tubing is placed in bags when not in use and the cleaning of smoking mouthpieces. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee ongoing monthly for a minimum of 6 months. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the committee. Any written action plan will be monitored by the administrator/designee monthly until resolved and substantial compliance is achieved at 95% or greater.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident D walked out of another resident's room and into the hallway. At 4:27 p.m. Resident D walked back into another resident's room. At 4:29 p.m., Resident D was in the hallway and the QMA told Resident D to go back to his room. The resident indicated he was "bored". At 4:37 p.m., Resident D was in the hallway walking back and forth down the hall to the nurses' station. At 4:52 p.m., Resident D was walking back and forth in the hallway. At 5:00 p.m., Resident D was walking in the hallway by the nurses' station. During an observation on 9/25/23 at 4:33 p.m. Resident FF walked into the courtyard. The resident walked over to the ground drain and pulled the front of his pants down and relived himself in the drain. During an observation on 9/25/23 at 5:15 p.m., the smoking mouthpiece and tubing was lying directly on the ground. During an observation on 9/26/23 at 2:24 p.m., Resident C was sitting in the main dining room with no mask. The staff working on the unit do not react to the resident. At 2:31 p.m., CNA 13 walked over to Rebecca and wiped her arm with a towel. The CNA did not have a mask on. During an observation on 9/27/23 at 11:40 a.m., The smoking mouthpieces, and tubing was lying directly on the ground. At 11:41 a.m., Resident B went out to smoke with two staff members, one staff member picked up the smoking mouthpiece and handed it to the resident to smoke. The mouthpiece was no cleaned prior to the resident's use. Review of the LTC (Long Term Care) Respiratory Surveillance Line List, on 9/23/23, indicated the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	following number of residents tested positive for Covid: one resident tested positive for Covid on 9/11/23, two residents tested positive for Covid on 9/14/23, two residents tested positive for Covid on 9/15/23, one resident tested positive for Covid on 9/17/23, two residents tested positive for Covid on 9/18/23, one resident tested positive on 9/20/23, 5 residents tested positive for Covid on 9/21/23, and two residents tested positive on 9/21/23 in the facility. Cross reference F725. The current facility policy titled "Staffing" with a revised date of October 2017, was provided by the Administrator on 09/14/23 at 3:00 P.M. The policy indicated, "...Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services..." The current facility policy titled "Emergency Procedure - Pandemic COVID 19" with a revised date of July 2016, was provided by the Administrator on 09/27/23. The policy indicated, "...Adherence to infection prevention and control policies and procedure is critical. Post signs for cough etiquette. Adherence to droplet precautions during the care of a resident with symptoms or a confirmed case of pandemic COVID-19 is a must..." The current facility policy titled "Infection Control" provided by the ADON on 9/23/23 at 12:36 p.m. The policy indicated, "...Transmission of infections in health care facilities can be prevented and controlled through the application of basic infection control 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(transmission-based) precautions which are specific to modes of transmission (airborne, droplet and contract)..." This Federal tag relates to Complaint IN00415026. 3.1-18(b)(1)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a sanitary and safe environment related to wet floors, missing privacy curtains, gouged wall with exposed wires, broken security door, flies around food, and damaged bed side tables on 1 of 3 units observed. (Wing 2) Findings include: During an observation on 9/21/23 at 1:58 p.m.2:21 p.m., the metal exit door from the Huntington's unit to Wing 3 had the door frame cracked with rubber shins under the door. The door hinges were broken. During an observation and interview on 9/23/23 at 9:03 a.m., the clean utility door was not shut and locked. At 9:05 a.m., the CNA indicate the door was supposed to be shut and locked and the door was now locked. During an interview on 9/24/23 at 8:32 a.m., CNA 6 indicated she was from an agency and the only aide since 8:00 a.m. The food tray sitting on a bed side table in the hallway was from last night. The food tray had food and two drink cups with dead	F 0921	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents will be affected by this alleged deficient practice. The metal exit door from the Huntington's Unit to Wing 3 has been repaired. The clean utility door was shut and locked. The old meal tray was removed and the spill on the floor was cleaned up. The mower and gas can were removed from the courtyard. The Housekeeper mopped the floor in Resident FF's room again. The hole with exposed wires in room 23 has been repaired. Rooms 15, 16, 20, 21, and 22 have had the privacy curtains fixed or replaced. The broken bedside table has been removed from the unit. The lock to the soiled utility room has been repaired. The sliding glass door to the courtyard	10/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	flies in the liquid. Beside the food tray was an area 5 feet long and 2 feet wide of a clear liquid on the floor. There were flies flying around the tray. Beside the liquid was an empty cup and 2 straws lying on the floor. During an observation and interview on 9/24/23 at 10:28 a.m., the ADON (Assistant Director of Nursing) indicated staff cannot exit through the secured door leading to the dining in the main hall. Resident Q did a full body ram into the door and busted the frame and door was hanging. The ADON indicated this had occurred on 9/9/23. During an observation and interview of the residents secured courtyard on 9/24/23 at 10:35 a.m., there was a push mower and two-gallon jug full of gas. The ADON indicated she would contact the maintenance staff to secure the mower and gas. During an observation on 9/25/23 at 8:35 a.m., of the Wing 2 dining room the breakfast trays arrived at 8:35 a.m. Table one had three females sitting at the table. The first resident (Resident S) was served at 8:36 a.m. The second resident (Resident T) was served at 8:58 a.m. and the third resident (Resident U) was served at 9:08 a.m. There were 5 flies flying around while the residents were being served. During an observation on 9/26/23 at 11:18 a.m., on the hallway by the nurses' station and the hallway entrance to the courtyard was a yellow caution sign. The sign had fallen flat on the ground and stuck out two feet. The housekeeper and CNA walked past the sign and stepped over the sign to keep walking without picking the sign up. At 11:19 a.m., a second CNA stepped over the sign then turned around and picked the sign up.		**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 to be affected, no other residents were affected by this alleged deficient practice. The metal exit door from the Huntington's Unit to Wing 3 has been repaired. The clean utility door was shut and locked. The od meal tray was removed and the spill on the floor was cleaned up. The mower and gas can were removed from the courtyard. The Housekeeper mopped the floor in Resident FF's room again. The hoe with exposed wires in room 23 has been repaired. Rooms 15, 16, 20, 21, and 22 have had the privacy curtains fixed or replaced. The broken bedside table has been removed from the unit. The lock to 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. Any broken bedside tables will be removed and replaced with proper bedside tables. Any nonfunctioning privacy curtain will 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an observation on 9/26/23 at 2:27 p.m., the glass sliding door to the courtyard was wide open. There were two flies flying around the door. During an observation on 9/26/23 at 2:29 p.m., Resident Q was observed to be banging on the metal door he had broken prior. During an observation of Residents FF room, on 9/27/23 at 11:34 a.m., the resident's room had just been moped by Housekeeper 15. At 11:35 a.m., the resident walked across the room and sat down in his bed. The floor was very wet and shiny. There was visible water standing on the floor. A nursing staff member was asked if the flooring was supposed to be extremely wet. The staff indicated the housekeeper was not wringing out his mop appropriately. At 11:37 a.m., the Housekeeper was instructed by the nursing staff member to wring out his mop and re-mop the resident's room se he did not fall. The floor would not dry appropriately with being so wet. Review of a resident's fall IDT Note, dated 7/4/23, indicated the resident slipped on wet floor and fell. The resident claimed housekeeping left the floor too wet. It was determined that the resident spilled a drink on floor then slipped in it. During an environment observation on 9/27/23 at 4:11 p.m., Resident Room 23 had a hole above the resident's bed. The hole was approximately 4 inches wide with exposed wires. There used to be a light socket attached to the wall. In the hole the wires were close to the service and had plastic screw caps attached. Rooms 22, 21, 20, 15, 16, and 18 all had broken/missing curtain hooks and/or missing privacy curtains.		findings will be corrected. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** Residents will be provided with a safe, clean, comfortable, and homelike environment. All staff are expected to complete maintenance work orders when equipment/items need to be repaired or replaced. All staff will be in-serviced over Quality of Life-Homelike Environment and Maintenance Work Orders policy and procedures. All housekeeping staff will be in-serviced over the proper way to mop the floor. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** Maintenance Director/Designee will audit 10 rooms weekly times 2 months, then every two weeks times 2 months, then monthly ongoing. The Housekeeping/Laundry Supervisor will randomly observe the cleaning of 3 rooms, including isolation rooms, weekly times 3 months, then monthly times 3 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee ongoing monthly for a minimum of 6 months. If any patterns are identified at the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an observation on 9/27/23 at 4:12 p.m., there was a bed side table sitting outside Room 22. The table had infection control personal infection protection sitting on the top of the table. The table edges were missing the trim. The left side front corner had a big piece of the corning missing. The corner had exposed sharp, pressed board fragments sticking out. During an observation on 9/27/23 at 1:15 p.m., the lock to the soiled utility room was broken. The door did not lock. A staff member indicated it had been broken for a while. The current facility policy titled "Emergency Procedure - Pandemic COVID 19" with a revised date of July 2016, was provided by the Administrator on 09/27/23. The policy indicated, "...Adherence to infection prevention and control policies and procedure is critical. Post signs for cough etiquette. Adherence to droplet precautions during the care of a resident with symptoms or a confirmed case of pandemic COVID-19 is a must..." The current facility policy titled "Infection Control" provided by the ADON on 9/23/23 at 12:36 p.m. The policy indicated, "...Transmission of infections in health care facilities can be prevented and controlled through the application of basic infection control 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)..." The current facility policy titled "Smoking Policy - Residents" with a revised date of July 2017, was		monthly QAPI meeting, an action plan will be written by the committee. Any written action plan will be monitored by the administrator/designee monthly until resolved and substantial compliance is achieved at 95% or greater.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	09/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	provided by the Administrator on 09/27/23. The policy indicated, "...The facility shall establish and maintain safe resident smoking practices..." This Federal tag relates to Complaint IN00417850 3.1-19(a)(4)			