STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING _____ B. WING _____	R-C 12/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit (PSR) to the investigation of Nursing Home Complaints IN00417850, IN00416781, IN00415518, IN00415026, and the PSR to a COVID-19 Focused Infection Control Survey completed on September 27, 2023.

This visit was in conjunction with the PSR to the Investigation of Nursing Home Complaints IN00419530, IN00419736, IN00420807, and IN00421147 completed on November 20, 2023, which resulted in unrelated deficiencies cited.

Complaint IN00417850 - Corrected.

Complaint IN00416781 - Corrected.

Complaint IN00415518 - Corrected.

Complaint IN00415026 - Corrected.

Unrelated deficiencies - Corrected.

Survey dates: December 20, and 21, 2023

Facility number: 000115
Provider number: 155208
AIM number: 100291080

Census Bed Type:
SNF/NF: 63
Residential: 6
Total: 69

Census Payor Type:
Medicare: 6
Medicaid: 56

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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 _____ B. WING _____	R-C 12/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	Continued From page 1 Other: 1 Total: 63 Hanover Nursing Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the investigation of Complaints IN00417850, IN00416781, IN00415518, IN00415026. Quality review completed on January 1, 2024.	{F 000}		