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	03/23/2023

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 Complaint IN00403163. Complaint IN00403163 - Federal/State deficiency related to the allegations is cited at F677. Survey dates: March 22 and 23, 2023 Facility number: 000115 Provider number:155208 AIM number: 100291080 Census Bed Type: SNF/NF: 70 Residential: 9 Total: 79 Census Payor Type: Medicare: 4 Medicaid: 65 Other: 1 Total: 70 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 30, 2023.	F 0000	The creation and submission of this Plan of Correction (POC) does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies/2567, or of any violation of regulation	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review, the facility	F 0677	The facility does ensure that a resident who requires extensive	04/10/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Mace	Consultant	04/06/2023

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.

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	failed to ensure a resident who required extensive assistance for Activities of Daily Living (ADL) received appropriate services related to incontinence care for 1 of 3 residents reviewed for ADL's. (Resident B) Findings include: During an interview on 3/22/23 at 3:58 p.m., Resident B indicated a night shift staff member, CNA 2, threw a brief at him and told him to change himself. He had to wait until the day shift staff member came in and cleaned him up. A Quarterly MDS assessment, dated 1/7/23, indicated Resident B was cognitively intact. He had adequate hearing and vision and required the extensive assistance of one staff member for ADLs (activities of daily living). The resident's diagnosis included, but was not limited to, Huntington's disease. The resident was always incontinent of bladder. A Care Plan, dated 10/13/22, indicated Resident B was incontinent of bowel and bladder. The interventions included, but was not limited to, the staff will assist with incontinent care. During an interview on 3/22/23 at 1:19 p.m., the Social Service Director (SSD) indicated Resident C stated a CNA threw a brief at Resident B. The SSD indicated the Regional Director for the company re-interviewed them and they told her the same thing, that a CNA threw a brief at Resident B and told him to do it himself. It was a night shift aide. Resident B and C were cognitively intact. During an interview on 3/22/23 at 1:29 p.m., the Assistant Director of Nursing (ADON) indicated there was an incident involving a CNA that was		assistance with ADLs, receives appropriate services with incontinence care when required. Resident B now receives incontinent care when needed and in a dignified and respectful manner. The C.N.A. involved in the alleged incident was suspended immediately upon Administrator notification and subsequently terminated. Abuse policy and procedure/Resident rights in-services were initiated with staff at the time, with in-services also on 3-15 and 3-24. All department staff scheduled to receive re-education on abuse policy/procedure and resident rights on 4-10-23. The Administrator and/or Designee will perform walking rounds 5 times a week x 1 month and then weekly x 5 months to observe that resident rights and dignity are being respected and that incontinent care is being provided when needed. Findings will be reported during the facility monthly QAPI meeting. The SSD/Designee will complete abuse/resident right questionnaire with 5 randomly selected	

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	terminated. During an interview on 3/22/23 at 1:49 p.m., the Minimum Data Set (MDS) Coordinator indicated, Resident B stated, he did not want to make waves, but he put on his call light because he needed changed, CNA 2 walked into his room, took a brief out of the closet, threw it at him, told him to change himself, turned off the call light, and left the room. After that he put the light on again, she walked in, turned off the light, and left again. The CNA was a staff employee. There was an Agency Nurse working that night, and he indicated he was not comfortable with talking with her, so when the staff changed shifts, he put on his light and the day shift changed him. Resident C reported it to the Rehab Director and another CNA, and they both reported it to administrative staff. During an interview on 3/22/23 at 3:55 p.m., Resident C indicated there was a situation where CNA 2 threw a brief at his roommate, Resident B, and told him to change himself. He waited to tell the day shift staff and they immediately went in to take care of Resident B. An Incident Report, dated 3/3/23, indicated Resident C reported to a CNA (Certified Nurse Aide) that Resident B was upset because a CNA came in the room last night, threw a brief at him, and told him to change himself. An Incident Report and Investigation, dated 3/3/23, indicated Resident B stated that CNA 2 came in the room and answered his call light. He told her that he was soiled and needed assistance with getting changed. CNA 2 took a brief out of the closet and threw it at him and told him he could change himself. Resident C stated, CNA 2 answered the call light, got a brief out of the		residents weekly x 1 month and then monthly x 5 months. Allegations will be reported to the Administrator immediately. Findings will be reported during the facility monthly QAPI meeting. 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 or his/her designee monthly until resolved and substantial compliance is achieved at 95% or greater.	

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	closet, threw it at Resident B and stated, he could change himself. The resident's roommate was not assisted with being changed. A Progress Note, dated 3/3/23 at 4:06 p.m., indicated Resident C reported that Resident B, his roommate, turned his call light on to be changed because he was soiled. A CNA staff member answered the call light, told the resident he could change himself, and threw a brief at him. The writer spoke with Resident B, he stated he turned his call light on to be changed because he was soiled. A CNA staff member answered the call light and told him he could change himself and threw a brief at him. The incident happened the previous evening and he felt uncomfortable saying anything to the night shift staff. This Federal tag F677 relates to Complaint IN00403163. 3.1-38(a)(3)			