PRINTED: 01/11/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) F		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155208	B. WING			12/13/2022	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	₹			LAGRANGE RD		
HANOVE	R NURSING CENT	ΓER			/ER, IN 47243		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG				TAG			DATE
F 0000							
Plda 00							
Bldg. 00			EO	000	The current licence was received	(ad	
	This was an offsite Licensure Investigation		F 00)00	The current license was received		
					that allows the facility to operate		
	Survey				as a residential care facility, a	<u>-</u>	
	a			residents had the potential to		be	
	Survey Date: 12/13/22				affected by this finding.		
	Facility number: 00	00115			administrator was re-educated	that	
	Provider number: 1				the renewal application is to b		
	AIM number: 1002	91080			completed annually at least 45		
					days prior to the expiration of		
	This state finding is	s cited in accordance with 410			license		
	IAC 16.2.						
					the regional Director and or hi	s/her	
	Quality review com	npleted December 13, 2022			designee will ensure the		
					application is sent timely prior	to	
					the expiration date		
					in addition, ongoing complian	ce	
					will be monitored by QAPI time		
					one year .		
					if noncompliance is noted, an		
					action plan will be written by the	ne	
					QAPI committee		
F 9999							
Bldg. 00							
			F 99	999	The current license was received	/ed	01/03/2023
	16.2-3.1-2(h)(1) - L	Licenses			that allows the facility to opera	ate	
	(h) For the renewal	l of a license, the director may			as a residential care facility. A	.II	
	issue a full license	for any period up to one (1)			residents had the potential to	be	
	year, issue a probat	ionary license, or deny a			affected by thus finding.		
	license application	upon receipt and review of the]		
	following requirem				administrator was re-educated	that	
		all submit a renewal application			the renewal application is to b	е	
		ast forty-five (45) days prior to			completed annually at least 45		
	the expiration of the				days prior to the expiration of		
					<u> </u>		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			3	TITLE		(X6) DATE	

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

Sarah McKenzie/Claire Matheny AIT/HFA 01/03/2023

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

PRINTED: 01/11/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTI		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	î ´	2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/13/2022		
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	This state rule was not met as evidenced by: Based on document review, the facility failed to				the regional Director and or his designee will ensure the	s/her		
	ensure it had timely renewed their license to operate as a health care facility before their current license expired on 10/31/22.				application is sent timely prior to the expiration date in addition, ongoing compliance			
	application and pays	neerived the facility's renewal ment post marked 11/4/22, ast 45 days of the current ate of 10/31/22.			will be monitored by QAPI time one year . if noncompliance is noted, an action plan will be written by th QAPI committee	es		
R 0000								
Bldg. 00	This was an offsite Residential Licensure Investigation Survey Survey Date: 12/13/22		R 0000		The current license was received that allows the facility to operate as a residential care facility, all residents had the potential to be affected by this finding.			
	Facility number: 000 This State Residenti accordance with 410	al Finding is cited in			administrator was re-educated the renewal application is to be completed annually at least 45 days prior to the expiration of t license	9		
	Quality review com	pleted December 13, 2022			the regional Director and or his designee will ensure the application is sent timely prior the expiration date			
					in addition, ongoing compliand will be monitored by QAPI time one year . if noncompliance is noted, an action plan will be written by the QAPI committee	es		

State Form Event ID: CNRS11 Facility ID: 000115 If continuation sheet Page 2 of 3

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

PRINTED: 01/11/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTR		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION ID:		IDENTIFICATION NUMBER	a. building 00			COMPLETED	
155208		B. WING			12/13/2022		
		100200	ъ. W			12/13/	
NAME OF T	DOLUBER OF CHEST TO			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	t .		410 W	LAGRANGE RD		
HANOVE	R NURSING CENT	TER			/ER, IN 47243		
10000	IN NORONO OEM			11/11/01			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
R 9999							
Bldg. 00							
			R 9	999	The current license was received		01/04/2023
	16.2-5-1.1 Licenses	16.2-5-1.1 Licenses		-	that allows the facility to opera		
	(1) The facility shall submit a renewal application				as a residential care facility. A		
	to the director at least forty-five (45) days prior to			residents had the potential to b			
	to the director at least forty-five (45) days prior to the expiration of the license.			l · · · · · · · · · · · · · · · · · · ·			
	the expiration of the	e ncense.			affected by thus finding.		
	This state rule was not met as evidenced by:				administrator was re-educated that		
				the renewal application is to be			
	Based on document review, the facility failed to			completed annually at least 45			
	ensure it had timely renewed their license to			days prior to the expiration of the			
	operate as a residential care facility before their				license		
	current license expi	-					
		<u>-</u> <u></u> -			the regional Director and or hi	is/her	
	The agency receive	d the facility's renewal			designee will ensure the	0,1101	
		-			_	. 4 -	
		ment post marked 11/4/22,			application is sent timely prior	το	
		ast 45 days of the current			the expiration date		
	license expiration d	ate of 10/31/22.					
					in addition, ongoing compliar	ice	
					will be monitored by QAPI tim	es	
					one year .		
					if noncompliance is noted, an		
					action plan will be written by t		
						, IG	
					QAPI committee		
					1		

State Form Event ID: CNRS11 Facility ID: 000115 If continuation sheet Page 3 of 3