

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155208		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 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 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 0000  Bldg. 00	<p>This was an offsite Licensure Investigation Survey</p> <p>Survey Date: 12/13/22</p> <p>Facility number: 000115 Provider number: 155208 AIM number: 100291080</p> <p>This state finding is cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed December 13, 2022</p>			F 0000	<p>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.</p> <p>administrator was re-educated that the renewal application is to be completed annually at least 45 days prior to the expiration of the license</p> <p>the regional Director and or his/her designee will ensure the application is sent timely prior to the expiration date</p> <p>in addition, ongoing compliance will be monitored by QAPI times one year . if noncompliance is noted, an action plan will be written by the QAPI committee</p>		
F 9999  Bldg. 00	<p>16.2-3.1-2(h)(1) - Licenses</p> <p>(h) For the renewal of a license, the director may issue a full license for any period up to one (1) year, issue a probationary license, or deny a license application upon receipt and review of the following requirements:</p> <p>(1) The facility shall submit a renewal application to the director at least forty-five (45) days prior to the expiration of the license.</p>			F 9999	<p>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.</p> <p>administrator was re-educated that the renewal application is to be completed annually at least 45 days prior to the expiration of the</p>		01/03/2023

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

TITLE

(X6) DATE

Sarah McKenzie/Claire Matheny

AIT/HFA

01/03/2023

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 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 30 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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155208		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 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 DEFICIENCY (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
R 0000  Bldg. 00	<p>This state rule was not met as evidenced by:</p> <p>Based on document review, the facility failed to ensure it had timely renewed their license to operate as a health care facility before their current license expired on 10/31/22.</p> <p>The state agency received the facility's renewal application and payment post marked 11/4/22, which was not at least 45 days of the current license expiration date of 10/31/22.</p> <p>This was an offsite Residential Licensure Investigation Survey</p> <p>Survey Date: 12/13/22</p> <p>Facility number: 000115</p> <p>This State Residential Finding is cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed December 13, 2022</p>			R 0000	<p>license</p> <p>the regional Director and or his/her designee will ensure the application is sent timely prior to the expiration date</p> <p>in addition, ongoing compliance will be monitored by QAPI times one year .</p> <p>if noncompliance is noted, an action plan will be written by the QAPI committee</p> <p>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.</p> <p>administrator was re-educated that the renewal application is to be completed annually at least 45 days prior to the expiration of the license</p> <p>the regional Director and or his/her designee will ensure the application is sent timely prior to the expiration date</p> <p>in addition, ongoing compliance will be monitored by QAPI times one year .</p> <p>if noncompliance is noted, an action plan will be written by the QAPI committee</p>		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155208		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 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
R 9999  Bldg. 00	<p>16.2-5-1.1 Licenses</p> <p>(1) The facility shall submit a renewal application to the director at least forty-five (45) days prior to the expiration of the license.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on document review, the facility failed to ensure it had timely renewed their license to operate as a residential care facility before their current license expired on 10/31/22.</p> <p>The agency received the facility's renewal application and payment post marked 11/4/22, which was not at least 45 days of the current license expiration date of 10/31/22.</p>			R 9999	<p>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 thus finding.</p> <p>administrator was re-educated that the renewal application is to be completed annually at least 45 days prior to the expiration of the license</p> <p>the regional Director and or his/her designee will ensure the application is sent timely prior to the expiration date</p> <p>in addition, ongoing compliance will be monitored by QAPI times one year .</p> <p>if noncompliance is noted, an action plan will be written by the QAPI committee</p>		01/04/2023