| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 11/20/2023 |

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

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Nursing Home Complaints IN00419530, IN00419736, IN00420807, and IN00421147. This visit included the investigation of Residential complaints IN00418288 and IN00418707.<br><br>Unrelated deficiencies are cited.<br><br>Complaint IN00419530 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00419736 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00420807 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00421147 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00418288 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00418707 - No deficiencies related to the allegations are cited.<br><br>Survey dates: November 15, 16, 17, and 20, 2023<br><br>Facility number: 000115<br>Provider number: 155208<br>AIM number: 100291080<br><br>Census Bed Type:<br>SNF/NF: 70<br>Residential: 6<br>Total: 76 | F 0000 | This plan of correction is to serve as Hanover Nursing Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Hanover Nursing Center or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in the facility, nor does this submission constitute an agreement or admission of the survey allegations. This plan of correction is prepared and or executed solely as required. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Stefanie Jenkins | Administrator | 12/19/2023 |

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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| | Census Payor Type:<br>Medicare: 5<br>Medicaid: 64<br>Other: 1<br>Total: 70<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on November 27, 2023. | | | |
| F 0557<br>SS=D<br>Bldg. 00 | 483.10(e)(2)<br>Respect, Dignity/Right to have Prsnl Property<br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.<br>Based on record review, observation, and interview, the facility failed to accurately inventory residents' personal property for 2 of 15 residents reviewed for personal property. (Residents F and G)<br><br>Findings include:<br><br>1. Resident F's clinical record was reviewed on 11/17/23 at 1:08 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 08/03/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, stroke, non-Alzheimer's dementia, diabetes, anxiety, depression, and psychotic disorder. The assessment indicated an admission date of 03/11/21 and admission/reentry into the facility date of 01/04/22. | F 0557 | **What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:**<br>No residents will be affected by this alleged deficient practice. Personal inventory sheets have been completed for residents F and G. All residents residing and/or admitting to the facility will have a completed personal inventory sheet and it will be kept in the resident's chart.<br>**How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And** | 12/13/2023 |

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| | The resident was observed on 11/15/23 at 2:19 P.M. The resident was in bed in her room. A large black purse was tucked under the resident's right arm. The resident indicated that was her purse; she had the purse for a long time.<br><br>The resident was observed on 11/20/23 at 10:04 A.M. The resident was in bed asleep. A large black purse was laying on the bed in the upper left corner near the resident's head.<br><br>During an interview on 11/20/23 at 10:06 A.M., QMA (Qualified Medication Aide) 8 indicated she had worked at this facility since 2017 and was familiar with Resident F. The resident usually had her black purse with her. An inventory of personal items was taken upon a resident's admission to the facility. Any time personal items were brought into the facility or taken out of the facility, the inventory list should be updated.<br><br>Resident F's inventory of personal items was reviewed with QMA 8 and LPN (Licensed Practical Nurse) 7 on 11/20/23 at 10:10 A.M. Resident F's inventory listed her admission date as 02/26/15. Various items of clothing and other items, including a television and a cell phone were listed as being brought to the facility on either 02/27/15 or 03/02/15. There were no purses or handbags listed on the inventory. The "items added after admission" section of the inventory was blank. LPN 7 indicated the resident had a couple of purses and they should be listed on the inventory sheet.<br><br>2. During an interview on 11/15/23 at 12:01 P.M., Resident G indicated he arrived at the facility about six weeks ago. He brought three small boxes of personal belongings with him. The facility did | | **What Corrective Action(s) Will Be Taken:**<br>All residents have the potential to be affected, no other residents were affected by this alleged deficient practice. All residents residing and/or admitting to the facility will have a completed personal inventory sheet and it will be kept in the resident's chart. An audit was completed on all residents currently residing in the facility to ensure a completed personal inventory sheet was on file. Any resident found to not have a personal inventory sheet on file will have one completed immediately.<br>**What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:**<br>An audit was completed on all residents currently residing in the facility to ensure a completed personal inventory sheet was on file. Any resident found to not have a personal inventory sheet on file will have one completed immediately. All nursing staff, all activity staff, medical records, and all management staff will be in-serviced over the facility's Personal Inventory Record policy and procedure.<br>**How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** | |

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| | not take inventory of his personal items.<br><br>The resident's clinical record was reviewed on 11/17/23 at 1:26 P.M. An Admission MDS assessment, dated 10/11/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to stroke, hypertension, diabetes, anxiety, and depression. The resident's admission date was 10/02/23. The resident's paper chart at the nurses' station was reviewed and lacked record of an inventory of the resident's items.<br><br>During an interview on 11/15/23 at 2:25 P.M., QMA 8 indicated the residents' inventory sheets were completed upon admission and were usually kept in the resident's chart under the "miscellaneous" tab. The resident was fairly new, so his inventory list might still be in medical records department.<br><br>During an interview on 11/16/23 at 11:05 A.M., the Medical Records staff indicated she looked for the inventory sheet and she could not find an inventory sheet for Resident G. She told the staff to create an inventory sheet for the resident.<br><br>A current, undated "Resident Admission Agreement" was provided by the Administrator on 11/17/23 at 11:48 A.M. The Agreement indicated the following, "...The Resident shall complete an inventory form listing the times that the Resident brings to the Facility at the time of admission. Additions and deletions to the inventory shall be brought to the attention of the Facility's administration so that records are kept current..."<br><br>The current facility policy, titled "Personal Inventory Record", dated 10/2014, was provided | | Medical Records/Designee will monitor new admissions on the next business day after admitting to ensure timely completion of the resident's personal inventory sheet weekly times 4 weeks, then every two weeks times 8 weeks, 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 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. | |

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| | by the Corporate Support Staff on 11/20/23 at 11:51 A.M. The policy indicated, "...The facility must inventory, upon admission and at the time of discharge, the resident's personal belongings including money and valuables declared by the resident at the time of admission and throughout the stay of the resident..."<br><br>3.1-9(g) | | | |
| F 0740<br>SS=D<br>Bldg. 00 | 483.40<br>Behavioral Health Services<br>§483.40 Behavioral health services.<br>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 well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.<br>Based on record review and interview, the facility failed to provide behavior health services for a resident's psychological needs (Resident J), and to complete ongoing monitoring for residents with behaviors (Residents C and B) for 3 of 15 residents reviewed for behavior health.<br><br>Findings include:<br><br>1. The clinical record for Resident J was reviewed on 11/15/23 at 2:30 P.M. An Annual MDS (Minimum Data Set) assessment, dated 10/21/2023, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, Huntington's disease, hypertension, and depression. | F 0740 | **What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:**<br>Resident J did receive behavioral health services for his psychological needs. Resident J will continue to receive behavioral health services for his psychological needs in a timely manner when warranted. Residents C and B will have ongoing monitoring, such as 15-minute checks, thoroughly completed and documented on | 12/13/2023 |

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| | A progress note, dated 10/20/2023 at 2:45 P.M., indicated the SSD (Social Service Director) asked the resident questions from Section D (Mood) of the MDS assessment, including the PHQ-9 (a questionnaire used for screening, diagnosing, monitoring, and measuring the severity of depression). The resident reported he had little interest or pleasure in doing things, had been having a difficult time falling asleep, had been feeling tired every day, and had been having thoughts that he would be better off dead or of hurting himself in some way. The SSD indicated she would make referrals to ancillary service providers and to mental health services.<br><br>The clinical record lacked documentation that the SSD notified psychiatric services of the resident's statements, or that the resident was monitored for indications of depression or self-harm until 11/01/23, when a routine psychiatric NP (Nurse Practitioner) visit was made.<br><br>During an interview on 11/16/23 at 1:54 P.M., the psychologist indicated she saw Resident J every five weeks, but the Psych NP saw him more frequently. Additionally, there were on call services available 24 hours a day through her company.<br><br>During an interview on 11/16/23 at 2:18 P.M., the SSD indicated if a resident had told her they were having thoughts of self harm or thinking they would be better off dead, she would reach out to psychiatric services. She did not reach out to psychiatric services on 10/20/23 when she completed the MDS interview with Resident J.<br><br>During an interview on 11/17/23 at 2:12 P.M., the psychiatric NP indicated she took her own calls | | appropriate form when warranted.<br>**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:**<br>All residents have the potential to be affected, no other residents were affected by this alleged deficient practice. All residents will receive behavioral health services for their psychological needs in a timely manner if/when warranted. Any resident placed on specialized monitoring, such as 15-minute checks, will have ongoing monitoring thoroughly documented on appropriate form if/when specialized monitoring is warranted.<br>**What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:**<br>Nursing staff will be notified if/when a resident is placed on or taken off of specialized monitoring. Nursing staff will thoroughly and timely document on the appropriate form when a resident is placed on specialized monitoring. All nursing staff will be in-serviced over the facility's Behavior Management Program, including specialized monitoring policy and procedures.<br>**How The Corrective Action(s) Will Be Monitored To Ensure** | |

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| | during the day and there was always someone available 24 hours a day.<br>2. The clinical record for Resident C was reviewed on 11/16/23 at 10:30 A.M. A Quarterly MDS assessment, dated 10/05/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, Huntington's disease, orthostatic hypotension, non-Alzheimer's dementia, anxiety, and depression.<br><br>A Progress Note, dated 11/04/23 at 12:05 P.M., indicated there was peer (resident) to peer contact reported. Resident C was reported to have struck Resident B while they were walking in the Wing 2 hallway leading to the nurse's station. Resident B had yelled out that Resident C had hit him. Resident C admitted to the nurse that he had struck or had contact with Resident B. Both residents were immediately separated by staff. After the assessment Resident B was found to have no injuries. Resident C was placed on 1:1 (one staff to one resident) monitoring. Resident B was already on 15 minute monitoring. All appropriate parties were notified.<br><br>The "15 Minute Monitoring" for Resident C were provided by the Administrator of 11/16/23 at 3:43 P.M. The form indicated, "...Resident's whereabouts are to be visually observed and recorded every 15 minutes. Re-direct the resident as/if needed. 15 minute checks will continue until the IDT [Interdisplinary Team] has determined otherwise..."<br><br>The record lacked documentation the resident was monitored every 15 minutes on the following dates and times:<br><br>- On 11/04/23 from 10:45 P.M.,(the last documented observation) to 11/05/23 at 6:00 | | **The Deficient Practice Will Not Recur:**<br>DON/Designee will monitor specialized monitoring forms for thorough and timely completion daily on scheduled workdays times 4 weeks, then 2 times a week times 8 weeks, then weekly 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. | |

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| | A.M., (the next observation documented)<br><br>- No record was available for 11/07/23,<br><br>- On 11/13/23 from 6:00 P.M. to 11/14/23 at 6:00 A.M.<br><br>- On 11/14/23 from 6:00 P.M. to 11/15/23 at 6:00 A.M.<br><br>3. The clinical record for Resident B was reviewed on 11/16/23 at 10:30 A.M. A Quarterly MDS assessment, dated 09/25/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, COVID-19, Huntington's disease, anxiety, and depression.<br><br>A Progress Note, dated 11/04/23 at 12:05 P.M., indicated there was peer (resident) to peer contact reported. Resident C was reported to have struck Resident B while they were walking in the Wing 2 hallway leading to the nurse's station. Resident B had yelled out that Resident C had hit him. Resident C admitted to the nurse that he had struck or had contact with Resident B. Both residents were immediately separated by staff. After the assessment Resident B was found to have no injuries. Resident C was placed on 1:1 monitoring. Resident B was already on 15 minute monitoring. All appropriate parties were notified.<br><br>The 15 Minute Monitoring records for Resident B lacked documentation the resident was monitored every 15 minutes on the following dates and times:<br><br>- On 11/04/23 from 10:45 P.M. to 11/05/23 at 6:00 A.M.<br><br>- No record was available for 11/07/23, | | | |

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| | - On 11/13/23 from 6:00 P.M. to 11/14/23 at 6:00 A.M.<br><br>- On 11/14/23 from 6:00 P.M. to 11/15/23 at 6:00 A.M.<br><br>During an interview on 11/16/23 at 11:54 A.M., LPN (Licensed Practical Nurse) 2 indicated if a resident was on 15 minute monitoring, they would document the resident's whereabouts on the form and leave the form in a binder for the DON (Director of Nursing) to collect when it was completed. The IDT team would determine when a resident was removed from the monitoring. The monitoring was completed on a paper form and not in the electronic health record.<br><br>During an interview on 11/17/23 at 9:36 A.M., the Administrator indicated Resident B and C were to be on 15 minute monitoring until the IDT determined the residents no longer needed to be monitored. The LPN that was working on 11/16/23 just assumed the 15 minute monitoring had stopped because there wasn't a paper to fill out. She was educated that she needed to speak up if there were no more forms.<br><br>3.1-37(a) | | | |
| R 0000<br><br>Bldg. 00 | This visit was for the Investigation of Residential Complaints IN00418288 and IN00418707. This visit included the Investigation of Nursing Home Complaints IN00419530, IN00419736, IN00420807, and IN00421147.<br><br>Complaint IN00418288 - No deficiencies related to | R 0000 | This plan of correction is to serve as Hanover Nursing Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Hanover Nursing Center or its management | |

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| | the allegations are cited.<br><br>Complaint IN00418707 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00419530 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00419736 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00420807 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00421147 - No deficiencies related to the allegations are cited.<br><br>Survey dates: November 15, 16, 17, and 20, 2023.<br><br>Facility number: 000115<br><br>Residential Census: 6<br><br>Hanover Nursing Center was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Residential Complaints IN00418288 and IN00418707.<br><br>Quality review completed on November 27, 2023. | | company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in the facility, nor does this submission constitute an agreement or admission of the survey allegations. This plan of correction is prepared and or executed solely as required. | |