Jay Nowlin

PRINTED: 04/22/2025 FORM APPROVED OMB NO. 0938-039

04/10/2025

		X1) PROVIDER/SUPPLIER/CLIA	· /		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155208	B. WI	NG		03/27/	2025
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							,
	Licensure Survey and IN00455300, IN004 included a State Resident IN00455 related to the allegar F925. Complaint IN00455 the allegations are complaint IN00455 related to the allegar F925. Survey dates: March 2025 Facility number: 00 Provider number: 15	1916 - Federal/State deficiencies tions are cited at F584 and in 20, 21, 24, 25, 26, and 27, 0115 55208	F 00	000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions seforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law	t nent he	
	AIM number: 10029 Census Bed Type: SNF/NF: 70 Residential: 4 Total: 74 Census Payor Type: Medicare: 1 Medicaid: 59 Other: 10 Total: 70 These deficiencies raccordance with 410	reflect State Findings cited in					
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIGI	NATURI	3	TITLE		(X6) DATE

Any defiency statement 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 disclodays 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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Administrator

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155208	B. W	ING		03/27	/2025
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDERIC IV AN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	VIE.	DATE
	Quality review com	pleted on April 1, 2025.					
F 0577 SS=E Bldg. 00	483.10(g)(10)(11) Right to Survey Rel Info Based on observation failed to have the St view for 2 of 6 days Findings include: During an observation laminated piece of puth Administrator's results were in a whore The living room and observed, and no whoserved, and no whoserved, and no whoserved, and no whoserved living room and survey results. During an observation the living room and survey results. During an interview Minimum Data Set the State survey results. During an interview Minimum Data Set the State survey results. During an interview did the state survey results. During an interview with They should be available asking the staff. During an interview the Administrator in the state of the state of the staff.	esults/Advocate Agency on and interview, the facility rate survey results available to	F 0:	577	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions s forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken f those residents identified: Survey Book is now on the talt the lobby for all to view. 2) How the facility identified other residents: All residents have the potential be affected by the alleged defipractice.	of ot ment the et or	04/10/2025
		they would just follow the			System changes:		

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

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/27/2025		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	3.1-3(b)(1)			Admin, Director of Nursing, Assistant Director of Nursing educated by Vice president of operations on regulation requisively book availability 4) How the corrective action will be monitored: Administrator/Designee will of Survey book placement/avail weekly for 4 weeks then even other week for 8 weeks then monthly times 3 months to er Survey results binder is in pla and available.	of uiring ns check ability ry nsure		
				The results of these audits be reviewed in Quality Assurance Meeting monthly months or until an average 100 % compliance or great is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise plan of correction as indicated.	/ x6 of eer e		
				5) Date of compliance: 04//10/15			
F 0584 SS=E Bldg. 00	review, the facility safe environment re and safe walkways	ortable/Homelike on, interview, and record failed to provide a clean and elated to a dirty shower room for 2 of 4 facility areas and the outside courtyard)	F 0584	F584 Safe/Clean/Comfortable/Ho like environment	04/10/2025		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE (A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 03/27/2025	
NAME OF F	PROVIDER OR SUPPLIEF	· :		T ADDRESS, CITY, STATE, ZIP COD		
APERIO	N CARE HANOVER	8		/ LAGRANGE RD OVER, IN 47243		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Findings include:			This Plan of Correction is the center's credible allegation of compliance.		
	1. During an observation of Wing 2, on 03/21/25 through 03/25/25, the following concerns were			Compilarios.		
				Preparation and/or execution	of	
	_	lowing dates and times:		this plan of correction does no		
				constitute admission or agree		
	- On 03/21/25 at 10	:25 A.M., the Shower Room had		by the provider of the truth of t		
	-	ng urine odor; the toilet base		facts alleged or conclusions se	et	
		ight-inch band of black debris		forth in the statement of		
		and a one-foot-long, a		deficiencies. The plan of		
		a three-foot-long stripe of		correction is prepared and/or		
	black/brown residue around the tile areas in the			executed solely because it is		
shower stall.			required by the provisions of			
	0.00/04/07 .40			federal and state law.		
		:33 A.M., the bathroom shared				
		23 and 24, had a baseball size		1) Immediate actions taken for	or	
	_	athroom floor where tiles were		those residents identified:		
	_	in Room 23 was observed to			,	
	_	n toileting and unsteady on his		Resident B is being take		
	feet.			an alternate area to smoke. Bi		
	On 02/24/25 at 10	26 A M the Sheyyan Deem had		obtained for repair of concrete		
		:26 A.M., the Shower Room had ilet base had one inch by		The Shower room in win	y ∠	
		black debris around toilet base;		has been deep cleaned and pressure washed. Quotes		
	-	g, a two-foot-long, and a		obtained to renovate the bathr	room	
		be of black/brown residue		replacing walls and floors.	OOM	
		s in the shower stall.		Bathroom floor shared b	v	
				room 23 and 24 has been	,	
	- On 03/24/25 at 3:1	17 P.M., the bathroom shared by		replaced.		
		and 28, had a strong urine		Bathroom shared by roo	om	
	odor.			27 and 28 has been deep clea		
				Resident room 18 bathr		
	- On 03/25/25 at 10	:23 A.M., the bathroom shared		door has been cleaned.		
	by Resident Rooms	23 and 24, had a baseball size		Wing two floors have be	en	
	shallow pit in the ba	athroom floor where tiles were		deep cleaned,		
	missing.			Pest Control called in to		
				treat gnats on unit 2		
		:25 A.M., Resident Room 18's		Maintenance request for	ms	
	bathroom door had	brown stains and chunks of		audited 100 percent to make s	sure	

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155208	B. W.	ING		03/27/	2025
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			LAGRANGE RD		
ΔPERIO!	N CARE HANOVER	9			/ER, IN 47243		
711 E11101		`		11/110	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		
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TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	brown debris on the	e doorknob to the bathroom.			all requests completed.		
	02/25/25 + 10.25 + 14						
	During an interview, on 03/27/25 at 10:25 A.M., Licensed Practical Nurse (LPN) 7 indicated there was a resident who resided in Room 23 who was able to use the bathroom without staffs'				2) How the facility identified		
					other residents:		
		room without staffs'			All residents have the potentia		
	assistance.				be affected by the alleged def		
	D	iti f 03/20/25			practice. All residents are goir	-	
	-	ous interview, from 03/20/25 a staff member indicated a			an alternate area for smoking.		
	-				residents rooms and common areas inspected for cleanlines		
	group of volunteers had complained, while on				and cleaned or repaired if nee		
	Wing 2, the floors were filthy with food particles;				and cleaned or repaired if fiee	ueu.	
	spilled fluid;, and a swarm of gnats. A volunteer even started cleaning the floor because the spills				3) Measures put into place/		
		ursing staff would not clean			System changes:		
		eft it for Housekeeping. "Wing			System changes.		
	2 was always a mes				Staff have been educated that	•	
	2 was arways a mes				residents will be taken to alter		
	During an interview	v, on 03/27/25 at 10:12 A.M.,			smoking area until repairs are		
	_	Supervisor indicated they had			made. Outdoor patio will be		
		lists for each unit. Staff were to			closed for use until repairs are	1	
	-	er they were completed. They			completed. Housekeepers		
		check off list for deep			educated on use of checklist,		
	_	clean they pulled everything			deep cleans and shower room	1	
		room, cleaned the walls, the			cleaning. Maintenance educat		
		bedding, pulled out the beds,			on inspection sheet and policy		
		me, window blinds, the trim,			Housekeeping to keep binder		
	and the bathrooms.	Rooms were deep cleaned			checklists in office. Maintenar		
	every couple of wee	eks and as needed. Some were			to keep rounding sheets in a		
	done more often. Sl	he kept the deep clean check			binder in office according to po	olicy.	
	off lists. She kept th	ne daily check-off lists for					
	about two weeks. B	Blank checklists were provided			4) How the corrective actions	3	
		ng Supervisor. She indicated			will be monitored:		
	she did not have an	y completed checklists for any					
		ne had just thrown them away.			Admin/Designee will complete	:	
	None of the checkli	ists included cleaning the walls			daily audit of check off sheets	,	
	of the shower room	s.			observations of Wing 2 to ens	ure	
					cleanliness, and maintenance	,	
	_	v, on 03/27/25 at 2:48 P.M.,			inspection sheets for (3 times	а	
	when asked for the	building inspections for the			week for)?4 weeks then (3 tim	es a	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/27/2025	
	PROVIDER OR SUPPLIER N CARE HANOVER	410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243		
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	interior and exterior of the building, the Maintenance Director indicated he walked through the building everyday but did not document his observations.		week?) every other week for 8 weeks then monthly times 3 months to ensure all sheets a inspections are being done.		
	2. During an observation, on 03/27/25 at 11:11 A.M., Resident B was outside in the courtyard in his wheelchair with a group of residents that were awaiting to smoke. While propelling himself, he fell forward, with the wheelchair still attached to his back because he used a seat belt for positioning and landed face down with his forehead touching the sidewalk. Another resident turned the resident to his side as no staff were within five feet of this resident. During an interview, on 03/27/25 at 1:26 P.M., CNA 8 indicated they had put in a work order for the concrete chipping. No one was with the resident when he fell. They had put the work order in about two weeks ago because they noticed it was getting worse, and all the rain had not helped. The resident had a scrape on his forehead and a little bump on the back of his head from today's fall.		The results of these audits we be reviewed in Quality Assurance Meeting monthly months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise plan of correction as indicated.	x6 of er the	
	The Progress Notes for Resident B were provided by the DON on 03/27/25 at 3:14 P.M. A note, dated 03/27/25 at 11:00 A.M., indicated the resident had an unwitnessed fall in the courtyard smoking area. The resident's wheelchair tipped over as he was propelling it on the concrete. The resident's statement indicated, "I was coming to smoke and the chair tipped over because of the concrete." The resident received a scrape to the forehead and a small bump on the top of his head. The "MAINTENANCE REQUEST" forms were				
	provided by the Administrator on 03/27/25 at 1:50 P.M. A request, from CNA 9, dated 03/12/25,				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL 03/27	ETED
	PROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243		
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	_	valk had a "big chunk" out of ease look at it and see if done.				
	Policy" was provide Nurse Consultant of policy indicated, " facility, equipment, rooms are maintain provide a comfortal prevent the develop infectionmaintain	I "Housekeeping Service ed by the Corporate Clinical in 03/27/25 at 1:45 P.M. The .PurposeTo ensure that the furnishings [sic] and resident ed in a sanitary manner; to ble environment, and to ment and transmission of a clean, odor free,orderly in meettheresidents right for ortable homelike				
	and Inspections" po DON on 03/27/25 a indicated, "Inspection at leastThe but be conducted and desinspection will be conducted and desinspection will be conducted and desinspection will be conducted and design.	d "Preventative Maintenance blicy was provided by the at 2:40 P.M. The policy stion checklists are developed ildingExterior inspection will ocumented weeklyInterior onducted and documented of flooringCement sent room will be inspected and dy"				
	01/01/15, was proved 2:40 P.M. The policy should conduct assess including events lead determine when post	policy, with a reviewed date of ided by the DON on 03/27/25 at by indicated, "Licensed nurse essment immediately, ading up to the fall to ssible and causative factors" to Complaints IN00455300				
	3.1-19(f)(5)					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
		155208	B. WI	NG		03/27/	2025
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0684 SS=D Bldg. 00	failed to administer	riew and interview, the facility prescribed medications related	F 06	584	F- 684 Quality of care		04/10/2025
	to insulin administrative reviewed for Quality Findings include: The clinical record on 03/27/25 at 10:4. Data Set (MDS) assindicated the resider impaired. The reside were not limited to, dementia, and parary 2025 EAdministration Record Administration Record provided by the Dir 03/27/25 at 11:37 ATM The physician's order and a discontinued or resident was to recet to be administration Record Administration Record Administration Record Administration Record Administration Record Administration Record Indicates scheduled for 9:00 ATM The record lacked of the resident receiver following dates and	for Resident 12 was reviewed 5 A.M. A Quarterly Minimum lessment, dated 02/07/25, int was moderately cognitively ent's diagnoses included, but diabetes, hypertension, noid schizophrenia. Electronic Medication ord/Electronic Treatment ord (EMAR/ETAR) was ector of Nursing (DON) on i.M. er, with a start date of 11/13/24 date of 01/14/25, indicated the ive Humalog (insulin) 12 units,			Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only ir response to the regulatory requirements. What corrective actions have been accomplished for those residents found to have been affected by the deficient practice. Resident 12 assessed with no negative outcome. Licensed nursing staff educate on proper documentation of administration per order, and refusal and notification of refus MD as per policy How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: All residents receiving prescrit medications related insulin administration have the potent to be affected by the deficient practice.	any y the n e e a to e o e tial	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155208	B. WIN	NG		03/27/	2025
		<u> </u>		CTDEET 4	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD _AGRANGE RD		
ΛDEDIΩ!	N CARE HANOVER	•					
AFERIUI	N CARE HANOVER			HAINUV	'ER, IN 47243		
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TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		d Glucose Fingerstick					
	_	was reviewed and indication			Measures the facility will take	е	
	the following: on January 3, at 7:00 P.M., the resident blood sugar value was 390; on January 4, at 7:00 P.M., the resident's blood sugar value was				to ensure that the problem w	rill	
					be corrected and will not rec	ur:	
					All nursing staff educated on		
	143; and on January 5, at 7:00 P.M., the resident's				proper documentation of		
	blood sugar value w	vas 280.			administration per order, and		
					refusal and notification of refu	sal to	
	_	for January 2025 were			MD as per policy		
		ON on 03/27/25 at 11:37 A.M.					
		locumentation as to why the					
	medication was not given.				Quality assurance plans to		
					monitor facility performance	to	
		es Care Plan, with an initiated			make sure that corrections a	re	
		dicated the staff were to			achieved and are permanent	:	
		ent's diabetes medication as					
	ordered by the doct	or.			Administrator/ DON and or		
					designee will perform Medica		
	1	y, on 03/26/25 at 1:33 P.M., RN			Record Reviews with appropri		
		dent refused a medication or			documentation and MD notific		
	1 -	re to mark it as refused on the			three times a week for four we		
		they also documented in the			then weekly times eight weeks		
	_	e EMAR ETAR should not			ensure these Physician Order		
	have blanks on it.				have been followed. The resul		
					the above audits will be review		
		d, facility policy titled,			in the Quality Assurance Meet	•	
		nistration General Guidelines",			monthly until 100% complianc		
		e MDS Coordinator on			achieved for three consecutive		
		M. The policy indicated,			months. The QAA Committee		
		administered as prescribed in			identify any trends or patterns		
	_	od nursing principles and			make recommendations to rev		
	1 -	by persons legally authorized			the plan of correction as indica	ated.	
		of regularly scheduled					
		held, refused, not available, or			Any discrepancies will be repo	orted	
	~	er than the scheduled timeAn			to the QAA Committee with		
		enteredIf 3 consecutive			recommendations and educat	ion	
		lication are withheld, refused,			provided as needed		
		physician is notified. Nursing					
		fication and physician					
	response"						

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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0692 SS=D Bldg. 00	-	n Status Maintenance	F 04	702			04/10/2025
		eal consumption's and have	F 06	092	F692 Nutrition/Hydration Sta	atue	04/10/2025
		ble for 1 of 3 residents			Maintenance	itus	
	reviewed for nutrition				Maintenance		
	Teviewed for nutrition	on. (Resident 43)					
	reviewed on 03/25/2 Minimum Data Set 01/20/25, indicated intact. The resident' were not limited to,	ord for Resident 43 was 25 at 11:46 A.M. A Quarterly (MDS) assessment, dated the resident was cognitively s diagnoses included, but Huntington's disease, anemia, axiety, depression, and ss.			Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only ir response to the regulatory requirements. 1) What corrective actions he been accomplished for those	any y the n ave	
	_	tion Record for the resident			residents found to have been	n	
		meals for the following dates			affected by the deficient		
	and times: On 01/02/25 at dir On 01/07/25 at dir On 01/11/25 at dir On 01/16/25 at dir On 01/23/25 at dir On 01/28/25 at dir On 02/01/25 at dir On 02/05/25 at dir On 02/05/25 at dir On 02/11/25 at dir On 02/11/25 at dir On 02/11/25 at dir On 02/13/25 at dir On 02/13/25 at dir On 02/17/25 at dir On 02/20/25 at dir	nner,			practice? Resident 43 assessed with no negative outcome. CNA's educated on proper documentation of meal consumption. Mighty shakes stock, house supplements to be offered if not available. 2) How will the facility identity other residents having the potential to be affected by the same deficient practice? All residents have the potential be affected by the same allegate deficiency.	in be fy ne al to	

PRINTED: 04/22/2025 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155208	B. WI	NG		03/27	/2025
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R	410 W LAGRANGE RD				
APERIO	N CARE HANOVER	र		HANOVER, IN 47243			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	- On 03/03/25 at di	nner,					
	- On 03/09/25 at di	nner,			3) The measures the facility	will	
	- On 03/11/25 at di	nner,			take or systems the facility		
	- On 03/18/25 at di	nner, and			alter to ensure that the prob		
	- On 03/22/25 at dinner.				will be corrected and will no		
					re-cur:		
	During an interview	v, on 03/27/25 at 1:24 P.M.,			CNA's educated on proper		
	Certified Nurse Aide (CNA) 8 indicated the				documentation of meal		
		sumptions were to be			consumption. Mighty shakes	to be	
		electronic computer system			kept in stock with house		
	after each meal. If the resident refused the meal there was a place in the computer system for them to document that.				supplements to be offered if n	ot	
					available.		
	The current facility	policy titled, "Caregiver			4) How the corrective action	s	
	Documentation" w	ith a revision date of 01/15/18,			will be monitored:		
	was provided by th	e Clinical Corporate Nurse			DON will complete daily medi	cal	
	Consultant on 03/2	7/25 at 2:29 P.M. The policy			record review for 4 weeks the		
	indicated, "To est	tablish a system for providing			weekly review every other we	ek for	
	and documenting a	ppropriate care provided to the			8 weeks then monthly times 3		
	resident at the CNA	A/caregiver levelThe			months to ensure all sheets a	nd	
	CNA/Caregivers w	rill document resident's care in			inspections are being done.		
	electronic medical	record according to their					
	assignment and tas	ks completed as assignedin			The results of the above audit	ts will	
	accordance with the	e CNA's/caregiver's training			be reviewed in the Quality		
	and resident's plan	of careThe CNA will			Assurance Meeting monthly u	ıntil	
	complete all require	ed documentation for each			100% compliance is achieved	l for 3	
	resident under their	care assignment before			consecutive months. The QA	4	
	clocking out at the	end of the shift"			Committee will identify any tre	ends	
					or patterns and make		
	1b. A current open-	ended physician's order, with			recommendations to revise th	е	
	a start date of 04/28	8/22, indicated the resident was			plan of correction as indicated	d.	
	to receive a mighty	shake (supplement) with					
	meals.	•			The Administrator will monitor	-	
					completion of the Quality		
	The March 2025 E	lectronic Medication			Assurance monitoring.		
	Administration Red	cord (EMAR) indicated the					
		ceived the mighty shake on the					

following dates and times:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208			A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING 00 COMPLETE B. WING 03/27/20			ETED
		133206	B. WI			03/21/	2025
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	- On 03/06/25 at 12 - On 03/10/25 at 12 - On 03/11/25 at 7:0 P.M. The Progress Notes the mighty shakes wand times with the reserved by the supplement and does never been out of maware of. The current, undate "Medication Admir was provided by the 03/27/25 at 1:15 P.I."Medications are accordance with go	200 P.M. and 5:00 P.M., and 200 A.M., 12:00 P.M., and 5:00 Were reviewed and indicated were unavailable for the dates resident had not received it. 27, on 03/26/25 at 1:47 P.M., Nurse (Licensed Practical fithey were out of mighty give the resident an alternate reument it. The facility had highty shakes that she was d. facility policy titled, histration General Guidelines", and M. The policy indicated, administered as prescribed in od nursing principles and by persons legally authorized					
F 0755 SS=D Bldg. 00	Based on record rev failed to ensure a m	/Pharmacist/Records view and interview, the facility edication was available for 1 of ed for pharmacy services.	F 07	755	F755 Pharmacy Svc/Procedures/Pharmacists ecords	s/R	04/10/2025
	Findings include:	for Resident 56 was reviewed			This Plan of Correction is the center's credible allegation of compliance		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CO A. BUILDING B. WING	nstruction <u>00</u>	X3) DATE SURVEY COMPLETED 03/27/2025
	PROVIDER OR SUPPLIER N CARE HANOVER	410 W L	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD ZER, 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	on 03/27/25 at 1:44 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 12/10/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, Huntington's disease, chorea (neurological disorder that causes involuntary muscle movements), hypertension, and depression. A physician's order, dated 09/13/24 through 09/25/24, indicated the resident was to receive Austedo (a medication for chorea) 18 milligrams (mg), twice a day. The September 2024 Electronic Medication Administration Record (EMAR) indicated the resident had not received the medication on the following dates and times: - On 09/20/24 at bedtime, - On 09/21/24 at bedtime, - On 09/22/24 at bedtime, and		Preparation and/or execution of this plan of correction does not constitute admission or agreen by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident 56 now receives medications as per Physicians orders. Resident 56 assessed with no negative outcome	nent ne t
	- On 09/23/24 at bedtime. A physician's order, dated 10/19/24 through 11/13/24, indicated the resident was to receive Austedo XR (extended release) 18 mg, once a day for Huntington's disease. The October and November 2024 EMAR indicated the resident had not received the medication from 10/20/24 through 11/2/24. The Progress Notes indicated the following: - On 09/20/24 the medication was not available from the pharmacy to administer, - On 09/21/24 they were waiting on the medication to arrive from the pharmacy,		2) How the facility identified other residents: All residents have the potential be affected by the alleged deficient practice. 3) Measures put into place/System changes: Licensed Nursing staff have be educated on contacting Pharm & MD if medication not available in the back up Medication Bank	een acy ale k.
	to arrive from the pharmacy, On 09/22/24 the medication was not available		4) How the corrective actions	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/27/2025	
	PROVIDER OR SUPPLIEF		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION to administer.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	- On 09/23/24 the n from the pharmacy On 10/20/24 the n - On 10/23/24 the n - On 10/25/24 the n - On 10/25/24 the n - On 10/25/24 the n - On 10/26/24 the n - On 10/28/24 the n - On 10/29/24 the n - On 10/30/24 the n - On 10/30/24 the n and the Nurse Pract - On 10/31/24 the n and the Nurse Pract - On 11/01/24 the n and - On 11/02/24 the n - On 11/02/24 the n and - On 11/02/24 the n and the Nurse Pract - On 10/31/24 the n and - On 11/02/24 the n and the Nurse Practical No.	nedication was not available, nedication was not available.		DON/Designee will complete: Medical record reviews a wee 4 weeks then every other wee 8 weeks then monthly times 3 months to ensure medication available and administered an appropriate action is taken if unavailable. The results of these audits was be reviewed in Quality Assurance Meeting monthly months or until an average of 100 % compliance or greate is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise of plan of correction as indicate	ek for ek for is is nd /or vill x6 of er
	"Medication Admir	d, facility policy titled, nistration General Guidelines", e MDS Coordinator on			

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03/27/25 at 1:15 P.M. The policy indicated,

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	ROVIDER OR SUPPLIER		410) W L	DDRESS, CITY, STATE, ZIP COD AGRANGE RD ER, IN 47243		
(X4) ID PREFIX TAG	SUMMARY STATEMENT O (EACH DEFICIENCY MUST BE P REGULATORY OR LSC IDENTIFY	RECEDED BY FULL	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0756 SS=D Bldg. 00	"Medications are administered accordance with good nursing propractices and only by persons leg to do soIf a dose of regularly so medications is withheld, refused, given at a time other than the schexplanatory note is enteredIf 3 doses of a vital medication are wornot available the physician is redocuments the notification and presponse" 3.1-25(a) 483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report On Based on interview and record refailed to address pharmacy reconsof 5 residents reviewed for medicirregularities. (Residents 37, 32, and Findings include: 1. The clinical record for Resider on 03/26/25 at 2:25 P.M. A Quart Data Set (MDS) assessment, date indicated the resident was cognit resident's diagnoses included, but limited to, stroke, diabetes, irrital syndrome, anxiety, and depression. The pharmacist reviewed the resimedications monthly and made the recommendations: - A Consultant Pharmacist Recomprescriber, dated 12/20/24, indicator current physician's orders included Loperamide (an anti-diarrheal medicator current).	inciples and ally authorized cheduled not available, or eduled timeAn consecutive ithheld, refused, notified. Nursing hysician It Irregular, Act view, the facility mendations for 3 cation and 4) and 37 was reviewed terly Minimum and 01/29/25, ively intact. The total bowel on. Ident's me following Interpretation of the following mendation to atted the resident's ed an order for	F 0756		F756 Drug Regimen Review, report Irregular, Act on This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions seforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:	t ment he et	04/10/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u> COMPLETED			ETED
		155208	B. WING 03/27/2025			2025	
				CEREE	A DODDEGG CHEV CHARE THE COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
ADEDIO	N OADE HANOVE	n			LAGRANGE RD		
APERIO	N CARE HANOVE	К		HANO	/ER, IN 47243		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	solution, 1 mg (mi	lligrams) per 7.5 (milliliter) mL.			All recommendations for resid	ent	
	The resident was to	o receive 30 mL (4 mg) every			4, 32 and 37 have been review	wed	
	twelve hours as ne	eded and the resident had a			and updated.		
	current order for L	operamide oral capsules, 2 mg					
	every 4 hours as no	eeded. It was recommended			Resident 4, 32 and 37 have be	een	
	that the prescriber	review the continued use of the			assessed with no negative		
	duplicate orders.				outcome noted.		
	- A Consultant Pha	armacy Recommendation to			2) How the facility identified		
	Nursing, dated 12/	20/24, indicated the resident			other residents:		
	had a current phys	ician's order for Topamax (an					
anticonvulsant medication that was also used to treat migraine headaches and bipolar disorder) for				All residents have the potentia	al to		
				be affected by the alleged def			
depression. Depression was not an appropriate				practice.			
	diagnosis for the use of the medication. It was						
	recommended that	the order be updated with an			3) Measures put into place/		
	appropriate suppor	tive diagnosis and to contact			System changes:		
	the prescriber for o	larification.			DON/ADON and Social service	es	
					director educated on GDR pol	icy.	
	- A Consultant Pha	armacist Recommendation to					
	Prescriber, dated 0	1/20/25, indicated the resident			Licensed Nursing staff have b	een	
		ne (an antidepressant) 30 mg		educated on Pharmacy			
		24. It was recommended to			recommendations policy		
		se reduction of the medication.					
		eduction was contraindicated,			4) How the corrective actions	S	
		document the clinical			will be monitored:		
	rationale.						
					DON/Designee will complete s		
		ical record lacked any indication			Medical record reviews a wee		
		onded to the pharmacist's			4 weeks then every other wee		
	recommendations.				8 weeks then monthly times 3		
					months to ensure antibiotic		
	_	w, on 03/26/25 at 2:07 P.M., the			medication is available and		
		g (DON) indicated the			administered and /or appropri	ate	
	^	ed the residents' medications			action is taken if unavailable.		
	1	ved the recommendations via					
		follow through. There was			The results of these audits w	/ill	
		from the provider within a			be reviewed in Quality	_	
	week, if not soone				Assurance Meeting monthly		
	documentation to i	ndicate whether the physician			months or until an average of	of	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
		155208	B. W	ING		03/27/2	2025
		ı		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			LAGRANGE RD		
ΔDEDIΩN	N CARE HANOVER	9			/ER, IN 47243		
AI ENION	V OAKE HANOVER	·		IIANOV	LIX, IIV #1 Z#0		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
	-	ee with the recommendation			100 % compliance or greate	er	
	and the rationale.				is achieved x3 consecutive		
		rd for Resident 32 was reviewed			months. The QA Committee		
		A.M. A Quarterly MDS			will identify any trends or		
		2/05/25, indicated the resident			patterns and make		
		gnitively impaired. The			recommendations to revise		
	_	s included, but were not			plan of correction as indicate	ed.	
		Alzheimer's disease, cerebral					
		izure disorder, depression, and					
	bipolar.						
	A Dhammaay Daaam	nmendation, dated 12/20/24,					
	_	4 day stop date to the					
		n (an anxiety medication) that					
	was given as neede	· · · · · · · · · · · · · · · · · · ·					
	was given as neede	u.					
	The current physici	an's order, with a start date of					
		the resident was to be given					
		very 4 hours as needed for					
	anxiety.	•					
	The clinical record	lacked indication the physician					
	was made aware of	the recommendation.					
	_	v, on 03/26/25 at 2:35 P.M., the					
		pharmacy review from 12/20/24					
	was not reviewed o	_	1				
		rd for Resident 4 was reviewed					
		P.M. An Annual MDS					
		3/06/25, indicated the resident					
		gnitively impaired. The					
	_	s included, but were not					
		on's disease, hypertension,					
		anxiety, and psychotic					
	disorder.						
	The sheet	iorred the medidantle					
	-	iewed the resident's					
	recommendations:	ly and made the following	1				
	recommendations:						
	i e e e e e e e e e e e e e e e e e e e		1		İ		

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	PROVIDER OR SUPPLIER N CARE HANOVER	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	- A Consultant Pharmacist Recommendation to Prescriber, dated 12/20/24, indicated the resident currently received Mirtazapine (antianxiety) 15 mg every night, Sertraline (antidepressant) 50 mg every night, and Trazadone (antidepressant) 50 mg every night. A trial dose reduction was recommended.					
	There was no indication the physician or prescriber responded to the pharmacist's recommendation.					
	During an interview, on 03/27/25 at 10:25 A.M., the DON indicated she did not see anything in the resident's clinical record that addressed the pharmacy recommendation.					
	The current facility policy, titled Psychotropic Medication-Gradual Dose Reduction, revised on 02/01/18, was provided by the DON on 03/26/25 at 2:47 P.M. The policy indicated, "The pharmacist will report any irregularities to the Director of Nursing. The Director of Nursing will notify or direct licensed staff to notify attending physician as necessary"					
	3.1-25(i)					
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals					
, v	Based on observation and interview, the facility failed to store medications appropriately for 1 of 2 medication storage rooms (Wing 2 Medication Storage Room) and 3 of 4 medication carts observed (Wing 2 Medication Cart and Wing 3 Medication Carts).	F 0761	F761 Label/Store Drugs and Biologicals This Plan of Correction is the center's credible allegation of compliance.	04/10/2025		
	Findings include:		Preparation and/or execution	of		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155208	B. W	WING 03/27/2025		2025	
			_	CTREET	ADDRESS OF A TE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
ABEDIO	LOADE LIANOVEE				LAGRANGE RD		
APERIO	N CARE HANOVER	(HANOV	/ER, IN 47243		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDENCE NAME CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
		ion, on 03/21/25 at 10:16 A.M.,			this plan of correction does no	t	
	_	tion Storage Room had three			constitute admission or agreer		
	_	-tube feeding formula that			by the provider of the truth of t		
		nat were sitting on the bare			facts alleged or conclusions se		
		ned boxes sitting on the bare			forth in the statement of	,,	
	_	of Nursing (DON) indicated the			deficiencies. The plan of		
	boxes were supplies	- ' ' ' '			correction is prepared and/or		
	boxes were supplied	s.			executed solely because it is		
	During an observati	ion, on 03/21/25 at 10:19 A.M.,			required by the provisions of		
	_	on Cart contained a loose					
	_	e a drawer. Licensed Practical		federal and state law.			
		oved the pill and disposed of it		4) Immediate actions tolera			
	at that time.	oved the pin and disposed of it		1) Immediate actions taken those residents identified:		זנ	
	at that time.				those residents identified:		
	During on observati	ion and interview, on 03/21/25			No residents were affected by	thio	
	_	ing 3 Medication Cart			_	uus	
		wing loose pills inside the			alleged deficient practice. Medications for Wing 2 and Wing		
	drawers:	wing loose pins inside the			_	ing	
	drawers:				3 now properly stored.		
	- a white round nill	, LPN 10 indicated it was a			2) How the facility identified		
	Tylenol,	, El IV 10 indicated it was a			other residents:		
		10 indicated was a coenzyme,			other residents.		
	_	LPN 10 indicated was			All residents have the potentia	l to	
	risperidone, and	LI N 10 indicated was					
	_	and and mill I DN indicated			be affected by the alleged defi	cient	
	was baclofen.	a colored pill, LPN indicated			practice.		
	was vacioicii.				3) Measures put into place/		
	I DN 10 ramayad al	ll the loose pills from the cart					
	and placed them in	•			System changes:		
	and placed them in	a medication cup.			Licensed Nursing staff educate	ad	
	During on observati	ion and interview, on 03/21/25			on storage of medications poli		
	_	ing 3 Medication Cart			on storage of medications poil	Су	
		hite round pill, lots of small					
					A) Have the comment of the continue		
		opeared to powdered pill			4) How the corrective actions	•	
		e corners of the drawers, LPN			will be monitored:		
		e pill was a trazodone, the			DON/D : "" :		
	_	sible for cleaning out the			DON/Designee will inspect me	ed	
		at cart was pretty dirty. She			rooms and carts daily for 4		
	would clean it out to	hat day.			weeks then every other week	for 8	
					weeks then monthly times 3		

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	PROVIDER OR SUPPLIER	410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD /ER, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	The current, undated, facility policy titled, "Medication Storage" was provided by the Administrator on 03/27/25 at 10:02 A.M. The policy indicated, "Medications and biologicals are stored safely, securely, and properly, following the manufacturer's recommendations or those of the supplierMedication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures and humidity" 3.1-25(o)		months to ensure Medication storage policy being followed The results of these audits was be reviewed in Quality Assurance Meeting monthly months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	x6 f er
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement, Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to follow appropriate guidelines related to the use of hairnets in the kitchen for 3 of 3 kitchen observations. (Dietary Manager, Cooks 4 and 5, and the Corporate Dietary Consultant) Findings include: 1. During a tour of the kitchen, on 03/20/25 at 11:01 A.M., the Dietary Manager (DM) had three inches of hair outside of her hairnet on each side and the back of her head while she was in the food preparation area. During an observation, on 03/26/25 at 11:54 A.M., the DM had three inches of hair exposed outside the hairnet while in the food preparation area. During a kitchen observation, on 03/27/25 at 11:42 A.M., Cook 4 had six inches of hair exposed outside her hairnet on the right side of her face, Cook 5 had two inches of hair exposed outside the	F 0812	F812 Food Procurement, Store/Prepare/Serve Sanitary Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only ir response to the regulatory requirements. 1)What corrective actions habeen accomplished for those residents found to have been affected by the deficient practice? No residents were affected by alleged deficient practice Dietary staff now wearing hair	s the any / the the the the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. BUILDING <u>00</u> COMPLETE		(X3) DATE SURVEY COMPLETED 03/27/2025	
	ROVIDER OR SUPPLIER		410 \	ET ADDRESS, CITY, STATE, ZIP COD W LAGRANGE RD OVER, IN 47243	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	hairnet around her for hair exposed outs of face and on the best Corporate Dietary Cobangs and two inch hairnet on both side preparation area. During an interview the DM indicated hair. If hair cannot be two hairnets should The current "Hair Research was provided by the 03/27/25 at 3:15 P.I.	ELSC IDENTIFYING INFORMATION face, the DM had three inches side the hairnet on both sides ack of her neck, and the Consultant had three inches of es of hair exposed outside the s of her face while in the food 7, on 03/27/25 at 11:56 A.M., airnets should cover all the be contained with one hair net, be used. 9. Director of Nursing on M. The policy indicated, "Staff aints in all food production,		CROSS-REFERENCED TO THE APPROF	tify the htial to y will y will and ucated earing ons eek for h dits will / until ed for 3 AA trends
				plan of correction as indicat . The Administrator will monit completion of the Quality	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) D			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETED			LETED
		155208	B. W	NG		03/27	/2025
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	2			LAGRANGE RD		
APERIO	N CARE HANOVER	t		HANOVER, IN 47243			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
					Assurance monitoring.		
F 0880	400 00/->/4>/0>/4>	(-)(f)					
SS=D	483.80(a)(1)(2)(4)						
Bldg. 00	Infection Prevention	on & Control					
blug. 00	Raced on observation	on, interview, and record	EO	200	F880 Infection Prevention an	d	04/10/2025
		failed to follow infection	F 08	000	Control	ıu	04/10/2025
		elated to enhanced barrier					
	_	3 wound care observations.					
	(Residents 75, 4, an				This Plan of Correction is the		
	(1001001110 70, 1, 111				center's credible allegation of		
	Findings include:				compliance.		
	S						
1. The clinical record for Resident 75 was reviewed		rd for Resident 75 was reviewed			Preparation and/or execution	of	
	on 03/24/25 at 11:3	4 A.M. An Admission			this plan of correction does no		
	Minimum Data Set	(MDS) assessment, dated			constitute admission or agree		
	01/27/25, indicated	the resident was cognitively			by the provider of the truth of	the	
	intact. The resident'	s diagnoses included, but			facts alleged or conclusions s	et	
		Parkinson's disease,			forth in the statement of		
		cancer, hypertension,			deficiencies. The plan of		
		nic obstructive pulmonary			correction is prepared and/or		
	disease.				executed solely because it is		
					required by the provisions of		
		sician's order, with a start			federal and state law.		
		dicated the resident was in					
	_	ecautions (for a chronic			1) Immediate actions taken f	or	
	wound.				those residents identified:		
	During an observati	ion, on 03/26/25 at 11:22 A.M.,			Posident 75 A and 21 access	od	
	_	and a sign on it that indicated			Resident 75, 4 and 31 assess with no negative outcomes from		
		vere in enhanced barrier			alleged deficient practice.	1111	
	· ·	one must wear gloves and a			Enhanced Barrier Precautions	.	1
	1	ng wound care. Licensed			being followed per policy.	•	
	1 -	(N) 2 entered the resident's			Same remarked per perioy.		
		wound treatment care without			2) How the facility identified		1
	donning a gown.				other residents:		
	2. The clinical recor	rd for Resident 4 was reviewed			All residents have the potentia	al to	
	on 03/26/25 at 3:08	P.M. An Annual MDS			be affected by the alleged def		
	assessment, dated 0	3/06/25, indicated the resident			practice.		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208				(X3) DATE SURVEY COMPLETED 03/27/2025	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL DUE OF DEFITIEVING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
PREFIX TAG	REGULATORY OF was moderately cogresident's diagnoses limited to, Parkinso diabetes, dementia, disorder. An open-ended phy date of 12/27/24, in enhanced barrier proportion of the STOP that they was precautions. Every gown when providing the resident's room care without donning an interview 3 indicated gloves a during a wound drewas on enhanced by 3. The clinical record on 03/25/25 at 9:46 assessment, dated 1 was moderately cogresident's diagnoses limited to, dementia dementia, anxiety, disorder. An open-ended phy date of 01/29/25, in enhanced barrier protransmitting multid [MDRO] and target precautions do not a serior of the proposition of the control of the proposition of the control o	R LSC IDENTIFYING INFORMATION gnitively impaired. The sincluded, but were not on's disease, hypertension, anxiety, and psychotic risician's order, with a start dicated the resident was in ecautions for a chronic wound. Sion, on 03/26/25 at 11:46 A.M., and a sign on it that indicated were in enhanced barrier one must wear gloves and a ng wound care. LPN 2 entered and provided wound treatment ag a gown. Sy, on 03/26/25 at 3:17 P.M., LPN and a gown should be worn ssing change if the resident arrier precautions. The resident 31 was reviewed A.M. A Quarterly MDS 2/26/24, indicated the resident gnitively impaired. The sincluded, but were not a, diabetes, non-Alzheimer depression, and psychotic resician's order, with a start dicated the resident was in ecautions (to reduce the risk of rug-resistant organisms and MDRO when contact apply for residents identified		PREFIX TAG	3) Measures put into place/ System changes: Nursing staff have been reeducated on the Facilitys' -Enhanced Barrier Precuations care for residents on EBP. 4) How the corrective actions will be monitored: DON/Designee will complete sobservations of ADL care for residents who are on EBP we for 4 weeks then 5 observation every other week for 8 weeks 5 observations of ADL care including catheter care, period treatments, glucose monitoring month for 3 months to verify compliance. The results of these audits were be reviewed in Quality Assurance Meeting monthly months or until an average of 100 % compliance or greaters achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise to plan of correction as indicated.	s 5 5 cek ns then are, g a vill x6 of er	DATE DATE
	at higher risk) for a During an observat	ion, on 03/26/25 at 3:17 P.M.,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 03/27/2025
	ROVIDER OR SUPPLIER	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the resident's door had a sign on it that indicated to STOP that they were in enhanced barrier precautions. Everyone must wear gloves and a gown when providing wound care. RN 6 entered the resident's room and provided wound treatment care without donning a gown. The current facility policy titled, "Enhanced Barrier Precautions" with a revision date of 05/07/24, was provided by the Corporate Clinical Nurse Support on 03/27/25 at 2:07 P.M. The policy indicated, "To reduce the risk of transmitting multidrug-resistant organisms [MDRO] and targeted MDRO when contact precautions do not apply for residents identified at higher riskEBP are used in conjunction with standard precautions and expand to use of PPE [Personal Protective Equipment] to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothingWounds generally include chronic wounds"			
F 0925 SS=F Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program			
	Based on observation, record review, and interview, the facility failed to ensure an effective pest control was in place for residents' bathrooms and bedrooms related to gnats or drain flies. This deficient practice had the potential to affect 70 of	F 0925	F925 Maintains Effective Pes control program This Plan of Correction is the	t 04/10/2025
	70 residents that resided in the facility. Findings include:		center's credible allegation of compliance.	
	During an observation of Wing 2, on 03/21/25 through 03/25/25, the following concerns were observed on the following dates and times:		Preparation and/or execution of this plan of correction does no constitute admission or agreed by the provider of the truth of the truth of the constitute admission or agreed by the provider of the truth of the truth of the constitute and the constitute admission and the constitute and the constit	t ment

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		00	COMPLETED	
		155208	B. WING			03/27/2025	
				CTREET	ADDRESS SITY STATE ZID SOD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
ADEDIO	U OADE HANOVED				LAGRANGE RD		
APERIOI	N CARE HANOVER	t .		HANOV	/ER, IN 47243		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DATE
					facts alleged or conclusions s	et	
	- On 03/21/25 at 10	:25 A.M., the Wing 2 Shower			forth in the statement of		
		pors; a strong urine odor; the			deficiencies. The plan of		
	1	inch by eight-inch band of			correction is prepared and/or		
	black debris around				executed solely because it is		
	one-foot-long, a two				required by the provisions of		
	1	be of black/brown residue			federal and state law.		
		s in the shower stall.			Todorar arra stato ram:		
					1) Immediate actions taken f	or	
	- On 03/21/25 at 10	:33 A.M., the bathroom shared			those residents identified:		
		23 and 24, had a swarm of			those residents identified.		
	•	he room and multiple gnats on			Resident B is being take	n to	
	the walls.	ne reem une mempre grane en			an alternate area to smoke.		
	the wans.				Quotes obtained for repair of		
	- On 03/21/25 at 10	:39 A.M., the bathroom shared			concrete		
		25 and 26, had several gnats			The Shower room in wir	, , , ,	
	1 -	m. Resident D indicated they			has been deep cleaned and	iy z	
		with gnats for a while.			· -		
	nave nad a problem	with ghats for a white.			pressure washed. Quotes obtained to reno	voto	
	On 03/24/25 at 10):24 A.M., the Resident Room			the bathroom replacing walls		
		flying about in the residents'			floors.	ariu	
	bedroom.	flying about in the residents				h.,	
	bedroom.				Bathroom floor shared I	ОУ	
	0:- 02/24/25 -+ 2.1	17 D.M. 4h - h - 4h			room 23 and 24 has been		
		17 P.M., the bathroom shared by			replaced.		
		and 28, had several gnats			Bathroom shared by roo	l l	
		idents' bedroom area. Resident			27 and 28 has been deep clea		
		we had a problem with gnats in			Resident room 18 bathro	oom	
	their room and bath	room for a while.			door has been cleaned.		
	0.00/24/25	204426 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			Wing two floors have be	en	
		224 A.M., in the Resident Room			deep cleaned,		
	26, had a few gnats flying about in the residents' bedroom.						
					Pest Control called in to		
					treat gnats on unit 2. (Schedu	led	
		17 P.M., the bathroom shared			routinely)		
	by Resident Rooms 27 and 28 had several gnats flying about the residents' bedroom. Resident E				Maintenance request		
					forms audited 100 percent to		
		had a problem with gnats in			make sure all requests comple	eted.	
	their room and bath	room for a while.					
					2) How the facility identified		
- On 03/25/25 at 10:14 A.M., the bathroom shared				other residents:			

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPL	ETED
		155208	B. WING			03/27/2025	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			AGRANGE RD		
APERION CARE HANOVER					'ER, IN 47243		
, u LINOI	· OARE HAROVER			11/11/07	E. N. 11 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	
	•	27 and 28 had several gnats					
	flying about the roo	om and on the walls.			All residents have the potentia		
					be affected by the alleged defi		
		:23 A.M., the bathroom shared			practice. All residents are goin	-	
	l -	23 and 24 had several gnats			an alternate area for smoking.		
	flying about the roo	om and on the walls.			residents' rooms and common		
	0. 02/05/05 110	20.434 4 33.53			areas inspected for cleanlines		
		:30 A.M., on the walls in the			and cleaned or repaired if nee	ded.	
	1	there were several gnats					
	observed on the wa	IIS.			3) Measures put into place/		
	D	02/27/25 -4 10:11 A M			System changes:		
	1	y, on 03/27/25 at 10:11 A.M., rector indicated the facility			All Ctaff bays been advected t	hat	
		provider who came into the			All Staff have been educated t residents will be taken to alter		
		veeks. The pest control			smoking area until repairs are		
	1	rmally go into the residents'	made. Outdoor patio will be				
	bedrooms or bathro		closed for use until repairs are				
	bedrooms of batillo	onis.			completed. All housekeepers	·	
	During an interview	y, on 03/27/25 at 10:12 A.M.,			educated on use of checklist,		
	_	Supervisor indicated they had			deep cleans and shower room		
		lists for each unit. Staff were to			cleaning. Maintenance educat		
	_	er they were completed. They			on inspection sheet and policy		
		check off list for deep			Housekeeping to keep binder		
		clean they pulled everything			checklists in office. Maintenar		
		room, cleaned the walls, the			to keep rounding sheets in a		
		bedding, pulled out the beds,			binder in office according to po	olicy.	
		ne, window blinds, the trim,			3	,	
		Rooms were deep cleaned			4) How the corrective actions	6	
	every couple of wee	eks and as needed. Some were			will be monitored:		
		ne kept the deep clean check					
	off lists. She kept th	ne daily check-off lists for			Admin/Designee will complete		
	about 2 weeks. Blas	nk checklists were provided by			daily audit of check off sheets	and	
	the Housekeeping Supervisor. She indicated she had just thrown them away and did not have any				maintenance inspection sheet	s for	
					4 weeks then every other wee	k for	
	_	ts for any of the units. None of			8 weeks then monthly times 3		
	the checklists include	ded cleaning the walls of the			months to ensure all sheets ar	nd	
	shower rooms.				inspections are being done.		
		sit records for the last 3			The results of these audits w	rill	
months were provided by the Maintenance				be reviewed in Quality			

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STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155208	B. WING 03/27/2025				
				STREET A	ADDRESS, CITY, STATE, ZIP COD	1	_
NAME OF P	ROVIDER OR SUPPLIER	2			_AGRANGE RD		
APERION	N CARE HANOVER	t			ER, IN 47243		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	DATE	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		
		5 at 11:50 A.M. Only one			Assurance Meeting monthly		
		/25, included a service			months or until an average of		
	documented as "On	e Shot".			100 % compliance or greate	er	
		02/25/25 2.40 P.15			is achieved x3 consecutive		
	-	y on 03/27/25 at 2:48 P.M.,			months. The QA Committee		
		building inspections for the			will identify any trends or		
		of the building, the tor indicated he walked			patterns and make recommendations to revise t	uh a	
		g everyday but did not			plan of correction as indicate		
	document his obser				pian or correction as indicate	eu.	
	document ms ouser	vanons.					
	During an interview	on 03/27/25 at 2:50 P.M., the					
	-	ol company indicated "One					
		rnal code for just a one-time					
		sed a product in the drains					
		less hospitable for gnats and					
	drain flies. They can	me out twice a month for					
	routine services. Th	ey applied a general					
	application for pests	s in the common areas and in					
	the kitchen for pree	mptive maintenance and did					
		ts' bathrooms or bedrooms.					
		y had put in the drains, they					
		a time frame as to when the					
	-	ate itself because of other					
	factors.						
	2.5 1						
	•	ration on 03/27/25 at 11:11 vas outside in the courtyard in					
	· ·	•					
		a group of residents that were While propelling himself, he					
		ne wheelchair still attached to					
	his back because he						
	positioning and landed face down with his forehead touching the sidewalk. Another resident turned the resident to his side as no staff were						
	within five feet of the						
	During an interview	on 03/27/25 at 1:26 P.M., CNA					
	-	d put in a work order for the					
	concrete chipping. No one was with the resident						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED B. WING 03/27/2025			ETED				
NAME OF PROVIDER OR SUPPLIER APERION CARE HANOVER			410 W I	STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243					
(X4) ID PREFIX TAG	(EACH DEFICIENCE REGULATORY OR When he fell. They he about two weeks ag getting worse, and a resident had a scrap bump on the back of the Progress Notes by the DON on 03/2 dated 03/27/25 at 11 resident had an unw smoking area. The rover as he was prop	ESTATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION and put the work order in to because they noticed it was all the rain had not helped. The te on his forehead and a little of his head from today's fall. for Resident B were provided to 17/25 at 3:14 P.M. A note, to 00 A.M., indicated the itnessed fall in the courtyard the esident's wheelchair tipped telling it on the concrete. The	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	Ε	(X5) COMPLETION DATE			
	smoke and the chair concrete." The resid forehead and a smal The "MAINTENAN provided by the Adr P.M., and included, following: - A request, from Clindicating the sidew	indicated, "I was coming to tipped over because of the lent received a scrape to the I bump on the top of his head. INCE REQUEST" forms were ministrator on 03/27/25 at 1:50 but was not limited to, the NA 9, dated 03/12/25, alk had a "big chunk" out of							
	something could be The current undated Policy" was provide Nurse Consultant or policy indicated, " facility, equipment, rooms are maintaine provide a comfortab prevent the developinfectionmaintain	"Housekeeping Service and by the Corporate Clinical in 03/27/25 at 1:45 P.M. The PurposeTo ensure that the furnishings [sic] and resident and in a sanitary manner; to all environment, and to ment and transmission of a clean, odor free,orderly in meettheresidents right for							

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

PRINTED: 04/22/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		00	(X3) DATE SURVEY COMPLETED 03/27/2025	
		ADDRESS, CITY, STATE, ZIP COD	03/27/2025	
	410 W	LAGRANGE RD		
		/ER, IN 4/243		
SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
ndated "Preventative Maintenance as" policy was provided by the 7/25 at 2:40 P.M. The policy inspection checklists are developed the buildingExterior inspection will and documented weeklyInterior all be conducted and documented lition of flooringCement resident room will be inspected and nonthly" Falls" policy, with a reviewed date of provided by the DON on 03/27/25 at a policy indicated, "Licensed nurse at assessment immediately, ats leading up to the fall to the possible and causative factors"				
visit included a Recertification and re Survey and the Investigation of the Complaints IN00455300, and IN00455916. 200455300 - Federal/State deficiencies callegations are cited at F584 and 200455842 - No deficiencies related to so are cited.	R 0000	this plan of correction does no constitute admission or agreed by the provider of the truth of t	t ment the	
	IDENTIFICATION NUMBER 155208 PPLIER OVER MARY STATEMENT OF DEFICIENCIE FICIENCY MUST BE PRECEDED BY FULL	IDENTIFICATION NUMBER 155208 STREET 410 W HANON MARY STATEMENT OF DEFICIENCIE FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION Indated "Preventative Maintenance ns" policy was provided by the 7/25 at 2:40 P.M. The policy Inspection checklists are developed The buildingExterior inspection will and documented weeklyInterior Il be conducted and documented dition of flooringCement resident room will be inspected and monthly" Falls" policy, with a reviewed date of s provided by the DON on 03/27/25 at e policy indicated, "Licensed nurse et assessment immediately, ints leading up to the fall to en possible and causative factors" relates to Complaints IN00455300 P16. R 0000 R 0000 R 0000 R 0000 R 000455842 - No deficiencies related to s are cited.	DENTIFICATION NUMBER 155208 B. WING STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243 MARY STATEMENT OF DEFICIENCIE FICIENCY MUST BE PRECEDED BY FULL RRY OR LSC IDENTIFYING INFORMATION and lated "Preventative Maintenance ns" policy was provided by the 7/25 at 2:40 P.M. The policy Inspection checklists are developed he buildingExterior inspection will and documented weeklyInterior il be conducted and documented dition of flooringCement resident room will be inspected and nonthly" Falls" policy, with a reviewed date of sprovided by the DON on 03/27/25 at e e policy indicated, "Licensed nurse et assessment immediately, nts leading up to the fall to en possible and causative factors" relates to Complaints IN00455300 pl16. R 0000 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution: this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions st forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>00</u>			COMPLETED	
		155208	B. WING			03/27/2025	
NAME OF PROVIDER OR SUPPLIER APERION CARE HANOVER			STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID				(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION			COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
	related to the allegations are cited at F584 and F925. Survey dates: March 20, 21, 24, 25, 26, and 27, 2025				federal and state law		
	Facility number: 00	0115					
	Residential Census: 4						
	These State Residential Findings are cited in accordance with 410 IAC 16.2-5.						
	Quality review completed on April 1, 2025.						
R 0214 Blda. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency						
Bldg. 00	Based on record review and interview, the facility failed to ensure residents' Service Plans were reviewed in a timely manner for 2 of 7 residents reviewed for Evaluation of Needs. (Residents 2 and 9)		R 02	214	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of	of.	04/10/2025
	Findings include: 1. The clinical record for Resident 2 was reviewed on 03/27/25 at 10:00 A.M. The resident's diagnoses included, but were not limited to, heart failure and hypertension. The resident's Service Plan in the Electronic Health Record (EHR) was initiated on 04/16/21 and most recently reviewed on 03/21/24, after the resident experienced a fall. 2. The clinical record for Resident 9 was reviewed on 03/27/25 at 10:15 A.M. The resident's diagnoses included, but were not limited to, diabetes and schizophrenia. The resident received a Medicaid Waiver. The resident's Service Plan in the EHR was initiated on 03/04/24. The next				this plan of correction does no constitute admission or agreer by the provider of the truth of t	t nent	
					facts alleged or conclusions see forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.		
					Immediate actions taken for those residents identified: Resident 2 and 9 have update service plans		

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

PRINTED: 04/22/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/27/2025		
NAME OF PROVIDER OR SUPPLIER APERION CARE HANOVER			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		I	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
		ate was 06/04/24. There was no ce Plan had been reviewed.			2) How the facility identified other residents:		
	the Director of Nurresponsibility of the	w, on 03/27/25 at 10:40 A.M., sing (DON) indicated it was the e nurse that provided care for DON to update the residents'			All residents have the potential be affected by the alleged definence.		
	Service Plans according to the facility policy. The current, undated facility policy titled				3) Measures put into place/ System changes:		
	"Evaluation of Resiby the DON on 03/2 indicated, "An evneeds will be compevery six (6) month	ident's Needs" was provided 27/25 at 10:38 A.M. The policy aluation of the Resident's leted at admission and at least as thereafterA service plan will l on the evaluation and will be			Licensed nursing staff educate on completion of service plans required 4) How the corrective actions will be monitored:	s as	
	updated as needed;	num of every six (6) months and Medicaid Waiver residents lan updated at least every three			DONDesignee will check 2 set plans weekly for 4 weeks ther every other week for 8 weeks monthly times 3 months to ensight service plans are updated as required	n then	
					The results of these audits we be reviewed in Quality Assurance Meeting monthly months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	x6 f er	
					5) Date of compliance: 04//10/2025		

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