STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING _____ B. WING _____	R-C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE HANOVER	410 W LAGRANGE RD HANOVER, IN 47243

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the investigation of Nursing Home complaints IN00455300 and IN00455916 completed on March 27, 2025. This visit included a PSR to the State Residential Licensure Survey completed on March 27, 2025. This visit was in conjunction with the investigation of Nursing Home Complaints IN00457113, IN00457358, and Residential Complaint IN00458545. Complaint IN00455300 - Corrected Complaint IN00455916 - Corrected Complaint IN00457113 - No deficiencies related to the allegations are cited. Complaint IN00457358 - No deficiencies related to the allegations are cited. Complaint IN00458545 - No deficiencies related to the allegations are cited. Survey dates: April 30 and May 1, 2025 Facility number: 000115 Provider number: 155208 AIM number: 100291080 Census Bed Type: SNF/NF: 70 Residential: 4 Total: 74 Census Payor Type: Medicare: 3 Medicaid: 60 Other: 7	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING _____ B. WING _____	R-C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE HANOVER	410 W LAGRANGE RD HANOVER, IN 47243

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Total: 70 Aperion Care Hanover was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Recertification and State Licensure Survey and the Investigations of Nursing Home Complaints IN00455300 and IN00455916. Quality review completed on May 2, 2025.	{F 000}		