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	04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/16/25 Facility Number: 000115 Provider Number: 155208 AIM Number: 100291080 At this Emergency Preparedness survey, Aperion Care Hanover was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 125 certified beds. At the time of the survey, the census was 71. Quality Review completed on 04/23/25	E 0000	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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.*	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update Annually Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director (MD) on 04/16/25 at 12:15 p.m., the EPP lacked a cover page, and no date could be found to show the EPP was reviewed and updated within the last year. Based on an	E 0004	**1) Immediate actions taken for those residents identified:** No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. -Cover page has been added to EPP and date of review added and will be updated	05/05/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jay Nowlin	Administrator	05/05/2025

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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	interview during records review, the MD agreed no documentation was provided indicating the EPP was updated within the last year. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present.		annually to ensure ongoing compliance **3) Measures put into place/ System changes:** All Staff have been educated of location of EP plan. EP plan updated and reviewed. Cover page has been added to EPP and date of review added and will be updated annually to ensure ongoing compliance **4) How the corrective actions will be monitored:** Admin/Designee will complete daily audit of EP plans for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure EP plans have required information and are updated and reviewed **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 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.**	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.1 Development of EP Policies and Procedures			

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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director (MD) on 04/16/25 at 12:15 p.m., the EPP lacked a cover page, and no date could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the MD agreed no documentation was provided indicating the EPP Policies and Procedure's was updated within the last year. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present.	E 0013	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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:** No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. All EP plans have a cover page, and plans reviewed and updated **3) Measures put into place/ System changes:** All Staff have been educated of location of EP plan. EP plan updated, reviewed and cover page in place **4) How the corrective actions will be monitored:** Admin/Designee will complete daily audit of EP plans for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure EP plans have required	05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.1 Development of Communication Plan Based on record review and interview, the failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director (MD) on 04/16/25 at 12:15 p.m., the EPP lacked a cover page, and no date could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the MD agreed no documentation was provided indicating the EPP Communication Plan was updated within the last year. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present.	E 0029	information and are updated and reviewed *Preparation and/or execution of this plan of correction does not constitute admission or agreement 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:** No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. All EP plans have a cover page, and plans reviewed, including EPP communication plan, and updated **3) Measures put into place/ System changes:** All Staff have been educated of location of EP plan. EP plan updated, including EPP communication plan, reviewed and	05/05/2025

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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			cover page in place **4) How the corrective actions will be monitored:** Admin/Designee will complete daily audit of EP plans for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure EP plans have required information and are updated and reviewed	
E 0030 SS=F Bldg. --	403.748(c)(1), 416.54(c)(1), 418.113(c)(Names and Contact Information Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the current staff. This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director (MD) on 04/16/25 at 12:18 p.m., the facility's communication plan was not current. The communication plan did not include an updated list of names and contact information for current staff. The MD stated that most of the contact info was from the old ownership (13 months ago) and he did not recognize the names listed for facility personnel. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present.	E 0030	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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:** No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. All EP plans have a cover page, and plans reviewed	05/05/2025

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			and updated with current contact names **3) Measures put into place/ System changes:** All Staff have been educated of location of EP plan. EP plan updated, reviewed and cover page in place, and all contact names are current. **4) How the corrective actions will be monitored:** Admin/Designee will complete daily audit of EP plans for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure EP plans have required information and are updated and reviewed	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing Based on record review and interview, the facility failed review and update the Emergency Preparedness Plan's (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director (MD) on 04/16/25 at 12:15 p.m., the EPP lacked a cover page, and no date could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the MD agreed	E 0036	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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:**	05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	no documentation was provided indicating the EPP Training and Testing Plan was updated within the last year. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present.		No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** All Staff have been educated of location of EP plan. EP plan updated, reviewed and cover page in place, and all contact names are current, Training and testing plan in place. **4) How the corrective actions will be monitored:** Admin/Designee will complete daily audit of EP plans for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure EP plans have required information and are updated and reviewed	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected	E 0037	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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*	05/05/2025

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	155208	A. BUILDING -- B. WING	04/16/2025

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	roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on records review and interview with the Maintenance Director (MD) on 04/16/25 at 12:19 p.m., there was no documentation for EPP training. Based on an interview at the time of records review, the MD stated the facility uses a computer program for staff training but no documentation or evidence of staff training was provided during the survey. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present.		*executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** All Staff have been educated of location of EP plan. EP plan updated, reviewed and cover page in place, and all contact names are current, Training and testing plan in place. **4) How the corrective actions will be monitored:** Admin/Designee will complete daily audit of EP plans for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure EP plans have required information and are updated and reviewed	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility	E 0039	*Preparation and/or execution of*	05/05/2025

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	failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director (MD) on 04/16/25 at 12:20		*this plan of correction does not constitute admission or agreement 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:** No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** All Staff have been educated of location of EP plan. EP plan updated, reviewed and cover page in place, and all contact names are current, Training and testing plan in place. A full scale community based exercise is scheduled with the local fire department, which will be our second. **4) How the corrective actions will be monitored:** Admin/Designee will complete	

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	p.m., the facility was able to provide documentation of a tabletop exercise of choice. However, the facility was unable to provide documentation of a full-scale exercise or any documentation of actual events to test the emergency preparedness plan. Based on interview at the time of record review, the MD agreed that a full-scale exercise or documentation of any actual events was not conducted or available for review. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present.		daily audit of EP plans for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure EP plans have required information and are updated and reviewed **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 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.**	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director (MD) on 04/16/25 at 11:23 a.m., no documentation was available for review to show the available percentage of load placed upon the generator during monthly load tests. Based on an interview at the time of record review, the Maintenance Director stated he was unaware that he needed to record and keep a record of the	E 0041	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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:** No Residents were identified in the deficiency **2) How the facility identified**	05/05/2025

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	percentage of load placed upon the generator during the monthly load tests. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present.		**other residents:** All residents have the potential to be affected by the alleged deficient practice. Maintenance director educated on load percentage test. Test is now scheduled monthly with documentation of percentage of load placed upon generator during load tests. **3) Measures put into place/ System changes:** Maintenance director educated on load percentage test. Test is now scheduled monthly with documentation of percentage of load placed upon generator during load tests. **4) How the corrective actions will be monitored:** Admin/Designee will complete daily audit of Monthly load test sheet for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure load tests ate being done and recorded **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or**	

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/16/25 Facility Number: 000115 Provider Number: 155208 AIM Number: 100291080 At this Life Safety Code survey, Aperion Care Hanover was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA)101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 125 and had a census of 71 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has a detached wooden storage garage and a detached	K 0000	**patterns and make recommendations to revise the plan of correction as indicated.** *Preparation and/or execution of this plan of correction does not constitute admission or agreement 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.*	

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	wooden building housing the emergency generator which were not sprinkled. Quality Review completed on 04/23/25			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure 1 of over 5 exit discharge paths that lead from the facility to the public way was readily accessible at all times. This deficient practice could affect 20 residents in the facility. Findings include: Based on observation and interview with the Maintenance Director (MD) on 04/16/25 at 1:05 p.m. the exit discharge path from (1) wing three exit door and (2) the exit door from the dining room marked facility exits, each led to the parking area which had cars parked and obstructing access to the public way. The MD stated that this would be corrected by restricting the ability to park at the end of the sidewalk. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)	K 0211	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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:** No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Maintenance director placed a no parking sign in the spot, and painted the parking spot as no parking allowed **4) How the corrective actions**	05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			will be monitored: Admin/Designee will complete daily audit of all entrances with parking spaces for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure all parking spaces are clear in front of sidewalks **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 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.**	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors 1. Based on observation and interview, the facility failed to ensure the means of egress through the facility exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect all staff, visitors and residents. Findings include:	K 0222	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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:**	05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	04/16/2025

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

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	Based on observations and interview on 04/16/25 during a tour of the facility with the Maintenance Director, the following was noted: a. at 12:35 p.m. The exit door to the front of the building was not posted with the code to actuate the door release. b. at 12:57 p.m. the exit door near RR#65 was not posted with the code to actuate the door release. c. at 1:02 p.m. the exit door near RR#51 was not posted with the code to actuate the door release. d. at 1:03 p.m. the exit door, marked a facility exit, leading out of the skilled nursing side into the Assisted Living side was not posted with the code to actuate the door release. e. at 1:05 p.m. the actual exit door to the outside, following the path into and through the assisted living area was not posted with the code to actuate the door release. f. at 1:42 p.m. the service hall exit door was not posted with the code to actuate the door release. g. at 2:20 p.m. all exit doors from the Huntington's Unit were not posted with the code to actuate the door releases. No documentation of a clinical diagnosis was provided for the Huntington's Unit residents. Based on interview at the time of each observation, the Maintenance Director acknowledged the codes were not posted at the previously mentioned exit doors. 2. Based on observation and interview, the facility failed to ensure all exterior exit doors were readily accessible and able to open on first try. This deficient practice could affect all occupants in the facility. Findings include: Based on observations and interview on 04/16/25 during a tour of the facility with the Maintenance		No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Maintenance director posted a hint for the code for all egress doors above the keypad, quotes being obtained to make doors Controlled Egress locking doors. Waiver has been requested until work can be done to make doors with 15 second egress Exit door near room 65 was adjusted to be opened easily on first try. Exit door on wing 3 was adjusted to be opened easily on the first try. The exit door in the main dining room was adjusted so that it could be opened easily on the first try. **4) How the corrective actions will be monitored:** Admin/Designee will complete daily audit of all egress doors for codes, and that all exit doors open easily on the first try to be posted for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure all required doors have codes posted, and all exit doors open easily on the first try	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	04/16/2025

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

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	Director, the following was noted: a) at 12:47 p.m. the exit door near RR#65 would not open easily on the first try when tested. The Surveyor, then the Maintenance Director tried to open the door, and the Maintenance Director was able, after considerable effort to open the exit door. b) at 1:22 p.m. wing three exit door would not open easily on the first try when tested. The Surveyor, then the Maintenance Director tried to open the door, and the Maintenance Director was able, after considerable effort to open the exit door. c) at 12:50 p.m. the exit door from the main dining area, marked as a facility exit would not open easily on the first try when tested. The Surveyor, then the Maintenance Director tried to open the door, and the Maintenance Director was able, after considerable effort to open the exit door. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		**The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 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.**	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure 1 of 3 courtyard doors to the outside of the facility was not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word	K 0293	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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.*	05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	04/16/2025

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

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	NO, unless such sign is an approved existing sign. This deficient practice could affect 12 residents. Findings include: Based on observation and interview with the Maintenance Director (MD) on 04/16/25 at 1:45 p.m. the sliding glass door on wing two, to the outside courtyard was not an exit door and the door was not posted with a "NO EXIT" sign. Based on interview at the time of the observations, the MD stated the courtyard is not an exit to the public way and acknowledged the courtyard door did not have a "NO EXIT" sign posted. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		**1) Immediate actions taken for those residents identified:** No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** No exit sign put on the sliding glass door to the courtyard. All other doors to courtyard audited for no exit signs, all doors to courtyard have no exit signs on them. **4) How the corrective actions will be monitored:** Admin/Designee will complete daily audit of all courtyard doors for no exit signs for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure all doors to the courtyard have no exit signs on them **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	04/16/2025

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

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			will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of all battery operated smoke alarms in resident rooms and through the facility was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on records review and interview with the Maintenance Director on 04/16/25 at 12:06 p.m., a complete itemized list for preventative maintenance of resident room battery operated smoke alarms was not available for review. Based on interview at the time of review, the Maintenance Director stated no documentation was available to reflect the age of the batteries, when the appliances are tested or cleaned and that he was unsure what the manufacturer recommendation was regarding testing and	K 0300	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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:** No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** All resident room smoke detectors have been inspected, cleaned, new batteries put in them and will be audited according to policy **4) How the corrective actions**	05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	04/16/2025

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

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	cleaning frequency. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		**will be monitored:** Admin/Designee will complete daily audit for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure all audits are completed **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 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**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure that 2 of over 20 hazardous area doors, such as a storage room door, was provided with a self-closing device. This deficient practice could affect up to 10 residents and staff. Findings include: 1. Based on observation and interview with the Maintenance Director (MD) on 04/16/25 at 1:05 p.m. the kitchen storage room attached to the small dining room, over 50 square feet in size, contained at least 20 medium and large cardboard boxes. The corridor door to this room was not provided with a self-closing device. This was confirmed by the Maintenance Director at the time of observation.	K 0321	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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:** No Residents were identified in the deficiency	05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	04/16/2025

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

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	2. Based on observation and interview with the Maintenance Director (MD) on 04/16/25 at 1:36 p.m. 1 of 2 doors separating the dining area from the kitchen serving area, equipped with a self-closing device, failed to self-close and latch positively into the door frame. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		**2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Kitchen storage room door had a self-closer installed. Both doors separating the dining area from the kitchen serving area have been adjusted to close and latch. All boxes have been removed from the floor. All storage areas inspected and no boxes on the floor **4) How the corrective actions will be monitored:** Admin/Designee will complete daily audit of 5 self closing doors in hazardous areas 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure all doors close and latch as required and not storage areas have boxes on the floor **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 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**	

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	155208	A. BUILDING 01 B. WING	04/16/2025

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

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			plan of correction as indicated.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2 states that cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice affected 6 staff, and no residents. Findings include: Based on observation and interview with the Maintenance Director (MD) on 04/16/25 at 1:38 p.m. the electric wheeled two (6) burner flat grill which was located on the cooking line under the	K 0324	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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:** No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Lines have been painted on the floor for the stove to be placed and kept while in use. **4) How the corrective actions will be monitored:** Admin/Designee will complete daily audit of stove location to	05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	04/16/2025

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

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	hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview with the MD the facility was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		ensure it is in painted lines for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure stove is in designated location **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 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.**	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants.	K 0345	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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:** No Residents were identified in the deficiency **2) How the facility identified other residents:**	05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on records review and interview with the Maintenance Director on 04/16/25 at 11:43 a.m., no documentation could be provided regarding a visual semi-annual fire alarm system inspection. During the survey the maintenance Director telephoned the vendor who stated that they did not conduct a semi-annual visual inspection of the fire alarm system. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Semi annual fire alarm system inspection scheduled, contract signed with vendor to continue inspections at required times. **4) How the corrective actions will be monitored:** Admin/Designee will complete daily audit of Fire alarm system inspection for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure all fire alarm inspections have been done as scheduled **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 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.**	
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility did not provide adequate signage for 1 of 1 fire	K 0351	*Preparation and/or execution of this plan of correction does not*	05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	04/16/2025

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

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	department connection (FDC). NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, 13.7 Fire Department Connections. 13.7.1 Fire department connections shall be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all residents. Findings include: Based on observation and interview with the Maintenance Director (MD) on 04/16/25 at 12:40 p.m. the FDC located near the front parking lot was not provide with a FDC identification sign that was legible. The signage provided was faded to the point that the letters were not discernable. The MD agreed that the signage was faded to all white and no letters on the sign could be understood. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		*constitute admission or agreement 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:** No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Faded FDC sign replaced with a new one. **4) How the corrective actions will be monitored:** Admin/Designee will complete daily audit of Fire alarm system inspection for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure sign in place an clearly visible, not faded **The results of these audits will be reviewed in Quality**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	04/16/2025

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

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			Assurance Meeting monthly x6 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.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect 40 residents in two smoke compartments. Findings include: Based on records review and interview with the Maintenance Director on 04/16/25 at 2:25 p.m., the attic above the electrical closet on wing four contained wire and conduit draped across the sprinkler head. Additionally, the sprinkler pipe near the attic entrance, at this aforementioned location, had a grounding collar and wire attached to the sparkler pipe. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and	K 0353	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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:** No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** All sprinkler pipes Inspected and no conduit of wires are draped on	05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Executive Director present. 2. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director on 04/16/25 at 11:20 a.m., there was no weekly inspection of the dry pipe sprinkler system's gauges and valves for the weeks prior to July 2024. During an interview at the time of record review, the Maintenance Director stated the inspection of gauges and valves before July 2024 were not completed by the previous Maintenance director. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		them. The grounded wire was removed from the pipe on wing 4 and no other wires were found to be grounded during the inspection of all pipes. Weekly inspection of dry pipe sprinkler systems gauges and valves has been completed every week since July 2024 and will continue to be completed. **4) How the corrective actions will be monitored:** Admin/Designee will complete weekly audit of 1 wings sprinkler pipes , and weekly inspection sheet of dry pipe gauges and valves. For 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure all sheets and inspections are being done. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 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.**	

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	155208	A. BUILDING 01 B. WING	04/16/2025

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K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure all kitchen corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 8 residents and staff. Findings include: Based on observation and interview with the Maintenance Director (MD) on 04/16/25 at 1:36 p.m. the kitchen door into the serving area was propped open with a door stop. Based on interview at the time of observation, the MD acknowledged the door stop was present and used to hold open the self-closing door. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)	K 0363	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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:** No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** All fire doors audited to ensure no door stops in place. The door stop has been removed from the kitchen door **4) How the corrective actions will be monitored:** Admin/Designee will complete daily audit of fire doors for door stops for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure no door	05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			stops are being used. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 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.**	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review and interview with the Maintenance Director on 04/16/25 at 11:30 a.m., 9 of 12 quarterly fire drills were conducted near the end of the month, around the 30th day of the month. These conditions do not allow fire drills to be conducted on unexpected and unpredictable days. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b) 3.1-51(c)	K 0712	*agreement 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:** No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Fire drills are scheduled at more	05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	04/16/2025

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			random times throughout to month **4) How the corrective actions will be monitored:** Admin/Designee will complete daily audit of schedule of fire drlls for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure fire drills are at unexpected and random times of the month. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 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.**	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview the facility failed to ensure 1 of 2 smoking areas was provided with metal or noncombustible containers with self-closing cover. This deficient practice could affect 10 people in the smoking area. Findings include: Based on observation and interview with the Maintenance Director (MD) on 04/16/25 at 1:05 p.m. in the smoking area there was a noncombustible container to dispose cigarette butts. However, cigarette butts were observed	K 0741	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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**	05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	04/16/2025

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	loose in temporary receptacles which were not emptied once not in use. The MD stated that the temporary uncovered receptacles would need to be emptied into the red noncombustible receptacle after each use. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		**those residents identified:** No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** All temporary uncovered receptacles have been removed and replaced with proper receptacles for used cigarette butts **4) How the corrective actions will be monitored:** Admin/Designee will complete daily audit of smoking area receptacles for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure no uncovered temporary receptacles are being used and only proper covered receptacles are being used. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 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**	

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	155208	A. BUILDING 01 B. WING	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			recommendations to revise the plan of correction as indicated.	
K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of	K 0761	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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:** No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Annual fire door inspection has been completed and will continue to be completed as scheduled. **4) How the corrective actions will be monitored:**	05/05/2025

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	155208	A. BUILDING 01 B. WING	04/16/2025

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

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	damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on records review and interview with the Maintenance Director on 04/16/25 at 11:55 a.m., no documentation of an annual inspection for the fire door assemblies was available for review. Based on observation during the tour which began around 12:35 p.m., there were fire doors observed where the Skilled Nursing Wing meets the Assisted Living Area and at the Oxygen Transfilling/Storage Room. Based on interview at the time of records review, the Maintenance Director stated an annual fire door inspection was not completed within the last year. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present.		Admin/Designee will complete weekly audit of Fire door inspection for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure Inspection has been completed. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 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.**	

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	155208	A. BUILDING 01 B. WING	04/16/2025

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

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K 0918 SS=F Bldg. 01	3.1-19(b) NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to exercise the generator for 12 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, Chapter 8. NFPA 110 Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.	K 0918	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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:** No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Monthly load test has been completed for current month. Monthly load tests are scheduled and will be documented every month to include percentage of load placed upon the generator during testing moving forward **4) How the corrective actions will be monitored:**	05/05/2025

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	155208	A. BUILDING 01 B. WING	04/16/2025

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

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	Findings include: Based on records review and interview with the Maintenance Director on 04/16/25 at 11:23 a.m., no documentation was available for review to show the available percentage of load placed upon the generator during monthly load tests. Based on an interview at the time of record review, the Maintenance Director stated he was unaware that he needed to record and keep a record of the percentage of load placed upon the generator during the monthly load tests. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		Admin/Designee will complete weekly audit of generator load test for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure generator load test are being completed **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 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.**	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens 1. Based on observation and interview, the facility failed to ensure 2 of 2 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 3 residents in therapy and 2 staff in the MDS office. Findings include: Based on observation and interview with the Maintenance Director (MD) on 04/16/25 at 12:42 p.m. (a) in the Therapy Office area, a dorm style refrigerator (high amp draw appliance) was powered by a power strip. (b) at 12:45 p.m. in the	K 0920	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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:** No Residents were identified in the deficiency	05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	04/16/2025

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

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	MDS office, a dorm style refrigerator (high amp draw appliance) was powered by a power strip. The MD stated the mini refrigerators would need to be plugged directly into the wall. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present. 2. Based on observation and interview, the facility failed to ensure power strips in resident rooms were of UL rating of 1363A or 60601-1. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice affects 4 residents and staff. Findings include: Based on observation and interview with the Maintenance Director (MD) on 04/16/25 during the facility tour, power strips lacking a UL rating of 1363A or 60601-1 label were observed in the following locations; a) at 1:06 p.m. Resident Room # 51 b) at 1:12 p.m. Resident Room # 39 c) at 1:15 p.m. Resident Room # 36 This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		**2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** All refrigerators are plugged into wall outlet. Power strips in resident rooms 51, 39 and 36 have been changed to approved hospital grade surge protectors. An audit of all rooms was done and all surge protecters have been replaced with hospital grade surge protectors. **4) How the corrective actions will be monitored:** Admin/Designee will complete weekly audit of 5 resident rooms for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure all refrigerators are plugged into the wall and approved surge protectors are being used. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 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**	

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	155208	A. BUILDING 01 B. WING	04/16/2025

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

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			plan of correction as indicated.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents. Findings include: Based on records review, interview and facility	K 0921	*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 agreement 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:** No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** All PCREE items tested, if it failed it was replaced, all equipment tested logged. Any new equipment will be tested. **4) How the corrective actions**	05/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	04/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	tour with the Maintenance Director (MD) on 04/16/25, at 11:10 a.m. and throughout the afternoon tour, no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour revealed that the facility provided electric beds for all residents. The MD stated that PCREE such as nebulizers, oxygen concentrators, vital signs monitors, and other electrical medical equipment was present and in use at the facility. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		**will be monitored:** Admin/Designee will complete weekly audit of 5 resident rooms for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure all PCREE items have been tested and logged. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 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.**	
K 9999 Bldg. 01	3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(a) The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. 3.1-19(ff)(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012. This State Rule has not been met as evidenced by: Based on observation and interview, the facility	K 9999	*Preparation and/or execution of this plan of correction does not constitute admission or agreement 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:**	05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	04/16/2025

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	failed to provide a smoke detectors in 1 of over 30 resident sleeping rooms. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of Room 65. Findings include: Based on observation and interview with the Maintenance Director (MD) on 04/16/25 at 1:45 p.m. all resident sleeping rooms in the facility were equipped with a smoke detector except resident sleeping Room 65. A ceiling mounted ring to affix a smoke detector was noted in the room but no smoke detector was mounted in the mounting ring. Based on interview at the time of the observations, the MD agreed resident sleeping Room 65 was not currently provided with a smoke detector and contacted an assistant to have it installed. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b) 3.1-19(ff)(3)		No Residents were identified in the deficiency **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Smoke detector placed in room 65. Audit done of all resident rooms, all rooms have a operating smoke detector. **4) How the corrective actions will be monitored:** Admin/Designee will complete weekly audit of 5 resident rooms for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure all resident rooms have operating smoke detectors **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 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.**	