STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155208	B. WING		04/16/2025
	PROVIDER OR SUPPLIER		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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
E 0000					
Bldg	conducted by the Ir accordance with 42 Survey Date: 04/10 Facility Number: 0 Provider Number: 100 At this Emergency Care Hanover was Emergency Prepare Medicare and Mediand Suppliers, 42 C The facility has 125	5/25 00115 155208 291080 Preparedness survey, Aperion found not in compliance with edness Requirements for caid Participating Providers FR 483.73.	E 0000	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.	ot ment the
E 0004 SS=F Bldg	the survey, the census was 71. Quality Review completed on 04/23/25 E 0004 SS=F 403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update		E 0004	1) Immediate actions taken f those residents identified: No Residents were identified in the deficiency 2) How the facility identified other residents: All residents have the potentiabe affected by the alleged defipracticeCover page has been added to EPP and date of revadded and will be updated	ied al to icient en

 Jay Nowlin
 Administrator
 05/05/2025

 Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are 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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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/16/2025
	PROVIDER OR SUPPLIE		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
	no documentation v EPP was updated v	cords review, the MD agreed was provided indicating the within the last year. This finding		annually to ensure ongoing compliance	
	at the time of disco	by the Maintenance Director very and again at the exit e MD and Executive Director		3) Measures put into place/ System changes: All Staff have been educated	of
	present.			location of EP plan. EP plan updated and reviewed. Cover has been added to EPP and of review added and will be updated annually to ensure ongoing compliance	page
				4) How the corrective action will be monitored: Admin/Designee will complete daily audit of EP plans for 4 w then every other week for 8 w then monthly times 3 months ensure EP plans have require information and are updated a reviewed	e eeks eeks to d
				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 plan of correction as indicated.	x6 of er the
E 0013 SS=F Bldg	` '	4(b), 418.113(b), 441.1 P Policies and Procedures			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	ľ	JILDING	nstruction 	COMP	E SURVEY PLETED 6/2025
	PROVIDER OR SUPPLIEF			410 W I	ADDRESS, CITY, STATE, ZIP COD _AGRANGE RD /ER, IN 47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
	failed to review and Preparedness Plan's at least annually in 483.73(a). This define occupants. Findings include: Based on records remaintenance Direct p.m., the EPP lacked could be found to shand updated within interview during remodocumentation with EPP Policies and Profit the last year. This fithe Maintenance Direct p.m. and Profit is the Maintenance p.m. and Profit is the Maintenance p.m. and Profit	view and interview, the facility I update the Emergency (EPP) Policies and Procedures accordance with 42 CFR icient practice could affect all eview and interview with the for (MD) on 04/16/25 at 12:15 d a cover page, and no date thow the EPP was reviewed the last year. Based on an cords review, the MD agreed was provided indicating the rocedure's was updated within inding was acknowledged by rector at the time of discovery t conference with the MD and present.	E 00	013	Preparation and/or executivis plan of correction does constitute admission or a by the provider of the trut facts alleged or conclusion forth in the statement of deficiencies. The plan of correction is prepared an executed solely because required by the provisions federal and state law. 1) Immediate actions take those residents identified. No Residents were idented in the deficiency. 2) How the facility identified to the residents: All residents have the post be affected by the alleged practice. All EP plans have cover page, and plans reand updated. 3) Measures put into plated system changes: All Staff have been educated location of EP plan. EP pupdated, reviewed and continuous place. 4) How the corrective active daily audit of EP plans for then every other week for then every other week for then monthly times 3 more ensure EP plans have reconstructed.	es not greement th of the ons set d/or it is s of centified dential to d deficient /e a viewed ce/ ated of blan over page ctions plete r 4 weeks r 8 weeks oths to	05/05/2025

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	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 155208 B. WING		(X3) DATE SURVEY COMPLETED 04/16/2025		
	PROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD DVER, 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)	DATE
				information and are updated reviewed	and
E 0029 SS=F Bldg	Development of C Based on record revitor review and update Preparedness Plan's least annually in acc 483.73(a). This definition occupants. Findings include: Based on records remaintenance Direct p.m., the EPP lacker could be found to sland updated within interview during record documentation with EPP Communication last year. This finding Maintenance Direct	view and interview with the or (MD) on 04/16/25 at 12:15 d a cover page, and no date now the EPP was reviewed the last year. Based on an cords review, the MD agreed was provided indicating the n Plan was updated within the ng was acknowledged by the or at the time of discovery and afterence with the MD and	E 0029	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 of 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 those residents identified: No Residents were identified to the residents: All residents have the potentified other residents: All residents have the potentified practice. All EP plans have a cover page, and plans review including EPP communication plan, and updated 3) Measures put into place/ System changes:	of ement if the set for fied al to ficient
				All Staff have been educated location of EP plan. EP plan updated, including EPP communication plan, reviewe	

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CENTERS FOR	MEDICARE & MEDIC				OMB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155208	B. WING		04/16/2025	
NAME OF PROVIDER OR SUPPLIER APERION CARE HANOVER CHAMARY STATEMENT OF REFIGIENCIE			410 W HANO\	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, 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 APPROPRIA DEFICIENCY)		
E 0030 SS=F Bldg	403.748(c)(1), 416 Names and Conta Based on record rev failed to ensure the communication plar contact information deficient practice co Findings include: Based on records re Maintenance Direct p.m., the facility's ocurrent. The commu an updated list of na for current staff. Th contact info was fro months ago) and he listed for facility pe This finding was ac Maintenance Direct	riew and interview, the facility emergency preparedness in includes (1) Names and for the current staff. This build affect all occupants. View and interview with the or (MD) on 04/16/25 at 12:18 communication plan was not unication plan did not include times and contact information the MD stated that most of the m the old ownership (13 did not recognize the names resonnel. knowledged by the or at the time of discovery and ofference with the MD and	E 0030	cover page in place 4) How the corrective actions will be monitored: Admin/Designee will completed daily audit of EP plans for 4 withen every other week for 8 withen monthly times 3 months ensure EP plans have required information and are updated a reviewed Preparation and/or execution this plan of correction does not constitute admission or agreed by the provider of the truth of facts alleged or conclusions is 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 if those residents identified: No Residents were identified other residents:	s ereeks reeks reeks to ed and of 05/05/2025 of ment the et	
	Executive Director	present.		All residents have the potential be affected by the alleged def practice. All EP plans have a		

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cover page, and plans reviewed

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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 04/16/2025			LETED		
	PROVIDER OR SUPPLIE N CARE HANOVER			410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD /ER, IN 47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
					and updated with current cont names 3) Measures put into place/ System changes:	act	
					All Staff have been educated location of EP plan. EP plan updated, reviewed and cover in place, and all contact name are current.	page	
					4) How the corrective action will be monitored:	s	
					Admin/Designee will complete daily audit of EP plans for 4 w then every other week for 8 w then monthly times 3 months ensure EP plans have require information and are updated a reviewed	reeks reeks to ed	
E 0036 SS=F Bldg	403.748(d), 416.5 EP Training and	64(d), 418.113(d), 441.1 Festing					
blug	failed review and u Preparedness Plan's Plan at least annua 483.73(a). This def occupants. Findings include: Based on records re Maintenance Direct p.m., the EPP lacked could be found to s and updated within	view and interview, the facility pdate the Emergency is (EPP) Training and Testing ally in accordance with 42 CFR received and interview with the eview and interview with the tor (MD) on 04/16/25 at 12:15 and a cover page, and no date how the EPP was reviewed the last year. Based on an cords review, the MD agreed	E 00	036	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 fithose residents identified:	ot ement the set	05/05/2025

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/16/2025	
	PROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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 APPROPRIA DEFICIENCY)	DATE
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			No Residents were identifi in the deficiency 2) How the facility identified other residents:		
	with the MD and Ex	xecutive Director present.		All residents have the potential be affected by the alleged definence. 3) Measures put into place/ System changes:	
				All Staff have been educated of location of EP plan. EP plan updated, reviewed and cover in place, and all contact name are current, Training and testin plan in place.	page s
				4) How the corrective actions will be monitored: Admin/Designee will complete daily audit of EP plans for 4 withen every other week for 8 withen monthly times 3 months to ensure EP plans have require information and are updated a reviewed	eeks eeks to
E 0037 SS=F Bldg	403.748(d)(1), 410 EP Training Progr	3.54(d)(1), 418.113(d)(am			
-	failed to conduct an Emergency Prepare facility must do all training in emergen procedures to all ne individuals providing	view and interview, the facility nual training for the dness Program (EPP). The LTC of the following: (i) Initial cy preparedness policies and w and existing staff, ng services under arrangement, sistent with their expected	E 0037	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 so forth in the statement of deficiencies. The plan of correction is prepared and/or	nt ment the

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	(X2) MULTIPLE C A. BUILDING B. WING	<u></u>	DMPLETED 1/16/2025
	PROVIDER OR SUPPLIEF		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R 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
	training at least ann documentation of a	mergency preparedness ually; (iii) Maintain Il emergency preparedness nstrate staff knowledge of		executed solely because it is required by the provisions of federal and state law.	
		res in accordance with 42 CFR deficient practice could affect acility.		Immediate actions taken for those residents identified:	
	Findings include: Based on records re	eview and interview with the		No Residents were identified in the deficiency 2) How the facility identified other residents:	
	p.m., there was no or Based on an interving review, the MD start program for staff to	documentation for EPP training. ew at the time of records ted the facility uses a computer aining but no documentation or unining was provided during the		All residents have the potential to be affected by the alleged deficient practice. 3) Measures put into place/ System changes:	
		for at the time of discovery and afterence with the MD and		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), 410 EP Testing Requi	3.54(d)(2), 418.113(d)(rements			
-	Based on record rev	view and interview, the facility	E 0039	Preparation and/or execution of	05/05/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. BUILDING COMPLETE		(X3) DATE SURVEY COMPLETED 04/16/2025	
	PROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIA DEFICIENCY)	
TAG	failed to conduct explan at least twice punannounced staff of procedures. The LT following: (i) Participate in an is community-based a. When a community-based function of the emergency plant of the emergen	ercises to test the emergency ser year, including drills using the emergency. C facility must do the annual full-scale exercise that driven a contain a contain an annual individual, sonal exercise. It is exercise an actual natural gency that requires activation and, the LTC facility is exempt ext required full-scale in a reindividual, facility-based are exercise for 1 year following that exercise that may similed to the following: the exercise that is rean individual, facility-based drill; or see or workshop that is led by a des a group discussion, using yerelevant emergency scenario, in statements, directed the ded questions designed to ency plan. C facility's response to and action of all drills, tabletop gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This build affect all occupants.	TAG	this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions of 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 to those residents identified: No Residents were identified the deficiency 2) How the facility identified other residents: All residents have the potentiable affected by the alleged defipractice. 3) Measures put into place/System changes: All Staff have been educated location of EP plan. EP plan updated, reviewed and cover in place, and all contact name are current, Training and testiplan in place. A full scale community based exercise is scheduled with the local fire department, which will be our second. 4) How the corrective action will be monitored:	ied of page es ng
		view and interview with the or (MD) on 04/16/25 at 12:20		Admin/Designee will complete	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. BUILDING COMP.		(X3) DATE SURVEY COMPLETED 04/16/2025	
	ROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	However, the facilit documentation of a documentation of a emergency prepared interview at the time	as able to provide tabletop exercise of choice. Ty was unable to provide full-scale exercise or any ctual events to test the thess plan. Based on the of record review, the MD ale exercise or documentation		daily audit of EP plans for 4 we then every other week for 8 we then monthly times 3 months the ensure EP plans have required information and are updated a reviewed The results of these audits we then monthly times 3 months to ensure EP plans have required information and are updated a reviewed	eeks d d nd
	of any actual events available for review This finding was ac	was not conducted or knowledged by the		be reviewed in Quality Assurance Meeting monthly months or until an average o 100 % compliance or greate	x6 f
		or at the time of discovery and afterence with the MD and present.		is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise t plan of correction as indicate	he
E 0041 SS=F Bldg		(e), 485.542(e), 485.62 LTC Emergency Power			
9	failed to implement inspection, testing, found in the Health 110, and Life Safety	riew and interview, the facility the emergency power system and maintenance requirements Care Facilities Code, NFPA y Code in accordance with 42 This deficient practice could	E 0041	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 set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is	t ment the
	Based on records re	view and interview with the or (MD) on 04/16/25 at 11:23		required by the provisions of federal and state law.	
	a.m., no documenta show the available p upon the generator	tion was available for review to percentage of load placed during monthly load tests. ew at the time of record review,		Immediate actions taken for those residents identified: No Residents were identified.	
	the Maintenance Di	rector stated he was unaware cord and keep a record of the		in the deficiency 2) How the facility identified	

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	OF CORRECTION	IDENTIFICATION NUMBER 155208	A. BUILDING B. WING		COMPLETED 04/16/2025
	PROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	REGULATORY OR percentage of load p during the monthly This finding was act Maintenance Direct	LSC IDENTIFYING INFORMATION placed upon the generator load tests. knowledged by the or at the time of discovery and ference with the MD and		CROSS-REFERENCED TO THE APPROPRIA	al to ficient and on how of uring set to there by the content and the content
				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	vill x6 of er

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. BUILDING B. WING		COMPLETED 04/16/2025	
	PROVIDER OR SUPPLIER N CARE HANOVER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243	
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	EMENT OF DEFICIENCIE IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				patterns and make recommendations to revise t plan of correction as indicate	· -
K 0000					
Bldg. 01	Department of Health in 483.90(a). Survey Date: 04/16/25 Facility Number: 00011 Provider Number: 1552 AIM Number: 1002910 At this Life Safety Code Hanover was found not Requirements for Partic Medicare/Medicaid, 42 Life Safety from Fire an National Fire Protection Life Safety Code (LSC) Health Care Occupancie This one story facility was a fire all detection in the corridor corridors, plus battery of all resident sleeping rood capacity of 125 and had of this visit. All areas where resident were sprinkled and all a services were sprinkled.	accordance with 42 CFR 15 108 108 108 108 108 108 108 108 108 108	K 0000	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 of 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.	nt ment the

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 04/16/2025			LETED	
	PROVIDER OR SUPPLIER			410 W I	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243		
K 0211 SS=E Bldg. 01	SUMMARY S (EACH DEFICIEN) REGULATORY OR wooden building ho generator which we Quality Review com NFPA 101 Means of Egress - Based on observation failed to ensure 1 of that lead from the fareadily accessible at practice could affect Findings include: Based on observation Maintenance Direct p.m. the exit dischart exit door and (2) the room marked facility area which had cars access to the publicy would be corrected park at the end of the This finding was acc Maintenance Direct	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION Dusing the emergency re not sprinkled. Inpleted on 04/23/25 General In and interview, the facility Fover 5 exit discharge paths acility to the public way was at all times. This deficient at 20 residents in the facility. In and interview with the for (MD) on 04/16/25 at 1:05 for path from (1) wing three for exit door from the dining for y exits, each led to the parking for parked and obstructing for way. The MD stated that this for the dividence of the parking that the sidewalk. In and interview with the facility to the sidewalk. In a state of the parking that the sidewalk is the sidewalk in the MD and the for at the time of discovery and the force with the MD and	K 0	HANOV ID PREFIX TAG		of the the et	(X5) COMPLETION DATE 05/05/2025
					Maintenance director placed a parking sign in the spot, and painted the parking spot as no parking allowed 4) How the corrective actions		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/16/2025		
	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0222 SS=F Bldg. 01	failed to ensure the facility exits was rewithout a clinical dissecurity measures. of egress shall not block that requires the egress side unless of 19.2.2.2.4. Door-lo permitted in accordance.	tion and interview, the facility means of egress through the adily accessible for residents agnosis requiring specialized Doors within a required means e equipped with a latch or e use of a tool or key from the therwise permitted by LSC cking arrangements shall be ance with 19.2.2.2.5.2. This buld affect all staff, visitors and	K 0222	Admin/Designee will complete daily audit of all entrances wit parking spaces for 4 weeks the every other week for 8 weeks monthly times 3 months to enall parking spaces are clear infront of sidewalks The results of these audits where the end of the end	then sure vill x6 of er the ed. 05/05/2025 the et		
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155208	B. W	NG		04/16/	2025
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			LAGRANGE RD		
APERIO	N CARE HANOVER	8		HANOVER, IN 47243			
		`		1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)	. ,	DATE
		ons and interview on 04/16/25			No Residents were identif	ied	
	during a tour of the facility with the Maintenance				in the deficiency		
	Director, the following was noted: a. at 12:35 p.m. The exit door to the front of the				2) How the facility identified other residents:		
	_				other residents.		
	building was not posted with the code to actuate the door release.				All residents have the potential	al to	
		e exit door near RR#65 was not			be affected by the alleged def		
	_	e to actuate the door release.			practice.	1010111	
	_	exit door near RR#51 was not			3) Measures put into place/		
	posted with the code to actuate the door release.				System changes:		
	d. at 1:03 p.m. the exit door, marked a facility exit,						
	leading out of the skilled nursing side into the				Maintenance director posted	a hint	
	Assisted Living side was not posted with the				for the code for all egress doc	ors	
	code to actuate the				above the keypad, quotes being		
	_	ectual exit door to the outside,			obtained to make doors Controlled		
		nto and through the assisted			Egress locking doors. Waiver has		
		posted with the code to			been requested until work can be		
	actuate the door rele			done to make doors with 15			
	_	ervice hall exit door was not			second egress Exit door near		
		e to actuate the door release.			room 65 was adjusted to be		
	-	xit doors from the Huntington's d with the code to actuate the			opened easily on first try. Exit		
	_	ocumentation of a clinical			door on wing 3 was adjusted to		
		ided for the Huntington's Unit			opened easily on the first try. The		
	residents.	race for the Hantington's Chit			exit door in the main dining room was adjusted so that it could be		
	Based on interview	at the time of each			opened easily on the first try.	50	
	observation, the Ma	aintenance Director					
		codes were not posted at the			4) How the corrective action	s	
	previously mention	ed exit doors.			will be monitored:		
		ation and interview, the facility			Admin/Designee will complete)	
		exterior exit doors were readily			daily audit of all egress doors	for	
		to open on first try. This			codes, and that all exit doors	-	
		ould affect all occupants in the			easily on the first try to be pos		
	facility.				for 4 weeks then every other		
	F: 1: : 1 1				for 8 weeks then monthly time	es 3	
	Findings include:				months to ensure all required		
	Događar store	ons and interview on 04/16/25			doors have codes posted, and		
					exit doors open easily on the	ıırSī	
during a tour of the facility with the Maintenance				try			

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 04/16/2025		
	ROVIDER OR SUPPLIER N CARE HANOVER	410 W I	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
	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 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.		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 to plan of correction as indicated.	x6 f r
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 agreed 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.	t ment he

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	(X2) MULTIPLE A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 04/16/2025
	PROVIDER OR SUPPLIEF		410 V	T ADDRESS, CITY, STATE, ZIP COD V LAGRANGE RD DVER, IN 47243	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	(X5) E COMPLETION DATE
		n is an approved existing practice could affect 12		1) Immediate actions taken those residents identified:	for
	Maintenance Direct p.m. the sliding gla outside courtyard w door was not posted Based on interview observations, the M an exit to the public courtyard door did posted. This finding was ac Maintenance Direct	ED stated the courtyard is not way and acknowledged the not have a "NO EXIT" sign knowledged by the cor at the time of discovery and afterence with the MD and		No Residents were ident in the deficiency 2) How the facility identified other residents: All residents have the potent be affected by the alleged depractice. 3) Measures put into place/System changes: No exit sign put on the slidin glass door to the courtyard other doors to courtyard aud for no exit signs, all doors to courtyard have no exit signs them. 4) How the corrective action will be monitored: Admin/Designee will comple daily audit of all courtyard dofor no exit signs for 4 weeks every other week for 8 week monthly times 3 months to eall doors to the courtyard have exit signs on them 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	g All lited on ns te pors s then s then nsure ve no will y x6 of ter

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/16/2025	
	PROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				will identify any trends or patterns and make recommendations to revise to plan of correction as indicate	-
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other				
	documentation for to fall battery operatoroms and through NFPA 101 in 4.6.12 features obvious to the Code, shall be maintained the manufacturer's publication of the requirements of 14.2.1.1.1 Inspection programs shall satistication code and conform to manufacturer's publication.	he preventative maintenance ed smoke alarms in resident the facility was complete. 2.3 states existing life safety the public, if not required by naintained. NFPA 72, 29.10 ests. Fire-warning equipment and tested in accordance with published instructions and per Chapter 14. NFPA 72, n, testing, and maintenance of the preventative maintenance of the service of the	K 0300	Preparation and/or execution of this plan of correction does no constitute admission or agreed 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:	t ment he et
	Maintenance Direct complete itemized l maintenance of resi	eview and interview with the for on 04/16/25 at 12:06 p.m., a sist for preventative dent room battery operated not available for review. Based		All residents have the potentia be affected by the alleged defipractice. 3) Measures put into place/ System changes:	
	was available to ref when the appliances that he was unsure v	or stated no documentation lect the age of the batteries, s are tested or cleaned and what the manufacturer		All resident room smoke detect have been inspected, cleaned, new batteries put in them and be audited according to policy	, will
	recommendation wa	as regarding testing and		4) How the corrective actions	;

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER 155208	A. BUILDING <u>01</u> COMPLETED B. WING 04/16/2025				
		100200	D. W1	_		04/10/	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD		
APERION	N CARE HANOVER				/ER, IN 47243		
(X4) ID		ARY 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 DEFICIENCY)	TE	COMPLETION
TAG	cleaning frequency.	LSC IDENTIFYING INFORMATION		TAG	will be monitored:		DATE
		or at the time of discovery and ference with the MD and			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		
K 0321 SS=E	NFPA 101 Hazardous Areas	- Enclosure			recommendations to revise t plan of correction as indicate	-	
Bldg. 01	failed to ensure that doors, such as a stor with a self-closing of could affect up to 10. Findings include: 1. Based on observa Maintenance Direct p.m. the kitchen sto small dining room, contained at least 20 boxes. The corridor provided with a self	on and interview, the facility 2 of over 20 hazardous area rage room door, was provided device. This deficient practice 0 residents and staff. attion and interview with the or (MD) on 04/16/25 at 1:05 rage room attached to the over 50 square feet in size, 0 medium and large cardboard or door to this room was not 0-closing device. This was aintenance Director at the time	K 0.	321	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 of 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	or	05/05/2025

	T OF DEFICIENCIES OF CORRECTION	S X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 04/16/2025	
	PROVIDER OR SUPPLIER		410	EET ADDRESS, CITY, STATE, ZIP COD W LAGRANGE RD NOVER, IN 47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPRO	ON (X5) D BE COMPLETION DATE	
	2. Based on observa Maintenance Direct p.m. 1 of 2 doors so the kitchen serving self-closing device, positively into the d This finding was ac Maintenance Direct	tion and interview with the or (MD) on 04/16/25 at 1:36 eparating the dining area from area, equipped with a failed to self-close and latch door frame. knowledged by the or at the time of discovery and afterence with the MD and		2) How the facility identification other residents: All residents have the pote be affected by the alleged practice. 3) Measures put into place System changes: Kitchen storage room door self-closer installed. Both of separating the dining area kitchen serving area have adjusted to close and latch boxes have been removed floor. All storage areas instand no boxes on the floor. 4) How the corrective activities monthly times 3 months to all doors close and latch as required and not storage at have boxes on the floor. The results of these audit be reviewed in Quality Assurance Meeting mont months or until an average 100 % compliance or greats achieved x3 consecutive months. The QA Commit will identify any trends or patterns and make	ed Intial to deficient e/ I had a doors from the been I. All from the spected ions lete doors (s then eks then ensure s reas ts will hly x6 ge of eater //e tee	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 04/16/2025				
	PROVIDER OR SUPPLIER			410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD /ER, 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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities				plan of correction as indicate	ed.	
	failed to provide an returning cooking a when the kitchen he was designed and ir extinguishing syster Ventilation Control Commercial Cookin Edition Section 12. appliances requiring moved, modified, o re-evaluation of the the system installer otherwise allowed be extinguishing syster fire-extinguishing syster fire-extinguishing syster fire-extinguishing system of the purpocleaning, provided the approved design locoperations, and any fire-extinguishing system appliances are recommanufacturer's liste 12.1.2.3.1 An approximate that will ensure that an approved design practice affected 6 systems. Findings include: Based on observation Maintenance Direct p.m. the electric who	on and interview, the facility approved method for ppliances to where they were odd extinguishing equipment installed for 1 of 1 kitchen hood on. NFPA 96 Standard for and Fire Protection of and Operations Section 2011 1.2.2 states that cooking a protection shall not be a rearranged without prior after-extinguishing system by or servicing agent, unless by the design of the fire on. Section 12.1.2.3 The system shall not require the cooking appliances are obes of maintenance and the appliances are returned to be action prior to cooking disconnected system nozzles attached to the anected in accordance with the design manual. Section oved method shall be provided the appliance is returned to location. The deficient staff, and no residents.	K 0	324	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 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 be affected by the alleged defipractice. 3) Measures put into place/ System changes: Lines have been painted on the floor for the stove to be placed kept while in use. 4) How the corrective actions will be monitored: Admin/Designee will complete daily audit of stove location to	t ment the the et	05/05/2025

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AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155208	B. W	NG		04/16/	2025
	ROVIDER OR SUPPLIER			410 W L	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
	approved method th appliance was return location after it had and cleaning. Based the facility was not should be provided was returned to an a maintenance or clean This finding was ac Maintenance Direct	knowledged by the or at the time of discovery and ference with the MD and			ensure it is in painted lines for weeks then every other weeks weeks then monthly times 3 months to ensure stove is in designated location 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 to plan of correction as indicated.	for 8 vill x6 f br	
K 0345 SS=F Bldg. 01	failed to maintain 1 accordance with NF Sections 19.3.4.5.1 14.3.1 states that un 14.3.2, visual insped accordance with the more often if requiripurisdiction. Table must be visually ins a. Control unit troub. Remote annuncia c. Initiating devices fire alarm boxes, he etc.) d. Notification applie. Magnetic hold-op	riew and interview, the facility of 1 fire alarm systems in PA 72, as required by LSC 101 and 9.6. NFPA 72, Section less otherwise permitted by ctions shall be performed in schedules in Table 14.3.1, or ed by the authority having 14.3.1 states that the following pected semi-annually: ble signals tors (e.g. duct detectors, manual at detectors, smoke detectors,	K 0	345	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 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:	or	05/05/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/16/2025	
	ROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance Direct documentation coul visual semi-annual During the survey the telephoned the vendo	view and interview with the or on 04/16/25 at 11:43 a.m., no d be provided regarding a fire alarm system inspection. The maintenance Director lor who stated that they did annual visual inspection of m.		All residents have the potential be affected by the alleged definenctice. 3) Measures put into place/ System changes: Semi annual fire alarm system inspection scheduled, contract signed with vendor to continuinspections at required times.	ricient n ot e
	again at the exit cor Executive Director 3.1-19(b)	or at the time of discovery and afterence with the MD and		4) How the corrective action will be monitored: Admin/Designee will complete daily audit of Fire alarm syste inspection for 4 weeks then expected other week for 8 weeks then monthly times 3 months to entire alarm inspections have been done as scheduled The results of these audits who 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.	e m every sure vill x6 of er
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System	- Installation			
-		on and interview, the facility quate signage for 1 of 1 fire	K 0351	Preparation and/or execution this plan of correction does no	

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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	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 04/16/2025	
	PROVIDER OR SUPPLIE		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, IN 47243		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIENT REGULATORY OF DEPICION REGULATORY OF DEPICION AND ASSESSION OF SETTING ASSESSIO	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION tion (FDC). NFPA 25, Standard Testing, and Maintenance of Protection Systems, 2011 Department Connections. 13.7.1 Innections shall be inspected the following: ment connections are visible vivels are not damaged and re in place and undamaged. place and in good condition. Igns are in place. e is not leaking. drain valve is in place and ment connection clapper(s) is in g properly. tice could affect all residents.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATION OF CONSTITUTE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATION OF CONSTITUTE ACTION OF THE APPROPRIATION OF THE PROVIDER OF THE PROVIDER OF THE APPROPRIATION OF THE PROVIDER OF THE APPROPRIATION OF THE	DATE COMPLETION DATE ceement of the s set or is of ntified ced ntial to deficient	
	Maintenance Direct p.m. the FDC locat was not provide withat was legible. The tothe point that the The MD agreed the white and no letter understood. This finding was as Maintenance Direct	on and interview with the tor (MD) on 04/16/25 at 12:40 ed near the front parking lot th a FDC identification sign ne signage provided was faded eletters were not discernable. At the signage was faded to all son the sign could be eknowledged by the tor at the time of discovery and inference with the MD and present.		System changes: Faded FDC sign replaced venew one. 4) How the corrective action will be monitored: Admin/Designee will compled daily audit of Fire alarm systems inspection for 4 weeks the monthly times 3 months to sign in place an clearly visit faded The results of these audits be reviewed in Quality	ete stem n every n ensure ole, not	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ í	PLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDI B. WING	NG <u>01</u>	COMPLETED
		155208	B. WING		04/16/2025
	PROVIDER OR SUPPLIE N CARE HANOVEF		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD 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	PREF	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TA	G DEFICIENCY)	DATE
				Assurance Meeting monthly months or until an average 100 % compliance or great is achieved x3 consecutive months. The QA Committed will identify any trends or patterns and make recommendations to revise plan of correction as indicated	of eer e the
K 0353	NFPA 101				
SS=F Bldg. 01		- Maintenance and Testing			
	failed to maintain I accordance with LS automatic sprinkler and maintained in a Standard for the In Maintenance of Wa Systems. NFPA 25 sprinkler piping shaloads by materials a hung from the pipe	ation and interview, the facility of 1 sprinkler system in SC 9.7.5. LSC 9.7.5 requires all expected accordance with NFPA 25, spection, Testing, and ater-Based Fire Protection 5, 2011 edition, 5.2.2.2 requires all not be subjected to external either resting on the pipe or This deficient practice could in two smoke compartments.	K 0353	Preparation and/or execution this plan of correction does not constitute admission or agreed by the provider of the truth of facts alleged or conclusions of 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 those residents identified:	ot ement i the set
	Maintenance Direct attic above the elect contained wire and sprinkler head. Add near the attic entral location, had a growt to the sparkler pipe. This finding was add Maintenance Direct.	eview and interview with the tor on 04/16/25 at 2:25 p.m., the strical closet on wing four conduit draped across the ditionally, the sprinkler pipe ace, at this aforementioned unding collar and wire attached according to the tor at the time of discovery and an according to the tor at the time of discovery and an according to the tor at the time of discovery and an according to the tor at the time of discovery and an according to the tor at the time of discovery and an according to the tor at the time of discovery and an according to the tor at the time of discovery and an according to the tor at the time of discovery and an according to the tor at the time of discovery and according to the tor at the time of discovery and according to the tor at the time of discovery and according to the tor at the time of discovery and according to the tor at the time of discovery and according to the torus according to t		No Residents were identified in the deficiency 2) How the facility identified other residents: All residents have the potentified be affected by the alleged depractice. 3) Measures put into place/ System changes: All sprinkler pipes Inspected no conduit of wires are drape	al to ficient and

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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 04/16/2025			
	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 LSC IDENTIFYING INFORMATION present.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) them. The grounded wire was	DATE		
	2. Based on record of facility failed to ma accordance with LS automatic sprinkler and maintained in a Standard for the Ins Maintenance of Wa Systems. NFPA 25 indicates the require testing. NFPA 25, 5 pipe sprinkler system and gauges on dry so inspected weekly to pressure is being mastates valves should valves secured lock shall be permitted to	review and interview, the intain 1 of 1 sprinkler system in C 9.7.5. LSC 9.7.5 requires all systems shall be inspected ecordance with NFPA 25, pection, Testing, and ter-Based Fire Protection, 2011 edition, Table 5.1.1.2 and frequency of inspection and .2.4.1 states gauges on wet must shall be inspected monthly systems (5.2.4.2) shall be ensure normal water or air aintained. NFPA 25 13.3.2.1 be inspected weekly or so or supervised (13.3.2.1.1) to be inspected monthly. This build affect all occupants.		removed from the pipe on wing and no other wires were found be grounded during the inspect of all pipes. Weekly inspection dry pipe sprinkler systems gat and valves has been complete every week since July 2024 at will continue to be completed. 4) How the corrective actions will be monitored: Admin/Designee will complete weekly audit of 1 wings sprink pipes, and weekly inspection sheet of dry pipe gauges and valves. For 4 weeks then ever other week for 8 weeks then monthly times 3 months to ensall sheets and inspections are being done.	g 4 I to ction of uges ed and		
	Based on records re Maintenance Direct there was no weekly sprinkler system's g weeks prior to July the time of record re Director stated the i valves before July 2 previous Maintenan This finding was ac Maintenance Direct	knowledged by the or at the time of discovery and ference with the MD and		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 or he		

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MVST21

Facility ID: 000115

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155208	B. W	B. WING			/2025
APERION	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243			
(X4) ID		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	.TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	_	TAG DEFICIENCY)		DATE	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation failed to ensure all key provided with a meadoor closed, had no latching and would at This deficient practic staff. Findings include: Based on observation Maintenance Direct p.m. the kitchen door propped open with a interview at the time acknowledged the dused to hold open the This finding was act Maintenance Direct.	knowledged by the or at the time of discovery and afterence with the MD and	K 0	363	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 of 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 be affected by the alleged defining practice. 3) Measures put into place/System changes: All fire doors audited to ensure 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 of the stops for 4 weeks then every	of of of ment the et	05/05/2025
					week for 8 weeks then monthl times 3 months to ensure no contact the state of the s	-	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUI		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/16/2025	
	PROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD VER, 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				tops are being used. The results of these audits with be reviewed in Quality Assurance Meeting monthly of 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 indicate	k6 f r
K 0712 SS=C Bldg. 01	failed to conduct que unexpected days and varying conditions. affect all residents, Findings include: Based on records resident and the month, and month. These conditions conducted on une days. This finding was ac Maintenance Direct	or at the time of discovery and afterence with the MD and	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 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 be affected by the alleged deficiency. 3) Measures put into place/ System changes: Fire drills are scheduled at more	e it r ed to cient

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	OF CORRECTION	IDENTIFICATION NUMBER 155208	A. BUILDING B. WING	01	COMPLETED 04/16/2025		
	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				random times throughout to m 4) How the corrective actions will be monitored: Admin/Designee will complete daily audit of schedule of fire of for 4 weeks then every other v for 8 weeks then monthly time months to ensure fire drills are unexpected and random times the month. The results of these audits where the month of these audits where the month of	drills veek s 3 e at s of vill x6 f		
K 0741 SS=E Bldg. 01	failed to ensure 1 of with metal or nonco self-closing cover. Taffect 10 people in t Findings include: Based on observation Maintenance Director p.m. in the smoking noncombustible com	on and interview the facility 22 smoking areas was provided mbustible containers with This deficient practice could he smoking area. on and interview with the or (MD) on 04/16/25 at 1:05	K 0741	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 of 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	of 05/05/2025 It ment the et		

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	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155208	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/16/2025		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ON (X5) BE COMPLETION DATE		
	loose in temporary emptied once not in temporary uncovere be emptied into the after each use. This finding was ac Maintenance Direct	receptacles which were not a use. The MD stated that the ed receptacles would need to red noncombustible receptacle eknowledged by the tor at the time of discovery and inference with the MD and		No Residents were identified in the deficiency 2) How the facility identified other residents: All residents have the potent be affected by the alleged of practice. 3) Measures put into place System changes: All temporary uncovered receptacles have been remand replaced with proper receptacles for used cigare butts 4) How the corrective activatility and the week for 8 week monthly times 3 months to no uncovered temporary receptacles are being used only proper covered receptacles are being used only proper covered receptare being used. The results of these audits be reviewed in Quality Assurance Meeting monthmonths or until an average 100 % compliance or greis achieved x3 consecutive months. The QA Committed will identify any trends or patterns and make	ed Intified Intial to deficient Indial to defici		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M				X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL		
		155208	B. W	NG		04/16/	04/16/2025	
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	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 DEFICIENCY)		TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1.2	DATE	
					recommendations to revise t plan of correction as indicate			
K 0761	NFPA 101							
SS=F	Maintenance, Insp	ection & Testing - Doors						
Bldg. 01		on, records review, and	K 0	761			05/05/2025	
		ty failed to ensure annual			Preparation and/or execution of			
		ng of all fire door assemblies			this plan of correction does no			
	_	accordance of LSC 19.1.1.4.1.1			constitute admission or agreer			
		nings in dividing fire barriers			by the provider of the truth of t			
	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				facts alleged or conclusions se	₽₹		
					forth in the statement of			
					deficiencies. The plan of			
		Table 8.3.4.2 shall be			correction is prepared and/or executed solely because it is			
		red, listed, labeled fire door			required by the provisions of			
		window assemblies and their			federal and state law.			
		ware, including all frames,			rederar and state law.			
	closing devices, and				1) Immediate actions taken for	or		
	_	requirements of NFPA 80,			those residents identified:	-		
		oors and Other Opening						
	Protectives, except	as otherwise specified in this			No Residents were identifi	ed		
	Code. NFPA 80 5.2	.1 states fire door assemblies			in the deficiency			
	shall be inspected as	nd tested not less than			2) How the facility identified			
	· ·	ten record of the inspection			other residents:			
	_	kept for inspection by the						
		.4.1 states fire door assemblies			All residents have the potentia			
		pected from both sides to			be affected by the alleged defi	cient		
		ondition of door assembly.			practice.			
	•	ates as a minimum, the			3) Measures put into place/			
	following items sha				System changes:			
	either the door or fra	r breaks exist in surfaces of			Annual fire door inspection	1		
		light frames, and glazing beads			has been completed and will continue to be completed as			
		ely fastened in place, if so			scheduled.			
	equipped.	in place, if so			Soriodulou.			
		, hinges, hardware, and			4) How the corrective actions	.		
		eshold are secured, aligned,			will be monitored:	•		
		er with no visible signs of						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/16/2025		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 410 W LAGRANGE RD HANOVER, IN 47243			
APERION (X4) ID PREFIX TAG	summary: (EACH DEFICIEN REGULATORY OR damage. (4) No parts are mis (5) Door clearances listed in 4.8.4 and 6 (6) The self-closing the active door com from the full open p (7) If a coordinator closes before the ac (8) Latching hardward door when it is in th (9) Auxiliary hardward prohibit operation a frame. (10) No field modif have been performe (11) Gasketing and	statement of Deficiencie CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION using or broken. do not exceed clearances 3.1.7. device is operational; that is, pletely closes when operated position. is installed, the inactive leaf tive leaf. are operates and secures the ne closed position. are items that interfere or are not installed on the door or ications to the door assembly d that void the label. edge seals, where required, are			every sure ed. vill x6 of er	
	This deficient pract Findings include: Based on records re Maintenance Direct documentation of at door assemblies wa on observation duri around 12:35 p.m., where the Skilled N Assisted Living Are Transfilling/Storage the time of records Director stated an a not completed withi This finding was ac Maintenance Direct	knowledged by the or at the time of discovery and afterence with the MD and		plan of correction as indicat	ed.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY	
AND PLAN	OF CURRECTION	IDENTIFICATION NUMBER 155208	B. W		<u>U I </u>	- COMPLETED 04/16/2025	
		100200		_	ADDRESS SITE OF THE SOR	0 17 1 07	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD		
APERION	N CARE HANOVER			HANOVER, IN 47243			
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	-	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	3.1-19(b)	LSC IDENTIFYING INFORMATION		TAG	DET TOTELNOT?		DATE
	3.1-19(0)						
K 0918	NFPA 101						
SS=F	Electrical Systems	s - Essential Electric Syste					
Bldg. 01							
		riew and interview, the facility	K 0	918	Preparation and/or execution		05/05/2025
		e generator for 12 of 12 months			this plan of correction does not		
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				constitute admission or agree			
					by the provider of the truth of the facts alleged or conclusions so		
				forth in the statement of	<i>-</i> 1		
	_	e emergency electrical system			deficiencies. The plan of		
	-	with NFPA 110, Chapter 8.			correction is prepared and/or		
	NFPA 110 Section 8.4.2 states diesel generator				executed solely because it is		
		be exercised at least once			required by the provisions of		
		mum of 30 minutes, using one			federal and state law.		
	of the following me						
		intains the minimum exhaust recommended by the			1) Immediate actions taken for those residents identified:	or	
	manufacturer	recommended by the			those residents identified.		
		temperature conditions and at			No Residents were identifi	ed	
		cent of the EPS (Emergency			in the deficiency		
	Power Supply) nam	-		2) How the facility identi			
		es diesel-powered EPS			other residents:		
		not meet the requirements of					
		sed monthly with the available			All residents have the potentia		
		Power Supply System) load and nually with supplemental			be affected by the alleged def	icient	
		n 50 percent of the EPS			practice. 3) Measures put into place/		
		g for 30 continuous minutes			System changes:		
	_	75 percent of the EPS			Monthly load test has been	n	
	nameplate kW rating	g for 1 continuous hour for a			completed for current month.		
		f not less than 1.5 continuous			Monthly load tests are schedu	led	
	•	.2 of NFPA 99 requires a			and will be documented every		
		spection, performance,			month to include percentage of		
		nd repairs for the generator to			load placed upon the generate		
		ned and available for thority having jurisdiction.			during testing moving forward		
		ice could affect all occupants.			4) How the corrective actions	•	
	This deficient practi	co coura arroot air occupants.			will be monitored:	•	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155208	B. WI	NG		04/16/	2025
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				_AGRANGE RD		
ADEDION							
APERION CARE HANOVER			паноч	'ER, 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Findings include:						
					Admin/Designee will complete		
	Based on records review and interview with the Maintenance Director on 04/16/25 at 11:23 a.m., no				weekly audit of generator load	test	
					for 4 weeks then every other w	veek	
	documentation was	available for review to show			for 8 weeks then monthly times	s 3	
	the available percen	tage of load placed upon the			months to ensure generator lo	ad	
	-	onthly load tests. Based on an			test are being completed		
	interview at the time	e of record review, the					
		or stated he was unaware that			The results of these audits w	ill	
		and keep a record of the			be reviewed in Quality		
	percentage of load placed upon the generator during the monthly load tests.				Assurance Meeting monthly		
					months or until an average o		
					100 % compliance or greate	r	
This finding was acknowledged by the				is achieved x3 consecutive			
		or at the time of discovery and			months. The QA Committee		
	-	ference with the MD and			will identify any trends or		
	Executive Director	present.			patterns and make		
					recommendations to revise t	-	
	3.1-19(b)				plan of correction as indicate	ed.	
K 0920	NFPA 101						
SS=E		ent - Power Cords and					
Bldg. 01	Extens						
	1. Based on observa	ation and interview, the facility	K 0920		Preparation and/or execution of		05/05/2025
	failed to ensure 2 of	2 power strips were not used			this plan of correction does no		
	as a substitute for fi	xed wiring to provide power			constitute admission or agreer	nent	
	equipment with a hi	gh current draw.			by the provider of the truth of t	he	
	NFPA-70/2011, 400	0.8 state unless specifically			facts alleged or conclusions se	et .	
	permitted in 400.7 f	lexible cords and cables shall			forth in the statement of		
	not be used for (1) a	s a substitute for fixed wiring.			deficiencies. The plan of		
	This deficient practi	ice could affect up to 3			correction is prepared and/or		
	residents in therapy	and 2 staff in the MDS office.			executed solely because it is		
					required by the provisions of		
	Findings include:				federal and state law.		
	Based on observation	on and interview with the			1) Immediate actions taken fo	or	
	Maintenance Direct	or (MD) on 04/16/25 at 12:42			those residents identified:	ļ	
		apy Office area, a dorm style				ļ	
	* '	np draw appliance) was			No Residents were identifi	ed	
		r strip. (b) at 12:45 p.m. in the			in the deficiency		
	· -	_	1		i .	I.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COM		COMPL	ETED	
		155208	B. W	ING		04/16/2025	
				CTD DET	ADDRESS CITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD LAGRANGE RD		
ΔDEDIΩN	N CARE HANOVER	2			/ER, IN 47243		
AFERIO	N CARE HANOVER	·	_	TIANOV	TLIN, IIN 41240		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE A		ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		n style refrigerator (high amp			2) How the facility identified		
	* *	as powered by a power strip.			other residents:		
		mini refrigerators would need					
	to be plugged direc	tly into the wall.			All residents have the potenti		
	Tl.:- £ 1'	.11 - 1 1 1 41.			be affected by the alleged de	ricient	
	-	cknowledged by the			practice.		
		tor at the time of discovery and needed on the modern of t			3) Measures put into place/		
	Executive Director				System changes:	ed	
	Executive Director present.				All refrigerators are plugg into wall outlet. Power strips i		
	2 Based on observ	ation and interview, the facility			resident rooms 51, 39 and 36		
		wer strips in resident rooms			been changed to approved he		
	-	of 1363A or 60601-1. Patient		grade surge protectors. A		-	
	care vicinity is defined as a space, within a				of all rooms was done and all		
	location intended for the examination and			surge protecters have been			
		ts, extending 6 feet beyond the		replaced with hospital grade surge		surge	
		the bed, chair, table, treadmill,			protectors.	3	
		supports the patient during					
		eatment. A patient care vicinity			4) How the corrective action	s	
	extends vertically to	o 7 feet 6 inches above the			will be monitored:		
	floor. This deficien	t practice affects 4 residents					
	and staff.				Admin/Designee will complete	Э	
					weekly audit of 5 resident roo		
	Findings include:				for 4 weeks then every other		
					for 8 weeks then monthly time		
		on and interview with the			months to ensure all refrigera	tors	
		tor (MD) on 04/16/25 during			are plugged into the wall and		
		wer strips lacking a UL rating			approved surge protectors an	е	
		-1 label were observed in the			being used.		
	following locations					•••	
	a) at 1:06 p.m. Res				The results of these audits v	VIII	
	b) at 1:12 p.m. Res c) at 1:15 p.m. Res				be reviewed in Quality	6	
	() at 1:13 p.m. Kes	ident Koon # 30			Assurance Meeting monthly		
	This finding was a	cknowledged by the			months or until an average of 100 % compliance or great		
	_	tor at the time of discovery and			is achieved x3 consecutive	El	
		nference with the MD and			months. The QA Committee		
	Executive Director				will identify any trends or	7	
	LACCULTE DIRECTOR	present.			patterns and make		
	3.1-19(b)				recommendations to revise	the	
	(-)						1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING		COMPI	X3) DATE SURVEY COMPLETED 04/16/2025				
	PROVIDER OR SUPPLIER		4	110 W L	DDRESS, CITY, STATE, ZIP COD AGRANGE RD ER, IN 47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID EFIX ſAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) plan of correction as indicate		(X5) COMPLETION DATE
K 0921 SS=F Bldg. 01	interview, the facility required maintenance and us receive continuous practice affects all reliable to the facility required maintenance and us receive continuous practice affects all reliable to the facility required to	view, observation, and ty failed to conduct the ce and maintain complete aspections for Patient Care equipment (PCREE). NFPA 99 and 10.3 and 10.5 states the esistance, leakage current, and for fixed and portable PCREE aired in 10.3. Testing intervals policies and protocols. All ent care rooms is tested in 3.5.4 or 10.3.6 before being put er any repair or modification. In the fixed and portable policies and protocols are several electrical rates compliance with NFPA stem. Service manuals, poedures provided by the de information as required by considered in the development retrical equipment maintenance available, and safety labels rating instructions on the e. A record of electrical pairs, and modifications is griod of time to demonstrate redance with the facility's esponsible for the testing, e of electrical appliances training. This deficient	K 092	1	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 agreed by the provider of the truth of a facts alleged or conclusions of 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 be affected by the alleged defipractice. 3) Measures put into place/ System changes: All PCREE items tested, if failed it was replaced, all equipment tested logged. Any new equipment will be tested.	of ot ment the et ied icient	05/12/2025

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155208		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 04/16/2025			
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		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA 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.			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	STANDARDS 3.1-19(a) The facility constructed, equippe the health and safety the public. 3.1-19(ff)(3) Have a smoke detector in each, 2012. This State Rule has	y must be designed, ed, and maintained to protect y of residents, personnel, and battery operated or hard-wired ach resident's room before July not been met as evidenced by:	K 9999	Preparation and/or execution this plan of correction does not constitute admission or agreed by the provider of the truth of facts alleged or conclusions of 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:	ot ment the et		
Based on observation and interview, the facility							

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMI	COMPLETED		
		155208	B. WING		04/16/2025				
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP COD				
				410 W LAGRANGE RD					
APERION CARE HANOVER			HANOVER, IN 47243						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COM-				
TAG			TAG DEFICIENCY)			DATE			
	failed to provide a smoke detectors in 1 of over 30			No Residents were identified					
	resident sleeping rooms. This deficient practice		in the deficiency						
	could affect over 10	residents, staff, and visitors	2) How the facility identif		ed				
	in the vicinity of Room 65.			other residents:					
	Findings include:		All residents have the pote		ntial to				
					be affected by the alleged	be affected by the alleged deficient			
	Based on observation and interview with the			practice.					
	Maintenance Director (MD) on 04/16/25 at 1:45				3) Measures put into place	s put into place/			
	p.m. all resident sle	eeping rooms in the facility		System changes:					
	were equipped with a smoke detector except			Smoke detecto		l in			
	resident sleeping Room 65. A ceiling mounted			room 65. Audit done of all					
	ring to affix a smoke detector was noted in the			resident rooms, all rooms have a					
		detector was mounted in the		operating smoke detector.					
	mounting ring. Based on interview at the time of								
	the observations, the MD agreed resident				4) How the corrective actions				
	sleeping Room 65 was not currently provided with			will be monitored:					
	a smoke detector and contacted an assistant to								
	have it installed.		Admin/Designee will complete						
			weekly audit of 5 resident roor						
	This finding was acknowledged by the		for 4 weeks then every other week			er week			
		or at the time of discovery and			for 8 weeks then monthly				
again at the exit conference with the						months to ensure all resident			
	Executive Director present.				rooms have operating sme	ke			
					detectors				
	3.1-19(b)								
	3.1-19(ff)(3)				The results of these audi	s will			
				be reviewed in Quality					
				Assurance Meeting monthly		-			
				months or until an					
					100 % compliance or greater				
				is achieved x3 consecuti					
			months. The QA Committee						
			will identify any trends or						
				patterns and make					
					recommendations to rev				
					plan of correction as indicated.				
					I		1		

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